(5) Amended

a. tii i i iiaiioi i	a. ejeteme	/ C.I			00	0 0 0	. <b>_</b>
	required by law (42 USC 1395g; 4					FORM APPROV	'ED
payments made	since the beginning of the cost r	reporting period being	deemed overpay	ments (42	2 USC 1395g).	OMB NO. 093	8-0050
						EXPIRES 09-	30-2025
HOSPITAL AND H AND SETTLEMENT	IOSPITAL HEALTH CARE COMPLEX COST SUMMARY	REPORT CERTIFICATION	Provider CCN: 1		From 01/01/2023 To 12/31/2023		repared:
PART I - COST	REPORT STATUS						
Provi der	1. [ X ] Electronically prepared o	cost report			Date: 5/23/202	Z4 Time:	9:53 am
use only	2. [ ] Manually prepared cost re	eport					
	3. [ 0 ] If this is an amended rep 4. [ F ] Medicare Utilization. Ent					ost report	
Contractor use only	(1) As Submitted 7. Co	ate Received: ontractor No. N ]Initial Report fo N ]Final Report for	r this Provider this Provider C	11. Co CCN 12. [	PR Date: ontractor's Vendo 0]If line 5, co number of tim	lumn 1 is 4:	

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

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 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 01/01/2023 and ending 12/31/2023 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.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONI C	
	1			SIGNATURE STATEMENT	
1	Jean	ne Wickens	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Jeanne Wickens			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

	·		Ti tle XVIII				
		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	263, 980	30, 857	0	0	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2.00
3.00	SUBPROVI DER - I RF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	TOTAL	0	263, 980	30, 857	0	0	200.00
The ab	ove amounts represent "due to" or "due from"	the applicable	program for t	he element of	the above compl	ex 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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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

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 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/23/2024 9:53 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: P0 Box: 728 1.00 Street: 401 SAWYER ROAD 1.00 Zip Code: 46755-0728 County: NOBLE 2.00 City: KENDALLVILLE State: IN 2.00 Provi der Component Name CCN CBSA Payment System (P, T, 0, or N)
V | XVIII | XIX Certi fi ed Number Number Туре 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 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 10.00 Hospi tal -Based NF 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 Hospi tal -Based (CORF) I 17.10 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2023 12/31/2023 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 UCPs, including supplemental UCPs, for N Ν 22 01 this 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) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν 22.02 Ν 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. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? 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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0146 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/23/2024 9:53 am 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 paid days eligible Medi cai d Medi cai d days unpai d pai d days el i gi bl e days unpai d 1.00 2. 00 3.00 4. 00 5. 00 6. 00 24.00 If this provider is an IPPS hospital, enter the 20 858 61 24.00 163 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in 0 35.00 effect in the cost reporting period. Endi ng: Begi nni ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 36 00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 01/01/2023 12/31/2023 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν N 40.00 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX V 1. 00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N N N 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N 47.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 Ν N Ν 48.00 Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? For cost reporting 56.00 Ν 56.00 periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, Ν 57.00 is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.

HUSPI I	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider CC		Period: From 01/01/2 To 12/31/2		Part I Date/Time Pre 5/23/2024 9:5	pared:
				•		V	XVIII XIX	
58. 00	If line 56 is yes, did this facility elect cost reimb	oursemen	t for physici	ans' services	as	1. 00 N	2.00 3.00	58.00
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complet	e Wkst. D-5.					
59. 00	Are costs claimed on line 100 of Worksheet A? If yes	s, compl	ete Wkst. D-2	, Pt. I. NAHE 413.85	Worksheet	N F A	Pass-Through	59.00
				Y/N	Li ne #		Qualification Criterion Code	
				1. 00	2. 00		3. 00	
60.00	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 colis "Y", are you impacted by CR 11642 (or subsequent (adjustment? Enter "Y" for yes or "N" for no in colur	.85? (s lumn 1. CR) NAHE	ee If column 1	N				60.00
	adjustilient: Enter 1 for yes of N for no fire cordi	Y/N	IME	Direct GME	IME		Direct GME	
		1. 00	2. 00	3. 00	4. 00		5. 00	-
61. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			_	0. 00		61.00
61. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)							61.01
61. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)							61.02
61. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see							61.03
61. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the							61. 04
61. 05	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line							61. 05
61. 06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)							61.06
		Pro	gram Name	Program Code	IME FTE Co		Unweighted Direct GME FTE Count	
61 10	Of the FTEs in line 61.05, specify each new program		1. 00	2. 00	3. 00	0. 00	4.00	61. 10
01.10	specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.					0.00	0. 00	01.10
61. 20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.					0. 00	0. 00	61. 20
							1. 00	
	ACA Provisions Affecting the Health Resources and Se							
62. 00	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc		in this cost	reporting pe	riod for whi	i ch	0.00	62.00
62. 01	Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC pro	a Teachi gram. (s	ee instructio		o your hospi	i tal	0. 00	62.01
63. 00	Teaching Hospitals that Claim Residents in Nonprovider set when the set of th	ettings	during this c			ter	N	63. 00

Health Financial Systems	COMMUNITY HOSPITAL OF	NOBLE CTY, INC	In Lieu	u of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE	COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0146	Peri od:	Worksheet S-2

	Financial Systems		SPITAL OF NOBLE CTY,			u of Form CMS-2	
HOSPI T	AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ATA Provi der CC	F	eriod: rom 01/01/2023 o 12/31/2023	Worksheet S-2 Part I Date/Time Pre 5/23/2024 9:5	pared:
				Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Yea	ur ETE Residents in N	lonnrovider Settings	1.00	2.00	3.00	
	period that begins on or after J	luly 1, 2009 and befo	re June 30, 2010.		,		
64. 00	Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ros settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	uber of unweighted no etations occurring in e number of unweighte eur hospital. Enter i 1 + column 2)). (see	n-primary care all nonprovider d non-primary care n column 3 the ratio instructions)	0.00			64.00
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1. 00	2. 00	3. 00	4. 00	5. 00	
65. 00	Enter in column 1, if line 63 is yes, or your facility 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 FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	0.000000 Ratio (col. 1/ (col. 1 + col. 2))	65.00
				Si te 1.00	2.00	3. 00	
	Section 5504 of the ACA Current		n Nonprovider Setting				
66. 00	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations or Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-prima occurring in all nonp unweighted non-prima al. Enter in column column 2)). (see in	rovider settings. ry care resident 3 the ratio of structions)	0.00			66.00
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
67. 00	Enter in column 1 the program	1. 00	2. 00	3.00	4. 00	5. 00 0. 000000	67.00
57.00	Enter in column 1, the program 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)			0, 00	, 3.00	0.00000	. 07. 00

		1	) 12/31/	2023	5/23/20		
				+	1.0	0	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49						
68.00	For a cost reporting period beginning prior to October 1, 2022, did you om MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Fir (August 10, 2022)?						68. 00
	(Magast 10, 2022).			1.00	0.00	2.00	
	Inpatient Psychiatric Facility PPS			1. 00	2.00	3. 00	
70. 00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it cont Enter "Y" for yes or "N" for no.	ain an IPF sub	provi der?	N			70. 00
71. 00	If line 70 is yes: Column 1: Did the facility have an approved GME teachi			N	N	0	71. 00
	recent cost report filed on or before November 15, 2004? Enter "Y" for y 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents						
	program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for y	es or "N" for	no.				
	Column 3: If column 2 is Y, indicate which program year began during this (see instructions)	s cost reportin	g perioa.				
75 00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it of	contain an IDE		N			75. 00
	subprovider? Enter "Y" for yes and "N" for no.			l IN			
76. 00	If line 75 is yes: Column 1: Did the facility have an approved GME teachirecent cost reporting period ending on or before November 15, 2004? Enter					0	76. 00
	no. Column 2: Did this facility train residents in a new teaching program	n in accordance	with 42				
	CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If indicate which program year began during this cost reporting period. (see						
				-	1. 0	0	
	Long Term Care Hospital PPS						
80. 00 81. 00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for Is this a LTCH co-located within another hospital for part or all of the		period? I	Enter	N N		80. 00 81. 00
	"Y" for yes and "N" for no.		<u> </u>				
85. 00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Ente	er "Y" for yes	or "N" fo	no.	N		85. 00
86. 00	Did this facility establish a new Other subprovider (excluded unit) under	42 CFR Section	n				86. 00
87. 00	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.  100 Is this hospital an extended neoplastic disease care hospital classified under section						87. 00
	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		Approved	for	Numbei	of	
			Permane		Appro		
			Adjustm (Y/N)		Perman Adjustr		
99 00	Column 1: Is this hospital approved for a permanent adjustment to the TEF	EDA target	1. 00 N		2. 0		88. 00
86.00	amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete of					U	88.00
	89. (see instructions) Column 2: Enter the number of approved permanent adjustments.						
	режиние до достигнительного в при	Wkst. A Line	Effecti		Appro		
		No.	Date		Permai Adjust		
					Amount Di scha		
		1. 00	2.00		3. 0	0	
89. 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based.	0.00	)			0	89. 00
	Column 2: Enter the effective date (i.e., the cost reporting period						
	beginning date) for the permanent adjustment to the TEFRA target amount per discharge.						
	Column 3: Enter the amount of the approved permanent adjustment to the						
	TEFRA target amount per discharge.	1	V		XLX		
	Title V and XIX Services		1.00		2.0	0	
90.00	Does this facility have title V and/or XIX inpatient hospital services? E	nter "Y" for	N		Υ		90.00
91. 00	yes or "N" for no in the applicable column.  Is this hospital reimbursed for title V and/or XIX through the cost repor		N	ŀ	N		91.00
92. 00	full or in part? Enter "Y" for yes or "N" for no in the applicable column Are title XIX NF patients occupying title XVIII SNF beds (dual certificat				N		92.00
93. 00	instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V ar	nd XIX? Enter	N		N		93. 00
94. 00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for n	no in the	N		N		94.00
95. 00	applicable column. If line 94 is "Y", enter the reduction percentage in the applicable colum		0.00		0. 0	0	95. 00
	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for rapplicable column.		N		N		96. 00
97. 00	If line 96 is "Y", enter the reduction percentage in the applicable colum	ın.	0.00		0.0	0	97. 00

Ith Financial Systems	COMMUNITY HOSPITAL OF	NOBLE	CTY	, INC		In Lie	u of Form	CMS-2552-10	
		_			T				

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	OF NOBLE CTY,  Provider C		eri od:	wof Form CMS Worksheet S	
TOST THE AND HOST THE HEACHT GARE COMMERCENT TOATTON DATA	Trovider c	F	rom 01/01/2023 o 12/31/2023	Part I	
			V	5/23/2024 9: XIX	53 am
			1.00	2.00	
98.00 Does title V or XIX follow Medicare (title XVIII) for the instepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX.			Y	Y	98. 00
98.01 Does title V or XIX follow Medicare (title XVIII) for the r. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t title XIX.			Y	Y	98. 01
98.02 Does title V or XIX follow Medicare (title XVIII) for the countries bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes for title V, and in column 2 for title XIX.			Y	Y	98. 02
98.03 Does title V or XIX follow Medicare (title XVIII) for a crireimbursed 101% of inpatient services cost? Enter "Y" for yellow for title V, and in column 2 for title XIX.			N	N	98. 03
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XIX.			N	N	98. 04
98.05 Does title V or XIX follow Medicare (title XVIII) and add by Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.		Y	Y	98. 05	
98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.		Y	Y	98. 06	
Rural Providers  105.00 Does this hospital qualify as a CAH?  106.00 If this facility qualifies as a CAH, has it elected the all	-inclusive met	thod of payment	N		105. 00 106. 00
for outpatient services? (see instructions)  107.00 Column 1: If line 105 is Y, is this facility eligible for contraining programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded	structions) Rs in an			107.00	
Enter "Y" for yes or "N" for no in column 2. (see instruct 107.01 If this facility is a REH (line 3, column 4, is "12"), is i reimbursement for L&R training programs? Enter "Y" for yes	t eligible for				107. 01
instructions) 108.00 Is this a rural hospital qualifying for an exception to the	CRNA fee sche	edul e? See 42	N		108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupational	Speech	Respiratory	′
	1. 00	Occupati onal 2.00	Speech 3. 00	Respiratory 4.00	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	1. 00				
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	1.00 N al Demonstrati "Y" for yes or	on project (§4	3.00 110A f yes,	4.00	109.00
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.  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 Wo	1.00 N al Demonstrati "Y" for yes or	on project (§4	3.00 H10A f yes, ugh 215, as	1. 00 N	109.00
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.  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 Wo	al Demonstrati "Y" for yes or rksheet E-2, I  the Frontier ( ost reporting olumn 1 is Y, rticipating ir	on project (§2-"N" for no. I i nes 200 throu	3.00 110A f yes,	1.00	110.00
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.  110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this current or yes or "N" for no in column 1. If the response to contegration prong of the FCHIP demonstration for this call integration prong of the FCHIP demonstration for this call integration prong of the FCHIP demonstration for the participate in the graph of the FCHIP demonstration for this call integration prong of the FCHIP demonstration for the participate in the graph of the FCHIP demonstration for the participate in the graph of the FCHIP demonstration for the participate in the graph of the participate in the graph of the participate in the graph of the	al Demonstrati "Y" for yes or rksheet E-2, I  the Frontier ( ost reporting olumn 1 is Y, rticipating ir	on project (§4 "N" for no. I ines 200 throu Community period? Enter enter the n column 2. s; and/or "C"	3.00 110A f yes, ugh 215, as	1.00 N	110.00
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.  110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this comparts of the project integration prong of the FCHIP demoin which this CAH is participate all that apply: "A" for Ambulance services; "B" for a for tele-health services.	al Demonstrati "Y" for yes or rksheet E-2, I  the Frontier ( ost reporting olumn 1 is Y, rticipating ir dditional beds  Ith Model eporting olumn 1 is pating in the	on project (§2-"N" for no. I i nes 200 throu	3.00 H10A f yes, ugh 215, as	1. 00 N	110.00
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.  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 Wo applicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this compared by "Y" for yes or "N" for no in column 1. If the response to converted integration prong of the FCHIP demo in which this CAH is pared by "A" for Ambulance services; "B" for an after the le-heal th services.  112.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If comparticipation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of 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	al Demonstrati "Y" for yes or rksheet E-2, I  the Frontier ( ost reporting olumn 1 is Y, rticipating ir dditional beds  Ith Model eporting olumn 1 is pating in the ased  or "N" for no B, or E only) 93" percent (includes	on project (§2 "N" for no. I ines 200 throu	3.00 110A f yes, ugh 215, as	1.00 N	110.00
<ul> <li>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.</li> <li>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 Wo applicable.</li> <li>111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this complete and the response to complete the response of the FCHIP demoin which this CAH is passed in the response to complete and the response to the respon</li></ul>	al Demonstrati "Y" for yes or rksheet E-2, I  the Frontier ( ost reporting olumn 1 is Y, rticipating ir dditional beds  Ith Model eporting olumn 1 is pating in the ased  or "N" for no B, or E only) 93" percent (includes irs) based on	on project (§4-"N" for no. I i nes 200 throuse 200 thr	3.00 110A f yes, ugh 215, as	1.00 N	110.00

Health Financial Systems	COMMUNITY HOSPITAL OF	NOBLE CTY, I	NC	In Lie	of Form CMS	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	NTIFICATION DATA	Provi der CC		Period: From 01/01/2023 To 12/31/2023	Worksheet S Part I Date/Time P 5/23/2024 9	repared:
			Premi ums	Losses	Insurance	
			1.00	2.00	2.00	
118.01 List amounts of malpractice premiums a	nd paid Losses:		1. 00 132, 59	2. 00 2. 670	3. 00	0118.01
			·			
118.02 Are mal practice premiums and paid loss	es reported in a cost o	enter other 1	than the	1. 00 Y	2. 00	118. 02
Administrative and General? If yes, so and amounts contained therein. 119.00D0 NOT USE THIS LINE	ubmit supporting schedu	ule listing co	ost centers			119. 00
120.00 Is this a SCH or EACH that qualifies for \$3121 and applicable amendments? (see "N" for no. Is this a rural hospital would harmless provision in ACA §3121 and Enter in column 2, "Y" for yes or "N"	nstructions) Enter in th < 100 beds that quand applicable amendment	column 1, "Y' Nifies for th	" for yes or he Outpatient		Y	120. 00
121.00 Did this facility incur and report cos	ts for high cost implar	ntable devices	s charged to	Υ		121. 00
patients? Enter "Y" for yes or "N" for 122.00 Does the cost report contain healthcar Act?Enter "Y" for yes or "N" for no in the Worksheet A line number where thes				122. 00		
123.00 Did the facility and/or its subprovide services, e.g., legal, accounting, tax management/consulting services, from a	and/or	Y	Υ	123. 00		
for yes or "N" for no.  If column 1 is "Y", were the majority professional services expenses, for se located in a CBSA outside of the main "N" for no.	of the expenses, i.e., rvices purchased from u nospital CBSA? In colum	greater than Inrelated orga	50% of total anizations			
Certified Transplant Center Informatio 125.00 Does this facility operate a Medicare-		enter? Enter '	"Y" for ves	N		125. 00
and "N" for no. If yes, enter certific	ation date(s) (mm/dd/yy	yyy) below.	,			
126.00  f this is a Medicare-certified kidney in column 1 and termination date, if a			ilication dat	e		126. 00
127.00  f this is a Medicare-certified heart   in column 1 and termination date, if a		er the certif	fication date	•		127. 00
128.00 If this is a Medicare-certified liver	transplant program, ent		fication date			128. 00
in column 1 and termination date, if a 129.00 If this is a Medicare-certified lung t	ransplant program, ente	er the certifi	ication date			129. 00
in column 1 and termination date, if a 130.00 If this is a Medicare-certified pancre.	oplicable, in column 2. as transplant program,	enter the cer	rtification			130. 00
date in column 1 and termination date, 131.00 If this is a Medicare-certified intest	if applicable, in colu	ımn 2.				121 00
date in column 1 and termination date,			certification	1		131.00
132.00 If this is a Medicare-certified islet in column 1 and termination date, if a			fication date	•		132. 00
133.00 Removed and reserved						133. 00
134.00  f this is a hospital-based organ proci in column 1 and termination date, if a		PO), enter th	he OPO number			134. 00
All Providers  140.00 Are there any related organization or	anno affi ao aosta ao da	fined in CMC	Dub 1F 1	Y	15H032	140.00
chapter 10? Enter "Y" for yes or "N" for are claimed, enter in column 2 the hom	or no in column 1. If y e office chain number.	es, and home	office costs		130032	140.00
If this facility is part of a chain or			ugh 143 the r		of the home	
office and enter the home office contr 141.00Name: PARKVIEW HEALTH SYSTEM, INC.	actor name and contract Contractor's Name: WISC		IAN Contracto	or's Number: 0810	1	141. 00
	SERV	'I CES			•	
142.00 Street: 10501 CORPORATE DRIVE 143.00 City: FORT WAYNE	PO Box: 5600 State: IN	1	Zip Code:	4684	5-1700	142. 00 143. 00
					1.00	
144.00 Are provider based physicians' costs i	ncluded in Worksheet A?	)			1. 00 Y	144. 00
				1.00	2. 00	
145.00 If costs for renal services are claime				1.00	2.00	145. 00
inpatient services only? Enter "Y" for no, does the dialysis facility include						
period? Enter "Y" for yes or "N" for	no in column 2.					444 ==
146.00 Has the cost allocation methodology ch Enter "Y" for yes or "N" for no in col- yes, enter the approval date (mm/dd/yy	umn 1. (See CMS Pub. 15			N		146. 00

Health Financial Systems	COMMUNITY HOSPITAL O	F NOBLE CTY, I	I NC	In Lie	eu of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CC	CN: 15-0146	Period: From 01/01/2023 To 12/31/2023		epared:
					5/23/2024 9.	os alli
					1. 00	
147.00 Was there a change in the statist					N	147. 00 148. 00
148.00 Was there a change in the order of 149.00 Was there a change to the simplif				or no	N N	148.00
147. 00 was there a change to the shillpiri	ed cost finding method: El	Part A	Part B	Title V	Title XIX	147.00
		1. 00	2. 00	3. 00	4.00	
Does this facility contain a prov or charges? Enter "Y" for yes or						
155. 00 Hospi tal	·	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	N	157. 00 158. 00
159. 00 SNF		N	l N	N	N	159.00
160.00HOME HEALTH AGENCY		N	N N	N N	N	160.00
161. 00 CMHC		.,,	l N	N	N	161. 00
161. 10 CORF			N	N	N	161. 10
					1.00	
Mul ti campus					1.00	
165.00 Is this hospital part of a Multic. Enter "Y" for yes or "N" for no.	ampus hospital that has one	e or more camp	uses in dif	ferent CBSAs?	N	165. 00
	Name	County	State Z	ip Code   CBSA	FTE/Campus	
	0	1. 00	2.00	3.00 4.00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.0	00 166. 00
					1.00	
Health Information Technology (HI	T) inconting in the America	an Pocovory an	nd Poinvostm	iont Act	1.00	
167.00 s this provider a meaningful use				ent Act	Υ	167. 00
168.00 If this provider is a CAH (line 1	D5 is "Y") and is a meaning	ıful user (lin		"), enter the		168. 00
reasonable cost incurred for the 168.01 If this provider is a CAH and is	not a meaningful user, does	this provide				168. 01
exception under §413.70(a)(6)(ii) 169.00 If this provider is a meaningful	user (line 167 is "Y") and				9. 9	99169. 00
transition factor. (see instruction	ons)			Begi nni ng	Endi ng	
				1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	peginning date and ending o	late for the r	eporti ng	1.00	2.00	170. 00
				1.00	2. 00	
171.00 fline 167 is "Y", does this pro	vider have any days for inc	li vi dual s enco	lled in	1.00 N		0171.00
section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (:	reported on Wkst. S-3, Pt. umn 1. If column 1 is yes,	I, line 2, co	I. 6? Enter			1,1.00

	Financial Systems COMMUNITY HOSPITAL OF NO				eu of Form CMS-	
IOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0146	Peri od: From 01/01/2023 To 12/31/2023		epared:
				Y/N	Date	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT	OUESTION	NAIRE	1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N for mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			er all dates in	the	
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the begreporting period? If yes, enter the date of the change in column			N		1.00
	reporting period: IT yes, enter the date of the change IT cordin	III 2. (300	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare Progryes, enter in column 2 the date of termination and in column 3, voluntary or "I" for involuntary.		N			2.00
00	Is the provider involved in business transactions, including macontracts, with individuals or entities (e.g., chain home officer or medical supply companies) that are related to the provider conficers, medical staff, management personnel, or members of the officers through ownership, control, or family and other since the control of directors through ownership, control, or family and other since the control of the control	ces, drug or its ne board	N			3.00
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
00	Column 1: Were the financial statements prepared by a Certific Accountant? Column 2: If yes, enter "A" for Audited, "C" for C or "R" for Reviewed. Submit complete copy or enter date available column 3. (see instructions) If no, see instructions.	Compiled,	Y	A	03/24/2022	4.00
00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit reconci		N			5.00
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities					
00	Column 1: Are costs claimed for a nursing program? Column 2: the legal operator of the program?	If yes, is	s the provide	r N		6.00
00 00	Are costs claimed for Allied Health Programs? If "Y" see instru Were nursing programs and/or allied health programs approved an		wed during th	e N		7. 00 8. 00
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved grac program in the current cost report? If yes, see instructions.	duate medio	cal education	N		9.00
. 00	Was an approved Intern and Resident GME program initiated or recost reporting period? If yes, see instructions.	enewed in <sup>1</sup>	the current	N		10.00
. 00	Are GME cost directly assigned to cost centers other than I & R Teaching Program on Worksheet A? If yes, see instructions.	R in an App	proved	N		11.00
					Y/N 1.00	
00	Bad Debts					10.00
. 00 . 00	Is the provider seeking reimbursement for bad debts? If yes, se If line 12 is yes, did the provider's bad debt collection polic period? If yes, submit copy.			ost reporting	Y N	12. 00 13. 00
. 00	If line 12 is yes, were patient deductibles and/or coinsurance instructions.	amounts wa	aived? If yes	, see	N	14.00
. 00	Bed Complement Did total beds available change from the prior cost reporting p				N	15.00
		Y/N	t A Date	Y/N	rt B Date	
		1.00	2. 00	3. 00	4. 00	
-	PS&R Data					4
. 00	Was the cost report prepared using the PS&R Report only?  If either column 1 or 3 is yes, enter the paid-through	N		N		16.00

		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	05/02/2024	Υ	05/02/2024	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.					

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 P	eri od:	Worksheet S-		
				rom 01/01/2023 to 12/31/2023	Part II   Date/Time Pr	epared.	
					5/23/2024 9:		
			iption D	Y/N 1.00	Y/N 3. 00		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R		<i>y</i>	N N	N	20.00	
	Report data for Other? Describe the other adjustments:						
		Y/N 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	
23. 00	00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.						
24.00							
25.00	If yes, see instructions	. the cost rose	nting nonlocal	l£ voo ooo		25. 00	
25. 00	.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see 25 instructions.						
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.	o cost roporti	ng portod? If	voc cubmit		27. 00	
27.00	00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit 27 copy.						
	Interest Expense						
28. 00	00 Were new Loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.						
29. 00							
	treated as a funded depreciation account? If yes, see instructions						
30. 00	Has existing debt been replaced prior to its scheduled mat instructions.	urity with new	debt? If yes,	see		30.00	
31. 00	Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If yes,	see		31.00	
	instructions.					_	
32. 00	Purchased Services Have changes or new agreements occurred in patient care se	rvices furnish	ed through con	tractual		32.00	
02.00	arrangements with suppliers of services? If yes, see instr		ca till oagii con	liactaai		02.00	
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap	plied pertaini	ng to competiti	ive bidding? If		33.00	
	no, see instructions. Provider-Based Physicians						
34.00		arrangement wi	th provider-bas	sed physicians?		34.00	
25 00	If yes, see instructions.					25.00	
35. 00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i	nstructions.	nts with the pi	rovi der-based		35.00	
	The state of the s			Y/N	Date		
	Home Offi on Conta			1.00	2. 00		
36. 00	Home Office Costs Were home office costs claimed on the cost report?					36.00	
37. 00	If line 36 is yes, has a home office cost statement been p	repared by the	home office?			37. 00	
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of	fica difforant	from that of			38.00	
36.00	the provider? If yes, enter in column 2 the fiscal year en					36.00	
39. 00	If line 36 is yes, did the provider render services to oth					39. 00	
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If was soo			40.00	
40.00	instructions.	: Home office:	11 yes, see			40.00	
	Cost Report Preparer Contact Information	1.	00	2.	00		
41. 00	Enter the first name, last name and the title/position	JILL		THOMPSON		41.00	
	held by the cost report preparer in columns 1, 2, and 3,						
42. 00	respectively. Enter the employer/company name of the cost report	PARKVIEW HEALT	H SYSTEM INC			42.00	
12.00	preparer.		JIJIEW, TNO.			12.00	
43. 00		3373027646		JILL. THOMPSON@I	PARKVI EW. COM	43.00	
	report preparer in columns 1 and 2, respectively.	I		I		II	

Heal th	Financial Systems COMMUNITY HOSE	PITAL (	OF NOBLE CTY,	INC	In Lieu	of Form C	MS-2	552-10
HOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIR	RE	Provi der C	CN: 15-0146	riod: om 01/01/2023 12/31/2023		Pre	pared:
			3.	00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/positio	n S	SR FINANCIAL (	COORDI NATOR				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 of the c	ost						43.00
	report preparer in columns 1 and 2, respectively.							

33.01

0 34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0146 Peri od: Worksheet S-3 From 01/01/2023 Part I 12/31/2023 Date/Time Prepared: 5/23/2024 9:53 am I/P Days / 0/P Visits / Tri ps Bed Days CAH/REH Hours Component Worksheet A No. of Beds Title V Li ne No. Avai I abl e 1.00 2.00 3.00 4.00 5.00 PART I - STATISTICAL DATA 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 30.00 31 11, 315 0.00 0 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 2.00 3.00 HMO IPF Subprovider HMO IRF Subprovider 3.00 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) 8.00 INTENSIVE CARE UNIT 31.00 0 0.00 0 8.00 9.00 CORONARY CARE UNIT 32.00 0 0 0.00 0 9.00 BURN INTENSIVE CARE UNIT 0 10.00 33.00 0.00 0 10.00 0 11.00 SURGICAL INTENSIVE CARE UNIT 34.00 C 0 0.00 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 15.00 CAH visits 0 15.00 15. 10 REH hours and visits 0.00 0 15.10 SUBPROVIDER - IPF 40.00 0 0 16.00 16.00 0 17.00 SUBPROVIDER - IRF 0 0 0 17.00 41.00 18.00 SUBPROVI DER 18.00 SKILLED NURSING FACILITY 19.00 19.00 44.00 0 20.00 NURSING FACILITY 45.00 0 0 0 20.00 OTHER LONG TERM CARE 0 21.00 46.00 C 21.00 HOME HEALTH AGENCY 101.00 22.00 22.00 AMBULATORY SURGICAL CENTER (D. P. ) 23.00 115.00 23.00 HOSPI CE 116.00 0 0 24.00 24.00 24.10 HOSPICE (non-distinct part) 30.00 24.10 CMHC - CMHC CMHC - CORF 99.00 25.00 0 25.00 99.10 25. 10 25 10 0 RURAL HEALTH CLINIC 88.00 0 26.00 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 26. 25 27.00 Total (sum of lines 14-26) 31 27.00 Observation Bed Days 28.00 28 00 Ambul ance Trips 29.00 29.00 30.00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 31.00 Labor & delivery days (see instructions) 0 32 00 32 00 Ω 32.01 Total ancillary labor & delivery room 32.01 outpatient days (see instructions) LTCH non-covered days 33.00

30.00

0

33.01

LTCH site neutral days and discharges

34.00 Temporary Expansion COVID-19 PHE Acute Care

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 15-0146

Peri od: Worksheet S-3 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

5/23/2024 9:53 am Full Time Equivalents I/P Days / O/P Visits / Trips 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 PART I - STATISTICAL DATA 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 1, 016 123 4, 595 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 2,037 887 2.00 3.00 HMO IPF Subprovider HMO IRF Subprovider 3 00 4.00 0 C 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF C 6.00 C Total Adults and Peds. (exclude observation 1, 016 7.00 123 4.595 7.00 beds) (see instructions) 8.00 INTENSIVE CARE UNIT 0 8.00 0 C 9.00 CORONARY CARE UNIT 0 0 0 9.00 BURN INTENSIVE CARE UNIT 10.00 0 10.00 0 0 11.00 SURGICAL INTENSIVE CARE UNIT 0 C 0 11 00 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 13.00 NURSERY 40 13.00 462 14.00 Total (see instructions) 1, 016 163 5,057 0.00219. 25 14.00 15.00 CAH visits C 0 15.00 15. 10 REH hours and visits 0 0 0 15.10 0 SUBPROVIDER - IPF 0 0.00 16.00 16.00 0 0.00 17.00 SUBPROVIDER - IRF 0 C 0 0.00 0.00 17.00 18.00 SUBPROVI DER 18.00 SKILLED NURSING FACILITY 19.00 0 0.00 0.00 19.00 20.00 NURSING FACILITY 0 0 0.00 0.00 20.00 OTHER LONG TERM CARE 0 0.00 21.00 0.00 21.00 HOME HEALTH AGENCY 0 0.00 0.00 22.00 0 0 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 0.00 0.00 23.00 HOSPI CE C 0 0.00 24.00 0.00 24.00 24.10 HOSPICE (non-distinct part) 121 24.10 CMHC - CMHC CMHC - CORF 0.00 25.00 0 0 0.00 25.00 0 0 0.00 25 10 C 0 00 25 10 RURAL HEALTH CLINIC 0.00 26.00 C 0 0.00 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.00 0.00 26. 25 27.00 Total (sum of lines 14-26) 0.00 219. 25 27.00 Observation Bed Days 1, 017 28 00 2, 380 28 00 Ambul ance Trips 29.00 1, 409 29.00 30.00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 0 31.00 Labor & delivery days (see instructions) 0 32 00 103 32.00 61 32.01 Total ancillary labor & delivery room 0 32.01 outpatient days (see instructions) LTCH non-covered days 33.00 LTCH site neutral days and discharges 33.01 0 33.01 34.00 Temporary Expansion COVID-19 PHE Acute Care 0 0 34.00

Health Financial SystemsCOMMUNITY HOSHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 15-0146

Peri od: Worksheet S-3 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/23/2024 9:53 am Peri od:

						5/23/2024 9: 5	3 am
		Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
	I	11. 00	12. 00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	370	64	1, 888	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
0.00	for the portion of LDP room available beds)			0.47	407		0.00
2.00	HMO and other (see instructions)			367	427		2.00
3.00	HMO I PF Subprovi der				0		3.00
4. 00	HMO I RF Subprovi der				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
8. 00	beds) (see instructions)						8.00
9. 00	INTENSIVE CARE UNIT						9.00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0.00	0	370	64	1, 888	
15. 00	CAH visits	0.00	U	370	04	1,000	15.00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVI DER - I PF	0.00	0	0	0	0	16.00
17. 00	SUBPROVI DER - I RF	0.00	0		0	0	17. 00
	SUBPROVI DER	0.00	O		٩	O	18.00
19. 00	SKILLED NURSING FACILITY	0.00					19.00
20. 00	NURSING FACILITY	0.00					20.00
21. 00	OTHER LONG TERM CARE	0.00				0	21.00
22. 00	HOME HEALTH AGENCY	0.00				_	22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	0.00					23.00
24. 00	HOSPICE	0.00					24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC	0.00					25.00
25. 10	CMHC - CORF	0.00					25. 10
26.00	RURAL HEALTH CLINIC	0.00					26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28. 00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
	LTCH non-covered days			0			33. 00
	LTCH site neutral days and discharges			0			33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care						34.00

In Lieu of Form CMS-2552-10

Period: Worksheet S-3

From 01/01/2023 Part II

To 12/31/2023 Date/Time Prepared: 5/23/2024 9:53 am Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION COMMUNITY HOSPITAL OF NOBLE CTY, INC
Provider CCN: 15-0146

						12/31/2023	5/23/2024 9:5	3 am
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst.	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	A-6) 3. 00	4.00	5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200. 00	18, 793, 595	7, 589, 561	26, 383, 156	599, 848. 17	43. 98	1. 00
	instructions)					·		
2. 00	Non-physician anesthetist Part A		0	0	0	0. 00	0. 00	2. 00
3. 00	Non-physician anesthetist Part B		0	0	0	0. 00	0. 00	3. 00
4. 00	Physician-Part A -		40, 000	0	40, 000	71. 91	556. 25	4. 00
4. 01	Administrative Physicians - Part A - Teaching		0	0	0	0.00	0. 00	4. 01
5. 00	Physician and Non Physician-Part B		0	0	0	0. 00	0. 00	5. 00
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0. 00	0. 00	6. 00
7. 00	Interns & residents (in an approved program)	21. 00	0	0	0	0. 00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved		0	0	0	0. 00	0. 00	7. 01
8. 00	programs) Home office and/or related		5, 049, 359	0	5, 049, 359	129, 402. 60	39. 02	8. 00
9. 00	organization personnel SNF	44.00	0	0	0	0.00	0. 00	9. 00
10. 00	Excluded area salaries (see instructions)	44.00	3, 940, 108	101, 334	4, 041, 442	127, 797. 54	31. 62	
11. 00	OTHER WAGES & RELATED COSTS  Contract labor: Direct Patient		0	0	O	0.00	0. 00	11. 00
	Care							
12. 00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13. 00	Contract Labor: Physician-Part A - Administrative		0	0	0	0. 00	0. 00	13. 00
14. 00	Home office and/or related organization salaries and		0	0	О	0. 00	0. 00	14. 00
14. 01	wage-related costs Home office salaries		5, 049, 359	0	5, 049, 359	129, 402. 60	39. 02	14. 01
14. 02	Related organization salaries		0	0	0	0.00		14.02
15. 00	Home office: Physician Part A - Administrative		0	0	0	0. 00	0. 00	15. 00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 00
16. 01	Home office Physicians Part A		0	0	0	0. 00	0. 00	16. 01
16. 02	- Teaching Home office contract		0	0	0	0. 00	0. 00	16. 02
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see		5, 879, 230	0	5, 879, 230			17. 00
18. 00	instructions) Wage-related costs (other) (see instructions)							18. 00
19. 00	Excluded areas		1, 610, 651	0	1, 610, 651			19. 00
20. 00	Non-physician anesthetist Part A		0	0	0			20.00
21. 00	Non-physician anesthetist Part B		0	0	0			21. 00
22. 00	Physician Part A - Administrative		0	0	0			22. 00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0	0	0			22. 01 23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	0			24. 00 25. 00
25. 50	approved program) Home office wage-related		2, 540, 202	0	2, 540, 202			25. 50
25. 51	(core) Rel ated organization		0	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative -		0	0	O			25. 52
	- Administrative -  wage-related (core)							

42.00

Social Service

43.00 Other General Service

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0146 Peri od: Worksheet S-3 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/23/2024 9:53 am 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. col. 4 3) 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 2, 091, 993 -2, 091, 993 0.00 0. 00 26.00 27.00 Administrative & General 5.00 633,000 8, 546, 902 9, 179, 902 136, 253. 58 67.37 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 7.00 432, 955 467, 407 12, 330. 50 37.91 30.00 34, 452 . Laundry & Linen Service 8.00 0.00 31.00 31.00 0.00 32.00 20, 863. 02 Housekeepi ng 9.00 462, 294 36, 787 499, 081 23. 92 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) -176, 343 34.00 Dietary 10.00 486, 557 310, 214 12, 426. 33 24. 96 34.00 Dietary under contract (see 35.00 0.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 0 215, 060 215, 060 8, 587. 00 25.04 36.00 0.00 37.00 Maintenance of Personnel 12.00 0.00 37.00 Nursing Administration 57. 19 38.00 38.00 13.00 538, 872 42,880 581, 752 10, 173. 00 39.00 Central Services and Supply 14.00 0.00 0.00 39.00 11, 707. 65 40.00 Pharmacy 15.00 719, 436 57, 248 776, 684 66. 34 40.00 Medical Records & Medical Records Library 41.00 16.00 0 0 0.00 0.00 41.00

0

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0.00

0.00

0.00 42.00

0.00 43.00

17.00

nour tri	Trianeral Systems	OOMMO	INT TO HOOF TIME	OI NODEL OTT,	1110	111 210	u 01 101111 01110 2	002 10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2023 To 12/31/2023		pared:
		Worksheet A	Amount	Recl assi fi cat	Adjusted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.		(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet	-,			
				A-6)				
		1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
PART III - HOSPITAL WAGE INDEX SUMMARY								
1.00	Net salaries (see		13, 744, 236	7, 589, 561	21, 333, 79	7 470, 445. 57	45. 35	1.00
	instructions)							
2.00	Excluded area salaries (see		3, 940, 108	101, 334	4, 041, 44	2 127, 797. 54	31. 62	2.00
	instructions)							
3.00	Subtotal salaries (line 1		9, 804, 128	7, 488, 227	17, 292, 35	5 342, 648. 03	50. 47	3.00
	minus line 2)							
4.00	Subtotal other wages & related		5, 049, 359	0	5, 049, 35	9 129, 402. 60	39. 02	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		8, 419, 432	0	8, 419, 43	0.00	48. 69	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		23, 272, 919	7, 488, 227	30, 761, 14	6 472, 050. 63	65. 16	6.00
7.00	Total overhead cost (see		5, 365, 107	6, 664, 993	12, 030, 10	212, 341. 08	56. 65	7.00
	i nstructi ons)							

COMMUNITY HOSPITAL OF NOBLE CTY, INC Provider CCN: 15-0146 Health Financial Systems
HOSPITAL WAGE RELATED COSTS

		372372024 7. 3	o an
		Amount	
		Reported	
		1, 00	
PART IV - WAGE RE	ATED COSTS		
Part A - Core Lis			
RETIREMENT COST			
00 401K Employer Con	tri buti ons	0	1.
00 Tax Sheltered Ann	uity (TSA) Employer Contribution	417, 251	2.
00 Nonqualified Defi	ned Benefit Plan Cost (see instructions)	0	3.
.00 Qualified Defined	Benefit Plan Cost (see instructions)	1, 294, 115	4.
PLAN ADMINISTRATI	/E COSTS (Paid to External Organization)		
.00 401K/TSA Plan Adm	inistration fees	0	5.
. 00 Legal /Accounti ng/	Management Fees-Pension Plan	3, 725	6.
00 Employee Managed	Care Program Administration Fees	69, 138	7.
HEALTH AND INSURA	NCE COST		
00 Health Insurance	(Purchased or Self Funded)	0	8.
01 Health Insurance	(Self Funded without a Third Party Administrator)	0	8.
02 Health Insurance	(Self Funded with a Third Party Administrator)	3, 021, 563	8
03 Health Insurance		0	
00 Prescription Drug	Pl an	847, 335	9
0.00 Dental, Hearing a	nd Vision Plan	104, 139	10
I.00 Life Insurance (I	f employee is owner or beneficiary)	19, 840	11.
2.00 Accident Insuranc	e (If employee is owner or beneficiary)	0	12.
3.00 Disability Insura	nce (If employee is owner or beneficiary)	72, 872	13.
1.00 Long-Term Care In	surance (If employee is owner or beneficiary)	0	14.
5.00 'Workers' Compens	ation Insurance	11, 425	15.
5.00 Retirement Health	Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16
Noncumulative por	tion)		
TAXES			
7.00 FICA-Employers Po		1, 568, 977	17.
3.00 Medicare Taxes -		0	18.
0.00 Unemployment Insu	rance	0	19.
0.00 State or Federal	Unemployment Taxes	0	20
OTHER			
.00 Executive Deferre	d Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	12, 255	21.
instructions))			
2.00 Day Care Cost and	Allowances	0	22.
3.00 Tuition Reimburse		47, 246	23
4.00 Total Wage Relate	d cost (Sum of lines 1 -23)	7, 489, 881	24.
Part B - Other th	an Core Related Cost		
5.00 OTHER WAGE RELATE	D COSTS (SPECIFY)		25

16. 10 Hospital -Based-CMHC 10

17.00 RENAL DIALYSIS I

18.00 Other

COMMUNITY HOSPITAL OF NOBLE CTY, INC Health Financial Systems In Lieu of Form CMS-2552-10 HOSPITAL CONTRACT LABOR AND BENEFIT COST Worksheet S-3 Part V Provider CCN: 15-0146 Peri od: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/23/2024 9:53 am 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 7, 489, 881 1.00 0 0 0 0 0 0 0 Hospi tal 7, 489, 881 2.00 2.00 HOSPITAI SUBPROVIDER - IPF SUBPROVIDER - IRF Subprovider - (Other) Swing Beds - SNF Swing Beds - NF 3.00 3.00 0 4.00 0 4.00 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 SKILLED NURSING FACILITY 8.00 0 8.00 9.00 NURSING FACILITY 0 9.00 OTHER LONG TERM CARE I 10.00 10.00 11.00 Hospi tal -Based HHA 0 0 0 0 0 0 0 0 11.00 12.00 AMBULATORY SURGICAL CENTER (D. P.) I 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

0 16. 10

0 17.00

Health Financial Systems	COMMUNITY H	HOSPITAL OF N	IOBLE CTY, IN	IC	In Lieu	u of Form CMS-2	2552-10
HOSPITAL UNCOMPENSATED AND INDIGENT CA	RE DATA		Provi der CCN	: 15-0146	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Pre 5/23/2024 9:5	pared:
						1. 00	
DART I _ HOSDITAL AND HOSDITAL (	OMDLEY DATA						

		T	rom 01/01/2023 o 12/31/2023				
				1. 00			
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA						
	Uncompensated and Indigent Care Cost-to-Charge Ratio						
1. 00	Cost to charge ratio (see instructions)			0. 192067	1.00		
	Medicaid (see instructions for each line)			0.040.400			
2.00	Net revenue from Medicaid			3, 068, 438	2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?	4- 6 M!::	-10	Y Y	3.00		
4. 00 5. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental paymen		a?	Υ	4. 00 5. 00		
6. 00	If line 4 is no, then enter DSH and/or supplemental payments from Medica Medicaid charges		24, 285, 253	1			
7. 00	Medicaid cost (line 1 times line 6)			4, 664, 396			
8. 00	Difference between net revenue and costs for Medicaid program (see instr	uctions)		1, 595, 958			
0.00	Children's Health Insurance Program (CHIP) (see instructions for each li			1, 373, 730	0.00		
9. 00	Net revenue from stand-alone CHIP	110)		54, 096	9.00		
10.00				104, 059	1		
11. 00				19, 986			
12.00	· · · · · · · · · · · · · · · · · · ·	uctions)		0	1		
	Other state or local government indigent care program (see instructions				İ		
13.00	Net revenue from state or local indigent care program (Not included on I	ines 2, 5 or 9)		4, 182, 681	13. 00		
14.00	Charges for patients covered under state or local indigent care program	n lines 6 or	30, 278, 591	14.00			
	10)						
15.00			5, 815, 518	15.00			
16. 00							
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see						
47.00	instructions for each line)		1		47.00		
17. 00				0			
18.00			(E   !	0			
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent 8, 12 and 16)	care programs	(Sum of Times	3, 228, 795	19.00		
	12 414 10	Uni nsured	Insured	Total (col. 1			
		pati ents	pati ents	+ col . 2)			
		1.00	2. 00	3. 00			
	Uncompensated care cost (see instructions for each line)	,					
20.00		5, 015, 825		6, 931, 170			
21. 00	The state of the s	963, 374	1, 754, 847	2, 718, 221	21.00		
	instructions)	_	_	_			
22. 00	1 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	0	0	0	22. 00		
22.00	charity care	062 274	1 754 047	2 710 221	22.00		
23.00	Cost of charity care (see instructions)	963, 374	1, 754, 847	2, 718, 221	23.00		
				1. 00			
24. 00	Does the amount on line 20 col. 2, include charges for patient days beyo	nd a Length of	stav limit	N	24. 00		
50	imposed on patients covered by Medicaid or other indigent care program?			••			
25. 00							
25. 01							
26. 00				4, 827, 602			
27. 00	, ,						
27. 01							
28. 00	· · · · · · · · · · · · · · · · · · ·			4, 686, 833			
00 00							

	chari ty care						
23.00	Cost of charity care (see instructions)	963, 374	1, 754, 847	2, 718, 221	23.00		
24.00	Does the amount on line 20 col. 2, include charges for patient days beyon	stay limit	N	24.00			
	imposed on patients covered by Medicaid or other indigent care program?						
25.00	If line 24 is yes, enter the charges for patient days beyond the indigen	s length of	0	25.00			
	stay limit						
25. 01	Charges for insured patients' liability (see instructions)		198, 653	25. 01			
26.00	Bad debt amount (see instructions)			4, 827, 602	26.00		
27.00	Medicare reimbursable bad debts (see instructions)			91, 500	27.00		
27. 01	Medicare allowable bad debts (see instructions)			140, 769	27. 01		
28.00	Non-Medicare bad debt amount (see instructions)			4, 686, 833	28.00		
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see	instructions)		949, 455	29.00		
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)				30.00		
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			6, 896, 471	31.00		

	Financial Systems COMMUNITY HOSPITAL OF	-		u of Form CMS-2	
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CCN: 15-0146	Peri od: From 01/01/2023 To 12/31/2023		pared:
				1.00	
	PART II - HOSPITAL DATA			1. 00	
	Uncompensated and Indigent Care Cost-to-Charge Ratio				
1. 00	Cost to charge ratio (see instructions)			0. 192067	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid				2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?				4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments	from Medicaid			5.00
6.00	Medi cai d charges				6.00
7.00	Medicaid cost (line 1 times line 6)				7.00
8.00	Difference between net revenue and costs for Medicaid program				8.00
	Children's Health Insurance Program (CHIP) (see instructions	for each line)			
9. 00	Net revenue from stand-alone CHIP				9. 00
	Stand-al one CHIP charges				10.00
	Stand-alone CHIP cost (line 1 times line 10)				11.00
12.00	Difference between net revenue and costs for stand-alone CHIF		. \		12.00
12 00	Other state or local government indigent care program (see in				13.00
	Net revenue from state or local indigent care program (Not in Charges for patients covered under state or local indigent ca				14.00
14.00	10)	ire program (Not Therade	a in ines o or		14.00
15. 00	State or local indigent care program cost (line 1 times line	14)			15.00
					1 . 1 . 1 . 1

16.00 Difference between net revenue and costs for state or local indigent care program (see instructions)

Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines

Private grants, donations, or endowment income restricted to funding charity care

Government grants, appropriations or transfers for support of hospital operations

29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see

		patrents	patrents	+ COI. 2)	
		1. 00	2. 00	3. 00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	5, 015, 825	1, 915, 345	6, 931, 170	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see	963, 374	1, 754, 847	2, 718, 221	21.00
	instructions)				
22.00	Payments received from patients for amounts previously written off as	0	0	0	22.00
	charity care				
23.00	Cost of charity care (see instructions)	963, 374	1, 754, 847	2, 718, 221	23.00
				1. 00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyon	nd a Length of	stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent care program?				
25.00	If line 24 is yes, enter the charges for patient days beyond the indigen-	t care program'	s length of	0	25.00
	stay limit				
25. 01	25.01 Charges for insured patients' liability (see instructions)				
26.00	26.00 Bad debt amount (see instructions)				
27.00	Medicare reimbursable bad debts (see instructions)			91, 500	27.00
27. 01	Medicare allowable bad debts (see instructions)			140, 769	27. 01

Uni nsured

patients

Insured

pati ents

16.00

17.00

18.00

19.00

Total (col. 1

4, 686, 833

3, 667, 676

949, 455

3, 667, 676 31.00

28.00

29.00

30.00

+ col. 2)

instructions for each line)

28.00 Non-Medicare bad debt amount (see instructions)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

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

8, 12 and 16)

17.00

	Financial Systems COMML SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	JNITY HOSPITAL OF	Provider C		In Lie eriod:	u of Form CMS-2 Worksheet A	2552-10
KLULAS	STITICATION AND ADJUSTIMENTS OF TRIAL BALANCE (	JI EXFENSES	Frovider C	F	rom 01/01/2023		norod.
					o 12/31/2023	5/23/2024 9:5	pared: 3 am
	Cost Center Description	Sal ari es	Other		Reclassificat	Reclassified Trial Balance	
				+ col . 2)	i ons (See A-6)	(col. 3 +-	
					, , ,	col . 4)	
	GENERAL SERVICE COST CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	00100 CAP REL COSTS-BLDG & FIXT		1, 930, 232	1, 930, 232	-106, 922	1, 823, 310	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		743, 294	743, 294	210, 622		
3. 00 4. 00	OO300 OTHER CAP REL COSTS   OO400 EMPLOYEE BENEFITS DEPARTMENT	2, 091, 993	0 6, 299, 314	0 8, 391, 307	0 -2, 091, 993	0 6, 299, 314	1
5. 00	00500 ADMI NI STRATI VE & GENERAL	633, 000	24, 558, 079				1
6.00	00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7. 00 8. 00	OO7OO   OPERATION OF PLANT   OO8OO   LAUNDRY & LINEN SERVICE	432, 955	683, 442 163, 598			1, 150, 849 163, 598	
9. 00	00900 HOUSEKEEPI NG	462, 294	99, 405				1
10.00	01000 DI ETARY	486, 557	246, 860	733, 417	-282, 876	450, 541	10.00
11.00	O1100   CAFETERI A   O1200   MAI NTENANCE OF PERSONNEL	0	-3, 838	-3, 838	321, 593 0		1
12. 00 13. 00	01300 NURSI NG ADMI NI STRATI ON	538, 872	4, 537	543, 409	_	-	1
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500 PHARMACY	719, 436	55, 008	774, 444	57, 248	831, 692	1
16. 00 17. 00	01600   MEDICAL RECORDS & LIBRARY   01700   SOCIAL SERVICE		0	0	0	0	16.00 17.00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	o	0	O	0	0	19.00
20.00	02000 NURSI NG PROGRAM	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	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>				Ū	] 22.00
30.00	03000 ADULTS & PEDIATRICS	3, 080, 462	878, 851	3, 959, 313	-856, 367	3, 102, 946	1
31. 00 32. 00	03100   INTENSIVE CARE UNIT   03200   CORONARY CARE UNIT		0	0	0	0	31.00
33.00	03300 BURN INTENSIVE CARE UNIT	o o	Ö	ő	0	ő	
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40. 00 41. 00	04000  SUBPROVI DER - I PF   04100  SUBPROVI DER - I RF	0	0	0	0	0	
43. 00	04300 NURSERY		0	Ö	224, 921	1	
44. 00	04400 SKILLED NURSING FACILITY	O	0	0	0	0	
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0	0	0	0	
40.00	ANCILLARY SERVICE COST CENTERS				U		1 40.00
50.00	05000 OPERATING ROOM	1, 113, 303	773, 978	1, 887, 281	100, 812		1
51. 00 52. 00	O5100   RECOVERY ROOM   O5200   DELIVERY ROOM & LABOR ROOM		0	0	907, 730	0 907, 730	
53.00	05300 ANESTHESI OLOGY	o o	1, 177, 222	1, 177, 222		1, 177, 222	
54.00	05400 RADI OLOGY - DI AGNOSTI C	1, 331, 125	958, 723	2, 289, 848	126, 098		
55. 00 56. 00	05500   RADI OLOGY-THERAPEUTI C   05600   RADI OI SOTOPE		0	0	0	0	
	05700 CT SCAN	o o	Ö	ő	0	ő	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	
59. 00 60. 00	O5900   CARDI AC   CATHETERI ZATI ON   O6000   LABORATORY		3, 018, 442	3, 018, 442	0	0 3, 018, 442	
60. 01	06001 BLOOD LABORATORY	o o	0	0	0	0	1
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	0	0	61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.		0	0	0		62.00
64.00	06400 I NTRAVENOUS THERAPY	o o	Ö	Ö	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	766, 665	179, 361				1
66. 00 67. 00	O6600   PHYSI CAL THERAPY   O6700   OCCUPATI ONAL THERAPY	1, 246, 355	42, 406	1, 288, 761	-591, 410 489, 386		
68. 00	06800 SPEECH PATHOLOGY		0	Ö	201, 202		
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	
70. 00 71. 00	07000   ELECTROENCEPHALOGRAPHY   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS	0	988, 256	988, 256	0 -557, 010	0 431, 246	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		988, 230	988, 230	557, 010		1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	4, 134, 808	4, 134, 808	0	4, 134, 808	
74. 00 75. 00	07400  RENAL DI ALYSI S   07500  ASC (NON-DI STI NCT PART)	0	0	0	0	0	74. 00 75. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	331, 407	115, 758	447, 165	26, 371	473, 536	1
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78. 00		0	0	0	0	0	78.00
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	o	O	0	89.00
	09000 CLINIC	46, 790	4, 289 444, 499				1
91. 00 92. 00	O9100   EMERGENCY   O9200   OBSERVATION   BEDS (NON-DISTINCT PART)	1, 572, 273	444, 499	2, 016, 772	129, 761	2, 146, 533	91.00
		· '		•	· '		

Health Financial Systems COMMU	JNITY HOSPITAL O	F NOBLE CTY, I	I NC	In Lie	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	OF EXPENSES	Provi der CC		Peri od:	Worksheet A	
				From 01/01/2023 To 12/31/2023		narod:
				10 12/31/2023	5/23/2024 9: 5	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat		
			+ col . 2)	i ons (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1. 00	2.00	3. 00	4. 00	5. 00	
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	(	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	3, 757, 732	825, 491	4, 583, 22	3 100, 559	4, 683, 782	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	(	0	0	96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	(	0	0	
99. 00 09900 CMHC	0	0	(	0	0	99. 00
99. 10   09910   CORF	0	0	(	0	0	
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
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0		0	0	102.00
SPECIAL PURPOSE COST CENTERS		ام				105.00
105. 00 10500 KI DNEY ACQUI SITI ON	0	0	(	0		105.00
106. 00 10600 HEART ACQUISITION 107. 00 10700 LIVER ACQUISITION		0	(	0		106. 00 107. 00
107. 00 10700 ETVER ACQUISITION 108. 00 10800 LUNG ACQUISITION		0	(			107.00
109. 00 10900 PANCREAS ACQUISITION		0		0		109.00
110. 00 11000   NTESTI NAL ACQUI SI TI ON		0		0		1109.00
111. 00 11100 I SLET ACQUI SI TI ON		0		0		111.00
113. 00 11300   NTEREST EXPENSE		0	·	0		113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF		0	·	0		114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P. )		0	·	0		115.00
116. 00 11600 HOSPI CE	o o	0	·	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	18, 611, 219	48, 322, 015	66, 933, 23	4 -775	66, 932, 459	
NONREI MBURSABLE COST CENTERS	,,	,,	227 . 227 = 2	.,		1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9, 261	9, 26	1 0	9, 261	190. 00
191. 00 19100 RESEARCH	O	0	. (	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	35, 197	1, 457	36, 65	4 2, 801	39, 455	192.00
193. 00 19300 NONPALD WORKERS	O	0	(	0	0	193.00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	(	0	0	194.00
194. 01 07951 PALN CLINIC	0	0	(	0		194. 01
194. 02 07952 OCC HEALTH	0	0	(	0	0	194. 02
194. 03 07953  FOUNDATI ON	0	5, 800	5, 800	0		194. 03
194.04 07954 PHYSICIAN OFFICES	0	0	(	0		194. 04
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	147, 179	37, 368	184, 54	· ·		
194. 06 07956 VACANT SPACE	0	0	(	0		194. 06
200.00   TOTAL (SUM OF LINES 118 through 199)	18, 793, 595	48, 375, 901	67, 169, 49	6 0	67, 169, 496	200.00

Health FinancialSystemsCOMMUNITY HOSPITRECLASSIFICATIONAND ADJUSTMENTS OF TRIALBALANCE OF EXPENSES

Provi der CCN: 15-0146

Period: Worksheet A From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/23/2024 9:53 am

				5/23/2024 9:5	
	Cost Center Description	Adjustments	Net Expenses	, , , , , , , , , , , , , , , , , , , ,	
		(See A-8)	For		
		6. 00	Allocation 7.00		
GFI	NERAL SERVICE COST CENTERS	6.00	7.00		
	1100 CAP REL COSTS-BLDG & FLXT	-1, 480, 774	342, 536		1.00
2.00 00	200 CAP REL COSTS-MVBLE EQUIP	230, 439		·	2.00
3.00 00	300 OTHER CAP REL COSTS	0	0		3.00
4.00 00	400 EMPLOYEE BENEFITS DEPARTMENT	-3, 887	6, 295, 427		4.00
5.00 00	500 ADMINISTRATIVE & GENERAL	-9, 774, 060	16, 270, 660		5. 00
	600 MAINTENANCE & REPAIRS	0	0	l .	6.00
	0700 OPERATION OF PLANT	-814	1, 150, 035	l .	7. 00
	800 LAUNDRY & LINEN SERVICE	0	163, 598		8. 00
	900 HOUSEKEEPI NG	0	598, 486		9.00
	000 DI ETARY	-694	449, 847	l .	10.00
	100 CAFETERI A	-218, 480	99, 275		11.00
	200 MAI NTENANCE OF PERSONNEL	0	0 F04 300	l .	12.00
	300 NURSING ADMINISTRATION 400 CENTRAL SERVICES & SUPPLY	0	586, 289 0		13. 00 14. 00
	500 PHARMACY	-831, 692	0		15.00
	600 MEDICAL RECORDS & LIBRARY	-831, 092	0		16.00
	700 SOCI AL SERVI CE	0	0		17.00
	900 NONPHYSI CI AN ANESTHETI STS	0	0		19.00
	000 NURSI NG PROGRAM	0	o		20.00
21. 00 02	100 I&R SERVICES-SALARY & FRINGES APPRVD	0	o		21.00
22. 00 02	200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		22. 00
IN	PATIENT ROUTINE SERVICE COST CENTERS				
	000 ADULTS & PEDIATRICS	-2, 700	3, 100, 246		30.00
1	100 INTENSIVE CARE UNIT	0	0		31.00
1	200 CORONARY CARE UNIT	0	0		32.00
	300 BURN INTENSIVE CARE UNIT	0	0		33.00
1	3400 SURGICAL INTENSIVE CARE UNIT	0	0		34.00
	000 SUBPROVI DER - I PF	0	0		40.00
	100  SUBPROVI DER - I RF 300  NURSERY	0	224, 921		41.00
	400 SKILLED NURSING FACILITY	0	224, 921		43. 00 44. 00
	500 NURSING FACILITY	0	0		45.00
	600 OTHER LONG TERM CARE	o o	0	l .	46.00
	CILLARY SERVICE COST CENTERS		-		1
50.00 05	OOO OPERATING ROOM	0	1, 988, 093		50.00
	100 RECOVERY ROOM	0	0	l .	51.00
	200 DELIVERY ROOM & LABOR ROOM	0	907, 730		52.00
	300 ANESTHESI OLOGY	-1, 177, 222	0		53.00
1	400 RADI OLOGY-DI AGNOSTI C	-6	2, 415, 940		54.00
	500 RADI OLOGY-THERAPEUTI C	0	0		55.00
4	600 RADI OI SOTOPE	0	0		56.00
	700 CT SCAN 800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		57. 00 58. 00
4	1900 CARDIAC CATHETERIZATION	0	0		59.00
4	000 LABORATORY	0	3, 018, 442		60.00
	001 BLOOD LABORATORY	0			60.01
	100 PBP CLINICAL LAB SERVICES-PRGM ONLY	ő	Ö		61.00
	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	o		62.00
63.00 06	300 BLOOD STORING, PROCESSING & TRANS.	0	o		63.00
64. 00 06	400 INTRAVENOUS THERAPY	0	0		64.00
	500 RESPI RATORY THERAPY	-210	1, 006, 823	l control of the cont	65.00
	600 PHYSI CAL THERAPY	-1, 078	696, 273	l .	66. 00
1	0700 OCCUPATI ONAL THERAPY	0	489, 386		67.00
	800 SPEECH PATHOLOGY	0	201, 202		68.00
	900 ELECTROCARDI OLOGY	0	0		69.00
	OOO ELECTROENCEPHALOGRAPHY	0	421 244		70.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS 200 IMPL. DEV. CHARGED TO PATIENTS	0	431, 246 557, 010		71. 00 72. 00
	300 DRUGS CHARGED TO PATIENTS	0	4, 134, 808		73.00
	400 RENAL DI ALYSI S	0	4, 134, 600		74.00
	500 ASC (NON-DISTINCT PART)	o	n		75.00
	698 HYPERBARI C OXYGEN THERAPY	Ö	473, 536		76. 98
	7700 ALLOGENEIC STEM CELL ACQUISITION	Ö	0		77. 00
	800 CAR T-CELL IMMUNOTHERAPY	0	0		78. 00
	TPATIENT SERVICE COST CENTERS				]
	800 RURAL HEALTH CLINIC	0	0		88. 00
	900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89. 00
	000 CLINIC	0	54, 802	l .	90.00
1	1100 EMERGENCY	-32, 679	2, 113, 854		91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	HER REIMBURSABLE COST CENTERS 400 HOME PROGRAM DIALYSIS	0	0		94.00
/T. UU  U7	TOO TOWN TINOONAM DIALISIS	ı	ı	<u> </u>	1 /4.00

 
 Health Financial
 Systems
 COMMUNITY HOSPIT

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provi der CCN: 15-0146

			10 12/31/2023 Date/II me Pr 5/23/2024 9:	repared: 53 am
Cost Center Description	Adjustments	Net Expenses	, , , , , , , , , , , , , , , , , , , ,	
	(See A-8)	For		
		Allocation		
	6. 00	7. 00		
95. 00 09500 AMBULANCE SERVICES	-1, 631	4, 682, 151		95.00
96. 00  09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
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
102.00 10200 OPIOID TREATMENT PROGRAM	0	0		102. 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 ACQUISITION	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		110.00
111.00 11100 I SLET ACQUISITION	0	0		111.00
113. 00 11300 I NTEREST EXPENSE	0	0		113.00
114.00 11400 UTILIZATION REVIEW-SNF	0	0		114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		115.00
116. 00 11600 HOSPI CE	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-13, 295, 488	53, 636, 971		118. 00
NONREI MBURSABLE COST CENTERS	. 1			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9, 261		190. 00
191. 00 19100 RESEARCH	0	0		191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	39, 455		192. 00
193. 00 19300 NONPALD WORKERS	0	0		193. 00
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0		194.00
194. 01 07951 PAIN CLINIC	0	0		194. 01
194. 02 07952 OCC HEALTH	0	0		194. 02
194. 03 07953 FOUNDATI ON	0	5, 800		194. 03
194. 04 07954 PHYSI CI AN OFFI CES	0	0		194. 04
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	0	182, 521		194. 05
194. 06 07956 VACANT SPACE	0	0		194. 06
200.00   TOTAL (SUM OF LINES 118 through 199)	-13, 295, 488	53, 874, 008		200. 00

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10 RECLASSI FI CATIONS Provi der CCN: 15-0146 Peri od: Worksheet A-6 From 01/01/2023 Date/Time Prepared: 12/31/2023 5/23/2024 9:53 am Increases 0ther Cost Center Sal ary Line # 2.00 3.00 4.00 5.00 INTEREST EXPENSE 1.00 0.00 1.00 B - REHAB THERAPY OCCUPATIONAL THERAPY 1.00 67.00 473, 283 16, 103 1.00 SPEECH PATHOLOGY 194, 582 2.00 68.00 6, 620 2.00 667, 865 22, 723 C - INSURANCE 1.00 CAP REL COSTS-BLDG & FIXT 1.00 0 54, 921 1.00 2.00 2.00 CAP REL COSTS-MVBLE EQUIP 48, 779 2.00 0 103, 700 - CLINIC DIETICIAN 1.00 0.00 1.00 ō G - EMPLOYEE SALARY BENEFITS ADMINISTRATIVE & GENERAL 1.00 5.00 957, 341 0 1.00 2.00 OPERATION OF PLANT 7.00 34, 452 0 2.00 3.00 HOUSEKEEPI NG 9.00 36, 787 0 3.00 10.00 0 4 00 DI FTARY 38.717 4 00 5.00 NURSING ADMINISTRATION 13.00 42,880 0 5.00 6.00 PHARMACY 15.00 57, 248 0 6.00 ADULTS & PEDIATRICS 30.00 7 00 276, 284 0 7 00 8.00 OPERATING ROOM 50.00 100, 812 0 8.00 9.00 RADI OLOGY-DI AGNOSTI C 54.00 126, 098 9.00 10.00 RESPIRATORY THERAPY 65.00 61,007 0 10.00 99, 178 PHYSI CAL THERAPY 11 00 66.00 11 00 12.00 HYPERBARIC OXYGEN THERAPY 76.98 26, 371 0 12.00 13.00 CLINIC 90.00 3, 723 13.00 EMERGENCY 91.00 129, 761 14.00 14.00 15 00 AMBULANCE SERVICES 95 00 100, 559 0 15 00 16.00 PHYSICIANS' PRIVATE OFFICES 192.00 2,801 0 16.00 17.00 COMMUNITY & VOLUNTEER 194.05 17.00 SERVI CES 2, 094, 019 Ō H - CAFETERIA 1.00 CAFETERI A 11.00 215, 060 106, 533 1.00 215, 060 106, 533 I - DEPRECIATION CAP REL COSTS-MVBLE EQUIP 1.00 2.00 161,843 1.00 161, 843 J - HOME OFFICE SALARIES ADMINISTRATIVE & GENERAL 1.00 5.00 7, 589, 561 0 1.00 7, 589, 561 K - LAUNDRY 1 00 0.00 1.00 0 ō ō M - IMPLANTS IMPL. DEV. CHARGED TO 72. 00 0 1.00 557, 010 1.00 PAT I ENTS

ō

159, 466

643, 567

803, 033

11, 369, 538

43.00

52.00

0. 00

0.00

557, 010

65, 455

264, 163

329, 618

1, 281, 427

1.00

2.00

1.00

1.00

500.00

N - OB

NURSERY

P - OTHER

500.00 Grand Total: Increases

DELIVERY ROOM & LABOR ROOM

PERSONAL PROP TAX

1.00

2.00

1.00

A - INTEREST EXPENSE			Decreases				
1.00		Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.	
1.00			7. 00	8. 00	9. 00	10.00	
O	1 00	A - INTEREST EXPENSE	0.00	ما	0		1 100
1.00	1.00				0	<u> </u>	1.00
1.00		B - REHAB THERAPY		<u> </u>			
1.00	1. 00		66. 00	667, 865	22, 723	0	1.00
1. 00				0	0	0	2.00
1.00		0 — — — — —		667, 865	22, 723		
1.00							
1.00		ADMINISTRATIVE & GENERAL		0	103, 700	12	1.00
1.00	2.00		0.00		0	12	2. 00
1.00		0		0	103, 700		_
O	1 00	F - CLINIC DIETICIAN	0.00				4
1.00   MEDIOVE SALARY BENETITS   1.00   1.	1.00				0	<u> </u>	1.00
1.00   EMPLOYEE BEREFITS DEPARTMENT   4,00   2,091,993   0   0   0   2.00   0   0   0   0   0   0   0   0   0		C EMPLOYEE SALARY RENEELTS		U	0		_
2.00   COMMUNITY & VOLUNTEER   194.05   2.026   0   0   0   3.0	1 00		4 00	2 001 003	0	O	1 1 00
SERVICES							
3.00   0.00   0.00   0   0   0   0   0	2.00		171.00	2, 020	· ·		2.00
4.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00	3.00	52.W. 525	0.00	o	0	0	3.00
5.00				ō			4. 00
6.00			0.00	O			5. 00
7. 00			0. 00	o	0	0	6. 00
9.00   0.00   0.00   0   0   0   0   10.00   11.00   11.00   12.00   12.00   0.00   0   0   0   0   0   12.00   12.00   12.00   0.00   0   0   0   0   0   0   12.00	7.00		0.00	O	0	0	7. 00
10.00	8.00			0	0	0	8. 00
11.00	9.00			0	0	0	9. 00
12.00			0.00	0	0	0	10.00
13.00				0	0	0	11.00
14, 00				0			
15.00				0			
1.00				0			
17.00				0			
Note			0.00	0			
H - CAFETERIA	17.00				0	<u> </u>	17.00
1. 00 DI ETARY		U CAEETEDIA		2, 094, 019	0		
1. OC	1 00		10.00	215 060	106 533	0	1 1 00
DEPRECIATION	1.00	0					1.00
1. 00		I - DEPRECLATION		210,000	100,000		
1.00	1.00		1. 00	0	161, 843	9	1.00
1.00   ADMINISTRATIVE & GENERAL   5.00   0   7,589,561   0   0   0   7,589,561   0   0   0   0   0   0   0   0   0							
1.00			·				
1.00	1.00	ADMI NI STRATI VE & GENERAL	5. 00				1.00
1. 00		0		0	7, 589, 561		
0		K - LAUNDRY					
M - IMPLANTS   MEDICAL SUPPLIES CHARGED TO   71.00   0   557,010   0   0   1.00   0   557,010   0   0   1.00   0   1.00   0   0   0   0   0   0   0   0   0	1.00		0.00	•	0	0	1.00
1. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 557, 010 0 1. 00  PATI ENTS 0 0 557, 010 0 557, 010 0 1. 00  N - 0B  ADULTS & PEDI ATRI CS 30. 00 803, 033 329, 618 0 0 2. 00  0 0 0 803, 033 329, 618 0 0 2. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0		0	0		_
PATI ENTS 0 0 557, 010  1. 00 ADULTS & PEDI ATRI CS 30. 00 803, 033 329, 618 0 1. 00  2. 00 0 803, 033 329, 618  P - OTHER  1. 00 0 0 0 0 0 0 1. 00  0 - PERSONAL PROP TAX  1. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
0	1. 00		71. 00	0	557, 010	0	1.00
N - OB ADULTS & PEDI ATRI CS 30.00 803,033 329,618 0 0.00 0 0 0 0 2.00 0 803,033 329,618 P - OTHER  1.00 0 0 0 0 0 0 1.00 0 0 0 0 0 1.00 0 0 0 0 1.00 1.00			+	+		<del> </del>	
1. 00 ADULTS & PEDIATRICS 30. 00 803, 033 329, 618 0 2. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				U	557,010		_
2. 00	1 00		20.00	902 022	220 410		1 00
0 803, 033 329, 618  P - OTHER  1. 00 0 0 0 0 1. 00  0 - PERSONAL PROP TAX  1. 00 0 0 0 0 1. 00  1. 00 0 0 1. 00		ADULIS & PEDIATRICS		003, 033			
1. 00 P - OTHER  1. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	∠. ∪∪		— — <del>" 0. 00 </del>	803 033 0			2.00
1. 00		D _ OTHER		003, 033	327, 018		
0	1 00	F - UTHER	0.00	٥	^		1 100
1.00 Q - PERSONAL PROP TAX  1.00 0 0 0 0 1.00  1.00	1.00		— — <del>"                                 </del>	쓹		+	1.00
1.00 0 0 0 0 1.00		O - PERSONAL PROP TAX		U	0		
	1 00	2 I LIGOTIAL I RUF TAX	0.00	٥	0	n	1 100
500.00 Grand Total: Decreases 3,779,977 8,870,988 500.00	1. 50			<del> </del> _	0	<del> </del>	1.00
[ 5,11,11]	500.00	Grand Total: Decreases		3, 779, 977	8, 870, 988		500.00
			1	-1 -1 -1 -1	., ,	1	1

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

Provi der CCN: 15-0146

				'	12/31/2023	5/23/2024 9:5	3 am
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2.00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	0	0	(	0	0	
2.00	Land Improvements	755, 392	0	(	0	0	2.00
3.00	Buildings and Fixtures	4, 270, 602	0	(	0	0	3.00
4.00	Building Improvements	21, 157	0	(	0	0	4.00
5.00	Fixed Equipment	900, 581	0	(	0	0	5.00
6.00	Movable Equipment	14, 448, 659	1, 764, 566	C	1, 764, 566	891, 538	6.00
7.00	HIT designated Assets	3, 173, 747	162, 883	C	162, 883	0	7. 00
8.00	Subtotal (sum of lines 1-7)	23, 570, 138	1, 927, 449	C	1, 927, 449	891, 538	8. 00
9.00	Reconciling Items	3, 173, 747	162, 883	C	162, 883	0	9. 00
10.00	Total (line 8 minus line 9)	20, 396, 391	1, 764, 566	C	1, 764, 566	891, 538	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	0	0				1.00
2.00	Land Improvements	755, 392	354, 030				2.00
3.00	Buildings and Fixtures	4, 270, 602	795, 986				3.00
4.00	Building Improvements	21, 157	21, 157				4.00
5.00	Fixed Equipment	900, 581	94, 324				5.00
6.00	Movable Equipment	15, 321, 687	8, 485, 280				6.00
7.00	HIT designated Assets	3, 336, 630	0				7. 00
8.00	Subtotal (sum of lines 1-7)	24, 606, 049	9, 750, 777				8.00
9.00	Reconciling Items	3, 336, 630	0				9. 00
10.00	Total (line 8 minus line 9)	21, 269, 419	9, 750, 777				10.00

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

					rom 01/01/2023 o 12/31/2023		pared: 3 am
			SU	JMMARY OF CAPIT	AL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see instructions)	
					instructions)	,	
		9. 00	10. 00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	399, 040	1, 531, 192	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	670, 834	55, 325	14, 085	0	3, 050	2.00
3.00	Total (sum of lines 1-2)	1, 069, 874	1, 586, 517	14, 085	0	3, 050	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1)				
		Capi tal -Relat					
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI					
1. 00	CAP REL COSTS-BLDG & FLXT	0	1, 930, 232	•			1. 00
2. 00	CAP REL COSTS-MVBLE EQUIP	0	743, 294	•			2.00
3. 00	Total (sum of lines 1-2)	0	2, 673, 526				3. 00

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

	MITT HOST TAL				U OI TOTIII CIVIS-2	
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		eri od:	Worksheet A-7	
				rom 01/01/2023		
				o 12/31/2023		
	0014	DUTATION OF DA	TI 00	ALLOCATION OF	5/23/2024 9: 5	3 am
	COM	PUTATION OF RA	1105	ALLOCATION OF	OTHER CAPITAL	
				D 11 (		
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						
1.00 CAP REL COSTS-BLDG & FLXT	5, 947, 732	0	5, 947, 732	0. 244483	0	1.00
2. 00 CAP REL COSTS-MVBLE EQUIP	18, 658, 318	278, 215	18, 380, 103	0. 755517	0	2.00
3.00 Total (sum of lines 1-2)	24, 606, 050	278, 215	24, 327, 835	1.000000	0	3.00
	ALLOCA <sup>-</sup>	TION OF OTHER (	CAPI TAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at				
		ed Costs	through 7)			
	6, 00	7. 00	8.00	9, 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		7.00	0.00	7.00	10.00	
1. 00 CAP REL COSTS-BLDG & FIXT	0	0		-1, 243, 577	1, 531, 192	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0			1, 063, 116		2.00
3.00 Total (sum of lines 1-2)	0			-180, 461		3.00
3.00   Total (Suill Of Titles 1-2)	0		JMMARY OF CAPIT		1, 300, 317	3.00
		30	JIVIIVIART OF CAPIT	AL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
cost center bescription	Tillerest	(see		Capi tal -Rel at		
		,	I listi ucti olis)			
		instructions)		ed Costs (see	9 through 14)	
	11.00	10.00	40.00	instructions)	45.00	
DART LILL DESCRIPTION OF CARLEY COOTS OF	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C			1 -	_	0.40 ==:	
1.00 CAP REL COSTS-BLDG & FIXT	0			_	342, 536	1.00
2. 00 CAP REL COSTS-MVBLE EQUIP	14, 085				, ,	2.00
3.00  Total (sum of lines 1-2)	14, 085	103, 700	3, 050	0	1, 526, 891	3.00

	Financial Systems	СОММО	NITY HOSPITAL O	Provider CCN: 15 0146		u of Form CMS-2 Worksheet A-8	2552-10
ADJUS1	MENTS TO EXPENSES				Period: From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
				Expense Classification or		5/23/2024 9: 5	3 am
			Т	o/From Which the Amount is			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3. 00	4.00	Ref. 5.00	
1. 00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FLXT	1.00	0	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		olo	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2.00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00
	(chapter 2)		9				
4. 00	Trade, quantity, and time discounts (chapter 8)		o o		0.00	0	4. 00
5. 00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5. 00
6. 00	Rental of provider space by suppliers (chapter 8)		0		0. 00	0	6. 00
7. 00	Tel ephone servi ces (pay	А	-11, 597 A	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service (chapter 21)	А	-763 C	PERATION OF PLANT	7. 00	0	8. 00
9.00	Parking Lot (chapter 21)		0		0.00	0	9.00
10. 00	Provi der-based physician adjustment	A-8-2	-1, 209, 901			0	10. 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12. 00		A-8-1	-5, 672, 241			0	12.00
	Laundry and linen service		О		0.00	0	13. 00
	Cafeteria-employees and guests Rental of quarters to employee	A	-51, 777 C O	CAFETERI A	11. 00 0. 00	0	14. 00 15. 00
	and others Sale of medical and surgical		0		0.00	0	16. 00
10.00	supplies to other than		o o		0.00	J	10.00
17. 00	patients Sale of drugs to other than		О		0.00	0	17.00
18. 00	patients Sale of medical records and		0		0.00	0	18. 00
	abstracts Nursing and allied health				0.00	0	19. 00
19.00	education (tuition, fees,				0.00	O	19.00
20. 00	books, etc.) Vending machines		O		0.00	0	20. 00
21. 00	Income from imposition of interest, finance or penalty		0		0.00	0	21. 00
00.00	charges (chapter 21)				0.00		00.00
22.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	OIR	RESPI RATORY THERAPY	65.00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	OP	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		olu	JTILIZATION REVIEW-SNF	114. 00		25.00
	(chapter 21)					_	
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		OC	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		olc	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
	Non-physician Anesthetist		0	IONPHYSICIAN ANESTHETISTS	19.00	0	28.00
	Physicians' assistant Adjustment for occupational	A-8-3	0 0	OCCUPATI ONAL THERAPY	0. 00 67. 00	U	29. 00 30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		OA	DULTS & PEDIATRICS	30. 00		30. 99
	instructions)	l	ı I		1 1		

ADJUSTMENTS TO EXPENSES Provider CCN: 15-0146 Peri od: Worksheet A-8 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/23/2024 9:53 am 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 32.00 0 0.00 Depreciation and Interest OTHER ADJUSTMENTS (SPECIFY) 33.00 0.00 33.00 (3)33.01 TELEPHONE -3, 887 EMPLOYEE BENEFITS DEPARTMENT 4.00 33.01 0 Α PHARMACY SALES -829, 533 PHARMACY 33.05 В 15.00 0 33.05 33.06 SELF INSURANCE OEMPLOYEE BENEFITS DEPARTMENT 4.00 33.06 Α LOBBY DUES 33.09 -6, 467 ADMINISTRATIVE & GENERAL 5.00 33.09 Α -1, 526, 264 CAP REL COSTS-BLDG & FIXT INTERUNIT SUBSIDY 1.00 33.14 33. 14 Α 33. 18 OTHER OPERATING REVENUE В -51 OPERATION OF PLANT 7.00 33.18 OTHER OPERATING REVENUE -694 DI ETARY 10.00 33. 20 33. 20 В OTHER OPERATING REVENUE В -166, 703 CAFETERI A 11.00 33. 21 33, 21 0 -2, 159 PHARMACY OTHER OPERATING REVENUE 15.00 33.23 В 33.23 -2, 700 ADULTS & PEDIATRICS 33. 24 OTHER OPERATING REVENUE В 30.00 0 33.24 OTHER OPERATING REVENUE -6 RADI OLOGY-DI AGNOSTI C 54.00 33. 25 33. 25 В OTHER OPERATING REVENUE -210 RESPIRATORY THERAPY 65.00 0 33.26 33. 26 В OTHER OPERATING REVENUE -1, 078 PHYSI CAL THERAPY 0 33 27 В 66.00 33 27 33.30 OTHER OPERATING REVENUE В -1, 631 AMBULANCE SERVICES 95.00 0 33.30 OTHER OPERATING REVENUE OCOMMUNITY & VOLUNTEER 33.31 В 194.05 33.31 SERVI CES ADMIN PHYS SALARIES 38, 556 ADMINISTRATIVE & GENERAL 5.00 33. 33 0 33.33 Α 33.34 LOBBYING EXPENSE Α OPHYSICAL THERAPY 66.00 0 33.34 33. 35 LOBBYING EXPENSE Α -2, 442 ADMINISTRATIVE & GENERAL 5.00 33.35 33 36 HOSPITAL ASSESSMENT FEE -4, 119, 869 ADMI NI STRATI VE & GENERAL 33 36 5 00 Α DEPRECIATION RELIFING 45, 490 CAP REL COSTS-BLDG & FIXT 33.37 Α 1.00 33.37 ADJUSTMENT-BLD DEPRECIATION RELIFING 230, 439 CAP REL COSTS-MVBLE EQUIP 33.38 33.38 Α 2.00 ADJUSTMENT-EQU TOTAL (sum of lines 1 thru 49) 50.00 50.00 -13, 295, 488 (Transfer to Worksheet A,

column 6, line 200.)

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

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

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

B. Amount Received - if cost cannot be determined.

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

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

OFFICE	C0515			Γο 12/31/2023		
	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 ADJUSTI	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OF	R CLAIMED HOME	
	OFFICE COSTS:					
1.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	14, 048, 332	11, 377, 727	1.00
2.00	5. 00	ADMINISTRATIVE & GENERAL	PPG SUBSI DY	0	7, 881, 810	2.00
3.00	5. 00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE ELIMINATION	0	461, 036	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			14, 048, 332	19, 720, 573	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/					
Symbol (1)	Name	Percentage of	Name	Percentage of				
		Ownershi p		Ownershi p				
1. 00	2. 00	3. 00	4. 00	5. 00				
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

6. 00	В	0.00 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.

Health Financial Systems			COMMUNITY HOSPITAL	OF NOBLE CTY, INC	In Lie	u of Form CMS-	2552-10
STATEME OFFICE		SERVICES FROM	RELATED ORGANIZATIONS AND HOM	E Provider CCN: 15-0146	Peri od: From 01/01/2023 To 12/31/2023	Worksheet A-8 Date/Time Pre	
					10 12/31/2023	5/23/2024 9:5	
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:						
1.00	2, 670, 605	0					1.00
2.00	-7, 881, 810	0					2.00
3.00	-461, 036	0					3.00
4.00	0	0					4.00
5.00	-5, 672, 241						5.00
* The	amounts on line	es 1-4 (and sub	bscripts as appropriate) are t	ransferred in detail to Wo	orksheet A, column	6, lines as	
appropr	iate. Positive a	amounts increas	se cost and negative amounts d	ecrease cost. For related o	organization or ho	me office cos	t which
			columns 1 and/or 2, the amoun				
	Related Orga	anization(s)					
	and/or Ho						
	Type of	Busi ness					

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:

- 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 01/01/2023 To 12/31/2023 Date/Time Prepared: Provi der CCN: 15-0146

									То	12/31/2023	Date/Time Pre 5/23/2024 9:5	
	Wkst. A Line #		Cost	Center/Physi ci an	Total	Pro	fessi onal	Provi der		RCE Amount	Physi ci an/Prov	
				I denti fi er	Remuneration	Co	omponent	Component			ider Component	
											Hours	
	1. 00			2. 00	3. 00		4.00	5. 00		6. 00	7. 00	
1. 00	53.00				1, 177, 222		1, 177, 222		0	239, 400	0	1. 00
2.00	91.00	DR.	В		40, 000		0	40, 00	00	211, 500	72	2.00
3.00	0.00				C		0		0	0	0	3.00
4.00	0.00				C		0		0	0	0	4.00
5. 00	0.00				C		0		0	0	0	5.00
6.00	0.00				C		0		0	0	0	6.00
7.00	0.00				C		0		0	0	0	7.00
8.00	0.00				C		0		0	0	0	8.00
9.00	0.00				C		0		0	0	0	9.00
10.00	0.00				C		0		0	0	0	10.00
200.00					1, 217, 222		1, 177, 222		00			200.00
	Wkst. A Line #		Cost	Center/Physi ci an	Unadjusted RCE			Cost of			Physician Cost	
				l denti fi er	Li mi t	Unad		Memberships			of Malpractice	
							Limit	Conti nui ng	S	hare of col.	Insurance	
								Educati on		12		
	1.00			2. 00	8. 00		9. 00	12. 00	_	13. 00	14. 00	
1. 00	53. 00				C	1	0		0	0	0	1.00
2. 00	91. 00		В		7, 321		366		0	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	4				2	0		0	0	0	5.00
6. 00	0.00	4				2	0		0	0	0	6.00
7. 00	0.00	4				2	0		0	0	0	7.00
8. 00	0.00	4				2	0		0	0	0	8.00
9. 00	0.00	4				2	0		0	0	0	9.00
10.00	0.00				7 004	<u>'</u>	0			0	0	10.00
200.00	WI+ A I : //		C+	C+/Db	7, 321		366		0	0	0	200.00
	Wkst. A Line #		Cost	Center/Physician	Provi der	Adj	usted RCE	RCE		Adjustment		
				I denti fi er	Component Share of col.		Limit	Di sal I owance	•			
					14							
	1.00			2. 00	15. 00		16. 00	17. 00		18. 00		
1. 00	53. 00				C	)	0		0	1, 177, 222		1. 00
2.00	91.00	DR.	В			o	7, 321	32, 67	9	32, 679		2.00
3.00	0.00					ol	0		0	0		3.00
4.00	0.00				C	o	0		0	0		4.00
5.00	0.00				C	o	0		0	0		5.00
6.00	0.00					)	0		0	O		6.00
7.00	0.00				C	o	0		0	0		7.00
8.00	0.00					)	0		0	o		8.00
9.00	0.00					)	0		0	0		9.00
10.00	0.00					)	0		0	0		10.00
200.00					C	)	7, 321	32, 67	9	1, 209, 901		200.00

| Period: | Worksheet B | From 01/01/2023 | Part | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS COMMUNITY HOSPITAL OF NOBLE CTY, INC
Provider CCN: 15-0146

					o 12/31/2023		
			CAPI TAL REI	LATED COSTS		5/23/2024 9: 5	3 am
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	oust deliter bescription	for Cost	DEDG & TTXT	MVBLL LQOIT	BENEFI TS	Subtotal	
		Allocation (from Wkst A			DEPARTMENT		
		col. 7)					
	CENEDAL SERVICE COST CENTERS	0	1. 00	2. 00	4. 00	4A	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	342, 536	342, 536				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	1, 184, 355	l e	1, 184, 355			2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	6, 295, 427 16, 270, 660	0 74, 039		-,,	18, 548, 550	4. 00 5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	1, 150, 035 163, 598	1	1	111, 530 0	1, 316, 925 166, 059	7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	598, 486	3, 560	3, 727	119, 088	724, 861	9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	449, 847 99, 275	l	1		541, 856 155, 332	10.00 11.00
12. 00	01200 MAINTENANCE OF PERSONNEL	0	0	I		133, 332	12.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	586, 289	997 9, 155	l .		726, 203 9, 155	13. 00 14. 00
15. 00	01500 PHARMACY	0	2, 700	l .	-	191, 425	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	4, 124	0	0	4, 124	16.00
17. 00 19. 00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0		0	0	0	17. 00 19. 00
20. 00	02000 NURSING PROGRAM	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	0	21. 00 22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	3, 100, 246	43, 059	95, 527 0		3, 848, 186 0	30.00 31.00
32. 00	03200 CORONARY CARE UNIT	0	ő	ő	Ö	0	32.00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	33. 00 34. 00
40.00	04000 SUBPROVI DER – I PF	0		0	0	0	40.00
41.00	04100 SUBPROVI DER - I RF	0	0	7 222	0	0	41.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	224, 921 0	619 0			270, 924 0	43. 00 44. 00
45. 00	04500 NURSING FACILITY	0	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	1, 988, 093	45, 047	157, 605	289, 706	2, 480, 451	50.00
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	907, 730	0 3, 975	0 29, 592	0 153, 565	0 1, 094, 862	51.00 52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 55. 00	05400   RADI OLOGY-DI AGNOSTI C   05500   RADI OLOGY-THERAPEUTI C	2, 415, 940	21, 773	360, 951	347, 715 0	3, 146, 379 0	54. 00 55. 00
56.00	05600 RADI 0I SOTOPE	0	ő	ő	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	59.00
60.00	06000 LABORATORY	3, 018, 442	8, 320	0	0	3, 026, 762	60.00
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		U	0	60. 01 61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	1		0	62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0	0		0	63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	1, 006, 823	l	1		1, 298, 053	65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	696, 273 489, 386				889, 985 602, 318	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	201, 202	ő	ő		247, 632	68. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	69. 00 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	431, 246	Ö	Ö	0	431, 246	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	557, 010	l e	0	0	557, 010	1
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	4, 134, 808 0	0	0	0	4, 134, 808 0	73. 00 74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	-	0	75.00
76. 98 77. 00	07698 HYPERBARIC OXYGEN THERAPY 07700 ALLOGENEIC STEM CELL ACQUISITION	473, 536 0	4, 226 0	13, 331		576, 464 0	76. 98 77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0			0	78. 00
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC	0	l 0	0	O	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	O	0	0	89. 00
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	54, 802 2, 113, 854	l	0 35, 910	,	66, 855 2, 573, 927	90. 00 91. 00
71.00	107.00  EMERGENOT	2, 113, 034	10,032	35, 710	1 400, 131	2,010,721	, , , , , , ,

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0146 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/23/2024 9:53 am CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP Subtotal for Cost BENEFLTS DEPARTMENT Allocation (from Wkst A col. 7) 0 1.00 2.00 4. 00 4A 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 O OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 95.00 09500 AMBULANCE SERVICES 4, 682, 151 328, 068 920, 646 5, 930, 865 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 96.00 0  $\cap$ 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 0 97.00 99. 00 09900 CMHC 0 0 0 0 99.00 0 0 o 99. 10 09910 CORF 0 99. 10 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 0 101.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 0 0 0 105. 00 106.00 10600 HEART ACQUISITION 0 0 0 0 0 106.00 0 107. 00 10700 LIVER ACQUISITION 0 0 0 0 107.00 0 108. 00 10800 LUNG ACQUISITION 0 0 108 00 Ω 109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 0 0 0 111.00 11100 I SLET ACQUISITION 0 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 0 116,00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 53, 636, 971 311, 546 1, 183, 294 6, 251, 724 53, 561, 217 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 11, 856 190. 00 9, 261 2, 513 82 191. 00 19100 RESEARCH 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 39, 455 16, 195 202 9,067 64, 919 192. 00 193. 00 19300 NONPALD WORKERS 0 193.00 0 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 194.00 0 0 0 194. 01 07951 PAIN CLINIC 0 194 01 0 C 0 0 194. 02 07952 OCC HEALTH 0 0 0 194. 02 194. 03 07953 FOUNDATI ON 5, 800 194. 03 5,800 C 0 0 194. 04 07954 PHYSICIAN OFFICES 0 194, 04 C 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 230, 216 194. 05 182, 521 12, 282 777 34, 636 0 194.06 194.06 07956 VACANT SPACE C 200.00 Cross Foot Adjustments 0 200.00 Negative Cost Centers 0 201.00 201.00 202.00 TOTAL (sum lines 118 through 201) 53, 874, 008 342, 536 1, 184, 355 6, 295, 427 53, 874, 008 202. 00 Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Cost Center Description	ADMI NI STRATI V	MAINTENANCE &	OPERATION OF	LAUNDRY &	5/23/2024 9: 5 HOUSEKEEPI NG	3 am
oost content bescription	E & GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5. 00	6. 00	7. 00	8. 00	9. 00	
1. 00 GENERAL SERVICE COST CENTERS  1. 00 O0100 CAP REL COSTS-BLDG & FLXT			1			1 00
1.00   00100   CAP REL COSTS-BLDG & FLXT 2.00   00200   CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00 O0400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	18, 548, 550					5. 00
6.00 00600 MAINTENANCE & REPAIRS	0	0				6.00
7.00 00700 OPERATION OF PLANT	691, 486	0	2, 008, 411			7.00
8.00   00800   LAUNDRY & LINEN SERVICE	87, 194	0	20, 603			8.00
9. 00   00900   HOUSEKEEPI NG	380, 607	0	29, 802	0	1, 135, 270	9. 00
10. 00   01000   DI ETARY	284, 516	0	65, 847	0	38, 179	10.00
11. 00   01100   CAFETERI A 12. 00   01200   MAI NTENANCE OF PERSONNEL	81, 561	0	39, 687 0	0	23, 011 0	11. 00 12. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	381, 312	0	8, 345	0	4, 839	13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	4, 807	0	76, 649		44, 442	14. 00
15. 00 01500 PHARMACY	100, 513	0	22, 601	0	13, 104	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	2, 165	0	34, 526	0	20, 019	16.00
17. 00   01700   SOCI AL SERVI CE	0	0	0	0	0	17.00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	19. 00
20. 00 02000 NURSI NG PROGRAM	0	0	0	0	0	20.00
21.00   02100   L&R SERVICES-SALARY & FRINGES APPRVD 22.00   02200   L&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	21. 00 22. 00
I NPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		<u> </u>		0	22.00
30. 00   03000   ADULTS & PEDI ATRI CS	2, 020, 590	0	360, 496	106, 184	209, 019	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00 03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34. 00   03400   SURGI CAL INTENSI VE CARE UNI T	0	0	0	0	0	34.00
40. 00   04000   SUBPROVI DER -   I PF	0	0	0	0	0	40. 00 41. 00
41. 00   04100   SUBPROVI DER - I RF 43. 00   04300   NURSERY	142, 256	0	5, 182	1, 713	0 3, 005	41.00
44. 00 04400 SKILLED NURSING FACILITY	142, 230	0	3, 162	1, 713	3,003	44.00
45. 00 04500 NURSING FACILITY		0	Ö	0	0	45. 00
46.00 04600 OTHER LONG TERM CARE	O	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATING ROOM	1, 302, 425	0	377, 148	59, 807	218, 674	50.00
51. 00   05100   RECOVERY ROOM	0	0	0	0	10, 205	51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM 53. 00   05300   ANESTHESI OLOGY	574, 886	0	33, 278	1, 714	19, 295 0	52. 00 53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 652, 088	0	182, 288	27, 509	105, 692	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   05700   CT   SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0 (5)	0	0	59.00
60. 00   06000  LABORATORY 60. 01   06001  BLOOD LABORATORY	1, 589, 280	0	69, 656	0	40, 387 0	60. 00 60. 01
61. 00   06100   PBP CLINICAL LAB SERVICES-PRGM ONLY	١	Ü	0	U	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.	O	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	681, 576	0	44, 432	·	25, 762	65.00
66. 00   06600   PHYSI CAL THERAPY	467, 310	0	192, 069	0	111, 363	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	316, 263	0	0	0	0	67.00
68. 00   06800   SPEECH PATHOLOGY 69. 00   06900   ELECTROCARDI OLOGY	130, 026	0	0	0	0	68. 00 69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0		0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	226, 437	0	0	0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	292, 473	0	Ö	Ō	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 171, 088	0	0	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	302, 687	0	35, 380	396	20, 513	76. 98
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0	ı <sub>l</sub> 0	0	0	78. 00
88. 00 08800 RURAL HEALTH CLINIC	O	0	0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	Ö	Ō	0	89.00
90. 00 09000 CLI NI C	35, 104	0	Ō	0	0	90.00
91. 00 09100 EMERGENCY	1, 351, 507	0	150, 966	64, 432	87, 532	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS  94. 00 09400 HOME PROGRAM DIALYSIS	1 0	0	0	_	0	04.00
95. 00   09500   AMBULANCE SERVI CES	3, 114, 155	0		0	0	94. 00 95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	Ö			0	96.00
· · · · · ·						

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0146 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/23/2024 9:53 am ADMINISTRATIV MAINTENANCE & Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG E & GENERAL **REPAIRS** LINEN SERVICE PLANT 9. 00 5.00 6.00 7.00 8.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 0 0 0 0 99.00 09900 CMHC 0 0 99.00 99. 10 09910 CORF 0 0 0 0 99. 10 0 0 0 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 C 102.00 10200 OPIOID TREATMENT PROGRAM 0 0 0 0 0 102.00 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 0 0 106.00 0 107.00 10700 LIVER ACQUISITION 0 0 0 107.00 0 0 108. 00 10800 LUNG ACQUISITION 0 0 0 108.00 109. 00 10900 PANCREAS ACQUISITION 0 0 109 00 0 0 0 110.00 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 1114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 115.00 116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 18, 384, 312 0 1, 748, 955 271, 794 984, 836 118.00 118.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0146

Period: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

5/23/2024 9:53 am Cost Center Description DI ETARY CAFETERI A MAI NTENANCE NURSI NG CENTRAL ADMI NI STRATI O SERVICES & OF PERSONNEL **SUPPLY** Ν 12.00 10 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 930, 398 10 00 01100 CAFETERI A 299, 591 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 0 12.00 13.00 01300 NURSING ADMINISTRATION 0 7,460 1, 128, 159 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 143, 407 14.00 01500 PHARMACY 1,847 15 00 0 0 8.585 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 0 0 16.00 01700 SOCIAL SERVICE 0 17 00 0 0 17.00 0 0 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 0 0 19.00 02000 NURSING PROGRAM 0 0 20 00 C 0 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 0 21.00 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 0 0 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 930, 398 48.475 0 445, 682 17, 510 30.00 31.00 03100 INTENSIVE CARE UNIT 0 0 31.00 32.00 03200 CORONARY CARE UNIT 0 0 0 0 32.00 C 0 03300 BURN INTENSIVE CARE UNIT 0 33.00 C 0 0 33.00 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 C 0 0 34.00 04000 SUBPROVI DER - I PF 0 40.00 0 0 0 40.00 0 04100 SUBPROVI DER - I RF 0 41.00 C 0 0 41.00 04300 NURSERY 0 43.00 2, 981 27, 406 0 43.00 0 44.00 04400 SKILLED NURSING FACILITY 0 0 44.00 04500 NURSING FACILITY 0 45.00 0 0 0 45.00 46.00 04600 OTHER LONG TERM CARE 0 46 00 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 20, 582 0 189, 230 23, 132 50.00 0 51.00 05100 RECOVERY ROOM 0 0 51.00 0 52 00 05200 DELIVERY ROOM & LABOR ROOM 12, 031 0 110, 613 52 00 0 05300 ANESTHESI OLOGY 0 53.00 0 0 0 53.00 4, 791 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 27.849 54.00 0 55 00 05500 RADI OLOGY-THERAPEUTI C 0 0 Ω 55 00 C 05600 RADI OI SOTOPE 0 56.00 C 0 0 56.00 0 05700 CT SCAN 0 57.00 57.00 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 58.00 0 0 05900 CARDI AC CATHETERI ZATI ON 0 59 00 59 00 0 0 60.00 06000 LABORATORY 0 0 0 60.00 60.01 06001 BLOOD LABORATORY 0 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 62 00 C 0 0 62 00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. C 0 0 0 63.00 06400 I NTRAVENOUS THERAPY 0 0 64.00 0 64.00 0 06500 RESPIRATORY THERAPY 0 0 4,879 65.00 15, 755 0 65.00 66 00 06600 PHYSI CAL THERAPY 10, 525 0 854 66.00 06700 OCCUPATI ONAL THERAPY 8, 610 0 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 3, 540 0 O 68.00 0000000 06900 ELECTROCARDI OLOGY 0 69.00 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY C 0 0 Λ 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 50,064 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 C 0 0 3, 180 73.00 74.00 07400 RENAL DIALYSIS C 0 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 75.00 0 07698 HYPERBARI C OXYGEN THERAPY 0 74, 821 5, 330 76.98 76.98 8.138 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77 00 C 0 77 00 78.00 0 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 09000 CLI NI C 0 0 217 90.00 851 90.00 91.00 09100 EMERGENCY 30, 499 0 280, 407 15, 946 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 95. 00 09500 AMBULANCE SERVICES 87, 792 0 0 15, 135 95.00 Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-0146

			1	0 12/31/2023	Date/IIMe Pre   5/23/2024 9:5	
Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	
·			OF PERSONNEL	ADMI NI STRATI O	SERVICES &	
				N	SUPPLY	
	10. 00	11. 00	12.00	13.00	14.00	
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
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10  09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0		101.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS			1			
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0		105.00
106. 00 10600 HEART ACQUISITION	0	0	0	0		106.00
107. 00 10700 LI VER ACQUI SI TI ON	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   NTESTINAL ACQUISITION	0	0	0	0		110.00
111. 00 11100   SLET ACQUISITION	0	0	0	ol ol	0	111.00
113. 00 11300   INTEREST EXPENSE						113.00
114. 00 11400 UTILIZATION REVIEW-SNF		0			0	114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0			115.00
116.00 11600 HOSPICE 118.00  SUBTOTALS (SUM OF LINES 1 through 117)	020 200	202 472		1 120 150	142, 885	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	930, 398	293, 673		1, 128, 159	142, 885	] 1 1 8 . UU
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	ار	113	190. 00
191. 00 19100 RESEARCH		0				191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		1, 268				192.00
193. 00 19300 NONPALD WORKERS		1, 200	١	i ol		193.00
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS		0	١			194.00
194. 01 07951 PAIN CLINIC		0	١	o o		194. 01
194. 02 07952 OCC HEALTH		0	0	o o		194. 02
194. 03 07953 FOUNDATI ON		0	0	o o		194. 03
194. 04 07954 PHYSI CI AN OFFI CES	o	0	0	o		194. 04
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	l ol	4, 650	l o	ol		194. 05
194. 06 07956 VACANT SPACE	o	0	0	ol	0	194.06
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	o	0	0	ol		201.00
202.00 TOTAL (sum lines 118 through 201)	930, 398	299, 591	0	1, 128, 159	143, 407	
	'		•			•

| Period: | Worksheet B | From 01/01/2023 | Part | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS COMMUNITY HOSPITAL OF NOBLE CTY, INC
Provider CCN: 15-0146

					o 12/31/2023		
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	NURSI NG PROGRAM	os alli
		15. 00	16. 00	17. 00	19. 00	20.00	
13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS-BLDG & FIXT  00200 CAP REL COSTS-BUDG & 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  01100 CAFETERIA  01200 MAINTENANCE OF PERSONNEL  01300 NURSING ADMINISTRATION  01400 CENTRAL SERVICES & SUPPLY  01500 PHARMACY  01600 MEDICAL RECORDS & LIBRARY  01700 SOCIAL SERVICE  01900 NONPHYSICIAN ANESTHETISTS  02000 NURSING PROGRAM  02100 I&R SERVICES-SALARY & FRINGES APPRVD  02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	338, 075 0 0 0 0 0	60, 834 0 0 0 0	C C C C		0	1. 00 2. 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 19. 00 20. 00 21. 00 22. 00
33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY 04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0 0 0 0 0 0 0 0	3, 746 0 0 0 0 0 0 196 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00
62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 98 77. 00 78. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05100 RECOVERY ROOM & LABOR ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC 05500 RADIOLOGY-THERAPEUTIC 05600 RADIOLOGY-THERAPEUTIC 05600 RADIOLOGY-THERAPEUTIC 05600 RADIOLOGY-THERAPEUTIC 05900 CARDIAC CATHETERIZATION 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06600 PHYSICAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 07698 HYPERBARIC OXYGEN THERAPY 07700 ALLOGENEIC STEM CELL ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6, 278 0 790 0 9, 939 0 0 0 0 0 9, 075 0 0 0 3, 250 1, 085 351 250 0 0 660 723 5, 952 0 0 1, 107			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 60. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 98 77. 00 78. 00
88. 00 89. 00 90. 00 91. 00 92. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 0 0 0	0 0 59 12, 048	0 0 0 0	0	0 0 0 0	89. 00 90. 00
94. 00 95. 00	OTHER REIMBURSABLE COST CENTERS O9400 HOME PROGRAM DI ALYSIS O9500 AMBULANCE SERVICES	0	0 5, 325	0	1	0	

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 01/01/2023 Part I 12/31/2023 Date/Time Prepared: 5/23/2024 9:53 am Cost Center Description **PHARMACY** MEDI CAL SOCI AL NONPHYSI CI AN NURSI NG RECORDS & SERVI CE ANESTHETI STS **PROGRAM** LI BRARY 15. 00 17.00 19.00 20.00 16 00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 96.00 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 97.00 09900 CMHC 0 99.00 99.00 0 0 0 0 0 0 0 0 99. 10 99. 10 09910 CORF 0 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 0 105.00 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 106.00 10600 HEART ACQUISITION 0000 0 0 0 0 0 106.00 107.00 10700 LIVER ACQUISITION 0 0 107.00 0 108.00 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 0 110.00 0 111.00 11100 I SLET ACQUISITION o 0 Ω 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 115.00 0 0 0 0 116. 00 11600 HOSPI CE 0 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 338, 075 60,834 0 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 0 0 191. 00 19100 RESEARCH 0 C 0 191.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 00000000 0 0 0 0 0 0 0 0 0 0 193. 00 19300 NONPALD WORKERS 0 0 193.00 0 194.00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 194.00 0 194. 01 07951 PAIN CLINIC 0 0 194.01 194. 02 07952 OCC HEALTH 0 0 194. 02 194. 03 07953 FOUNDATI ON 0 0 194. 03 0 194. 04 07954 PHYSICIAN OFFICES 0 0 0 194.04 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 0 194. 05 0

0

60,834

338, 075

0

0

0

0 194.06

0 200.00

0 201.00

0 202.00

194.06 07956 VACANT SPACE

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

200.00

201.00

202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0146

				To	12/31/2023	Date/Time Pre 5/23/2024 9:5	
		INTERNS &	RESI DENTS			7 20, 2021 7. 0	
	Cook Cooker December 1	CEDVI CEC CALA	CEDVI CEC OTHE	Cubastal	1 + 0	T-+-1	
	Cost Center Description	RY & FRINGES	SERVICES-OTHE R PRGM COSTS	Subtotal	Intern & Residents	Total	
		KI & IKINGLS	K FRGW COSTS		Cost & Post		
					Stepdown		
		24.22		0.4.00	Adjustments	04.00	
	GENERAL SERVICE COST CENTERS	21. 00	22. 00	24. 00	25. 00	26. 00	
	00100 CAP REL COSTS-BLDG & FIXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	00500 ADMI NI STRATI VE & GENERAL						5.00
	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6. 00 7. 00
	00800 LAUNDRY & LINEN SERVICE						8.00
	00900 HOUSEKEEPI NG						9.00
	01000 DI ETARY						10.00
	01100 CAFETERI A						11.00
	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION						12.00 13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY						15.00
	01600 MEDICAL RECORDS & LIBRARY						16.00
	01700 SOCIAL SERVICE						17.00
	01900 NONPHYSI CI AN ANESTHETI STS						19.00
	02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0					20. 00 21. 00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD		ĺ				22. 00
- t	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	0	ł .		0	7, 990, 286	
	03100 INTENSIVE CARE UNIT	0			0	0	
	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	
	03400 SURGICAL INTENSIVE CARE UNIT		Ö	Ö	ő	Ö	
	04000 SUBPROVI DER - I PF	0	0	0	0	0	1
	04100 SUBPROVI DER - I RF	0	0	0	0	0	
	04300 NURSERY	0	0		0	453, 663	1
	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	-	_	0	0	
	04600 OTHER LONG TERM CARE		1		ő	Ö	1
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	l .		0	4, 677, 727	50.00
	O5100   RECOVERY ROOM   O5200   DELIVERY ROOM & LABOR ROOM	0		_	0	0 1, 847, 469	
	05300 ANESTHESI OLOGY				0	1, 647, 409	
	05400 RADI OLOGY-DI AGNOSTI C	0	Ö	_	Ö	5, 156, 535	1
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
	05600 RADI OI SOTOPE	0	0	0	0	0	
	05700 CT SCAN	0	0	0	0	0	
	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION			0	0	0	
	06000 LABORATORY		Ö	4, 735, 160	ő	4, 735, 160	1
	06001 BLOOD LABORATORY	0	0	0	0	0	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			0		0	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	
	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0		0	0	0	
	06500 RESPIRATORY THERAPY			2, 075, 392	0	2, 075, 392	1
	06600 PHYSI CAL THERAPY	0	Ō	1, 673, 191	0	1, 673, 191	
	06700 OCCUPATI ONAL THERAPY	0	0	927, 542	0	927, 542	67.00
	06800 SPEECH PATHOLOGY	0	0	381, 448	0	381, 448	1
	06900 ELECTROCARDI OLOGY	0	0	0	0	0	
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			708, 407	O O	0 708, 407	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	850, 206	ol	850, 206	1
73. 00	07300 DRUGS CHARGED TO PATIENTS		Ō	6, 653, 103	o	6, 653, 103	
74. 00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
	07500 ASC (NON-DISTINCT PART)	0	0	1 024 001	0	1 024 924	
	07698 HYPERBARIC OXYGEN THERAPY 07700 ALLOGENEIC STEM CELL ACQUISITION		0	1, 024, 836	0	1, 024, 836 0	1
	07800 CAR T-CELL IMMUNOTHERAPY			0	0	0	1
	OUTPATIENT SERVICE COST CENTERS						1
	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0	102.000	0	0 103, 086	89. 00 90. 00
70 00	U7UUU  ULI NI U	1 0	)  0	103, 086	U	10.3 080	1 7U. UU
	09100 EMERGENCY	0	0	4, 567, 264	O	4, 567, 264	1

0

 $\cap$ 

53, 874, 008

0

0 201.00

53, 874, 008 202. 00

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | P Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HOSPITAL OF NOBLE CTY, INC
Provider CCN: 15-0146

				lo	12/31/2023	Date/lime Pre 5/23/2024 9:5	
			CAPI TAL REI	LATED COSTS			
	Coot Conton Decemintion	Di nonti v	DIDC 0 FLVT	M/DLE FOLLID	Cubtatal	EMDL OVEE	
	Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs					
	GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	2A	4. 00	
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL	2, 116, 278	74, 039	13, 378	2, 203, 695	0	5.00
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0	28, 606	26, 754	55, 360	0	6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	2, 461	20, 734	2, 461	0	8.00
9. 00	00900 HOUSEKEEPI NG	0	3, 560	3, 727	7, 287	0	9. 00
10.00	01000 DI ETARY	0	7, 865		17, 987	0	10.00
11. 00 12. 00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL	0	4, 740 0	1	4, 740 0	0	11. 00 12. 00
13. 00	01300 NURSING ADMINISTRATION	0	997		1, 099	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	9, 155		9, 155	0	14.00
15.00	01500 PHARMACY	0	2, 700		6, 097	0	15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	4, 124 0	1	4, 124 0	0	16. 00 17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.00
20.00	02000 NURSI NG PROGRAM	0	0	0	0	0	20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22. 00	O2200   1 & R SERVI CES-OTHER PRGM COSTS APPRVD   INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	22. 00
30. 00	03000 ADULTS & PEDIATRICS	0	43, 059	95, 527	138, 586	0	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	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	0	0	0	0	41.00
43.00	04300 NURSERY	0	619	7, 333	7, 952	0	43.00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0	0	0	0	44. 00 45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	45, 047		202, 652 0	0	50.00
51. 00 52. 00	O5100   RECOVERY ROOM   O5200   DELIVERY ROOM & LABOR ROOM	0	3, 975	0 29, 592	33, 567	0	51.00 52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	Ö	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	21, 773	360, 951	382, 724	0	54.00
55. 00 56. 00	05500  RADI OLOGY-THERAPEUTI C   05600  RADI OI SOTOPE	0	0	0	0	0	55. 00 56. 00
57. 00	05700 CT SCAN	0		0	0	0	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60.00	06000 LABORATORY 06001 BLOOD LABORATORY	0	8, 320	0	8, 320 0	0	60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				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 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	5, 307	88, 428	93, 735	0	64. 00 65. 00
66.00	06600 PHYSI CAL THERAPY	0	22, 941	9, 069	32, 010		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
70.00		0	0	0	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	Ö	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	0	0	0	73. 00 74. 00
		0	0	0	0	0	75.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	4, 226	13, 331	17, 557	0	76. 98
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	78. 00
88. 00		ol	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90.00	09000 CLINIC	0	10.000	0	62 040	0	90.00
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	ا	18, 032	35, 910	53, 942 0	0	91. 00 92. 00
	1	<u> </u>	1	1		·	

| Period: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time | Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HOSPITAL OF NOBLE CTY, INC
Provider CCN: 15-0146

			То	12/31/2023	Date/Time Prep 5/23/2024 9:53	
		CAPITAL REL	ATED COSTS		7. 00	y dili
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	0	1. 00	2.00	2A	4. 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	328, 068	328, 068	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
99. 00   09900   CMHC	0	0	0	0	0	99. 00
99. 10  09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0		101. 00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS		0		ام		105 00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0		105.00
106. 00 10600 HEART ACQUISITION	0	0	0	0		106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	0	U		107. 00 108. 00
108. 00 10800 LUNG ACQUISITION 109. 00 10900 PANCREAS ACQUISITION	0	0	0	O O		108.00
110.00 11000  INTESTINAL ACQUISITION	0	0	0	0		110, 00
111. 00 11100   INTESTITIAL ACQUISITION		0	0	0		111.00
113. 00 11300   NTEREST EXPENSE	l o	U	٩	U U		111.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P. )	0	0	0	0		115.00
116. 00 11600 HOSPI CE		0		0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 116, 278	311, 546	1, 183, 294	3, 611, 118		118.00
NONREI MBURSABLE COST CENTERS	2/110/2/0	0117010	17 1007 27 1	0, 011, 110	0	
190. 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN	0	2, 513	82	2, 595	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	o	16, 195	202	16, 397	0	192.00
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 00
194. 01 07951 PAIN CLINIC	0	0	0	0	0	194. 01
194. 02 07952 OCC HEALTH	0	0	0	0	0	194. 02
194. 03 07953 FOUNDATI ON	0	0	0	0	0	194. 03
194. 04 07954 PHYSICIAN OFFICES	0	0	0	0		194. 04
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	0	12, 282	777	13, 059		194. 05
194. 06 07956 VACANT SPACE	0	0	0	0		194. 06
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers	0.447.070	0	0	0		201.00
202.00   TOTAL (sum lines 118 through 201)	2, 116, 278	342, 536	1, 184, 355	3, 643, 169	0  :	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0146

Peri od: Worksheet B From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared:

5/23/2024 9:53 am 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, 203, 695 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 82, 154 0 137, 514 7.00 00800 LAUNDRY & LINEN SERVICE 1, 411 14, 231 8 00 8 00 10.359 Ω 9.00 00900 HOUSEKEEPI NG 45, 219 C 2.041 54, 547 9.00 1, 834 01000 DI ETARY 33, 803 4,509 10.00 10.00 11.00 01100 CAFETERI A 9,690 0 2,717 0 1, 106 11.00 01200 MAINTENANCE OF PERSONNEL 12 00 Ω C 0 0 0 12 00 13.00 01300 NURSING ADMINISTRATION 45, 303 571 0 232 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 571 5, 248 434 2, 135 14.00 01500 PHARMACY 15.00 11.942 1.547 15.00 0 630 01600 MEDICAL RECORDS & LIBRARY 0 16.00 257 C 2.364 962 16.00 17.00 01700 SOCIAL SERVICE 0 0 0 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 19 00 0 0 0 19.00 02000 NURSING PROGRAM o 20.00 0 0 0 20.00 0 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 0 C 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 0 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 10, 043 03000 ADULTS & PEDLATRICS 240, 061 24, 683 30.00 5, 517 30.00 31.00 03100 INTENSIVE CARE UNIT C 0 31.00 32.00 03200 CORONARY CARE UNIT 0 0 0 0 0 32.00 03300 BURN INTENSIVE CARE UNIT 33.00 0 0 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 0 C 0 0 0 34 00 04000 SUBPROVIDER - IPF 0 0 0 40.00 40.00 0 04100 SUBPROVI DER - I RF 41.00 0 0 0 0 41.00 O 04300 NURSERY 43.00 16, 901 0 355 89 144 43.00 44.00 04400 SKILLED NURSING FACILITY 0 C 0 0 0 44.00 45.00 04500 NURSING FACILITY 0 0 0 45.00 04600 OTHER LONG TERM CARE 0 46.00 0 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 154, 738 Ω 25,823 3, 108 10,506 50.00 05100 RECOVERY ROOM 51.00 C 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 68.301 0 2.278 89 927 52.00 05300 ANESTHESI OLOGY 53.00 C  $\cap$ 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 196, 281 C 12, 481 1,430 5,078 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 55.00 0 0 56 00 05600 RADI OI SOTOPE 0 O 0 0 0 56 00 57.00 05700 CT SCAN 0 C 0 0 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 58.00 0 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 ol 59.00 0 0 1, 941 06000 LABORATORY 188, 818 0 60 00 0 4.769 60.00 60.01 06001 BLOOD LABORATORY C 0 0 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 0 0 0 62.00 0 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 0 0 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 C 0 0 0 64.00 06500 RESPIRATORY THERAPY 65.00 80, 976 3,042 88 1, 238 65.00 0 06600 PHYSI CAL THERAPY 5, 351 66.00 66.00 55.520 Ω 13, 151 0 67.00 06700 OCCUPATI ONAL THERAPY 37, 574 C 0 0 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 15, 448 0 68.00 0 06900 ELECTROCARDI OLOGY 69.00 0 0 69.00 0 0 70 00 07000 ELECTROENCEPHALOGRAPHY 0 C 0 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 26, 902 o 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 34, 748 0 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 257.942 73.00 0 0 0 73.00 74.00 07400 RENAL DIALYSIS Ω C 0 0 0 74 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 75.00 75.00 76. 98 07698 HYPERBARIC OXYGEN THERAPY 35, 962 0 2, 422 21 986 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 C 0 77.00 0 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 0 C 0 0 0 90.00 09000 CLI NI C 4, 171 C 0 90.00 09100 EMERGENCY 91.00 160, 569 C 10, 337 3, 348 4, 206 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 94.00 09500 AMBULANCE SERVICES 95.00 369, 971 0 0 0 0 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 96 00 0

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54, 547 202. 00

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0146 Peri od: Worksheet B From 01/01/2023 Part II 12/31/2023 Date/Time Prepared: 5/23/2024 9:53 am ADMINISTRATIV MAINTENANCE & Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG E & GENERAL **REPAIRS** LINEN SERVICE PLANT 9. 00 5.00 6.00 7.00 8.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 0 0 0 99.00 09900 CMHC C 0 0 99.00 99. 10 09910 CORF 0 0 0 0 99. 10 0 0 0 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 102.00 10200 OPIOID TREATMENT PROGRAM 0 0 0 0 0 102.00 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 0 106.00 0 0 107.00 10700 LIVER ACQUISITION 0 0 0 107.00 0 108. 00 10800 LUNG ACQUISITION 0 0 0 0 0 108.00 109. 00 10900 PANCREAS ACQUISITION 0 0 109 00 Ω 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 0 115.00 116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 119, 749 2, 184, 181 0 47, 319 118. 00 118.00 14, 124 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 740 1, 441 586 190. 00 191. 00 19100 RESEARCH 0 0 0 191.00 0 0 3, 777 192. 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 107 4,050 0 9, 283 193. 00 19300 NONPALD WORKERS 0 0 0 0 0 193.00 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194.00 194. 01 07951 PAIN CLINIC 0 194. 01 0 0 0 0 194. 02 07952 OCC HEALTH 0 0 194.02 0 0 0 194. 03 07953 FOUNDATI ON 0 0 0 0 194. 03

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194. 04 07954 PHYSICIAN OFFICES

194.06 07956 VACANT SPACE

200.00

201.00

202.00

194. 05 07955 COMMUNITY & VOLUNTEER SERVICES

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0146

Peri od: Worksheet B From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared:

5/23/2024 9:53 am Cost Center Description DI ETARY CAFETERI A MAI NTENANCE NURSI NG CENTRAL ADMI NI STRATI O SERVICES & OF PERSONNEL **SUPPLY** Ν 12.00 10 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 58, 133 10 00 01100 CAFETERI A 11.00 18, 253 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 0 12.00 13.00 01300 NURSING ADMINISTRATION 0 454 47, 659 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 17, 543 14.00 01500 PHARMACY 0 15 00 0 226 523 0 15.00 0 16.00 01600 MEDICAL RECORDS & LIBRARY 0 0 16.00 01700 SOCIAL SERVICE 17 00 Ω 0 0 0 17.00 0 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 0 19.00 0 02000 NURSI NG PROGRAM 0 0 20 00 C 0 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 0 21.00 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 0 0 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 58, 133 2, 953 0 18.827 2.142 30.00 03100 INTENSIVE CARE UNIT 0 0 31.00 32.00 03200 CORONARY CARE UNIT 0 0 0 32.00 0 0 0 03300 BURN INTENSIVE CARE UNIT 0 33.00 C 0 0 33.00 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 C 0 0 34.00 04000 SUBPROVI DER - I PF 0 0 40.00 0 0 0 40.00 0 04100 SUBPROVI DER - I RF 0 0 0 41.00 0 41.00 04300 NURSERY 0 43.00 182 1, 158 0 43.00 0 0 44.00 04400 SKILLED NURSING FACILITY 0 0 44.00 04500 NURSING FACILITY 0 45.00 C 0 0 0 45.00 46.00 04600 OTHER LONG TERM CARE 0 0 46 00 0 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 1, 254 0 7, 994 2, 830 50.00 0 51.00 05100 RECOVERY ROOM 0 0 51.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 0 733 4.673 0 52 00 05300 ANESTHESI OLOGY 0 0 53.00 0 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 1,697 586 54.00 55 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 Ω 55 00 C 05600 RADI OI SOTOPE 0 56.00 C 0 0 56.00 05700 CT SCAN 0 0 57.00 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 0 0 0 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59 00 59 00 0 0 60.00 06000 LABORATORY 0 0 60.00 60.01 06001 BLOOD LABORATORY 0 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 C 0 0 0 62 00 62.00 0 o 63.00 06300 BLOOD STORING, PROCESSING & TRANS. C 0 0 63.00 06400 I NTRAVENOUS THERAPY 0 64.00 64.00 0 06500 RESPIRATORY THERAPY 0000000000000 597 65.00 0 65.00 960 66 00 06600 PHYSI CAL THERAPY 641 0 105 66.00 67.00 06700 OCCUPATI ONAL THERAPY 525 o 67.00 0 68.00 06800 SPEECH PATHOLOGY 216 0 Ω 68.00 0 0 06900 ELECTROCARDI OLOGY 0 69.00 C 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY C 0 Λ 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 6, 123 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 C 0 0 389 73.00 74.00 07400 RENAL DIALYSIS C 0 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 75.00 0 07698 HYPERBARI C OXYGEN THERAPY 652 76.98 76.98 496 3.161 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77 00 C 0 0 77 00 78.00 0 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 C 0 0 89.00 09000 CLI NI C 0 0 27 90.00 52 0 90.00 91.00 09100 EMERGENCY 0 1, 858 0 11, 846 1, 951 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 95. 00 09500 AMBULANCE SERVICES 5, 349 0 0 1, 852 95.00 Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0146 Peri od: Worksheet B From 01/01/2023 Part II 12/31/2023 Date/Time Prepared: 5/23/2024 9:53 am 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 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 96.00 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 97.00 99. 00 09900 CMHC 0 99.00 0 0 0 0 0 0 0 0 99. 10 99. 10 09910 CORF 0 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 0 105.00 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 106.00 10600 HEART ACQUISITION 0000 0 0 0 0 0 106.00 107.00 10700 LIVER ACQUISITION 0 0 107.00 0 108.00 10800 LUNG ACQUISITION 0 0 108.00 109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 o 0 110.00 0 111.00 11100 I SLET ACQUISITION o 0 111.00 0 Ω 113.00 11300 INTEREST EXPENSE 113.00

116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 58, 133 17,893 0 47, 659 17, 480 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 54 190. 00 0 0 οĺ 191. 00 19100 RESEARCH 0 C 0 0 191.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 77 0 7 192. 00 00000000 0 0 0 193. 00 19300 NONPALD WORKERS 0 0 193.00 0 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 0 194.00 0 194. 01 07951 PAIN CLINIC 0 0 194.01 194. 02 07952 OCC HEALTH 0 0 194. 02 0 0 0 194. 03 07953 FOUNDATI ON 0 0 194. 03 0 194. 04 07954 PHYSICIAN OFFICES 0 0 194.04 C 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 2 194. 05 283 0 194.06 07956 VACANT SPACE 0 0 0 0 194.06 C 200.00 Cross Foot Adjustments 200.00 0 201.00 201.00 Negative Cost Centers 0 202.00 TOTAL (sum lines 118 through 201) 58, 133 18, 253 0 47, 659 17, 543 202. 00

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114.00

0 115.00

114.00 11400 UTILIZATION REVIEW-SNF

115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared:
5/23/2024 9:53 am

			'	0 12/31/2023	5/23/2024 9:5	
Cost Center Description	PHARMACY	MEDI CAL	SOCI AL	NONPHYSI CI AN	NURSI NG	
		RECORDS & LI BRARY	SERVI CE	ANESTHETI STS	PROGRAM	
	15. 00	16. 00	17. 00	19.00	20.00	
GENERAL SERVICE COST CENTERS				1		
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00   00200   CAP   REL   COSTS-MVBLE   EQUI   P						2.00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00   00500   ADMINI STRATI VE & GENERAL 6. 00   00600   MAI NTENANCE & REPAI RS						5. 00 6. 00
7.00   OO700 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
12.00 01200 MAINTENANCE OF PERSONNEL						12.00
13.00 O1300 NURSING ADMINISTRATION						13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00   01500   PHARMACY	20, 965					15.00
16. 00   01600   MEDI CAL RECORDS & LI BRARY	0	7, 707				16.00
17. 00   01700   SOCIAL SERVICE	0	0				17.00
19. 00   01900   NONPHYSI CI AN ANESTHETI STS 20. 00   02000   NURSI NG PROGRAM		0		U	0	19. 00 20. 00
21. 00   02100   1&R SERVICES-SALARY & FRINGES APPRVD	0	0				21.00
22. 00   02200   &R SERVICES-OTHER PRGM COSTS APPRVD		0				22.00
INPATIENT ROUTINE SERVICE COST CENTERS	91			1		1 22.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	475	C			30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	C	)		31.00
32.00 03200 CORONARY CARE UNIT	0	0	C	)		32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	C	)		33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T	0	0	C			34.00
40. 00   04000   SUBPROVI DER -   1 PF	0	0	(			40.00
41. 00   04100   SUBPROVI DER -   RF	0	0				41.00
43.00   04300   NURSERY 44.00   04400   SKILLED   NURSING FACILITY	0	25				43.00
44.00   O4400   SKILLED NURSING FACILITY 45.00   O4500   NURSING FACILITY	0	0				44. 00 45. 00
46. 00   04600   OTHER LONG TERM CARE	0	0				46.00
ANCI LLARY SERVICE COST CENTERS	١					10.00
50. 00 05000 OPERATI NG ROOM	0	795	C			50.00
51.00   05100   RECOVERY ROOM	0	0	C	)		51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	100	C	)		52.00
53. 00   05300   ANESTHESI OLOGY	0	0	C	)		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	1, 259	C			54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	0	C			55.00
56. 00   05600   RADI 01 SOTOPE	0	0				56.00
57. 00 05700 CT SCAN	0	0				57. 00 58. 00
58.00   O5800   MAGNETI C RESONANCE I MAGING (MRI) 59.00   O5900   CARDI AC CATHETERI ZATI ON		0				59.00
60. 00   06000   LABORATORY		1, 150				60.00
60. 01 06001 BLOOD LABORATORY	0	1, 150				60.01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		· ·				61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	o	0	C			62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	C	)		63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	C	)		64.00
65. 00 06500 RESPI RATORY THERAPY	0	412	C	)		65.00
66. 00   06600   PHYSI CAL THERAPY	0	137	C			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	44	C			67.00
68. 00 06800 SPEECH PATHOLOGY	0	32				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
70. 00   07000   ELECTROENCEPHALOGRAPHY 71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS	0	84				70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		92				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	20, 965	754				73.00
74. 00   07400   RENAL DI ALYSI S	0	0				74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	ď			75.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	140	C	1		76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	C	)		77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	C			78. 00
OUTPATIENT SERVICE COST CENTERS						1
88. 00   08800   RURAL HEALTH CLINIC	0	0	C			88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.00
90. 00   09000   CLI NI C 91. 00   09100   EMERGENCY	0	1 507	(			90.00
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	ا	1, 526		1		91.00
OTHER REIMBURSABLE COST CENTERS						72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	O	0				94.00
95. 00 09500 AMBULANCE SERVICES	o	675				95.00
				•	•	•

194.06 07956 VACANT SPACE

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

200.00

201.00

202.00

194. 06

0 200.00

0 201.00

0 202.00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0146 Peri od: Worksheet B From 01/01/2023 Part II 12/31/2023 Date/Time Prepared: 5/23/2024 9:53 am Cost Center Description **PHARMACY** MEDI CAL SOCI AL NONPHYSI CI AN NURSI NG RECORDS & SERVI CE ANESTHETI STS **PROGRAM** LI BRARY 15. 00 17.00 19.00 20.00 16 00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 0 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 99. 00 09900 CMHC 0 99.00 0 0 0 0 99. 10 99. 10 09910 CORF 0 0 0 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 101.00 10100 HOME HEALTH AGENCY 101.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 105.00 106.00 10600 HEART ACQUISITION 0000 0 0 106.00 0 107.00 10700 LIVER ACQUISITION 107.00 0 108.00 10800 LUNG ACQUISITION 0 108.00 109. 00 10900 PANCREAS ACQUISITION 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 0 111.00 11100 I SLET ACQUISITION 0 0 111. 00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 115.00 0 0 0 116. 00 11600 HOSPI CE 0 0 r 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 20, 965 7,707 0 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 0 191. 00 19100 RESEARCH 0 C 191. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192.00 00000000 193. 00 19300 NONPALD WORKERS 0 193.00 0 0 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 194. 00 194. 01 07951 PAIN CLINIC 0 194.01 194. 02 07952 OCC HEALTH 0 194. 02 194. 03 07953 FOUNDATI ON 0 0 194. 03 194. 04 07954 PHYSICIAN OFFICES 0 0 194. 04 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 194. 05

0

7, 707

20, 965

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| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | P Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HOSPITAL OF NOBLE CTY, INC
Provider CCN: 15-0146

				1	0 12/31/2023	Date/lime Pre 5/23/2024 9:5	
		INTERNS &	RESI DENTS				
	Cost Center Description	SEDVI CES_SALA	SERVI CES-OTHE	Subtotal	Intern &	Total	
	cost center bescription	RY & FRINGES	R PRGM COSTS	Subtotal	Resi dents	Total	
					Cost & Post		
					Stepdown		
		21. 00	22. 00	24. 00	Adjustments 25.00	26. 00	
	GENERAL SERVICE COST CENTERS	21.00	22.00	24.00	23.00	20.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 00	OO400						4. 00 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 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A						11.00
12.00	01200 MAINTENANCE OF PERSONNEL						12.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00 15. 00	O1400   CENTRAL SERVI CES & SUPPLY   O1500   PHARMACY						14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16.00
17. 00	01700 SOCIAL SERVICE						17. 00
19.00	01900 NONPHYSI CI AN ANESTHETI STS						19.00
20. 00 21. 00	O2000   NURSING PROGRAM   O2100   I&R SERVICES-SALARY & FRINGES APPRVD						20. 00 21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD		O				22.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS			501, 420	0		30.00
31. 00 32. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT			0		0	31.00 32.00
33. 00	03300 BURN INTENSIVE CARE UNIT			Ö	0	ő	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT			0	0	0	34.00
40.00	04000 SUBPROVI DER - I PF			0	0	0	40.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY			0 26, 806	0	0 26, 806	41.00 43.00
44. 00	04400 SKILLED NURSING FACILITY			0	0	1	44.00
45. 00	04500 NURSING FACILITY			0			45.00
46. 00	O4600 OTHER LONG TERM CARE   ANCILLARY SERVICE COST CENTERS			0	0	0	46. 00
50.00	05000 OPERATING ROOM			409, 700	0	409, 700	50.00
51.00	05100 RECOVERY ROOM			0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM			110, 668	0	110, 668	52.00
53. 00 54. 00	05300   ANESTHESI OLOGY   05400   RADI OLOGY-DI AGNOSTI C			601, 536	0	0 601, 536	53. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C			0	0	0	55.00
56.00	05600 RADI OI SOTOPE			0	0	0	56.00
	05700 CT SCAN   05800 MAGNETIC RESONANCE IMAGING (MRI)			0	0	1	57. 00 58. 00
	05900 CARDI AC CATHETERI ZATI ON				0	ľ	1
60.00	06000 LABORATORY			204, 998	0	204, 998	60.00
60. 01	06001 BLOOD LABORATORY			0	0	0	60.01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS			0	0	0	61. 00 62. 00
63. 00	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			181, 048	0	181, 048	65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY			106, 915 38, 143		106, 915 38, 143	1
68. 00	06800 SPEECH PATHOLOGY			15, 696		15, 696	68.00
69. 00	06900 ELECTROCARDI OLOGY			0	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY			22 100	0	22 100	70.00
	07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   07200   IMPL. DEV. CHARGED TO PATIENTS			33, 109 34, 840	0	33, 109 34, 840	1
73.00	07300 DRUGS CHARGED TO PATIENTS			280, 050	Ö	280, 050	1
	07400 RENAL DI ALYSI S			0	0	0	74.00
	07500 ASC (NON-DISTINCT PART) 07698 HYPERBARIC OXYGEN THERAPY			0 61, 397	0	0 61, 397	75. 00 76. 98
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION			01, 397	0	l	77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY			0			78. 00
00.00	OUTPATIENT SERVICE COST CENTERS			_	_	_	00.00
88. 00 89. 00	08800  RURAL HEALTH CLINIC   08900  FEDERALLY QUALIFIED HEALTH CENTER			0	0		88. 00 89. 00
90.00	09000 CLINIC			4, 257	0		90.00
91.00	09100 EMERGENCY			249, 583	0	249, 583	91.00
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Health Financial Systems In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0146 Peri od: Worksheet B From 01/01/2023 Part II 12/31/2023 Date/Time Prepared: 5/23/2024 9:53 am INTERNS & RESIDENTS SERVI CES-SALA | SERVI CES-OTHE Cost Center Description Subtotal Intern & Total R PRGM COSTS RY & FRINGES Residents Cost & Post Stepdown Adjustments 21. 00 22. 00 24.00 25.00 26.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 0 95.00 09500 AMBULANCE SERVICES 705, 915 705, 915 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 96.00 0 0 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 99. 00 09900 CMHC 0 o 0 99.00 0 0 99. 10 09910 CORF 99. 10 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 100, 00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00 0 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 0 105. 00 106.00 10600 HEART ACQUISITION 0 0 0 106.00 107. 00 10700 LIVER ACQUISITION 0 0 0 0 107.00 108. 00 10800 LUNG ACQUISITION 0 0 108.00 109. 00 10900 PANCREAS ACQUISITION 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION o 0 110.00 0 111.00 11100 I SLET ACQUISITION 0 o 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 ol 0 115.00 116. 00 11600 HOSPI CE 0 0 116,00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 3, 566, 081 3, 566, 081 118. 00 NONREIMBURSABLE COST CENTERS 0 5, 416 190. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 5, 416 191. 00 19100 RESEARCH 0 191.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 33, 698 0 33, 698 192. 00 193. 00 19300 NONPALD WORKERS 0 0 193.00 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 194.01 07951 PAIN CLINIC 0 0 0 0 0 0 0 0 0 0 0 194.00 0 194 01 0 194. 02 07952 OCC HEALTH 0 194. 02 194. 03 07953 FOUNDATI ON 362 194. 03 362 194. 04 07954 PHYSICIAN OFFICES 0 194.04 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 37, 612 194. 05 37, 612 194.06 07956 VACANT SPACE 0 0 194.06 200.00 Cross Foot Adjustments 0 200.00 0 Negative Cost Centers 0 201.00 201.00  $\cap$ 202.00 TOTAL (sum lines 118 through 201) 3, 643, 169 3, 643, 169 202. 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 01/01/2023 12/31/2023 Date/Time Prepared: 5/23/2024 9:53 am CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliatio ADMINISTRATIV Cost Center Description (SQUARE FEET) (DOLLAR **BENEFITS** F & GENERAL n DEPARTMENT VALUE) (ACCUM. COST) (GROSS SALARIES) 1. 00 2.00 4.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 137, 798 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 908, 828 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 26, 383, 156 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 29, 785 10, 266 9, 179, 902 -18, 548, 550 35, 325, 458 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 11, 508 20,530 467, 407 0 1, 316, 925 7.00 00800 LAUNDRY & LINEN SERVICE 0 166, 059 8 00 990 8 00 0 499, 081 0 9.00 00900 HOUSEKEEPI NG 1, 432 2,860 724, 861 9.00 10.00 01000 DI ETARY 3.164 7,767 310, 214 541, 856 10.00 0 11.00 01100 CAFETERI A 1,907 215,060 155, 332 11.00 01200 MAINTENANCE OF PERSONNEL 0 12 00 12 00 C 0 0 13.00 01300 NURSING ADMINISTRATION 401 78 581, 752 0 726, 203 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 3,683 9, 155 14.00 0 01500 PHARMACY 776, 684 191, 425 15.00 1.086 2.607 15.00 0 01600 MEDICAL RECORDS & LIBRARY 16.00 1,659 0 4, 124 16.00 17.00 01700 SOCIAL SERVICE 0 0 17.00 0 C 0 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 0 19.00 0 0 02000 NURSI NG PROGRAM 0 0 0 20 00 20 00 C 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 C 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 0 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 17.322 73.304 2, 553, 713 3, 848, 186 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 0 03200 CORONARY CARE UNIT 0 0 32.00 0 32.00 0 03300 BURN INTENSIVE CARE UNIT 33.00 0 C 0 33.00 0 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34.00 C 0 34 00 04000 SUBPROVIDER - IPF 40.00 0 0 0 0 40.00 04100 SUBPROVI DER - I RF 0 41.00 0 0 0 41.00 04300 NURSERY o 270.924 43.00 249 5, 627 159, 466 43.00 04400 SKILLED NURSING FACILITY 44 00 0 0 0 0 44.00 04500 NURSING FACILITY 0 45.00 45.00 0 0 04600 OTHER LONG TERM CARE 46.00 0 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 18, 122 120, 940 1, 214, 115 0 2, 480, 451 50.00 51.00 05100 RECOVERY ROOM 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 599 0 1, 094, 862 22, 708 643.567 52.00 0 05300 ANESTHESI OLOGY 53.00 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 8, 759 276, 979 1, 457, 223 0 3, 146, 379 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 o 05600 RADI OI SOTOPE 0 56.00 0 56.00 0 0 0 57.00 05700 CT SCAN 0 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 58.00 0 05900 CARDI AC CATHETERI ZATI ON 0 59.00 0 0 59.00 06000 LABORATORY 0 3, 026, 762 60.00 3, 347 C 60.00 60.01 06001 BLOOD LABORATORY 0 0 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 61.00 61.00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 62.00 0 62.00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 C 0 Λ 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 0 0 64.00 06500 RESPIRATORY THERAPY o 65.00 2, 135 67,856 827, 672 1, 298, 053 65.00 0 889, 985 66 00 06600 PHYSI CAL THERAPY 9 229 6, 959 677, 668 66 00 06700 OCCUPATI ONAL THERAPY 67.00 C 473, 283 602, 318 67.00 06800 SPEECH PATHOLOGY 0 194, 582 0 247, 632 68.00 68.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 69.00 C 0 0 0 70 00 07000 ELECTROENCEPHALOGRAPHY 0 70 00 C 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 431, 246 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 557, 010 0 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 4. 134. 808 73.00 07400 RENAL DIALYSIS 0 0 74 00 C 0 74 00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 75.00 0 07698 HYPERBARIC OXYGEN THERAPY 76.98 1.700 10, 230 357, 778 576, 464 76.98 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 77.00 0 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 0 0 n 88.00

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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 01/01/2023 12/31/2023 Date/Time Prepared: 5/23/2024 9:53 am 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 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 94.00 0 95.00 09500 AMBULANCE SERVICES 251, 747 3, 858, 291 5, 930, 865 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 96.00 0 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 C 0 0 97.00 99. 00 09900 CMHC 0 0 0 0 o 0 99.00 0 99. 10 09910 CORF 0 0 99. 10 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 100, 00 C 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 0 0 0 105. 00 106.00 10600 HEART ACQUISITION 0 0 0 0 0 106.00 0 107. 00 10700 LIVER ACQUISITION 0 0 0 107.00 0 0 108. 00 10800 LUNG ACQUISITION 0 0 108 00 Ω 109. 00 10900 PANCREAS ACQUISITION 0 C 0 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 O 0 0 111.00 C 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 01116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 125, 331 908, 014 26, 200, 005 -18, 548, 550 35, 012, 667 118. 00 NONREIMBURSABLE COST CENTERS 11, 856 190. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1,011 63 191. 00 19100 RESEARCH 0 191.00 0 0 C 192.00 19200 PHYSICIANS' PRIVATE OFFICES 6,515 155 37, 998 0 64, 919 192. 00 193. 00 19300 NONPALD WORKERS 0 193.00 0 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194.00 194. 01 07951 PAIN CLINIC 0 0 194 01 0 C 194. 02 07952 OCC HEALTH 0 0 0 194. 02 194. 03 07953 FOUNDATI ON 5, 800 194. 03 0 C 0 0 0 194. 04 07954 PHYSICIAN OFFICES 0 194, 04 0 C 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 230, 216 194. 05 4, 941 596 145, 153 194.06 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, 342, 536 1, 184, 355 6, 295, 427 18, 548, 550 202. 00 Part I) 0. 525076 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 2. 485784 1. 303167 0.238615 2, 203, 695 204. 00 204.00 Cost to be allocated (per Wkst. B, Part II)

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0.062383 205.00

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II)

(per Wkst. B-2)

Parts III and IV)

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D,

NAHE adjustment amount to be allocated

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 01/01/2023 12/31/2023 Date/Time Prepared: 5/23/2024 9:53 am Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY LINEN SERVICE **REPALRS** PLANT (SQUARE FEET) (MEALS (SQUARE FEET) (SQUARE FEET) (POUNDS OF SERVED) LAUNDRY) 6. 00 7. 00 9. 00 10.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2 00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 6.00 00600 MAINTENANCE & REPAIRS 108, 013 6.00 00700 OPERATION OF PLANT 7.00 11,508 96, 505 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 990 990 258, 763 8.00 9 00 00900 HOUSEKEEPI NG 1, 432 1, 432 0 94,083 9 00 01000 DI ETARY 24, 190 3.164 10.00 3.164 3, 164 0 10.00 01100 CAFETERI A 1, 907 11.00 1, 907 0 1,907 Λ 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 0 0 12.00 13.00 01300 NURSING ADMINISTRATION 401 401 401 13.00 0 01400 CENTRAL SERVICES & SUPPLY 3, 683 3,683 14.00 3.683 7,894 14.00 0 15.00 01500 PHARMACY 1,086 1,086 0 1,086 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 1,659 1,659 0 1,659 0 01700 SOCIAL SERVICE 17.00 0 0 17.00 0 C 0 01900 NONPHYSICIAN ANESTHETISTS 19 00 C 0 19 00

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NONREIMBURSABLE COST CENTERS

190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN

192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES

194.00 07950 OTHER NONREIMBURSABLE COST CENTERS

194. 05 07955 COMMUNITY & VOLUNTEER SERVICES

Cross Foot Adjustments

Cost to be allocated (per Wkst. B,

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D,

Unit cost multiplier (Wkst. B, Part I)

NAHE adjustment amount to be allocated

Negative Cost Centers

191. 00 19100 RESEARCH

193. 00 19300 NONPALD WORKERS

194. 04 07954 PHYSICIAN OFFICES

Part I)

Part II)

(per Wkst. B-2)

Parts III and IV)

II)

194. 01 07951 PAIN CLINIC

194. 02 07952 OCC HEALTH

194. 03 07953 FOUNDATI ON

194.06 07956 VACANT SPACE

200.00

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COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0146 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/23/2024 9:53 am Cost Center Description CAFETERI A MAI NTENANCE NURSI NG CENTRAL **PHARMACY** ADMI NI STRATI O (MEALS OF PERSONNEL SERVICES & (COSTED SERVED) (NUMBER **SUPPLY** REQUIS.) Ν HOUSED) (DIRECT NURS (COSTED HRS. ) REQUIS.) 11. 00 12.00 15.00 13.00 14.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 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 408, 562 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 01300 NURSING ADMINISTRATION 167, 337 13.00 10.173 13.00 01400 CENTRAL SERVICES & SUPPLY 2, 830, 943 14.00 0 14.00 15.00 01500 PHARMACY 11, 708 0 36, 455 4,072,029 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 0 0 0 0 16.00 01700 SOCIAL SERVICE 0 17 00 0 C 0 0 17 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 C 0 0 0 19.00 02000 NURSING PROGRAM 0 0 0 20.00 0 0 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 0 0 21.00 0 21.00 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 0 0 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 66, 107 66, 107 345, 665 0 30.00 31 00 03100 INTENSIVE CARE UNIT 0 Ω 31 00 03200 CORONARY CARE UNIT 32.00 0 C 0 0 0 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 33.00 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 34.00 04000 SUBPROVI DER - I PF 0 40 00 0 Ω 0 40 00 0 04100 SUBPROVI DER - I RF 0 41.00 0 C C 0 41.00 04300 NURSERY 0 43.00 43.00 4.065 0 4.065 0 ol 44.00 04400 SKILLED NURSING FACILITY 0 0 C 0 44.00 04500 NURSING FACILITY Ω 0 0 45 00 45 00 0 0 04600 OTHER LONG TERM CARE 46.00 0 0 0 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 28, 068 0 28, 068 0 50.00 456, 637 05100 RECOVERY ROOM 51.00 0 0 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 16, 407 0 16, 407 0 0 52.00 53 00 05300 ANESTHESI OLOGY 0 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 37.978 54.00 0 0 94, 585 54.00 0 0 55 00 05500 RADI OLOGY-THERAPEUTI C 0 Ω 0 0 55.00 56.00 05600 RADI OI SOTOPE 0 0 0 0 0 56.00 05700 CT SCAN 0 57.00 0 0 57.00 0 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 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 0 0 0 Ω 60.00 06001 BLOOD LABORATORY 0 0 0 60.01 0 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 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 63.00 06400 INTRAVENOUS THERAPY 64.00 0 C 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 21.485 C 96, 311 0 65.00 66, 00 06600 PHYSI CAL THERAPY 14, 353 16, 867 0 66.00 06700 OCCUPATI ONAL THERAPY 11, 742 67.00 67.00 0 06800 SPEECH PATHOLOGY 68.00 4,828 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY C 0 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 988, 256 71.00 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 C 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 62, 779 4, 072, 029 73.00 07400 RENAL DIALYSIS 74.00 0 0 0 0 74.00 0 75 00 07500 ASC (NON-DISTINCT PART) 0 Ω 0 75 00 0 0 07698 HYPERBARIC OXYGEN THERAPY 76.98 11,098 0 11,098 105, 215 0 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 77.00 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 0 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER C 0 0 0 89.00 90 00 09000 CLINIC 1, 160 4, 287 90 00 Ω 0 0 91.00 09100 EMERGENCY 41, 592 C 41, 592 314, 792 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00

In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0146 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/23/2024 9:53 am Cost Center Description CAFETERI A MAI NTENANCE NURSI NG CENTRAL **PHARMACY** OF PERSONNEL ADMI NI STRATI O SERVICES & (COSTED (MEALS SERVED) (NUMBER Ν **SUPPLY** REQUIS.) (DIRECT NURS HOUSED) (COSTED HRS.) REQUIS.) 11. 00 12.00 13.00 14.00 15.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 0 09500 AMBULANCE SERVICES 119, 728 0 298, 777 95.00 95.00 C 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 o 97.00 97.00 0 09900 CMHC 0 99.00 0 99.00 0 0 0 0 99. 10 09910 CORF 0 99. 10 0 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 o 0 101.00 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 Ω 0 0 102.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 105.00 0 0 o 0 106.00 106.00 10600 HEART ACQUISITION 0 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 107, 00 C 108.00 10800 LUNG ACQUISITION 0 0 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 0 0 109.00 0 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110,00 C 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 C 0 0 0 115.00 116. 00 11600 HOSPI CE 0 C 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 400, 492 4, 072, 029 118. 00 118.00 0 167, 337 2, 820, 626 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 0 8,747 191. 00 19100 RESEARCH 0 0 0 191.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 192.00 1,729 0 1, 191 193. 00 19300 NONPALD WORKERS 0 0 193.00 0 0 0 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 194.00 0 0 0 194. 01 07951 PAIN CLINIC 0 0 0 0 194. 01 194. 02 07952 OCC HEALTH 0 194. 02 0 0 0 0 194. 03 194. 03 07953 FOUNDATI ON 0 0 Ω 0 194. 04 07954 PHYSICIAN OFFICES 0 0 0 0 0 194.04 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 194.05 6, 341 0 379 194.06 07956 VACANT SPACE C 0 0 194.06 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 299, 591 1, 128, 159 143, 407 338, 075 202. 00 Part I) 0. 083024 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.733282 0.000000 6.741838 0.050657 204.00 Cost to be allocated (per Wkst. B, 18, 253 47,659 17, 543 20, 965 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.044676 0.000000 0.284809 0.006197 0.005149 205.00 II)206.00 206.00 NAHE adjustment amount to be allocated

207.00

(per Wkst. B-2)

Parts III and IV)

NAHE unit cost multiplier (Wkst. D,

207.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0146 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/23/2024 9:53 am INTERNS & **RESI DENTS** MEDI CAL SOCI AL NONPHYSI CI AN NURSI NG SERVI CES-SALA Cost Center Description RECORDS & SERVI CE **ANESTHETLSTS PROGRAM** RY & FRINGES (ASSI GNED (ASSI GNED (TIME SPENT) LI BRARY (ASSI GNED (GROSS TIME) TIME) TIME) CHARGES) 16. 00 17. 00 19.00 20.00 21.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12 00 12 00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 275, 834, 211 16.00 17.00 01700 SOCIAL SERVICE 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 19.00 0 02000 NURSI NG PROGRAM 0 0 20 00 20 00 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 16, 949, 385 0 30.00 0 31.00 03100 INTENSIVE CARE UNIT C 0 0 0 31.00 03200 CORONARY CARE UNIT 0 0 0 32.00 0 0 32.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 33.00 0 0 0 33.00 0 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 0 0 34 00 04000 SUBPROVI DER - I PF 40.00 0 0 0 0 40.00 04100 SUBPROVI DER - I RF 0 41.00 0 0 41.00 0 04300 NURSERY 885.873 0 0 43.00 43.00 0 04400 SKILLED NURSING FACILITY 0 44 00 0 C 0 44 00 04500 NURSING FACILITY 0 0 0 45.00 45.00 0 04600 OTHER LONG TERM CARE 46.00 0 0 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 28, 405, 516 0 0 0 0 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 52.00 3, 575, 171 0 05300 ANESTHESI OLOGY 0 0 53.00 0 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 44, 971, 387 C 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 55.00 0 05600 RADI OI SOTOPE 0 56.00 0 0 56.00 0 57.00 05700 CT SCAN 0 C 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 59.00 06000 LABORATORY 41, 061, 216 0 60.00 C 0 60.00 60.01 06001 BLOOD LABORATORY C 0 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 62.00 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 C 0 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 0 64.00 06500 RESPIRATORY THERAPY 65.00 14, 706, 974 0 0 0 0 0 65.00 66 00 06600 PHYSI CAL THERAPY 4. 908. 284 0 0 0 66 00 06700 OCCUPATI ONAL THERAPY 0 67.00 1,587,598 C 0 67.00 06800 SPEECH PATHOLOGY 1, 129, 293 0 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 69.00 0 0 70 00 07000 ELECTROENCEPHALOGRAPHY Ω 0 70 00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 987, 575 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 270, 355 0 0 72.00 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 26, 931, 790 0 0 0 73.00 0 07400 RENAL DIALYSIS 74 00 0 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 75.00 07698 HYPERBARIC OXYGEN THERAPY 0 0 76.98 5, 011, 095 0 76.98 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 0 n 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 0 0 89.00 0 90.00 09000 CLI NI C 265, 804 0 0 0 90.00 91. 00 09100 EMERGENCY 55, 092, 034 0 0 ol 91.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0146 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/23/2024 9:53 am INTERNS & **RESI DENTS** NONPHYSI CI AN NURSI NG Cost Center Description MEDI CAL SOCI AL SERVI CES-SALA RY & FRINGES RECORDS & **SERVICE ANESTHETISTS** PROGRAM (ASSI GNED (ASSI GNED LI BRARY (TIME SPENT) (ASSI GNED (GROSS TIME) TIME) TIME) CHARGES) 19.00 20.00 21.00 16. 00 17. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 95.00 09500 AMBULANCE SERVICES 24, 094, 861 0 0 o 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 96.00 0 0 0 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 97.00 99. 00 09900 CMHC 0 0 o 0 99.00 0 0 99. 10 09910 CORF 0 0 99.10 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 0 100, 00 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 0 0 0 105. 00 106.00 10600 HEART ACQUISITION 0 0 0 0 0 106.00 0 107. 00 10700 LIVER ACQUISITION 0 0 0 0 0 107.00 0 108.00 10800 LUNG ACQUISITION 01108 00 Ω 109. 00 10900 PANCREAS ACQUISITION C 0 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 o 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 o O 0 111.00 C 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 ol 0 115.00 116. 00 11600 HOSPI CE Ω 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 275, 834, 211 0 0 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 191. 00 19100 RESEARCH 0 0 0 191.00 Ω 0 o 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 193. 00 19300 NONPALD WORKERS 0 0 193.00 0 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194.00 194. 01 07951 PAIN CLINIC 0 0 194 01 Ω 0 194. 02 07952 OCC HEALTH 0 194. 02 0 0 194. 03 07953 FOUNDATI ON 0 194.03 0 194. 04 07954 PHYSICIAN OFFICES 0 194.04 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 0 0 0 194.05 C 194.06 07956 VACANT SPACE 0 0 0 194.06 200.00 Cross Foot Adjustments 200.00 201. 00 201 00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, 60, 834 0 0 202.00 Part I) 0.000000 203.00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000221 0.000000 0.000000 0.000000 0 204.00 204.00 Cost to be allocated (per Wkst. B, 7.707 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000028 0.000000 0.000000 0.000000 0.000000 205.00 II) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 207.00 NAHE unit cost multiplier (Wkst. D, 0.000000

Parts III and IV)

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0146 Period: Worksheet B-1

From 01/01/2023 12/31/2023 Date/Time Prepared: 5/23/2024 9:53 am INTERNS & **RESI DENTS** Cost Center Description SERVI CES-OTHE R PRGM COSTS (ASSI GNED TIME) 22.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FLXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 |01300| NURSI NG ADMI NI STRATI ON 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16 00 17.00 01700 SOCIAL SERVICE 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 20.00 02000 NURSING PROGRAM 20.00 02100 | &R SERVICES-SALARY & FRINGES APPRVD 21 00 21 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 30.00 0 03100 INTENSIVE CARE UNIT 31 00 31 00 32.00 03200 CORONARY CARE UNIT 32.00 03300 BURN INTENSIVE CARE UNIT 00000 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 0 45.00 04600 OTHER LONG TERM CARE 0 46.00 46.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0 50 00 51.00 05100 RECOVERY ROOM 0 51.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 05300 ANESTHESI OLOGY 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0000000 55.00 56.00 05600 RADI OI SOTOPE 56.00 05700 CT SCAN 57.00 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 59.00 60.00 06000 LABORATORY 60.00 06001 BLOOD LABORATORY 60.01 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 000000000000000 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 63.00 64.00 06400 I NTRAVENOUS THERAPY 64.00 65.00 06500 RESPIRATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 66.00 66.00 67 00 06700 OCCUPATIONAL THERAPY 67 00 68.00 06800 SPEECH PATHOLOGY 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 07400 RENAL DIALYSIS 74 00 74 00 75.00 07500 ASC (NON-DISTINCT PART) 75.00 0 07698 HYPERBARI C OXYGEN THERAPY 76.98 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90.00 90 00 09000 CLI NI C 91.00 09100 EMERGENCY 0 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0146 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/23/2024 9:53 am INTERNS & **RESI DENTS** Cost Center Description SERVI CES-OTHE R PRGM COSTS (ASSI GNED TIME) 22. 00 OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DIALYSIS 94.00 95. 00 09500 AMBULANCE SERVICES 0 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 0 0 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 99. 00 09900 CMHC 99.00 0 99. 10 09910 CORF 99.10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 100.00 0 101.00 10100 HOME HEALTH AGENCY 101.00 102.00 10200 OPIOID TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 105.00 0 106. 00 10600 HEART ACQUISITION 106.00 107. 00 10700 LIVER ACQUISITION 107.00 108. 00 10800 LUNG ACQUISITION 0 0 108.00 109. 00 10900 PANCREAS ACQUISITION 109.00 110.00 11000 INTESTINAL ACQUISITION 110.00 111.00 11100 I SLET ACQUISITION 0 111.00 113. 00 11300 | INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114 00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115.00 116. 00 11600 HOSPI CE 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 191. 00 19100 RESEARCH 0 191.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0000000 192.00 193. 00 19300 NONPALD 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 194.03 194. 04 07954 PHYSICIAN OFFICES 194.04 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 194. 05 194.06 194. 06 07956 VACANT SPACE 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 202.00 Cost to be allocated (per Wkst. B, 0 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 203. 00 204.00 Cost to be allocated (per Wkst. B, 204.00 Part II) 0.000000 205.00 Unit cost multiplier (Wkst. B, Part 205.00 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)

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
From 01/01/2023
To 12/31/2023
Period:
From 01/01/2023
To 12/31/2023
Date/Time Prepared:
5/23/2024 9: 53 am

			'	0 12/31/2023	5/23/2024 9: 5	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Total Cost (from Wkst.	Therapy Limit	Total Costs	RCE Di sal I owance	Total Costs	
	B, Part I, col. 26)	,				
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	7, 990, 286		7, 990, 286	0	7, 990, 286	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0			0	0	31.00
32. 00 03200 CORONARY CARE UNIT	0			0	0	32.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0			0	0	33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT	0			0	0	34.00
40. 00   04000   SUBPROVI DER -   I PF	0			0	0	40.00
41. 00   04100   SUBPROVI DER - I RF 43. 00   04300   NURSERY	452 442		452.443	0	452 (42	41. 00 43. 00
44.00 04400 SKILLED NURSING FACILITY	453, 663 0		453, 663		453, 663 0	44.00
45.00 04400 SKILLED NORSING FACILITY	0				0	45.00
46. 00   04600   OTHER LONG TERM CARE	0				0	46.00
ANCI LLARY SERVICE COST CENTERS				,		1 40.00
50. 00 05000 OPERATING ROOM	4, 677, 727		4, 677, 727	0	4, 677, 727	50.00
51. 00   05100 RECOVERY ROOM	0		,,,,,,,,		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 847, 469		1, 847, 469	0	1, 847, 469	52.00
53. 00   05300   ANESTHESI OLOGY	0			0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	5, 156, 535		5, 156, 535	0	5, 156, 535	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0		(	0	0	55.00
56. 00   05600   RADI OI SOTOPE	0		(	0	0	56.00
57. 00   05700   CT   SCAN	0		(	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0	0	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0			0	0	59.00
60. 00   06000   LABORATORY	4, 735, 160		4, 735, 160	0	4, 735, 160	60.00
60. 01 06001 BLOOD LABORATORY	0			0	0	60.01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0	0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0	0	62. 00 63. 00
63. 00   06300   BLOOD STORING, PROCESSING & TRANS. 64. 00   06400   INTRAVENOUS THERAPY	0					64.00
65. 00 06500 RESPIRATORY THERAPY	2, 075, 392	0	2, 075, 392		2, 075, 392	65.00
66. 00   06600   PHYSI CAL THERAPY	1, 673, 191	0	1, 673, 191		1, 673, 191	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	927, 542	0	927, 542		927, 542	67.00
68. 00 06800 SPEECH PATHOLOGY	381, 448	0	381, 448		381, 448	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	Ĭ	]		0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		Ì	0	Ō	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	708, 407		708, 407	0	708, 407	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	850, 206		850, 206	0	850, 206	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 653, 103		6, 653, 103	0	6, 653, 103	73.00
74.00 07400 RENAL DIALYSIS	0		(	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0		(	0	0	75. 00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	1, 024, 836	i e	1, 024, 836		1, 024, 836	76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0		C	0	0	77. 00
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY	0			) 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS		I				00.00
88.00   08800   RURAL HEALTH CLINIC 89.00   08900   FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	88. 00 89. 00
89. 00   08900   FEDERALLY QUALI FI ED HEALTH CENTER 90. 00   09000   CLI NI C	103, 086		103, 086		103, 086	90.00
91. 00   09100   EMERGENCY	4, 567, 264	l	4, 567, 264			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 726, 433		2, 726, 433		2, 726, 433	92.00
OTHER REIMBURSABLE COST CENTERS	2,720,700		2,720, 400		2,720,100	1 00
94. 00 09400 HOME PROGRAM DIALYSIS	0			0	0	94.00
95. 00 09500 AMBULANCE SERVICES	9, 153, 272		9, 153, 272	_	1	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0			0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0		l c	0	0	97.00
99. 00 09900 CMHC	0		l c	)	0	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		[ c	)		101.00
102.00 10200 OPIOID TREATMENT PROGRAM	0		C	)	0	102.00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KI DNEY ACQUI SI TI ON	0		[ C	)	l e	105.00
106. 00 10600 HEART ACQUI SI TI ON	0			2		106.00
107. 00 10700 LI VER ACQUI SI TI ON	0					107.00
108. 00 10800 LUNG ACQUI SI TI ON	0					108.00
109.00 10900 PANCREAS ACQUISITION	0				•	109.00
110.00 11000 INTESTINAL ACQUISITION 111.00 11100 ISLET ACQUISITION						110. 00 111. 00
113.00 11300 INTEREST EXPENSE				<u>'</u>		113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P. )	0				n	115.00
Solitor one Server (B.1.)	1 0	I	1	1	1 0	1

Health Financial	COMMUNITY HOSPITAL OF NOBLE CTY, INC			In Lieu of Form CMS-2552-10				
COMPUTATION OF R	RATIO OF COSTS TO CHARGES			Period:   Workshe   From 01/01/2023   Part     To 12/31/2023   Date/Ti   5/23/20				
				Title	XVIII	Hospi tal	PPS	
						Costs		
Cost	t Center Description	Total Cost (from Wkst. B, Part I, col. 26)	The	erapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1. 00		2. 00	3.00	4. 00	5. 00	
116.00 11600 HOSF	PLCE	0				0	0	116. 00
201. 00 Less	total (see instructions) s Observation Beds al (see instructions)	55, 705, 020 2, 726, 433 52, 978, 587		0	55, 705, 02 2, 726, 43 52, 978, 58	3	2, 726, 433	201. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES COMMUNITY HOSPITAL OF NOBLE CTY, INC Provider CCN: 15-0146 In Lieu of Form CMS-2552-10 Peri od: Worksheet C From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

				0 12/31/2023	Date/lime Pre   5/23/2024 9:5	
		Title	xVIII	Hospi tal	PPS	
		Charges	1			
Cost Center Description	Inpatient	Outpati ent	,	Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpatient Ratio	
	6. 00	7. 00	8.00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7. 00		
30. 00 03000 ADULTS & PEDIATRICS	14, 346, 283		14, 346, 283			30.00
31.00 03100 INTENSIVE CARE UNIT	0		0			31.00
32.00 03200 CORONARY CARE UNIT	0		0			32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0		0			33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT	0		0			34.00
40. 00   04000   SUBPROVI DER -   I PF	0					40.00
41. 00   04100   SUBPROVI DER -   RF	005 073		005 073			41.00
43. 00   04300   NURSERY 44. 00   04400   SKILLED   NURSING   FACILITY	885, 873 0		885, 873			43. 00 44. 00
45. 00   04500 NURSI NG FACILITY						45.00
46. 00 04600 OTHER LONG TERM CARE	0					46.00
ANCI LLARY SERVICE COST CENTERS	91					10.00
50. 00 05000 OPERATING ROOM	7, 052, 992	21, 352, 524	28, 405, 516	0. 164677	0.000000	50.00
51.00   05100   RECOVERY ROOM	0	0	O.	0. 000000	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 575, 171	0	3, 575, 171	0. 516750	0.000000	52.00
53. 00   05300   ANESTHESI OLOGY	0	0	0	0. 000000	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 966, 238	40, 005, 149	44, 971, 387	0. 114663	0. 000000	1
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	0		0.000000	0.000000	55.00
56. 00   05600   RADI 01 SOTOPE 57. 00   05700   CT   SCAN	0	0		0. 000000 0. 000000	0. 000000 0. 000000	56. 00 57. 00
58.00   05700   CT   SCAN 58.00   05800   MAGNETIC RESONANCE   MAGING (MRI)		0		0.000000	0.000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0		0. 000000	0. 000000	59.00
60. 00 06000 LABORATORY	7, 854, 999	33, 206, 217	41, 061, 216		0. 000000	60.00
60. 01   06001   BLOOD   LABORATORY	0	0	C	0. 000000	0.000000	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	o	0. 000000	0.000000	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	C	0.000000	0.000000	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0. 000000	0.000000	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0.000000	0. 000000	1
65. 00 06500 RESPI RATORY THERAPY	3, 238, 185	11, 468, 789			0.000000	65.00
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   OCCUPATI ONAL THERAPY	206, 957	4, 701, 327		0. 340891	0. 000000 0. 000000	66. 00 67. 00
68. 00   06800   SPEECH PATHOLOGY	122, 499 95, 781	1, 465, 099 1, 033, 512			0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	73, 701	1, 033, 312	1, 127, 273	0. 000000	0. 000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	l ol	0	l o	0. 000000	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	463, 018	2, 524, 557	2, 987, 575		0.000000	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	282, 649	2, 987, 706			0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	5, 415, 378	21, 516, 412	26, 931, 790	0. 247035	0.000000	73.00
74. 00   07400   RENAL DI ALYSI S	0	0	0		0.000000	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	0	0. 000000	0. 000000	75.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	44, 333	4, 966, 762	5, 011, 095		0.000000	76. 98
77.00   07700   ALLOGENEIC STEM CELL ACQUISITION 78.00   07800   CAR T-CELL IMMUNOTHERAPY		0		0. 000000 0. 000000	0. 000000 0. 000000	77. 00 78. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	0	1	0.000000	0.000000	78.00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0			88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	o	0	o c			89.00
90. 00  09000   CLI NI C	5, 959	259, 845	265, 804	0. 387827	0.000000	90.00
91. 00   09100   EMERGENCY	7, 353, 469	47, 738, 565	55, 092, 034	0. 082902	0.000000	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	214, 430	2, 388, 672	2, 603, 102	1. 047378	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS			ı	0.000000	0.00000	04.00
94. 00   09400   HOME PROGRAM DI ALYSIS 95. 00   09500   AMBULANCE SERVICES	0 0	24, 094, 861	24 004 041	0.000000	0.000000	
96. 00   09600 DURABLE MEDICAL EQUIP-RENTED		24, 094, 861	24, 094, 861	0. 379885 0. 000000	0. 000000 0. 000000	1
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0		0.000000	0.000000	
99. 00 09900 CMHC		0		0.000000	0.000000	99.00
99. 10 09910 CORF	l o	0	l o			99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	d			100.00
101.00 10100 HOME HEALTH AGENCY	0	0	o			101.00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	O			102.00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	1			105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0			106.00
107. 00 10700 LIVER ACQUISITION	0	0				107.00
108.00 10800 LUNG ACQUISITION 109.00 10900 PANCREAS ACQUISITION		0				108. 00 109. 00
110. 00 11000   NTESTINAL ACQUISITION		0				1109.00
111. 00 11100   ISLET ACQUISITION		0				111.00
113. 00 11300   NTEREST EXPENSE	1	O				113.00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	1			115.00
116. 00 11600 HOSPI CE	0	0	0			116. 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 CCN: 15-0146		Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/23/2024 9:53 am	
			Title XVIII		Hospi tal	PPS	
	Cost Center Description	I npati ent	Charges Outpati ent 7.00	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o 10.00	
200. 00 201. 00 202. 00	Subtotal (see instructions) Less Observation Beds Total (see instructions)	56, 124, 214 56, 124, 214					200. 00 201. 00 202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 15-0146

		T		5/23/2024 9: 53 am
Cost Contor Doscription	PPS Inpatient	Title XVIII	Hospi tal	PPS
Cost Center Description	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS				30.00
31. 00   03100   INTENSIVE CARE UNIT				31.00
32. 00 03200 CORONARY CARE UNIT				32.00
33. 00   03300   BURN INTENSIVE CARE UNIT 34. 00   03400   SURGICAL INTENSIVE CARE UNIT				33. 00 34. 00
40. 00   04000 SUBPROVI DER - I PF				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
46.00 O4600 OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS	T T			
50. 00   05000   OPERATI NG ROOM	0. 164677			50.00
51. 00   05100   RECOVERY ROOM	0.000000			51. 00 52. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM   53.00   05300   ANESTHESIOLOGY	0. 516750 0. 000000			53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 114663			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55.00
56. 00   05600   RADI 01 SOTOPE	0. 000000			56.00
57. 00   05700   CT   SCAN	0. 000000			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0. 000000			59.00
60. 00   06000   LABORATORY	0. 115320			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 63.00   06300   BLOOD STORING, PROCESSING & TRANS.	0.000000			62.00
63.00   06300   BLOOD STORING, PROCESSING & TRANS. 64.00   06400   INTRAVENOUS THERAPY	0. 000000 0. 000000			63. 00 64. 00
65. 00   06500   RESPI RATORY   THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 340891			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 584242			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 337776			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 237118			71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 259974			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 247035			73.00
74. 00   07400   RENAL DI ALYSI S 75. 00   07500   ASC (NON-DI STI NCT PART)	0.000000			74. 00 75. 00
75. 00   07500   ASC (NON-DISTINCT PART) 76. 98   07698   HYPERBARI C OXYGEN THERAPY	0. 000000 0. 204513			76. 98
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			77.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78.00
OUTPATIENT SERVICE COST CENTERS	0.00000			76.66
88. 00 08800 RURAL HEALTH CLINIC				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
90. 00  09000 CLI NI C	0. 387827			90.00
91. 00   09100   EMERGENCY	0. 083496			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 047378			92. 00
OTHER REIMBURSABLE COST CENTERS	0.000000			04.00
94. 00 09400 HOME PROGRAM DIALYSIS	0. 000000			94.00
95. 00   09500   AMBULANCE SERVICES 96. 00   09600   DURABLE MEDICAL EQUIP-RENTED	0. 379885 0. 000000			95. 00 96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED	0. 000000			97.00
99. 00   09900   CMHC	0.000000			99.00
99. 10 09910 CORF				99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM				100.00
101.00 10100 HOME HEALTH AGENCY				101.00
102.00 10200 OPIOID TREATMENT PROGRAM				102. 00
SPECIAL PURPOSE COST CENTERS				
105. 00 10500 KI DNEY ACQUI SI TI ON				105. 00
106. 00 10600 HEART ACQUI SI TI ON				106. 00
107. 00 10700 LI VER ACQUI SI TI ON				107.00
108.00 10800 LUNG ACQUISITION				108.00
109. 00 10900 PANCREAS ACQUISITION 110. 00 11000 INTESTINAL ACQUISITION				109. 00 110. 00
111.00 11100 ISLET ACQUISITION				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
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201.00

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 CCN: 15-0146	Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/23/2024 9:5		
		Title XVIII	Hospi tal	PPS		
Cost Center Description	PPS Inpatient					
	Ratio					
	11. 00					
202.00 Total (see instructions)					202.00	

Heal th 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

Period:
From 01/01/2023
To 12/31/2023

Provider CCN: 15-0146

Provider

		Ti +I	e XIX	Hospi tal	5/23/2024 9: 5 PPS	3 4111
		11 (1	E ALA	Costs	FF3	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
cost center bescription	(from Wkst.	Adj.	10141 00313	Di sal I owance	10141 00313	
	B, Part I,	Auj .		Di Sai i Owanee		
	col . 26)					
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	7, 990, 286		7, 990, 286	0	7, 990, 286	30.00
31. 00 03100 I NTENSI VE CARE UNI T	1,770,200		1, 770, 200	0	0	31.00
32. 00 03200 CORONARY CARE UNIT				0	Ö	32.00
33. 00 03300 BURN INTENSIVE CARE UNIT				0	0	33.00
34. 00   03400   SURGI CAL   INTENSI VE CARE UNI T				0	0	34.00
40. 00   04000   SUBPROVI DER -   PF				0	0	40.00
	0			0	0	•
	_		452 ((2	0	_	41.00
43. 00   04300   NURSERY	453, 663		453, 663	0	453, 663	43.00
44.00 04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
45. 00 04500 NURSING FACILITY	0		0	0	0	45.00
46. 00 O4600 OTHER LONG TERM CARE	0		0	0	0	46. 00
ANCILLARY SERVICE COST CENTERS		Γ				
50. 00   05000   OPERATING ROOM	4, 677, 727		4, 677, 727	0	.,	50.00
51. 00   05100   RECOVERY ROOM	0		0	0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 847, 469		1, 847, 469	0	1, 847, 469	52.00
53. 00 05300 ANESTHESI OLOGY	0		0	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	5, 156, 535		5, 156, 535	0	5, 156, 535	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0		0	0	0	55.00
56. 00   05600   RADI 01 SOTOPE	0		0	0	0	56.00
57. 00  05700 CT SCAN	0		0	0	0	57.00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0		0	0	0	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0		0	0	0	59.00
60. 00   06000   LABORATORY	4, 735, 160		4, 735, 160	0	4, 735, 160	60.00
60. 01   06001   BLOOD   LABORATORY	0		0	0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0		l 0	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	2, 075, 392	0	2, 075, 392	0	2, 075, 392	65.00
66. 00   06600 PHYSI CAL THERAPY	1, 673, 191	0	1, 673, 191	0	1, 673, 191	•
67. 00 06700 OCCUPATI ONAL THERAPY	927, 542	0	927, 542	0	927, 542	67.00
68. 00 06800 SPEECH PATHOLOGY	381, 448		381, 448		381, 448	68.00
69. 00 06900 ELECTROCARDI OLOGY	001,110	Ĭ	001,110	0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	708, 407		708, 407	0	708, 407	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	850, 206		850, 206	0	850, 206	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	6, 653, 103		6, 653, 103		6, 653, 103	1
74. 00   07400   RENAL DIALYSIS	0,055,105		0,055,105	0	0,055,105	74.00
75. 00   07500   ASC (NON-DISTINCT PART)				0	0	75.00
76. 98   07698   HYPERBARI C OXYGEN THERAPY	1, 024, 836		1 024 926	0	_	76. 98
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	1,024,630		1, 024, 836	0	1, 024, 836 0	77.00
	0		0	0	0	
78. 00 07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS				U	U	78. 00
			1 0	0	0	00 00
88. 00 08800 RURAL HEALTH CLINIC	0		0	0	0	•
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	100.00/		100 00/	0	0	89.00
90. 00   09000   CLI NI C	103, 086	l	103, 086		103, 086	
91. 00 09100 EMERGENCY	4, 567, 264		4, 567, 264			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 726, 433		2, 726, 433		2, 726, 433	92.00
OTHER REIMBURSABLE COST CENTERS	-		_			04.55
94. 00 09400 HOME PROGRAM DIALYSIS	0 450 070		0 450 070	_	0	94.00
95. 00 09500 AMBULANCE SERVICES	9, 153, 272		9, 153, 272	0	9, 153, 272	
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
99. 00  09900  CMHC	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			100.00
101.00 10100 HOME HEALTH AGENCY	0		0			101.00
102.00 10200 OPIOID TREATMENT PROGRAM	0		0		0	102.00
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		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		0		0	115.00
		•			•	·

Heal th Finar	ncial Systems	COMMUNITY HOSPITAL	OF NOBLE CTY,	INC	In Lie	u of Form CMS-2	2552-10
COMPUTATI ON	OF RATIO OF COSTS TO CHARGES		Provi der C		Peri od: From 01/01/2023	Worksheet C Part I	
					To 12/31/2023	Date/Time Pre 5/23/2024 9:5	pared: 3 am
			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	
116.00 11600	HOSPI CE	0			0	0	116. 00
200. 00	Subtotal (see instructions)	55, 705, 020	0	55, 705, 02	0 32, 679	55, 737, 699	200. 00
201. 00	Less Observation Beds	2, 726, 433		2, 726, 43	3	2, 726, 433	201.00
202. 00	Total (see instructions)	52, 978, 587	0	52, 978, 58	7 32, 679	53, 011, 266	202. 00

Provider CCN: 15-0146

Peri od:

From 01/01/2023

Part I

Date/Time Prepared: 12/31/2023 5/23/2024 9:53 am 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 30.00 14, 346, 283 14, 346, 283 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 885, 873 885, 873 43.00 43.00 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, 052, 992 21, 352, 524 28, 405, 516 0.164677 0.000000 50.00 05100 RECOVERY ROOM 0.000000 51.00 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 3, 575, 171 0.516750 0.000000 52.00 0 3, 575, 171 52.00 05300 ANESTHESI OLOGY 53 00 0.000000 0.000000 53 00 05400 RADI OLOGY-DI AGNOSTI C 40, 005, 149 44, 971, 387 0.114663 0.000000 54.00 4, 966, 238 54.00 55 00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0.000000 55.00 05600 RADI 01 S0T0PE 56,00 0 C 0 0.000000 0.000000 56,00 57.00 05700 CT SCAN 0 Ω 0 0.000000 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0.000000 0.000000 58.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0.000000 59.00 59.00 06000 LABORATORY 33, 206, 217 60.00 7, 854, 999 41, 061, 216 0.115320 0.000000 60 00 60.01 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 0 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 0 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. 63.00 0 C 0 0.000000 0.000000 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 0.000000 0.000000 64.00 06500 RESPIRATORY THERAPY 65.00 3, 238, 185 11, 468, 789 14, 706, 974 0.141116 0.000000 65.00 66 00 06600 PHYSI CAL THERAPY 206 957 4.701.327 4. 908. 284 0 340891 0.000000 66 00 06700 OCCUPATI ONAL THERAPY 67.00 122, 499 1, 465, 099 1, 587, 598 0.584242 0.000000 67.00 06800 SPEECH PATHOLOGY 95, 781 1, 033, 512 1, 129, 293 0.337776 0.000000 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0.000000 70 00 70 00 0.000000 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 463, 018 2, 524, 557 2, 987, 575 0. 237118 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 987, 706 3, 270, 355 0. 259974 0.000000 72.00 282, 649 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 5. 415. 378 21, 516, 412 26, 931, 790 0 247035 0.000000 73 00 07400 RENAL DIALYSIS 74.00 0.000000 0.000000 74.00 0 07500 ASC (NON-DISTINCT PART) 0.000000 0.000000 75.00 75.00 76. 98 07698 HYPERBARIC OXYGEN THERAPY 44, 333 4, 966, 762 5,011,095 0.204513 0.000000 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 77 00 0.000000 77 00 Ω 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0.000000 0 0 88.00 89 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0.000000 0.000000 89 00 0 90.00 09000 CLI NI C 5, 959 259, 845 265, 804 0.387827 0.000000 90.00 09100 EMERGENCY 7, 353, 469 0.082902 91.00 47, 738, 565 55, 092, 034 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS 92.00 214, 430 2, 388, 672 2, 603, 102 1.047378 0.000000 92.00 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0.000000 94.00 95 00 09500 AMBULANCE SERVICES 0 24, 094, 861 24, 094, 861 0.379885 0.000000 95.00 0 0.000000 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 96.00 0 96,00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0.000000 0.000000 97.00 09900 CMHC 0 0 99.00 99.00 99. 10 09910 CORF 0 0 0 99.10 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 100.00 0 101.00 10100 HOME HEALTH AGENCY 0 C 101.00 102.00 10200 OPIOID TREATMENT PROGRAM 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0.000000 0.000000 105.00 C 0 0 106.00 10600 HEART ACQUISITION 0.000000 0.000000 106.00 0 107.00 10700 LIVER ACQUISITION 0 0 0.000000 0.000000 107.00 0 108.00 10800 LUNG ACQUISITION 0 0.000000 0. 000000 108. 00 0 109. 00 10900 PANCREAS ACQUISITION C 0.000000 0.000000 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 0.000000 110.00 0 0.000000 0 111.00 11100 I SLET ACQUISITION C 0 0.000000 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 0 115.00 116. 00 11600 HOSPI CE 0 116 00

Health Fina	ancial Systems	COMMU	JNITY HOSPITAL (	OF NOBLE CTY,	INC	In Lie	u of Form CMS-	-2552-10
COMPUTATI O	N OF RATIO OF COSTS TO CHARGES			Provider Co		Period: From 01/01/2023 To 12/31/2023		
				Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description		Inpatient 6.00	Charges Outpati ent 7.00	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o 10.00	
200. 00 201. 00 202. 00	Subtotal (see instructions) Less Observation Beds Total (see instructions)		56, 124, 214 56, 124, 214					200. 00 201. 00 202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES In Lieu of Form CMS-2552-10 Peri od: Worksheet C
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/23/2024 9:53 am Provi der CCN: 15-0146

-		Title XIX	Hospi tal	5/23/2024 9: 5 PPS	3 am
Cost Center Description	PPS Inpatient	II the XIX	110Spi tai	FF3	
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					00.00
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   NTENSIVE CARE UNIT					30.00
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 -   PF					40.00
41. 00   04100   SUBPROVI DER -   RF					41.00
43. 00   04300   NURSERY 44. 00   04400   SKILLED NURSING FACILITY					43. 00 44. 00
45. 00   04500   NURSI NG   FACILITY					45.00
46. 00 04600 OTHER LONG TERM CARE					46.00
ANCILLARY SERVICE COST CENTERS					
50. 00   05000   OPERATING ROOM	0. 164677				50.00
51. 00 05100 RECOVERY ROOM	0.000000				51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM 53. 00   05300   ANESTHESI OLOGY	0. 516750 0. 000000				52. 00 53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 114663				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)	0.000000				58.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	0. 000000 0. 115320				59.00
60. 00   06000  LABORATORY 60. 01   06001  BLOOD LABORATORY	0. 000000				60. 00 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 INTRAVENOUS THERAPY	0. 000000				64.00
65. 00 06500 RESPI RATORY THERAPY	0. 141116				65.00
66. 00   06600   PHYSI CAL THERAPY	0. 340891				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 584242				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 337776				68.00
69. 00   06900   ELECTROCARDI OLOGY 70. 00   07000   ELECTROENCEPHALOGRAPHY	0. 000000 0. 000000				69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 237118				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 259974				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 247035				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 O7698 HYPERBARI C OXYGEN THERAPY	0. 204513				76. 98
77.00   07700   ALLOGENEIC STEM CELL ACQUISITION 78.00   07800   CAR T-CELL IMMUNOTHERAPY	0. 000000 0. 000000				77. 00 78. 00
OUTPATIENT SERVICE COST CENTERS	0.000000				78.00
88. 00 08800 RURAL HEALTH CLINIC	0.000000				88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89. 00
90. 00   09000   CLI NI C	0. 387827				90.00
91. 00   09100   EMERGENCY	0. 083496				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 047378				92.00
OTHER REIMBURSABLE COST CENTERS  94. 00 09400 HOME PROGRAM DI ALYSIS	0. 000000				04.00
95. 00   09500   AMBULANCE SERVICES	0. 000000				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
99. 00 09900 CMHC					99. 00
99. 10   09910   CORF					99. 10
100. 00 10000 I &R SERVICES-NOT APPRVD PRGM					100.00
101. 00 10100 HOME HEALTH AGENCY					101.00
102. 00 10200  OPI 0I D TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS					102.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0. 000000				105.00
106. 00 10600 HEART ACQUISITION	0. 000000				106.00
107.00 10700 LIVER ACQUISITION	0. 000000				107.00
108.00 10800 LUNG ACQUISITION	0. 000000				108.00
109. 00 10900 PANCREAS ACQUISITION	0. 000000				109.00
110. 00 11000 INTESTINAL ACQUISITION	0.000000				110.00
111.00 11100 ISLET ACQUISITION	0. 000000				111.00
113. 00 11300 INTEREST_EXPENSE 114. 00 11400 UTI LI ZATI ON_REVI EW-SNF					113. 00 114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P. )					115.00
116. 00 11600 HOSPI CE					116.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201. 00

Health Financial Systems	COMMUNITY HOSPITAL OF	NOBLE CTY, INC	In Lie	of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0146	Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/23/2024 9:5	
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
202.00 Total (see instructions)					202.00

Health Financial Systems COMMUNITY HOSPITAL CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY Peri od: Worksheet C From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared: Provi der CCN: 15-0146

			Ic	12/31/2023	Date/lime Pre   5/23/2024 9:5	
		Ti tl	e XIX	Hospi tal	PPS	<u> </u>
Cost Center Description	Total Cost	Capital Cost	Operati ng	Capi tal	Operati ng	
	(Wkst. B,	(Wkst. B,	Cost Net of	Reduction	Cost	
	Part I, col.	Part II col.	Capital Cost		Reducti on	
	26)	26)	(col. 1 -		Amount	
	1 00	2.00	col. 2)	4.00	F 00	
ANCILLARY SERVICE COST CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
50. 00 05000 OPERATING ROOM	4, 677, 727	409, 700	4, 268, 027	0	0	50.00
51. 00   05100   RECOVERY ROOM	4,077,727	1 407, 700	4, 200, 027	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 847, 469	110, 668	1, 736, 801	o	0	52.00
53. 00   05300   ANESTHESI OLOGY	0	0	0	O	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 156, 535	601, 536	4, 554, 999	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56. 00   05600   RADI 0I 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   MAGING (MRI)	0	0	0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	4 725 1/0	204 000	4 520 1/2	0	0	59.00
60. 00   06000   LABORATORY 60. 01   06001   BLOOD   LABORATORY	4, 735, 160	204, 998	4, 530, 162	0	0	60. 00 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	Ö	0	0	63.00
64.00 06400 I NTRAVENOUS THERAPY	0	Ö	o	o	0	64.00
65. 00 06500 RESPIRATORY THERAPY	2, 075, 392	181, 048	1, 894, 344	O	0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 673, 191	106, 915	1, 566, 276	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	927, 542	38, 143	889, 399	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	381, 448	15, 696	365, 752	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	708, 407		1	0	0	71.00
72.00   07200   IMPL. DEV. CHARGED TO PATIENTS 73.00   07300   DRUGS CHARGED TO PATIENTS	850, 206		1	0	0	72. 00 73. 00
74. 00   07400   RENAL DIALYSIS	6, 653, 103			0	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0			0	0	75.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	1, 024, 836	61, 397	963, 439	o	0	76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	O	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	О	0	78. 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	ı	0	0	0	89.00
90. 00   09000   CLI NI C	103, 086			0	0	90.00
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	4, 567, 264 2, 726, 433			0	0	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS	2, 720, 433	171,093	2, 555, 556	<u> </u>	0	72.00
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	9, 153, 272	1	1	0	0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	O	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	О	0	97.00
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		100.00
101. 00 10100 HOME HEALTH AGENCY	0		0	0		101.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS   105. 00   10500   KI DNEY ACQUI SI TI ON	0		0	ol	0	105.00
106. 00 10600 HEART ACQUISITION	0		_	0		106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	0	0		107.00
108. 00 10800 LUNG ACQUISITION	0	ĺ	Ö	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	o	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF				_	_	114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115.00
116. 00 11600 HOSPI CE	0	3 300 050	0	0		116. 00 200. 00
200.00 Subtotal (sum of lines 50 thru 199) 201.00 Less Observation Beds	47, 261, 071 2, 726, 433			o o		200.00
202.00 Total (line 200 minus line 201)	44, 534, 638			ol ol	0	202.00
202.00    1000 (1110 200 11110 201)	1 1, 554, 550	1 3,037,000	1 11, 470, 703	Ч	O	1-02.00

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF Provider CCN: 15-0146 REDUCTIONS FOR MEDICALD ONLY

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | 5/23/2024 9:53 am

		T; +1	e XIX	Hocni tal	PPS	3 am
Cost Contor Doscription	Cost Net of	Total Charges	Outpati ent	Hospi tal	PP3	
Cost Center Description			Cost to			
	Capital and	(Worksheet C,				
	Operating	Part I,	Charge Ratio			
	Cost	column 8)	(col. 6 /			
	Reduction	7.00	col . 7)			
	6. 00	7. 00	8. 00			
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	4, 677, 727	28, 405, 516	1			50.00
51.00  05100 RECOVERY ROOM	0	0	0. 000000			51.00
52.00  05200   DELIVERY ROOM & LABOR ROOM	1, 847, 469	3, 575, 171	0. 516750			52.00
53. 00   05300   ANESTHESI OLOGY	0	0	0. 000000			53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	5, 156, 535	44, 971, 387	0. 114663			54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	0	0.000000			55.00
56. 00   05600   RADI OI SOTOPE	0	0	0.000000			56.00
57. 00  05700 CT SCAN	0	0	0.000000			57.00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0	0	0.000000			58.00
59. 00   05900 CARDI AC CATHETERI ZATI ON	0	0	0.000000			59.00
60. 00   06000   LABORATORY	4, 735, 160	41, 061, 216	0. 115320			60.00
60. 01 06001 BLOOD LABORATORY	0	0	0. 000000			60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0. 000000			61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0. 000000			62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 000000			63.00
64. 00   06400   I NTRAVENOUS THERAPY	l o	i n	0. 000000			64.00
65. 00 06500 RESPIRATORY THERAPY	2, 075, 392	14, 706, 974				65.00
66. 00 06600 PHYSI CAL THERAPY	1, 673, 191	4, 908, 284	0. 340891			66.00
67. 00   06700   OCCUPATI ONAL THERAPY	927, 542	1, 587, 598				67.00
68. 00 06800 SPEECH PATHOLOGY	381, 448					68.00
	1					69.00
	0	0				
70. 00 07000 ELECTROENCEPHALOGRAPHY	700 407	0 007 575	0.000000			70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	708, 407	2, 987, 575				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	850, 206	3, 270, 355				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	6, 653, 103	26, 931, 790	1			73.00
74. 00   07400   RENAL DI ALYSI S	0	0	0. 000000			74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.000000			75. 00
76.98 07698 HYPERBARIC OXYGEN THERAPY	1, 024, 836	5, 011, 095				76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0				77. 00
78.00 O7800 CAR T-CELL IMMUNOTHERAPY	0	0	0. 000000			78. 00
OUTPATIENT SERVICE COST CENTERS	1					
88. 00   08800   RURAL HEALTH CLINIC	0	0	0. 000000			88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 000000			89. 00
90. 00  09000   CLI NI C	103, 086					90.00
91. 00   09100   EMERGENCY	4, 567, 264	55, 092, 034				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 726, 433	2, 603, 102	1. 047378			92.00
OTHER REIMBURSABLE COST CENTERS						
94.00   09400   HOME PROGRAM DIALYSIS	0	0	0. 000000			94.00
95. 00 09500 AMBULANCE SERVICES	9, 153, 272	24, 094, 861	0. 379885			95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000			96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000			97.00
99. 00 09900 CMHC	0	0	0.000000			99.00
99. 10  09910 CORF	0	0	0. 000000			99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0.000000			100.00
101.00 10100 HOME HEALTH AGENCY	0	0				101.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0					102.00
SPECIAL PURPOSE COST CENTERS	<u> </u>					1
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0.000000			105.00
106. 00 10600 HEART ACQUISITION	0	n	0. 000000			106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	i o	0. 000000			107.00
108. 00 10800 LUNG ACQUISITION	0	0	0. 000000			108.00
109. 00 10900 PANCREAS ACQUISITION	0	0	0. 000000			109.00
110.00 11000 INTESTINAL ACQUISITION		0	0.000000			1109.00
	0	0				
111.00 11100 ISLET ACQUISITION			0. 000000			111.00
113. 00 11300 I NTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	_	_	0.000000			114.00
115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.)	0	0	0.000000			115.00
116. 00 11600 HOSPI CE	0	0	0. 000000			116.00
200.00 Subtotal (sum of lines 50 thru 199)	47, 261, 071	260, 602, 055				200.00
201.00 Less Observation Beds	2, 726, 433					201.00
202.00   Total (line 200 minus line 201)	44, 534, 638	260, 602, 055				202. 00

Health Financial Systems	COMMUNITY HOSPITAL C	F NOBLE CTY,	I NC	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE	E CAPITAL COSTS	Provi der Co		Peri od: Worksheet D Part I To 12/31/2023 Date/Time Prepared: 5/23/2024 9:53 am		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2023	Worksheet D Part I	
				To 12/31/2023	Date/Time Pre	
		Ti +Lo	XVIII	Hospi tal	5/23/2024 9: 5 PPS	<u>3 am</u>
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
oost center beserveron	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	501, 420	0	501, 42	0 6, 975	71. 89	
31. 00   INTENSIVE CARE UNIT	0			0	0. 00	
32. 00 CORONARY CARE UNIT	0			0	0.00	
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	1
41.00 SUBPROVI DER - I RF 43.00 NURSERY	24 004	Ü	24 00	6 462	0. 00 58. 02	
44.00   SKILLED NURSING FACILITY	26, 806		26, 80	0 402		44.00
45.00 NURSING FACILITY	0				0.00	1
200.00 Total (lines 30 through 199)	528, 226		528, 22	6 7, 437	0.00	200.00
Cost Center Description	Inpati ent	I npati ent	320, 22	0 7,437		200.00
oost center beserveron	Program days	Program				
	· · · · · · · · · · · ·	Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 016	73, 040	1			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 41. 00   SUBPROVI DER - I RF	0	0				40. 00 41. 00
43. 00   NURSERY	0	0				43.00
44.00 SKILLED NURSING FACILITY		0				44.00
45. 00 NURSING FACILITY		0				45.00
200.00 Total (lines 30 through 199)	1, 016	73, 040				200.00
	., 010	. 5, 616	1			

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-0146 Peri od: Worksheet D From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/23/2024 9:53 am Title XVIII Hospi tal PPS 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 409, 700 28, 405, 516 0.014423 634, 106 9.146 05100 RECOVERY ROOM 0.000000 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 110, 668 3, 575, 171 0.030955 0 0 52.00 05300 ANESTHESI OLOGY 0.000000 53.00 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 601, 536 44, 971, 387 0.013376 1, 529, 775 20, 462 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 55.00 56.00 05600 RADI OI SOTOPE 0.000000 56.00 0 0 0 0.000000 57 00 05700 CT SCAN 0 0 57.00 C 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 204, 998 41, 061, 216 0.004992 1, 749, 810 8,735 60.00 60.00 06001 BLOOD LABORATORY 60.01 0 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 14, 706, 974 0.012310 65.00 181, 048 522, 193 6, 428 65.00 06600 PHYSI CAL THERAPY 106, 915 4, 908, 284 0.021783 62, 012 66.00 1.351 66.00 06700 OCCUPATI ONAL THERAPY 1, 587, 598 38, 143 31, 143 67.00 0.024026 748 67.00 68.00 06800 SPEECH PATHOLOGY 15, 696 1, 129, 293 0.013899 31, 507 438 68.00 06900 ELECTROCARDI OLOGY 69.00 0.000000 69.00 0 70 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70 00 0 |07100|MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 987, 575 71.00 33, 109 0.011082 101, 021 1, 120 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 34, 840 3, 270, 355 0.010653 95, 432 1,017 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 280,050 26, 931, 790 0.010398 1, 049, 608 10, 914 73.00 07400 RENAL DIALYSIS 74 00 0.000000 74 00 0 0 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 0 75.00 61, 397 07698 HYPERBARIC OXYGEN THERAPY 5, 011, 095 0.012252 24, 174 296 76. 98 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0.000000 0 77.00 0 0 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 78.00 0 78.00 0 0 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 88.00 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 C 0.000000 ol 0 89.00 90.00 09000 CLI NI C 4.257 265, 804 90.00 0.016016 0 0 91.00 09100 EMERGENCY 249, 583 55, 092, 034 0.004530 1, 842, 255 8, 345 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 171, 095 2,603,102 0.065727 0 92.00 OTHER REIMBURSABLE COST CENTERS 94 00 94 00 09400 HOME PROGRAM DIALYSIS 0.000000 0 0 95.00 09500 AMBULANCE SERVICES 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 0 0.000000 0 0 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 0.000000 0 200.00 Total (lines 50 through 199) 2, 503, 035 236, 507, 194 7, 673, 036 69, 000 200. 00

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Health Fir In Lieu of Form CMS-2552-10 APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-0146 Peri od: Worksheet D From 01/01/2023 Part III Date/Time Prepared: 12/31/2023 5/23/2024 9:53 am Title XVIII Hospi tal PPS Allied Health Allied Health All Other Cost Center Description Nursi ng Nursi ng Post-Stepdown Medi cal Program Program Cost Post-Stepdown Educati on Adjustments Adjustments Cost 2A 2. 00 1.00 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 40.00 04000 SUBPROVI DER - I PF 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 Cost Center Description I npati ent Swi ng-Bed Total Costs Per Diem (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, 975 0.00 1, 016 30.00 03100 INTENSIVE CARE UNIT 0.00 31.00 31.00 0 32.00 03200 CORONARY CARE UNIT 0 0 0.00 0 32.00 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 33.00 0.00 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 0.00 41.00 0 0 0 41.00 04300 NURSERY 0 43.00 462 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 45.00 Total (lines 30 through 199) 1, 016 200.00 200.00 7, 437 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 04400 SKILLED NURSING FACILITY 44.00 44.00 45.00 04500 NURSING FACILITY 45.00 Total (lines 30 through 199) 200.00 200.00

In Lieu of Form CMS-2552-10

Period:	Worksheet D
From 01/01/2023	Part IV
To 12/31/2023	Date/Time Prepared:
5//3/2024 9:53 am	Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0146 THROUGH COSTS

					12,01,2020	5/23/2024 9: 5	3 am
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anestheti st	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	1	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	1	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	)	0	0	55.00
56.00	05600 RADI OI SOTOPE	o	0	1	0 0	0	56.00
57.00	05700 CT SCAN	o	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	o	0	)	0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	l ol	0	)	0 0	0	59.00
60.00	06000 LABORATORY	0	0	,	0 0	0	60.00
60. 01	06001 BLOOD LABORATORY	o	0		0 0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	1	_				61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0	,	0 0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		0		0 0	-	63.00
64. 00	06400 I NTRAVENOUS THERAPY		0		0 0	0	64.00
65. 00	06500 RESPIRATORY THERAPY		0		0 0	1	65.00
66. 00	06600 PHYSI CAL THERAPY		0		0 0	1	66.00
67. 00	06700 OCCUPATI ONAL THERAPY		0		0 0	1	67.00
68. 00	06800 SPEECH PATHOLOGY		0		0 0		68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0			0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0		70.00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	70.00
	l l	0	0		0 0	1	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	U	1	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	U	1	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	Ü		0	0	75.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	Ü		0 0	0	76. 98
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	Ü		0 0	-	77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	1	0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	1	0 0	-	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	-	89. 00
90.00	09000 CLI NI C	0	0	1	0	•	90.00
91.00	09100 EMERGENCY	0	0	1	0	_	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS	1 .1		1	_	1	
94. 00	09400 HOME PROGRAM DIALYSIS	0	0	1	0 0	0	94.00
95.00	09500 AMBULANCE SERVICES			1			95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	1	0 0	1	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	1	0 0		97.00
200.00	Total (lines 50 through 199)	0	0	1	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 01/01/2023 | Part IV | To | 12/31/2023 | Date/Time Prepared: THROUGH COSTS

			''	0 12/31/2023	5/23/2024 9:5	
		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   OPERATI NG ROOM	0	0	0	28, 405, 516	0. 000000	50.00
51. 00   05100   RECOVERY ROOM	0	0	0	0	0. 000000	51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	3, 575, 171	0. 000000	52.00
53. 00   05300   ANESTHESI OLOGY	0	0	0	0	0. 000000	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	0	44, 971, 387	0. 000000	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	0	0	0	0. 000000	55. 00
56. 00   05600   RADI 0I SOTOPE	0	0	0	0	0. 000000	56. 00
57. 00 05700 CT SCAN	0	0	0	0	0. 000000	57. 00
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0. 000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0. 000000	59. 00
60. 00   06000   LABORATORY	0	0	0	41, 061, 216	0. 000000	60.00
60. 01   06001   BLOOD LABORATORY	0	0	0	0	0. 000000	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0. 000000	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0. 000000	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0	0. 000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0	0	14, 706, 974	0. 000000	65.00
66. 00   06600   PHYSI CAL THERAPY	0	0	0	4, 908, 284	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	1, 587, 598	0.000000	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	1, 129, 293	0.000000	68.00
69. 00   06900   ELECTROCARDI OLOGY 70. 00   07000   ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	· ·	0. 000000 0. 000000	70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2, 987, 575 3, 270, 355	0. 000000	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	26, 931, 790	0.000000	73.00
74. 00   07400   RENAL DI ALYSI S	0	0	0	20, 931, 790 0	0.000000	74.00
75. 00   07500   ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	74. 00 75. 00
76. 98   07698   HYPERBARI C OXYGEN THERAPY	0	0	0	5, 011, 095	0.000000	76. 98
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	5, 011, 0 <del>7</del> 5	0.000000	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS	O <sub>I</sub>		0	0	0.000000	70.00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0.000000	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	ő	0	0. 000000	89. 00
90. 00   09000   CLI NI C	0	0	ő	265, 804	0. 000000	90.00
91. 00 09100 EMERGENCY	0	0		55, 092, 034	0. 000000	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		2, 603, 102	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>			2,000,102	2. 222000	. 2. 00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0. 000000	94.00
95. 00 09500 AMBULANCE SERVICES		_				95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0. 000000	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	o	0	0	0	0.000000	97.00
200.00 Total (lines 50 through 199)	0	0	0	236, 507, 194		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 01/01/2023 | Part IV | To | 12/31/2023 | Date/Time Prepared: THROUGH COSTS

					10 12/31/2023	5/23/2024 9: 5	
			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 ÷	J	Costs (col.		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	634, 106		0 2, 081, 185	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	0		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, 529, 775		0 5, 724, 376	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, 749, 810		0 1, 999, 206	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	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. 000000	0		0 0	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00	06500 RESPIRATORY THERAPY	0. 000000	522, 193		0 1, 364, 060		65.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	62, 012		0 21, 952	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	31, 143	l .	0 13, 163	· ·	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	31, 507		0 3, 957	Ö	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	0.7557		0 0	1	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	1	0 0	Ö	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	101, 021		0 190, 329		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	95, 432		0 556, 668		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 049, 608	l .	0 9, 167, 359	l e	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	1, 017, 000	i	0 7, 107, 337	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	24, 174		0 1, 271, 386	0	76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	21, 171	1	0 1,271,000	Ö	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0		78. 00
70.00	OUTPATIENT SERVICE COST CENTERS	0. 000000			<u> </u>		70.00
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	1	0 0		89. 00
90.00	09000 CLINIC	0. 000000	0		0 0	0	90.00
91. 00	09100 EMERGENCY	0. 000000	1, 842, 255		0 4, 718, 022	Ö	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 186, 575		92.00
, 2. 00	OTHER REIMBURSABLE COST CENTERS				-, 100,070		12.00
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000	0		0 0	0	94.00
95. 00	09500 AMBULANCE SERVICES	0.00000	O			l	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	0	97.00
200.00		0.000000	7, 673, 036		0 27, 298, 238	· ·	200.00
200.00	1 1.5 ta. (1.1.55 55 till odgi 177)	ı I	., 5.6, 550	ı	-, -, -, -, -, -, -, -, -, -, -, -, -, -	'	,_00.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0146 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/23/2024 9:53 am Title XVIII Hospi tal Charges Costs PPS PPS Services Cost Center Description Cost to 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. 164677 2, 081, 185 342, 723 50.00 05100 RECOVERY ROOM 0 0 0.000000 51.00 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.516750 0 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 0 0 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.114663 5, 724, 376 0 656, 374 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0.000000 55.00 Ω 0 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 59 00 0.000000 Ω 59 00 60.00 06000 LABORATORY 0.115320 1, 999, 206 230, 548 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 0 63.00 63.00 C 06400 I NTRAVENOUS THERAPY 64.00 0.000000 0 0 64.00 0 06500 RESPIRATORY THERAPY 0 192, 491 65 00 0 141116 1, 364, 060 65 00 06600 PHYSI CAL THERAPY 0 66.00 0.340891 21, 952 7, 483 66.00 06700 OCCUPATI ONAL THERAPY 0.584242 13, 163 0 7, 690 67.00 0 68.00 06800 SPEECH PATHOLOGY 0.337776 3, 957 0 0 1, 337 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 190, 329 0 45, 130 71.00 0. 237118 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 259974 0 144, 719 72.00 556, 668 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0.247035 9, 167, 359 73.00 2, 264, 659 73.00 74.00 07400 RENAL DIALYSIS 0.000000 0 74.00 0 0 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 0 0 75.00 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 260, 015 76. 98 0.204513 1, 271, 386 0 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0.000000 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 88 00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90.00 09000 CLI NI C 0.387827 0 0 O 90.00 09100 EMERGENCY 391, 133 0.082902 4, 718, 022 0 0 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 1.047378 186, 575 195, 415 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0. 000000 94.00 09500 AMBULANCE SERVICES 0.379885 0 95.00 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 0.000000 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 0 0 0 97.00 0 0 200.00 Subtotal (see instructions) 27, 298, 238 4, 739, 717 200.00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 27, 298, 238 0 4, 739, 717 202. 00

Provider CCN: 15-0146

0

Peri od:

202.00

Worksheet D From 01/01/2023 Part V 12/31/2023 Date/Time Prepared: 5/23/2024 9:53 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 05100 RECOVERY ROOM 000000000000000000000000000000000 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 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 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 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 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 0 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 76. 98 0 76. 98 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90.00 09000 CLI NI C 0 0 90.00 09100 EMERGENCY 0 91.00 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 09500 AMBULANCE SERVICES 95.00 0 0 0 0 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 200.00 Subtotal (see instructions) 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

202.00

Net Charges (line 200 - line 201)

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

Health Financial Systems COMP	MUNITY HOSPITAL	OF NOBLE CTY,	INC	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	_ COSTS	Provi der C	Provider CCN: 15-0146		Worksheet D	
				From 01/01/2023		
				To 12/31/2023		
		T' 11		11	5/23/2024 9: 5	3 am
	1 2 11 1		e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Pati ent	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost	t	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	501, 420	0	501, 42	20 6, 975	71. 89	
31.00   INTENSIVE CARE UNIT	0			0 0	0.00	31.00
32.00 CORONARY CARE UNIT	0			0 0	0.00	32.00
33.00 BURN INTENSIVE CARE UNIT	0			0 0	0. 00	33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0.00	34.00
40. 00 SUBPROVI DER - I PF	0	l o	)	0 0	0.00	40.00
41. 00 SUBPROVI DER - I RF	0	0		0	0. 00	
43. 00 NURSERY	26, 806	_	26, 80	06 462	58. 02	
44.00 SKILLED NURSING FACILITY	20,000		20,00	0 0	0.00	
45. 00 NURSING FACILITY	0			0	0.00	
200.00 Total (lines 30 through 199)	528, 226		528, 22	7, 437		200.00
Cost Center Description	Inpati ent	Inpatient	320, 22	7, 437		200.00
cost center beservet on	Program days	Program				
	11 ogram days	Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7.00	-			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00 ADULTS & PEDIATRICS	123	8, 842				30.00
	123	8, 842	1			31.00
31. 00 INTENSIVE CARE UNIT	0	0				
32. 00 CORONARY CARE UNIT	0	0				32.00
33. 00 BURN INTENSIVE CARE UNIT	0	0	1			33.00
34. 00 SURGICAL INTENSIVE CARE UNIT	0	0	1			34.00
40. 00 SUBPROVI DER - I PF	0	0	1			40.00
41. 00 SUBPROVI DER - I RF	0	0	1			41.00
43. 00 NURSERY	40	2, 321				43.00
44.00 SKILLED NURSING FACILITY	0	0	1			44.00
45.00 NURSING FACILITY	0	0				45. 00
200.00 Total (lines 30 through 199)	163	11, 163				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-0146 Peri od: Worksheet D From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/23/2024 9:53 am Title XIX Hospi tal PPS 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 4. 00 5. 00 2.00 3.00 ANCILLARY SERVICE COST CENTERS 50 00 50 00 05000 OPERATING ROOM 409, 700 28, 405, 516 0.014423 337, 143 4,863 05100 RECOVERY ROOM 0.000000 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.030955 52.00 110, 668 3, 575, 171 80, 033 2, 477 52.00 05300 ANESTHESI OLOGY 0.000000 53.00 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 601, 536 44, 971, 387 0.013376 88, 322 1, 181 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 55.00 56.00 05600 RADI OI SOTOPE 0.000000 0 56.00 0 0 57 00 05700 CT SCAN 0 0.000000 0 57.00 C 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 204, 998 41, 061, 216 0.004992 250, 376 1, 250 60.00 60.00 06001 BLOOD LABORATORY 60.01 0 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 14, 706, 974 0.012310 723 65.00 181, 048 58, 707 65.00 06600 PHYSI CAL THERAPY 106, 915 4, 908, 284 0.021783 66.00 1.840 40 66.00 06700 OCCUPATI ONAL THERAPY 1, 587, 598 38, 143 67.00 0.024026 1, 134 27 67.00 68.00 06800 SPEECH PATHOLOGY 15, 696 1, 129, 293 0.013899 2,031 28 68.00 06900 ELECTROCARDI OLOGY 69.00 0.000000 0 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70 00 0 |07100|MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 987, 575 71.00 33, 109 0.011082 22, 188 246 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 34, 840 3, 270, 355 0.010653 O 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 280,050 26, 931, 790 0.010398 147, 089 1,529 73.00 07400 RENAL DIALYSIS 74 00 0.000000 74 00 Ω 0 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 0 75.00 61, 397 07698 HYPERBARIC OXYGEN THERAPY 5, 011, 095 0.012252 5, 359 76. 98 76.98 66 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0.000000 0 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 78.00 0 78.00 0 0 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 88.00 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 C 0.000000 0 0 89.00 90.00 09000 CLI NI C 4.257 90.00 265, 804 0.016016 0 0 91.00 09100 EMERGENCY 249, 583 55, 092, 034 0.004530 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 171, 095 2,603,102 0.065727 151, 460 9, 955 92.00 OTHER REIMBURSABLE COST CENTERS 94 00 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0 0 95.00 09500 AMBULANCE SERVICES 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 0 0.000000 0 0 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 0.000000 Ω 200.00 Total (lines 50 through 199) 2, 503, 035 236, 507, 194 1, 145, 682 22, 385 200. 00

Health Financial Systems COMM	UNITY HOSPITAL	OF NOBLE CIY,	INC	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS	STS Provider C	F	eriod: rom 01/01/2023 o 12/31/2023		pared:
		Ti +I	e XIX	Hospi tal	PPS	3 8111
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
cost center bescriptron	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments	0031	Educati on	
			Aujustillerits		Cost	
	Adjustments	1.00	2A	2.00	3. 00	
INDATIENT DOUTINE CEDVICE COCT CENTERS	1A	1.00	ZA	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS				1		
30. 00   03000   ADULTS & PEDI ATRI CS	C					30.00
31.00 03100 INTENSIVE CARE UNIT	C				l	31.00
32.00 03200 CORONARY CARE UNIT	C	1				32.00
33.00   03300   BURN INTENSIVE CARE UNIT	C	0	0	0	0	33.00
34.00   03400   SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40. 00   04000   SUBPROVI DER - I PF	0	0	0	0	0	40.00
41. 00   04100   SUBPROVI DER -   RF		0	ol o	0	0	41.00
43. 00 04300 NURSERY		0	ol o	0	0	43.00
44.00 04400 SKILLED NURSING FACILITY				0		44.00
45. 00 04500 NURSING FACILITY				0		45.00
200.00 Total (lines 30 through 199)			ή	0	l	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem	Inpati ent	200.00
cost center bescriptron	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,	Days		Frogram bays	
	,			col . 6)		
	instructions)	minus col. 4)	/ 00	7.00	0.00	
INPATIENT ROUTINE SERVICE COST CENTERS	4. 00	5. 00	6. 00	7. 00	8. 00	
	C		4 075	0.00	122	20.00
30. 00   03000   ADULTS & PEDI ATRI CS					l e	
31. 00 03100 I NTENSI VE CARE UNI T		0	1	0.00	l e	31.00
32. 00   03200   CORONARY CARE UNIT		0			0	32.00
33. 00 03300 BURN INTENSIVE CARE UNIT		0	0	0. 00	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0	'l ~		0	34.00
40. 00   04000   SUBPROVI DER - 1 PF	C	1	٦ ~		0	40.00
41. 00   04100   SUBPROVI DER - I RF	C	0	0		0	41.00
43. 00   04300   NURSERY		0	462	0.00	40	43.00
44.00   04400   SKILLED NURSING FACILITY		0	0	0.00	0	44.00
45.00 04500 NURSING FACILITY		0	0	0. 00	0	45.00
200.00 Total (lines 30 through 199)		0	7, 437		163	200.00
Cost Center Description	Inpatient			•		
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9. 00	1				
INPATIENT ROUTINE SERVICE COST CENTERS		·				
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31. 00 03100 I NTENSI VE CARE UNIT	C	l .				31.00
32. 00 03200 CORONARY CARE UNIT						32.00
33. 00 03300 BURN INTENSIVE CARE UNIT		l .				33.00
34.00   03400   SURGI CAL INTENSI VE CARE UNIT						34.00
						40.00
	_	1				
41. 00   04100   SUBPROVI DER -   I RF	C					41.00
43. 00   04300   NURSERY	C	l .				43.00
44.00  04400   SKILLED NURSING FACILITY	C	l .				44. 00
45.00 O4500 NURSING FACILITY	C					45.00
200.00 Total (lines 30 through 199)	C	)				200. 00

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC

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

								5/23/2024 9: 5	3 am
				Ti tl	e XIX	L.	Hospi tal	PPS	
	Cost Center Description	Non Physician		Nursi ng	Nursi ng		Allied Health	Allied Health	
		Anesthetist		Program	Program		Post-Stepdown		
		Cost	Pos	st-Stepdown	_		Adjustments		
				djustments			,		
		1. 00		2A	2.00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0		0		0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	l	0		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	l	0		0	0	0	52.00
53. 00	05300 ANESTHESI OLOGY	0	l	0		0	0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		l	0		0	0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C			0		0	0	0	55. 00
56. 00	i i		}	0		0	0	0	56.00
	05600 RADI OI SOTOPE	0		0		- 1	0		
57. 00	05700 CT SCAN	0	'	0		0	0	0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0		0	0	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	1	0		0	0	0	59. 00
60.00	06000 LABORATORY	0	1	0		0	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	1	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.	0	l	0		0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	l	0		0	0	ol	64.00
65.00	06500 RESPIRATORY THERAPY	0	l	0		0	0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0	l	0		0	0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	l	0		0	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY		ŀ	0		0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY			0		0	0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY		}	0		0	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		}	0		0	0	0	70.00
	I I	0		0		0	-		
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0		0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	1	0		U	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	1	0		0	0	0	75.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	1	0		0	0	0	76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0		0		0	0	0	77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0		0		0	0	0	78.00
	OUTPAȚI ENT SERVI CE 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		0		0	0	0	90.00
91.00	09100 EMERGENCY	0	l	0		0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	l			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					-	J		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	97. 00
200.00	1 1			0		0	0	-	200.00
200.00	Trotal (Tries so through 177)	1	1	O	l	U	O <sub>1</sub>	١	200.00

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0146 In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 01/01/2023 | Part IV | To | 12/31/2023 | Date/Time Prepared: THROUGH COSTS

			''	0 12/31/2023	5/23/2024 9:5	
		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   OPERATI NG ROOM	0	0	0	28, 405, 516	0. 000000	50.00
51. 00   05100   RECOVERY ROOM	0	0	0	0	0. 000000	51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	3, 575, 171	0. 000000	52.00
53. 00   05300   ANESTHESI OLOGY	0	0	0	0	0. 000000	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	0	44, 971, 387	0. 000000	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	0	0	0	0. 000000	55. 00
56. 00   05600   RADI 0I SOTOPE	0	0	0	0	0. 000000	56. 00
57. 00 05700 CT SCAN	0	0	0	0	0. 000000	57. 00
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0. 000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0. 000000	59. 00
60. 00   06000   LABORATORY	0	0	0	41, 061, 216	0. 000000	60.00
60. 01   06001   BLOOD LABORATORY	0	0	0	0	0. 000000	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0. 000000	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0. 000000	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0	0. 000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0	0	14, 706, 974	0.000000	65.00
66. 00   06600   PHYSI CAL THERAPY	0	0	0	4, 908, 284	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	1, 587, 598	0.000000	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	1, 129, 293	0.000000	68.00
69. 00   06900   ELECTROCARDI OLOGY 70. 00   07000   ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	· ·	0. 000000 0. 000000	70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2, 987, 575 3, 270, 355	0.000000	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	26, 931, 790	0.000000	73.00
74. 00 07400 RENAL DIALYSIS	0	0	0	20, 931, 790	0.000000	74.00
75. 00   07500   ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	74. 00 75. 00
76. 98   07698   HYPERBARI C OXYGEN THERAPY	0	0	0	5, 011, 095	0.000000	76. 98
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	5, 011, 0 <del>7</del> 5	0.000000	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS	O <sub>I</sub>		0	0	0.000000	70.00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0.000000	88. 00
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER	0	0	Ö	0	0. 000000	89. 00
90. 00   09000   CLI NI C	0	0	Ö	265, 804	0. 000000	90.00
91. 00 09100 EMERGENCY	0	0		55, 092, 034	0. 000000	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		2, 603, 102	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS	٥,			2/000/102	0.00000	72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0. 000000	94.00
95. 00 09500 AMBULANCE SERVICES		_				95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0. 000000	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0.000000	97.00
200.00 Total (lines 50 through 199)	0	0	0	236, 507, 194		200. 00
•	· '					

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC

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

					10 12/31/202	5/23/2024 9:5	
			Ti tl	e XIX	Hospi tal	PPS	<u> </u>
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	·	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	h Charges	Pass-Through	
		(col. 6 ÷	_	Costs (col.	8	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 OPERATI NG ROOM	0. 000000	337, 143		0		50.00
51.00	05100 RECOVERY ROOM	0. 000000	0		0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	80, 033		0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	88, 322		0	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	0	56.00
57.00	05700 CT SCAN	0. 000000	0		0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	59.00
60.00	06000 LABORATORY	0. 000000	250, 376		0	0	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 RESPIRATORY THERAPY	0. 000000	58, 707		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	1, 840		0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	1, 134		0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	2, 031		0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	0		0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	22, 188		0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	147, 089		0	0	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	0		0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0	0	75.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	5, 359		0	0	76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS					_	
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0		-	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0		89. 00
90.00	09000 CLI NI C	0. 000000	0		0	0	90.00
91.00	09100 EMERGENCY	0. 000000	0			0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	151, 460		0 (	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000	0		0	0	94.00
95.00	09500 AMBULANCE SERVI CES						95.00
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000	0		-	0	96.00
97.00	09700 DURABLE MEDI CAL EQUI P-SOLD	0. 000000	0			0	97.00
200.00	Total (lines 50 through 199)		1, 145, 682		0	0	200. 00

Provider CCN: 15-0146

Peri od:

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/23/2024 9:53 am 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, Subject To inst.) 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 50.00 05000 OPERATING ROOM 0. 164677 263, 929 50.00 05100 RECOVERY ROOM 0 0.000000 51.00 0 51.00 0 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0.516750 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.114663 0 481, 946 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0.000000 0 0 0 55.00 0 0 56.00 05600 RADI OI SOTOPE 0.000000 0 0 0 56.00 57.00 05700 CT SCAN 0.000000 0 0 57.00 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 0 0 0 58.00 0 05900 CARDI AC CATHETERI ZATI ON 0.000000 59.00 59 00 C 0 0 60.00 06000 LABORATORY 0.115320 0 448, 144 0 60.00 06001 BLOOD LABORATORY 0 60.01 0.000000 0 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61 00 0.000000 0 61 00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 0 0 63.00 63.00 06400 I NTRAVENOUS THERAPY 64.00 0.000000 0 0 64.00 99, 220 06500 RESPIRATORY THERAPY 0 65 00 0 141116 0 65 00 0 06600 PHYSI CAL THERAPY 0 66.00 0.340891 0 83, 355 0 66.00 06700 OCCUPATI ONAL THERAPY 0.584242 47, 333 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 0.337776 0 85, 587 0 68.00 06900 FLECTROCARDLOLOGY 0.000000 0 69 00 69 00 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0. 237118 33, 684 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 259974 0 72.00 3.308 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.247035 0 73.00 138, 059 0 73.00 74.00 07400 RENAL DIALYSIS 0.000000 0 0 74.00 0 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 0 0 0 0 75.00 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0.204513 0 36, 210 0 76.98 0 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90.00 09000 CLI NI C 0.387827 0 0 0 90.00 09100 EMERGENCY 0 91.00 0.082902 0 1, 059, 123 91.00 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 1.047378 0 95, 779 0 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 94.00 09500 AMBULANCE SERVICES 0 0 0.379885 95.00 0 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0.000000 0 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 0 97.00 0 200.00 Subtotal (see instructions) 0 2, 875, 677 0 200.00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 0 2, 875, 677 0 202.00

200.00

201.00

202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0146 Peri od: Worksheet D From 01/01/2023 Part V 12/31/2023 Date/Time Prepared: 5/23/2024 9:53 am Title XIX Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 43, 463 50.00 05100 RECOVERY ROOM 0 51.00 51.00 C 05200 DELIVERY ROOM & LABOR ROOM 52.00 Ω 52.00 53.00 05300 ANESTHESI OLOGY 000000000000000000000000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 55, 261 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 55.00 C 56.00 05600 RADI OI SOTOPE 0 56.00 57.00 05700 CT SCAN 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 05900 CARDI AC CATHETERI ZATI ON 59 00 C 59.00 60.00 06000 LABORATORY 51,680 60.00 06001 BLOOD LABORATORY 60.01 C 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61 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 06400 I NTRAVENOUS THERAPY 64.00 64.00 06500 RESPIRATORY THERAPY 65 00 14 002 65 00 06600 PHYSI CAL THERAPY 66.00 28, 415 66.00 06700 OCCUPATI ONAL THERAPY 27, 654 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 28, 909 68.00 69 00 06900 FLECTROCARDLOLOGY 69 00 C 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 7, 987 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 860 72.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 34, 105 73.00 74.00 07400 RENAL DIALYSIS C 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 75.00 07698 HYPERBARIC OXYGEN THERAPY 76. 98 76. 98 7, 405 0 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION C 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88 00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90.00 09000 CLI NI C 0 0 90.00 09100 EMERGENCY 0 87,803 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 100, 317 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 0 09500 AMBULANCE SERVICES 95.00 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 Ω 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00

487, 861

487, 861

200.00

201.00

202.00

Subtotal (see instructions)

Only Charges

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Health Financial Systems	COMMUNITY HOSPITAL OF	NOBLE CTY, INC	In Lieu	of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0146	Peri od: From 01/01/2023	Worksheet D-1
			To 12/31/2023	Date/Time Prepared: 5/23/2024 9:53 am
		Title XVIII	Hospi tal	PPS

			10 12/01/2020	5/23/2024 9: 5	3 am
		Title XVIII	Hospi tal	PPS	
	Cost Center Description				
	DADT I ALL DROW DED COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed day	excluding newborn)		6, 975	1.00
2. 00	Inpatient days (including private room days, excluding swing-			6, 975	2.00
3. 00	Private room days (excluding swing-bed and observation bed da		rivate room days	0, ,,0	3.00
0.00	do not complete this line.	, , , , , , , , , , , , , , , , , , ,	. varo i com dayo,	Ĭ	0.00
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		4, 595	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	5.00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7. 00
0.00	reporting period	da) -6t D	11 -6 +1+		0 00
8. 00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after becember s	31 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable t	o the Program (evoluding	r swing-had and	1, 016	9. 00
7. 00	newborn days) (see instructions)	o the rrogram (excruding	g swifig-bed and	1,010	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nlv (includina private m	room davs)	0	10.00
	through December 31 of the cost reporting period (see instruc				
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, e				
12.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	te room days)	0	12.00
	through December 31 of the cost reporting period			_	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.00
14 00	after December 31 of the cost reporting period (if calendar y		14 00		
14. 00 15. 00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	0	14. 00 15. 00		
16. 00	Nursery days (title V or XIX only)	0	16.00		
10.00	SWING BED ADJUSTMENT	0	10.00		
17. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 o	of the cost	0.00	17. 00
	reporting period	es in sugn bessinger or c		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0. 00	18.00
	reporting period				
19. 00		0. 00	19.00		
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to service	0. 00	20.00		
21 00	reporting period	(6)		7 000 204	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting ported (line	7, 990, 286 9 0	21. 00 22. 00
22.00	5 x line 17)	el 31 di the cost report	ing period (inte	١	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportir	na period (line 6	0	23. 00
20.00	x line 18)	or or the door ropertri	.g po oa (	Ĭ	20.00
24.00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	o	24.00
	7 x line 19)	•			
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25. 00
	x line 20)				
26. 00	Total swing-bed cost (see instructions)			0	26.00
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		7, 990, 286	27.00
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT			0	20.00
29. 00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	d and observation bed cr	iai ges)	0	28. 00 29. 00
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	. 11116 20)		0. 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 instruc	ctions)	0. 00	34.00
35. 00	Average per diem private room cost differential (line 34 x li		<i>,</i>	0. 00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	•		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	7, 990, 286	37.00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
38. 00	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see	instructions)		1, 145. 56	
39. 00	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	instructions) 38)		1, 163, 889	39. 00
39. 00 40. 00	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see	e instructions) e 38) am (line 14 x line 35)		· ·	39. 00 40. 00

		INITY HOSPITAL (				u of Form CMS-			
COMPUTA	ATION OF INPATIENT OPERATING COST		Provi der C	CCN: 15-0146	Peri od: From 01/01/2023	Worksheet D-1			
					To 12/31/2023	Date/Time Pre 5/23/2024 9:5			
				e XVIII	Hospi tal	PPS			
	Cost Center Description	Total Inpatient	Total Inpatient	Average Per Diem (col		Program Cost (col. 3 x			
		Cost	Days	÷ col . 2)		col . 4)			
42 00	NURSERY (title V & XIX only)	1. 00	2.00	3.00	4.00	5. 00	42.00		
42.00	Intensive Care Type Inpatient Hospital Units	<u> </u>		<u>J</u> 0. v	0		, 42.00		
	INTENSIVE CARE UNIT	0	(			l .			
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0 0	(			0	44. 00 45. 00		
	SURGI CAL INTENSIVE CARE UNIT	o	C			ő	46.00		
47. 00	OTHER SPECIAL CARE (SPECIFY)						47.00		
	Cost Center Description					1, 00			
	Program inpatient ancillary service cost (Wk					1, 072, 105	1		
	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				, column 1)	0 2, 235, 994	48. 01 49. 00		
	PASS THROUGH COST ADJUSTMENTS	41 thi ough 48. C	(See Thistia	ictions)		2, 233, 774	49.00		
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	om Wkst. D, su	m of Parts I and	73, 040	50.00		
51.00	<pre>III) Pass through costs applicable to Program inp</pre>	atient ancillar	v services (f	rom Wkst. D.	sum of Parts II	69, 000	51.00		
	and IV)								
52. 00 53. 00	Total Program excludable cost (sum of lines	Total Program excludable cost (sum of lines 50 and 51)  Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and							
55.00	medical education costs (line 49 minus line		rated, non-pri	iysi ci aii allest	netist, and	2, 093, 954	53.00		
	TARGET AMOUNT AND LIMIT COMPUTATION					0			
	Program di scharges Target amount per di scharge						54. 00 55. 00		
	Permanent adjustment amount per discharge					0.00			
	Adjustment amount per discharge (contractor					0.00			
56. 00 57. 00	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat			line 56 minus	line 53)	0	56. 00 57. 00		
58. 00	Bonus payment (see instructions)	ring cost and te	rger amount (	11110 00 1111110	11110 00)	ő	58.00		
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost rep	orting period	endi ng 1996,	0.00	59.00		
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	m prior vear	cost report.	updated by the	0.00	60.00		
	market basket)			•					
61. 00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les					0	61.00		
	53) are less than expected costs (lines 54 x								
(2.00	enter zero. (see instructions)						(2.00		
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0 0			
	PROGRAM INPATIENT ROUTINE SWING BED COST	(000 )				-			
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	mber 31 of th	ne cost report	ing period (See	0	64.00		
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportir	g period (See	0	65.00		
	instructions)(title XVIII only)			(E) (11 11					
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	64 plus line	65)(title XVI	II only); for	0	66.00		
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost r	eporting period	0	67.00		
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	o costs after [	ocombor 21 of	the cost ror	orting poriod	0	68.00		
08.00	(line 13 x line 20)	e costs after L	ecember 31 or	the cost rep	or tring perrod	0	08.00		
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00		
	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil		•		)		70.00		
	Adjusted general inpatient routine service c				,		71.00		
72.00	Program routine service cost (line 9 x line	•	. (1: - : 4: : :	! 05)			72.00		
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv						73.00 74.00		
75. 00	Capital -related cost allocated to inpatient			•	Part II, column		75.00		
74 00	26, line 45)	no 2)					7/ 00		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	. *					76. 00 77. 00		
70.00		,				ı	79.00		

78.00 | Inpatient routine service cost (line 74 minus line 77) 78.00 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 81.00 82.00 83.00 Reasonable inpatient routine service costs (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 2, 380 87. 00 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1, 145. 56 88. 00 MCRI F32 - 22. 2. 178. 1

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu						2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		pared: 3 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions	)			2, 726, 433	89.00
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	501, 420	7, 990, 286	0.06275	4 2, 726, 433	171, 095	90.00
91.00 Nursing Program cost	0	7, 990, 286	0.00000	0 2, 726, 433	0	91.00
92.00 Allied health cost	0	7, 990, 286	0.00000	0 2, 726, 433	0	92.00
93.00 All other Medical Education	0	7, 990, 286	0. 00000	0 2, 726, 433	0	93. 00

Health Financial Systems	COMMUNITY HOSPITAL OF NOBLE CTY,	I NC	In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider 0	CCN: 15-0146	Peri od: From 01/01/2023	Worksheet D-1	
				Date/Time Pre 5/23/2024 9:5	
	Ti ti	le XIX	Hospi tal	PPS	

		Ti +I o VI V	Hospi tal	5/23/2024 9: 5 PPS	3 am
	Cost Center Description	Title XIX	Hospi tal	PPS	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	re oveluding nowhern)		6, 975	1.00
2. 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			6, 975	2.00
3. 00	Private room days (excluding swing-bed and observation bed da		ivate room days,	0	3.00
	do not complete this line.	3.			
4. 00	Semi-private room days (excluding swing-bed and observation b			4, 595	4.00
5. 00	Total swing-bed SNF type inpatient days (including private roreporting period	om days) through Decembe	er 31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roo	m days) after December 3	of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	ill days) after becember 3	or the cost	U	8.00
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	123	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII of		nom days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, e		days) arter	· ·	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.00
40.00	through December 31 of the cost reporting period				40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13. 00
14. 00	Medically necessary private room days applicable to the Progr			0	14.00
15. 00	Total nursery days (title V or XIX only)	am (and all ing and ing a car		462	15.00
16. 00	Nursery days (title V or XIX only)			40	16. 00
47.00	SWING BED ADJUSTMENT	II Daniel 21	C. I.I I	0.00	47.00
17.00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 d	or the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0. 00	20. 00
20.00	reporting period	3 arter becember 31 or t	ine cost	0.00	20.00
21.00	Total general inpatient routine service cost (see instruction			7, 990, 286	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ing period (line	. 0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reporting	ng poriod (line A	0	23. 00
23.00	x line 18)	31 of the cost reportin	ig period (Title o	·	23.00
24.00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)			_	
25. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26, 00	Total swing-bed cost (see instructions)			0	26. 00
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		7, 990, 286	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	==,		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35. 00 36. 00
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line		
500	27 minus line 36)			., ,,,,,,	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			1 145 57	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 145. 56 140, 904	
	Medically necessary private room cost applicable to the Progr	•		140, 904	40.00
	Total Program general inpatient routine service cost (line 39			140, 904	

		NITY HOSPITAL C				u of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0146	Peri od: From 01/01/2023		
					To 12/31/2023	Date/Time Pre 5/23/2024 9:5	
	Control Description	Tabal		e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient	Total Inpati ent	Average Per Diem (col		Program Cost (col. 3 x	
		Cost	Days	÷ col . 2)	4.00	col . 4)	
42. 00	NURSERY (title V & XIX only)	1. 00 453, 663	2.00	3. 00 981. <sup>0</sup>	4. 00 95 40	5. 00 39, 278	42.00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0			0	
	BURN INTENSIVE CARE UNIT	0	0			0	
	SURGICAL INTENSIVE CARE UNIT	O	0			0	
47. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47.00
	cost center bescription					1.00	
	Program inpatient ancillary service cost (Wk					347, 466	
	Program inpatient cellular therapy acquisition Total Program inpatient costs (sum of lines				, column I)	0 527, 648	
17.00	PASS THROUGH COST ADJUSTMENTS	J	, ,	ĺ			17.00
50. 00	Pass through costs applicable to Program inpa	atient routine	servi ces (fro	m Wkst. D, su	m of Parts I and	11, 163	50.00
51. 00	III) Pass through costs applicable to Program inp.	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	22, 385	51.00
	and IV)	50 L 54)				00.540	
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost excludes the cost excludes the cost of th		lated non-nh	vsician anest	hetist and	33, 548 494, 100	
33. 00	medical education costs (line 49 minus line		ratea, non pri	ysi ci aii aiicst	netrat, and	474, 100	33.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges Target amount per discharge					0	54. 00 55. 00
	Permanent adjustment amount per discharge					0.00	
	Adjustment amount per discharge (contractor					0.00	
56. 00 57. 00	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat		ract amount (	lino 56 minus	lino 52)	0	1
58. 00	Bonus payment (see instructions)	ing cost and ta	rget amount (	Title 50 illitius	1111e 33)	0	
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost rep	orting period	endi ng 1996,	0.00	59.00
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	m nrior vear	cost report	undated by the	0.00	60.00
00.00	market basket)	01 11110 33 110	ii piroi yeai	cost report,	apaatea by the	0.00	00.00
61. 00	Continuous improvement bonus payment (if line					0	61.00
	55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x						
	enter zero. (see instructions)	,,,			,,		
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ont (soo instru	ctions)			0 0	
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mistru	ctions)			0	03.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost report	ing period (See	0	64.00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	er 31 of the	cost reportir	a period (See	0	65.00
00.00	instructions)(title XVIII only)	to arter become	01 01 110	cost reportir	g perrou (see		00.00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	<pre>II only); for</pre>	0	66.00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost r	eportina period	0	67.00
	(line 12 x line 19)	g			-h	_	
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after D	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (	line 67 + lin	e 68)		0	69.00
70 00	PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY	AND ICF/IID	ONLY	`		70.00
	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of				)		70.00 71.00
71.00	,		70 ÷ 1111 <del>0</del>	-/			72.00
	Medically necessary private room cost applications	able to Program					73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient			•	Dart II column		74. 00 75. 00
, 5. 00	26, line 45)	TOUTTHE SELVICE	CUSIS (IIUIII	WOI KSHEEL B,	rait II, COIUIIII		/3.00
	Per diem capital-related costs (line 75 ÷ li						76.00
77 OO	Program capital-related costs (line 9 x line	16)				i	77.00

77.00 Program capital-related costs (line 9 x line 76) 77.00 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79 00 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation
Inpatient routine service cost limitation (line 9 x line 81) 81.00 81.00 82.00 82 00 83.00 Reasonable inpatient routine service costs (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) 86.00 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 2, 380 87. 00 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1, 145. 56 88. 00 MCRI F32 - 22. 2. 178. 1

Health Financial Systems COMML	INITY HOSPITAL	OF NOBLE CTY,	I NC	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC	Provider CCN: 15-0146 Period:		Worksheet D-1	
				From 01/01/2023 To 12/31/2023		pared: 3 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions	)			2, 726, 433	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	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	501, 420	7, 990, 286	0. 06275	4 2, 726, 433	171, 095	90.00
91.00 Nursing Program cost	0	7, 990, 286	0.00000	0 2, 726, 433	0	91.00
92.00 Allied health cost	0	7, 990, 286	0.00000	0 2, 726, 433	0	92.00
93.00 All other Medical Education	О	7, 990, 286	0. 00000	0 2, 726, 433	0	93. 00

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

Health Financial Systems COMMUNITY HOSPITAL OF	NOBLE CTY,	I NC	In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0146	Peri od:	Worksheet D-3	3
			From 01/01/2023	Doto /Time Dro	norod.
			To 12/31/2023	Date/Time Pre 5/23/2024 9:5	
	Title	× XVIII	Hospi tal	PPS	o uni
Cost Center Description		Ratio of Cos		I npati ent	
		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			2, 251, 796		30. 00
31. 00   03100   I NTENSI VE CARE UNI T			0		31.00
32. 00   03200   CORONARY CARE UNIT			0		32.00
33. 00   03300   BURN   I NTENSI VE CARE UNI T			0		33.00
34. 00   03400  SURGI CAL I NTENSI VE CARE UNI T			0		34.00
40. 00   04000  SUBPROVI DER -   1 PF 41. 00   04100  SUBPROVI DER -   1 RF			0		40. 00 41. 00
43. 00   04100   SUBPROVIDER - TRF 43. 00   04300   NURSERY			0		43.00
ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00   05000   0PERATING ROOM		0. 16467	7 634, 106	104, 423	50.00
51. 00   05100   RECOVERY ROOM		0. 00000		1	51.00
52. 00 O5200 DELIVERY ROOM & LABOR ROOM		0. 51675			1
53. 00   05300   ANESTHESI OLOGY		0.00000		Ō	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 11466		175, 409	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.00000		0	55.00
56. 00   05600   RADI OI SOTOPE		0.00000		0	56.00
57. 00   05700   CT   SCAN		0.00000	0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.00000	0 0	0	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON		0.00000	0 0	0	59.00
60. 00   06000   LABORATORY		0. 11532	1, 749, 810	201, 788	60.00
60. 01   06001   BL00D   LABORATORY		0. 00000		0	60. 01
61.00 O6100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000		0	61. 00
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00000		0	62.00
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.		0.00000		0	63.00
64. 00   06400   I NTRAVENOUS THERAPY		0.00000		0	64.00
65. 00   06500   RESPI RATORY THERAPY		0. 14111		1	1
66. 00 06600 PHYSI CAL THERAPY		0. 34089		21, 139	
67. 00   06700   0CCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY		0. 58424 0. 33777		18, 195 10, 642	
69. 00   06900   ELECTROCARDI OLOGY		0. 00000		10, 642	1
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 00000		0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 23711		23, 954	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 25997		24, 810	1
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 24703			
74. 00 07400 RENAL DI ALYSI S		0.00000		0	1
75. 00 07500 ASC (NON-DISTINCT PART)		0.00000	0 0	0	75. 00
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 20451	3 24, 174	4, 944	76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION		0.00000	0 0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY		0. 00000	0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS					
88.00   08800   RURAL HEALTH CLINIC		0.00000		0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	1
90. 00   09000   CLI NI C		0. 38782			
91. 00   09100   EMERGENCY		0. 08349			
92. 00   O9200   OBSERVATION BEDS (NON-DISTINCT PART)		1. 04737	8 0	0	92.00
OTHER REI MBURSABLE COST CENTERS		0.00000	0		04.00
94. 00 09400 HOME PROGRAM DI ALYSI S		0.00000	0	0	
95. 00   09500   AMBULANCE SERVI CES 96. 00   09600   DURABLE MEDI CAL EQUI P-RENTED		0. 00000	0	0	95. 00 96. 00
97. 00   09700   DURABLE   MEDI CAL   EQUI P-RENTED 97. 00   09700   DURABLE   MEDI CAL   EQUI P-SOLD		0.00000		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)		0.00000	7, 673, 036		
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		7, 073, 030 N	1,072,103	201.00
202.00 Net charges (line 200 minus line 201)	( 07)	1	7, 673, 036		202.00
1 1 1 1 1 2 2 3 4 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		•	, 2, 2, 300	1	

Health Financial Systems	COMMUNITY HOSPITAL OF	NOBLE CTY,	INC	1	n Lieu of Form CMS-2552-10

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE (	STY, INC	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provid		Peri od:	Worksheet D-3	
		From 01/01/2023		
		To 12/31/2023	Date/Time Pre	pared:
			5/23/2024 9:5	3 am
	Title XIX	Hospi tal	PPS	
Cost Center Description	Ratio of Cos	t Inpatient	I npati ent	
	To Charges	Program	Program Costs	
		Charges	(col. 1 x	
		onal ges	col . 2)	
	1.00	2.00		
LADATI ENT. DOUTINE CERVICE COOT CENTERS	1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00  03000  ADULTS & PEDI ATRI CS		255, 895		30.00
31.00  03100 INTENSIVE CARE UNIT		0		31.00
32.00 03200 CORONARY CARE UNIT		0		32.00
33.00 03300 BURN INTENSIVE CARE UNIT		0		33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T		0		34.00
		0		
40. 00   04000   SUBPROVI DER -   I PF		0		40.00
41.00  04100 SUBPROVIDER - IRF		0		41.00
43. 00   04300  NURSERY		68, 060		43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 16467	7 337, 143	55, 520	50.00
51. 00   05100   RECOVERY ROOM	0.00000		0	51.00
	0. 51675		41, 357	52.00
53. 00   05300   ANESTHESI OLOGY	0.00000		0	53.00
54. 00   05400  RADI OLOGY-DI AGNOSTI C	0. 11466	3 88, 322	10, 127	54.00
55. 00  05500  RADI OLOGY-THERAPEUTI C	0.00000	0	0	55.00
56. 00  05600  RADI 0I SOTOPE	0. 00000	0	0	56.00
57. 00 05700 CT SCAN	0.00000		0	57.00
58. 00   05800   MAGNETIC RESONANCE   MAGING (MRI)	0. 00000		0	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0. 00000		0	59. 00
60. 00   06000   LABORATORY	0. 11532		28, 873	60.00
60. 01  06001 BL00D LABORATORY	0.00000	0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 00000	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.00000		0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 00000		0	63.00
· ·				
64. 00   06400   I NTRAVENOUS THERAPY	0.00000		0	64.00
65. 00   06500  RESPI RATORY THERAPY	0. 14111	6 58, 707	8, 284	65.00
66. 00  06600  PHYSI CAL THERAPY	0. 34089	1, 840	627	66.00
67. 00  06700  OCCUPATI ONAL THERAPY	0. 58424	2 1, 134	663	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 33777		686	68.00
69. 00 06900 ELECTROCARDI OLOGY	0.00000		0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 00000		Ö	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 23711		5, 261	71. 00
72.00 O720O IMPL. DEV. CHARGED TO PATIENTS	0. 25997	4 0	0	72.00
73.00   07300   DRUGS CHARGED TO PATIENTS	0. 24703	5 147, 089	36, 336	73.00
74.00   07400   RENAL DIALYSIS	0. 00000	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0.00000	0	0	75. 00
76. 98 O7698 HYPERBARI C OXYGEN THERAPY	0. 20451		1, 096	76. 98
	0.00000		0	77. 00
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY	0. 00000	0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS				
88. 00  08800 RURAL HEALTH CLINIC	0.00000	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 00000	0	0	89.00
90. 00   09000   CLI NI C	0. 38782		0	90.00
91. 00   09100   EMERGENCY	0. 08349		0	91. 00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	1. 04737			92. 00
	1.04737	8 151, 460	158, 636	92.00
OTHER REIMBURSABLE COST CENTERS				
94. 00 09400 HOME PROGRAM DI ALYSI S	0.00000	0 0	0	94.00
95. 00  09500  AMBULANCE SERVI CES				95.00
96. 00   09600   DURABLE MEDI CAL EQUI P-RENTED	0.00000	0 0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0.00000		0	97. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)	0.0000	1, 145, 682	347, 466	
	41)	1, 145, 002	347, 400	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line	01)	0		201.00
202.00 Net charges (line 200 minus line 201)		1, 145, 682		202. 00

Health Financial Systems	COMMUNITY HOSPITAL OF NOBLE CTY, INC	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0146	Peri od:	Worksheet E

From 01/01/2023 Part A To 12/31/2023 Date/Time Prepared: 5/23/2024 9:53 am Title XVIII Hospi tal 1.00 PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS 1.00 DRG Amounts Other than Outlier Payments 1.00 2, 096, 463 1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 (see 1.01 instructions) 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see 642, 649 1.02 instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1.03 0 1.03 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after 1.04 0 1.04 October 1 (see instructions) 2.00 Outlier payments for discharges. (see instructions) 2.00 2.01 Outlier reconciliation amount 0 2.01 Outlier payment for discharges for Model 4 BPCI (see instructions) 2 02 0 2 02 2.03 Outlier payments for discharges occurring prior to October 1 (see instructions) 0 2.03 2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) O 2.04 3.00 Managed Care Simulated Payments 0 3.00 24. 15 Bed days available divided by number of days in the cost reporting period (see instructions) 4 00 4 00 Indirect Medical Education Adjustment 5.00 FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on 0.00 5.00 or before 12/31/1996. (see instructions) 5.01 FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions) 0.00 5.01 6.00 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for 0.00 6.00 new programs in accordance with 42 CFR 413.79(e) 6.26 Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of 6.26 the CAA 2021 (see instructions) MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) 7 00 0 00 7 00 7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the 0.00 7.01 cost report straddles July 1, 2011 then see instructions. 7.02 Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural 0.00 7.02 track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions) 8.00 Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for 0.00 8.00 affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost 8.01 0.00 8.01 report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital 8.02 0.00 8.02 under § 5506 of ACA. (see instructions) 8. 21 The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see 0.00 8.21 instructions) 9.00 Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or 0.00 9.00 minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) 10.00 FTE count for allopathic and osteopathic programs in the current year from your records 0 00 10 00 FTE count for residents in dental and podiatric programs. 0.00 11.00 Current year allowable FTE (see instructions) 0.00 12.00 12.00 Total allowable FTE count for the prior year. 0.00 13.00 13.00 14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, 0.00 14.00 otherwise enter zero. 15.00 Sum of lines 12 through 14 divided by 3. 0.00 15.00 Adjustment for residents in initial years of the program (see instructions) 0 00 16 00 16 00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 0.00 18.00 Adjusted rolling average FTE count 18.00 19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.00 0.000000 20.00 Prior year resident to bed ratio (see instructions) 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.00 IME payment adjustment (see instructions) 22.00 IME payment adjustment - Managed Care (see instructions) 22.01 0 22.01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23.00 (f)(1)(iv)(C).24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 If the amount on line 24 is greater than -O-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28 00 IME add-on adjustment amount (see instructions) 28.00 0 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0 28.01 29.00 Total IME payment ( sum of lines 22 and 28) 0 29.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.01 29.01 0 Disproportionate Share Adjustment 4. 97 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Percentage of Medicaid patient days (see instructions) 31.00 21.53 31.00 32 00 Sum of lines 30 and 31 26 50 32 00 33.00 Allowable disproportionate share percentage (see instructions) 11. 08 | 33. 00

	Financial Systems COMMUNITY HOSPITAL OF ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0146	Peri od: From 01/01/2023	u of Form CMS-2   Worksheet E   Part A	<u> </u>
			To 12/31/2023		
		Title XVIII	Hospi tal	PPS	Jani
				1. 00	
34. 00	Disproportionate share adjustment (see instructions)		D.1	75, 874	34.00
			Prior to 10/1 1.00	2.00	
	Uncompensated Care Payment Adjustment				
35. 00 35. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		6, 874, 403, 459 0. 000108058	5, 938, 006, 757 0. 000109886	
35. 01	Hospital UCP, including supplemental UCP (see instructions)		742, 834	652, 504	
35. 03	Pro rata share of the hospital UCP, including supplemental U	CP (see instructions)	555, 599	164, 017	35. 03
36. 00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03) Additional payment for high percentage of ESRD beneficiary di	ischarges (Lines 40 thre	719, 616		36.00
40. 00	Total Medicare discharges (see instructions)	rscharges (Triles 40 till c	0		40.00
41. 00	Total ESRD Medicare discharges (see instructions)		0		41.00
41. 01 42. 00	Total ESRD Medicare covered and paid discharges (see instruc Divide line 41 by line 40 (if less than 10%, you do not qual	•	0.00		41. 01 42. 00
43.00	Total Medicare ESRD inpatient days (see instructions)	rry for adjustment)	0.00		43.00
44. 00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44.00
45. 00	days) Average weekly cost for dialysis treatments (see instruction:	s)	0. 00		45.00
	Total additional payment (line 45 times line 44 times line 4		0		46.00
47.00	Subtotal (see instructions)		3, 534, 602		47.00
48. 00	Hospital specific payments (to be completed by SCH and MDH, only. (see instructions)	smail rurai nospitais	4, 222, 606		48. 00
				Amount	
49. 00	Total payment for inpatient operating costs (see instruction:	5)		1. 00 4, 050, 605	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I a		·)	208, 200	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt			0	51.00
52. 00 53. 00	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment	ine 49 see instructions)		0	52. 00 53. 00
54. 00	Special add-on payments for new technologies			0	54.00
54. 01	Islet isolation add-on payment	(0)		0	54. 01
55. 00 55. 01	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cellular therapy acquisition cost (see instructions)	69)		0	55. 00 55. 01
56.00	Cost of physicians' services in a teaching hospital (see int	ructions)		0	56.00
57. 00	Routine service other pass through costs (from Wkst. D, Pt.		through 35).	0	57.00
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58)	IV, col. 11 line 200)		0 4, 258, 805	58.00 59.00
50.00	Primary payer payments			0	60.00
51.00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		4, 258, 805	
52. 00 53. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			398, 172 1, 725	
	Allowable bad debts (see instructions)			71, 509	
	Adjusted reimbursable bad debts (see instructions)			46, 481	
56. 00 57. 00	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63)	tructions)		21, 949 3, 905, 389	66. 00 67. 00
58. 00	Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (	see instructions)	3, 903, 309	68.00
59. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96)	.(For SCH see instruction	ins)	0	69.00
70. 00 70. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons	tration) adjustment (cos	instructions)	0	70.00 70.50
70. 30 70. 75	N95 respirator payment adjustment amount (see instructions)	tration) adjustment (see	: Tristructions)	0	70. 30
70. 87	Demonstration payment adjustment amount before sequestration			0	70.87
70. 88 70. 89	SCH or MDH volume decrease adjustment (contractor use only)	tructions)		0	70.88
70. 89 70. 90	Pioneer ACO demonstration payment adjustment amount (see ins HSP bonus payment HVBP adjustment amount (see instructions)	LI UCLI OIIS)		1, 074	70. 89 70. 90
70. 91	HSP bonus payment HRR adjustment amount (see instructions)			-1, 406	1
70. 92	Bundled Model 1 discount amount (see instructions)			0	70. 92
70. 93 70. 94	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			4, 924 0	70. 93 70. 94
	printer day as the fit amount (see Fristlactions)			0	70. 95

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

	Financial Systems COMMUNITY HOSPITAL OF ATION OF REIMBURSEMENT SETTLEMENT		CN: 15-0146	Peri od:	u of Form CMS-2 Worksheet E	
				From 01/01/2023 To 12/31/2023	Part A	
		Title	e XVIII	Hospi tal	PPS	s alli
				(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0	0	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	n column O	,	2023	454, 126	70. 97
	the corresponding federal year for the period ending on or af		<b>'</b>	2023	454, 120	70.77
1	Low Volume Payment-3	ŕ	] 2	2024	148, 321	70. 98
	HAC adjustment amount (see instructions)				0	
	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			4, 512, 428	1
	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration				90, 249	l
	Sequestration adjustment-PARHM pass-throughs					71.02
1	Interim payments				4, 158, 199	
	Interim payments-PARHM					72. 01
	Tentative settlement (for contractor use only)				0	
1	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (line 71 minus lines 71.01, 71.0	22 72 and			242 000	73.01
74. 00	Barance due provider/program (Title 71 millius Titles 71.01, 71.0	02, 72, and			263, 980	74.00
74. 01	Balance due provider/program-PARHM (see instructions)					74. 01
	Protested amounts (nonallowable cost report items) in accorda	ance with			87, 510	75.00
Į.	CMS Pub. 15-2, chapter 1, §115.2					1
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)	of 2.02			0	00 00
	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum plus 2.04 (see instructions)	01 2.03			0	90.00
	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
	Operating outlier reconciliation adjustment amount (see instr	ructions)			0	
	Capital outlier reconciliation adjustment amount (see instruc				0	
1	The rate used to calculate the time value of money (see instr	,			0.00	
1	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruc				0	
70.00	Trille varue or money for capital related expenses (see fristruc	2015)		Prior to 10/1		70.00
				1. 00	2.00	
	HSP Bonus Payment Amount			1. 00	2.00	
100.00	HSP bonus amount (see instructions)				2.00	100.00
100.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			1. 00	2. 00	
100. 00 101. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)	ns)		1. 00	2. 00 130, 061 1. 0082607283	101. 00
100. 00 101. 00 102. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment	ns)		1. 00 385, 942 1. 0000000000	2. 00 130, 061 1. 0082607283	
100. 00 101. 00 102. 00 103. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)	,		1. 00 385, 942 1. 0000000000 0	2. 00 130, 061 1. 0082607283 1, 074	101. 00 102. 00 103. 00
100. 00 101. 00 102. 00 103. 00 104. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)	s)		1. 00 385, 942 1. 0000000000 0	2. 00 130, 061 1. 0082607283 1, 074	101. 00 102. 00
100. 00 101. 00 102. 00 103. 00 104. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst	s) cration) Adj		1. 00 385, 942 1. 0000000000 0	2. 00 130, 061 1. 0082607283 1, 074 0. 9969 -403	101. 00 102. 00 103. 00 104. 00
100. 00 101. 00 102. 00 103. 00 104. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe	s) cration) Adj		1. 00 385, 942 1. 0000000000 0	2. 00 130, 061 1. 0082607283 1, 074 0. 9969 -403	101. 00 102. 00 103. 00
100. 00 101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst	s) cration) Adj		1. 00 385, 942 1. 0000000000 0	2. 00 130, 061 1. 0082607283 1, 074 0. 9969 -403	101. 00 102. 00 103. 00 104. 00
100. 00 101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) RURA adjustment amount for HSP bonus payment (see instructions) RURA Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.	s) ration) Adj eriod under		1. 00 385, 942 1. 0000000000 0	2. 00 130, 061 1. 0082607283 1, 074 0. 9969 -403	101. 00 102. 00 103. 00 104. 00 200. 00
100. 00 101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) RRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration po Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions)	s) ration) Adj eriod under		1. 00 385, 942 1. 0000000000 0	2. 00 130, 061 1. 0082607283 1, 074 0. 9969 -403	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
100.00 101.00 102.00 103.00 104.00 200.00 201.00 202.00 203.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	s) rration) Adj eriod under ne 49)	the 21st	1. 00 385, 942 1. 0000000000 0 0. 9974 -1, 003	2. 00 130, 061 1. 0082607283 1, 074 0. 9969 -403	101. 00 102. 00 103. 00 104. 00 200. 00
100.00 101.00 102.00 103.00 104.00 200.00 201.00 202.00 203.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HVBP adjustment for HSP Bonus Payment HRR Adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir	s) rration) Adj eriod under ne 49)	the 21st	1. 00 385, 942 1. 0000000000 0 0. 9974 -1, 003	2. 00 130, 061 1. 0082607283 1, 074 0. 9969 -403	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
100.00 101.00 102.00 103.00 104.00 200.00 201.00 202.00 203.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A insperiod)	s) rration) Adj eriod under ne 49)	the 21st	1. 00 385, 942 1. 0000000000 0 0. 9974 -1, 003	2.00 130,061 1.0082607283 1,074 0.9969 -403 strati on	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
100.00 101.00 102.00 103.00 104.00 200.00 201.00 202.00 203.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HVBP adjustment for HSP Bonus Payment HRR Adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir	s) rration) Adj eriod under ne 49)	the 21st	1. 00 385, 942 1. 0000000000 0 0. 9974 -1, 003	2.00 130,061 1.0082607283 1,074 0.9969 -403	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
100.00 101.00 102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration po Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	s) cration) Adj eriod under ne 49) n first year	the 21st	1. 00 385, 942 1. 0000000000 0 0. 9974 -1, 003	2.00 130,061 1.0082607283 1,074 0.9969 -403	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
100.00 101.00 102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir peeriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	s) cration) Adj eriod under ne 49) n first year	the 21st	1. 00 385, 942 1. 0000000000 0 0. 9974 -1, 003	2.00 130,061 1.0082607283 1,074 0.9969 -403	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
100.00 101.00 102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst	ration) Adjuration Adj	the 21st	1. 00 385, 942 1. 0000000000 0 0. 9974 -1, 003	2.00 130,061 1.0082607283 1,074 0.9969 -403	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00
100.00 101.00 102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00 208.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst	ration) Adjuration Adj	the 21st	1. 00 385, 942 1. 0000000000 0 0. 9974 -1, 003	2.00 130,061 1.0082607283 1,074 0.9969 -403 strati on	101. 00 102. 00 103. 00 104. 00 200. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00
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100.00 101.00 102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00 209.00 211.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration po Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	ration) Adj eriod under ne 49) n first year tructions)	the 21st	1. 00 385, 942 1. 0000000000 0 0. 9974 -1, 003	2.00 130,061 1.0082607283 1,074 0.9969 -403 strati on	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00
100.00 101.00 102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00 208.00 209.00 211.00 211.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line	ration) Adj eriod under ne 49) n first year tructions)	the 21st	1. 00 385, 942 1. 0000000000 0 0. 9974 -1, 003	2.00  130,061  1.0082607283 1,074  0.9969 -403	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00
100.00 101.00 102.00 103.00 104.00 200.00 201.00 203.00 204.00 205.00 206.00 207.00 208.00 210.00 211.00 212.00 213.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration po Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	ration) Adjuration) Adjuration Ad	of the curre	1. 00 385, 942 1. 0000000000 0 0. 9974 -1, 003	2.00 130,061 1.0082607283 1,074 0.9969 -403 strati on	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00

Provider CCN: 15-0146

Peri od:

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

From 01/01/2023 Part A Exhibit 5 Date/Time Prepared: 5/23/2024 9:53 am 12/31/2023 Title XVIII Hospi tal Period to Total (cols. Wkst. E, Pt. Amt. from Period on Wkst. E, Pt. 10/01 after 10/01 A. line 2 and 3) A) 0 1.00 2.00 3.00 4.00 1.00 DRG amounts other than outlier payments 1. 00 1.00 DRG amounts other than outlier payments for 1.01 1.01 2,096,463 0 0 1.01 discharges occurring prior to October 1 1 02 DRG amounts other than outlier payments for 642, 649 2, 540, 745 1 02 2, 540, 745 1.02 discharges occurring on or after October 1 DRG for Federal specific operating payment 1.03 1.03 0 1.03 for Model 4 BPCI occurring prior to October 1 04 DRG for Federal specific operating payment 1 04 0 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 0 2.01 **BPCI** 2.02 2.02 Outlier payments for discharges occurring 2.03 0 0 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 0 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01  $\mathbf{C}$ 0 3.00 Managed care simulated payments 4.00 3.00 0 4.00 Indirect Medical Education Adjustment 0.000000 0.000000 0.000000 5.00 Amount from Worksheet E, Part A, line 21 21.00 5.00 (see instructions) 6.00 IME payment adjustment (see instructions) 22.00 0 6.00 0 6.01 IME payment adjustment for managed care (see 22.01 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8.00 IME adjustment (see instructions) 28.00 0 0 8.00 0 IME payment adjustment add on for managed 0 28 01 C 0 8 01 8 01 0 care (see instructions) 9.00 Total IME payment (sum of lines 6 and 8) 29.00 0 0 9.00 0 Total IME payment for managed care (sum of 9.01 29.01 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 10.00 Allowable disproportionate share percentage 33.00 0.1108 0.1108 0.1108 (see instructions) 11.00 Di sproporti onate share adjustment (see 34.00 75,874 0 75, 874 75, 874 11.00 instructions) Uncompensa<u>ted care payments</u> 719, 616 11.01 36 00 555, 625 164,017 719, 642 11.01 Additional payment for high percentage of ESRD beneficiary discharges Total ESRD additional payment (see 12.00 46.00 12.00 instructions) 47.00 13.00 Subtotal (see instructions) 3, 534, 602 555, 625 2, 978, 977 3, 534, 602 13.00 14.00 Hospital specific payments (completed by SCH 48.00 4, 222, 606 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 555.625 15 00 49 00 4 050 605 3, 494, 980 4,050,605 15 00 (see instructions) 16.00 Payment for inpatient program capital (from 50.00 208, 200 0 208, 200 208, 200 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 0 0 17.00 0 Net organ acquisition cost 17.01 17.01 17.02 Credits received from manufacturers for 68.00  $\cap$ Λ 17.02 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 18.00 amount (see instructions) 19.00 SUBTOTAL 3, 703, 180 4, 258, 805 19.00 555, 625

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10 HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provi der CCN: 15-0146 Peri od: Worksheet E From 01/01/2023 Part A Exhibit 5 Date/Time Prepared: 5/23/2024 9:53 am 12/31/2023 Title XVIII Hospi tal PPS Wkst. L, line (Amt. from Wkst. L) 2.00 3.00 4.00 Ω 1.00 20.00 Capital DRG other than outlier 1.00 208, 200 0 208, 200 208, 200 20.00 Model 4 BPCI Capital DRG other than outlier 1. 01 0 20.01 20.01 21 00 Capital DRG outlier payments 2.00 0 0 21.00 0 2. 01 Model 4 BPCI Capital DRG outlier payments 21.01 0 0 0 21.01 22.00 Indirect medical education percentage (see 5.00 0.0000 0.0000 0.0000 22.00 instructions) 23.00 Indirect medical education adjustment (see 6.00 0 23.00  $\mathbf{C}$ 0 instructions) 0.0000 0.0000 24.00 24.00 Allowable disproportionate share percentage 10.00 0.0000 (see instructions) 25.00 Disproportionate share adjustment (see 11.00 0 0 25.00 instructions) 26.00 Total prospective capital payments (see 12.00 208, 200 0 208, 200 208, 200 26.00 instructions) Wkst. E, Pt. (Amt. from A, line Wkst. E, Pt. A) n 1 00 2.00 3. 00 4 00 27.00 27.00 28.00 Low volume adjustment prior to October 1 70. 96 0 0 28.00 Low volume adjustment on or after October 1 70. 97 29.00 454, 126 454, 126 454, 126 29.00 70. 93 4, 924 4, 924 4, 924 30.00 HVBP payment adjustment (see instructions) O 30.00 HVBP payment adjustment for HSP bonus 30.01 70. 90 1,074 0 1,074 1,074 30.01 payment (see instructions) HRR adjustment (see instructions) 70. 94 6, 904 31.00 -6, 904 0 31.00 HRR adjustment for HSP bonus payment (see 70. 91 -1, 406 -1, 003 -403 -1, 406 31.01 31.01 instructions) (Amt. to Wkst. E, Pt. 1.00 2.00 3.00 4. 00 0 32.00 HAC Reduction Program adjustment (see 70. 99 32.00 0 instructions) 100.00 Transfer HAC Reduction Program adjustment to 100.00 Ν

Wkst. E, Pt. A.

Health Financial Systems	COMMUNITY HOSPITAL OF	NOBLE CTY, INC	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0146	From 01/01/2023	Worksheet E Part B Date/Time Prepared:

12/31/2023 | Date/Time Prepared: 5/23/2024 9:53 am 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) 4, 739, 717 2.00 2.00 3.00 OPPS or REH payments 4, 264, 953 3 00 4.00 Outlier payment (see instructions) 4.00 0 4.01 Outlier reconciliation amount (see instructions) 0 4.01 5.00 0.864 Enter the hospital specific payment to cost ratio (see instructions) 5.00 4, 095, 115 6.00 Line 2 times line 5 6.00 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 0.00 7.00 8.00 Transitional corridor payment (see instructions) 0 8.00 Ancillary service other pass through costs including REH direct graduate medical education costs from 9 00 0 9 00 Wkst. D, Pt. IV, col. 13, line 200 10.00 Organ acquisitions 0 10.00 11.00 Total cost (sum of lines 1 and 10) (see instructions) 0 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 0 14.00 Total reasonable charges (sum of lines 12 and 13) Aggregate amount actually collected from patients liable for payment for services on a charge basis 15.00 15.00 0 Amounts that would have been realized from patients liable for payment for services on a chargebasis 0 16.00 16.00 had such payment been made in accordance with 42 CFR §413.13(e) 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 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 19.00 0 instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20.00 instructions) 21.00 21.00 Lesser of cost or charges (see instructions) 0 22.00 Interns and residents (see instructions) 22.00 Cost of physicians' services in a teaching hospital (see instructions) 23.00 23.00 0 4, 264, 953 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 24.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions) 25.00 780, 298 25.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 26,00 Ω 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, 484, 655 27.00 instructions) 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 28.00 0 28 50 REH facility payment amount (see instructions) 28 50 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00 30.00 Subtotal (sum of lines 27, 28, 28.50 and 29) 3, 484, 655 30.00 31 00 Primary payer payments 604 31 00 32.00 Subtotal (line 30 minus line 31) 3, 484, 051 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) 33.00 33.00 69, 260 34 00 Allowable bad debts (see instructions) 34 00 35.00 Adjusted reimbursable bad debts (see instructions) 45,019 35.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28.044 36.00 37.00 Subtotal (see instructions) 3, 529, 070 37.00 38.00  ${\tt MSP-LCC}\ reconciliation\ amount\ from\ PS\&R$ 50 38 00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.00 0 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 N95 respirator payment adjustment amount (see instructions) 39.75 39.75 0 39 97 Demonstration payment adjustment amount before sequestration 0 39 97 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 0 39 99 RECOVERY OF ACCELERATED DEPRECIATION 39 99 40.00 Subtotal (see instructions) 3, 529, 020 40.00 40.01 Sequestration adjustment (see instructions) 70, 580 40 01 Demonstration payment adjustment amount after sequestration 40.02 40.02 Sequestration adjustment-PARHM pass-throughs 40.03 40.03 3, 427, 583 41.00 41.00 Interim payments 41.01 Interim payments-PARHM 41.01 42.00 Tentative settlement (for contractors use only) 42.00 Tentative settlement-PARHM (for contractor use only) 42.01 42.01 43.00 Balance due provider/program (see instructions) 30.857 43.00 Balance due provider/program-PARHM (see instructions) 43.01 43.01 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 §115. 2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 91.00 0 0 00 92.00 92 00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00

Health Financial Systems	COMMUNITY HOSPITAL OF	NOBLE CTY, INC	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0146	Peri od:	Worksheet E	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pre	
				5/23/2024 9:5	3 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94.00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

Peri od:

1.00

2.00

8.00

From 01/01/2023 Part I 12/31/2023 Date/Time Prepared: 5/23/2024 9:53 am Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy Amount mm/dd/yyyy Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 4, 158, 199 3, 427, 583 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 3.51 0 0 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, 158, 199 3, 427, 583 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 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 263, 980 30, 857 6.01 SETTLEMENT TO PROGRAM 6.02 6.02 7.00 Total Medicare program liability (see instructions) 4, 422, 179 3, 458, 440 7.00 Contractor NPR Date Number (Mo/Day/Yr)

8.00 Name of Contractor

Heal th	Financial Systems COMMUNITY HOSPITAL OF	NOBLE CTY, INC	In Lie	u of Form CMS-	2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0146 Period: W					
			From 01/01/2023 To 12/31/2023	Date/Time Pre		
				5/23/2024 9: 5	3 am	
		Title XVIII	Hospi tal	PPS		
				4 00		
	TO BE COMPLETED BY CONTRACTOR FOR MONOTANDARD COOT REPORTS			1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				-	
4 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				1 00	
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 lin	e 14		1.00 2.00	
	2.00 Medicare days (see instructions)					
	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					
	4.00 Total inpatient days (see instructions)					
	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						
	line 168					
8. 00	Calculation of the HIT incentive payment (see instructions)				8. 00 9. 00	
9. 00						
10.00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)					
	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH				30.00	
	30.00   Initial/interim HIT payment adjustment (see instructions)					
	31.00 Other Adjustment (specify)					
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instructio	ns)		32.00	

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu				of Form CMS-2	552-10	
OUTLI E	ER RECONCILIATION AT TENTATIVE SETTLEMENT	Provi der C	CN: 15-0146	Peri od:	Worksheet E-5	
				From 01/01/2023 To 12/31/2023	Date/Time Prep 5/23/2024 9:53	oared: B am
		Title	e XVIII		PPS	
					1. 00	
TO BE COMPLETED BY CONTRACTOR						
1.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)					0	1.00
2.00 Capital outlier from Wkst. L, Pt. I, line 2				0	2.00	
3.00 Operating outlier reconciliation adjustment amount (see instructions)				0	3.00	
4.00 Capital outlier reconciliation adjustment amount (see instructions)					0	4.00
5.00 The rate used to calculate the time value of money (see instructions)					0.00	5.00
6.00 Time value of money for operating expenses (see instructions)					0	6.00
7. 00	Time value of money for capital related expenses (				0	7. 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

Temporary   Investments	oni y)					5/23/2024 9: 5	3 am
1.00			General Fund			Plant Fund	
Cash on hand in banks			1.00			4. 00	
Temporarry investments							
Notes receivable   0			34, 923		0		1.00 2.00
Accounts receivable				-	-		3.00
O			25, 071, 970	-	0		4.00
Inventorry		Other receivable	0	0	0		
Prepaid expenses	6. 00	Allowances for uncollectible notes and accounts receivable	-14, 453, 104	0	0		6.00
9.00   0 their currient assets   0   0   0   0   0   1   11.00   0 trem other funds   43,199,136   0   0   0   1   11.00   10 trem other funds   43,199,136   0   0   0   1   11.00   10 trem other funds   54,404,029   0   0   0   1   12.00   Land   70   70   70   70   70   70   70   7				"	0		7.00
10.00   Due from other funds			48, 523		0		
11.00   Ditail current assets (sum of lines 1-10)   10   10   11   12.00   12.00   12.00   13.00   1			/2 100 126	T .	0		9.00
FIXED ASSETS					0		11.00
12.00   Land	11.00		01, 101, 02,	<u> </u>			11.00
14.00   Accumul ated depreciation   -707, 883   0   0   1    -16.00   Accumul ated depreciation   -707, 883   0   0   0    -16.00   Accumul ated depreciation   -708, 755   0   0   0    -17.00   Lasehold improvements   1,415,776   0   0   0    -18.00   Accumul ated depreciation   -709, 755   0   0   0    -18.00   Accumul ated depreciation   -709, 755   0   0   0    -19.00   Fixed equipment   180,080   0   0   0    -19.00   Accumul ated depreciation   -107, 793   0   0   0    -19.00   Accumul ated depreciation   -107, 793   0   0   0    -19.00   Accumul ated depreciation   -107, 793   0   0   0    -19.00   Accumul ated depreciation   -107, 793   0   0   0    -19.00   Accumul ated depreciation   -108, 799   0   0   0    -19.00   Accumul ated depreciation   -108, 799   0   0   0    -19.00   Accumul ated depreciation   -108, 799   0   0   0    -19.00   Accumul ated depreciation   -108, 799   0   0   0    -19.00   Accumul ated depreciation   -108, 799   0   0   0   0    -19.00   Accumul ated depreciation   -331, 05   0   0   0   0    -19.00   Accumul ated depreciation   -311, 00   0   0   0    -19.00   Accumul ated depreciation   -311, 00   0   0   0    -19.00   Accumul ated depreciation   -311, 00   0   0   0    -19.00   Accumul ated depreciation   -311, 00   0   0   0    -19.00   Accumul ated depreciation   -311, 00   0   0   0   0    -19.00   Accumul ated depreciation   -311, 00   0   0   0   0    -19.00   Accumul ated depreciation   -311, 00   0   0   0   0   0    -19.00   Accumul ated depreciation   -311, 00   0   0   0   0   0    -19.00   Accumul ated depreciation   -311, 00   0   0   0   0   0   0    -19.00   Accumul ated depreciation   -311, 00   0   0   0   0   0   0   0   0   0	12.00		0	0	0	0	12.00
15.00   Buildings	13.00			_	0	0	13.00
16.00   Accumul ated depreciation   -2,730,105   0   0   0   18.00   Accumul ated depreciation   -798,755   0   0   0   18.00   Accumul ated depreciation   -798,755   0   0   0   18.00   Accumul ated depreciation   -798,755   0   0   0   0   19.00   Fixed equip ment   180,000   0   0   0   0   0   0   0   0					-		14.00
17.00   Leasehold Improvements					0		15.00
18.00   Accumul ated depreciation   -798,755   0   0   0   15					0		16. 00 17. 00
19.00   Fixed equipment		· •			0		18.00
20.00   Accumulated depreciation   -107, 293   0   0   0   2   2   2   2   2   0   Accumulated depreciation   -107, 293   0   0   0   0   2   2   2   2   2   0   Accumulated depreciation   -876, 288   0   0   0   2   2   2   2   2   0   Accumulated depreciation   -9, 698, 148   0   0   0   2   2   2   2   0   0   0					0		19.00
21.00		' '			0		20.00
23.00   Maj or movable equipment   12, 361, 679   0   0   0   22   25.00   Minor equipment depreciable   -9,698, 148   0   0   0   0   25   25.00   Minor equipment depreciable   790, 709   0   0   0   27   27.00   Minor equipment depreciable   -331, 036   0   0   0   0   27   27.00   HIT designated Assets   0   0   0   0   0   0   27   28   28   28   28   28   28   28		'			0	0	21.00
24.00 Accumulated depreciation	22. 00	Accumulated depreciation	-876, 288	0	0	0	22.00
25.00 Minor equipment depreciable 790,709 0 0 0 0 2 2 2 2 2 0 0 Minor equipment depreciable -331,036 0 0 0 0 2 2 2 2 0 0 Minor equipment depreciable -331,036 0 0 0 0 0 0 0 2 2 2 3 0 0 0 0 0 0 0 0 0		, ,	12, 361, 679	0	0		23.00
26.00   Accumul ated depreciation   -331, 036   0   0   0   0   22 28.00   Accumul ated depreciation   0   0   0   0   0   0   0   0   0		·			0		24.00
27.00   HIT designated Assets   0   0   0   0   0   228			1		0		25.00
28.00 Accumula face depreciation			-331, 036		0		26. 00 27. 00
29.00   Minor equipment-nondepreciable   0   0   0   0   0   25			0		0		28.00
30. 00   Total fixed assets (sum of lines 12-29)   5,999.001   0   0   0   0   3		·		1	0		
OTHER ASSETS   Investments   0   0   0   0   0   3   32   20   Deposits on leases   0   0   0   0   0   0   0   33   32   20   Deposits on leases   0   0   0   0   0   0   0   33   33		1	5, 999, 001	-	0		
32.00   Deposits on Leases   0   0   0   0   0   33     33.00   Due from owners/officers   0   0   0   0   0   33     34.00   Other assets   55,910   0   0   0   0   34     35.00   Total a other assets (sum of lines 31-34)   55,910   0   0   0   0   33     36.00   Total a assets (sum of lines 11, 30, and 35)   60,518,940   0   0   0   0   33     37.00   Accounts payable   1,226,765   0   0   0   0   33     38.00   Sal aries, wages, and fees payable   1,094,141   0   0   0   0   34     40.01   Accounts payable   0   0   0   0   0   34     40.02   Accounts payable   0   0   0   0   0   0     40.02   Accounts payable (short term)   228,053   0   0   0   0   0   0     40.00   Deferred income   0   0   0   0   0   0     41.00   Deferred income   0   0   0   0   0     42.00   Accelerated payments   0   0   0   0   0     43.00   Due to other funds   0   0   0   0   0     44.00   Other current liabilities   2,176,042   0   0   0   0     45.00   Total current liabilities (sum of lines 37 thru 44)   4,725,001   0   0   0   0     46.00   Mortgage payable   397,504   0   0   0   0   0     47.00   Notes payable   397,504   0   0   0   0   0     48.00   Unsecured Labilities (sum of lines 46 thru 49)   397,504   0   0   0   0     49.00   Other long term liabilities (sum of lines 46 thru 49)   397,504   0   0   0   0     51.00   Total liabilities (sum of lines 45 and 50)   5,122,505   0   0   0     52.00   General fund balance   55,396,435   0   0   0   0     56.00   Governing body created - endowment fund balance   0   56     58.00   Donor created - endowment fund balance   0   55     58.00   Plant fund balance - reserve for plant improvement, replacement, and expansion   10   0   0   0     56.00   Coverning body created - endowment fund balance   0   56     57.00   Plant fund balance - reserve for plant improvement, replacement, and expansion   50,518,940   0   0   0   0     58.00   Other limities   0   0   0   0   0     59.00   Total liabilities (sum of lines 52 thru 58)   0   0   0   0   0     59.00   Total liabilities a							
Due from owners/officers			0	0	0	-	31.00
34.00   Other assets   55,910   0   0   0   0   38   35.00   Total other assets (sum of lines 31-34)   55,910   0   0   0   0   38   36.00   Total assets (sum of lines 11, 30, and 35)   60,518,940   0   0   0   0   38   36.00   CURRENT LIABILITIES			0	1	0	-	32.00
35.00			55.010	-	0	-	33.00
Total assets (sum of lines 11, 30, and 35)   60,518,940   0   0   0   0   36			1		0		34.00 35.00
CURRENT LIABILITIES   37.00   Accounts payable   1,226,765   0   0   0   0   33.00   Sal aries, wages, and fees payable   1,094,141   0   0   0   0   33.00   Payroll taxes payable   0   0   0   0   0   0   34.00   Notes and loans payable (short term)   228,053   0   0   0   0   0   44.00   Accelerated payments   0   0   0   0   0   44.00   Accelerated payments   0   0   0   0   0   0   44.00   Accelerated payments   0   0   0   0   0   0   0   0   0		1	1		-		36.00
37.00   Accounts payable	00.00		00,010,710	<u> </u>			00.00
39.00   Payroll taxes payable   0   0   0   0   36	37. 00		1, 226, 765	0	0	0	37.00
40.00 Notes and loan's payable (short term)  228,053  0  0  0  0  41.00 Deferred income  0  0  0  0  42.00 Accelerated payments  0  0  0  0  43.00 Due to other funds  0  0  144.00 Other current liabilities  2,176,042  0  10 0  10 0  45.00 Total current liabilities (sum of lines 37 thru 44)  47.725,001  10 0  10 0  48.00 Unscurred loans  49.00 Other long term liabilities  10 0  10 0  47.00 Other long term liabilities  10 0			1, 094, 141	0	0		38.00
41.00 Deferred income 42.00 Accelerated payments 0 0 0 0 0 0 42 43.00 Due to other funds 0 0 0 0 0 0 0 44 44.00 Other current liabilities 45.00 Total current liabilities (sum of lines 37 thru 44) 4,725,001 0 0 0 0 0 0 0 45.00 Mortgage payable 46.00 Mortgage payable 47.00 Notes payable 48.00 Unsecured loans 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0		0		39.00
42.00 Accelerated payments			228, 053	0	0		40.00
43.00 Due to other funds  44.00 Other current liabilities  45.00 Total current liabilities (sum of lines 37 thru 44)  45.00 Total current liabilities (sum of lines 37 thru 44)  45.00 Total current liabilities (sum of lines 37 thru 44)  45.00 Total current liabilities  46.00 Mortgage payable  47.00 Notes payable  48.00 Unsecured loans  48.00 Unsecured loans  49.00 Other long term liabilities  49.00 Total long term liabilities (sum of lines 46 thru 49)  49.00 Total liabilities (sum of lines 46 thru 49)  49.00 Total liabilities (sum of lines 45 and 50)  49.00 Total liabilities (sum of lines 45 and 50)  49.00 Donor created - endowment fund balance  50.00 Specific purpose fund  50.00 Donor created - endowment fund balance - restricted  50.00 Governing body created - endowment fund balance  50.00 Flant fund balance - invested in plant  50.00 Total liabilities and fund balances (sum of lines 51 and 60, 518, 940)  50.00 Total liabilities and fund balances (sum of lines 51 and 60, 518, 940)			0	0	0	0	41. 00 42. 00
44.00       Other current liabilities       2,176,042       0       0       0       44         45.00       Total current liabilities (sum of lines 37 thru 44)       4,725,001       0       0       0       45         46.00       Mortgage payable       0       0       0       0       0       0       0       47       48.00       0			0	0	0	0	
45.00   Total current liabilities (sum of lines 37 thru 44)			2, 176, 042	0	0		
LONG TERM LIABILITIES					0	-	
47.00 Notes payable 397,504 0 0 0 47 48.00 Unsecured Loans 0 0 0 0 0 0 48 49.00 Other Long term Liabilities 0 0 0 0 0 0 0 48 50.00 Total long term Liabilities (sum of Lines 46 thru 49) 397,504 0 0 0 0 0 50  Total Liabilities (sum of Lines 45 and 50) 5, 122,505 0 0 0 0 50  CAPITAL ACCOUNTS  52.00 General fund balance  Specific purpose fund 55, 396, 435 0 55, 396, 435 0 56  50.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total Liabilities and fund balances (sum of Lines 51 and 60, 518, 940 0 0 0 0 660							
48.00 Unsecured Loans 0 0 0 0 0 48 49.00 Other Long term Liabilities 50.00 Total Long term Liabilities (sum of Lines 46 thru 49) 51.00 Total Liabilities (sum of Lines 45 and 50) CAPITAL ACCOUNTS  52.00 General fund balance 53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total Liabilities and fund balances (sum of Lines 51 and 60, 518, 940) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	46. 00		0	T .	0		
49.00       Other long term liabilities       0       0       0       0       49.00         50.00       Total long term liabilities (sum of lines 46 thru 49)       397,504       0       0       0       50.50         51.00       Total liabilities (sum of lines 45 and 50)       5,122,505       0       0       0       55.00         52.00       General fund balance       55,396,435       0       55.396,435		' '	397, 504		-		
50.00       Total long term liabilities (sum of lines 46 thru 49)       397,504       0       0       0       5         51.00       Total liabilities (sum of lines 45 and 50)       5,122,505       0       0       0       5         52.00       General fund balance       55,396,435       0       5       5         53.00       Specific purpose fund       0       5       5         54.00       Donor created - endowment fund balance - restricted       0       5         55.00       Bonor created - endowment fund balance - unrestricted       0       5         56.00       Governing body created - endowment fund balance       0       5         57.00       Plant fund balance - invested in plant       0       5         58.00       Plant fund balance - reserve for plant improvement, replacement, and expansion       0       5         59.00       Total fund balances (sum of lines 52 thru 58)       55,396,435       0       0       0         60.00       Total liabilities and fund balances (sum of lines 51 and 60,518,940       0       0       0       6			0	-			48.00
51.00 Total liabilities (sum of lines 45 and 50)  CAPITAL ACCOUNTS  52.00 General fund balance 53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 66.00 Governing body created - endowment fund balance 67.00 Plant fund balance - invested in plant 68.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 69.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 60,518,940  51.22,505  0 0 0 0 52.00 0 0 53.396,435 0 0 0 54.00 0 55.396,435 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	207 504		-		49. 00 50. 00
CAPITAL ACCOUNTS         52.00       General fund bal ance       55, 396, 435       52         53.00       Specific purpose fund       0       53         54.00       Donor created - endowment fund bal ance - unrestricted       0       54         55.00       Donor created - endowment fund bal ance - unrestricted       0       55         56.00       Governing body created - endowment fund bal ance       0       55         57.00       Plant fund bal ance - invested in plant       0       57         58.00       Plant fund bal ance - reserve for plant improvement, replacement, and expansion       0       56         59.00       Total fund bal ances (sum of lines 52 thru 58)       55, 396, 435       0       0       0       60         60.00       Total liabilities and fund bal ances (sum of lines 51 and       60, 518, 940       0       0       0       60		,			-		
52.00 General fund balance  53.00 Specific purpose fund  54.00 Donor created - endowment fund balance - restricted  55.00 Donor created - endowment fund balance - unrestricted  56.00 Governing body created - endowment fund balance  57.00 Plant fund balance - invested in plant  58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion  59.00 Total fund balances (sum of lines 52 thru 58)  55, 396, 435  0  56, 396, 435  0  0  57.00 Specific purpose fund  0  58.00 Specific purpose fund  0  54.00 Specific purpose fund  0  55.396, 435  0  0  0  0  0  0  0  0  0  0  0  0  0	01.00		0,122,000	<u> </u>			01.00
54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 54.00 Donor created - endowment fund balance 55.50 Donor created - endowment fund balance 56.50 Donor created - endowment fund balance 56.50 Donor created - endowment fund balance 57.00 Flant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total liabilities and fund balances (sum of lines 51 and 60,518,940 Donor created - endowment fund balance - restricted 55.50 Donor created - endowment fund balance 56.50 Donor created - endowment fund balance 57.00 Flant fund balance - invested in plant 58.00 Donor created - endowment fund balance 58.50 Donor created - endowment fund balance 59.50 Donor created - e	52.00		55, 396, 435				52.00
55.00 Donor created - endowment fund balance - unrestricted 66.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 60,518,940 0 55 56 57 58 57 58 58 59 60 59 60 60 60 60 60 60 60 60 60 60 60 60 60	53.00	Specific purpose fund		0			53.00
56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 60,518,940 0 56.00 56.00 Formula fund balances (sum of lines 51 and					0		54.00
57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 60,518,940 0 0 0 66					0		55.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion  59.00 Total fund balances (sum of lines 52 thru 58)  60.00 Total liabilities and fund balances (sum of lines 51 and 60,518,940 0 0 0 66		1			0	,	56.00
replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 60,518,940 0 0 66		•					57. 00 58. 00
59.00       Total fund balances (sum of lines 52 thru 58)       55,396,435       0       0       0       55,000         60.00       Total liabilities and fund balances (sum of lines 51 and 60,518,940       0       0       0       0	JU. UU						] 50.00
60.00 Total liabilities and fund balances (sum of lines 51 and 60,518,940 0 0 60	59. 00		55, 396, 435	l	0	0	59.00
[59]					0		60.00
		[59]					

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

| Peri od: | Worksheet G-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

				Т	o 12/31/2023	Date/Time Pre 5/23/2024 9:5	
		General	Fund	Speci al Pu	rpose Fund	Endowment Fund	
		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 9. 00 10. 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 ASSET TRANSFERS  Total additions (sum of line 4-9)	461, 036 111, 813 0 0 0	2.00 47, 256, 593 7, 566, 993 54, 823, 586	0 0 0 0 0	0	0 0 0 0 0	5. 00 6. 00 7. 00 8. 00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)  Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0 0 0 0 0	572, 647 55, 396, 435 0 55, 396, 435	0 0 0 0 0	o	0 0 0 0 0	11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
	sheet (line 11 minus line 18)	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	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 ASSET TRANSFERS  Total additions (sum of line 4-9)	0	0 0 0 0 0	0.00			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Subtotal additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)  Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	0 0 0 0 0	0000			10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

Peri od:

From 01/01/2023 Parts I & II Date/Time Prepared: 12/31/2023 5/23/2024 9:53 am 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 11, 140, 312 11, 140, 312 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) 11, 140, 312 11, 140, 312 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 16.00 11 - 15) 17.00 11, 140, 312 11, 140, 312 17 00 Total inpatient routine care services (sum of lines 10 and 16) 18.00 Ancillary services 39, 893, 017 39, 893, 017 18.00 Outpatient services 188, 887, 258 188, 887, 258 19.00 0 19.00 RURAL HEALTH CLINIC 0 20.00 0 0 20.00 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULANCE SERVICES 24, 094, 551 0 24, 094, 551 23.00 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 27.00 OTHER (SPECIFY) 0 27.00 28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 51, 033, 329 212, 981, 809 264, 015, 138 28.00 line 1) PART II - OPERATING EXPENSES 29.00 Operating expenses (per Wkst. A, column 3, line 200) 67, 169, 496 29.00 30.00 HOME OFFICE EXPENSE 461, 036 30.00 31.00 31.00 C 32.00 0 32 00 33.00 0 33.00 34.00 34.00 35.00 0 35.00 Total additions (sum of lines 30-35) 461, 036 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 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 67, 630, 532 43.00

to Wkst. G-3, line 4)

111	COMMUNITY HOCDITA	L OF NORLE CTV. LNC	1-11-	6 F OMC /	2552 10
	Financial Systems COMMUNITY HOSPITA ENT OF REVENUES AND EXPENSES	L OF NOBLE CTY, INC Provider CCN: 15-0146	Peri od:	u of Form CMS-2 Worksheet G-3	
	EIN G. NEVENSES AND EIN EIGES		From 01/01/2023		pared:
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3			264, 015, 138	•
2. 00	Less contractual allowances and discounts on patients' a	ccounts		190, 301, 189	2.00
3.00	Net patient revenues (line 1 minus line 2)			73, 713, 949	3.00
4.00	00 Less total operating expenses (from Wkst. G-2, Part II, line 43)				
5.00	5.00 Net income from service to patients (line 3 minus line 4)				
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7. 00	Income from investments			58, 156	7.00
8. 00	Revenues from telephone and other miscellaneous communication	ation services		0	8.00
9. 00	Revenue from television and radio service			ĺ	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses	0	11.00		
12.00	Parking Lot receipts			ĺ	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			167, 397	14.00
	Revenue from rental of living quarters			0	15.00

16.00

17.00

18.00

20.00

21.00

0 22.00

24.01

24.50

25.00

26.00

0 27.00

0

0 19.00

0 23.00

0

0 28.00

7, 566, 993 29. 00

627, 628 630, 395

1, 483, 576

7, 566, 993

16.00 Revenue from sale of medical and surgical supplies to other than patients

17.00 Revenue from sale of drugs to other than patients

18.00 Revenue from sale of medical records and abstracts

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)

Revenue from gifts, flowers, coffee shops, and canteen

19.00 Tuition (fees, sale of textbooks, uniforms, etc.)

21.00 Rental of vending machines

COVI D-19 PHE Funding

27. 00 OTHER EXPENSES (SPECIFY)

24. 00 OTHER (SPECIFY)

Rental of hospital space

Governmental appropriations

Total (line 5 plus line 25)

25.00 Total other income (sum of lines 6-24)

20.00

22.00

23.00

24. 01

24. 50

Heal th	Financial Systems	COMMUNITY HOSPITAL OF	NOBLE CTY, INC	In Lie	u of Form CMS-2	2552-10
	ALCULATION OF CAPITAL PAYMENT    Provider CCN: 15-0146					
			Title XVIII	Hospi tal	PPS	
	PART I - FULLY PROSPECTIVE METHOD				1. 00	
	CAPITAL FEDERAL AMOUNT					İ
1.00	Capital DRG other than outlier				208, 200	1.00
1. 01	Model 4 BPCI Capital DRG other than	outlier			0	1
2.00	Capital DRG outlier payments				0	
2. 01 3. 00	Model 4 BPCI Capital DRG outlier pa Total inpatient days divided by num		porting ported (see ins	tructions)	0 12. 87	2. 01 3. 00
4. 00	Number of interns & residents (see		portrig perrod (see ris	tructrons)	0.00	1
5. 00	Indirect medical education percenta				0.00	
6. 00	Indirect medical education adjustme		sum of lines 1 and 1.0	1, columns 1 and	0	6.00
	1.01)(see instructions)					
7. 00	OD Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)				0. 00	7.00
8.00						8.00
9.00						9. 00
10.00						10.00
11.00	Disproportionate share adjustment ( Total prospective capital payments				0 208, 200	
12. 00	Total prospective capital payments	(See Thistructions)			208, 200	12.00
					1. 00	
	PART II - PAYMENT UNDER REASONABLE					
1.00	Program inpatient routine capital c				0	
2.00	Program inpatient ancillary capital				0	
3. 00 4. 00						3.00
4. 00 5. 00	Total inpatient program capital cos	,			0	
3.00	Total Tripatifent program capital cos	it (IIIIe 3 X IIIIe 4)			U	3.00
					1. 00	
	PART III - COMPUTATION OF EXCEPTION					
1. 00	Program inpatient capital costs (se				0	1.00
2.00	Program inpatient capital costs for		ces (see instructions)		0	2.00
3. 00 4. 00	Net program inpatient capital costs				0 0. 00	3. 00 4. 00
4. 00 5. 00	Applicable exception percentage (se Capital cost for comparison to paym				0.00	5.00
6. 00	Percentage adjustment for extraordi		nstructions)		0.00	
7.00						

0

0

0

0

0 12.00

0 14.00

0 15.00

0 16.00

0 17.00

7.00

8.00

9.00

10.00

11.00

0 13.00

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

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)

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

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

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

Capital minimum payment level (line 5 plus line 7)

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

17.00 Current year exception offset amount (see instructions)

Current year operating and capital costs (see instructions)

Worksheet L, Part III, line 14)

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

Current year allowable operating and capital payment (see instructions)

7.00

8.00

9.00

10.00

12.00

13.00

14.00

15.00

16.00