(5) Amended

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0146 Worksheet S Peri od: From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/18/2023 11:21 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/18/2023 Time: 11:21 am] Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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 01/01/2022 and ending 12/31/2022 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 1 | | | ELECTRONI C | | | | |
|---|--|-----------------------------------|---|---|---|--|--|--|
| | | | | SIGNATURE STATEMENT | | | | |
| 1 | Jeanne 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 | | | |

| | | Title XVIII | | | | |
|-------------------------------------|---|--------------------------------------|----------|---------|-----------|---------|
| | Title V | Part A | Part B | HIT | Title XIX | |
| | 1. 00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| PART III - SETTLEMENT SUMMARY | | | | | | |
| HOSPI TAL | 0 | 43, 432 | -39, 750 | 0 | 0 | 1.00 |
| SUBPROVI DER - I PF | 0 | 0 | 0 | | 0 | 2.00 |
| SUBPROVI DER - I RF | 0 | 0 | 0 | | 0 | 3.00 |
| SWING BED - SNF | 0 | 0 | 0 | | 0 | 5.00 |
| SWING BED - NF | 0 | | | | 0 | 6.00 |
| SKILLED NURSING FACILITY | 0 | 0 | 0 | | 0 | 7.00 |
| NURSING FACILITY | 0 | | | | 0 | 8.00 |
| HOME HEALTH AGENCY I | 0 | 0 | 0 | | 0 | 9.00 |
| RURAL HEALTH CLINIC I | 0 | | 0 | | 0 | 10.00 |
| FEDERALLY QUALIFIED HEALTH CENTER I | 0 | | 0 | | 0 | 11.00 |
| CMHC I | 0 | | 0 | | 0 | 12.00 |
| TOTAL | 0 | 43, 432 | -39, 750 | 0 | 0 | 200.00 |
| H | HOSPITAL SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IRF SWING BED - SNF SWING BED - NF SKILLED NURSING FACILITY NURSING FACILITY HOME HEALTH AGENCY I RURAL HEALTH CLINIC I FEDERALLY QUALIFIED HEALTH CENTER I CMHC I TOTAL | 1.00 PART III - SETTLEMENT SUMMARY | Title V | Title V | Title V | Title V |

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The 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 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.

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0146 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/18/2023 11:21 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 Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 COMMUNITY 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 17.00 Hospital -Based (CMHC) I 17.00 17. 10 Hospital -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) 01/01/2022 12/31/2022 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.

Health Financial Systems 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 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/18/2023 11:21 am In-State In-State Out-of Out-of Medi cai d 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 96 52 987 67 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. 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 01/01/2022 12/31/2022 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 45.00 Ν with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν N 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.

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

| Heal th | Financial Systems | COMMUNITY HOS | SPITAL OF NOBLE CTY, | INC | In Lie | u of Form CMS-2 | 2552-10 |
|---------|--|-----------------------|-----------------------|--|--|---|---------|
| HOSPI T | AL AND HOSPITAL HEALTH CARE COMP | LEX IDENTIFICATION DA | ATA Provider Co | F | eriod: rom 01/01/2022 o 12/31/2022 | Worksheet S-2 Part I Date/Time Pre 5/18/2023 11: | pared: |
| | | | <u> </u> | Unwei ghted | Unwei ghted | Ratio (col. | |
| | | | | FTEs Nonprovider Site | FTEs in Hospital | 1/ (col. 1 + col. 2)) | |
| | | 1.00 | 2. 00 | 3. 00 | | | |
| | Section 5504 of the ACA Base Yea period that begins on or after J | | | -This base year | ris your cost | reporting | |
| 64.00 | Enter in column 1, if line 63 is | yes, or your facili | ty trained residents | 0.00 | 0.00 | 0. 000000 | 64. 00 |
| | in the base year period, the numeresident FTEs attributable to ro | | | | | | |
| | settings. Enter in column 2 the | number of unweighte | d non-primary care | | | | |
| | resident FTEs that trained in yo of (column 1 divided by (column | | | | | | |
| | 2. (ee. a | Program Name | Program Code | Unwei ghted | Unwei ghted | Ratio (col. | |
| | | | | FTEs Nonprovi der | FTEs in Hospital | 3/ (col. 3 + col. 4)) | |
| | | | | Si te | noop: tai | | |
| 4E 00 | Enter in column 1 if line 42 | 1. 00 | 2. 00 | 3.00 | 4. 00 | 5.00 | 4E 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 | Ratio (col. 1/ (col. 1 + col. 2)) | 65. 00 |
| | Section 5504 of the ACA Current | Year FTE Residents i | n Nonprovider Setting | 1.00 | 2.00 For cost report | 3.00 | |
| | beginning on or after July 1, 20 | 010 | | | | | |
| 66. 00 | Enter in column 1 the number of FTEs attributable to rotations o | | | 0.00 | 0.00 | 0. 000000 | 66.00 |
| | Enter in column 2 the number of FTEs that trained in your hospit | | | | | | |
| | (column 1 divided by (column 1 + | | | | | | |
| | | Program Name | Program Code | Unwei ghted FTEs | Unweighted FTEs in | Ratio (col. 3 + | |
| | | | | Nonprovi der | Hospi tal | col . 4)) | |
| | | 1.00 | 2.00 | Si te | 1.00 | F 00 | |
| 67. 00 | Enter in column 1, the program | 1. 00 | 2. 00 | 3.00 | 4. 00 | 5. 00 0. 000000 | 67.00 |
| | name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) | | | | | | |

| Heal th | Financial Systems COMMUNITY HOSPITA | L OF NOBLE CTY, | I NC | In | Lieu | of Fori | m CMS-2 | 2552-10 |
|---------|---|---|---|--------------------------------------|-----------|---|--------------------------------|------------------|
| | TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provi der CC | | Period: From 01/01/ To 12/31/ | 2022 | Workshe Part I Date/Ti 5/18/20 | et S-2 me Pre | pared: |
| | | | | | | 1. C | 00 | |
| 68.00 | Direct GME in Accordance with the FY 2023 IPPS Final Rule For a cost reporting period beginning prior to October 1, MAC to apply the new DGME formula in accordance with the (August 10, 2022)? | 2022, di d you o | btain permis | sion from yo | | N | | 68.00 |
| | | | | _ | 1. 00 | 2. 00 | 3. 00 | - |
| | Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), | or does it cont | ain an IPF s | ubprovi der? | N | | | 70.0 |
| | Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an apprecent cost report filed on or before November 15, 2004? 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Column 3: If column 2 is Y, indicate which program year b (see instructions) Inpatient Rehabilitation Facility PPS | Enter "Y" for y y train residents ? Enter "Y" for y | res or "N" fo in a new te res or "N" fo | r no. (see achi ng r no. | N | N | 0 | 71.00 |
| 75. 00 | Is this facility an Inpatient Rehabilitation Facility (IF | RF), or does it c | ontain an IR | F | N | | | 75.00 |
| | subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an apprecent cost reporting period ending on or before November no. Column 2: Did this facility train residents in a new CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for indicate which program year began during this cost report | 15, 2004? Enter teaching program no. Column 3: If | "Y" for yes in accordan column 2 is | or "N" for ce with 42 Y, | | | 0 | 76. 00 |
| | | | | | - | 1. C | 10 | |
| | Long Term Care Hospital PPS | | | | | 1. 0 | 10 | |
| | Is this a long term care hospital (LTCH)? Enter "Y" for Is this a LTCH co-located within another hospital for par "Y" for yes and "N" for no. TEFRA Providers | | | ng period? E | inter | N N | | 80.00 81.00 |
| | Is this a new hospital under 42 CFR Section §413.40(f)(1) Did this facility establish a new Other subprovider (excl §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. | | | | no. | N | | 85. 00 86. 00 |
| 87. 00 | Is this hospital an extended neoplastic disease care hosp 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. | oital classified | under sectio | n | | N | | 87.00 |
| | | | | Approved Permane Adjustme (Y/N) 1.00 | nt ent | Number Appro Permai Adjusti 2.0 | oved nent ments | |
| | Column 1: Is this hospital approved for a permanent adjust amount per discharge? Enter "Y" for yes or "N" for no. If 89. (see instructions) Column 2: Enter the number of approved permanent adjustme | f yes, complete c | | ne | | | 0 | 88.00 |
| | | | Wkst. A Lin No. | Date | ve | Appro Permai Adjust Amount Discha | nent tment t Per arge | |
| 89. 00 | Column 1: If line 88, column 1 is Y, enter the Worksheet | A line number | 1. 00 | 2. 00 | | 3. C | | 89.0 |
| _ /. 00 | on which the per discharge permanent adjustment approval Column 2: Enter the effective date (i.e., the cost report | was based. | | | | | J | 57. 5 |

| stems | COMMUNITY HOSPITAL OF | NOBLE CTY, INC | In Lieu | of Form CMS-2552-10 |
|-------|-----------------------|----------------|---------|---------------------|
| | | | | |

| Health Financial Systems COMMUNITY HOSPITAL OF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provi der C | CN: 15-0146 P | eri od: | worksheet S | |
|---|---|---|--------------------------------|---------------------|--------------------|
| | | | rom 01/01/2022 o 12/31/2022 | | |
| | | | V | 5/18/2023 1 XI X | 1:21 am |
| | | | 1. 00 | 2. 00 | |
| 98.00 Does title V or XIX follow Medicare (title XVIII) for the interest stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for column 1 for title V, and in column 2 for title XIX. | | | Y | Υ | 98.00 |
| 98.01 Does title V or XIX follow Medicare (title XVIII) for the rep C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for tit title XIX. | | | Y | Y | 98.0 |
| Does title V or XIX follow Medicare (title XVIII) for the cal bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or for title V, and in column 2 for title XIX. | | | Y | Υ | 98. 02 |
| 98.03 Does title V or XIX follow Medicare (title XVIII) for a criti reimbursed 101% of inpatient services cost? Enter "Y" for yes | | | N | N | 98. 03 |
| for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH routpatient services cost? Enter "Y" for yes or "N" for no in | | | N | N | 98.04 |
| in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add bac Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co | | | Y | Υ | 98. 0 |
| column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost r Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX. | | | Y | Υ | 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-i for outpatient services? (see instructions) | inclusive met | chod of payment | N : | | 105. 00 106. 00 |
| 107.00 Column 1: If line 105 is Y, is this facility eligible for costraining 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 yapproved medical education program in the CAH's excluded IPF | 1. (see ins you train I&F | structions) Rs in an | | | 107.00 |
| Enter "Y" for yes or "N" for no in column 2. (see instruction 108.00 Is this a rural hospital qualifying for an exception to the CCFR Section §412.113(c). Enter "Y" for yes or "N" for no. | N | | 108.00 | | |
| | Physi cal | Occupati onal | Speech | Respi ratory | /_ |
| 109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. | 1. 00 N | 2. 00 | 3. 00 | 4.00 | 109.00 |
| | | | | 1. 00 | |
| 110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ | Y" for yes or | "N" for no. I | f yes, | N | 110. 0 |
| | | | 1.00 | 2. 00 | |
| 111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for additional for tele-health services. | st reporting Iumn 1 is Y, ticipating ir | period? Enter enter the column 2. | N N | 2.00 | 111.00 |
| por tere meditir est vreesi | | | | | |
| 112.00 Did this hospital participate in the Pennsylvania Rural Healt | th Model | 1.00 N | 2. 00 | 3. 00 | 112.00 |
| (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If col "Y", enter in column 2, the date the hospital began participa demonstration. In column 3, enter the date the hospital ceas participation in the demonstration, if applicable. 113.00 Did this hospital participate in the Community Health Access | porting lumn 1 is ating in the sed | IN . | | | 113. 00 |
| Transformation (CHART) model for any portion of the current of reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information | | | | | |
| 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93" for short term hospital or "98" percent for long term care (i psychiatric, rehabilitation and long term hospitals providers the definition in CMS Pub.15-1, chapter 22, §2208.1. | , or E only) 3" percent includes | N | | | 0115.00 |
| the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y" 1 "N" for no. | for yes or | N | | | 116.00 |
| | | l v | 1 | | 117.00 |
| 117.00 Is this facility legally-required to carry malpractice insura "Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claims-made or occurrence poli | | Y | | | 117.00 |

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0146 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/18/2023 11:21 am Premi ums Losses Insurance 1.00 2.00 3.00 118.01 List amounts of malpractice premiums and paid losses: 91, 499 0118.01 1.00 2.00 118.02 Are mal practice premiums and paid losses reported in a cost center other than the 118. 02 Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 119.00 DO NOT USE THIS LINE 119 00 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA Ν 120.00 §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable devices charged to 121.00 patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the 122.00 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included. 123.00 Did the facility and/or its subproviders (if applicable) purchase professional 123.00 services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no. Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes Ν 125.00 and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 of this is a Medicare-certified kidney transplant program, enter the certification date 126,00 in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare-certified heart transplant program, enter the certification date 127.00 in column 1 and termination date, if applicable, in column 2. 128.00|f this is a Medicare-certified liver transplant program, enter the certification date 128.00 in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare-certified lung transplant program, enter the certification date 129.00 in column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare-certified pancreas transplant program, enter the certification 130.00 date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare-certified intestinal transplant program, enter the certification 131.00 date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare-certified islet transplant program, enter the certification date 132.00 in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved 133 00 134.00 If this is a hospital-based organ procurement organization (0P0), enter the 0P0 number 134.00 in column 1 and termination date, if applicable, in column 2 ALL Providers 140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, 15H032 140.00 chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions) 3.00 1.00 2.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number. 141. 00 Name: PARKVIEW HEALTH SYSTEM, INC. Contractor's Name: WISCONSIN PHYSICIAN Contractor's Number: 08101 141.00 SERVI CES 142.00 Street: 10501 CORPORATE DRIVE PO Box: 5600 142.00 143.00 Ci ty: FORT WAYNE Zip Code: 46845-1700 143.00 State: ΙN 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144.00 1.00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is 145.00 no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.

| HOSPITAL AND HOSPITAL HEALTH CARE COMPL | EX IDENTIFICATION DATA | Provi der C | | | od: 01/01/2022 12/31/2022 | Worksheet S- Part I Date/Time Pr 5/18/2023 11 | epared |
|---|--|--|--------------------------------------|--------------|--|--|--------------------|
| | | | | | | 1. 00 | - |
| 147.00Was there a change in the statist | ical hasis? Enter "V" fo | or ves or "N" for | - no | | | 1.00 N | 147.0 |
| 148.00 Was there a change in the order of | | | | | | N | 148. 0 |
| 149.00Was there a change to the simplif | | | | for no. | | N | 149.0 |
| · · · · · · · · · · · · · · · · · · · | | Part A | Part | | Title V | Title XIX | |
| | | 1. 00 | 2. 00 | | 3. 00 | 4. 00 | 7 |
| Does this facility contain a provor charges? Enter "Y" for yes or | | | om the app | lication | of the low | | |
| 155. 00 Hospi tal | | N | N | | N | N | 155. C |
| 56.00 Subprovi der - IPF | | N | N | | N | N | 156.0 |
| 57.00 Subprovi der - IRF | | N | N | | N | N | 157. 0 |
| 58. 00 SUBPROVI DER | | | | | | | 158. 0 |
| 59. 00 SNF | | N | N | | N | N | 159. (|
| 60. 00 HOME HEALTH AGENCY | | N | l N | | N | N | 160. (|
| 61. 00 CMHC | | | l N | | N | N | 161. (|
| 61. 10 CORF | | | N N | | N | N | 161. 1 |
| Market | | | | | | 1. 00 | |
| Multicampus 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. | ampus hospital that has | one or more camp | ouses in d | i fferent | CBSAs? | N | 165.0 |
| , | Name | County | State | Zip Cod | le CBSA | FTE/Campus | |
| | 0 | 1. 00 | 2.00 | 3.00 | 4. 00 | 5. 00 | |
| 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) | | | | | | 0.0 | 0166. |
| | | | | | | 1. 00 | |
| Health Information Technology (HI | T) incentive in the Ame | erican Recovery a | nd Rei nves | tment Ac | t | Υ | |
| 167.00 is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 168.00 if this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the | | | | | | | 167. 168. |
| 68.00 If this provider is a CAH (line 1 | 05 is "Y") and is a mea | ningful user (lir | ne 167 is | Y), en | ter the | | 1 |
| 68.00 If this provider is a CAH (line 1 reasonable cost incurred for the 68.01 If this provider is a CAH and is | 05 is "Y") and is a mea HIT assets (see instruc not a meaningful user, | ningful user (lir tions) does this provide | er qualify | for a h | | | 168. |
| 68.00 If this provider is a CAH (line 1 reasonable cost incurred for the 68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful | 05 is "Y") and is a mea HIT assets (see instruc not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") | ningful user (lir tions) does this provide "N" for no. (see | er qualify instructi | for a hoons) | ardshi p | 9. 9 | |
| 68.00 If this provider is a CAH (line 1 reasonable cost incurred for the 68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) | 05 is "Y") and is a mea HIT assets (see instruc not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") | ningful user (lir tions) does this provide "N" for no. (see | er qualify instructi | for a hons) | ardshi p , enter the | | 168. (99169. (|
| 68.00 If this provider is a CAH (line 1 reasonable cost incurred for the 68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful | 05 is "Y") and is a mea HIT assets (see instruc not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") | ningful user (lir tions) does this provide "N" for no. (see | er qualify instructi | for a hons) | ardshi p | 9. 9 Endi ng 2. 00 | |
| 68.00 If this provider is a CAH (line 1 reasonable cost incurred for the 68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful | 05 is "Y") and is a mea HIT assets (see instruc not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons) | ningful user (lir tions) does this provide "N" for no. (see and is not a CAH | er qualify instructi (line 105 | for a hons) | ardshi p , enter the Begi nni ng | Endi ng | |

171.00|fline 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)

1.00

Ν

2.00

0171.00

| PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions) 1.00 Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation. | | Financial Systems COMMUNITY HOSPITAL OF NO AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | | CCN: 15-0146 | Peri od: From 01/01/2022 To 12/31/2022 | | 2 epared: |
|--|------|--|---------------------------------|----------------|--|-------------|--------------|
| PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX RELIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions) 2.00 Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions) 2.00 Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3. "V" for voluntary or "I" for involuntary. 1.00 1.00 2.00 3.00 1.00 1.00 2.00 3.00 1.00 2.00 3.00 1.00 2.00 3.00 Financial staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) 1.00 2.00 3.00 7.00 1.00 2.00 3.00 1.00 2.00 3.00 1.00 2.00 3.00 1.00 2.00 3.00 3.00 4.00 Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 3.00 Approved Educational Activities 5.00 Approved Educational Activities 3.00 Are costs claimed for Allied Heal th Programs? If "Y" see Instructions. Are costs claimed for Interns and Resident KME program in Internet of the programs and/or allied heal th programs approved and/or renewed during the cost cost claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions. 3.00 3.00 4 | | | | | Y/N | | |
| General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation Has the provider changed ownership i mmediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions) V/N | | | | | 1. 00 | 2. 00 | |
| Has the provider changed ownership immediately prior to the beginning of the cost N reporting period? If yes, enter the date of the change in column 2. (see instructions) N | | General Instruction: Enter Y for all YES responses. Enter N for mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS | | | er all dates in | the | |
| reporting period? If yes, enter the date of the change in column 2. (see instructions) | | | ni nni na of | the cost | N | | 1.0 |
| Mas the provider terminated participation in the Medicare Program? If 1.00 2.00 3.00 3.00 1.00 2.00 3.00 | | | | | | | '.' |
| Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. 1.00 Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) V/N Type | | | • | | | V/I | |
| yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary, or "I" for involuntary, or "I" for involuntary, or "I" for involuntary, or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) VN | | | | | 2. 00 | 3. 00 | |
| contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) V/N Type Date 1.00 2.00 3.00 | | yes, enter in column 2 the date of termination and in column $\tilde{3}$, voluntary or "I" for involuntary. | "V" for | | | | 2. |
| Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. .00 Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation. Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved Rad Debts Is the provider seeking reimbursement for bad debts? If yes, see instructions. Y/N 1.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting N | | contracts, with individuals or entities (e.g., chain home officer medical supply companies) that are related to the provider conficers, medical staff, management personnel, or members of the of directors through ownership, control, or family and other si | ces, drug or its ne board | N | | | 3. (|
| Financial Data and Reports 1.00 2.00 3.00 | | Total one in port (coo Theth detrone) | | Y/N | Type | Date | |
| Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation. Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program? On Are costs claimed for Allied Health Programs? If "Y" see instructions. Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions. On Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions. On Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions. On Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions. Do Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions. Bad Debts Is the provider seeking reimbursement for bad debts? If yes, see instructions. Y If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting | | | | 1.00 | | 3. 00 | |
| those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper | 00 | Column 1: Were the financial statements prepared by a Certific Accountant? Column 2: If yes, enter "A" for Audited, "C" for Cor "R" for Reviewed. Submit complete copy or enter date available column 3. (see instructions) If no, see instructions. | Compiled, ole in | | A | 03/24/2022 | 4.0 |
| Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions. Bad Debts 2.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. Y/N 1.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting | 00 | | | N | | | 5. |
| Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions. Bad Debts Is the provider seeking reimbursement for bad debts? If yes, see instructions. Y/N 1.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting | | | | | | Legal Oper. | |
| Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. N Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions. N Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved N Teaching Program on Worksheet A? If yes, see instructions. Y/N 1.00 Bad Debts Is the provider seeking reimbursement for bad debts? If yes, see instructions. Y If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting | ı | Approved Educational Activities | | | 1. 00 | 2.00 | - |
| Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved N Teaching Program on Worksheet A? If yes, see instructions. Bad Debts Is the provider seeking reimbursement for bad debts? If yes, see instructions. Y/N 1.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting | 00 | Column 1: Are costs claimed for a nursing program? Column 2: | If yes, i | s the provide | er N | | 6. (|
| Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions. 0.00 Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions. 1.00 Are GME cost directly assigned to cost centers other than I & R in an Approved Notation and Program on Worksheet A? If yes, see instructions. Y/N | 00 | Were nursing programs and/or allied health programs approved ar | | ewed during th | | | 7. (8. (|
| 0.00 Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions. 1.00 Are GME cost directly assigned to cost centers other than I & R in an Approved N Teaching Program on Worksheet A? If yes, see instructions. Y/N 1.00 Bad Debts 2.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. Y Is the provider seeking reimbursement for bad debts of lection policy change during this cost reporting N | 00 | Are costs claimed for Interns and Residents in an approved grad | duate medi | cal education | n N | | 9. (|
| 1.00 Are GME cost directly assigned to cost centers other than I & R in an Approved N Teaching Program on Worksheet A? If yes, see instructions. Y/N 1.00 | . 00 | Was an approved Intern and Resident GME program initiated or re | enewed in | the current | N | | 10.0 |
| Y/N 1.00 Bad Debts 2.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. Y 3.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting N | . 00 | Are GME cost directly assigned to cost centers other than I & F | R in an Ap | proved | N | | 11. (|
| Bad Debts 2.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 3.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting N | | | | | | | |
| 3.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting N | | | | | | | |
| [period: ii yes, Submit Copy. | . 00 | If line 12 is yes, did the provider's bad debt collection police | | | cost reporting | | 12. 13. |
| 4.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see N instructions. | . 00 | If line 12 is yes, were patient deductibles and/or coinsurance | amounts v | vaived? If yes | s, see | N | 14. (|

| | Bed Complement | | | | | | | |
|--------|--|----------------|----------------|-----------|------------|--------|--|--|
| 15.00 | Did total beds available change from the prior cost report | ing period? If | yes, see instr | ructions. | N | 15.00 | | |
| | | Par | t A | Par | t B | | | |
| | | Y/N | Date | Y/N | Date | | | |
| | | 1. 00 | 2. 00 | 3. 00 | 4. 00 | | | |
| | PS&R Data | | | | | | | |
| 16.00 | Was the cost report prepared using the PS&R Report only? | 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 | | Y | 05/02/2022 | Υ | 05/02/2022 | 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 | , , , , , , , , , , , , , , , , , , , | N | | Y | | 18. 00 | | |
| | Report data for additional claims that have been billed | | | | | | | |
| | but are not included on the PS&R Report used to file this | | | | | | | |
| | cost report? If yes, see instructions. | | | | | | | |
| 19. 00 | , | N | | N | | 19. 00 | | |
| | Report data for corrections of other PS&R Report | | | | | | | |
| | information? If yes, see instructions. | | | | | | | |

| Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lie | eu of Form CMS- | -2552-10 | | | | | | |
|--|-----------------|----------|--|--|--|--|--|--|
| HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0146 Period: | Worksheet S-2 | | | | | | | |
| From 01/01/2022 To 12/31/2022 | | enared· | | | | | | |
| | 5/18/2023 11 | | | | | | | |
| Description Y/N | Y/N | | | | | | | |
| 20.00 If line 16 or 17 is yes, were adjustments made to PS&R N | 3. 00 N | 20.00 | | | | | | |
| Report data for Other? Describe the other adjustments: | 14 | 20.00 | | | | | | |
| Y/N Date Y/N | Date | | | | | | | |
| 1.00 2.00 3.00 | 4.00 | 04.00 | | | | | | |
| 21.00 Was the cost report prepared only using the provider's N N records? If yes, see instructions. | | 21.00 | | | | | | |
| | 1. 00 | | | | | | | |
| COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) | 1.00 | | | | | | | |
| Capital Related Cost | | | | | | | | |
| 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions | | 22.00 | | | | | | |
| 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions. | | 23. 00 | | | | | | |
| 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? | | 24.00 | | | | | | |
| If yes, see instructions 25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see | | 25.00 | | | | | | |
| instructions. | | 25.00 | | | | | | |
| 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. | | 26. 00 | | | | | | |
| 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit | | 27. 00 | | | | | | |
| COPY. | | | | | | | | |
| 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting | | 28. 00 | | | | | | |
| period? If yes, see instructions. | | | | | | | | |
| 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions | | 29. 00 | | | | | | |
| 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see | | | | | | | | |
| instructions. | | | | | | | | |
| 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. | | 31.00 | | | | | | |
| Purchased Servi ces | | | | | | | | |
| 32.00 Have changes or new agreements occurred in patient care services furnished through contractual | | 32. 00 | | | | | | |
| arrangements with suppliers of services? If yes, see instructions. 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? I | ļ f | 33.00 | | | | | | |
| no, see instructions. | | | | | | | | |
| Provi der-Based Physi ci ans | 4 | 24.00 | | | | | | |
| 34.00 Were services furnished at the provider facility under an arrangement with provider-based physicians If yes, see instructions. | 1 | 34.00 | | | | | | |
| 35.00 If fine 34 is yes, were there new agreements or amended existing agreements with the provider-based | | 35. 00 | | | | | | |
| physicians during the cost reporting period? If yes, see instructions. Y/N | Dato | | | | | | | |
| 1.00 | 2.00 | | | | | | | |
| Home Office Costs | 1 | | | | | | | |
| 36.00 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 prepared by the home office? If yes, see instructions. | | 37.00 | | | | | | |
| 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of | | 38.00 | | | | | | |
| the provider? If yes, enter in column 2 the fiscal year end of the home office. | | 20.00 | | | | | | |
| 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. | | 39. 00 | | | | | | |
| 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see | | 40.00 | | | | | | |
| i nstructi ons. | | | | | | | | |
| 1.00 | . 00 | | | | | | | |
| Cost Report Preparer Contact Information | | 1 | | | | | | |
| 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, | | 41.00 | | | | | | |
| respectively. 42.00 Enter the employer/company name of the cost report PARKVIEW HEALTH SYSTEM, INC. | | 42.00 | | | | | | |
| preparer. | DADIMI EW CO. | | | | | | | |
| 43.00 Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively. | ºPAKKVIEW.COM | 43.00 | | | | | | |

| Heal th | Financial Systems | COMMUNITY HOSPITAL | OF I | NOBLE CTY, INC | | | In Lieu | of Form CMS- | 2552-10 |
|---------|--|--------------------|-------|----------------|---------|------|------------|---------------|---------|
| HOSPI T | AL AND HOSPITAL HEALTH CARE REIMBURSEMEN | T QUESTI ONNAI RE | | Provi der CCN: | 15-0146 | Peri | | Worksheet S-2 | 2 |
| | | | | | | From | | | nared: |
| | | | | | | 10 | 12/31/2022 | 5/18/2023 11: | 21 am |
| | | | | | | | | | |
| | | | | 3. 00 | | | | | |
| | Cost Report Preparer Contact Information | ١ | | | | | | | |
| 41.00 | Enter the first name, last name and the | title/position | DI RI | ECTOR REIMBURS | EMENT | | | | 41.00 |
| | held by the cost report preparer in col | umns 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 add | | | | | | | | 43.00 |
| | report preparer in columns 1 and 2, res | pecti vel y. | | | | | | | |

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0146

| | | | | | | I/P Days / O/P Visits / | |
|------------------|---|-------------------------|-------------|-----------------------|-----------|----------------------------|------------------|
| | | | | | | Trips | |
| | Component | Worksheet A Line No. | No. of Beds | Bed Days Available | CAH Hours | Title V | |
| | | 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 Subprovi der | | | | | | 3.00 |
| 4.00 | HMO I RF Subprovi der | | | | | | 4.00 |
| 5.00 | Hospital Adults & Peds. Swing Bed SNF | | | | | 0 | 5.00 |
| 6. 00 | Hospital Adults & Peds. Swing Bed NF | | 24 | 11 215 | 0.00 | 0 | 6.00 |
| 7. 00 | Total Adults and Peds. (exclude observation beds) (see instructions) | | 31 | 11, 315 | 0. 00 | U | 7. 00 |
| 8. 00 | INTENSIVE CARE UNIT | 31.00 | 0 | 0 | 0. 00 | 0 | 8. 00 |
| 9. 00 | CORONARY CARE UNIT | 32.00 | | _ | 0.00 | _ | 9.00 |
| 10. 00 | BURN INTENSIVE CARE UNIT | 33.00 | | _ | 0.00 | | 10.00 |
| 11. 00 | SURGICAL INTENSIVE CARE UNIT | 34.00 | | _ | 0.00 | | 11.00 |
| 12. 00 | OTHER SPECIAL CARE (SPECIFY) | 34.00 | | J | 0.00 | Ŭ | 12.00 |
| 13. 00 | NURSERY | 43.00 | | | | 0 | 13.00 |
| 14. 00 | Total (see instructions) | 10.00 | 31 | 11, 315 | 0. 00 | | 14. 00 |
| 15. 00 | CAH visits | | | 11,010 | 0.00 | Ö | 15. 00 |
| 16. 00 | SUBPROVIDER - IPF | 40.00 | 0 | 0 | | 0 | 16.00 |
| 17. 00 | SUBPROVIDER - IRF | 41.00 | 0 | 0 | | 0 | 17.00 |
| 18.00 | SUBPROVI DER | | | | | | 18.00 |
| 19.00 | SKILLED NURSING FACILITY | 44.00 | 0 | 0 | | 0 | 19.00 |
| 20.00 | NURSING FACILITY | 45. 00 | 0 | 0 | | 0 | 20.00 |
| 21.00 | OTHER LONG TERM CARE | 46. 00 | 0 | 0 | | | 21.00 |
| 22. 00 | HOME HEALTH AGENCY | 101.00 | | | | 0 | 22. 00 |
| 23.00 | AMBULATORY SURGICAL CENTER (D. P.) | 115. 00 | | | | | 23.00 |
| 24.00 | HOSPI CE | 116. 00 | | 0 | | | 24. 00 |
| 24. 10 | HOSPICE (non-distinct part) | 30.00 | | | | | 24. 10 |
| 25. 00 | CMHC - CMHC | 99. 00 | | | | 0 | 25. 00 |
| 25. 10 | CMHC - CORF | 99. 10 | | | | 0 | 25. 10 |
| 26. 00 | RURAL HEALTH CLINIC | 88. 00 | | | | 0 | 26.00 |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER | 89. 00 | | | | 0 | 26. 25 |
| 27. 00 | Total (sum of lines 14-26) | | 31 | | | | 27. 00 |
| 28. 00 | Observation Bed Days | | | | | 0 | 28. 00 |
| 29. 00 | Ambulance Trips | | | | | | 29. 00 |
| 30. 00 31. 00 | Employee discount days (see instruction) Employee discount days - LRF | | | | | | 30. 00 31. 00 |
| 32.00 | Labor & delivery days (see instructions) | | 0 | 0 | | | 32.00 |
| 32. 00 | Total ancillary labor & delivery room | | U | U | | | 32.00 |
| 32.01 | outpatient days (see instructions) | | | | | | 32.01 |
| 33. 00 | | | | | | | 33. 00 |
| 33. 01 | LTCH site neutral days and discharges | | | | | | 33. 01 |
| | Temporary Expansion COVID-19 PHE Acute Care | 30.00 | 0 | О | | 0 | |
| 50 | i i i i j i i j i i più i i i i i i i i i i i i i i i i | 23.00 | ١ | ١ | ļ | ı | |

34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0146

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Peri od: Worksheet S-3 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022

5/18/2023 11:21 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, 091 64 4, 710 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 1, 933 1,043 2.00 HMO I RF Subprovi der 3.00 3 00 4.00 0 C 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 0 6.00 C Total Adults and Peds. (exclude observation 1,091 4, 710 7.00 64 7.00 beds) (see instructions) 8.00 INTENSIVE CARE UNIT 0 8.00 9.00 CORONARY CARE UNIT 0 0 0 9.00 10.00 BURN INTENSIVE CARE UNIT 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 32 399 13.00 14.00 Total (see instructions) 1, 091 96 5.109 0.00221.00 14.00 15.00 CAH visits C 0 15.00 16.00 SUBPROVIDER - IPF 0 0 0.00 0.00 16.00 SUBPROVIDER - IRF 0 0 0 0.00 17.00 17.00 0.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 0 0 0 0.00 0.00 19.00 NURSING FACILITY 0.00 20.00 0 0 0.00 20.00 21.00 OTHER LONG TERM CARE 0 0.00 0.00 21.00 HOME HEALTH AGENCY 0 0 0.00 22.00 0 0.00 22.00 AMBULATORY SURGICAL CENTER (D. P.) 0.00 23.00 0.00 23.00 24.00 HOSPI CE 0 0 0 0.00 0.00 24.00 HOSPICE (non-distinct part) 24.10 86 24.10 0.00 25.00 CMHC - CMHC C 0 0.00 25.00 CMHC - CORF 0.00 25. 10 0 0 0 0 0.00 25.10 RURAL HEALTH CLINIC 0.00 26 00 C 0 0 00 26 00 0.00 FEDERALLY QUALIFIED HEALTH CENTER 0 26. 25 C 0.00 26. 25 27.00 Total (sum of lines 14-26) 0.00 221.00 27.00 28.00 Observation Bed Days 1, 119 2,674 28.00 Ambul ance Trips 29 00 0 29 00 Employee discount days (see instruction) 30.00 0 30.00 Employee discount days - IRF 0 31.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room 92 32.00 32.00 0 67 32.01 32.01 0 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 LTCH site neutral days and discharges 33.01 0 34.00 Temporary Expansion COVID-19 PHE Acute Care

Health Financial SystemsCOMMUNITY HOSHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 15-0146

Peri od: Worksheet S-3 From 01/01/2022 Part I To 12/31/2022 Date/Ti me Prepared: 5/18/2023 11:21 am

| Full 1 Time Equivalents Figurity alents Four time Figurity alents Figurity Figurity alents Figurity alen | | | | | | | 5/18/2023 11: | 21 am |
|--|--------|--|---------|---------|-------------|-----------|---------------|--------|
| Nonpal d Workers Title V Title XVII Title XIX Patients | | | | | Di sch | arges | | |
| Morkers Workers Patt ents | | Component | | Title V | Title XVIII | Title XIX | Total All | |
| PART I - STATISTICAL DATA 1.00 | | • | Workers | | | | Pati ents | |
| 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 8 exclude Swing Bed, Observation Bed and Hospice days) (see Instructions for col. 2 7 for the portion of LDP room available beds) 7 | | | 11. 00 | 12. 00 | 13.00 | 14. 00 | 15. 00 | |
| 8 exclude SWing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LOP room available beds) | | | | | | | | |
| 2.00 HM0 and other (see Instructions) 367 448 2.00 4.00 HM0 IPF Subprovider 4.00 0 3.00 4.00 HM0 IPF Subprovider 5.00 HSD IPF Subprovider 6.00 HSD IPF Subprovider 6.00 HSD ITM Adult s & Peds. Swing Bed SNF 6.00 Hospital Adult s & Peds. Swing Bed NF 7.00 Total Adult sand Peds, (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT SUBJECT CARE UNIT SUBJEC | 1. 00 | 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 | | C | 389 | 23 | 1, 714 | 1.00 |
| 3.00 HMO IPF Subprovi der | 2 00 | | | | 367 | 118 | | 2 00 |
| MMO IRF Subprovider | | | | | 307 | 140 | | |
| 5.00 | | | | | | 0 | | |
| 6. 00 Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) R. 00 | | | | | | ٥ | | |
| 7.00 Total Adults and Peds (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 8.00 0.00 COROMARY CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 11.00 1 | | , , | | | | | | |
| beds) (see instructions) | | | | | | | | |
| 9.00 CORONARY CARE UNIT 10.00 10.00 BURN INTENSIVE CARE UNIT 11.00 | | beds) (see instructions) | | | | | | |
| 10.00 BURN INTENSIVE CARE UNIT | | | | | | | | |
| 11.00 SURGICAL INTENSIVE CARE UNIT | | | | | | | | |
| 12.00 OTHER SPECIAL CARE (SPECIFY) | | 1 | | | | | | |
| 13.00 NURSERY | | | | | | | | |
| 14. 00 Total (see instructions) 0. 00 0 0 0 0 0 15. 00 15. 00 CAH visits 15. 00 CAH visits 0. 00 0 0 0 0 0 0 0 15. 00 17. 00 SUBPROVIDER - IPF 0. 0. 00 0 0 0 0 0 0 17. 00 18. 00 SUBPROVIDER - IRF 0. 0. 00 0 0 0 0 0 0 17. 00 18. 00 SUBPROVIDER 19. 00 SKILLED NURSING FACILITY 0. 00 OVER CARE 19. | | | | | | | | |
| 15. 00 CAH visits | | · · | 0.00 | (| 389 | 23 | 1 714 | |
| 16. 00 SUBPROVI DER - IPF | | , , | 0.00 | | , | | .,, | |
| 17. 00 SUBPROVI DER - IRF | | y and the second | 0.00 | (| ol ol | 0 | 0 | |
| 19. 00 | | 1 | 0.00 | C | o | 0 | | |
| 20.00 NURSING FACILITY 0.00 OTHER LONG TERM CARE 0.00 21.00 22.00 HOME HEALTH AGENCY 0.00 22.00 AMBULATORY SURGICAL CENTER (D.P.) 0.00 23.00 AMBULATORY SURGICAL CENTER (D.P.) 0.00 24.00 HOSPICE (non-distinct part) 24.10 ED. COMPART OF COMPART | 18.00 | SUBPROVI DER | | | | | | 18.00 |
| 21.00 OTHER LONG TERM CARE 0.00 22.00 HOME HEALTH AGENCY 0.00 22.00 23.00 AMBULATORY SURGICAL CENTER (D.P.) 0.00 23.00 HOSPICE 0.00 24.10 HOSPICE 0.00 24.10 HOSPICE 0.00 24.10 HOSPICE 0.00 24.10 CMHC - CMHC 25.00 CMHC - CORF 0.00 25.10 CMHC - CORF 0.00 25.10 CMHC - CORF 0.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 27.00 Doservation Bed Days 29.00 Ambul ance Trips 29.00 Ambul ance Trips 29.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days and discharges 0.00 33.01 LTCH site neutral days and discharges 0.00 0.00 22.00 22.00 23.00 LTCH non-covered days and discharges 0.00 0.00 21.00 22.00 22.00 23.00 LTCH non-covered days and discharges 0.00 0.00 21.00 22.00 22.00 23.00 LTCH non-covered days and discharges 0.00 0.00 23.00 0.00 23.00 LTCH non-covered days and discharges 0.00 0.00 23.00 0.00 24.10 0.00 23.00 24.10 0.00 24.10 0.00 24.10 0.00 24.10 0.00 24.10 0.00 25.10 0.00 25.10 0.00 25.10 0.00 25.10 0.00 25.10 0.00 25.10 0.00 25.10 0.00 25.10 0.00 25.10 0.00 25.10 0.00 25.10 0.00 25.10 0.00 25.10 0.00 26.10 0.00 25.10 0.0 | 19.00 | SKILLED NURSING FACILITY | 0.00 | | | | | 19.00 |
| 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 00 24. 00 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 00 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 01 LTCH site neutral days and discharges | 20.00 | NURSING FACILITY | 0.00 | | | | | 20.00 |
| 23.00 24.00 HOSPICE 0.00 24.10 HOSPICE (non-distinct part) 24.10 25.00 CMHC - CMHC 25.10 26.00 RURAL HEALTH CLINIC 26.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 28.00 Observation Bed Days 29.00 30.00 Employee discount days (see instruction) 29.00 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.00 LTCH non-covered days 0 33.00 LTCH site neutral days and discharges 0 0.00 22.00 23.00 23.00 23.01 CTCH non-covered days 0 33.00 33.01 LTCH site neutral days and discharges 0 0.00 0 | 21.00 | OTHER LONG TERM CARE | 0.00 | | | | 0 | 21.00 |
| 24. 00 HOSPICE | 22.00 | HOME HEALTH AGENCY | 0.00 | | | | | 22.00 |
| 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 00 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 01 LTCH site neutral days and discharges | 23.00 | AMBULATORY SURGICAL CENTER (D. P.) | 0.00 | | | | | 23.00 |
| 25. 00 CMHC - CMHC | 24.00 | HOSPI CE | 0.00 | | | | | 24.00 |
| 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 29. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 01 LTCH site neutral days and discharges | 24. 10 | HOSPICE (non-distinct part) | | | | | | 24. 10 |
| 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 26. 00 26. 25 Total (sum of lines 14-26) 0. 00 28. 00 Observation Bed Days 29. 00 Ambul ance Trips Employee discount days (see instruction) Employee discount days - IRF 20. 00 Employee discount days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) 31. 00 LTCH non-covered days 31. 00 33. 00 LTCH site neutral days and discharges | 25.00 | CMHC - CMHC | 0.00 | | | | | 25.00 |
| 26. 25 27. 00 Total (sum of lines 14-26) | 25. 10 | CMHC - CORF | | | | | | 25. 10 |
| 27.00 Total (sum of lines 14-26) | 26.00 | RURAL HEALTH CLINIC | | | | | | |
| 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 28.00 29.00 30.00 30.00 31.00 31.00 32.01 33.00 33.01 | | FEDERALLY QUALIFIED HEALTH CENTER | | | | | | |
| 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 29.00 30.00 31.00 31.00 32.01 33.00 33.01 | | , | 0.00 | | | | | |
| 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days 33.00 LTCH site neutral days and discharges 30.00 31.00 31.00 31.00 32.00 33.00 33.01 | | 1 | | | | | | |
| 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 31.00 32.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | | | | | | |
| 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 32.00 32.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | | | | | | |
| 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 31.01 LTCH site neutral days and discharges 32.01 outpatient days (see instructions) 33.00 and outpatient days | | 1 1 3 | | | | | | |
| outpati ent days (see i nstructions) 33.00 LTCH non-covered days 33.01 LTCH si te neutral days and discharges 0 33.01 | | | | | | | | |
| 33.01 LTCH site neutral days and discharges 0 33.01 | 32. 01 | | | | | | | 32.01 |
| | 33.00 | LTCH non-covered days | | | 0 | | | 33.00 |
| 34.00 Temporary Expansion COVID-19 PHE Acute Care | | | | | 0 | | | 33. 01 |
| | 34.00 | Temporary Expansion COVID-19 PHE Acute Care | | | | | | 34.00 |

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION COMMUNITY HOSPITAL OF NOBLE CTY, INC
Provider CCN: 15-0146

| | | | | | To | 12/31/2022 | Date/Time Prep 5/18/2023 11: | |
|------------------|---|------------------------|--------------------|-------------------------|-------------------------|--------------------------|---------------------------------|------------------|
| | · | Wkst. A Line Number | Amount Reported | Reclassificat ion of | Adj usted Sal ari es | Paid Hours Related to | Average Hourly Wage | |
| | | Namber | Reported | Sal ari es | (col.2 ± col. | Salaries in | (col. 4 ÷ | |
| | | | | (from Wkst. A-6) | 3) | col. 4 | col. 5) | |
| | PART II - WAGE DATA | 1. 00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | 6. 00 | |
| | SALARI ES | | | | | | | |
| 1. 00 | Total salaries (see instructions) | 200. 00 | 18, 562, 863 | 4, 451, 182 | 23, 014, 045 | 575, 634. 52 | 39. 98 | 1. 00 |
| 2. 00 | Non-physician anesthetist Part | | 0 | О | 0 | 0. 00 | 0. 00 | 2. 00 |
| 3. 00 | Non-physician anesthetist Part | | 0 | О | 0 | 0. 00 | 0. 00 | 3. 00 |
| 4. 00 | Physician-Part A - Administrative | | 43, 333 | О | 43, 333 | 77. 90 | 556. 26 | 4. 00 |
| 4. 01 5. 00 | Physicians - Part A - Teaching Physician and Non | | 0 | 0 | 0 | 0. 00 0. 00 | | 4. 01 5. 00 |
| 6. 00 | Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC | | 0 | 0 | 0 | 0. 00 | 0. 00 | 6. 00 |
| 7. 00 | services Interns & residents (in an | 21. 00 | 0 | 0 | 0 | 0. 00 | 0. 00 | 7. 00 |
| 7. 01 | approved program) Contracted interns and residents (in an approved | | 0 | 0 | 0 | 0. 00 | 0. 00 | 7. 01 |
| 8. 00 | programs) Home office and/or related | | 4, 451, 182 | 0 | 4, 451, 182 | 96, 521. 56 | 46. 12 | 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) OTHER WAGES & RELATED COSTS | | 3, 980, 043 | 157, 777 | 4, 137, 820 | 129, 512. 26 | 31. 95 | 10. 00 |
| 11. 00 | Contract labor: Direct Patient | | 1, 674, 078 | 0 | 1, 674, 078 | 11, 420. 00 | 146. 59 | 11. 00 |
| 12. 00 | Care Contract Labor: Top Level | | 0 | 0 | 0 | 0. 00 | 0. 00 | 12. 00 |
| | management and other management and administrative services | | | | | | | |
| 13. 00 | Contract Labor: Physician-Part | | 0 | О | 0 | 0. 00 | 0. 00 | 13. 00 |
| 14. 00 | A - Administrative Home office and/or related organization salaries and | | 0 | O | 0 | 0. 00 | 0. 00 | 14. 00 |
| 14. 01 | wage-related costs Home office salaries | | 4, 451, 182 | o | 4, 451, 182 | 96, 521. 56 | | 14. 01 |
| 14. 02 15. 00 | Related organization salaries Home office: Physician Part A | | 0 | 0 | 0 | 0. 00 0. 00 | | 14. 02 15. 00 |
| 16. 00 | - Administrative Home office and Contract | | 0 | 0 | 0 | 0. 00 | 0. 00 | 16. 00 |
| 16. 01 | Physicians Part A - Teaching Home office Physicians Part A | | 0 | | 0 | 0. 00 | | |
| | - Teachi ng | | 0 | _ | | | | 16. 01 |
| 16. 02 | Home office contract Physicians Part A - Teaching | | 0 | О | 0 | 0. 00 | 0. 00 | 16. 02 |
| 17 00 | WAGE-RELATED COSTS | | E 010 2EE | | E 010 255 | | | 17 00 |
| | Wage-related costs (core) (see instructions) | | 5, 019, 355 | О | 5, 019, 355 | | | 17. 00 18. 00 |
| 18. 00 | Wage-related costs (other) (see instructions) | | 4.0 | _ | 4 40= === | | | |
| 19. 00 20. 00 | Excluded areas Non-physician anesthetist Part | | 1, 439, 801 0 | 0 | 1, 439, 801 0 | | | 19. 00 20. 00 |
| 21. 00 | Non-physician anesthetist Part | | 0 | 0 | 0 | | | 21. 00 |
| 22. 00 | Physician Part A - Administrative | | 0 | О | 0 | | | 22. 00 |
| 22. 01 | Physician Part A - Teaching | | 0 | 0 | 0 | | | 22. 01 |
| 23. 00 24. 00 | Physician Part B Wage-related costs (RHC/FQHC) | | 0 | | 0 | | | 23. 00 24. 00 |
| 25. 00 | Interns & residents (in an approved program) | | 0 | 0 | 0 | | | 25. 00 |
| 25. 50 | Home office wage-related | | 1, 480, 313 | О | 1, 480, 313 | | | 25. 50 |
| 25. 51 | (core) Related organization | | 0 | 0 | 0 | | | 25. 51 |
| 25. 52 | wage-related (core) Home office: Physician Part A - Administrative - | | 0 | O | 0 | | | 25. 52 |
| | wage-related (core) | | | | | | | |

42.00

Social Service

43.00 Other General Service

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0146 Peri od: Worksheet S-3 From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/18/2023 11:21 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. 3) col. 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 25.53 Home office: Physicians Part A 0 25. 53 - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 2, 154, 028 -2, 154, 028 0.00 0. 00 26.00 27.00 Administrative & General 5.00 847, 881 5, 363, 183 6, 211, 064 106, 179. 85 58. 50 27.00 28.00 0.00 28.00 Administrative & General under 0.00 contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 30.00 Operation of Plant 7.00 385, 727 31, 556 417, 283 12, 039. 34 34. 66 30.00 Laundry & Linen Service 8.00 0.00 31.00 31.00 0.00 32.00 23, 189. 25 Housekeepi ng 9.00 450, 318 36,820 487, 138 21. 01 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 34.00 Dietary 10.00 479, 254 -228, 045 251, 209 11, 097. 15 22. 64 34.00 Dietary under contract (see 35.00 0.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 0 267, 252 267, 252 11, 235. 00 23. 79 36.00 0.00 37.00 Maintenance of Personnel 12.00 0.00 37.00 Nursing Administration 39, 869 51. 24 38.00 38.00 13.00 487, 426 527, 295 10, 290. 25 39.00 Central Services and Supply 14.00 0.00 0.00 39.00 12, 110. 95 59. 94 40.00 Pharmacy 15.00 671,032 54, 889 725, 921 40.00 Medical Records & Medical Records Library 41.00 16.00 0 C 0 0.00 0.00 41.00

0

0

0

0

0

0

0.00

0.00

0.00 42.00

0.00 43.00

17.00

18.00

Total overhead cost (see

instructions)

7.00

47. 74

7.00

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0146 Peri od: Worksheet S-3 From 01/01/2022 To 12/31/2022 Part III Date/Time Prepared: 5/18/2023 11:21 am Worksheet A Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Line Number Reported ion of Sal ari es Related to (col.2 ± col. Salaries in Sal ari es 3) (from col. 4 Worksheet A-6) 1. 00 2.00 3.00 4.00 5.00 6.00 PART III - HOSPITAL WAGE INDEX SUMMARY Net salaries (see 14, 111, 681 4, 451, 182 479, 112. 96 1.00 18, 562, 863 38. 74 1.00 instructions) 2.00 Excluded area salaries (see 3, 980, 043 157, 777 4, 137, 820 129, 512. 26 31.95 2.00 instructions) 3.00 Subtotal salaries (line 1 10, 131, 638 4, 293, 405 14, 425, 043 349, 600. 70 41. 26 3.00 minus line 2) 4.00 6, 125, 260 6, 125, 260 107, 941. 56 4.00 Subtotal other wages & related 56. 75 costs (see inst.) 5.00 Subtotal wage-related costs 6, 499, 668 6, 499, 668 0.00 45.06 5.00 (see inst.) 6.00 Total (sum of lines 3 thru 5) 22, 756, 566 4, 293, 405 27, 049, 971 457, 542. 26 59. 12 6.00

5, 475, 666

3, 411, 496

8, 887, 162

186, 141. 79

In Lieu of Form CMS-2552-10

| Period: | Worksheet S-3 |
| From 01/01/2022 | Part IV |
| To 12/31/2022 | Date/Time Prepared: |
| 5/18/2023 | 11: 21 am Health Financial Systems
HOSPITAL WAGE RELATED COSTS COMMUNITY HOSPITAL OF NOBLE CTY, INC
Provider CCN: 15-0146

| | | 5/18/2023 11: | 21 am |
|--------|---|---------------|--------|
| | | Amount | |
| | | Reported | |
| | | 1. 00 | |
| | PART IV - WAGE RELATED COSTS | | |
| | Part A - Core List | | |
| | RETI REMENT COST | | |
| 1.00 | 401K Employer Contributions | 0 | 1.00 |
| 2.00 | Tax Sheltered Annuity (TSA) Employer Contribution | 391, 034 | 2.00 |
| 3.00 | Nonqualified Defined Benefit Plan Cost (see instructions) | 1, 209, 886 | 3.00 |
| 4.00 | Qualified Defined Benefit Plan Cost (see instructions) | 0 | 4.00 |
| | PLAN ADMINISTRATIVE COSTS (Paid to External Organization) | | |
| 5.00 | 401K/TSA Plan Administration fees | 0 | 5.00 |
| 6.00 | Legal/Accounting/Management Fees-Pension Plan | 2, 854 | 6.00 |
| 7.00 | Employee Managed Care Program Administration Fees | 60, 814 | 7.00 |
| | HEALTH AND INSURANCE COST | | |
| 8.00 | Health Insurance (Purchased or Self Funded) | 0 | 8.00 |
| 8. 01 | Health Insurance (Self Funded without a Third Party Administrator) | 0 | 8. 01 |
| 8. 02 | Health Insurance (Self Funded with a Third Party Administrator) | 2, 480, 825 | 8. 02 |
| 8.03 | Health Insurance (Purchased) | 0 | 8. 03 |
| 9.00 | Prescription Drug Plan | 676, 510 | 9.00 |
| 10.00 | Dental, Hearing and Vision Plan | 78, 334 | 10.00 |
| 11.00 | Life Insurance (If employee is owner or beneficiary) | 15, 224 | 11.00 |
| 12.00 | Accident Insurance (If employee is owner or beneficiary) | 0 | 12.00 |
| 13.00 | Disability Insurance (If employee is owner or beneficiary) | 60, 197 | 13.00 |
| 14.00 | Long-Term Care Insurance (If employee is owner or beneficiary) | 0 | 14.00 |
| 15.00 | 'Workers' Compensation Insurance | 8, 996 | 15.00 |
| 16.00 | Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. | 0 | 16.00 |
| | Noncumul ati ve portion) | | |
| | TAXES | | |
| 17.00 | FICA-Employers Portion Only | 1, 402, 941 | 17.00 |
| 18.00 | Medicare Taxes - Employers Portion Only | 0 | 18.00 |
| 19.00 | Unempl oyment Insurance | 0 | 19. 00 |
| 20.00 | State or Federal Unemployment Taxes | 0 | 20.00 |
| | OTHER | | |
| 21.00 | Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see | 48, 732 | 21.00 |
| | instructions)) | | |
| | Day Care Cost and Allowances | 0 | |
| 23.00 | Tuition Reimbursement | 22, 808 | 23. 00 |
| 24.00 | Total Wage Related cost (Sum of lines 1 -23) | 6, 459, 155 | 24.00 |
| | Part B - Other than Core Related Cost | | |
| 25. 00 | OTHER WAGE RELATED COSTS (SPECIFY) | | 25. 00 |
| | | | |

18.00 Other

0 17.00

0 18.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST Provider CCN: 15-0146 Worksheet S-3 Peri od: From 01/01/2022 To 12/31/2022 Part V Date/Time Prepared: 5/18/2023 11: 21 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: 6, 459, 155 1.00 Total facility's contract labor and benefit cost 1, 674, 078 1.00 Hospi tal 1, 674, 078 6, 459, 155 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 0 4.00 5.00 0 0 5.00 6.00 6.00 0 0 0 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 16. 10 Hospi tal -Based-CMHC 10 17. 00 RENAL DIALYSIS I 0 16. 10

| ı | | | From 01/01/2022 To 12/31/2022 | | pared: | | | | |
|--------|--|--------------------------|----------------------------------|---------------|--------|--|--|--|--|
| 1 | | | | 1.00 | | | | | |
| Į. | Uncompensated and indigent care cost computation | | | | | | | | |
| | Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided | d by line 202 colu | mn 8) | 0. 195354 | 1.00 | | | | |
| | Medicaid (see instructions for each line) | | | | | | | | |
| | Net revenue from Medicaid | | | 4, 602, 156 | 1 | | | | |
| | Did you receive DSH or supplemental payments from Medicaid? | | : -10 | Y Y | 3.00 | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | < zero then enter zero) | e / iiii iidə ədiii əi i | THOS Z drid o, TT | | 0.00 | | | | |
| - | Children's Health Insurance Program (CHIP) (see instructions for ea | ach line) | | | İ | | | | |
| | Net revenue from stand-alone CHIP | , | | 62, 944 | 9.00 | | | | |
| 10.00 | Stand-alone CHIP charges | | | 89, 283 | 10.0 | | | | |
| 11.00 | Stand-alone CHIP cost (line 1 times line 10) | | | 17, 442 | 11.0 | | | | |
| 12. 00 | Difference between net revenue and costs for stand-alone CHIP (line | e 11 minus line 9; | if < zero then | 0 | 12.0 | | | | |
| | enter zero) | | | | | | | | |
| | Other state or local government indigent care program (see instructions for each line) | | | | | | | | |
| | Net revenue from state or local indigent care program (Not included | | | 5, 968, 403 | | | | | |
| | Charges for patients covered under state or local indigent care pro | ogram (Not include | d in lines 6 or | 31, 887, 260 | 14.00 | | | | |
| | 10) | | | 6, 229, 304 | 15 0 | | | | |
| | State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indiger | nt caro program (| ino 15 minus lino | | | | | | |
| | 13; if < zero then enter zero) | int care program (i | THE TO IIITHUS TITLE | 200, 901 | 10.0 | | | | |
| | Grants, donations and total unreimbursed cost for Medicaid, CHIP ar | nd state/Local ind | igent care progra | ms (see | l | | | | |
| | instructions for each line) | na stato, robar rna | gont out o progre | | | | | | |
| | Private grants, donations, or endowment income restricted to fundir | ng charity care | | 0 | 17.0 | | | | |
| 18. 00 | Government grants, appropriations or transfers for support of hospi | ital operations | | 0 | 18.0 | | | | |
| | Total unreimbursed cost for Medicaid , CHIP and state and local inc 8, 12 and 16) | digent care progra | ms (sum of lines | 260, 901 | 19.0 | | | | |
| 1 | | Uni nsured | Insured | Total (col. 1 | | | | | |
| | | pati ents | pati ents | + col . 2) | | | | | |
| | | 1.00 | 2.00 | 3. 00 | | | | | |
| | Uncompensated Care (see instructions for each line) | | | | 4 | | | | |
| | Charity care charges and uninsured discounts for the entire facilit (see instructions) | ty 5, 173, 4 | 1, 427, 731 | 6, 601, 160 | 20.00 | | | | |
| | Cost of patients approved for charity care and uninsured discounts instructions) | (see 1,010,6 | 1, 427, 731 | 2, 438, 381 | 21.00 | | | | |
| | Payments received from patients for amounts previously written off charity care | as | 0 0 | 0 | 22. 00 | | | | |
| | Cost of charity care (line 21 minus line 22) | 1, 010, 6 | 50 1, 427, 731 | 2, 438, 381 | 23.00 | | | | |

imposed on patients covered by Medicaid or other indigent care program?

Total bad debt expense for the entire hospital complex (see instructions)

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

Non-Medicare bad debt expense (see instructions)

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

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

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

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

If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of

0 25.00

3, 846, 735 31.00

26.00

27.00

27.01

28.00

29.00

30.00

5, 782, 046

5, 666, 252

1, 147, 453

3, 585, 834

75, 266

115, 794

25.00

26.00

27.00

stay limit

| NECEA | SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (| JNITY HUSPITAL U | Provi der C | | Peri od: | Worksheet A | 2332-10 |
|--|--|--|--|--|--|--|--|
| The state of the s | | JI EXI ENSES | Trovider C | F | rom 01/01/2022 | | |
| | | | | Ι Τ | Го 12/31/2022 | Date/Time Pre 5/18/2023 11: | epared: |
| | Cost Center Description | Sal ari es | Other | Total (col. 1 | Recl assi fi cat | Reclassi fied | 21 4111 |
| | | | | + col . 2) | ions (See | Trial Balance | |
| | | | | | A-6) | (col. 3 +- | |
| | | | | | | col. 4) | |
| | | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | GENERAL SERVICE COST CENTERS | | 1 000 001 | 1 200 00 | | 1 00/ //0 | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FLXT | | 1, 928, 884 | | | 1, 806, 660 | |
| 2. 00 3. 00 | 00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS | | 1, 033, 758 | 1, 033, 758 | 215, 976 | | 1 |
| 4. 00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | 2, 154, 028 | 6, 209, 867 | 8, 363, 895 | -2, 154, 028 | 0 6, 209, 867 | |
| 5. 00 | 00500 ADMINISTRATIVE & GENERAL | 847, 881 | 21, 561, 284 | | | | |
| 6. 00 | 00600 MAI NTENANCE & REPAI RS | 0 | 0 0 | 22, 107, 100 | 0 010, 217 | 0 | 1 |
| 7. 00 | 00700 OPERATION OF PLANT | 385, 727 | 799, 007 | 1, 184, 734 | 31, 556 | | |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | 0 | 156, 661 | 156, 661 | | 195, 352 | |
| 9.00 | 00900 HOUSEKEEPI NG | 450, 318 | 109, 251 | 559, 569 | -1, 871 | 557, 698 | 9.00 |
| 10.00 | 01000 DI ETARY | 479, 254 | 325, 951 | | | | |
| 11. 00 | 01100 CAFETERI A | 0 | 1, 067 | 1, 067 | 440, 503 | 441, 570 | |
| 12.00 | 01200 MAI NTENANCE OF PERSONNEL | 0 | 0 | C | 0 | 0 | |
| 13.00 | 01300 NURSI NG ADMI NI STRATI ON | 487, 426 | 25, 795 | 513, 221 | 39, 869 | 553, 090 | 1 |
| 14.00 | 01400 CENTRAL SERVICES & SUPPLY | (71 022 | (2.552 | 724 504 | 0 | 700 473 | |
| 15. 00 16. 00 | 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY | 671, 032 | 63, 552 | 734, 584 | 54, 889 | 789, 473 0 | 1 |
| 17. 00 | 01700 SOCIAL SERVICE | | 0 | | | 0 | |
| 19.00 | 01900 NONPHYSI CI AN ANESTHETI STS | 0 | 0 | | | 0 | |
| 20.00 | 02000 NURSI NG PROGRAM | 0 | 0 | | | Ö | |
| 21.00 | 02100 I&R SERVICES-SALARY & FRINGES APPRVD | 0 | 0 | C | 0 | 0 | 21.00 |
| 22. 00 | 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD | 0 | 0 | l c | 0 | 0 | 22.00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 | 03000 ADULTS & PEDIATRICS | 3, 063, 457 | 1, 438, 539 | 4, 501, 996 | -590, 944 | 3, 911, 052 | 30.00 |
| 31. 00 | 03100 INTENSIVE CARE UNIT | 0 | 0 | C | 0 | 0 | |
| 32.00 | 03200 CORONARY CARE UNIT | 0 | 0 | C | 0 | 0 | |
| 33.00 | 03300 BURN INTENSIVE CARE UNIT | 0 | 0 | | 0 | 0 | |
| 34.00 | 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF | 0 | 0 | | 0 | 0 | |
| 40. 00 41. 00 | 04100 SUBPROVI DER – TPF | 0 | 0 | | | 0 | |
| 41.00 | 04100 SUBPROVIDER - TRF | | 0 | | 160, 023 | 160, 023 | |
| 44. 00 | 04400 SKILLED NURSING FACILITY | | 0 | | 100,023 | 0 | |
| 45. 00 | 04500 NURSING FACILITY | 0 | 0 | | | Ö | |
| 46. 00 | 04600 OTHER LONG TERM CARE | o | 0 | | o o | Ö | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 | 05000 OPERATING ROOM | 993, 889 | 965, 457 | 1, 959, 346 | 112, 752 | 2, 072, 098 | 50.00 |
| 51.00 | 05100 RECOVERY ROOM | 0 | 0 | C | 0 | 0 | |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | C | 758, 026 | | |
| 53.00 | 05300 ANESTHESI OLOGY | 0 | 1, 234, 701 | | | 1, 234, 701 | 1 |
| 54.00 | 05400 RADI OLOGY - DI AGNOSTI C | 1, 293, 293 | 811, 046 | 2, 104, 339 | 116, 293 | | 1 |
| 55. 00 56. 00 | 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE | | 0 | | 0 | 0 0 | |
| 57.00 | | | 0 | | | 0 | |
| 58. 00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | | 0 | | | 0 | 1 |
| 59. 00 | 05900 CARDI AC CATHETERI ZATI ON | o | 0 | | o o | Ö | |
| 60.00 | 06000 LABORATORY | 0 | 2, 945, 886 | 2, 945, 886 | 6 | 2, 945, 886 | |
| 60. 01 | 06001 BLOOD LABORATORY | 0 | 0 | C | 0 | 0 | 60.01 |
| 61.00 | 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | | 0 | C | 0 | 0 | 61.00 |
| 62.00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | | 0 | 0 | 0 | 0 | |
| 63.00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | 0 | 1 | 0 | 0 | |
| 64.00 | 06400 I NTRAVENOUS THERAPY | 0 | 0 | 00 | 0 | 0 | |
| 65.00 | 06500 RESPI RATORY THERAPY | 690, 735 | 133, 758 | | | 881, 001 | |
| 66.00 | 06600 PHYSI CAL THERAPY | 1, 148, 055 | 46, 725 | 1, 194, 780 | | 654, 129 | |
| 67. 00 68. 00 | 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY | | 0 | | 443, 369 191, 189 | 443, 369 191, 189 | |
| uo. UU | | | 0 | | 171, 189 | 191, 189 | |
| 60 00 | INAGONI EL ECTROCARDI OLOGV | | U | 1 | | 0 | |
| 69. 00 70. 00 | 06900 ELECTROCARDI OLOGY | n n | Λ | 1 |) '' | | |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 656 492 | 656 492 | 0 2 -422 351 | | 70.00 |
| | 1 | 0 0 | 0 656, 492 0 | 656, 492 656, 492 | 2 -422, 351 422, 351 | 234, 141 422, 351 | 70. 00 71. 00 |
| 70. 00 71. 00 | 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 0 | 0 656, 492 0 3, 451, 706 | C | 422, 351 | 234, 141 | 70.00 71.00 72.00 |
| 70. 00 71. 00 72. 00 | 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 0 0 | 0 | C | 422, 351 | 234, 141 422, 351 | 70.00 71.00 72.00 73.00 |
| 70. 00 71. 00 72. 00 73. 00 | 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS | 0 0 0 | 0 | C | 422, 351 | 234, 141 422, 351 3, 451, 706 | 70.00 71.00 72.00 73.00 74.00 |
| 70. 00 71. 00 72. 00 73. 00 74. 00 | 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS | 0 0 0 0 0 0 0 0 320, 600 | 0 | 3, 451, 706 0 0 | 0 422, 351 6 0 0 0 | 234, 141 422, 351 3, 451, 706 0 | 70.00 71.00 72.00 73.00 74.00 75.00 |
| 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 | 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 | 0 | 0 3, 451, 706 0 0 | 3, 451, 706 0 0 | 0 422, 351 6 0 0 0 | 234, 141 422, 351 3, 451, 706 0 0 | 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 98 |
| 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 98 77. 00 | 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 0UTPATIENT SERVICE COST CENTERS | 0 0 320, 600 | 0 3, 451, 706 0 0 | 3, 451, 706 0 0 | 0 422, 351 6 0 0 0 | 234, 141 422, 351 3, 451, 706 0 0 451, 389 | 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 98 77. 00 |
| 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 98 77. 00 | 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 0UTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC | 0 0 320, 600 | 0 3, 451, 706 0 0 | 3, 451, 706 0 0 | 0 422, 351 6 0 0 0 | 234, 141 422, 351 3, 451, 706 0 0 451, 389 0 | 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 98 77. 00 |
| 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 98 77. 00 88. 00 89. 00 | 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 0UTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER | 320, 600 | 0 3, 451, 706 0 0 104, 568 0 | 3, 451, 706 3, 451, 706 6 425, 168 | 0 422, 351 0 0 0 0 0 0 3 26, 221 0 0 | 234, 141 422, 351 3, 451, 706 0 0 451, 389 0 | 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 98 77. 00 88. 00 89. 00 |
| 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 98 77. 00 88. 00 89. 00 90. 00 | 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 0UTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER | 0 0 320, 600 0 0 0 36, 813 | 0 3, 451, 706 0 0 104, 568 0 0 0 0 1, 571 | 3, 451, 706 3, 451, 706 6 425, 168 6 7 8 | 0 422, 351 0 0 0 0 0 0 3 26, 221 0 0 0 4 3, 012 | 234, 141 422, 351 3, 451, 706 0 0 451, 389 0 0 41, 396 | 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 98 77. 00 88. 00 89. 00 90. 00 |
| 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 98 77. 00 88. 00 90. 00 91. 00 | 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 0UTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY | 320, 600 | 0 3, 451, 706 0 0 104, 568 0 | 3, 451, 706 3, 451, 706 6 425, 168 6 7 8 | 0 422, 351 0 0 0 0 0 0 3 26, 221 0 0 0 4 3, 012 | 234, 141 422, 351 3, 451, 706 0 0 451, 389 0 | 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 98 77. 00 88. 00 90. 00 91. 00 |
| 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 98 77. 00 88. 00 89. 00 90. 00 | 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 0UTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 0 320, 600 0 0 0 36, 813 | 0 3, 451, 706 0 0 104, 568 0 0 0 0 1, 571 | 3, 451, 706 3, 451, 706 6 425, 168 6 7 8 | 0 422, 351 0 0 0 0 0 0 3 26, 221 0 0 0 4 3, 012 | 234, 141 422, 351 3, 451, 706 0 0 451, 389 0 0 41, 396 | 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 98 77. 00 88. 00 89. 00 90. 00 |
| 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 98 77. 00 88. 00 90. 00 91. 00 | 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 0UTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0THER REIMBURSABLE COST CENTERS | 0 0 320, 600 0 0 0 36, 813 | 0 3, 451, 706 0 0 104, 568 0 0 0 0 1, 571 | 3, 451, 706 3, 451, 706 425, 168 0 0 38, 384 2, 193, 066 | 0 422, 351 0 0 0 0 0 0 3 26, 221 0 0 0 4 3, 012 | 234, 141 422, 351 3, 451, 706 0 451, 389 0 0 41, 396 2, 339, 177 | 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 98 77. 00 88. 00 89. 00 90. 00 91. 00 92. 00 |

| Health Financial Systems COMMU | JNITY HOSPITAL O | F NOBLE CTY, | I NC | In Lie | u of Form CMS-: | 2552-10 |
|---|------------------|--------------|--------------|------------------|-----------------------------|----------|
| RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (| F EXPENSES | Provi der CO | | Peri od: | Worksheet A | |
| | | | | rom 01/01/2022 | | |
| | | | | o 12/31/2022 | Date/Time Pre 5/18/2023 11: | |
| Cost Center Description | Sal ari es | Other | Total (col 1 | Recl assi fi cat | Reclassi fi ed | Z I alli |
| oost center bescription | Sururres | o thei | + col . 2) | i ons (See | Trial Balance | |
| | | | | A-6) | (col. 3 +- | |
| | | | | | col. 4) | |
| | 1.00 | 2.00 | 3.00 | 4. 00 | 5. 00 | |
| 95. 00 09500 AMBULANCE SERVICES | 3, 786, 472 | 925, 482 | 4, 711, 954 | 152, 768 | 4, 864, 722 | 95.00 |
| 96.00 09600 DURABLE MEDICAL EQUIP-RENTED | O | 0 | (| 0 | 0 | 96.00 |
| 97.00 09700 DURABLE MEDICAL EQUIP-SOLD | o | 0 | (| 0 | 0 | 97.00 |
| 99. 00 09900 CMHC | o | 0 | (| 0 | 0 | 99.00 |
| 99. 10 09910 CORF | o | 0 | (| 0 | 0 | 99. 10 |
| 100.00 10000 I&R SERVICES-NOT APPRVD PRGM | o | 0 | (| 0 | 0 | 100.00 |
| 101.00 10100 HOME HEALTH AGENCY | o | 0 | (| 0 | 0 | 101.00 |
| 102.00 10200 OPI OID TREATMENT PROGRAM | o | 0 | (| 0 | 0 | 102.00 |
| SPECIAL PURPOSE COST CENTERS | | | | | | |
| 105. 00 10500 KI DNEY ACQUI SI TI ON | 0 | 0 | (| 0 | 0 | 105.00 |
| 106.00 10600 HEART ACQUISITION | 0 | 0 | (| 0 | 0 | 106.00 |
| 107.00 10700 LIVER ACQUISITION | 0 | 0 | (| 0 | 0 | 107.00 |
| 108.00 10800 LUNG ACQUISITION | 0 | 0 | (| 0 | | 108.00 |
| 109.00 10900 PANCREAS ACQUISITION | 0 | 0 | (| 0 | | 109. 00 |
| 110.00 11000 INTESTINAL ACQUISITION | 0 | 0 | (| 0 | | 110.00 |
| 111.00 11100 ISLET ACQUISITION | 0 | 0 | (| 0 | | 111.00 |
| 113.00 11300 INTEREST EXPENSE | | 0 | (| 0 | | 113.00 |
| 114.00 11400 UTILIZATION REVIEW-SNF | 0 | 0 | (| 0 | | 114.00 |
| 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) | 0 | 0 | (| 0 | | 115.00 |
| 116. 00 11600 HOSPI CE | 0 | 0 | (| 0 | | 116. 00 |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) | 18, 369, 292 | 45, 563, 762 | 63, 933, 054 | -5, 009 | 63, 928, 045 | 118. 00 |
| NONREI MBURSABLE COST CENTERS | | | | | | |
| 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 12, 873 | | | | 190.00 |
| 191. 00 19100 RESEARCH | 0 | 637 | 637 | | | 191.00 |
| 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES | 45, 181 | 1, 946 | 47, 127 | 3, 696 | | 192.00 |
| 193. 00 19300 NONPAI D WORKERS | 0 | 0 | (| 0 | | 193.00 |
| 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS | 0 | 0 | (| 0 | | 194. 00 |
| 194. 01 07951 PAIN CLINIC | 0 | 0 | (| 0 | | 194. 01 |
| 194. 02 07952 OCC HEALTH | 0 | 0 | | 0 | | 194. 02 |
| 194. 03 07953 FOUNDATI ON | 0 | 74, 461 | 74, 461 | 0 | | 194. 03 |
| 194. 04 07954 PHYSI CI AN OFFI CES | 0 | 0 | (| 0 | | 194.04 |
| 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES | 148, 390 | 66, 186 | 214, 576 | 1, 313 | | |
| 194. 06 07956 VACANT SPACE | 0 | 0 | (4.000.700 | 0 | | 194.06 |
| 200.00 TOTAL (SUM OF LINES 118 through 199) | 18, 562, 863 | 45, 719, 865 | 64, 282, 728 | 0 | 64, 282, 728 | [200.00 |

In Lieu of Form CMS-2552-10

Health FinancialSystemsCOMMUNITY HOSPITRECLASSIFICATIONAND ADJUSTMENTS OF TRIALBALANCE OF EXPENSES Period: Worksheet A From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/18/2023 11:21 am Provi der CCN: 15-0146

| Cost Center Description | | | | | 5/18/2023 11: | |
|--|-------|--|--------------|-------------|---|---------|
| MINOSTITUM 1.00 0.00 7.00 1 | | Cost Center Description | | | | |
| Fine Fine Striver COST CENTRES | | | (See A-6) | | | |
| 0.00 0.0000 CAR PELL DOSTS-BULDE & FIXT -1,472,853 333,807 1,00 | | DENIEDAL CEDILIOE COCT CENTEDO | 6. 00 | 7. 00 | | |
| 2.00 00000 O0000 O00000 O0000 O0000 O0000 O0000 O00000 O0000 O0000 O0000 O0000 O0000 O0000 O0000 O00000 O0000 O0000 O0000 O0000 O00000 O000000 O00000000 | 1 00 | | 1 472 OE2 | 222 007 | 1 | 1 00 |
| 3.00 DOSCOOL THE CAP SEL COSTS 2 0.00 DOSCOOL SURFER COST 2 0.00 | | | 1 | | | |
| 4.00 0.0000 EMPLOYEE BENEFITS DEPARTMENT | | + I | 0 | | • | 1 |
| D. D. D. DO DOSCO ADMIN IN STRATI VE & CENERAL -9, 540, 3817 3, 6817, 032 6, 00 1, 215, 54 | | 1 1 | _2 983 | | 1 | 1 |
| DOCAD DOCAD GENTALING OF PLANES 0 | | 1 1 | | | l e e e e e e e e e e e e e e e e e e e | 1 |
| 7. 00 000000 (ALMORY A) LINEN STEPLICE 7.00 7.773 7.775 7.975 7.00 | | | | | | 1 |
| 8. 00) 0000000 LAUNINERY AL LINITH STEVICE 0 19-5, 357 / 698 9 00 00000 000000 DEFRANT 10 00 00 00 00 00 00 0 | | | _ | | 1 | 1 |
| 9.00 00900 0005KEFEP MS | | 1 1 | 0 | | | |
| 10.00 01000 DETARY | | | 0 | | | |
| 1.2.00 1.200 MAINTENANCE OF PERSONNEL 0 1.2.00 1.3.00 | | | -771 | | | 10.00 |
| 13.00 01300 MURSING ADMINISTRATION -200 502,890 113.00 115.00 | 11.00 | 01100 CAFETERI A | -312, 665 | 128, 905 | | 11.00 |
| 14.00 1400 CRITICAL SERVICES & SUPPLY 0 0 11.00 16.00 1000 HERDICAL RECORDS & LIBBRARY 789, 473 0 16.00 17.00 1700 0 0 0 1700 17.00 1700 0 0 0 0 1700 17.00 1700 0 0 0 0 1700 17.00 1700 0 0 0 0 1700 17.00 0 0 0 0 0 0 1700 17.00 0 0 0 0 0 0 0 17.00 0 0 0 0 0 0 17.00 0 0 0 0 0 0 0 0 17.00 0 0 0 0 0 0 0 0 17.00 0 0 0 0 0 0 0 0 17.00 0 0 0 0 0 0 0 0 17.00 0 0 0 0 0 0 0 0 17.00 0 0 0 0 0 0 0 0 17.00 0 0 0 0 0 0 0 0 17.00 0 0 | 12.00 | 01200 MAINTENANCE OF PERSONNEL | 0 | 0 | | 12.00 |
| 15.00 10500 PHASMACY 17.00 15.00 16.00 17.00 1 | 13.00 | | -200 | 552, 890 | | 13.00 |
| 16.00 16.00 16.00 16.00 17.0 | 14.00 | 01400 CENTRAL SERVICES & SUPPLY | 0 | 0 | | 14.00 |
| 17.00 01700 SOCIAL SERVICE 0 0 0 17.00 | | I I | -789, 473 | | 1 | |
| 19.00 01900 MORPHYSICI AN AMESTHETISTS 0 0 0 20.00 20. | | | 0 | | • | |
| 20.00 2000 NURSI NG PROCRAM 0 0 22.00 | | | 0 | 0 | | |
| 21.00 0 2010 IAS SERVICES-SALARY & FRINCES APPRVD 0 0 22.00 22.00 222.01 IAS SERVICES-CONTER PRINCE COST SEPRIFY 0 0 0 22.00 31.00 0 3000 ABURTS & PETROL FROM 1 1 0 0 0 31.00 31.00 0 31.00 ABURTS & PETROL FROM 1 1 0 0 0 32.00 33.00 0 31.00 INTENSIVE CARE UNIT 1 0 0 0 32.00 33.00 0 33.00 BURN INTENSIVE CARE UNIT 1 0 0 0 33.00 33.00 0 33.00 BURN INTENSIVE CARE UNIT 1 0 0 0 34.00 41.00 0 40.00 ABURTS & PETROL FROM 1 1 0 0 0 0 4.00 41.00 0 40.00 ABURTS & PETROL FROM 1 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | 0 | 0 | | 1 |
| 22 00 | | 1 1 | 0 | | 1 | 1 |
| IMPATI ENT ROUTINE SERVICE COST CENTERS 39, 886 3,950,938 31,00 310,00 310,00 310,00 310,00 310,00 310,00 310,00 310,00 310,00 320,00 3 | | 1 1 | 0 | | | |
| 30.00 30000 ADULTS & PEDI ATRICS 39,886 3,950,988 30.00 31.00 | 22.00 | | 0 | 0 | | 22.00 |
| 31.00 03100 INTENSIVE CARE UNIT | 30 00 | | 39 886 | 3 950 938 | | 30.00 |
| 32 00 33200 CORROMARY CARE UNIT | | 1 1 | 0,,000 | | | |
| 33.00 03300 BURN INTERSIVE CARE UNIT 0 0 0 33.00 40.00 300 SURGICAL INTERSIVE CARE UNIT 0 0 0 0 40.00 40000 SURGICAD SURGICAL INTERSIVE CARE UNIT 0 0 0 41.00 40000 SURGICAD SURGICAL INTERSIVE CARE UNIT 0 0 0 43.00 440.00 440.00 440.00 43.00 43000 SURGICAD SURGICAL INTERSIVE CARE UNIT 0 0 0 43.00 43000 SURGICAD SURGI | | 1 | 0 | - | · | |
| 40. 00 0.400.00 SUPPROVI DER - I PF | | 1 | 0 | 0 | | |
| 1.1 00 0.4100 SUBPROVI DER - I BF | 34.00 | 1 1 | 0 | 0 | | 34.00 |
| 43. 00 04300 NURSERY 0 160,023 43. 00 44. 00 04400 OSKILLED NURSING FACILITY 0 0 0 0 46. 00 04500 ON SKILLED NURSING FACILITY 0 0 0 0 46. 00 04600 OTHER LONG FERM CARE 0 0 0 ANCILLARY SERVICE COST CENTERS | 40.00 | 04000 SUBPROVI DER - I PF | 0 | 0 | | 40.00 |
| 44. 00 04400 SKILLED NURSING FACILITY | 41.00 | 04100 SUBPROVI DER - I RF | 0 | 0 | | 41.00 |
| 45.00 04500 OHSEN ING FACILITY | | | 0 | 160, 023 | | 1 |
| Accord Oxford Carlot C | | | 0 | | 1 | |
| ANCILLARY SERVICE COST CENTERS 50.00 50.00 50.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 52. | | | 0 | l . | | 1 |
| 50. 00 05000 0FEATI NG ROOM | 46.00 | | 0 | 0 |) | 46.00 |
| 51.00 05100 RECOVERY ROOM 0 0 0 52.00 652 | 50 00 | | | 2 072 008 | | 50.00 |
| S2.00 05200 DELIVERY ROOM & LABOR ROOM 0 758,026 53.00 05300 ABSTREES LOLGY -1,234,701 0 53.00 05500 ABSTREES LOLGY 54.00 55.00 | | | | | | 1 |
| S3.00 05300 ANESTHESI OLOGY | | I I | 0 | | • | 1 |
| 54. 00 | | | -1, 234, 701 | | | |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 54.00 | | _ | 2, 220, 632 | | 54.00 |
| 56.00 0500 0500 CARDIOL SOTOPE 0 0 0 0 0 0 0 0 0 0 | 55.00 | | 0 | | | 55.00 |
| 58. 00 05900 CARDIAC CATHETERI ZATI ON 0 0 0 0 0 0 0 0 0 | 56.00 | | 0 | 0 | | 56.00 |
| 59.00 05900 CARDIAC CATHETERIZATION 0 0 0 0 06000 LABORATORY 0 0 0 0 0 0 0 0 0 | 57.00 | | 0 | 0 | | 57.00 |
| 60. 00 06000 LABORATORY 0 2,945,886 60. 00 60. 01 06001 BLOOD LABORATORY 0 0 0 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 881, 001 66. 00 06600 PHST CAL THERAPY 0 443, 369 67. 00 06700 0CCUPATI ONAL THERAPY 0 443, 369 68. 00 06800 SPEECH PATHOLOGY 0 191, 189 68. 00 06900 ELECTROCARDI OLOGY 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 234, 141 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 242, 351 72. 00 07300 DRUGS CHARGED TO PATIENTS 0 3, 451, 706 74. 00 07400 RELAG LA SUPPLIES 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY -3, 335 448, 054 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 90. 00 09000 CLINIC 0 41, 396 91. 00 09000 ELBERGENCY -35, 402 2, 303, 775 91. 00 07400 MENGERNOY 0 0 91. 00 09000 CLINIC 0 41, 396 91. 00 09400 HOME PROGRAM DIALYSIS 0 0 94. 00 09400 HOME PROGRAM DIALYSIS 0 0 94. 00 09400 HOME PROGRAM DIALYSIS 0 0 | | | 0 | | • | 1 |
| 60. 01 06001 0L000 LABORATORY 0 0 0 61.00 61. 00 06100 0BPP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 0 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 64. 00 06400 NITRAVENOUS THERAPY 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 881, 001 65. 00 66. 00 06600 PHYSI CAL THERAPY 13, 348 640, 781 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 443, 369 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 191, 189 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 70. 00 7000 ELECTROCARDI OLOGY 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 234, 141 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 422, 351 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 3, 451, 706 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 76. 99 07698 HYPERBARI C 0XYGEN THERAPY -3, 335 448, 054 76, 98 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 89. 00 08800 RURAL HEALTH CLINI C 0 0 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 90. 00 09000 DISSERVATI ON BEDS (NON-DI STI NCT PART) 91.00 90. 00 09000 DISSERVATI ON BEDS (NON-DI STI NCT PART) 0 90. 00 09000 DISSERVATI ON BEDS (NON-DI STI NCT PART) 0 90. 00 09000 09500 DISSERVATI ON BEDS (NON-DI STI NCT PART) 0 90. 00 09000 09500 DISSERVATI ON BEDS (NON-DI STI NCT PART) 0 90. 00 09000 09500 DISSERVATI ON BEDS (NON-DI STI NCT PART) 0 91. 00 09400 HOME PROGRAM DI ALYSI S 0 0 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 | | | 0 | | • | |
| 61.00 06100 PPP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 0 0 0 0 0 0 0 0 | | 1 1 | 0 | | | |
| 62. 00 66200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 63. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 881, 001 66. 00 06600 PHYSI CAL THERAPY -13, 348 640, 781 66. 00 06700 0CCUPATI ONAL THERAPY 0 443, 369 68. 00 06800 SPECH PATHOLOGY 0 191, 189 69. 00 06900 ELECTROCARDI OLOGY 0 0 70. 00 07000 ELECTROCARDI OLOGY 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 234, 141 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 422, 351 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 3, 451, 706 74. 00 07400 RENAL DI ALYSIS 0 0 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY -3, 335 448, 054 77. 00 08900 REDRALL PI ALYSIS 0 0 88. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 90. 00 09000 CLI NI C 0 0 90. 00 09000 CLI NI C 0 0 91. 00 09100 EMERGENCY -35, 402 2, 303, 775 94. 00 09400 HOME PROGRAM DI ALYSIS 0 0 94. 00 09400 HOME PROGRAM DI ALYSIS 0 0 94. 00 09400 HOME PROGRAM DI ALYSIS 0 0 94. 00 09400 HOME PROGRAM DI ALYSIS 0 0 94. 00 09400 HOME PROGRAM DI ALYSIS 0 0 94. 00 09400 HOME PROGRAM DI ALYSIS 0 0 94. 00 09400 HOME PROGRAM DI ALYSIS 0 0 | | 1 1 | 0 | - | 1 | 1 |
| 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 0 0 | | | 0 | | • | |
| 64. 00 06400 INTRAVENOUS THERAPY 0 0 065.00 65.00 65.00 665.00 665.00 665.00 665.00 665.00 665.00 666.00 665.00 667.00 667.00 667.00 667.00 667.00 667.00 667.00 667.00 667.00 667.00 667.00 667.00 667.00 668.00 668.00 668.00 668.00 668.00 668.00 668.00 668.00 668.00 668.00 668.00 668.00 668.00 668.00 669.00 668 | | + + | 0 | | i e | |
| 65. 00 | | The state of the s | 0 | | i e | |
| 66. 00 06600 PHYSI CAL THERAPY -13, 348 640, 781 66. 00 6700 0CCUPATI ONAL THERAPY 0 443, 369 67. 00 6800 SPEECH PATHOLOGY 0 191, 189 68. 00 69. 00 6900 ELECTROCARDI OLOGY 0 0 0 0 69. 00 69. 00 7000 ELECTROCARDI OLOGY 0 0 0 0 70. 00 7000 ELECTROCARDI OLOGY 0 0 0 70. 00 710. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 234, 141 71. 00 7200 I MPL. DEV. CHARGED TO PATI ENTS 0 422, 351 72. 00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 3, 451, 706 73. 00 74. 00 7400 RENAL DI ALYSI S 0 3, 451, 706 75. 00 7500 ASC (NON-DI STI NCT PART) 0 0 0 0 7500 ASC (NON-DI STI NCT PART) 0 0 0 0 7500 ASC (NON-DI STI NCT PART) 75. 00 7000 ALLOGENEIC STEM CELL ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | 0 | | i e | |
| 67. 00 06700 0CCUPATI ONAL THERAPY 0 443, 369 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 191, 189 68. 00 690. 00 6900 ELECTROCARDI OLOGY 0 0 0 0 0 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 234, 141 71. 00 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 422, 351 72. 00 07300 DRUGS CHARGED TO PATIENTS 0 3, 451, 706 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 3, 451, 706 73. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 755. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 755. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 755. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 775. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | · · · · · · · · · · · · · · · · · · · | -13, 348 | | i e | |
| 69. 00 | | 1 1 | 0 | 1 | l e e e e e e e e e e e e e e e e e e e | 67.00 |
| 70. 00 | 68.00 | 06800 SPEECH PATHOLOGY | 0 | 191, 189 | | 68.00 |
| 71. 00 | 69.00 | 06900 ELECTROCARDI OLOGY | 0 | 0 | | 69.00 |
| 72. 00 | 70.00 | | 0 | 0 | | |
| 73. 00 | | | 0 | | | |
| 74. 00 | | | 0 | | | |
| 75. 00 | | | 0 | | | 1 |
| 76. 98 | | + I | 0 | | 1 | 1 |
| 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 77. 00 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 89. 00 90. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 90. 00 90. 00 09000 CLINIC 0 41, 396 90. 00 91. 00 09100 EMERGENCY -35, 402 2, 303, 775 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 94. 00 | | | 2 225 | | 1 | |
| SECTION SUBSIDIARY SUBSTRICT COST CENTERS SECTION SECT | | I I | | | | |
| 88. 00 | 77.00 | | | 1 0 | <u>'</u> | 17.00 |
| 89. 00 | 88 NN | | 0 | 0 | | 88 00 |
| 90. 00 | | I I | 0 | | • | |
| 91. 00 | | | 0 | | • | |
| 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 92. 00 0THER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DIALYSIS 0 0 94. 00 0 94. 00 0 0 0 0 0 0 0 0 0 | | I I | -35, 402 | 1 | | |
| 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 94. 00 | 92.00 | 1 1 | | | | 92.00 |
| | | | | | | |
| 95. 00 09500 AMBULANCE SERVICES -1, 650 4, 863, 072 95. 00 | | 1 | - | | • | |
| | 95.00 | U95UU AMBULANCE SERVI CES | -1, 650 | 4, 863, 072 | [| J 95.00 |

 Health Financial
 Systems
 COMMUNITY HOSPIT

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 15-0146

Peri od: Worksheet A From 01/01/2022 To 12/31/2022 Date/Time Prepared:

| | | | To | o 12/31/2022 | Date/Time Pre 5/18/2023 11: | |
|---|---------------|--------------|----|--------------|-----------------------------|--------------------|
| Cost Center Description | Adjustments | Net Expenses | | | 37 107 2023 11. | Z I dili |
| | (See A-8) | For | | | | |
| | , , , | Allocation | | | | |
| | 6. 00 | 7. 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 OPI OI D TREATMENT PROGRAM | 0 | 0 | | | | 102.00 |
| SPECIAL PURPOSE COST CENTERS 105, 00 10500 KI DNEY ACQUI SI TI ON | | 0 | | | | 105 00 |
| 105. 00 10500 REDNEY ACQUISITION 106. 00 10600 HEART ACQUISITION | 0 | 0 | | | | 105. 00 106. 00 |
| 107. 00 10700 LIVER ACQUISITION | 0 | 0 | | | | 106.00 |
| 107. 00 10700 LIVER ACQUISITION 108. 00 10800 LUNG ACQUISITION | 0 | 0 | | | | 107.00 |
| 109. 00 10900 PANCREAS ACQUISITION | 0 | 0 | | | | 109.00 |
| 110. 00 11000 NTESTI NAL ACQUI SI TI ON | | 0 | | | | 110, 00 |
| 111. 00 11100 SLET ACQUISITION | 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 | 0 | 0 | | | | 116.00 |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) | -13, 368, 613 | 50, 559, 432 | | | | 118.00 |
| NONREI MBURSABLE COST CENTERS | | | | | | |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 12, 873 | | | | 190. 00 |
| 191. 00 19100 RESEARCH | 0 | 637 | | | | 191.00 |
| 192.00 19200 PHYSICIANS' PRIVATE OFFICES | 0 | 50, 823 | | | | 192.00 |
| 193. 00 19300 NONPALD WORKERS | 0 | 0 | | | | 193. 00 |
| 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | | | | 194. 00 |
| 194. 01 07951 PAIN CLINIC | 0 | 0 | | | | 194. 01 |
| 194. 02 07952 OCC HEALTH | 0 | 0 | | | | 194. 02 |
| 194. 03 07953 FOUNDATI ON | 0 | 74, 461 | | | | 194. 03 |
| 194. 04 07954 PHYSI CI AN OFFI CES | 0 | 0 | | | | 194.04 |
| 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES | 0 | 215, 889 | | | | 194. 05 |
| 194. 06 07956 VACANT SPACE | 0 | 0 | | | | 194.06 |
| 200.00 TOTAL (SUM OF LINES 118 through 199) | -13, 368, 613 | 50, 914, 115 | | | | 200.00 |
| | | | | | | |

Health Financial Systems RECLASSIFICATIONS COMMUNITY HOSPITAL OF NOBLE CTY, INC
Provider CCN: 15-0146 | Peri od: | Worksheet A-6 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared:

| | | | | | To 12/31/20 | 022 Date/Time Prepared: 5/18/2023 11:21 am |
|------------------|------------------------------|-------------------|--------------------|------------------|-------------|---|
| | | Increases | | | L , | 37 107 2023 11. 21 dill |
| | Cost Center | Li ne # | Sal ary | 0ther | | |
| | 2. 00 | 3. 00 | 4. 00 | 5. 00 | | |
| | A - INTEREST EXPENSE | | | | | |
| 1. 00 | | 0.00 | 0_ | <u>0</u> | | 1.00 |
| | TOTALS | | 0 | 0 | | |
| | B - REHAB THERAPY | | | | | |
| 1. 00 | OCCUPATI ONAL THERAPY | 67. 00 | 426, 030 | 17, 339 | | 1.00 |
| 2.00 | SPEECH PATHOLOGY | 6800 | 18 <u>3, 7</u> 12 | <u>7, 4</u> 77 | | 2.00 |
| | 0 | | 609, 742 | 24, 816 | | |
| | C - I NSURANCE | | . Т | | | |
| 1. 00 | CAP REL COSTS-BLDG & FIXT | 1. 00 | 0 | 46, 346 | | 1.00 |
| 2. 00 | CAP REL COSTS-MVBLE EQUIP | | 0 | 47, 406 | | 2.00 |
| | 0 | | 0 | 93, 752 | | |
| | F - CLINIC DIETICIAN | 0.00 | | | | 1.00 |
| 1. 00 | | 0.00 | 0 | <u>0</u> | | 1.00 |
| | O SMBLOVEE OALABY BENEFITO | | 0 | O | | |
| | G - EMPLOYEE SALARY BENEFITS | | 040 004 | | | 1.00 |
| 1.00 | ADMINISTRATIVE & GENERAL | 5. 00 | 912, 001 | 0 | | 1.00 |
| 2.00 | OPERATION OF PLANT | 7. 00 | 31, 556 | 0 | | 2.00 |
| 3.00 | HOUSEKEEPI NG | 9. 00 | 36, 820 | 0 | | 3.00 |
| 4.00 | DIETARY | 10.00 | 39, 207 | 0 | | 4.00 |
| 5.00 | NURSI NG ADMI NI STRATI ON | 13. 00 | 39, 869 | 0 | | 5.00 |
| 6.00 | PHARMACY | 15. 00 | 54, 889 | 0 | | 6.00 |
| 7.00 | ADULTS & PEDIATRICS | 30. 00 | 327, 105 | 0 | | 7. 00 |
| 8.00 | OPERATING ROOM | 50.00 | 112, 752 | 0 | | 8.00 |
| 9.00 | RADI OLOGY - DI AGNOSTI C | 54.00 | 116, 293 | 0 | | 9.00 |
| 10.00 | RESPIRATORY THERAPY | 65. 00 | 56, 508 | 0 | | 10.00 |
| 11.00 | PHYSI CAL THERAPY | 66. 00 | 93, 907 | 0 | | 11.00 |
| 12.00 | HYPERBARI C OXYGEN THERAPY | 76. 98 | 26, 221 | 0 | | 12.00 |
| 13.00 | CLI NI C | 90.00 | 3, 012 146, 111 | 0 | | 13.00 |
| 14. 00 15. 00 | EMERGENCY AMBULANCE SERVICES | 91. 00 95. 00 | 152, 768 | 0 | | 14. 00 15. 00 |
| 16. 00 | PHYSICIANS' PRIVATE OFFICES | 192. 00 | 3, 696 | 0 | | 16.00 |
| 17. 00 | COMMUNITY & VOLUNTEER | 194. 05 | 1, 313 | 0 | | 17. 00 |
| 17.00 | SERVI CES | 174.03 | 1, 313 | 0 | | 17.00 |
| | 0 - | + | 2, 154, 028 | — — _ō | | |
| | H - CAFETERIA | | 2, 101, 020 | | | |
| 1. 00 | CAFETERI A | 11. 00 | 267, 252 | 173, 251 | | 1.00 |
| 1.00 | 0 | | 267, 252 | 173, 251 | | 1.00 |
| | I - DEPRECIATION | | 207, 202 | 1,0,201 | | |
| 1. 00 | CAP REL COSTS-MVBLE EQUIP | 2. 00 | 0 | 168, 570 | | 1.00 |
| 00 | 0 | | | 168, 570 | | 155 |
| | J - HOME OFFICE SALARIES | | -1 | | | |
| 1.00 | ADMINISTRATIVE & GENERAL | 5. 00 | 4, 451, 182 | 0 | | 1.00 |
| | 0 | — — + | 4, 451, 182 | <u>o</u> | | |
| | K - LAUNDRY | | | - 1 | | |
| 1.00 | LAUNDRY & LINEN SERVICE | 8. 00 | 0 | 38, 691 | | 1.00 |
| | | + | | 38, 691 | | 1 |
| | M - IMPLANTS | <u>'</u> | | | | |
| 1.00 | IMPL. DEV. CHARGED TO | 72.00 | 0 | 422, 351 | | 1.00 |
| | PATI ENTS | | | | | |
| | 0 | | | 422, 351 | | |
| | N - OB | | | | | |
| 1.00 | NURSERY | 43.00 | 114, 636 | 45, 387 | | 1.00 |
| 2.00 | DELIVERY ROOM & LABOR ROOM | 5200 | 543, 028 | <u>214, 9</u> 98 | | 2.00 |
| | 0 | | 657, 664 | 260, 385 | | |
| | P - OTHER | | | | | |
| 1.00 | | 0.00 | 0 | 0 | | 1.00 |
| | 0 | | 0 | 0 | | |
| | Q - PERSONAL PROP TAX | | | | | |
| 1.00 | | 0.00 | | 0 | | 1.00 |
| | 0 | | 0 | | | |
| | Grand Total: Increases | | 8, 139, 868 | 1, 181, 816 | | 500.00 |

| | | | | | ' | 5/18/2 | 2023 11: 21 am |
|----------------|-------------------------------|----------------|------------------|-----------------------|----------------|--------|----------------|
| | | Decreases | | | | | |
| | Cost Center | Li ne # | Sal ary | Other 0 | Wkst. A-7 Ref. | | |
| | 6. 00 A - INTEREST EXPENSE | 7. 00 | 8. 00 | 9. 00 | 10.00 | | |
| 1. 00 | A - INTEREST EXPENSE | 0.00 | 0 | | 0 0 | | 1.00 |
| 1.00 | TOTALS — — — — | | — — — — — | | 4 | | 1.00 |
| | B - REHAB THERAPY | | <u> </u> | | <u> </u> | | |
| 1.00 | PHYSI CAL THERAPY | 66.00 | 609, 742 | 24, 81 | 6 10 | | 1.00 |
| 2.00 | | 000 | 0 | | 010 | | 2.00 |
| | 0 | | 609, 742 | 24, 81 | 6 | | |
| | C - I NSURANCE | | . 1 | | -1 | | |
| 1.00 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 93, 75 | | | 1.00 |
| 2. 00 | | 0.00 | | | 012 | | 2. 00 |
| | F - CLINIC DIETICIAN | | U _I | 93, 73 | | | |
| 1. 00 | I CEINIC BIETICIAN | 0.00 | 0 | | 0 0 | | 1.00 |
| 00 | | | — — ŏ | | | | |
| | G - EMPLOYEE SALARY BENEFITS | | | | ' | | |
| 1.00 | EMPLOYEE BENEFITS DEPARTMENT | 4. 00 | 2, 154, 028 | | 0 0 | | 1.00 |
| 2.00 | | 0. 00 | 0 | | 0 0 | | 2.00 |
| 3. 00 | | 0.00 | 0 | | 0 0 | | 3.00 |
| 4.00 | | 0.00 | 0 | | 0 | | 4.00 |
| 5. 00 | | 0.00 | 0 | | 0 0 | | 5.00 |
| 6. 00 7. 00 | | 0. 00 0. 00 | 0 | | | | 6. 00 7. 00 |
| 8. 00 | | 0.00 | 0 | | | | 8.00 |
| 9. 00 | | 0.00 | 0 | | ol ol | | 9.00 |
| 10.00 | | 0.00 | o | | o o | | 10.00 |
| 11.00 | | 0.00 | O | | 0 0 | | 11.00 |
| 12.00 | | 0.00 | 0 | | 0 0 | | 12.00 |
| 13.00 | | 0.00 | 0 | | 0 0 | | 13.00 |
| 14.00 | | 0. 00 | 0 | | 0 | | 14.00 |
| 15.00 | | 0.00 | 0 | | 0 | | 15.00 |
| 16.00 | | 0.00 | 0 | | 0 0 | | 16.00 |
| 17. 00 | | 0.00_ | 0 2, 154, 028 | | 0 0 | | 17. 00 |
| | H - CAFETERIA | | 2, 154, 020 | <u>'</u> | <u> </u> | | |
| 1. 00 | DI ETARY | 10.00 | 267, 252 | 173, 25 | 1 0 | | 1.00 |
| | 0 | | 267, 252 | 173, 25 | | | |
| | I - DEPRECIATION | | | • | ' | | |
| 1.00 | CAP REL COSTS-BLDG & FIXT | 100 | 0 | 16 <u>8, 5</u> 7 | | | 1.00 |
| | 0 | | 0 | 168, 57 | 0 | | |
| 4 00 | J - HOME OFFICE SALARIES | 5 00 | ما | | | | 1.00 |
| 1. 00 | ADMI NI STRATI VE & GENERAL | | 0 | <u>4, 451, 18</u> | | | 1.00 |
| | O K - LAUNDRY | | 0 | 4, 451, 18 | 2 | | |
| 1. 00 | HOUSEKEEPI NG | 9. 00 | 0 | 38, 69 | 1 0 | | 1.00 |
| 1.00 | 0 | | — — ў | $\frac{30,67}{38,69}$ | | | 1.00 |
| | M - IMPLANTS | | -1 | | | | |
| 1.00 | MEDICAL SUPPLIES CHARGED TO | 71. 00 | 0 | 422, 35 | 1 0 | | 1.00 |
| | PATI ENTS | | | | L | | |
| | 0 | | 0 | 422, 35 | 1 | | |
| 4 00 | N - OB | 00.00 | | 0/0.00 | - 0 | | 1.00 |
| 1.00 | ADULTS & PEDIATRICS | 30.00 | 657, 664 | 260, 38 | | | 1.00 |
| 2. 00 | | | 0 | | <u> </u> | | 2. 00 |
| | P - OTHER | | 657, 664 | 200, 38 | <u>ی</u> ا | | |
| 1. 00 | TOTTLEN | 0.00 | 0 | | 0 0 | | 1.00 |
| 00 | | | — — ŏ | | | | 1.30 |
| | Q - PERSONAL PROP TAX | | <u> </u> | | | | |
| 1.00 | | 0.00 | 0 | | 0 0 | | 1.00 |
| | 0 | | 0 | | 0 | | |
| 500.00 | Grand Total: Decreases | | 3, 688, 686 | 5, 632, 99 | 8 | | 500.00 |
| | | | | | | | |

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

Provi der CCN: 15-0146

| | | | | ' | 0 12/31/2022 | 5/18/2023 11: | |
|-------|--|--------------|--------------|-----------------|--------------|---------------|-------|
| | · | | <u> </u> | 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 | 0 | 1.00 |
| 2.00 | Land Improvements | 755, 392 | 0 | 0 | 0 | 0 | 2.00 |
| 3.00 | Buildings and Fixtures | 3, 912, 444 | 358, 157 | 0 | 358, 157 | 0 | 3.00 |
| 4.00 | Building Improvements | 7, 379 | 13, 778 | 0 | 13, 778 | 0 | 4.00 |
| 5.00 | Fixed Equipment | 595, 100 | 305, 481 | 0 | 305, 481 | 0 | 5.00 |
| 6.00 | Movable Equipment | 12, 545, 236 | 2, 043, 939 | 0 | 2, 043, 939 | 140, 516 | 6. 00 |
| 7.00 | HIT designated Assets | 3, 173, 747 | 63, 921 | 0 | 63, 921 | 0 | 7. 00 |
| 8.00 | Subtotal (sum of lines 1-7) | 20, 989, 298 | 2, 785, 276 | 0 | 2, 785, 276 | 140, 516 | 8.00 |
| 9.00 | Reconciling Items | 3, 173, 747 | 63, 921 | 0 | 63, 921 | 0 | 9. 00 |
| 10.00 | Total (line 8 minus line 9) | 17, 815, 551 | 2, 721, 355 | 0 | 2, 721, 355 | 140, 516 | 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 | 286, 788 | | | | 2.00 |
| 3.00 | Buildings and Fixtures | 4, 270, 601 | 760, 722 | | | | 3.00 |
| 4.00 | Building Improvements | 21, 157 | 0 | | | | 4.00 |
| 5.00 | Fixed Equipment | 900, 581 | 39, 741 | | | | 5.00 |
| 6.00 | Movable Equipment | 14, 448, 659 | 8, 389, 513 | | | | 6.00 |
| 7.00 | HIT designated Assets | 3, 237, 668 | 0 | | | | 7.00 |
| 8.00 | Subtotal (sum of lines 1-7) | 23, 634, 058 | 9, 476, 764 | | | | 8. 00 |
| 9.00 | Reconciling Items | 3, 237, 668 | 0 | | | | 9. 00 |
| 10.00 | Total (line 8 minus line 9) | 20, 396, 390 | 9, 476, 764 | | | | 10.00 |
| | | | | | | | |

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

| RECON | CILIATION OF CAPITAL COSTS CENTERS | | Provi der Co | CN: 15-0146 | Peri od: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part II Date/Time Pre 5/18/2023 11: | pared: |
|-------|--|--------------------|---------------------------------------|---------------|--|--|--------|
| | | | SL | JMMARY OF CAP | I TAL | | |
| | Cost Center Description | Depreciation | Lease | Interest | Insurance (see | Taxes (see instructions) | |
| | | 9, 00 | 10. 00 | 11. 00 | instructions) | 13.00 | |
| | PART II - RECONCILIATION OF AMOUNTS FROM WOR | | | and 2 | | | |
| 1.00 | CAP REL COSTS-BLDG & FLXT | 1, 928, 884 | 0 | | 0 0 | 0 | 1.00 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | 1, 033, 758 | 0 | | 0 0 | 0 | 2.00 |
| 3.00 | Total (sum of lines 1-2) | 2, 962, 642 | 0 | | 0 0 | 0 | 3.00 |
| | | SUMMARY OF CAPITAL | | | | | |
| | Cost Center Description | Other | Total (1) | | | | |
| | · | Capi tal -Rel at | (sum of cols. | | | | |
| | | ed Costs (see | 9 through 14) | | | | |
| | | instructions) | | | | | |
| | | 14. 00 | 15. 00 | | | | |
| | PART II - RECONCILIATION OF AMOUNTS FROM WOR | KSHEET A, COLUN | · · · · · · · · · · · · · · · · · · · | | | | |
| 1.00 | CAP REL COSTS-BLDG & FLXT | 0 | 1, 928, 884 | 1 | | | 1.00 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | 0 | 1, 033, 758 | 1 | | | 2.00 |
| 3.00 | Total (sum of lines 1-2) | 0 | 2, 962, 642 | | | | 3.00 |

| Health Financial Systems | COMMUNITY HOSPITAL OF | NOBLE CTY, INC | In Lie | u of Form CMS-2552-10 |
|---|-----------------------|-----------------------|----------|-----------------------|
| DECONCLITATION OF CADITAL COSTS CENTEDS | | Providor CCN: 15 0146 | Pori od: | Workshoot A 7 |

| Heal th | n Financial Systems COMM | JNITY HOSPITAL | OF NOBLE CTY, | INC | In Lie | u of Form CMS-2 | 2552-10 |
|---------|--|--|--------------------------|---|-----------------------------|-----------------------------|---------|
| RECON | CILIATION OF CAPITAL COSTS CENTERS | | Provi der C | F | | Date/Time Pre 5/18/2023 11: | pared: |
| | | COM | PUTATION OF RA | TI OS | ALLOCATION OF | OTHER CAPITAL | |
| | Cost Center Description | Gross Assets | Capi tal i zed Leases | Gross Assets for Ratio (col. 1 - col. 2) | Ratio (see instructions) | Insurance | |
| | | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | PART III - RECONCILIATION OF CAPITAL COSTS O | | | | _ | | |
| 1. 00 | CAP REL COSTS-BLDG & FLXT | 5, 947, 732 | | 5, 947, 732 | | | 1.00 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | 17, 686, 327 | | | | | 2.00 |
| 3. 00 | Total (sum of lines 1-2) | 23, 634, 059 | | | | | 3. 00 |
| | | ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL | | | | OF CAPITAL | |
| | Cost Center Description | Taxes | Other | Total (sum of | Depreciation | Lease | |
| | | | Capi tal -Rel at | cols. 5 | | | |
| | | | ed Costs | through 7) | | | |
| | | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | |
| | PART III - RECONCILIATION OF CAPITAL COSTS O | | , | | | | |
| 1. 00 | CAP REL COSTS-BLDG & FLXT | 0 | 1 | (| 287, 461 | 0 | 1.00 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | 0 | | (| 1, 202, 328 | | 2.00 |
| 3.00 | Total (sum of lines 1-2) | 0 | · | (| 1, 489, 789 | 0 | 3.00 |
| | | SUMMARY OF CAPITAL | | | | | |
| | Cost Center Description | Interest | Insurance | Taxes (see | Other | Total (2) | |
| | | | (see | instructions) | • | | |
| | | | instructions) | | | 9 through 14) | |
| | | | | | instructions) | | |
| | | 11. 00 | 12. 00 | 13. 00 | 14. 00 | 15. 00 | |
| | PART III - RECONCILIATION OF CAPITAL COSTS O | | 1 | | | | |
| 1. 00 | CAP REL COSTS-BLDG & FIXT | 0 | 10,010 | • | 0 | 333, 807 | 1.00 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | 0 | 47, 406 | | 0 | 1, 249, 734 | 2.00 |
| 3.00 | Total (sum of lines 1-2) | 0 | 93, 752 | | 0 | 1, 583, 541 | 3.00 |

ADJUSTMENTS TO EXPENSES Provider CCN: 15-0146 Peri od: Worksheet A-8 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/18/2023 11:21 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 1.00 Investment income - CAP REL OCAP REL COSTS-BLDG & FIXT 1. 00 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other В -3, 068 PHARMACY 15.00 3.00 (chapter 2) 4.00 Trade, quantity, and time 0.00 4.00 di scounts (chapter 8) 5.00 Refunds and rebates of 5.00 0 0.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay 7.00 -13, 321 ADMINISTRATIVE & GENERAL 5 00 7.00 Α stations excluded) (chapter 8.00 Television and radio service -736 OPERATION OF PLANT 7.00 8.00 Α (chapter 21) 9.00 Parking lot (chapter 21) 0.00 9.00 -1, 270, 103 10.00 Provi der-based physici an 10.00 A-8-2 adjustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 12.00 A-8-1 -6, 725, 764 transactions (chapter 10) 13.00 13.00 Laundry and linen service 0.00 Cafeteria-employees and guests -82, 094 CAFETERI A 11.00 14.00 Α 14.00 15.00 Rental of quarters to employee 0.00 15.00 and others Sale of medical and surgical 16.00 16.00 0 0.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 17.00 pati ents Sale of medical records and 18.00 0.00 18.00 abstracts 19.00 Nursing and allied health 0.00 19.00 education (tuition, fees, books, etc.) 20.00 Vending machines 0.00 20.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 22.00 0 00 ol 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory ORESPIRATORY THERAPY 65.00 23.00 A-8-3 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical OPHYSICAL THERAPY 24.00 A - 8 - 366.00 therapy costs in excess of limitation (chapter 14) Utilization review OUTILIZATION REVIEW-SNF 25.00 25.00 114.00 physicians' compensation (chapter 21) OCAP REL COSTS-BLDG & FIXT 26.00 Depreciation - CAP REL 1.00 26.00 COSTS-BLDG & FLXT 27.00 Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 27.00 COSTS-MVBLE EQUIP Non-physician Anesthetist Physicians' assistant 28.00 ONONPHYSICIAN ANESTHETISTS 19.00 28.00 29 00 0.00 29 00 Adjustment for occupational O OCCUPATIONAL THERAPY 30.00 30.00 A-8-3 67.00 therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see 30.99 OADULTS & PEDIATRICS 30.00 30.99 instructions)

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10 Provider CCN: 15-0146 Peri od: Worksheet A-8 From 01/01/2022 | Date/Time Prepared:

| | | | | | 12/31/2022 | 5/18/2023 11: | |
|--------|---------------------------------|----------------|----------------|------------------------------|----------------|---------------|--------|
| | | | | Expense Classification on | Worksheet A | | |
| | | | | To/From Which the Amount is | to be Adjusted | | |
| | | | | | • | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | Cost Center Description | Basi s/Code | Amount | Cost Center | Li ne # | Wkst. A-7 | |
| | | (2) | | | | Ref. | |
| | | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| 31. 00 | Adjustment for speech | A-8-3 | 0 | SPEECH PATHOLOGY | 68. 00 | | 31.00 |
| | pathology costs in excess of | | | | | | |
| | limitation (chapter 14) | | | | | | |
| 32. 00 | CAH HIT Adjustment for | | 0 | | 0. 00 | 0 | 32.00 |
| | Depreciation and Interest | | | | | | |
| 33. 00 | OTHER ADJUSTMENTS (SPECIFY) | | 0 | | 0. 00 | 0 | 33. 00 |
| | (3) | | _ | | | _ | |
| 33. 01 | OTHER ADJUSTMENTS (SPECIFY) | | 0 | | 0. 00 | 0 | 33. 01 |
| | (3) | | | | | _ | |
| 33. 02 | TELEPHONE | А | -2, 983 | EMPLOYEE BENEFITS DEPARTMENT | 4. 00 | 0 | |
| 33. 03 | OTHER ADJUSTMENTS (SPECIFY) | | 0 | | 0. 00 | 0 | 33. 03 |
| | (3) | | _ | | | _ | |
| 33. 04 | PHYSI CI AN RECRUI TMENT | A | | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | |
| 33. 05 | PHARMACY SALES | В | | PHARMACY | 15. 00 | 0 | 33. 05 |
| 33. 06 | SELF INSURANCE | Α | 0 | EMPLOYEE BENEFITS DEPARTMENT | 4. 00 | 0 | 33.06 |
| 33. 07 | OTHER ADJUSTMENTS (SPECIFY) | | 0 | | 0. 00 | 0 | 33. 07 |
| | (3) | | | | | | |
| 33. 08 | OTHER ADJUSTMENTS (SPECIFY) | | 0 | | 0. 00 | 0 | 33. 08 |
| | (3) | _ | | | | | |
| 33. 09 | LOBBY DUES | Α | | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | |
| 33. 10 | LI QUOR | Α | | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | |
| 33. 11 | LIQUOR | Α | | FOUNDATI ON | 194. 03 | 0 | |
| 33. 12 | INTERUNIT SUBSIDY | А | 0 | PHYSI CAL THERAPY | 66. 00 | 0 | |
| 33. 13 | OTHER ADJUSTMENTS (SPECIFY) | | 0 | | 0. 00 | 0 | 33. 13 |
| | (3) | | | | | | |
| 33. 14 | INTERUNIT SUBSIDY | А | | CAP REL COSTS-BLDG & FLXT | 1. 00 | 9 | 33. 14 |
| 33. 15 | INTERUNIT SUBSIDY | Α | | COMMUNITY & VOLUNTEER | 194. 05 | 0 | 33. 15 |
| | | | | SERVI CES | | | |
| 33. 16 | INTERUNIT SUBSIDY | А | | RADI OLOGY-DI AGNOSTI C | 54. 00 | 0 | 000 |
| 33. 17 | OTHER OPERATING REVENUE | В | | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 33. 17 |
| 33. 18 | OTHER OPERATING REVENUE | В | | OPERATION OF PLANT | 7. 00 | 0 | 33. 18 |
| 33. 19 | OTHER OPERATING REVENUE | В | | DRUGS CHARGED TO PATIENTS | 73. 00 | 0 | 33. 19 |
| 33. 20 | OTHER OPERATING REVENUE | В | -771 | DI ETARY | 10. 00 | 0 | 33. 20 |
| 33. 21 | OTHER OPERATING REVENUE | В | -230, 571 | CAFETERI A | 11. 00 | 0 | 33. 21 |
| 33. 22 | OTHER OPERATING REVENUE | В | -200 | NURSING ADMINISTRATION | 13. 00 | 0 | 33. 22 |
| 33. 23 | OTHER OPERATING REVENUE | В | -3, 344 | PHARMACY | 15. 00 | 0 | 33. 23 |
| 33. 24 | OTHER OPERATING REVENUE | В | -835 | ADULTS & PEDIATRICS | 30. 00 | 0 | 33. 24 |
| 33. 25 | OTHER OPERATING REVENUE | В | | OPERATING ROOM | 50.00 | 0 | 00.20 |
| 33. 26 | OTHER OPERATING REVENUE | В | 0 | RESPI RATORY THERAPY | 65. 00 | 0 | 33. 26 |
| 33. 27 | OTHER OPERATING REVENUE | В | -13, 218 | PHYSI CAL THERAPY | 66. 00 | 0 | 33. 27 |
| 33. 28 | OTHER OPERATING REVENUE | В | -3, 335 | HYPERBARIC OXYGEN THERAPY | 76. 98 | 0 | 33. 28 |
| 33. 29 | OTHER OPERATING REVENUE | В | -1, 650 | AMBULANCE SERVICES | 95. 00 | 0 | 33. 29 |
| 33. 30 | OTHER OPERATING REVENUE | В | 0 | GIFT, FLOWER, COFFEE SHOP & | 190. 00 | 0 | 33. 30 |
| | | | | CANTEEN | | | |
| 33. 31 | OTHER OPERATING REVENUE | В | 0 | COMMUNITY & VOLUNTEER | 194. 05 | 0 | 33. 31 |
| | | | | SERVI CES | | | |
| 33. 32 | TELEMETRY CHARGES | Α | 40, 721 | ADULTS & PEDIATRICS | 30. 00 | 0 | 33. 32 |
| 33. 33 | ADMIN PHYS SALARIES | Α | | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | |
| 33. 34 | LOBBYING EXPENSE | А | -130 | PHYSI CAL THERAPY | 66. 00 | 0 | 33. 34 |
| 33. 35 | LOBBYING EXPENSE | А | | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 33. 35 |
| 33. 36 | HOSPITAL ASSESSMENT FEE | Α | · · | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | |
| 33. 37 | OTHER OPERATING REVENUE | В | | OPERATING ROOM | 50. 00 | 0 | 33. 37 |
| 33. 38 | OTHER OPERATING REVENUE | В | | HYPERBARIC OXYGEN THERAPY | 76. 98 | 0 | |
| 50. 00 | TOTAL (sum of lines 1 thru 49) | | -13, 368, 613 | | | _ | 50.00 |
| | (Transfer to Worksheet A, | | | | | | |
| | column 6, line 200.) | | | | | | |
| (1) De | scription - all chapter referer | ces in this co | lumn pertain t | o CMS Pub 15-1 | | | |

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

Worksheet A-8-1 From 01/01/2022

| 011102 | 556.16 | | 7 | Го 12/31/2022 | Date/Time Pre 5/18/2023 11: | |
|--------|------------------------------|-------------------------------|------------------------------|-----------------|-----------------------------|------|
| | Li ne No. | Cost Center | Expense Items | Amount of | Amount | |
| | | | | Allowable Cost | Included in | |
| | | | | | Wks. A, column | |
| | | | | | 5 | |
| | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | A. COSTS INCURRED AND ADJUST | MENTS REQUIRED AS A RESULT OF | TRANSACTIONS WITH RELATED OF | RGANIZATIONS OF | CLAIMED HOME | |
| | OFFICE COSTS: | | | | | |
| 1.00 | 5. 00 | ADMINISTRATIVE & GENERAL | HOME OFFICE ALLOCATION | 11, 192, 873 | 10, 227, 087 | 1.00 |
| 2.00 | 5. 00 | ADMINISTRATIVE & GENERAL | PPG SUBSI DY | 0 | 7, 128, 906 | 2.00 |
| 3.00 | 5. 00 | ADMINISTRATIVE & GENERAL | INTEREST EXPENSE ELIMINATION | 0 | 562, 644 | 3.00 |
| 4.00 | 0.00 | | | 0 | 0 | 4.00 |
| 5.00 | TOTALS (sum of lines 1-4). | | | 11, 192, 873 | 17, 918, 637 | 5.00 |
| | Transfer column 6, line 5 to | | | | | |
| | Worksheet A-8, column 2, | | | | | |
| | line 12. | | | | | |

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

| | | | Related Organization(s) and/ | or Home Office | | | | |
|---|-------|---------------|------------------------------|----------------|--|--|--|--|
| | | | | | | | | |
| | | | | | | | | |
| Symbol (1) | Name | Percentage of | Name | Percentage of | | | | |
| | | Ownershi p | | Ownershi p | | | | |
| 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | | | | |
| B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE: | | | | | | | | |

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

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

| 6. 00 | В | 0.00 PARKVI EW HEALTH 100.00 | 6.00 |
|--------|-------------------------|------------------------------|--------|
| 7. 00 | | 0.00 | 7. 00 |
| 8. 00 | | 0.00 | 8. 00 |
| 9. 00 | | 0.00 | 9. 00 |
| 10.00 | | 0.00 | 10.00 |
| 100.00 | G. Other (financial or | | 100.00 |
| | non-financial) specify: | | |

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

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

| Heal th | Financial Syste | ems | COMMUNITY HOSPITAL | OF NOBLE CTY | r, INC | In Lieu | u of Form CMS- | 2552-10 |
|---------|---------------------------|----------------------------|---|---------------|----------------|----------------------------------|--------------------------------|---------|
| STATEME | NT OF COSTS OF | SERVICES FROM | RELATED ORGANIZATIONS AND HOM | E Provi der | CCN: 15-0146 | Peri od: | Worksheet A-8 | 3-1 |
| OFFICE | COSTS | | | | | From 01/01/2022 To 12/31/2022 | Date/Time Pre 5/18/2023 11: | |
| | Net | Wkst. A-7 Ref. | | | | | | |
| | Adjustments | | | | | | | |
| | (col. 4 minus | | | | | | | |
| | col. 5)* | | | | | | | |
| | 6. 00 | 7. 00 | | | | | | |
| | A. COSTS INCUR | RED AND ADJUSTM | MENTS REQUIRED AS A RESULT OF | TRANSACTI ONS | S WITH RELATED | ORGANI ZATI ONS OR | CLAIMED HOME | |
| | OFFICE COSTS: | | | | | | | |
| 1.00 | 965, 786 | 0 | | | | | | 1.00 |
| 2.00 | -7, 128, 906 | 0 | | | | | | 2.00 |
| 3.00 | -562, 644 | 0 | | | | | | 3.00 |
| 4.00 | 0 | 0 |) | | | | | 4.00 |
| 5.00 | -6, 725, 764 | | | | | | | 5.00 |
| * The | amounts on line | es 1-4 (and sub | bscripts as appropriate) are t | ransferred i | n detail to Wo | rksheet A, column | 6, lines as | |
| appropr | i ate. Posi ti ve | amounts increas | se cost and negative amounts of columns 1 and/or 2, the amoun | ecrease cost | For related o | organization or ho | me office cos | |
| | Related Orga and/or Ho | anization(s) ome Office | | | | | <u>.</u> | |

Type of Business 6. 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.

| | TOT MID AT COMOTTE AND CONTROL OF | | | | | | |
|--------------------------|--|--|--------|--|--|--|--|
| 6.00 | HOME OFFICE | | 6.00 | | | | |
| 7.00 | | | 7.00 | | | | |
| 8.00 | | | 8.00 | | | | |
| 9.00 | | | 9.00 | | | | |
| 8. 00 9. 00 10. 00 | | | 10.00 | | | | |
| 100.00 | | | 100.00 | | | | |

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

 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related 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 01/01/2022 To 12/31/2022 Date/Time Prepared: Provi der CCN: 15-0146

| | | | | | | | To 12/31/202 | 2 Date/Time Pre 5/18/2023 11: | epared: :21 am |
|---------|--------------------|------|--------------------|----------------|---------------|-----------------|-------------------------|-------------------------------|-------------------|
| | Wkst. A Line # | Cost | Center/Physi ci an | Total | Professi onal | Provi der | RCE Amount | Physi ci an/Prov | |
| | | | l denti fi er | Remuneration | Component | Component | | ider Component | |
| | | | | | ' | ' | | Hours | |
| | 1.00 | | 2. 00 | 3. 00 | 4. 00 | 5. 00 | 6. 00 | 7. 00 | |
| 1.00 | 53. 00 DR | . A | | 1, 234, 701 | 1, 234, 70 | 1 | 0 239, 400 | 0 | 1.00 |
| 2.00 | 91. 00 DR | | | 43, 333 | | 0 43, 3 | 33 211, 500 | 78 | 2.00 |
| 3.00 | 0.00 | | | 0 | | 0 | 0 | | 3.00 |
| 4.00 | 0.00 | | | 0 | | 0 | 0 | ol o | 4.00 |
| 5.00 | 0.00 | | | 0 | | 0 | 0 | ol o | 5.00 |
| 6.00 | 0.00 | | | 0 | | 0 | 0 | ol o | 6.00 |
| 7.00 | 0.00 | | | 0 | | 0 | 0 | ol o | 7.00 |
| 8.00 | 0.00 | | | 0 | | 0 | 0 | ol o | 8. 00 |
| 9. 00 | 0.00 | | | 0 | | 0 | 0 | ol o | 9. 00 |
| 10.00 | 0.00 | | | 0 | | 0 | 0 | ol o | 10.00 |
| 200.00 | | | | 1, 278, 034 | 1, 234, 70 | 43, 3 | 33 | 78 | 200.00 |
| | Wkst. A Line # | Cost | Center/Physi ci an | Unadjusted RCE | | | Provi der | Physician Cost | |
| | | | l denti fi er | Limit | Unadjusted RC | E Memberships | & Component | of Mal practice | |
| | | | | | Limit | Continuing | Share of col. | Insurance | |
| | | | | | | Education | 12 | | |
| | 1.00 | | 2. 00 | 8. 00 | 9. 00 | 12. 00 | 13. 00 | 14. 00 | |
| 1.00 | 53. 00 DR | | | 0 | | 0 | 0 | 0 | |
| 2.00 | 91. 00 DR | . B | | 7, 931 | | | 0 | 0 | |
| 3.00 | 0.00 | | | 0 | | 0 | 0 | 0 | |
| 4.00 | 0.00 | | | 0 | | 0 | 0 | 0 | |
| 5.00 | 0.00 | | | 0 | | 0 | 0 | 0 | 5.00 |
| 6.00 | 0.00 | | | 0 | | 0 | 0 | 0 | 6. 00 |
| 7. 00 | 0.00 | | | 0 | | 0 | 0 | 0 | 7. 00 |
| 8. 00 | 0.00 | | | 0 | | 0 | 0 | 0 | |
| 9. 00 | 0.00 | | | 0 | | 0 | 0 | 0 | 9. 00 |
| 10.00 | 0.00 | | | 0 | | 0 | 0 | 0 | |
| 200.00 | | | | 7, 931 | | | 0 (| 0 | 200.00 |
| | Wkst. A Line # | Cost | Center/Physi ci an | Provi der | Adjusted RCE | | Adjustment | | |
| | | | l denti fi er | Component | Limit | Di sal I owance | 9 | | |
| | | | | Share of col. | | | | | |
| | 1 00 | | 2.00 | 14 | 1/ 00 | 17.00 | 10.00 | _ | |
| 1 00 | 1. 00 53. 00 DR | Λ. | 2. 00 | 15. 00 | 16. 00 | 17.00 | 18. 00 0 1, 234, 70° | 1 | 1. 00 |
| 1.00 | 91. 00 DR | | | | | <u> </u> | | | |
| 2.00 | 1 | . в | | | | 0 35, 40 | 1 | | 2.00 |
| 3.00 | 0.00 | | | 0 | | - | | | 3.00 |
| 4. 00 | 0.00 | | | 0 | | 0 | | | 4.00 |
| 5. 00 | 0.00 | | | 0 | | | | | 5.00 |
| 6. 00 | 0.00 | | | 0 | | | | | 6.00 |
| 7. 00 | 0.00 | | | 0 | | 0 | | | 7.00 |
| 8. 00 | 0.00 | | | 0 | | U | | | 8.00 |
| 9. 00 | 0.00 | | | 0 | | U | UJ (| | 9.00 |
| 10.00 | 0. 00 | | | 0 | | 0 | -1 | | 10.00 |
| 200. 00 | 1 | | | 0 | 7, 93 | 35, 40 | 02 1, 270, 103 | 5 | 200.00 |

| Period: | Worksheet B | From 01/01/2022 | Part | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS COMMUNITY HOSPITAL OF NOBLE CTY, INC
Provider CCN: 15-0146

| | | | | | o 12/31/2022 | | |
|------------------|---|----------------------------|-------------------|------------------|--------------|-------------------------|---|
| | | | CAPI TAL REI | LATED COSTS | | 5/18/2023 11: | 21 am |
| | Cost Center Description | Net Expenses | BLDG & FIXT | MVBLE EQUIP | EMPLOYEE | Subtotal | |
| | cost conton secon per on | for Cost | 5250 a | | BENEFI TS | 00010101 | |
| | | Allocation (from Wkst A | | | DEPARTMENT | | |
| | | col. 7) | | | | | |
| | GENERAL SERVI CE COST CENTERS | 0 | 1. 00 | 2. 00 | 4. 00 | 4A | |
| 1. 00 | 00100 CAP REL COSTS-BLDG & FLXT | 333, 807 | 333, 807 | | | | 1.00 |
| 2. 00 4. 00 | 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT | 1, 249, 734 6, 206, 884 | 0 | 1, 249, 734 0 | | | 2.00 4.00 |
| 5. 00 | 00500 ADMINISTRATIVE & GENERAL | 13, 687, 032 | 72, 154 | | | 15, 448, 361 | 5. 00 |
| 6. 00 7. 00 | 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT | 0 1, 215, 554 | 07.077 | 0 | 112 541 | 1 200 022 | 6. 00 7. 00 |
| 8. 00 | 00800 LAUNDRY & LINEN SERVICE | 195, 352 | 27, 877 2, 398 | 1 | | 1, 389, 023 197, 750 | 8.00 |
| 9.00 | 00900 HOUSEKEEPI NG 01000 DI ETARY | 557, 698 | 3, 469 | l . | , | 692, 554 | 9.00 |
| 10. 00 11. 00 | 01100 CAFETERI A | 403, 138 128, 905 | 7, 665 4, 620 | 1 | | 486, 530 205, 603 | 10.00 11.00 |
| 12.00 | 01200 MAINTENANCE OF PERSONNEL | 0 | 071 | _ | - | 0 | 12.00 |
| 13. 00 14. 00 | 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY | 552, 890 0 | 971 8, 922 | | _ | 756, 560 8, 922 | 13.00 14.00 |
| 15.00 | 01500 PHARMACY | 0 | 2, 631 | 1 | 195, 781 | 201, 664 | 15.00 |
| 16. 00 17. 00 | 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE | 0 | 4, 019 0 | 0 | 0 | 4, 019 0 | 16. 00 17. 00 |
| 19. 00 | 01900 NONPHYSICIAN ANESTHETISTS | 0 | 0 | 0 | 0 | 0 | 19. 00 |
| 20. 00 21. 00 | 02000 NURSING PROGRAM 02100 L&R SERVICES-SALARY & FRINGES APPRVD | 0 | 0 | 0 | 0 | 0 | 20. 00 21. 00 |
| 22. 00 | 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD | 0 | 0 | Ö | 0 | 0 | 22. 00 |
| 30. 00 | INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS | 3, 950, 938 | 41, 961 | 88, 799 | 737, 063 | 4, 818, 761 | 30.00 |
| 31.00 | 03100 INTENSIVE CARE UNIT | 0 | 0 | 0 | | 0 | 31.00 |
| 32. 00 33. 00 | 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT | 0 | 0 | 0 | 0 | 0 | 32. 00 33. 00 |
| 34.00 | 03400 SURGICAL INTENSIVE CARE UNIT | 0 | Ö | Ö | Ö | 0 | 34.00 |
| 40. 00 41. 00 | 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF | 0 | 0 | 0 | 0 | 0 | 40. 00 41. 00 |
| 43. 00 | 04300 NURSERY | 160, 023 | 603 | 5, 221 | 30, 917 | 196, 764 | 43.00 |
| 44. 00 45. 00 | 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY | 0 | 0 | 1 | | 0 | 44. 00 45. 00 |
| 46. 00 | 04600 OTHER LONG TERM CARE | 0 | 0 | ő | | 0 | 46.00 |
| 50. 00 | ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM | 2, 072, 098 | 43, 899 | 135, 892 | 298, 461 | 2, 550, 350 | 50.00 |
| 51.00 | 05100 RECOVERY ROOM | 0 | 0 | 0 | 0 | 0 | 51.00 |
| 52. 00 53. 00 | 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY | 758, 026 | 3, 873 | 24, 730 | | 933, 084 0 | 52.00 53.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 2, 220, 632 | 21, 218 | 374, 351 | 380, 165 | 2, 996, 366 | 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 | Ö | ő | 0 | 0 | 57. 00 |
| 58. 00 59. 00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION | 0 | 0 | | | 0 | 58. 00 59. 00 |
| 60.00 | 06000 LABORATORY | 2, 945, 886 | 8, 108 | | | 2, 953, 994 | 60.00 |
| 60. 01 | 06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | 0 | 0 | 0 | 0 | 0 | 60.01 |
| 61. 00 62. 00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0 | 0 | О | 0 | 0 | 61. 00 62. 00 |
| 63.00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | 0 | | | 0 | 63.00 |
| 64. 00 65. 00 | 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY | 881, 001 | 5, 172 | 0 64, 570 | - | 0 1, 152, 274 | 64. 00 65. 00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 640, 781 | 22, 357 | | | 844, 195 | 66.00 |
| 67. 00 68. 00 | 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY | 443, 369 191, 189 | 0 | 0 | | 558, 269 240, 736 | |
| 69. 00 | 06900 ELECTROCARDI OLOGY | 0 | 0 | 0 | 0 | 0 | 69. 00 |
| 70. 00 71. 00 | 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 234, 141 | 0 | 0 | 0 | 0 234, 141 | 70.00 71.00 |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENTS | 422, 351 | 0 | Ö | 0 | 422, 351 | 72. 00 |
| 73. 00 74. 00 | 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS | 3, 451, 706 | 0 | 0 | 0 | 3, 451, 706 0 | 73.00 74.00 |
| 75. 00 | 07500 ASC (NON-DISTINCT PART) | 0 | Ö | Ö | Ö | 0 | 75. 00 |
| 76. 98 | 07698 HYPERBARIC OXYGEN THERAPY | 448, 054 | 4, 118 0 | | | 558, 172 0 | 76. 98 77. 00 |
| | 77. 00 O7700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS | | 0 | | - | | |
| 88. 00 89. 00 | 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER | 0 | 0 | 0 | | 0 | 88. 00 89. 00 |
| 90.00 | 09000 CLI NI C | 41, 396 | Ö | O | 10, 741 | 52, 137 | 90.00 |
| 91. 00 92. 00 | 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 2, 303, 775 | 17, 572 | 31, 041 | 460, 222 | 2, 812, 610 0 | 91.00 92.00 |
| 72.00 | 11.11.11.1502 | 1 | ı | 1 | 1 | | , |

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0146 Peri od: Worksheet B From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/18/2023 11:21 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) 4. 00 0 1.00 2.00 4A OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 09500 AMBULANCE SERVICES 4, 863, 072 382, 594 1, 062, 413 6, 308, 079 95.00 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 0 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 97.00 0 0 0 0 0 0 99.00 09900 CMHC 0 0 0 0 99.00 99. 10 09910 CORF 0 0 0 0 o 0 99. 10 0 o 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 100.00 0 101.00 10100 HOME HEALTH AGENCY 0 0 C 0 101.00 102.00 10200 OPIOID TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 105, 00 0 106.00 10600 HEART ACQUISITION 0 0 0 0 106.00 107.00 10700 LIVER ACQUISITION 0 0 0 0 0 107.00 0 108.00 10800 LUNG ACQUISITION 0 0 0 108.00 0 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 0 Ω 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 111.00 0 113.00 11300 INTEREST EXPENSE 113 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 115.00 116. 00 11600 HOSPI CE 0 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 249, 034 50, 559, 432 303, 607 6, 153, 327 50, 474, 975 118. 00 118, 00 NONREI MBURSABLE COST CENTERS 12, 873 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2, 449 79 15, 401 190. 00 191. 00 19100 RESEARCH 637 191.00 637 0 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 79, 980 192. 00 50, 823 15, 782 193 13, 182 193. 00 19300 NONPALD WORKERS 0 0 193.00 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 194.00 0 0 0 194. 01 07951 PAIN CLINIC 0 0 0 194. 01 0 0 194. 02 07952 OCC HEALTH 0 0 194 02 Λ C 0 194. 03 07953 FOUNDATI ON 0 0 74, 461 194. 03 74, 461 194. 04 07954 PHYSICIAN OFFICES 0 194.04 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 40, 375 268, 661 194. 05 215, 889 11, 969 428 194.06 07956 VACANT SPACE 0 194.06 0 200.00 Cross Foot Adjustments 0 200.00

50, 914, 115

333, 807

1, 249, 734

6, 206, 884

0 201.00

50, 914, 115 202. 00

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0146

| Peri od: | Worksheet B | From 01/01/2022 | Part | | Date/Time Prepared: | 5/18/2023 | 11: 21 am |

| Cook Cooker Books at the | ADMINI CTDATIV | MAL NITENANCE O | ODEDATION OF | I ALINDDY 0 | 5/18/2023 11: | 21 am |
|--|---------------------|-----------------|--------------------|-------------------------|---------------|------------------|
| Cost Center Description | ADMINISTRATIV | REPAIRS | OPERATION OF PLANT | LAUNDRY & LINEN SERVICE | HOUSEKEEPI NG | |
| | 5. 00 | 6. 00 | 7. 00 | 8. 00 | 9. 00 | |
| GENERAL SERVICE COST CENTERS | 0.00 | 0.00 | 7.00 | 0.00 | 7.00 | |
| 1.00 O0100 CAP REL COSTS-BLDG & FLXT | | | | | | 1.00 |
| 2.00 O0200 CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4. 00 |
| 5. 00 00500 ADMINI STRATI VE & GENERAL | 15, 448, 361 | | | | | 5.00 |
| 6. 00 00600 MAI NTENANCE & REPAI RS | 0 | 0 | 1 004 0/4 | | | 6.00 |
| 7. 00 00700 OPERATION OF PLANT | 605, 038 | 0 | 1, 994, 061 | 204 242 | | 7.00 |
| 8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG | 86, 137 301, 666 | 0 | 20, 456 29, 589 | | 1, 023, 809 | 8. 00 9. 00 |
| 10. 00 01000 DI ETARY | 211, 925 | 0 | 65, 377 | 0 | 34, 431 | 1 |
| 11. 00 01100 CAFETERI A | 89, 558 | 0 | 39, 404 | 0 | 20, 752 | 11.00 |
| 12. 00 01200 MAINTENANCE OF PERSONNEL | 07,000 | 0 | 0,, 101 | 0 | 0 | 12.00 |
| 13. 00 01300 NURSING ADMINISTRATION | 329, 546 | 0 | 8, 286 | 0 | 4, 364 | 13.00 |
| 14.00 01400 CENTRAL SERVICES & SUPPLY | 3, 886 | 0 | 76, 101 | 9, 285 | | 14.00 |
| 15. 00 01500 PHARMACY | 87, 842 | 0 | 22, 440 | 0 | 11, 818 | 15.00 |
| 16.00 01600 MEDICAL RECORDS & LIBRARY | 1, 751 | 0 | 34, 280 | 0 | 18, 053 | 16.00 |
| 17.00 01700 SOCIAL SERVICE | 0 | 0 | 0 | 0 | 0 | 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 1&R SERVICES-SALARY & FRINGES APPRVD | 0 | 0 | 0 | 0 | 0 | 21.00 |
| 22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD INPATIENT ROUTINE SERVI CE COST CENTERS | 0 | 0 |] 0 | 0 | 0 | 22. 00 |
| 30. 00 03000 ADULTS & PEDIATRICS | 2, 098, 980 | 0 | 357, 921 | 107, 011 | 188, 498 | 30.00 |
| 31. 00 03100 NTENSI VE CARE UNI T | 2,070,700 | 0 | 337, 721 | 107,011 | 0 | 31.00 |
| 32. 00 03200 CORONARY CARE UNIT | 0 | 0 | 0 | 0 | Ö | 32.00 |
| 33. 00 03300 BURN INTENSIVE CARE UNIT | 0 | 0 | 0 | 0 | Ö | 33.00 |
| 34. 00 03400 SURGI CAL INTENSI VE CARE UNI T | 0 | 0 | 0 | 0 | Ö | 34.00 |
| 40. 00 04000 SUBPROVI DER - 1 PF | O | 0 | 0 | 0 | Ō | 40.00 |
| 41. 00 04100 SUBPROVI DER - RF | O | 0 | 0 | 0 | 0 | 41.00 |
| 43. 00 04300 NURSERY | 85, 707 | 0 | 5, 145 | 308 | 2, 710 | 43.00 |
| 44.00 04400 SKILLED NURSING FACILITY | 0 | 0 | 0 | 0 | 0 | 44.00 |
| 45.00 04500 NURSING FACILITY | 0 | 0 | 0 | 0 | 0 | 45.00 |
| 46.00 O4600 OTHER LONG TERM CARE | 0 | 0 | 0 | 0 | 0 | 46. 00 |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50. 00 05000 OPERATING ROOM | 1, 110, 894 | 0 | 374, 449 | 80, 650 | l | 50.00 |
| 51. 00 05100 RECOVERY ROOM | 0 | 0 | 0 | 0 | 0 | 51.00 |
| 52. 00 05200 DELI VERY ROOM & LABOR ROOM | 406, 437 | 0 | 33, 040 | 309 | | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 1, 305, 172 | 0 | 180, 985 | 30, 571 | 0 95, 315 | 53.00 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 1, 303, 172 | 0 | 100, 900 | 30, 371 | 95, 315 | 54. 00 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 IMAGING (MRI) | o o | 0 | 0 | 0 | Ö | 58.00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | O | 0 | Ō | 0 | Ō | 59.00 |
| 60. 00 06000 LABORATORY | 1, 286, 715 | 0 | 69, 158 | 0 | 36, 422 | 60.00 |
| 60. 01 06001 BLOOD LABORATORY | 0 | 0 | 0 | 0 | 0 | 60. 01 |
| 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | | | | | | 61.00 |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0 | 0 | 0 | 0 | 0 | 62.00 |
| 63.00 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | 0 | 0 | 0 | 0 | 63.00 |
| 64.00 06400 I NTRAVENOUS THERAPY | 0 | 0 | 0 | 0 | 0 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 501, 913 | 0 | 44, 115 | · · | 1 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 367, 719 | 0 | 190, 697 | 0 | 100, 430 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 243, 174 | 0 | 0 | 0 | 0 | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 104, 861 | 0 | 0 | 0 | 0 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | 0 | 0 | 0 | 69. 00 70. 00 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 101, 988 | 0 | 0 | 0 | | 70.00 |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS | 183, 970 | 0 | 0 | 0 | 0 | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 1, 503, 511 | 0 | 0 | 0 | 0 | 73.00 |
| 74. 00 07400 RENAL DI ALYSI S | 1, 303, 311 | 0 | 0 | 0 | Ö | 74.00 |
| 75. 00 07500 ASC (NON-DISTINCT PART) | o | 0 | o o | 0 | Ö | 75.00 |
| 76. 98 07698 HYPERBARI C OXYGEN THERAPY | 243, 131 | 0 | 35, 127 | 440 | 18, 499 | |
| 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | 0 | | 0 | 0 | 77.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88. 00 08800 RURAL HEALTH CLINIC | 0 | 0 | 0 | 0 | 0 | 88. 00 |
| 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER | 0 | 0 | 0 | 0 | 0 | 89. 00 |
| 90. 00 09000 CLI NI C | 22, 710 | 0 | 0 | 0 | 0 | 90.00 |
| 91. 00 09100 EMERGENCY | 1, 225, 131 | 0 | 149, 888 | 71, 604 | 78, 938 | 91.00 |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | .1 | | | | | |
| 94. 00 09400 HOME PROGRAM DIALYSIS | 0 747 747 | 0 | 0 | | 0 | 94.00 |
| 95. 00 09500 AMBULANCE SERVI CES | 2, 747, 717 | 0 | 0 | Ī | 0 | 95.00 |
| 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD | 0 | 0 | 0 | 0 | 0 | 96. 00 97. 00 |
| 71. 00 07/00 DURABLE WILDI CAL EQUIP-SULD | ı | 0 | 1 0 | 1 0 | 1 0 | 77.00 |
| | | | | | | |

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0146

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

| | | | | 12/01/2022 | 5/18/2023 11: | |
|--|------------------|---------------|--------------|---------------|---------------|---------|
| Cost Center Description | ADMI NI STRATI V | MAINTENANCE & | OPERATION OF | LAUNDRY & | HOUSEKEEPI NG | |
| | E & GENERAL | REPAI RS | PLANT | LINEN SERVICE | | |
| | 5. 00 | 6. 00 | 7. 00 | 8. 00 | 9. 00 | |
| 99. 00 09900 CMHC | 0 | 0 | 0 | 0 | 0 | |
| 99. 10 09910 CORF | 0 | 0 | 0 | 0 | 0 | |
| 100.00 10000 I&R SERVICES-NOT APPRVD PRGM | 0 | 0 | 0 | 0 | | 100.00 |
| 101.00 10100 HOME HEALTH AGENCY | 0 | 0 | 0 | 0 | | 101.00 |
| 102.00 10200 OPI OID TREATMENT PROGRAM | 0 | 0 | 0 | 0 | 0 | 102.00 |
| SPECIAL PURPOSE COST CENTERS | | | | | | |
| 105. 00 10500 KIDNEY ACQUISITION | 0 | 0 | 0 | 0 | | 105.00 |
| 106. 00 10600 HEART ACQUISITION | 0 | 0 | 0 | 0 | | 106. 00 |
| 107.00 10700 LIVER ACQUISITION | 0 | 0 | 0 | 0 | | 107.00 |
| 108.00 10800 LUNG ACQUISITION | 0 | 0 | 0 | 0 | | 108. 00 |
| 109. 00 10900 PANCREAS ACQUISITION | 0 | 0 | 0 | 0 | | 109. 00 |
| 110.00 11000 INTESTINAL ACQUISITION | 0 | 0 | 0 | 0 | | 110.00 |
| 111.00 11100 ISLET ACQUISITION | 0 | 0 | 0 | 0 | 0 | 111. 00 |
| 113.00 11300 INTEREST EXPENSE | | | | | | 113.00 |
| 114.00 11400 UTILIZATION REVIEW-SNF | | | | | | 114.00 |
| 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) | 0 | 0 | 0 | 0 | | 115.00 |
| 116. 00 11600 HOSPI CE | 0 | 0 | 0 | 0 | 0 | 116. 00 |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) | 15, 257, 079 | 0 | 1, 736, 458 | 302, 051 | 888, 143 | 118. 00 |
| NONREI MBURSABLE COST CENTERS | | | | | | |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 6, 708 | | 20, 890 | 0 | | 190. 00 |
| 191. 00 19100 RESEARCH | 277 | | 0 | 0 | | 191. 00 |
| 192.00 19200 PHYSICIANS' PRIVATE OFFICES | 34, 838 | 0 | 134, 618 | 2, 292 | | 192.00 |
| 193.00 19300 NONPALD WORKERS | 0 | 0 | 0 | 0 | | 193. 00 |
| 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | 0 | 0 | | 194. 00 |
| 194. 01 07951 PAIN CLINIC | 0 | 0 | 0 | 0 | | 194. 01 |
| 194. 02 07952 OCC HEALTH | 0 | 0 | 0 | 0 | | 194. 02 |
| 194. 03 07953 FOUNDATI ON | 32, 434 | 0 | 0 | 0 | | 194. 03 |
| 194. 04 07954 PHYSICIAN OFFICES | 0 | 0 | 0 | 0 | | 194. 04 |
| 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES | 117, 025 | 0 | 102, 095 | 0 | 53, 768 | |
| 194. 06 07956 VACANT SPACE | 0 | 0 | 0 | 0 | 0 | 194. 06 |
| 200.00 Cross Foot Adjustments | | | | | | 200.00 |
| 201.00 Negative Cost Centers | 0 | 0 | 0 | 0 | | 201.00 |
| 202.00 TOTAL (sum lines 118 through 201) | 15, 448, 361 | 0 | 1, 994, 061 | 304, 343 | 1, 023, 809 | 202.00 |

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0146

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

5/18/2023 11: 21 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 798, 263 10 00 01100 CAFETERI A 11.00 355, 317 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 0 12.00 13.00 01300 NURSING ADMINISTRATION 0 8,877 1, 107, 633 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 138, 272 14.00 01500 PHARMACY 15 00 0 0 2,005 10.447 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 0 0 16.00 01700 SOCIAL SERVICE 0 0 17 00 0 17.00 0 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 0 0 19.00 02000 NURSING PROGRAM 0 0 20 00 C 0 20.00 02100 | &R SERVICES-SALARY & FRINGES APPRVD 0 0 21.00 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 0 O 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 798, 263 59, 323 0 457, 605 20, 675 30.00 31.00 03100 INTENSIVE CARE UNIT 0 0 31.00 32.00 03200 CORONARY CARE UNIT 0 0 0 32.00 C 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 40.00 0 0 40.00 0 04100 SUBPROVI DER - I RF 0 41.00 0 0 41.00 04300 NURSERY 0 43.00 2,834 21, 859 0 43.00 44.00 0 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 0 46 00 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 23, 247 0 179, 322 23, 958 50.00 0 51.00 05100 RECOVERY ROOM 0 0 51.00 0 52 00 05200 DELIVERY ROOM & LABOR ROOM 13, 425 0 103, 558 52 00 0 0 53.00 05300 ANESTHESI OLOGY 0 0 0 53.00 5, 253 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 35, 736 54.00 0 55 00 05500 RADI OLOGY-THERAPEUTI C 0 0 55 00 C 0 0 56.00 05600 RADI OI SOTOPE C 0 0 56.00 0 05700 CT SCAN 0 57.00 57.00 0 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 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 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 C 0 0 0 63.00 06400 I NTRAVENOUS THERAPY 0 0 64.00 0 64.00 0 06500 RESPIRATORY THERAPY 0 0 65.00 17.598 0 3.634 65.00 66 00 06600 PHYSI CAL THERAPY 12, 376 0 802 66.00 06700 OCCUPATI ONAL THERAPY 9, 796 0 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 4, 224 0 0 O 68.00 0000000 0 06900 FLECTROCARDI OLOGY 0 69.00 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY C 0 0 Λ 70.00 36, 678 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS C 0 0 3, 346 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 07698 HYPERBARIC OXYGEN THERAPY 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 76.98 76.98 9.844 75.930 4.867 0 0 77.00 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 0 0 90.00 09000 CLI NI C 0 947 124 90.00 09100 EMERGENCY 0 0 269, 359 91.00 34, 920 18, 394 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 09500 AMBULANCE SERVICES 95.00 0 103, 691 0 0 17, 569 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 ol 96.00 0

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0146

| Peri od: | Worksheet B | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared:

| | | | ' | 0 12/31/2022 | 5/18/2023 11: 21 am |
|--|----------|------------|--------------|------------------|---------------------|
| 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 |
| 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 | 0 100.00 |
| 101.00 10100 HOME HEALTH AGENCY | 0 | 0 | 0 | 0 | 0 101.00 |
| 102.00 10200 OPIOLD 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 |
| 107.00 10700 LIVER ACQUISITION | 0 | 0 | 0 | 0 | 0 107. 00 |
| 108.00 10800 LUNG ACQUISITION | 0 | 0 | 0 | 0 | 0 108.00 |
| 109. 00 10900 PANCREAS ACQUISITION | 0 | 0 | 0 | 0 | 0 109. 00 |
| 110.00 11000 INTESTINAL ACQUISITION | 0 | 0 | 0 | 0 | 0 110.00 |
| 111.00 11100 ISLET ACQUISITION | 0 | 0 | 0 | 0 | 0 111.00 |
| 113. 00 11300 I NTEREST EXPENSE | | | | | 113.00 |
| 114.00 11400 UTILIZATION REVIEW-SNF | | | | | 114.00 |
| 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) | 0 | 0 | 0 | 0 | 0 115.00 |
| 116. 00 11600 HOSPI CE | 0 | 0 | 0 | 0 | 0 116.00 |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) | 798, 263 | 347, 285 | 0 | 1, 107, 633 | 137, 305 118. 00 |
| NONREI MBURSABLE COST CENTERS | | | | | |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | 0 | 0 | 690 190. 00 |
| 191. 00 19100 RESEARCH | 0 | 0 | 0 | 0 | 0 191.00 |
| 192.00 19200 PHYSICIANS' PRIVATE OFFICES | 0 | 1, 750 | 0 | 0 | 101 192. 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 PALN 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 | 60 | 0 | 0 | 0 194. 03 |
| 194. 04 07954 PHYSICIAN OFFICES | 0 | 0 | 0 | 0 | 0 194. 04 |
| 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES | 0 | 6, 222 | 0 | 0 | 176 194. 05 |
| 194. 06 07956 VACANT SPACE | 0 | 0 | 0 | 0 | 0 194. 06 |
| 200.00 Cross Foot Adjustments | | | | | 200.00 |
| 201.00 Negative Cost Centers | 0 | 0 | 0 | 0 | 0 201.00 |
| 202.00 TOTAL (sum lines 118 through 201) | 798, 263 | 355, 317 | 0 | 1, 107, 633 | 138, 272 202. 00 |
| | | | | | |

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0146

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

5/18/2023 11:21 am Cost Center Description **PHARMACY** MEDI CAL SOCI AL NONPHYSI CI AN NURSI NG RECORDS & SERVI CE **ANESTHETI STS PROGRAM** LI BRARY 17.00 19.00 20.00 15 00 16.00 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 10 00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 336, 216 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 58, 103 16.00 01700 SOCIAL SERVICE 17 00 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 19.00 0 0 02000 NURSING PROGRAM 0 20 00 0 C 0 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 21.00 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 0 4.048 0 0 0 30.00 03100 INTENSIVE CARE UNIT 0 0 0 0 31.00 0 32.00 03200 CORONARY CARE UNIT 0 0 0 32.00 0 03300 BURN INTENSIVE CARE UNIT 0 33.00 C 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0000 C 0 0 34.00 04000 SUBPROVI DER - I PF 0 40.00 0 0 0 0 0 40.00 04100 SUBPROVI DER - I RF 0 0 41.00 0 41.00 04300 NURSERY 0 43.00 153 0 43.00 44.00 04400 SKILLED NURSING FACILITY 0 0 44.00 04500 NURSING FACILITY 0 0 45.00 C 0 0 45.00 46.00 04600 OTHER LONG TERM CARE 0 0 0 0 46 00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 0 50.00 6, 198 0 51.00 05100 RECOVERY ROOM 0 0 0 51.00 0 52 00 05200 DELIVERY ROOM & LABOR ROOM 0 726 0 52 00 0 05300 ANESTHESI OLOGY 0 53.00 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 8, 925 0 0 54.00 54.00 55 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 Ω 55 00 r 05600 RADI OI SOTOPE 0 56.00 C 0 56.00 05700 CT SCAN 0 57.00 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 C 0 0 0 0 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59 00 59 00 0 60.00 06000 LABORATORY 8, 925 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 62.00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. C 0 0 63.00 06400 I NTRAVENOUS THERAPY 0 0 64.00 64.00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 65.00 0 65.00 2.661 0 66 00 06600 PHYSI CAL THERAPY 926 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 329 67.00 0 0 68.00 06800 SPEECH PATHOLOGY 199 0 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 C 0 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 620 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 577 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 336, 216 5, 960 0 0 73.00 0 74.00 07400 RENAL DIALYSIS 0 74.00 C 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 75.00 07698 HYPERBARIC OXYGEN THERAPY 07700 ALLOGENEIC STEM CELL ACQUISITION 1, 022 0 o 0 0 76.98 76.98 0 77.00 0 C 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 C 0 90.00 09000 CLI NI C 0 53 0 0 90.00 09100 EMERGENCY 0 0 0 91.00 11, 279 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 0 09500 AMBULANCE SERVICES 95.00 95.00 0 5, 502 0 0 0 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 ol 96.00 194. 06 07956 VACANT SPACE

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

200.00

201.00

202.00

0 194.06

0 200.00

0 201.00

0 202.00

COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0146 Peri od: Worksheet B From 01/01/2022 Part I 12/31/2022 Date/Time Prepared: 5/18/2023 11:21 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 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 97.00 0 99. 00 09900 CMHC 0 0 0 0 99.00 0 99. 10 09910 CORF 0 99. 10 0 0 0 0 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 100.00 101.00 10100 HOME HEALTH AGENCY o 0 0 101.00 102.00 10200 OPI OID TREATMENT PROGRAM 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 105, 00 0 0 0 0 0 106.00 10600 HEART ACQUISITION 0 0 0 106.00 0 0 0 107.00 10700 LIVER ACQUISITION 0 0 0 0 0 107.00 108.00 10800 LUNG ACQUISITION 0 0 108.00 0 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 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 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115.00 0 0 0 0 116.00 116. 00 11600 HOSPI CE 0 SUBTOTALS (SUM OF LINES 1 through 117) 336, 216 58, 103 0 118.00 0 0 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 00 0 0 191. 00 19100 RESEARCH 0 0 191.00 000000000 0 0 0 0 0 0 0 0 0 0 0 0 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 0 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 194.00 0 0 194. 01 07951 PAIN CLINIC 0 0 194. 01 194. 02 07952 OCC HEALTH 0 194.02 0 194. 03 07953 FOUNDATI ON 0 0 194.03 194. 04 07954 PHYSICIAN OFFICES 0 0 194. 04 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 0 194.05

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0

336, 216

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58, 103

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Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-0146

| Peri od: | Worksheet B | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared:

| | | | | T | o 12/31/2022 | Date/Time Pre 5/18/2023 11: | |
|------------------|--|----------------|--|----------------------|-----------------------|-----------------------------|------------------|
| | | INTERNS & | RESI DENTS | | | 37 107 2023 11. | Z i dili |
| | Overland Branch all an | CEDVILOEC CALA | CEDVI OFC. OTHE | | 1 . 1 0 | T. 1. 1 | |
| | Cost Center Description | RY & FRINGES | SERVICES-OTHE R PRGM COSTS | Subtotal | Intern & Residents | Total | |
| | | KI & IKINGLS | R FROM COSTS | | Cost & Post | | |
| | | | | | Stepdown | | |
| | | 21.00 | 20.00 | 24.22 | Adjustments | | |
| | GENERAL SERVICE COST CENTERS | 21. 00 | 22. 00 | 24. 00 | 25. 00 | 26. 00 | |
| 1. 00 | 00100 CAP REL COSTS-BLDG & FLXT | | | | | | 1.00 |
| 2. 00 | 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| 5.00 | 00500 ADMINISTRATIVE & GENERAL | | | | | | 5.00 |
| 6. 00 7. 00 | 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT | | | | | | 6. 00 7. 00 |
| 8. 00 | 00800 LAUNDRY & LINEN SERVICE | | | | | | 8.00 |
| 9. 00 | 00900 HOUSEKEEPI NG | | | | | | 9.00 |
| 10.00 | 01000 DI ETARY | | | | | | 10.00 |
| 11.00 | 01100 CAFETERI A | | | | | | 11.00 |
| 12.00 | O1200 MAI NTENANCE OF PERSONNEL O1300 NURSI NG ADMI NI STRATI ON | | | | | | 12. 00 13. 00 |
| | 01400 CENTRAL SERVICES & SUPPLY | | | | | | 14.00 |
| | 01500 PHARMACY | | | | | | 15.00 |
| | 01600 MEDICAL RECORDS & LIBRARY | | | | | | 16. 00 |
| 17. 00 | 01700 SOCIAL SERVICE | | | | | | 17.00 |
| | 01900 NONPHYSI CLAN ANESTHETI STS | | | | | | 19.00 |
| 20. 00 21. 00 | O2000 NURSING PROGRAM O2100 I&R SERVICES-SALARY & FRINGES APPRVD | 0 | | | | | 20. 00 21. 00 |
| | 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD | | ĺ | | | | 22.00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 | 03000 ADULTS & PEDIATRICS | C | l l | 1 | 0 | 8, 911, 085 | 30. 00 |
| | 1 1 | C | 1 | | 0 | 0 | 31.00 |
| 32. 00 33. 00 | 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT | 0 | | 0 | 0 | 0 | 32. 00 33. 00 |
| | 03400 SURGICAL INTENSIVE CARE UNIT | 0 | | | 0 | 0 | 34.00 |
| 40. 00 | 04000 SUBPROVI DER - I PF | | | o o | 0 | 0 | 40.00 |
| 41.00 | 04100 SUBPROVI DER - I RF | C |) c | 1 | 0 | 0 | 41.00 |
| 43.00 | 04300 NURSERY | C | C | | 0 | 315, 480 | 1 |
| 44. 00 45. 00 | 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY | C | 1 | | 0 | 0 | 44. 00 45. 00 |
| 46. 00 | 04600 OTHER LONG TERM CARE | | l control of the cont | • | 0 | 0 | 46.00 |
| | ANCILLARY SERVICE COST CENTERS | | | - | -1 | | |
| 50.00 | 05000 OPERATING ROOM | C | C | 4, 546, 270 | 0 | 4, 546, 270 | 50.00 |
| | 05100 RECOVERY ROOM | C | 1 | 1 | 0 | 0 | 51.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY | C | | | 0 | 1, 507, 979 0 | 52. 00 53. 00 |
| | 05400 RADI OLOGY-DI AGNOSTI C | | | 1 | 0 | 4, 658, 323 | 1 |
| 55. 00 | 05500 RADI OLOGY-THERAPEUTI C | C | | 0 | 0 | 0 | 55.00 |
| 56.00 | 05600 RADI OI SOTOPE | C |) c | 0 | 0 | 0 | 56. 00 |
| 57. 00 | 05700 CT SCAN | C | C | 0 | 0 | 0 | 57.00 |
| | 05800 MAGNETIC RESONANCE I MAGING (MRI) | 0 | | 0 | 0 | 0 | 1 |
| | 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY | | | 4, 355, 214 | 0 | 4, 355, 214 | 59. 00 60. 00 |
| 60. 01 | 06001 BLOOD LABORATORY | | | 0 | o | 4, 333, 214 | 60.01 |
| | 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | | | 0 | | 0 | 61.00 |
| 62.00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | C | C | 0 | 0 | 0 | 62.00 |
| 63.00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | | 0 | 0 | 0 | 63.00 |
| 64. 00 65. 00 | 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY | | | 1, 747, 301 | 0 | 0 1, 747, 301 | 64. 00 65. 00 |
| 66. 00 | 06600 PHYSI CAL THERAPY | | | 1, 517, 145 | 0 | 1, 517, 145 | 1 |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY | C | o c | 811, 568 | 0 | 811, 568 | 1 |
| | 06800 SPEECH PATHOLOGY | C |) C | 350, 020 | 0 | 350, 020 | 1 |
| | 1 1 | C | C | 0 | 0 | 0 | 69.00 |
| | 07000 ELECTROENCEPHALOGRAPHY | | | 0 0 | 0 | 0 272 427 | 70.00 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS | | | 373, 427 606, 898 | 0 | 373, 427 606, 898 | 71. 00 72. 00 |
| | 07300 DRUGS CHARGED TO PATIENTS | | | 5, 300, 739 | ol | 5, 300, 739 | 1 |
| | 07400 RENAL DI ALYSI S | |) c | 0 | o | 0 | 74.00 |
| | 07500 ASC (NON-DISTINCT PART) | C |) C | 0 | О | 0 | 75. 00 |
| 76. 98 | 07698 HYPERBARI C OXYGEN THERAPY | C | 1 | | 0 | 947, 032 | 76. 98 |
| 77. 00 | O7700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS | C |) <u> </u> |) 0 | 0 | 0 | 77. 00 |
| 88. NN | 08800 RURAL HEALTH CLINIC | | | | n | 0 | 88. 00 |
| | 08900 FEDERALLY QUALIFIED HEALTH CENTER | | | o o | ol | 0 | 89.00 |
| 90.00 | 09000 CLI NI C | C |) c | 75, 971 | 0 | 75, 971 | 90.00 |
| 91.00 | 09100 EMERGENCY | C |) C | 4, 672, 123 | 0 | 4, 672, 123 | 1 |
| 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 1 | 1 | | 0 | | 92. 00 |
| | | | | | | | |

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0146 Peri od: Worksheet B From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/18/2023 11:21 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 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 94.00 09500 AMBULANCE SERVICES 9, 182, 558 9, 182, 558 95.00 95.00 0000000 0 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 97.00 0 0 0 0 0 99.00 09900 CMHC 0 0 99.00 99. 10 09910 CORF 0 0 o 0 99. 10 0 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 100.00 0 101.00 10100 HOME HEALTH AGENCY 0 C 0 101.00 102.00 10200 OPIOID TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 0 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 105, 00 0 0 106.00 106.00 10600 HEART ACQUISITION 0 0 107.00 10700 LIVER ACQUISITION 0 0 0 0 0 0 107.00 0 108.00 10800 LUNG ACQUISITION 0 0 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 109.00 0 Ω 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 111.00 0 0 113.00 11300 INTEREST EXPENSE 113 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 0 115.00 0 116. 00 11600 HOSPI CE 0 ol 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 49, 879, 133 49, 879, 133 118. 00 0 0 0 118, 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 54, 691 190. 00 54, 691 191. 00 19100 RESEARCH 0 0000000000000 914 191.00 0 914 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 324, 475 324, 475 192. 00 0 o 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 194.00 0 194. 01 07951 PAIN CLINIC 0 0 0 0 0 194. 01 194. 02 07952 OCC HEALTH 0 194 02 0 \cap 106, 955 194. 03 07953 FOUNDATI ON 106, 955 194. 03 194. 04 07954 PHYSICIAN OFFICES 0 0 194.04 0 0 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 547, 947 194. 05 0 547, 947 194.06 07956 VACANT SPACE 0 0 194.06 0 0 200.00 Cross Foot Adjustments 0 0 200.00

0

50, 914, 115

0 201.00

50, 914, 115 202. 00

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0146

| | | | | Io | 12/31/2022 | Date/lime Pre 5/18/2023 11: | |
|------------------|---|--------------------------|-------------------|--------------|--------------------|----------------------------------|------------------|
| | | | CAPI TAL REI | ATED COSTS | | 107 107 2020 111 | 2 / (3 |
| | Cost Contor Dosorintion | Directly | BLDG & FIXT | MVBLE EQUIP | Subtotal | EMPLOYEE | |
| | Cost Center Description | Directly Assigned New | BLDG & FIXI | MARTE EGOLA | Subtotal | 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 & FLXT | | | | | | 1.00 |
| 2.00 | 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | 0 | 0 | _ | 0 | 0 | 4. 00 |
| 5.00 | 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS | 1, 958, 043 | 72, 154 | 14, 054 | 2, 044, 251 | 0 | 5.00 |
| 6. 00 7. 00 | 00700 OPERATION OF PLANT | 0 | 27, 877 | 33, 051 | 60, 928 | 0 | 6. 00 7. 00 |
| 8. 00 | 00800 LAUNDRY & LINEN SERVICE | o o | 2, 398 | | 2, 398 | Ö | 8.00 |
| 9. 00 | 00900 HOUSEKEEPI NG | 0 | 3, 469 | | 3, 475 | 0 | 9. 00 |
| 10.00 | 01000 DI ETARY | 0 | 7, 665 | | 15, 641 | 0 | 10.00 |
| 11. 00 12. 00 | 01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL | 0 | 4, 620 0 | 1 | 4, 620 0 | 0 | 11. 00 12. 00 |
| 13. 00 | 01300 NURSI NG ADMI NI STRATI ON | 0 | 971 | 60, 488 | 61, 459 | ő | 13.00 |
| 14.00 | 01400 CENTRAL SERVICES & SUPPLY | 0 | 8, 922 | 0 | 8, 922 | 0 | 14.00 |
| 15.00 | 01500 PHARMACY | 0 | 2, 631 | | 5, 883 | | 15.00 |
| 16. 00 17. 00 | 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE | 0 | 4, 019 0 | | 4, 019 0 | 0 | 16. 00 17. 00 |
| 19. 00 | 01900 NONPHYSI CI AN ANESTHETI STS | 0 | 0 | | 0 | 0 | 19.00 |
| 20.00 | 02000 NURSING 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 | 02200 1 & R SERVICES-OTHER PRGM COSTS APPRVD INPATIENT ROUTINE SERVICE COST CENTERS | 0 | 0 | 0 | 0 | 0 | 22. 00 |
| 30. 00 | 03000 ADULTS & PEDIATRICS | 0 | 41, 961 | 88, 799 | 130, 760 | 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 | 603 | 5, 221 | 5, 824 | 0 | 43.00 |
| 44. 00 | 04400 SKILLED NURSING FACILITY | 0 | 0 | 0 | 0 | 0 | 44.00 |
| 45. 00 46. 00 | 04500 NURSING FACILITY 04600 OTHER LONG TERM CARE | 0 | 0 | 0 | 0 | 0 | 45. 00 46. 00 |
| | ANCILLARY SERVICE COST CENTERS | | · | - | _ | | |
| 50.00 | 05000 OPERATING ROOM | 0 | 43, 899 | | 179, 791 | 0 | 50.00 |
| 51. 00 52. 00 | O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM | 0 | 0 3, 873 | 0 24, 730 | 0 28, 603 | 0 | 51. 00 52. 00 |
| 53. 00 | 05300 ANESTHESI OLOGY | 0 | 3, 8/3 | 24, 730 | 20, 003 | 0 | 53.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 0 | 21, 218 | 374, 351 | 395, 569 | 0 | 54.00 |
| 55.00 | 05500 RADI OLOGY-THERAPEUTI C | 0 | 0 | 0 | 0 | 0 | 55.00 |
| 56. 00 57. 00 | 05600 RADI 0I SOTOPE 05700 CT SCAN | 0 | 0 | 0 | 0 | 0 | 56. 00 57. 00 |
| 58. 00 | 05800 MAGNETIC RESONANCE I MAGING (MRI) | 0 | 0 | 0 | 0 | 0 | 58.00 |
| | 05900 CARDI AC CATHETERI ZATI ON | 0 | 0 | 0 | 0 | 0 | 59.00 |
| | 06000 LABORATORY | 0 | 8, 108 | 0 | 8, 108 | 0 | 60.00 |
| 60. 01 61. 00 | 06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | 0 | 0 | 0 | 0 | 0 | 60. 01 61. 00 |
| 62.00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0 | 0 | 0 | 0 | 0 | 62.00 |
| 63.00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | 0 | 0 | 0 | 0 | 63.00 |
| 64.00 | 06400 I NTRAVENOUS THERAPY | 0 | 0 | 0 | 0 | 0 | 64.00 |
| 65. 00 66. 00 | 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY | 0 | 5, 172 22, 357 | | 69, 742 32, 904 | 0 0 | 65. 00 66. 00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 0 | 22, 337 | 10, 547 | 32, 704 | 0 | 67.00 |
| 68. 00 | 06800 SPEECH PATHOLOGY | 0 | 0 | 0 | 0 | 0 | 68. 00 |
| 69. 00 | 06900 ELECTROCARDI OLOGY | 0 | 0 | 0 | 0 | 0 | 69. 00 |
| 70. 00 71. 00 | 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | 0 | 0 | 0 | 70.00 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS | | 0 | 0 | 0 | 0 | 71. 00 72. 00 |
| | 07300 DRUGS CHARGED TO PATIENTS | 0 | Ö | 0 | 0 | Ö | 73.00 |
| 74.00 | 07400 RENAL DIALYSIS | 0 | 0 | 0 | 0 | 0 | 74.00 |
| 75. 00 76. 98 | O7500 ASC (NON-DISTINCT PART) O7698 HYPERBARI C OXYGEN THERAPY | 0 | 0 | 12 443 | 14 500 | 0 | 75.00 |
| | 07700 ALLOGENEIC STEM CELL ACQUISITION | | 4, 118 0 | 12, 462 | 16, 580 0 | 0 | 76. 98 77. 00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| | 08800 RURAL HEALTH CLINIC | 0 | 0 | 0 | 0 | 0 | 88. 00 |
| | 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC | 0 | 0 | 0 | 0 | 0 0 | 89. 00 90. 00 |
| | 09100 EMERGENCY | | 17, 572 | 31, 041 | 48, 613 | _ | 90.00 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | ,,,,, | | 0 | | 92.00 |
| | | | | Ţ. | | | |

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HOSPITAL OF NOBLE CTY, INC
Provider CCN: 15-0146

| | | | То | 12/31/2022 | Date/Time Pre 5/18/2023 11: | |
|---|---------------|--------------|--------------|-------------|--------------------------------|--------------------|
| | | CAPI TAL REI | _ATED COSTS | | 07 107 2020 11. | Z i diii |
| Cost Center Description | Di rectly | BLDG & FIXT | MVBLE EQUIP | Subtotal | EMPLOYEE | |
| cost center bescription | Assigned New | DLUG & FIAI | MIVELE EQUIP | Subtotal | BENEFITS | |
| | Capi tal | | | | DEPARTMENT | |
| | Related Costs | | | | | |
| | 0 | 1. 00 | 2.00 | 2A | 4. 00 | |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 94. 00 09400 HOME PROGRAM DI ALYSI S | 0 | 0 | 0 | 0 | 0 | |
| 95. 00 09500 AMBULANCE SERVI CES | 0 | 0 | 382, 594 | 382, 594 | 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 99. 10 09910 CORF | 0 | 0 | 0 | 0 | 0 | 99. 00 99. 10 |
| 100.00 10000 1&R SERVICES-NOT APPRVD PRGM | 0 | 0 | 0 | 0 | 0 | |
| 101. 00 10100 HOME HEALTH AGENCY | 0 | 0 | 0 | 0 | _ | 101.00 |
| 102. 00 10200 OPI OI D TREATMENT PROGRAM | 0 | 0 | 0 | 0 | | 102.00 |
| SPECIAL PURPOSE COST CENTERS | <u> </u> | | <u> </u> | <u> </u> | | 102.00 |
| 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 |
| 107.00 10700 LIVER ACQUISITION | O | 0 | 0 | 0 | 0 | 107.00 |
| 108.00 10800 LUNG ACQUISITION | 0 | 0 | 0 | 0 | | 108. 00 |
| 109.00 10900 PANCREAS ACQUISITION | 0 | 0 | 0 | 0 | | 109. 00 |
| 110.00 11000 INTESTINAL ACQUISITION | 0 | 0 | 0 | 0 | | |
| 111. 00 11100 SLET ACQUISITION | 0 | 0 | 0 | 0 | 0 | 111.00 |
| 113. 00 11300 INTEREST EXPENSE | | | | | | 113.00 |
| 114. 00 11400 UTI LI ZATI ON REVI EW-SNF | | 0 | | 0 | 0 | 114. 00 115. 00 |
| 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 11600 HOSPICE | 0 | 0 | 0 | 0 | | |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) | 1, 958, 043 | 303, 607 | 1, 249, 034 | 3, 510, 684 | | 118.00 |
| NONREI MBURSABLE COST CENTERS | 1, 750, 043 | 303, 007 | 1, 247, 034 | 3, 310, 004 | 0 | 1110.00 |
| 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 2, 449 | 79 | 2, 528 | 0 | 190. 00 |
| 191. 00 19100 RESEARCH | 0 | 0 | О | 0 | 0 | 191.00 |
| 192.00 19200 PHYSICIANS' PRIVATE OFFICES | 0 | 15, 782 | 193 | 15, 975 | 0 | 192. 00 |
| 193.00 19300 NONPALD WORKERS | 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 | | 194. 01 |
| 194. 02 07952 OCC HEALTH | 0 | 0 | 0 | 0 | | 194. 02 |
| 194. 03 07953 FOUNDATI ON | 0 | 0 | 0 | 0 | | 194. 03 |
| 194. 04 07954 PHYSI CI AN OFFI CES | 0 | 0 | 0 | 10 007 | | 194.04 |
| 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES | 0 | 11, 969 | 428 | 12, 397 | | 194. 05 |
| 194.06 07956 VACANT SPACE 200.00 Cross Foot Adjustments | ا | 0 | | O O | 0 | 194. 06 200. 00 |
| 201.00 Negative Cost Centers | | 0 | | 0 | 0 | 200.00 |
| 202.00 TOTAL (sum lines 118 through 201) | 1, 958, 043 | 333, 807 | 1, 249, 734 | 3, 541, 584 | | 202.00 |
| 232. 33 TOTAL (Sum TITIOS TTO CHI Sugit 201) | 1, 700, 040 | 333, 007 | 1,217,754 | 3, 311, 304 | O | 1-32.00 |

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0146

Peri od: Worksheet B From 01/01/2022 Part II To 12/31/2022 Date/Time Prepared:

In Lieu of Form CMS-2552-10

5/18/2023 11:21 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 2,044,251 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 80,063 0 140, 991 7.00 00800 LAUNDRY & LINEN SERVICE 11, 398 15, 242 8 00 8 00 Ω 1 446 9.00 00900 HOUSEKEEPI NG 39.919 C 2,092 45, 486 9.00 01000 DI ETARY 28, 044 10.00 10.00 4,623 1.530 11.00 01100 CAFETERI A 11,851 0 2.786 ol 922 11.00 01200 MAINTENANCE OF PERSONNEL 12 00 C 0 0 0 12 00 13.00 01300 NURSING ADMINISTRATION 43,608 586 0 194 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 514 5, 381 465 1,781 14.00 01500 PHARMACY 15.00 1.587 0 15.00 525 11.624 01600 MEDICAL RECORDS & LIBRARY 0 16.00 232 C 2.424 802 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 03000 ADULTS & PEDLATRICS 8, 375 30.00 277, 753 25, 307 5, 360 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 SUBPROVI DER - I PF 0 0 0 40.00 40.00 0 04100 SUBPROVI DER - I RF 0 41.00 0 0 0 41.00 0 04300 NURSERY 43.00 11, 341 0 364 15 120 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 147,002 0 26, 474 4.039 8,760 50.00 05100 RECOVERY ROOM 51.00 C 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 53.783 0 773 52.00 2.336 15 05300 ANESTHESI OLOGY 53.00 C 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 172, 711 C 12, 797 1,531 4, 235 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 C 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 0 ol 59.00 0 06000 LABORATORY 170, 268 0 4.890 1,618 60 00 0 60.00 60.01 06001 BLOOD LABORATORY C 0 0 60.01 C 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 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 0 0 0 0 64.00 06500 RESPIRATORY THERAPY 65.00 66, 417 3, 119 94 1,032 65.00 06600 PHYSI CAL THERAPY 66.00 0 66.00 48.659 Ω 13, 483 4, 462 67.00 06700 OCCUPATI ONAL THERAPY 32, 179 C 0 0 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 13.876 68.00 06900 ELECTROCARDI OLOGY 69.00 0 0 0 0 69.00 0 0 70 00 07000 ELECTROENCEPHALOGRAPHY 0 C 0 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 13, 496 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 24.344 0 0 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 198, 956 0 73.00 0 0 73.00 74 00 07400 RENAL DIALYSIS 0 C 0 0 74 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 75.00 75.00 76. 98 07698 HYPERBARIC OXYGEN THERAPY 32, 173 0 2, 484 22 822 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 77.00 0 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 09000 CLINIC 3.005 90.00 90.00 C 0 0 0 91.00 09100 EMERGENCY 162, 119 C 10, 598 3, 586 3,507 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94 00 94.00 0 0 95.00 09500 AMBULANCE SERVICES 363, 603 C 0 0 0 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 0 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 97.00 97 00 0

| | | | | | 3/16/2023 11. | Z I alli |
|--|-------------|---------------|--------------|---------------|---------------|----------|
| Cost Center Description | | MAINTENANCE & | OPERATION OF | LAUNDRY & | HOUSEKEEPI NG | |
| | E & GENERAL | REPAI RS | PLANT | LINEN SERVICE | | |
| | 5. 00 | 6. 00 | 7. 00 | 8. 00 | 9. 00 | |
| 99. 00 09900 CMHC | 0 | 0 | 0 | 0 | 0 | 99.00 |
| 99. 10 09910 CORF | 0 | 0 | 0 | 0 | 0 | 99. 10 |
| 100.00 10000 I&R SERVICES-NOT APPRVD PRGM | 0 | 0 | 0 | 0 | 0 | 100.00 |
| 101.00 10100 HOME HEALTH AGENCY | 0 | 0 | 0 | 0 | 0 | 101.00 |
| 102.00 10200 OPIOID 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 |
| 107.00 10700 LIVER ACQUISITION | 0 | 0 | 0 | 0 | 0 | 107.00 |
| 108.00 10800 LUNG ACQUISITION | 0 | 0 | 0 | 0 | 0 | 108.00 |
| 109.00 10900 PANCREAS ACQUISITION | 0 | 0 | 0 | 0 | 0 | 109.00 |
| 110.00 11000 INTESTINAL ACQUISITION | 0 | 0 | 0 | 0 | 0 | 110.00 |
| 111.00 11100 ISLET ACQUISITION | 0 | 0 | 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 | 0 | 0 | 0 | 0 | 115.00 |
| 116. 00 11600 HOSPI CE | 0 | 0 | 0 | 0 | 0 | 116.00 |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) | 2, 018, 938 | 0 | 122, 777 | 15, 127 | 39, 458 | 118.00 |
| NONREI MBURSABLE COST CENTERS | | | | | | Ī |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 888 | 0 | 1, 477 | 0 | 489 | 190. 00 |
| 191. 00 19100 RESEARCH | 37 | 0 | 0 | 0 | 0 | 191.00 |
| 192.00 19200 PHYSICIANS' PRIVATE OFFICES | 4, 610 | 0 | 9, 518 | 115 | 3, 150 | 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 | 4, 292 | 0 | 0 | 0 | 0 | 194. 03 |
| 194. 04 07954 PHYSICIAN OFFICES | 0 | 0 | 0 | 0 | 0 | 194. 04 |
| 194.05 07955 COMMUNITY & VOLUNTEER SERVICES | 15, 486 | 0 | 7, 219 | 0 | 2, 389 | 194. 05 |
| 194.06 07956 VACANT SPACE | 0 | 0 | 0 | 0 | 0 | 194. 06 |
| 200.00 Cross Foot Adjustments | | | | | | 200.00 |
| 201.00 Negative Cost Centers | 0 | 0 | 0 | 0 | 0 | 201.00 |
| 202.00 TOTAL (sum lines 118 through 201) | 2, 044, 251 | 0 | 140, 991 | 15, 242 | 45, 486 | 202.00 |
| , | • | • | • | | | • |

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0146

Peri od: Worksheet B From 01/01/2022 Part II To 12/31/2022 Date/Time Prepared:

5/18/2023 11: 21 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 49,838 10 00 01100 CAFETERI A 11.00 20, 179 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 0 12.00 13.00 01300 NURSING ADMINISTRATION 0 504 106, 351 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 17,063 14.00 01500 PHARMACY 15.00 0 0 247 593 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 0 0 16.00 01700 SOCIAL SERVICE 0 17 00 Ω 0 0 0 17.00 0 01900 NONPHYSICIAN ANESTHETISTS 0 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 49.838 3, 369 0 43, 937 2, 551 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 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 43.00 161 2,099 0 43.00 0 0 44.00 04400 SKILLED NURSING FACILITY 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 0 17, 218 2, 956 50.00 1.320 0 51.00 05100 RECOVERY ROOM 0 0 51.00 0 52 00 05200 DELIVERY ROOM & LABOR ROOM 0 9, 943 762 0 52 00 05300 ANESTHESI OLOGY 0 0 53.00 0 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 2,029 0 54.00 648 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 58.00 0 0 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 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 62 00 C 0 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 0000000000 0 65.00 999 448 65.00 66 00 06600 PHYSI CAL THERAPY 703 0 99 66.00 06700 OCCUPATI ONAL THERAPY o 0 67.00 67.00 556 68.00 06800 SPEECH PATHOLOGY 240 0 0 68.00 0 0 06900 ELECTROCARDI OLOGY 0 69.00 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY C 0 Λ 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 4,528 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 C 0 0 413 73.00 0 74.00 07400 RENAL DIALYSIS C 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 75.00 07698 HYPERBARIC OXYGEN THERAPY 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 7, 291 559 601 76.98 76.98 0 0 77.00 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 C 0 0 90.00 09000 CLI NI C 0 54 15 90.00 09100 EMERGENCY 0 0 91.00 1, 983 25, 863 2, 270 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 09500 AMBULANCE SERVICES 95.00 0 5, 892 0 0 2, 168 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 0

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0146

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | To 12/31/2023 | To 1

| | | | ' | 0 12/31/2022 | 5/18/2023 11: | |
|---|----------|------------|--------------|------------------|---------------|----------|
| 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 | |
| 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | 0 | 0 | 0 | 0 | |
| 99. 00 09900 CMHC | 0 | 0 | 0 | 0 | 0 | |
| 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 | | | _ | | | |
| 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 ACQUISITION | 0 | 0 | 0 | 0 | | 108.00 |
| 109. 00 10900 PANCREAS ACQUISITION | 0 | 0 | 0 | 0 | | 109.00 |
| 110. 00 11000 I NTESTI NAL ACQUI SI TI ON | 0 | 0 | 0 | 0 | | 110.00 |
| 111.00 11100 I SLET ACQUI SI TI ON | 0 | 0 | 0 | 0 | 0 | 111.00 |
| 113.00 11300 INTEREST EXPENSE | | | | | | 113.00 |
| 114.00 11400 UTI LI ZATI ON REVI EW-SNF | | | | | | 114.00 |
| 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) | 0 | 0 | 0 | 0 | | 115.00 |
| 116. 00 11600 H0SPI CE | 0 | 0 | 0 | 0 | | 116.00 |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) | 49, 838 | 19, 724 | 0 | 106, 351 | 16, 944 | 118.00 |
| NONREI MBURSABLE COST CENTERS | | | | ام | 0.5 | |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | 0 | 0 | | 190.00 |
| 191. 00 19100 RESEARCH | 0 | 0 | 0 | 0 | | 191.00 |
| 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES | 0 | 99 | 0 | 0 | | 192.00 |
| 193. 00 19300 NONPAI D WORKERS | 0 | 0 | 0 | 0 | | 193.00 |
| 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS | 0 | 0 | 0 | 0 | | 194.00 |
| 194. 01 07951 PAIN CLINIC | 0 | 0 | 0 | 0 | | 194. 01 |
| 194. 02 07952 OCC HEALTH | 0 | 0 | 0 | 0 | | 194. 02 |
| 194. 03 07953 FOUNDATI ON | 0 | 3 | 0 | 0 | | 194. 03 |
| 194. 04 07954 PHYSI CI AN OFFI CES | 0 | 0 | 0 | 0 | | 194.04 |
| 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES | 0 | 353 | 0 | 0 | | 194.05 |
| 194. 06 07956 VACANT SPACE | 0 | 0 | 0 | 0 | 0 | 194.06 |
| 200.00 Cross Foot Adjustments | | _ | | | - | 200.00 |
| 201.00 Negative Cost Centers | 10 000 | 0 | 0 | 0 | | 201.00 |
| 202.00 TOTAL (sum lines 118 through 201) | 49, 838 | 20, 179 | l 0 | 106, 351 | 17, 063 | J202. 00 |
| | | | | | | |

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0146

Peri od: Worksheet B From 01/01/2022 Part II To 12/31/2022 Date/Time Prepared:

5/18/2023 11:21 am Cost Center Description **PHARMACY** MEDI CAL SOCI AL NONPHYSI CI AN NURSI NG **ANESTHETI STS** RECORDS & SERVI CE **PROGRAM** LI BRARY 17.00 19.00 20.00 15 00 16.00 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 10 00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 20, 459 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 7, 477 16.00 01700 SOCIAL SERVICE 17 00 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 0 19.00 0 02000 NURSING PROGRAM 0 20 00 0 C 0 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 0 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 0 0 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 515 0 30.00 03100 INTENSIVE CARE UNIT 0 31.00 00000000 0 32.00 03200 CORONARY CARE UNIT 32.00 0 03300 BURN INTENSIVE CARE UNIT 0 33.00 C 33.00 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT C 34.00 04000 SUBPROVI DER - I PF 0 40.00 40.00 0 41.00 04100 SUBPROVI DER - I RF 0 41.00 04300 NURSERY 0 43.00 20 43.00 0 44.00 04400 SKILLED NURSING FACILITY C 44.00 04500 NURSING FACILITY 0 0 45.00 C 45.00 46.00 04600 OTHER LONG TERM CARE 0 Ω 0 46 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 788 0 50.00 05100 RECOVERY ROOM 51.00 0 0 0 C 0 51.00 0 52 00 05200 DELIVERY ROOM & LABOR ROOM 92 52 00 0 53.00 05300 ANESTHESI OLOGY C 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 1, 135 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 55 00 C 0 05600 RADI OI SOTOPE 56.00 C 56.00 57.00 05700 CT SCAN 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59 00 59 00 C 60.00 06000 LABORATORY 1, 135 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 62.00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. C 0 63.00 06400 I NTRAVENOUS THERAPY 64.00 64.00 06500 RESPIRATORY THERAPY 00000 0 65.00 65.00 338 0 66 00 06600 PHYSI CAL THERAPY 118 66 00 67.00 06700 OCCUPATIONAL THERAPY 67.00 42 68.00 06800 SPEECH PATHOLOGY 25 0 68.00 0 06900 ELECTROCARDI OLOGY 69.00 69.00 C 70.00 07000 ELECTROENCEPHALOGRAPHY C 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 79 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 73 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 20.459 758 0 73.00 74.00 07400 RENAL DIALYSIS 0 C 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 07698 HYPERBARIC OXYGEN THERAPY 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 76. 98 76.98 130 0 0 77.00 C 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 C 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 0 0 89.00 C 90.00 09000 CLI NI C 0 90.00 09100 EMERGENCY 0 0 91.00 1, 522 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 09500 AMBULANCE SERVICES 95.00 0 700 0 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00

194. 03 07953 FOUNDATI ON

194. 06 07956 VACANT SPACE

200.00

201.00

202.00

194. 04 07954 PHYSICIAN OFFICES

194. 05 07955 COMMUNITY & VOLUNTEER SERVICES

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0146 Peri od: Worksheet B From 01/01/2022 Part II 12/31/2022 Date/Time Prepared: 5/18/2023 11:21 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 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 0 0 99. 00 09900 CMHC 0 99.00 99. 10 09910 CORF 0 0 0 0 99.10 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 101.00 102.00 10200 OPI OID TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 105.00 0 0 0 0 106.00 10600 HEART ACQUISITION 0 0 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 0 109.00 0 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 111.00 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.) 115.00 0 0 116. 00 11600 HOSPI CE 0 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) 7, 477 20, 459 0 0 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 0 0 191. 00 19100 RESEARCH 0 000000000 191.00 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 193. 00 19300 NONPALD WORKERS 0 0 0 0 193.00 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 194.00 0 194. 01 07951 PAIN CLINIC 0 194. 01 194. 02 07952 OCC HEALTH 194.02 0

0

0

20, 459

0

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0

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0

7, 477

194. 03

194. 04

194. 05

194.06

0 200.00

0 201.00

0 202.00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | To 12/31/2023 | To 1 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HOSPITAL OF NOBLE CTY, INC
Provider CCN: 15-0146

| | | | | To | 12/31/2022 | Date/Time Pre 5/18/2023 11: | |
|------------------|---|----------------|-------------------------------|---------------|-----------------------|-----------------------------|------------------|
| | | INTERNS & | RESI DENTS | | | 10, 10, 2020 111 | |
| | Cost Conton Decement on | CEDVI CEC CALA | CEDVI CES OTHE | Cubtatal | lntown 0 | Total | |
| | Cost Center Description | RY & FRINGES | SERVICES-OTHE R PRGM COSTS | Subtotal | Intern & Residents | Total | |
| | | | Tr. Tr. Cim GGGTG | | Cost & Post | | |
| | | | | | Stepdown | | |
| | | 21.00 | 22.00 | 24.00 | Adjustments | 24, 00 | |
| | GENERAL SERVICE COST CENTERS | 21. 00 | 22. 00 | 24. 00 | 25. 00 | 26. 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 | 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL | | | | | | 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 NURSING ADMINISTRATION | | | | | | 13.00 |
| 14.00 | | | | | | | 14.00 |
| 15. 00 16. 00 | | | | | | | 15. 00 16. 00 |
| 17. 00 | 01700 SOCIAL SERVICE | | | | | | 17. 00 |
| 19. 00 | | | | | | | 19. 00 |
| 20.00 | 02000 NURSI NG PROGRAM | | | | | | 20.00 |
| 21.00 | 02100 &R SERVICES-SALARY & FRINGES APPRVD 02200 &R SERVICES-OTHER PRGM COSTS APPRVD | | 0 | | | | 21. 00 22. 00 |
| 22.00 | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | 22.00 |
| 30.00 | 1 | | | 547, 765 | 0 | 547, 765 | 1 |
| 31.00 | 1 | | | 0 | 0 | 0 | 31.00 |
| 32. 00 33. 00 | 03200 CORONARY CARE UNIT | | | 0 | 0 | 0 | 32. 00 33. 00 |
| 34. 00 | 1 | | | o o | Ö | 0 | 34.00 |
| 40.00 | 04000 SUBPROVI DER - I PF | | | 0 | 0 | 0 | 40.00 |
| 41.00 | 1 | | | 0 | 0 | 0 | |
| 43. 00 44. 00 | 1 | | | 19, 944 0 | 0 | 19, 944 0 | 1 |
| 45. 00 | | | | Ö | 0 | 0 | |
| 46. 00 | | | | 0 | 0 | 0 | 46. 00 |
| 50. 00 | ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM | T | I | 388, 348 | O | 388, 348 | 50.00 |
| 51.00 | 1 1 | | | 0 | 0 | 0 300, 340 | 51.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | | | 96, 307 | 0 | 96, 307 | 1 |
| 53.00 | | | | 0 | 0 | 0 | |
| 54. 00 55. 00 | 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C | | | 590, 655 0 | 0 | 590, 655 0 | 1 |
| 56. 00 | 1 | | | Ö | ő | 0 | 1 |
| 57. 00 | 05700 CT SCAN | | | 0 | 0 | 0 | |
| | 05800 MAGNETIC RESONANCE IMAGING (MRI) | | | 0 | 0 | 0 | 1 |
| 59. 00 60. 00 | | | | 0 186, 019 | 0 | 0 186, 019 | |
| 60. 01 | 06001 BLOOD LABORATORY | | | 0 | Ö | 0 | |
| 61. 00 | | | | | | | 61.00 |
| 62.00 | | | | 0 | 0 | 0 | 1 |
| 63. 00 64. 00 | | | | 0 | 0 | 0 | |
| 65. 00 | | | | 142, 189 | Ö | 142, 189 | 1 |
| 66. 00 | 1 | | | 100, 428 | 0 | 100, 428 | 1 |
| 67.00 | 1 1 | | | 32, 777 | 0 | 32, 777 | 1 |
| 68. 00 69. 00 | | | | 14, 141 0 | 0 | 14, 141 0 | 1 |
| 70. 00 | 1 | | | Ö | Ö | 0 | 1 |
| 71. 00 | 1 1 | | | 18, 103 | 0 | 18, 103 | 1 |
| 72.00 | | | | 24, 417 | 0 | 24, 417 | 1 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS | 1 | | 220, 586 0 | O O | 220, 586 0 | 73. 00 74. 00 |
| | 07500 ASC (NON-DISTINCT PART) | | | Ö | Ö | 0 | 1 |
| 76. 98 | 07698 HYPERBARI C OXYGEN THERAPY | 1 | | 60, 662 | 0 | 60, 662 | 76. 98 |
| 77. 00 | | | | 0 | 0 | 0 | 77. 00 |
| 88. 00 | OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC | | | O | 0 | 0 | 88. 00 |
| 89. 00 | 08900 FEDERALLY QUALIFIED HEALTH CENTER | 1 | | Ö | ő | 0 | 89. 00 |
| 90.00 | | | | 3, 081 | 0 | 3, 081 | 90.00 |
| | O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART) | 1 | | 260, 061 | 0 | 260, 061 | 91. 00 92. 00 |
| | | 1 | 1 | <u> </u> | <u> </u> | ı <u> </u> | 55 |

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0146 Peri od: Worksheet B From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/18/2023 11:21 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 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 09500 AMBULANCE SERVICES 754, 957 754, 957 95.00 95.00 0 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 0 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 97.00 0 0 0 0 99.00 09900 CMHC 0 99.00 99. 10 09910 CORF 0 o 0 99. 10 0 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 100.00 0 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 102.00 10200 OPIOID TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 105, 00 0 106.00 10600 HEART ACQUISITION 0 106.00 0 107.00 10700 LIVER ACQUISITION 0 0 0 107.00 0 108.00 10800 LUNG ACQUISITION 0 108.00 0 109.00 10900 PANCREAS ACQUISITION 0 109.00 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 111.00 0 0 113.00 11300 INTEREST EXPENSE 113 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 115.00 116. 00 11600 HOSPI CE 0 ol 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 3, 460, 440 118.00 0 3, 460, 440 0 118, 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 5, 467 190. 00 5, 467 0 191. 00 19100 RESEARCH 37 191.00 37 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 33, 479 192. 00 33.479 o 193. 00 19300 NONPALD WORKERS 0 0 193.00 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 194.00 0 194. 01 07951 PAIN CLINIC 0 0 0 0 0 0 0 0 0 194. 01 0 194. 02 07952 OCC HEALTH 0 194 02 \cap 4, 295 194. 03 07953 FOUNDATI ON 4, 295 194. 03 194. 04 07954 PHYSICIAN OFFICES 0 194.04 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 37, 866 194. 05 37,866 0 194.06 194.06 07956 VACANT SPACE 0 200.00 Cross Foot Adjustments 0 0 200.00 201.00 Negative Cost Centers 0 201.00 3, 541, 584 202. 00 202.00 TOTAL (sum lines 118 through 201) 0 3, 541, 584

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 01/01/2022 12/31/2022 Date/Time Prepared: 5/18/2023 11:21 am CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliatio ADMINISTRATIV Cost Center Description (SQUARE FEET) (DOLLAR **BENEFLTS** 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 2.00 984, 571 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 23, 014, 045 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 29, 785 11,072 6, 211, 064 -15, 448, 361 35, 465, 754 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 11, 508 26,038 417, 283 0 1, 389, 023 7.00 00800 LAUNDRY & LINEN SERVICE 0 8 00 990 197, 750 8 00 0 00900 HOUSEKEEPI NG 0 9.00 1, 432 487, 138 692, 554 9.00 10.00 01000 DI ETARY 3.164 6, 284 251, 209 486, 530 10.00 0 11.00 01100 CAFETERI A 1, 907 267, 252 205, 603 11.00 01200 MAINTENANCE OF PERSONNEL 0 12 00 12 00 0 0 01300 NURSING ADMINISTRATION 13.00 401 47,654 527, 295 0 756, 560 13.00 01400 CENTRAL SERVICES & SUPPLY 0 8, 922 14.00 3.683 14.00 0 01500 PHARMACY 201,664 15.00 1.086 2.562 725, 921 15.00 0 4, 019 01600 MEDICAL RECORDS & LIBRARY 1, 659 16.00 0 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 NURSING PROGRAM 0 0 0 20 00 20 00 C 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 30.00 03000 ADULTS & PEDIATRICS 17.322 69, 958 2, 732, 898 4, 818, 761 30.00 31.00 03100 INTENSIVE CARE UNIT 0 31.00 0 03200 CORONARY CARE UNIT 0 0 32.00 0 0 32.00 03300 BURN INTENSIVE CARE UNIT 33.00 C 0 33.00 0

Health Financial Systems In Lieu of Form CMS-2552-10 COMMUNITY HOSPITAL OF NOBLE CTY, INC COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0146 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/18/2023 11:21 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 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 0 09500 AMBULANCE SERVICES 301, 417 3, 939, 240 6, 308, 079 95.00 95.00 0 0 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 0 0 0 0 99.00 09900 CMHC 0 0 0 99.00 99. 10 09910 CORF 0 0 0 o 0 99. 10 0 0 o 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 100.00 0 101.00 10100 HOME HEALTH AGENCY 0 0 C 0 101.00 102.00 10200 OPIOID TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 105, 00 106.00 10600 HEART ACQUISITION 0 106.00 0 0 0 0 107.00 10700 LIVER ACQUISITION 0 0 0 0 107.00 0 108.00 10800 LUNG ACQUISITION 0 0 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 109.00 0 O Ω 110.00 11000 INTESTINAL ACQUISITION 0 C 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 111.00 0 113.00 11300 INTEREST EXPENSE 113 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115.00 116. 00 11600 HOSPI CE 0 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) -15, 448, 361 35, 026, 614 118. 00 125, 331 984, 020 22, 815, 465 118, 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1, 011 15, 401 190. 00 62 0 0 191. 00 19100 RESEARCH 637 191.00 C 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 79, 980 192. 00 6,515 48,877 152 o 193. 00 19300 NONPALD WORKERS C 0 193.00 0 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 194.00 0 0 0 194. 01 07951 PAIN CLINIC 0 0 0 0 0 194. 01 194. 02 07952 OCC HEALTH 0 0 194 02 0 C 194. 03 07953 FOUNDATI ON 0 0 74, 461 194. 03 194. 04 07954 PHYSICIAN OFFICES 0 O 0 194.04 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 268, 661 194. 05 149, 703 4,941 337 194.06 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, 1, 249, 734 15, 448, 361 202. 00 333, 807 6, 206, 884 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 2. 422437 1. 269318 0.269700 0. 435585 203. 00 204.00 Cost to be allocated (per Wkst. B, 2, 044, 251 204. 00 Part II) 0.000000 0.057640 205.00 205.00 Unit cost multiplier (Wkst. B, Part II) NAHE adjustment amount to be allocated 206.00 206.00

207. 00

(per Wkst. B-2)

Parts III and IV)

207.00

NAHE unit cost multiplier (Wkst. D,

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

| Period: | Worksheet B-1 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared:

| | | | | | 0 12/31/2022 | Date/Time Pre 5/18/2023 11: | |
|------------------|---|----------------|----------------|---------------------|---------------|-----------------------------|------------------|
| | Cost Center Description | MAINTENANCE & | OPERATION OF | LAUNDRY & | HOUSEKEEPI NG | DI ETARY | zı allı |
| | | REPAIRS | PLANT | LINEN SERVICE | (SQUARE FEET) | (MEALS | |
| | | (SQUARE FEET) | (SQUARE FEET) | (POUNDS OF LAUNDRY) | | SERVED) | |
| | | 6. 00 | 7. 00 | 8.00 | 9. 00 | 10.00 | |
| 1 00 | GENERAL SERVICE COST CENTERS | | | 1 | | | 1 00 |
| 1. 00 2. 00 | 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | 1. 00 2. 00 |
| 4. 00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| 5.00 | 00500 ADMINISTRATIVE & GENERAL | | | | | | 5.00 |
| 6.00 | 00600 MAINTENANCE & REPAIRS | 108, 013 | l e | | | | 6.00 |
| 7. 00 8. 00 | 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE | 11, 508 990 | 96, 505 990 | 1 | | | 7. 00 8. 00 |
| 9. 00 | 00900 HOUSEKEEPI NG | 1, 432 | 1, 432 | | 94, 083 | | 9. 00 |
| 10.00 | 01000 DI ETARY | 3, 164 | 3, 164 | 1 | 3, 164 | 22, 762 | 10.00 |
| 11.00 | 01100 CAFETERI A | 1, 907 | 1, 907 | ı | 1, 907 | 0 | 11.00 |
| 12. 00 13. 00 | 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON | 0 401 | 0 401 | _ | 0 401 | 0 | 12. 00 13. 00 |
| 14. 00 | 01400 CENTRAL SERVICES & SUPPLY | 3, 683 | 3, 683 | | l : | 0 | 14. 00 |
| 15. 00 | 01500 PHARMACY | 1, 086 | l | 1 | 1, 086 | 0 | 15.00 |
| 16. 00 17. 00 | 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE | 1, 659 | 1, 659 | 0 | 1, 659 | 0 | 16. 00 17. 00 |
| 19. 00 | 01900 NONPHYSICIAN ANESTHETISTS | 0 | | 0 | 0 | 0 | 19.00 |
| 20.00 | 02000 NURSI NG PROGRAM | 0 | O | 0 | o | 0 | 20.00 |
| 21.00 | 02100 I &R SERVI CES-SALARY & FRINGES APPRVD | 0 | 0 | 0 | 0 | 0 | 21.00 |
| 22. 00 | O2200 I &R SERVICES-OTHER PRGM COSTS APPRVD I NPATIENT ROUTINE SERVICE COST CENTERS | 0 | 0 | 0 | 0 | 0 | 22. 00 |
| 30. 00 | 03000 ADULTS & PEDIATRICS | 17, 322 | 17, 322 | 89, 240 | 17, 322 | 22, 762 | 30.00 |
| 31.00 | 03100 INTENSIVE CARE UNIT | 0 | 0 | 0 | o | 0 | 31.00 |
| 32.00 | 03200 CORONARY CARE UNIT | 0 | 0 | 0 | 0 | 0 | 32.00 |
| 33. 00 34. 00 | 03400 SURGI CAL INTENSI VE CARE UNIT | 0 | 0 | 0 | 0 | 0 | 33. 00 34. 00 |
| 40. 00 | 04000 SUBPROVI DER - I PF | 0 | Ö | Ö | o | 0 | 40.00 |
| 41. 00 | 04100 SUBPROVI DER - I RF | 0 | 0 | 0 | o | 0 | 41.00 |
| 43.00 | 04300 NURSERY | 249 | 249 | 257 | 249 | 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 | Ö | Ö | Ö | 0 | 46. 00 |
| | ANCILLARY SERVICE COST CENTERS | 1 | | | | | |
| 50. 00 51. 00 | 05000 OPERATING ROOM 05100 RECOVERY ROOM | 18, 122 | 18, 122 | 67, 257 0 | 18, 122 | 0 | 50. 00 51. 00 |
| 52. 00 | 05200 DELIVERY ROOM & LABOR ROOM | 1, 599 | 1, 599 | | · · | 0 | 52.00 |
| 53.00 | 05300 ANESTHESI OLOGY | 0 | 0 | 0 | O | 0 | 53.00 |
| 54.00 | 05400 RADI OLOGY - DI AGNOSTI C | 8, 759 | 8, 759 | 25, 494 | 8, 759 | 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 | Ö | Ö | Ö | 0 | 57.00 |
| 58. 00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0 | 0 | 0 | 0 | 0 | 58.00 |
| 59. 00 60. 00 | 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY | 3, 347 | 0 3, 347 | 0 | 3, 347 | 0 | 59. 00 60. 00 |
| 60. 00 | 06001 BLOOD LABORATORY | 3, 347 | 3, 347 | 0 | 3, 347 | 0 | 60.00 |
| 61.00 | 1 1 | | | | | | 61.00 |
| 62.00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0 | 0 | 0 | 0 | 0 | 62.00 |
| 63. 00 64. 00 | 06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY | 0 | 0 | 0 | 0 | 0 | 63. 00 64. 00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 2, 135 | 2, 135 | 1, 562 | 2, 135 | 0 | 65.00 |
| 66. 00 | 06600 PHYSI CAL THERAPY | 9, 229 | 9, 229 | 0 | 9, 229 | 0 | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 0 | 0 | 0 | 0 | 0 | 67.00 |
| 68. 00 69. 00 | 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY | 0 | 0 | 0 | 0 | 0 | 68. 00 69. 00 |
| 70. 00 | | 0 | Ö | Ö | Ö | 0 | 70.00 |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 0 | 71.00 |
| 72. 00 73. 00 | 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 0 | 72. 00 73. 00 |
| 74.00 | 07400 RENAL DIALYSIS | | | 0 | | 0 | 74.00 |
| 75. 00 | 07500 ASC (NON-DISTINCT PART) | 0 | Ö | Ö | ō | 0 | 75. 00 |
| 76. 98 | 07698 HYPERBARI C OXYGEN THERAPY | 1, 700 | 1, 700 | i | 1, 700 | 0 | 76. 98 |
| 77. 00 | 07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS | 0 | 0 | 0 | 0 | 0 | 77. 00 |
| 88. 00 | 08800 RURAL HEALTH CLINIC | 0 | 0 | 0 | ol | 0 | 88. 00 |
| 89. 00 | 08900 FEDERALLY QUALIFIED HEALTH CENTER | 0 | 0 | Ō | o | 0 | 89.00 |
| 90.00 | 09000 CLINIC | 0 | 0 | 0 | 0 | 0 | 90.00 |
| 91. 00 92. 00 | O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART) | 7, 254 | 7, 254 | 59, 713 | 7, 254 | 0 | 91. 00 92. 00 |
| , 2. 00 | OTHER REIMBURSABLE COST CENTERS | | | | | | , 00 |
| 94.00 | 09400 HOME PROGRAM DI ALYSI S | 0 | l e | | l . | 0 | 94.00 |
| 95. 00 | 09500 AMBULANCE SERVICES | 0 | 0 | 0 | 0 | 0 | 95.00 |

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 01/01/2022 12/31/2022 Date/Time Prepared: 5/18/2023 11:21 am Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY LINEN SERVICE (SQUARE FEET) (MEALS REPAI RS **PLANT** (SQUARE FEET) (SQUARE FEET) (POUNDS OF SERVED) LAUNDRY) 6. 00 7. 00 9. 00 10.00 8.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 97.00 0 99. 00 09900 CMHC 0 99.00 0 0 0 Ω 0 99. 10 09910 CORF 0 0 0 0 99.10 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 102.00 10200 OPI OID TREATMENT PROGRAM 0 102.00 0 0 0 0 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 105. 00 106.00 10600 HEART ACQUISITION 0 0 0 106.00 0 0 οĺ 107.00 10700 LIVER ACQUISITION 0 0 107 00 0 108.00 10800 LUNG ACQUISITION 0 0 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 o 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 0 0 111.00 11100 I 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.) 0 115 00 0 C 0 0 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 251, 891 22, 762 118.00 118.00 95, 546 84,038 81, 616 NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1,011 1,011 0 1,011 191. 00 19100 RESEARCH 0 0 191.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 6,515 6, 515 1,911 6, 515

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798, 263 202. 00

49, 838 204. 00

35. 069985 203. 00

2. 189526 205. 00

201.00

206. 00

207.00

193. 00 19300 NONPALD WORKERS

194. 04 07954 PHYSICIAN OFFICES

Part I)

Part II)

(per Wkst. B-2)

Parts III and IV)

11)

194. 01 07951 PAIN CLINIC

194. 02 07952 OCC HEALTH

194. 03 07953 FOUNDATI ON

194.06 07956 VACANT SPACE

200.00

201.00

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206.00

207.00

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

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 01/01/2022 12/31/2022 Date/Time Prepared: 5/18/2023 11:21 am Cost Center Description CAFETERI A MAI NTENANCE NURSI NG CENTRAL **PHARMACY** ADMI NI STRATI O SERVICES & (MEALS OF PERSONNEL (COSTED SERVED) (NUMBER **SUPPLY** REQUIS.) Ν HOUSED) (DIRECT NURS (COSTED HRS.) REQUIS.) 11. 00 12.00 13.00 14.00 15.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10.00 11.00 01100 CAFETERI A 411, 897 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 01300 NURSING ADMINISTRATION 10, 290 13.00 166, 458 13.00 01400 CENTRAL SERVICES & SUPPLY 2, 474, 909 14.00 0 14.00 15.00 01500 PHARMACY 12, 111 0 35, 894 3, 391, 822 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 0 16.00 0 0 01700 SOCIAL SERVICE C 0 17 00 0 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 0 21.00 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 68, 770 68, 770 370, 048 0 30.00 31 00 03100 INTENSIVE CARE UNIT 0 Ω 31 00 0 0 03200 CORONARY CARE UNIT 32.00 0 C 0 0 0 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT ol 34.00 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 0 43.00 43.00 3.285 0 3.285 ol 44.00 04400 SKILLED NURSING FACILITY 0 0 C 0 44.00 04500 NURSING FACILITY 45 00 Ω 0 0 0 45 00 0 04600 OTHER LONG TERM CARE 46.00 0 0 0 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 26, 949 0 26, 949 428, 823 0 50.00 05100 RECOVERY ROOM 51.00 0 0 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 15, 563 0 0 52.00 15, 563 53 00 05300 ANESTHESI OLOGY 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 0 94,021 0 54.00 41, 426 05500 RADI OLOGY-THERAPEUTI C 0 55 00 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 57.00 0 0 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 0 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 20, 400 C 65,051 0 65.00 66, 00 06600 PHYSI CAL THERAPY 14, 347 14.359 0 66.00 06700 OCCUPATI ONAL THERAPY 11, 356 67.00 0 67.00 4, 897 06800 SPEECH PATHOLOGY 68.00 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 C 0 0 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 C 656, 492 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 59, 884 3, 391, 822 73.00 07400 RENAL DIALYSIS 74.00 0 0 0 0 74.00 0 75 00 07500 ASC (NON-DISTINCT PART) 0 0 0 75 00 0 07698 HYPERBARIC OXYGEN THERAPY 76.98 11, 411 0 11, 411 87, 120 0 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 77.00 0 0 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 88 00 0 C 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 C 0 0 0 89.00 90.00 09000 CLI NI C 1,098 0 0 2, 221 0 90.00 91 00 09100 EMERGENCY 40, 480 40 480 329, 232 91 00 C 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 0 94.00

In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0146 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/18/2023 11:21 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 95.00 95.00 09500 AMBULANCE SERVICES 120, 203 314, 465 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96,00 0 0 09700 DURABLE MEDICAL EQUIP-SOLD 0 97 00 97 00 C 0 0 0 99.00 09900 CMHC 0 0 99.00 99. 10 09910 CORF 0 0 0 0 99. 10 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 o 0 100.00 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 C 0 101.00 102.00 10200 OPIOID TREATMENT PROGRAM 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 0 105.00 105.00 10500 KI DNEY ACQUI SI TI ON 0 0 Ω 0 106.00 10600 HEART ACQUISITION 0 0 0 C 0 106.00 107. 00 10700 LIVER ACQUISITION 0 0 0 o 0 107.00 108. 00 10800 LUNG ACQUISITION 0 0 0 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 0 109, 00 C 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.) 0 115.00 0 0 116. 00 11600 HOSPI CE 0 0 0 116,00 SUBTOTALS (SUM OF LINES 1 through 117) 3, 391, 822 118. 00 118.00 402, 586 166, 458 2, 457, 610 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 12, 347 0 191.00 191. 00 19100 RESEARCH 0 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192.00 2,029 0 1,804 193. 00 19300 NONPALD WORKERS 0 193.00 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 194.00 0 0 ol 194. 01 07951 PAIN CLINIC 0 0 194. 01 0 0 0 0 194. 02 07952 OCC HEALTH 0 194. 02 0 0 194. 03 07953 FOUNDATI ON 0 0 0 194.03 69 194. 04 07954 PHYSICIAN OFFICES 0 194.04 0 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 0 194.05 7, 213 0 3, 148 194.06 07956 VACANT SPACE 0 0 194.06 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 355, 317 1, 107, 633 138, 272 336, 216 202. 00 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.862636 0.000000 6.654129 0.055870 0.099125 203.00 204.00 Cost to be allocated (per Wkst. B, 17,063 20, 459 204. 00 20.179 106, 351 Part II) 0.006032 205.00

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Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D,

(per Wkst. B-2)

Parts III and IV)

NAHE adjustment amount to be allocated

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10 Provider CCN: 15-0146 Peri od: From 01/01/2022 To 12/31/2022 Worksheet B-1 Date/Time Prepared: 5/18/2023 11: 21 am INTERNS & RESI DENTS Cost Center Description MEDI CAL SOCI AL NONPHYSI CI AN NURSI NG SERVI CES-SALA PROGRAM (ASSI GNED RY & FRINGES (ASSI GNED SERVICE (TIME SPENT) RECORDS & ANESTHETI STS (ASSI GNED LI BRARY (GROSS TIME) TIME) TIME)

| | | CHARGES) | | IIWE) | I I WE) | IIWE) | |
|--------|---|----------------|--------|----------|---------|--------|------------------|
| | | 16. 00 | 17. 00 | 19. 00 | 20. 00 | 21.00 | |
| | GENERAL SERVICE COST CENTERS | 10.00 | 171.00 | 177.00 | 20.00 | 211.00 | |
| | 00100 CAP REL COSTS-BLDG & FLXT | | | | | | 1.00 |
| 2.00 | 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| 5.00 | 00500 ADMINISTRATIVE & GENERAL | | | | | | 5.00 |
| 6.00 | 00600 MAINTENANCE & REPAIRS | | | | | | 6. 00 |
| 1 | 00700 OPERATION OF PLANT | | | | | | 7. 00 |
| 1 | 00800 LAUNDRY & LINEN SERVICE | | | | | | 8. 00 |
| | 00900 HOUSEKEEPI NG | | | | | | 9. 00 |
| | 01000 DI ETARY | | | | | | 10.00 |
| 1 | 01100 CAFETERI A | | | | | | 11.00 |
| | 01200 MAINTENANCE OF PERSONNEL | | | | | | 12.00 |
| | 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY | | | | | | 13. 00 14. 00 |
| | 01500 PHARMACY | | | | | | 15. 00 |
| 1 | 01600 MEDICAL RECORDS & LIBRARY | 255, 327, 467 | | | | | 16.00 |
| 1 | 01700 SOCIAL SERVICE | 200,027,107 | 0 | | | | 17. 00 |
| 1 | 01900 NONPHYSI CLAN ANESTHETI STS | 0 | 0 | 0 | | | 19.00 |
| 1 | 02000 NURSI NG PROGRAM | o | 0 | Ĭ | 0 | | 20.00 |
| 1 | 02100 &R SERVICES-SALARY & FRINGES APPRVD | O | 0 | | | 0 | 1 |
| 1 | 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD | 0 | 0 | | | | 22.00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| | 03000 ADULTS & PEDIATRICS | 17, 752, 748 | 0 | 0 | 0 | 0 | |
| 31.00 | 03100 INTENSIVE CARE UNIT | 0 | 0 | 0 | 0 | 0 | 31.00 |
| 1 | 03200 CORONARY CARE UNIT | 0 | 0 | 0 | 0 | 0 | |
| 1 | 03300 BURN INTENSIVE CARE UNIT | 0 | 0 | 0 | 0 | 0 | |
| 4 | 03400 SURGICAL INTENSIVE CARE UNIT | 0 | 0 | 0 | 0 | 0 | |
| 1 | 04000 SUBPROVI DER - I PF | 0 | 0 | 0 | 0 | 0 | 1 |
| 1 | 04100 SUBPROVI DER – I RF | (70.544 | 0 | 0 | 0 | 0 | 41.00 |
| | 04300 NURSERY | 672, 544 | 0 | 0 | 0 | 0 | 43.00 |
| | 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY | 0 | 0 | 0 | 0 | 0 | 44. 00 45. 00 |
| 1 | 04600 OTHER LONG TERM CARE | 0 | 0 | 0 | - | | 46.00 |
| + | ANCILLARY SERVICE COST CENTERS | U _I | 0 | 0 | U | 0 | 40.00 |
| | 05000 OPERATING ROOM | 27, 185, 280 | 0 | 0 | 0 | 0 | 50.00 |
| | 05100 RECOVERY ROOM | 0 | 0 | | | | 1 |
| | 05200 DELIVERY ROOM & LABOR ROOM | 3, 185, 835 | 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 | 39, 143, 357 | 0 | 0 | 0 | 0 | 54.00 |
| | 05500 RADI OLOGY-THERAPEUTI C | 0 | 0 | 0 | 0 | 0 | 55.00 |
| | 05600 RADI OI SOTOPE | 0 | 0 | 0 | 0 | 0 | 56.00 |
| 1 | 05700 CT SCAN | 0 | 0 | 0 | 0 | 0 | |
| 1 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0 | 0 | 0 | 0 | 0 | 58.00 |
| 1 | 05900 CARDI AC CATHETERI ZATI ON | 0 | 0 | 0 | 0 | 0 | |
| 1 | 06000 LABORATORY | 39, 143, 357 | 0 | 0 | 0 | 0 | |
| | 06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | ď | U | U | U | 0 | 60. 01 61. 00 |
| | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0 | 0 | _ | 0 | 0 | 1 |
| | 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | 0 | 0 | 0 | 0 | 1 |
| | 06400 I NTRAVENOUS THERAPY | 0 | 0 | 0 | 0 | 0 | |
| | 06500 RESPI RATORY THERAPY | 11, 669, 628 | 0 | 0 | 0 | Ö | |
| 4 | 06600 PHYSI CAL THERAPY | 4, 059, 965 | 0 | O | 0 | 0 | |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 1, 442, 924 | 0 | 0 | 0 | 0 | 67.00 |
| 68. 00 | 06800 SPEECH PATHOLOGY | 871, 346 | 0 | 0 | 0 | 0 | 68.00 |
| | 06900 ELECTROCARDI OLOGY | 0 | 0 | 0 | 0 | 0 | 69.00 |
| | 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | 0 | 0 | 0 | 70.00 |
| 1 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 2, 719, 328 | 0 | 0 | 0 | 0 | |
| | 07200 I MPL. DEV. CHARGED TO PATIENTS | 2, 532, 679 | 0 | 0 | 0 | 0 | 1 |
| | 07300 DRUGS CHARGED TO PATIENTS | 26, 140, 833 | 0 | 0 | 0 | 0 | |
| | 07400 RENAL DIALYSIS | 0 | 0 | 0 | 0 | 0 | |
| | 07500 ASC (NON-DISTINCT PART) 07698 HYPERBARIC OXYGEN THERAPY | 4 402 522 | 0 | 0 | 0 | 0 | |
| 1 | l I | 4, 483, 523 | 0 | 0 0 | | 0 | |
| | 07700 ALLOGENEIC STEM CELL ACQUISITION | U | 0 | | 0 | 0 | 17.00 |
| | 08800 RURAL HEALTH CLINIC | O | 0 | 0 | 0 | 0 | 88. 00 |
| 1 | 08900 FEDERALLY QUALIFIED HEALTH CENTER | Ö | 0 | Ö | o | Ö | 1 |
| | 09000 CLI NI C | 233, 549 | 0 | 0 | 0 | 0 | 1 |
| 91. 00 | 09100 EMERGENCY | 49, 957, 471 | 0 | 0 | 0 | 0 | 91.00 |
| 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | l | 92.00 |
| | | | | | | | |
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206.00

207. 00

Part I)

Part II)

(per Wkst. B-2)

Parts III and IV)

II)

Unit cost multiplier (Wkst. B, Part I)

NAHE adjustment amount to be allocated

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D,

203.00

204.00

205.00

206.00

207.00

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 01/01/2022 12/31/2022 Date/Time Prepared: 5/18/2023 11:21 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 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 01300 NURSING ADMINISTRATION 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 07698 HYPERBARI C OXYGEN THERAPY 0 76.98 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 89.00 90.00 09000 CLI NI C 0 90.00 91. 00 | 09100 | EMERGENCY 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0146 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/18/2023 11:21 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 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

COMPUTATION OF RATIO OF COSTS TO CHARGES COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10 Worksheet C Part I Date/Time Prepared: 5/18/2023 11: 21 am Provi der CCN: 15-0146 Peri od: From 01/01/2022 To 12/31/2022 Title XVIII Hospi tal PPS Costs Total Cost (from Wkst. RCE Di sal I owance Cost Center Description Therapy Limit Total Costs Total Costs Adj . B, Part I, col. 26) 1.00 2.00 3.00 4. 00 5. 00

| | | 1. 00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | |
|--------|--|---|-------|-----------------|---------|-------------|---------|
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 | 03000 ADULTS & PEDI ATRI CS | 8, 911, 085 | | 8, 911, 085 | 0 | 8, 911, 085 | 30.00 |
| | 03100 INTENSIVE CARE UNIT | 0 | | 0 | ol | 0 | 31.00 |
| | 03200 CORONARY CARE UNIT | | | ١ | ٥ | 0 | 32.00 |
| | 03300 BURN INTENSIVE CARE UNIT | | | ٥ | ٥ | 0 | 33.00 |
| | 03400 SURGICAL INTENSIVE CARE UNIT | | | 0 | ol ol | - | |
| | 1 | 0 | | 0 | U O | 0 | 34.00 |
| | 04000 SUBPROVI DER – I PF | 0 | | 0 | O | 0 | 40.00 |
| | 04100 SUBPROVI DER – I RF | 0 | | 0 | O | 0 | 41.00 |
| | 04300 NURSERY | 315, 480 | | 315, 480 | 0 | 315, 480 | 43.00 |
| 44.00 | 04400 SKILLED NURSING FACILITY | 0 | | 0 | 0 | 0 | 44.00 |
| 45.00 | 04500 NURSING FACILITY | 0 | | 0 | 0 | 0 | 45.00 |
| 46.00 | 04600 OTHER LONG TERM CARE | o | | 0 | ol | 0 | 46. 00 |
| | ANCILLARY SERVICE COST CENTERS | | | , | | | |
| | 05000 OPERATI NG ROOM | 4, 546, 270 | | 4, 546, 270 | 0 | 4, 546, 270 | 50.00 |
| | 05100 RECOVERY ROOM | 0 | | 0 | ol | 0 | 51.00 |
| | 05200 DELIVERY ROOM & LABOR ROOM | 1, 507, 979 | | 1, 507, 979 | ől | 1, 507, 979 | 52.00 |
| | 05300 ANESTHESI OLOGY | 1,007,777 | | 1,007,777 | o o | 0 | 53.00 |
| | 05400 RADI OLOGY-DI AGNOSTI C | 4, 658, 323 | | 4, 658, 323 | 0 | 4, 658, 323 | 54.00 |
| | | 4, 000, 323 | | 4, 000, 323 | o o | | |
| | 05500 RADI OLOGY-THERAPEUTI C | 0 | | 0 | U O | 0 | 55.00 |
| | 05600 RADI OI SOTOPE | 0 | | 0 | 0 | 0 | 56.00 |
| | 05700 CT SCAN | 0 | | 0 | O | 0 | 57.00 |
| 58. 00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0 | | 0 | O | 0 | 58. 00 |
| | 05900 CARDI AC CATHETERI ZATI ON | 0 | | 0 | 0 | 0 | 59. 00 |
| 60.00 | 06000 LABORATORY | 4, 355, 214 | | 4, 355, 214 | 0 | 4, 355, 214 | 60.00 |
| 60. 01 | 06001 BLOOD LABORATORY | 0 | | 0 | 0 | 0 | 60. 01 |
| 61.00 | 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | o | | 0 | ol | 0 | 61.00 |
| | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0 | | 0 | o | 0 | 62.00 |
| | 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | | ا | ام | 0 | 63.00 |
| | 06400 I NTRAVENOUS THERAPY | | | Ŏ | o o | 0 | 64.00 |
| | 06500 RESPI RATORY THERAPY | 1, 747, 301 | 0 | 1, 747, 301 | 0 | 1, 747, 301 | 65.00 |
| | | | 0 | | ol ol | | |
| 66.00 | 06600 PHYSI CAL THERAPY | 1, 517, 145 | 0 | 1, 517, 145 | U O | 1, 517, 145 | 66.00 |
| | 06700 OCCUPATI ONAL THERAPY | 811, 568 | 0 | 811, 568 | 0 | 811, 568 | |
| 68. 00 | 06800 SPEECH PATHOLOGY | 350, 020 | 0 | 350, 020 | 이 | 350, 020 | |
| | 06900 ELECTROCARDI OLOGY | 0 | | 0 | 0 | 0 | 69. 00 |
| | 07000 ELECTROENCEPHALOGRAPHY | 0 | | 0 | 0 | 0 | 70. 00 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 373, 427 | | 373, 427 | 0 | 373, 427 | 71.00 |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENTS | 606, 898 | | 606, 898 | 0 | 606, 898 | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 5, 300, 739 | | 5, 300, 739 | 0 | 5, 300, 739 | 73.00 |
| 74.00 | 07400 RENAL DI ALYSI S | o | | 0 | ol | 0 | 74.00 |
| 75.00 | 07500 ASC (NON-DISTINCT PART) | o | | 0 | ol | 0 | 75. 00 |
| | 07698 HYPERBARI C OXYGEN THERAPY | 947, 032 | | 947, 032 | ol | 947, 032 | 76. 98 |
| | 1 1 | 0 | | 0 | ol | 0 | 77. 00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | -1 | | |
| 88. 00 | 08800 RURAL HEALTH CLINIC | 0 | | 0 | 0 | 0 | 88. 00 |
| | 08900 FEDERALLY QUALIFIED HEALTH CENTER | o | | 0 | ol | 0 | 89. 00 |
| | 09000 CLI NI C | 75, 971 | | 75, 971 | ol | 75, 971 | 90.00 |
| | 09100 EMERGENCY | 4, 672, 123 | | 4, 672, 123 | 35, 402 | 4, 707, 525 | 91.00 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 3, 227, 010 | | 3, 227, 010 | , | 3, 227, 010 | |
| | OTHER REIMBURSABLE COST CENTERS | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | 5/ == : / 5 : 5 | | -,, | |
| 94.00 | | 0 | | 0 | ol | 0 | 94.00 |
| | | 9, 182, 558 | | 9, 182, 558 | o | 9, 182, 558 | |
| | 09600 DURABLE MEDICAL EQUIP-RENTED | 0, 102, 330 | | 0, 102, 330 | ő | 7, 102, 330 | 1 |
| | 09700 DURABLE MEDICAL EQUIP-SOLD | | | 0 | 0 | 0 | |
| | | | | 0 | ٩ | 0 | 99.00 |
| | 09910 CORF | | | 0 | | 0 | 99. 10 |
| | 1 | 0 | | 0 | | | |
| | 10000 I&R SERVICES-NOT APPRVD PRGM | 0 | | 0 | | | 100.00 |
| | 10100 HOME HEALTH AGENCY | 0 | | 0 | | | 101.00 |
| | 10200 OPI OI D TREATMENT PROGRAM | 0 | | 0 | | 0 | 102. 00 |
| | SPECIAL PURPOSE COST CENTERS | | | _ | 1 | | |
| | 10500 KIDNEY ACQUISITION | 0 | | 0 | | | 105.00 |
| | 10600 HEART ACQUISITION | 0 | | 0 | | | 106.00 |
| | 10700 LIVER ACQUISITION | 0 | | 0 | | | 107. 00 |
| | 10800 LUNG ACQUISITION | 0 | | 0 | | | 108. 00 |
| | 10900 PANCREAS ACQUISITION | 0 | | 0 | | | 109. 00 |
| 110.00 | 11000 INTESTINAL ACQUISITION | 0 | | 0 | | 0 | 110.00 |
| 111.00 | 11100 ISLET ACQUISITION | o | | 0 | | 0 | 111. 00 |
| 113.00 | 11300 I NTEREST EXPENSE | | | | ļ | | 113.00 |
| | 11400 UTILIZATION REVIEW-SNF | | | | | | 114.00 |
| | 11500 AMBULATORY SURGICAL CENTER (D. P.) | ol | | 0 | | 0 | 115.00 |
| | 11600 HOSPI CE | o | | 0 | | | 116.00 |
| | 1 | | · | 1 | I | | |
| | | | | | | | |

| Health Financial Systems | | COMMUNITY HOSPITAL OF NOBLE CTY, INC | | | INC | In Lieu of Form CMS-2552-10 | | | |
|--|-----------------------------|--------------------------------------|----|--------------|-------------|--|--------------|---------|--|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | | | | | | Peri od: | Worksheet C | | |
| | | | | | | | | | |
| | | | | Title | XVIII | From 01/01/2022 Part I To 12/31/2022 Date/T 5/18/2 Hospital Costs | | PPS | |
| | | | | | | Costs | | | |
| | Cost Center Description | Total Cost | Th | nerapy Limit | Total Costs | RCE | Total Costs | | |
| | | (from Wkst. | | Adj . | | Di sal I owance | | | |
| | | B, Part I, | | | | | | | |
| | | col. 26) | | | | | | | |
| | | 1. 00 | | 2. 00 | 3. 00 | 4. 00 | 5. 00 | | |
| 200.00 | Subtotal (see instructions) | 53, 106, 143 | 3 | 0 | 53, 106, 14 | 35, 402 | 53, 141, 545 | 200.00 | |
| 201. 00 | Less Observation Beds | 3, 227, 010 | | | 3, 227, 01 | 0 | 3, 227, 010 | 201.00 | |
| 202. 00 | Total (see instructions) | 49, 879, 133 | 3 | o | 49, 879, 13 | 35, 402 | 49, 914, 535 | 202. 00 | |

Provider CCN: 15-0146

Peri od:

From 01/01/2022

COMPUTATION OF RATIO OF COSTS TO CHARGES

Part I

Date/Time Prepared: 12/31/2022 5/18/2023 11:21 am Title XVIII 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 11, 439, 494 11, 439, 494 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 03200 CORONARY CARE UNIT 0 32.00 0 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 0 34 00 40.00 04000 SUBPROVI DER - I PF 0 40.00 41.00 04100 SUBPROVI DER - I RF 41.00 04300 NURSERY 43.00 43.00 672, 544 672, 544 04400 SKILLED NURSING FACILITY 44.00 0 44 00 45.00 04500 NURSING FACILITY 0 45.00 46.00 04600 OTHER LONG TERM CARE 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 7, 292, 515 19, 892, 765 27, 185, 280 0.167233 0.000000 50.00 05100 RECOVERY ROOM 0.000000 51.00 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 3, 185, 835 0.473339 0.000000 52.00 3, 185, 835 0 52.00 05300 ANESTHESI OLOGY 53 00 0.000000 0.000000 53 00 05400 RADI OLOGY-DI AGNOSTI C 7, 384, 853 31, 758, 504 0.119007 0.000000 54.00 39, 143, 357 54.00 55 00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0.000000 55.00 05600 RADI 0I SOTOPE 56,00 0 C 0 0.000000 0.000000 56,00 57.00 05700 CT SCAN 0 C 0 0.000000 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0.000000 0.000000 58.00 05900 CARDIAC CATHETERIZATION 0.000000 0.000000 59.00 59.00 06000 LABORATORY 31, 758, 504 60.00 7, 384, 853 39, 143, 357 0.111263 0.000000 60 00 60.01 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 0 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 0.000000 0.000000 64.00 06500 RESPIRATORY THERAPY 65.00 2, 720, 860 8, 948, 768 11, 669, 628 0.149731 0.000000 65.00 66 00 06600 PHYSI CAL THERAPY 205 546 3 854 419 4, 059, 965 0.373684 0.000000 66 00 06700 OCCUPATI ONAL THERAPY 67.00 123, 710 1, 319, 214 1, 442, 924 0.562447 0.000000 67.00 06800 SPEECH PATHOLOGY 104, 726 871, 346 0.401700 0.000000 68.00 766, 620 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0.000000 70 00 70 00 560, 466 0.000000 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 158, 862 2, 719, 328 0.137323 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 306, 925 2, 225, 754 2, 532, 679 0.239627 0.000000 72.00 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 5, 934, 083 20, 206, 750 26, 140, 833 0.202776 0.000000 73 00 07400 RENAL DIALYSIS 74.00 0.000000 0.000000 74.00 07500 ASC (NON-DISTINCT PART) 0.000000 0.000000 75.00 75.00 76.98 07698 HYPERBARI C OXYGEN THERAPY 75, 357 4, 408, 166 4, 483, 523 0.211225 0.000000 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 0.000000 77 00 77.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 231, 764 90 00 09000 CLI NI C 1.785 233, 549 0.325289 0.000000 90 00 91.00 09100 EMERGENCY 6, 149, 058 43, 808, 413 49, 957, 471 0.093522 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.511148 0.000000 92.00 6, 313, 254 6, 313, 254 92.00 OTHER REIMBURSABLE COST CENTERS 94 00 09400 HOME PROGRAM DIALYSIS 0.000000 0.000000 94 00 09500 AMBULANCE SERVICES 0 24, 133, 100 24, 133, 100 0.380496 0.000000 95.00 95.00 0.000000 96 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0.000000 96.00 0 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 97.00 97.00 0 0.000000 99.00 09900 CMHC C 0 99.00 09910 CORF 0 0 99.10 99.10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 C 0 101.00 102.00 10200 OPIOID TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 105.00 106. 00 10600 HEART ACQUISITION 0 0 C 106,00 0 107. 00 10700 LIVER ACQUISITION 0 107.00 108. 00 10800 LUNG ACQUISITION 0 0 108.00 0 109. 00 10900 PANCREAS ACQUISITION 0 109.00 0 110.00 11000 INTESTINAL ACQUISITION 0 110.00 111.00 11100 I SLET ACQUISITION 111.00 0 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 115.00 116. 00 11600 HOSPI CE 116.00 200.00 201, 784, 857 255, 327, 467 Subtotal (see instructions) 53 542 610 200.00

| Health Financial Systems | COMMUNIT | ΓΥ HOSPITAL ΟΙ | F NOBLE CTY, | I NC | In Lieu of Form CMS-2552-10 | | |
|------------------------------------|----------|----------------|------------------------|--------------|---|-------------|---------|
| COMPUTATION OF RATIO OF COSTS TO C | CHARGES | | Provi der CCN: 15-0146 | | Period: From 01/01/2022 To 12/31/2022 | | |
| | | | Title | XVIII | Hospi tal | PPS | |
| | | | Charges | | | | |
| Cost Center Description | on I | I npati ent | Outpati ent | Total (col. | 6 Cost or Other | TEFRA | |
| | | | | + col. 7) | Ratio | I npati ent | |
| | | | | | | Ratio | |
| | | 6. 00 | 7. 00 | 8.00 | 9. 00 | 10.00 | |
| 201.00 Less Observation Beds | | | | | | | 201.00 |
| 202.00 Total (see instruction | ns) | 53, 542, 610 | 201, 784, 857 | 255, 327, 46 | 7 | | 202. 00 |

COMMUNITY HOSPITAL OF NOBLE CTY, INC Provider CCN: 15-0146 | In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: | 5/18/2023 11:21 am Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES

| MARTIENT ROUTINE SERVICE COST CENTERS | - | | Title XVIII | Hospi tal | 5/18/2023 11:21 am PPS |
|--|--|---------------|-------------|-----------|---------------------------------------|
| | Cost Center Description | PPS Inpatient | | | |
| INVAILED TRANSPORT SERVICE COST CENTERS 30.00 | | | | | |
| 30.00 30.00 AUULIS & PEIDLATING SS 30.00 30. | INDATIENT DOUTINE SERVICE COST CENTERS | 11.00 | | | |
| 31-00 (30100 NIFERSIVE CARE UNIT 32,000 | | | | | 30.00 |
| 32 00 32000 500000 500000 50000 500000 500000 500000 500000 500000 5000000 500000 500000 5000000 5000000 5000000 50000000 5000000 500000000 | | | | | |
| 34.00 0.000 SURRECULA INTERSIVE CAME UNIT 40.00 0.000 50.0 | 32.00 03200 CORONARY CARE UNIT | | | | 32.00 |
| 40.00 00000 SUBRROVIDER - IPF | 1 I | | | | |
| 11.00 OH000 SUBRROVIDER - 1 IRF | + I | | | | |
| 43.00 0.500 MIRSTRY 44.00 0.400 0.500 MIRSTRY 44.00 0.400 0.500 MIRSTRY 44.00 0.400 0.500 MIRSTRY 45.00 0.500 0.500 MIRSTRY 65.00 0.500 0.500 MIRSTRY 65.00 0.500 | | | | | |
| 44.00 04000 STALLED NURSH NG FACILITY | | | | | |
| 45.00 0-6500 MIRSH MS FACILITY 45.00 | | | | | |
| ARCILLARY SERVICE COST CENTERS | 45.00 04500 NURSING FACILITY | | | | l l |
| 50.00 00000 OPERATINE ROOM 0.167233 50.00 51.00 | | | | | 46.00 |
| 51.00 05.00 05 | | 0.4/7000 | | | F0.00 |
| 52.00 05200 05200 05400 ALSARR ROOM 0.473339 52.00 53.00 05300 05300 05300 055 | | 1 1 | | | · · · · · · · · · · · · · · · · · · · |
| 53.00 03.00 AMESTHESI OLOGY 0.000000 55.00 | 1 1 | | | | l l |
| 54.00 6400 RADIOLOGY-DIAGNOSTIC 0.119007 55.00 55.00 6550 0600 RADIOLOGY-THEAPPUTIC 0.000000 55. | | 1 1 | | | |
| 56.00 56.00 RADIO ISTORPE 0.000000 55.00 | 1 1 | 1 1 | | | l l |
| 57.00 0700 CT SCAN 0.000000 55.00 550.00 55 | | 1 1 | | | l l |
| 58.00 08500 MAGNETIC RESONANCE INACING (MRI) 0.0000000 59.00 60.00 60600 60800 | | 1 | | | |
| 59. DO 05900 CARDIAC CATHETER IZATION 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000 | · · · · · · · · · · · · · · · · · · · | 1 | | | |
| 60.00 | | 1 | | | |
| 60.00 60.00 BLODD LABORATORY 0.000000 61.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 63.00 | | 1 | | | |
| 1. 00 06-100 PBP CLI NI CAL LAB SERVI CES-PROM ONLY 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000 | | 1 | | | l l |
| C. 20 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.0000000 63.00 63.00 64.00 6 | | 1 1 | | | |
| 64.00 | | 1 1 | | | |
| 65.00 06500 RESPIRATORY THERAPY 0.149731 66.00 06.00 06000 PHYSICAL THERAPY 0.373684 66.00 0600 06000 PHYSICAL THERAPY 0.562447 67.00 08.00 06800 08500 SPECH PATHOLOGY 0.401700 68.00 080.00 06900 059FECH PATHOLOGY 0.401700 69.00 070.00 07000 CELCTROCARDIOLOGY 0.000000 77.00 070.00 07000 LECTROCARDIOLOGY 0.000000 77.00 070.00 07000 LECTROCARDIOLOGY 0.000000 77.00 070.00 07000 LECTROCARDIOLOGY 0.000000 77.00 071.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.29627 72.00 072.00 07200 IMPL DEV CHARGED TO PATIENTS 0.29627 72.00 073.00 07300 IMPL DEV CHARGED TO PATIENTS 0.290627 73.00 074.00 07400 REMAL DIALYSIS 0.000000 74.00 074.00 07400 REMAL DIALYSIS 0.000000 74.00 075.00 07500 ASS (NON-DISTINCT PART) 0.000000 74.00 076.98 07698 07698 IVYERDRATIC COST CENTERS 088.00 08800 RUBALL HEALTH CLINIC 0.000000 090.00 08000 CENTERALLY QUALIFIED HEALTH CENTER 0.325289 0.00000 090.00 09000 CENTERALLY QUALIFIED HEALTH CENTER 0.000000 090.00 09000 0000 CENTERALLY QUALIFIED 0.000000 090.00 09000 0000 CENTERALLY QUALIFIED 0.000000 090.00 09000 0000 | 63.00 06300 BLOOD STORING, PROCESSING & TRANS. | 0. 000000 | | | 63.00 |
| 66.00 06600 PHYSI CAL THERAPY 0.5373684 66.00 67.00 670.00 007000 COULPATI TOMOL THERAPY 0.562447 67.00 68.00 06800 SPECH PATHOLOGY 0.401700 68.00 69.00 6 | + I | 0. 000000 | | | 64.00 |
| 67.00 06700 06700 06700 06700 06700 06700 0680 0680 06800 06800 06800 06800 06800 06800 06800 06800 06800 06800 06800 06800 06800 06800 06900 06900 06900 06100 06900 07100 | 1 I | 1 1 | | | |
| 88. 00 06800 SPECCH PATHOLOGY 0. 401700 6.8. 00 08900 ELCETROCACHO LOGY 0. 000000 70. 00 07000 ELCETROCACHO LOGY 0. 000000 77. 00 07000 ELCETROCACHO LOGRAPH 0. 0000000 77. 00 07000 MEDICAL SUPPLIE'S CHARGED TO PATIENTS 0. 239627 72. 00 07200 MEDICAL SUPPLIE'S CHARGED TO PATIENTS 0. 239627 72. 00 073000 073000 073000 073000 073000 0730 | | 1 1 | | | |
| 69 00 06900 06900 06ECTROCARDIOLOGY 0.000000 7.00 7 | | 1 1 | | | |
| 70. 00 070000 07000 07000 07000 07000 07000 07000 07000 07000 07000 070000 070000 070000 070000 070000 0700000 070000 070000 070000 070000 070000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 07000000 07000000 07000000 070000000 070000000 070000000 070000000 070000000 0700000000 | | 1 1 | | | |
| 17. 00 07100 MCDI CAL SUPPLIES CHARGED TO PATIENTS 0. 137323 72. 00 72. 00 72.00 | | 1 | | | l l |
| 12. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0. 202776 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 202776 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 74. 00 074. 00 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 08500 | + + | 1 1 | | | l l |
| 74. 00 07400 RANAL DI ALYSIS 0.000000 75. 00 | | 1 1 | | | |
| 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 75.00 07598 M75PSRARI C 0XYGEN THERAPY 0.21125 76.98 07598 M75PSRARI C 0XYGEN THERAPY 0.21125 77.00 017PATIENT SERVICE COST CENTERS 88.00 08900 08900 RUBAL HEALTH CLINI C 88.00 08900 08900 RUBAL HEALTH CLINI C 88.00 08900 08900 FEDERALLY QUALIFIED HEALTH CENTER 99.00 09.00 09900 011 | 73.00 07300 DRUGS CHARGED TO PATIENTS | 0. 202776 | | | 73.00 |
| 76.98 07596 NYPÉRBARIC COXYGEN THERÁPY 0.211225 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 00000000 077.00 0000000 078.00 08800 RURAL HEALTH CLINIC 88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 99.00 09000 01000 | + I | 1 1 | | | |
| 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000 | | | | | |
| DUTPATIENT SERVICE COST CENTERS 88. 00 | | 1 1 | | | |
| 88. 00 | | 0.000000 | | | //.00 |
| 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 99.00 | | T T | | | 88.00 |
| 91.00 09100 EMERGENCY 0.094231 0.511148 92.00 09200 DESERVATION BEDS (NON-DISTINCT PART) 0.511148 92.00 09400 HOME PROGRAM DI ALYSIS 0.000000 95.00 09400 HOME PROGRAM DI ALYSIS 0.000000 95.00 09600 AMBULANCE SERVI CES 0.380496 95.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 97.00 09700 0097000 009700 009700 009700 009700 009700 009700 0097000 009700 009700 009700 009700 009700 009700 0097000 009700 009700 009700 009700 009700 009700 0097000 009700 009700 009700 009700 009700 009700 00970 | · · · · · · · · · · · · · · · · · · · | | | | |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 511148 92. 00 OTHER REI IMBURSABLE COST CENTERS 94. 00 94. 00 09400 HOME PROGRAM DI ALYSI S 0. 000000 94. 00 95. 00 09500 AMBULANCE SERVICES 0. 380496 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RINTED 0. 000000 97. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0. 000000 97. 00 99. 00 09900 CMHC 99. 00 99. 10 09910 CORF 99. 10 100. 00 10000 IAR SERVI CES-NOT APPRVD PRGM 100. 00 101. 00 10100 HOME HEALTH AGENCY 101. 00 102. 00 10200 OPI OI D TREATMENT PROGRAM 102. 00 SPECIAL PURPOSE COST CENTERS 105. 00 106. 00 10600 HEART ACQUI SI TI ON 107. 00 107. 00 10700 LIVER ACQUI SI TI ON 107. 00 108. 00 10800 LUNG ACQUI SI TI ON 108. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 111. 00 11100 INTEREST EXPENSE 111. 00 113. 00 11300 INTEREST EXPENSE 113. 00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 116. 00 10500 LUSS Observation Beds 200. 00 201. 00 Subtotal (see instructions) 200. 00 201. 00 LESS Observation Beds 201. 00 | 90. 00 09000 CLI NI C | 0. 325289 | | | 90.00 |
| OTHER REIMBURSABLE COST CENTERS O. 00400 OMBUR PROGRAM DI ALYSI S O. 000000 | | | | | |
| 94. 00 09400 HOME PROGRAM DI ALYSIS 0.000000 99. 00 095. 00 09500 0MBULANCE SERVI CES 0.380496 95. 00 09600 0096000 009600 009600 009600 009600 009600 009600 0096000 009600 009600 009600 009600 009600 009600 0096000 009600 009600 009600 009600 009600 009600 0096000 009600 009600 009600 009600 009600 009600 0096000 009600 009600 009600 009600 009600 009600 0096000 009600 009600 009600 009600 009600 009600 0096000 009600 009600 009600 009600 009600 009600 0096000 0096000 009600 009600 009600 009600 009600 009600 0096000 009600 009600 009600 009600 009600 009600 0096000 009600 009600 0096000 0096000 0096000 0096000 0096000 0096000 0096000 0096000 0096000 00960000 00960000 00960000 009600000 00960000000 00960000000000 | | 0. 511148 | | | 92. 00 |
| 95. 00 09500 AMBULANCE SERVICES 0.380496 95. 00 96. 00 09700 DURABLE MEDI CAL EQUI P-RENTED 0.000000 97. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 97. 00 99. 00 09900 CMHC 99. 00 99. 10 09910 CORF 99. 10 100. 00 10000 1 &R SERVICES-NOT APPRVD PRGM 100. 00 101. 00 10100 HOME HEALTH AGENCY 1010. 00 102. 00 02000 OPI OI D TREATMENT PROGRAM 102. 00 SPECIAL PURPOSE COST CENTERS 105. 00 105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 107. 00 10700 LI VER ACQUI SI TI ON 107. 00 108. 00 10800 LIVER ACQUI SI TI ON 109. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 111. 00 11000 I NTERSTI NAL ACQUI SI TI ON 110. 00 111. 00 11300 I NTERST EXPENSE 113. 00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 116. 00 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00 | | 0.000000 | | | 04.00 |
| 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 97. 00 09900 CMHC 99. 00 09900 CMHC 99. 10 09910 CORF 99. 10 1000 10000 1&R SERVI CES-NOT APPRVD PRGM 100. 00 10100 10100 HOME HEALTH AGENCY 101. 00 10100 10000 101D TREATMENT PROGRAM 102. 00 102. 00 10200 0910 ID TREATMENT PROGRAM 105. 00 105. 00 105. 00 106. | | 1 1 | | | |
| 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 99.00 99900 CMHC 99.00 99910 099910 CORF 99.10 09910 CORF 99.10 000000 I&R SERVI CES-NOT APPRVD PRGM 99.10 100.000 I&R SERVI CES-NOT APPRVD PRGM 100.000 101.000 HOME HEALTH AGENCY 101.000 10200 OPI OI D TREATMENT PROGRAM 102.000 SPECI AL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON 106.000 10700 LI VER ACQUI SI TI ON 106.000 10700 LI VER ACQUI SI TI ON 107.000 109.000 LUNG ACQUI SI TI ON 108.000 109.000 LUNG ACQUI SI TI ON 109.000 109.000 PANCREAS ACQUI SI TI ON 109.000 110.000 110.000 1NTESTI NAL ACQUI SI TI ON 110.000 111.000 113.000 1NTERSTI NAL ACQUI SI TI ON 111.000 113.000 113.000 113.000 114.000 114.000 114.000 114.000 114.000 115.000 AMBULATORY SURGI CAL CENTER (D.P.) 115.000 116.000 10000 HOSPI CE 116.000 10000 Less Observati on Beds 201.000 201.000 Less Observation Beds 201.000 | | 1 1 | | | |
| 99. 10 | + I | | | | l l |
| 100. 00 10000 1&R SERVICES-NOT APPRVD PRGM 100. 00 101. 00 10100 HOME HEALTH AGENCY 101. 00 10200 0P10 ID TREATMENT PROGRAM 102. 00 10500 KI DNEY ACQUISITION 106. 00 10500 KI DNEY ACQUISITION 106. 00 107. 00 10700 LI VER ACQUISITION 107. 00 10800 LUNG ACQUISITION 108. 00 10900 PANCREAS ACQUISITION 109. 00 10900 INTESTINAL ACQUISITION 109. 00 110. 00 11000 INTESTINAL ACQUISITION 110. 00 111. 00 11100 ISLET ACQUISITION 111. 00 111. 00 111. 00 111. 00 114. 00 114. 00 114. 00 114. 00 114. 00 115. 00 115. 00 116. 00 HOSPICE 115. 00 116. 00 HOSPICE 116. 00 100. 00 | 99. 00 09900 CMHC | | | | 99.00 |
| 101. 00 10100 HOME HEALTH AGENCY 102. 00 10200 OPI 0I D TREATMENT PROGRAM 102. 00 SPECI AL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 106.00 HEART ACQUI SI TI ON 107. 00 10700 LI VER ACQUI SI TI ON 107. 00 108. 00 10800 LUNG ACQUI SI TI ON 108. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 110. 00 11000 INTESTI NAL ACQUI SI TI ON 110. 00 1100 ISLET ACQUI SI TI ON 111. 00 111. 00 113. 00 113. 00 113. 00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 115. 00 116. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00 | | | | | |
| 102. 00 10200 OPI OID TREATMENT PROGRAM 102. 00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SITI ON 106. 00 10600 HEART ACQUI SITI ON 106. 00 10700 LI VER ACQUI SITI ON 107. 00 10800 LUNG ACQUI SITI ON 108. 00 10800 LUNG ACQUI SITI ON 109. 00 10900 PANCREAS ACQUI SITI ON 109. 00 1000 INTESTI NAL ACQUI SITI ON 110. 00 111. 00 11100 ISLET ACQUI SITI ON 111. 00 113. 00 11300 INTEREST EXPENSE 113. 00 11400 UTILI ZATI ON REVIEW-SNF 114. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 115. 00 11600 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) Less Observation Beds 201. 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 10700 LI VER ACQUI SI TI ON 107. 00 10800 LUNG ACQUI SI TI ON 108. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 10900 PANCREAS ACQUI SI TI ON 110. 00 11000 I NTESTI NAL ACQUI SI TI ON 110. 00 111. 00 11100 I SLET ACQUI SI TI ON 111. 00 113. 00 11300 I NTEREST EXPENSE 113. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 115. 00 116. 00 1000 Less Observati on Beds 200. 00 200. 00 Less Observati on Beds 201. 00 | | | | | |
| 105. 00 | | | | | 102.00 |
| 106. 00 10600 10600 HEART ACQUISITION 106. 00 107. 00 10700 LI VER ACQUISITION 107. 00 108. 00 10800 LUNG ACQUISITION 108. 00 109. 00 10900 PANCREAS ACQUISITION 109. 00 110. 00 11100 INTESTINAL ACQUISITION 110. 00 11100 INTESTINAL ACQUISITION 111. 00 11130 INTEREST EXPENSE 113. 00 11300 INTERST EXPENSE 114. 00 11400 UTILIZATION REVIEW-SNF 114. 00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 116. 00 11600 Less Observation Beds 200. 00 201. 00 Less Observation Beds | | | | | 105. 00 |
| 108. 00 10800 LUNG ACQUISITION 108. 00 10900 PANCREAS ACQUISITION 109. 00 110. 00 11000 INTESTINAL ACQUISITION 110. 00 111. 00 111. 00 111. 00 113. 00 113. 00 113. 00 113. 00 114. 00 114. 00 114. 00 115. 00 115. 00 115. 00 115. 00 115. 00 115. 00 116. | | | | | |
| 109. 00 10900 10900 PANCREAS ACQUISITION 109. 00 110. 00 110. 00 110. 00 111. 00 | 107.00 10700 LIVER ACQUISITION | | | | 107. 00 |
| 110. 00 11000 1 NTESTI NAL ACQUI SITION 110. 00 111. 00 11100 1 SLET ACQUI SITION 111. 00 113. 00 113. 00 113. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 115. 00 11600 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00 | | | | | |
| 111. 00 11100 11100 11100 11100 11100 11100 11100 111100 | | | | | |
| 113. 00 | | | | | l l |
| 114.00 | 1 1 | | | | |
| 115. 00 | | | | | |
| 116. 00 11600 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00 | | | | | |
| 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00 | | | | | |
| 201.00 Less Observation Beds 201.00 | 200.00 Subtotal (see instructions) | | | | 200.00 |
| 202.00 Total (see instructions) 202.00 | | | | | |
| | 202.00 Total (see instructions) | | | | 202. 00 |

Health Financial Systems

COMMUNITY HOSPITAL OF NOBLE CTY, INC

In Lieu of Form CMS-2552-10

Provider CCN: 15-0146

Period:
From 01/01/2022
To 12/31/2022

Title XIX

Hospital

PPS

Cost Center Description

COMMUNITY HOSPITAL OF NOBLE CTY, INC

In Lieu of Form CMS-2552-10

Worksheet C
Part I
Date/Time Prepared:
5/18/2023 11: 21 am
PPS

Costs

Total Costs

Total Costs

RCE

Total Costs

| | | | | | 5/18/2023 11: | 21 am |
|--|---|-----------------------|----------------------|---------------------------------|----------------------|--------------------|
| | | Ti tl | e XIX | Hospi tal | PPS | |
| Cost Center Description | Total Cost (from Wkst. B, Part I, col. 26) | Therapy Limit Adj. | Total Costs | Costs RCE Di sal I owance | Total Costs | |
| | 1. 00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 8, 911, 085 | | 8, 911, 085 | 0 | 8, 911, 085 | 30.00 |
| 31. 00 03100 I NTENSI VE CARE UNI T | 0 | | 0 | 0 | 0 | 31.00 |
| 32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT | 0 | | 0 | 0 | 0 | 32. 00 33. 00 |
| 34. 00 03400 SURGI CAL INTENSI VE CARE UNI T | 0 | | | 0 | 0 | 34.00 |
| 40. 00 04000 SUBPROVI DER - 1 PF | 0 | | Ö | 0 | Ö | 40.00 |
| 41. 00 04100 SUBPROVI DER - I RF | 0 | | 0 | 0 | 0 | 41.00 |
| 43. 00 04300 NURSERY | 315, 480 | | 315, 480 | 0 | 315, 480 | 43.00 |
| 44.00 04400 SKILLED NURSING FACILITY | 0 | | 0 | 0 | 0 | 44.00 |
| 45.00 04500 NURSING FACILITY | 0 | | 0 | 0 | 0 | 45.00 |
| 46.00 04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS | 0 | | 0 | 0 | 0 | 46.00 |
| 50. 00 05000 OPERATING ROOM | 4, 546, 270 | | 4, 546, 270 | 0 | 4, 546, 270 | 50.00 |
| 51. 00 05100 RECOVERY ROOM | 0 | l . | 0 | | 0 | 51.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 1, 507, 979 | | 1, 507, 979 | 0 | 1, 507, 979 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0 | | 0 | 0 | 0 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 4, 658, 323 | | 4, 658, 323 | 0 | 4, 658, 323 | 54.00 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0 | | 0 | 0 | 0 | 55.00 |
| 56. 00 05600 RADI OI SOTOPE 57. 00 05700 CT SCAN | 0 | | 0 | 0 | 0 | 56. 00 57. 00 |
| 58.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE MAGING (MRI) | 0 | | | 0 | 0 | 58.00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | 0 | | 0 | 0 | Ö | 59.00 |
| 60. 00 06000 LABORATORY | 4, 355, 214 | | 4, 355, 214 | 0 | 4, 355, 214 | 60.00 |
| 60. 01 06001 BL00D 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. 64. 00 06400 INTRAVENOUS THERAPY | 0 | | 0 | 0 | 0 | 63.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 1, 747, 301 | 0 | 1, 747, 301 | 0 | 1, 747, 301 | 64. 00 65. 00 |
| 66. 00 06600 PHYSI CAL THERAPY | 1, 517, 145 | | | 0 | 1, 517, 145 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 811, 568 | | 811, 568 | | 811, 568 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 350, 020 | 0 | 350, 020 | 0 | 350, 020 | 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 72.00 07200 MPL. DEV. CHARGED TO PATIENTS | 373, 427 606, 898 | | 373, 427 606, 898 | 0 | 373, 427 606, 898 | 71. 00 72. 00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 5, 300, 739 | | 5, 300, 739 | | 5, 300, 739 | 73.00 |
| 74. 00 07400 RENAL DI ALYSI S | 0,000,707 | | 0,000,707 | 0 | 0,000,707 | 74.00 |
| 75.00 07500 ASC (NON-DISTINCT PART) | 0 | | 0 | 0 | 0 | 75.00 |
| 76. 98 07698 HYPERBARIC OXYGEN THERAPY | 947, 032 | | 947, 032 | 0 | 947, 032 | 76. 98 |
| 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | | 0 | 0 | 0 | 77. 00 |
| OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC | 0 | Ι | Ο | 0 | 0 | 88. 00 |
| 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER | 0 | | | 0 | 0 | • |
| 90. 00 09000 CLINIC | 75, 971 | | 75, 971 | 0 | 75, 971 | • |
| 91. 00 09100 EMERGENCY | 4, 672, 123 | | 4, 672, 123 | 35, 402 | 4, 707, 525 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 3, 227, 010 | | 3, 227, 010 | | 3, 227, 010 | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | 1 0 | 0 | 0 | 04.00 |
| 94. 00 09400 HOME PROGRAM DIALYSIS 95. 00 09500 AMBULANCE SERVICES | 0 9, 182, 558 | | 0 9, 182, 558 | | 9, 182, 558 | 94. 00 95. 00 |
| 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED | 0, 102, 330 | | 7, 102, 330 | 0 | 7, 102, 330 | 96.00 |
| 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | | Ö | 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 SERVI CES-NOT APPRVD PRGM | 0 | | 0 | | | 100.00 |
| 101.00 10100 HOME HEALTH AGENCY | 0 | • | 0 0 | | | 101. 00 102. 00 |
| 102.00 10200 OPI OI D TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS | | | | | U | 102.00 |
| 105. 00 10500 KI DNEY ACQUI SI TI ON | 0 | | 0 | | 0 | 105.00 |
| 106.00 10600 HEART ACQUISITION | 0 | | 0 | | 0 | 106. 00 |
| 107. 00 10700 LI VER ACQUI SI TI ON | 0 | | 0 | | | 107.00 |
| 108. 00 10800 LUNG ACQUI SI TI ON | 0 | | 0 | | | 108.00 |
| 109.00 10900 PANCREAS ACQUISITION | 0 | | | | | 109.00 |
| 110.00 11000 INTESTINAL ACQUISITION 111.00 11100 ISLET ACQUISITION | 0 | | | | | 110. 00 111. 00 |
| 113. 00 11300 INTEREST EXPENSE | | | ١ | | | 113.00 |
| 114. 00 11400 UTI LI ZATI ON REVI EW-SNF | | | | | | 114.00 |
| 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) | 0 | | 0 | | | 115.00 |
| 116. 00 11600 HOSPI CE | 0 | <u> </u> | 0 | <u> </u> | 0 | 116. 00 |
| | | | | | | |

| Health Financial Systems | | COMMUNITY HOSPITAL OF NOBLE CTY, INC | | | I NC | In Lieu of Form CMS-2552-10 | | |
|--|-----------------------------|--------------------------------------|-----|-----------------------|---------------|-----------------------------|-----------------------|---------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | | | | Provider CCN: 15-0146 | | Peri od: From 01/01/2022 | Worksheet C Part I | |
| | | | | | To 12/31/2022 | | | |
| | | | | Ti tl | e XIX | Hospi tal | PPS | |
| | | | | | | Costs | | |
| | Cost Center Description | Total Cost | The | erapy Limit | Total Costs | RCE | Total Costs | |
| | | (from Wkst. | | Adj . | | Di sal I owance | | |
| | | B, Part I, | | · | | | | |
| | | col. 26) | | | | | | |
| | | 1. 00 | | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| 200.00 | Subtotal (see instructions) | 53, 106, 143 | | 0 | 53, 106, 14 | 3 35, 402 | 53, 141, 545 | 200.00 |
| 201. 00 | Less Observation Beds | 3, 227, 010 |) | | 3, 227, 01 | 0 | 3, 227, 010 | 201.00 |
| 202. 00 | Total (see instructions) | 49, 879, 133 | | 0 | 49, 879, 13 | 35, 402 | 49, 914, 535 | 202. 00 |

Provider CCN: 15-0146

Peri od:

From 01/01/2022

COMPUTATION OF RATIO OF COSTS TO CHARGES

Part I

Date/Time Prepared: 12/31/2022 5/18/2023 11:21 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 11, 439, 494 11, 439, 494 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 03200 CORONARY CARE UNIT 0 32.00 0 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 0 34 00 40.00 04000 SUBPROVI DER - I PF 0 0 40.00 41.00 04100 SUBPROVI DER - I RF 41.00 04300 NURSERY 43.00 672, 544 672, 544 43.00 04400 SKILLED NURSING FACILITY 44.00 0 44 00 45.00 04500 NURSING FACILITY 0 45.00 46.00 04600 OTHER LONG TERM CARE 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 7, 292, 515 19, 892, 765 27, 185, 280 0.167233 0.000000 50.00 05100 RECOVERY ROOM 0.000000 51.00 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 3, 185, 835 0.473339 0.000000 52.00 3, 185, 835 0 52.00 05300 ANESTHESI OLOGY 53 00 0.000000 0.000000 53 00 05400 RADI OLOGY-DI AGNOSTI C 7, 384, 853 31, 758, 504 0.119007 0.000000 54.00 39, 143, 357 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 C 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 31, 758, 504 60.00 7, 384, 853 39, 143, 357 0.111263 0.000000 60 00 60.01 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 0 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 0.00000063.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0.000000 64.00 06500 RESPIRATORY THERAPY 65.00 2, 720, 860 8, 948, 768 11, 669, 628 0.149731 0.000000 65.00 66 00 06600 PHYSI CAL THERAPY 205 546 3 854 419 4, 059, 965 0.373684 0.000000 66 00 06700 OCCUPATI ONAL THERAPY 67.00 123, 710 1, 319, 214 1, 442, 924 0.562447 0.000000 67.00 06800 SPEECH PATHOLOGY 104, 726 871, 346 0.401700 0.000000 68.00 766, 620 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0.000000 70 00 70 00 560, 466 0.000000 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 158, 862 2, 719, 328 0.137323 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 306, 925 2, 225, 754 2, 532, 679 0.239627 0.000000 72.00 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 5, 934, 083 20, 206, 750 26, 140, 833 0.202776 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 HYPERBARI C OXYGEN THERAPY 75, 357 4, 408, 166 4, 483, 523 0.211225 0.000000 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 0.000000 77 00 77.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0.000000 0.000000 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0.000000 89.00 0 0.000000 90 00 09000 CLI NI C 1.785 231, 764 233, 549 0.325289 90 00 91.00 09100 EMERGENCY 6, 149, 058 43, 808, 413 49, 957, 471 0.093522 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 6, 313, 254 6, 313, 254 0.511148 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0.000000 94 00 09500 AMBULANCE SERVICES 0 24, 133, 100 24, 133, 100 0.380496 0.000000 95.00 95.00 0.000000 96 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0.000000 96.00 0 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 97.00 97.00 C 0 0.000000 99.00 09900 CMHC C 0 99.00 09910 CORF 0 0 99.10 99.10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 C 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 0 0.000000 0.000000 105.00 106. 00 10600 HEART ACQUISITION 0 0 0.000000 0. 000000 106. 00 C 0 107. 00 10700 LIVER ACQUISITION 0 0.000000 0.000000 107.00 108. 00 10800 LUNG ACQUISITION 0 0 0.000000 0.000000 108.00 0 109. 00 10900 PANCREAS ACQUISITION 0 0.000000 0. 000000 109. 00 C 0 110.00 11000 INTESTINAL ACQUISITION 0 0.000000 0.000000 110.00 111.00 11100 I SLET ACQUISITION 0.000000 0.000000 111.00 0 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 115.00 116. 00 11600 HOSPI CE 116.00 200.00 201, 784, 857 255, 327, 467 Subtotal (see instructions) 53 542 610 200 00

| Health Financial Systems | COMMUNITY HOSPITAL OF NOBLE CTY, INC In | | | In Lie | In Lieu of Form CMS-2552-10 | |
|--|---|---------------|--------------|---|-----------------------------|---------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | | Provi der Co | | Period: From 01/01/2022 To 12/31/2022 | Date/Time Pre | |
| | | | | | 5/18/2023 11: | 21 am |
| | | litl | e XIX | Hospi tal | PPS | |
| | | Charges | | | | |
| Cost Center Description | Inpatient | Outpati ent | Total (col. | 6 Cost or Other | TEFRA | |
| | | • | + col. 7) | Ratio | I npati ent | |
| | | | | | Ratio | |
| | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | |
| 201.00 Less Observation Beds | | | | | | 201.00 |
| 202.00 Total (see instructions) | 53, 542, 610 | 201, 784, 857 | 255, 327, 46 | 7 | | 202. 00 |

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES In Lieu of Form CMS-2552-10 Peri od: Worksheet C From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared: 5/18/2023 11: 21 am Provi der CCN: 15-0146

| | | Ti tle XIX | Hospi tal | 5/18/2023 11: 21 am PPS |
|---|------------------------|------------|-----------|----------------------------|
| Cost Center Description | PPS Inpatient | THE XIX | nospi tai | 113 |
| · | Ratio | | | |
| LAIDATI FAIT DOUTLAIF CERVILOE COCT OFAITERS | 11. 00 | | | |
| 30. 00 O3000 ADULTS & PEDIATRICS | | | | 30.00 |
| 31. 00 03100 NTENSI VE CARE UNI T | | | | 31.00 |
| 32. 00 03200 CORONARY CARE UNIT | | | | 32.00 |
| 33.00 03300 BURN INTENSIVE CARE UNIT | | | | 33.00 |
| 34. 00 03400 SURGICAL INTENSIVE CARE UNIT | | | | 34.00 |
| 40. 00 04000 SUBPROVI DER - PF | | | | 40.00 |
| 41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY | | | | 41. 00 43. 00 |
| 44. 00 04400 SKILLED NURSING FACILITY | | | | 44.00 |
| 45. 00 04500 NURSI NG FACI LI TY | | | | 45. 00 |
| 46.00 04600 OTHER LONG TERM CARE | | | | 46.00 |
| ANCILLARY SERVICE COST CENTERS | | | | |
| 50. 00 05000 OPERATING ROOM | 0. 167233 | | | 50.00 |
| 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM | 0. 000000 0. 473339 | | | 51. 00 52. 00 |
| 53. 00 05300 ANESTHESI OLOGY | 0. 000000 | | | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0. 119007 | | | 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 MAGNETIC RESONANCE I MAGING (MRI) | 0. 000000 | | | 58.00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | 0. 000000 | | | 59.00 |
| 60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY | 0. 111263 0. 000000 | | | 60.00 |
| 60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | 0. 000000 | | | 60. 01 |
| 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0. 000000 | | | 62.00 |
| 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. | 0. 000000 | | | 63.00 |
| 64.00 06400 INTRAVENOUS THERAPY | 0. 000000 | | | 64.00 |
| 65. 00 06500 RESPIRATORY THERAPY | 0. 149731 | | | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0. 373684 | | | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0. 562447 | | | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 0. 401700 | | | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0. 000000 | | | 69.00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS | 0. 000000 0. 137323 | | | 70. 00 71. 00 |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS | 0. 137323 | | | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 0. 202776 | | | 73.00 |
| 74. 00 07400 RENAL DI ALYSI S | 0. 000000 | | | 74.00 |
| 75.00 07500 ASC (NON-DISTINCT PART) | 0. 000000 | | | 75.00 |
| 76. 98 07698 HYPERBARI C OXYGEN THERAPY | 0. 211225 | | | 76. 98 |
| 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION | 0. 000000 | | | 77. 00 |
| 0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC | 0.000000 | | | 88. 00 |
| 88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER | 0. 000000 0. 000000 | | | 89.00 |
| 90. 00 09000 CLINI C | 0. 325289 | | | 90.00 |
| 91. 00 09100 EMERGENCY | 0. 094231 | | | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 511148 | | | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | |
| 94. 00 09400 HOME PROGRAM DI ALYSI S | 0. 000000 | | | 94.00 |
| 95. 00 O9500 AMBULANCE SERVICES 96. 00 O9600 DURABLE MEDICAL EQUIP-RENTED | 0. 380496 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 OPI OI D TREATMENT PROGRAM | | | | 102.00 |
| SPECIAL PURPOSE COST CENTERS | 0.000000 | | | 105.00 |
| 105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10600 HEART ACQUI SI TI ON | 0. 000000 0. 000000 | | | 105. 00 106. 00 |
| 107. 00 10700 LI VER ACQUI SI TI ON | 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 I SLET ACQUISITION | 0. 000000 | | | 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.) | | | | 115.00 |
| 116.00 11600 H0SPICE 200.00 Subtotal (see instructions) | | | | 116. 00 200. 00 |
| 201.00 Less Observation Beds | | | | 201. 00 |
| 202.00 Total (see instructions) | | | | 202.00 |
| | 1 | | | 1=32.00 |

Health Financial Systems COMMUNITY HOSPITA CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | Peri od: | Worksheet C | From 01/01/2022 | Part I I | To | 12/31/2022 | Date/Time | Prepared: | To | 12/31/2022 | Date/Time | Prepared: | To | 12/31/2023 Provider CCN: 15-0146

| | | | То | 12/31/2022 | Date/Time Pre 5/18/2023 11: | pared: 21 am |
|--|-----------------------------|---------------------------|-----------------------------|------------|-----------------------------|--------------------|
| | | | e XIX | Hospi tal | PPS | |
| Cost Center Description | Total Cost | Capital Cost | Operating | Capi tal | Operating | |
| | (Wkst. B, Part I, col. | (Wkst. B, Part II col. | Cost Net of Capital Cost | Reducti on | Cost Reduction | |
| | 26) | 26) | (col. 1 - | | Amount | |
| | | - 7 | col . 2) | | | |
| | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM | 4 544 270 | 200 240 | 4 157 022 | ٥ | 0 | 50.00 |
| 51. 00 05100 RECOVERY ROOM | 4, 546, 270 | 388, 348 | 4, 157, 922 | 0 | 0 | 51.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 1, 507, 979 | 96, 307 | 1, 411, 672 | ő | 0 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0 | 0 | 0 | 0 | 0 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 4, 658, 323 | 590, 655 | 4, 067, 668 | 0 | 0 | 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 58. 00 05800 MAGNETIC RESONANCE MAGING (MRI) | 0 | 0 | 0 | 0 | 0 | 57. 00 58. 00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | | | | 0 | 0 | 59.00 |
| 60. 00 06000 LABORATORY | 4, 355, 214 | 186, 019 | 4, 169, 195 | Ö | 0 | 60.00 |
| 60. 01 06001 BLOOD LABORATORY | 0 | 0 | 0 | 0 | 0 | 60. 01 |
| 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | 0 | 0 | 0 | 0 | 0 | 61.00 |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0 | 0 | 0 | 0 | 0 | 62.00 |
| 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | 0 | 0 | 0 | 0 | 63.00 |
| 64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY | 1, 747, 301 | 142, 189 | 1, 605, 112 | 0 | 0 | 64. 00 65. 00 |
| 66. 00 06600 PHYSI CAL THERAPY | 1, 517, 145 | 1 | | 0 | 0 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 811, 568 | | | ő | 0 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 350, 020 | | | 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 | 373, 427 | | | 0 | 0 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS | 606, 898 5, 300, 739 | 1 | | 0 | 0 | 72. 00 73. 00 |
| 74. 00 07400 RENAL DIALYSIS | 5, 300, 737 | 220, 380 | 5,000,155 | 0 | 0 | 74.00 |
| 75. 00 07500 ASC (NON-DISTINCT PART) | | Ö | Ö | Ö | 0 | 75.00 |
| 76. 98 07698 HYPERBARIC OXYGEN THERAPY | 947, 032 | 60, 662 | 886, 370 | 0 | 0 | 76. 98 |
| 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | 0 | 0 | 0 | 0 | 77. 00 |
| 0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC | | I 0 | | ما | 0 | 00.00 |
| 88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER | 0 | | 0 | 0 | 0 | 88. 00 89. 00 |
| 90. 00 09000 CLINIC | 75, 971 | 3, 081 | | 0 | 0 | 90.00 |
| 91. 00 09100 EMERGENCY | 4, 672, 123 | 1 | | 0 | 0 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 3, 227, 010 | 198, 364 | 3, 028, 646 | 0 | 0 | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | 1 | _ | | | _ | |
| 94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES | 9, 182, 558 | | | 0 | 0 | 94. 00 95. 00 |
| 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED | 9, 162, 556 | 754, 957 | 0, 427, 601 | 0 | 0 | 96.00 |
| 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD | | ĺ | Ö | ő | 0 | 97.00 |
| 99. 00 09900 CMHC | 0 | Ō | Ō | 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 | | 101. 00 102. 00 |
| 102. 00 10200 OPI 0I D TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS | | | ıj U | U | 0 | 102.00 |
| 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 | | 106. 00 |
| 107.00 10700 LIVER ACQUISITION | 0 | 0 | 0 | 0 | | 107. 00 |
| 108. 00 10800 LUNG ACQUISITION | 0 | 0 | 0 | 0 | | 108.00 |
| 109.00 10900 PANCREAS ACQUISITION | 0 | 0 | 0 | 0 | | 109. 00 110. 00 |
| 110.00 11000 INTESTINAL ACQUISITION 111.00 11100 ISLET ACQUISITION | | | | 0 | | 111.00 |
| 113. 00 11300 NTEREST EXPENSE | | I | | | | 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 | o | | 115.00 |
| 116. 00 11600 HOSPI CE | 0 | 0 | 0 | 0 | | 116.00 |
| 200.00 Subtotal (sum of lines 50 thru 199) | 43, 879, 578 | | | 0 | | 200. 00 201. 00 |
| 201.00 Less Observation Beds 202.00 Total (line 200 minus line 201) | 3, 227, 010 40, 652, 568 | | | 0 | | 201.00 |
| 202. 00 10tal (11116 200 IIII 1103 11116 201) | 1 70,032,300 | 2,072,731 | 31, 137, 037 | Ч | U | 1202.00 |

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

Provi der CCN: 15-0146 | Peri od: | From 01/01/2022

od: Worksheet C 01/01/2022 Part II 12/31/2022 Date/Time Prepared:

5/18/2023 11:21 am Title XIX Hospi tal PPS Total Charges Outpati ent Cost Center Description Cost Net of Capital and (Worksheet C, Cost to Operating Part I Charge Ratio Cost column 8) (col. 6 / Reducti on col. 7) 7.00 8.00 6.00 ANCILLARY SERVICE COST CENTERS 50 00 4, 546, 270 50 00 05000 OPERATING ROOM 27, 185, 280 0.167233 05100 RECOVERY ROOM 0.000000 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 1, 507, 979 3, 185, 835 0.473339 52.00 05300 ANESTHESI OLOGY 0.000000 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 4, 658, 323 39, 143, 357 0.119007 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 56.00 05600 RADI OI SOTOPE 0.000000 56.00 0 0.000000 57 00 05700 CT SCAN 0 57.00 Ω 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 C 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 59.00 60.00 06000 LABORATORY 4, 355, 214 39, 143, 357 0.111263 60.00 06001 BLOOD LABORATORY 0.000000 60.01 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0.000000 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0.000000 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63.00 63.00 0 C 64.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 06500 RESPIRATORY THERAPY 0.149731 65.00 1, 747, 301 11, 669, 628 65.00 06600 PHYSI CAL THERAPY 1, 517, 145 4, 059, 965 0.373684 66.00 66.00 06700 OCCUPATI ONAL THERAPY 1, 442, 924 811, 568 67.00 0.562447 67.00 68.00 06800 SPEECH PATHOLOGY 350,020 871, 346 0.401700 68.00 06900 ELECTROCARDI OLOGY 69.00 0.000000 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 719, 328 71.00 373, 427 0.137323 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 606, 898 2, 532, 679 0.239627 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 5, 300, 739 26, 140, 833 0.202776 73.00 07400 RENAL DIALYSIS 74 00 0.000000 74 00 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 75.00 07698 HYPERBARIC OXYGEN THERAPY 947, 032 4, 483, 523 0. 211225 76.98 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 0.000000 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0.000000 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89.00 90.00 09000 CLI NI C 75, 971 233, 549 0.325289 90.00 09100 EMERGENCY 91.00 91.00 4, 672, 123 49, 957, 471 0.093522 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 3, 227, 010 6, 313, 254 0.511148 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 0.000000 94.00 94.00 09500 AMBULANCE SERVICES 9, 182, 558 0.380496 95 00 24, 133, 100 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0.000000 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0.000000 97.00 0 99. 00 |09900 CMHC 99.00 C 0.000000 99. 10 09910 CORF 0 0 0.000000 99.10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0.000000 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0.000000 101.00 102.00 10200 OPIOID TREATMENT PROGRAM 0 0.000000 102.00 SPECIAL PURPOSE COST CENTERS 0 105. 00 10500 KI DNEY ACQUI SI TI ON 0.000000 105.00 0 106.00 10600 HEART ACQUISITION 0.000000 C 106.00 107.00 10700 LIVER ACQUISITION 0 0.000000 107. 00 0 108.00 10800 LUNG ACQUISITION 0.000000 108.00 109. 00 10900 PANCREAS ACQUISITION 0 0.000000 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 0.000000 110.00 111.00 11100 I SLET ACQUISITION 0 C 0.000000 111.00 113.00 11300 INTEREST EXPENSE 113.00 114. 00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0.000000 0 115.00 116. 00 11600 HOSPI CE 0.000000 116.00 200.00 Subtotal (sum of lines 50 thru 199) 43, 879, 578 243, 215, 429 200.00 201 00 Less Observation Beds 3 227 010 201 00 202.00 Total (line 200 minus line 201) 40, 652, 568 243, 215, 429 202.00

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

| Health Financial Systems COMM | UNITY HOSPITAL | OF NOBLE CIY, | INC | In Lie | u of Form CMS- | 2552-10 |
|--|----------------|-----------------|-------------|-----------------|----------------|---------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL | COSTS | Provi der Co | CN: 15-0146 | Peri od: | Worksheet D | |
| | | | | From 01/01/2022 | Part I | |
| | | | | To 12/31/2022 | | epared: |
| | | | | | 5/18/2023 11: | 21 am |
| | 1 | | XVIII | Hospi tal | PPS | |
| Cost Center Description | Capi tal | Swing Bed | Reduced | Total Patient | Per Diem | |
| | Related Cost | Adjustment | Capi tal | Days | (col. 3 / | |
| | (from Wkst. | | Related Cos | 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 | 547, 765 | 0 | 547, 70 | 55 7, 384 | 74. 18 | 30.00 |
| 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 | 0 | | 0 0 | 0.00 | 1 |
| 41. 00 SUBPROVI DER – I RF | 0 | 0 | | 0 | 0.00 | |
| 43. 00 NURSERY | 19, 944 | Ĭ | 19, 94 | - | 49. 98 | |
| 44.00 SKILLED NURSING FACILITY | 17,711 | | 17,7 | 0 | 0.00 | 1 |
| 45. 00 NURSING FACILITY | 0 | | | 0 | 0.00 | |
| 200.00 Total (lines 30 through 199) | 567, 709 | | 567, 70 | 09 7, 783 | | 200.00 |
| Cost Center Description | Inpati ent | Inpati ent | 307, 70 | 7,703 | | 200.00 |
| cost center bescription | Program days | Program | | | | |
| | Program days | Capital Cost | | | | |
| | | (col. 5 x | | | | |
| | | | | | | |
| | / 00 | col. 6) 7.00 | | | | |
| INDATI ENT DOUTINE CEDVI CE COCT CENTEDO | 6. 00 | 7.00 | | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | 1 001 | 00.000 | | | | 20.00 |
| 30. 00 ADULTS & PEDIATRICS | 1, 091 | 80, 930 | 1 | | | 30.00 |
| 31. 00 INTENSIVE CARE UNIT | 0 | 0 | | | | 31.00 |
| 32.00 CORONARY CARE UNIT | 0 | 0 | 1 | | | 32.00 |
| 33.00 BURN INTENSIVE CARE UNIT | 0 | 0 | 1 | | | 33.00 |
| 34.00 SURGICAL INTENSIVE CARE UNIT | 0 | 0 | | | | 34.00 |
| 40. 00 SUBPROVI DER - I PF | 0 | 0 |) | | | 40.00 |
| 41. 00 SUBPROVI DER - I RF | 0 | 0 | 1 | | | 41.00 |
| 43. 00 NURSERY | 0 | 0 | | | | 43.00 |
| 44.00 SKILLED NURSING FACILITY | 0 | 0 |) | | | 44.00 |
| 45.00 NURSING FACILITY | 0 | 0 |) | | | 45.00 |
| 200.00 Total (lines 30 through 199) | 1, 091 | 80, 930 |) | | | 200.00 |
| | . ' | • | • | | | • |

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-0146 Peri od: Worksheet D From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/18/2023 11:21 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 388.348 27, 185, 280 0.014285 252, 444 3.606 05100 RECOVERY ROOM 0.000000 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 96, 307 3, 185, 835 0.030230 0 0 52.00 05300 ANESTHESI OLOGY 0.000000 53.00 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 590, 655 54.00 39, 143, 357 0.015090 1, 948, 570 29, 404 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 Ω Ω 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 C 0.000000 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0 59.00 06000 LABORATORY 186, 019 39, 143, 357 0.004752 1, 875, 956 8, 915 60.00 60.00 06001 BLOOD LABORATORY 60.01 0.000000 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 C 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 0.012185 17, 319 65.00 142, 189 11, 669, 628 1, 421, 369 65.00 06600 PHYSI CAL THERAPY 100, 428 4, 059, 965 0.024736 1, 340 66.00 54, 168 66.00 06700 OCCUPATI ONAL THERAPY 1, 442, 924 67.00 32, 777 0.022716 25, 620 582 67.00 68.00 06800 SPEECH PATHOLOGY 14, 141 871, 346 0.016229 29, 362 477 68.00 06900 ELECTROCARDI OLOGY 69.00 0.000000 69.00 0 70 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70 00 0 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 719, 328 71.00 18, 103 0.006657 182, 890 1, 217 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 24, 417 2, 532, 679 0.009641 205, 445 1, 981 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 220, 586 26, 140, 833 0.008438 1, 244, 837 10,504 73.00 07400 RENAL DIALYSIS 74 00 0.000000 74 00 0 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 0 0 75.00 07698 HYPERBARIC OXYGEN THERAPY 60, 662 4, 483, 523 0.013530 0 0 76.98 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0.000000 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0.000000 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89.00 89.00 0 90.00 09000 CLI NI C 3, 081 233, 549 0.013192 0 90.00 3, 012, 321 91.00 09100 EMERGENCY 260,061 91.00 49, 957, 471 0.005206 15, 682 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 198, 364 6, 313, 254 0.031420 0 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 94.00 0.000000 0 09500 AMBULANCE SERVICES 95.00 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0.000000 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 0.000000 0 200.00 Total (lines 50 through 199) 2, 336, 138 219, 082, 329 10, 252, 982 91, 027 200. 00

45.00

200.00

45.00 04500 NURSING FACILITY

200.00

Total (lines 30 through 199)

In Lieu of Form CMS-2552-10

| Period: | Worksheet D |
| From 01/01/2022 | Part IV |
| To 12/31/2022 | Date/Time Prepared: | 5/18/2023 | 11: 21 am | Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0146 THROUGH COSTS

| | | | | | | 5/18/2023 11: | 21 am |
|--------|--|---------------|---------------|----------|---------------|---------------|--------|
| | | | Ti tl e | XVIII | Hospi tal | PPS | |
| | Cost Center Description | Non Physician | Nursi ng | Nursi ng | | Allied Health | |
| | | Anesthetist | 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 | 0 | 50.00 |
| 51.00 | 05100 RECOVERY ROOM | 0 | (| | 0 | 0 | 51.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | (|) | 0 | 0 | 52.00 |
| 53.00 | 05300 ANESTHESI OLOGY | 0 | (|) | 0 | 0 | 53.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 0 | (| | 0 | 0 | 54.00 |
| 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 | 0 | 59.00 |
| 60.00 | 06000 LABORATORY | 0 | (| | 0 0 | 0 | 60.00 |
| 60. 01 | 06001 BLOOD LABORATORY | 0 | (| | 0 0 | 0 | 60. 01 |
| 61.00 | 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | | | | | | 61.00 |
| 62.00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0 | | | 0 0 | 0 | 62.00 |
| 63.00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | | | 0 0 | 0 | 63.00 |
| 64.00 | 06400 I NTRAVENOUS THERAPY | 0 | | | 0 0 | 0 | 64.00 |
| 65.00 | 06500 RESPIRATORY THERAPY | 0 | | | 0 0 | 0 | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 0 | | | 0 0 | 0 | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 0 | | | 0 0 | 0 | 67.00 |
| 68.00 | 06800 SPEECH PATHOLOGY | 0 | | | 0 0 | 0 | 68. 00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0 | | | 0 0 | 0 | 69. 00 |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 0 | | | 0 0 | 0 | 70.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | | | 0 0 | 0 | 71.00 |
| 72.00 | 07200 I MPL. DEV. CHARGED TO PATIENTS | 0 | | | 0 0 | 0 | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | | | 0 0 | 0 | 73.00 |
| 74.00 | 07400 RENAL DIALYSIS | 0 | ĺ | | 0 0 | 0 | 74.00 |
| 75. 00 | 07500 ASC (NON-DISTINCT PART) | 0 | Ċ | | 0 0 | 0 | 75.00 |
| 76. 98 | 07698 HYPERBARI C OXYGEN THERAPY | 0 | Ċ | | 0 0 | 0 | 76. 98 |
| | 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | Ċ | | 0 0 | 0 | 77. 00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88. 00 | 08800 RURAL HEALTH CLINIC | 0 | (| | 0 0 | 0 | 88. 00 |
| 89. 00 | 08900 FEDERALLY QUALIFIED HEALTH CENTER | 0 | Ċ | 1 | 0 0 | l e | 89.00 |
| 90.00 | 09000 CLI NI C | 0 | Ċ | | 0 0 | 0 | 90.00 |
| 91. 00 | 09100 EMERGENCY | 0 | Ċ | | 0 0 | 0 | 91.00 |
| 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | | | 0 | 0 | 92.00 |
| 50 | OTHER REIMBURSABLE COST CENTERS | | | | | | 1 |
| 94.00 | 09400 HOME PROGRAM DIALYSIS | 0 | (| | 0 0 | 0 | 94.00 |
| 95. 00 | 09500 AMBULANCE SERVI CES | | | | | | 95.00 |
| 96.00 | 09600 DURABLE MEDI CAL EQUI P-RENTED | 0 | (| | 0 0 | 0 | 96.00 |
| 97. 00 | 09700 DURABLE MEDI CAL EQUI P-SOLD | 0 | | | 0 0 | Ö | 97. 00 |
| 200.00 | | 0 | | | 0 0 | | 200.00 |
| | , | -1 | • | 1 | 1 | | |

In Lieu of Form CMS-2552-10

| Period: | Worksheet D |
| From 01/01/2022 | Part IV |
| To 12/31/2022 | Date/Time Prepared: | 5/18/2023 | 11: 21 am | Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0146 THROUGH COSTS

| | | | | | | 5/18/2023 11: | 21 am |
|--------------|--------------------------------------|------------|---------------|--------------|---------------|---------------|--------|
| • | | | 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 | |
| | LARY SERVICE COST CENTERS | | | | | | |
| | OPERATING ROOM | 0 | 0 | C | 27, 185, 280 | 0.000000 | 50.00 |
| 51.00 05100 | RECOVERY ROOM | 0 | 0 | C | 0 | 0.000000 | 51.00 |
| 52.00 05200 | DELIVERY ROOM & LABOR ROOM | 0 | 0 | C | 3, 185, 835 | 0.000000 | 52.00 |
| | ANESTHESI OLOGY | 0 | 0 | C | 0 | 0.000000 | 53.00 |
| 54.00 05400 | RADI OLOGY-DI AGNOSTI C | 0 | 0 | C | 39, 143, 357 | 0.000000 | 54.00 |
| 55.00 05500 | RADI OLOGY-THERAPEUTI C | 0 | 0 | C | 0 | 0.000000 | 55.00 |
| 56.00 05600 | RADI OI SOTOPE | 0 | 0 | C | 0 | 0.000000 | 56.00 |
| 57.00 05700 | CT SCAN | 0 | 0 | C | 0 | 0.000000 | 57.00 |
| 58.00 05800 | MAGNETIC RESONANCE IMAGING (MRI) | 0 | 0 | C | 0 | 0.000000 | 58.00 |
| 59.00 05900 | CARDI AC CATHETERI ZATI ON | 0 | 0 | C | 0 | 0.000000 | 59.00 |
| 60.00 06000 | LABORATORY | 0 | 0 | C | 39, 143, 357 | 0.000000 | 60.00 |
| 60. 01 06001 | BLOOD LABORATORY | 0 | 0 | C | 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 | o | 0 | l c | 0 | 0.000000 | 62.00 |
| 63.00 06300 | BLOOD STORING, PROCESSING & TRANS. | o | 0 | l c | 0 | 0.000000 | 63.00 |
| 64. 00 06400 | I NTRAVENOUS THERAPY | o | 0 | l c | 0 | 0.000000 | 64.00 |
| 65.00 06500 | RESPI RATORY THERAPY | o | 0 | | 11, 669, 628 | 0.000000 | 65.00 |
| 66.00 06600 | PHYSI CAL THERAPY | o | 0 | | 4, 059, 965 | 0.000000 | 66.00 |
| 67. 00 06700 | OCCUPATI ONAL THERAPY | o | 0 | l c | 1, 442, 924 | 0.000000 | 67.00 |
| 68.00 06800 | SPEECH PATHOLOGY | o | 0 | l c | 871, 346 | 0.000000 | 68.00 |
| 69.00 06900 | ELECTROCARDI OLOGY | o | 0 | l c | 0 | 0.000000 | 69.00 |
| 70.00 07000 | ELECTROENCEPHALOGRAPHY | o | 0 | l c | 0 | 0.000000 | 70.00 |
| 71.00 07100 | MEDICAL SUPPLIES CHARGED TO PATIENTS | O | 0 | l c | 2, 719, 328 | 0.000000 | 71.00 |
| 72.00 07200 | IMPL. DEV. CHARGED TO PATIENTS | o | 0 | l c | 2, 532, 679 | 0.000000 | 72.00 |
| 73.00 07300 | DRUGS CHARGED TO PATIENTS | o | 0 | | 26, 140, 833 | 0.000000 | 73.00 |
| 74.00 07400 | RENAL DIALYSIS | O | 0 | l c | 0 | 0.000000 | 74.00 |
| 75.00 07500 | ASC (NON-DISTINCT PART) | O | 0 | l c | 0 | 0.000000 | 75.00 |
| 76. 98 07698 | HYPERBARI C OXYGEN THERAPY | o | 0 | | 4, 483, 523 | 0.000000 | 76. 98 |
| 77. 00 07700 | ALLOGENEIC STEM CELL ACQUISITION | o | 0 | l c | | 0.000000 | 77. 00 |
| OUTPA | TIENT SERVICE COST CENTERS | | | | | | |
| 88. 00 08800 | RURAL HEALTH CLINIC | 0 | 0 | C | 0 | 0.000000 | 88. 00 |
| 89. 00 08900 | FEDERALLY QUALIFIED HEALTH CENTER | O | 0 | C | 0 | 0.000000 | 89.00 |
| 90.00 09000 | CLINIC | O | 0 | C | 233, 549 | 0.000000 | 90.00 |
| 91.00 09100 | EMERGENCY | O | 0 | C | 49, 957, 471 | 0.000000 | 91.00 |
| 92.00 09200 | OBSERVATION BEDS (NON-DISTINCT PART) | o | 0 | l c | 6, 313, 254 | 0.000000 | 92.00 |
| OTHER | REIMBURSABLE COST CENTERS | | | | | | |
| | HOME PROGRAM DIALYSIS | 0 | 0 | C | 0 | 0.000000 | 94.00 |
| 95.00 09500 | AMBULANCE SERVICES | | | | | | 95.00 |
| 96.00 09600 | DURABLE MEDICAL EQUIP-RENTED | o | 0 | C | 0 | 0.000000 | 96.00 |
| 97.00 09700 | DURABLE MEDICAL EQUIP-SOLD | 0 | 0 | [c | 0 | 0.000000 | 97.00 |
| 200. 00 | Total (lines 50 through 199) | 0 | 0 | C | 219, 082, 329 | | 200.00 |
| * | | · | | | | | |

Heal th Financial Systems

COMMUNITY HOSPITAL OF NOBLE CTY, INC

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-0146

From 01/01/2022
To 12/31/2022

To 12/31/2022

To 12/31/2022

To 12/31/2022

From 01/01/2022
To 12/31/2022

From 01/01/2022
To 12/31/2022

To 12/31/2023 11: 21 am

PS

Cost Center Description

Outpatient
Ratio of Cost
to Charges
(col. 6 ÷
col. 7)

Costs (col. 8
x col. 10)

Ratio of Cost (col. 9
x col. 12)

| 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 | 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 OPERATING ROOM | 0. 000000 | 252, 444 | | 938, 928 | | 50.00 |
| 51.00 05100 RECOVERY ROOM | 0. 000000 | 0 | 0 | 0 | | 51.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0. 000000 | 0 | 1 | 0 | 1 | 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, 948, 570 | 0 | 7, 862, 258 | | 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 | " | 59.00 |
| 60. 00 06000 LABORATORY | 0. 000000 | 1, 875, 956 | 0 | 2, 518, 186 | 0 | 60.00 |
| 60. 01 06001 BL00D 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 RESPI RATORY THERAPY | 0.000000 | 1, 421, 369 | 0 | 3, 005, 629 | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0.000000 | 54, 168 | 0 | 29, 980 | 0 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0.000000 | 25, 620 | 0 | 12, 912 | 0 | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 0.000000 | 29, 362 | 0 | 3, 393 | 0 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0.000000 | 0 | 0 | 0 | 0 | 69.00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 0. 000000 | 0 | 0 | 0 | 0 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 000000 | 182, 890 | 0 | 181, 155 | 0 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 0. 000000 | 205, 445 | 0 | 530, 061 | 0 | 72.00 |
| 73.00 O7300 DRUGS CHARGED TO PATIENTS | 0. 000000 | 1, 244, 837 | 0 | 9, 622, 342 | 0 | 73.00 |
| 74. 00 07400 RENAL DI ALYSI S | 0.000000 | 0 | 0 | 0 | 0 | 74.00 |
| 75.00 07500 ASC (NON-DISTINCT PART) | 0.000000 | 0 | 0 | 0 | 0 | 75.00 |
| 76. 98 07698 HYPERBARIC OXYGEN THERAPY | 0.000000 | 0 | 0 | 0 | 0 | 76. 98 |
| 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION | 0. 000000 | 0 | 0 | 0 | 0 | 77.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88.00 08800 RURAL HEALTH CLINIC | 0.000000 | 0 | 0 | 0 | 0 | 88.00 |
| 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER | 0.000000 | 0 | 0 | 0 | 0 | 89.00 |
| 90. 00 09000 CLI NI C | 0. 000000 | 0 | 0 | 0 | 0 | 90.00 |
| 91. 00 09100 EMERGENCY | 0. 000000 | 3, 012, 321 | 0 | 4, 327, 474 | 0 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 000000 | 0 | 0 | 0 | 0 | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 94.00 09400 HOME PROGRAM DIALYSIS | 0.000000 | 0 | 0 | 0 | 0 | 94.00 |
| 95. 00 09500 AMBULANCE SERVICES | | | | | | 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 Total (lines 50 through 199) | | 10, 252, 982 | 0 | 29, 032, 318 | 0 | 200. 00 |

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0146 Peri od: Worksheet D From 01/01/2022 Part V Date/Time Prepared: 12/31/2022 5/18/2023 11:21 am Title XVIII Hospi tal PPS 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.) 2.00 5.00 1.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0. 167233 938, 928 157, 020 50.00 05100 RECOVERY ROOM 0 0 0.000000 51.00 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.473339 r 0 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 0 0 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.119007 7, 862, 258 0 935, 664 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 0.111263 2, 518, 186 280, 181 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 0 64.00 0.000000 0 0 64.00 0 06500 RESPIRATORY THERAPY 3,005,629 0 65 00 0 149731 450, 036 65 00 0 06600 PHYSI CAL THERAPY 66.00 0.373684 29, 980 11, 203 66.00 06700 OCCUPATI ONAL THERAPY 0.562447 12, 912 0 7, 262 67.00 0 68.00 06800 SPEECH PATHOLOGY 0.401700 3, 393 0 0 1, 363 68.00 06900 FLECTROCARDLOLOGY 0.000000 0 69 00 69 00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 24, 877 71.00 0.137323 181, 155 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 239627 0 127, 017 72.00 530, 061 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0.202776 9, 622, 342 1, 951, 180 73.00 73.00 74.00 07400 RENAL DIALYSIS 0.000000 0 0 74.00 07500 ASC (NON-DISTINCT PART) o 75.00 0.000000 0 0 0 75.00 07698 HYPERBARI C OXYGEN THERAPY 0 76.98 o 0 211225 0 76.98 0 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0.000000 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00 89.00 90.00 09000 CLI NI C 0. 325289 0 0 90.00 09100 EMERGENCY 91.00 91.00 0.093522 4, 327, 474 0 0 404, 714 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 0.511148 0 0 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0 0 94.00 95.00 09500 AMBULANCE SERVICES 0.380496 0 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0.000000 96.00 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 0.000000 0 97.00 200.00 Subtotal (see instructions) 29, 032, 318 0 0 4, 350, 517 200.00 Less PBP Clinic Lab. Services-Program 0 o 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 29, 032, 318 0 0 4, 350, 517 202. 00

202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0146 Peri od: Worksheet D From 01/01/2022 Part V 12/31/2022 Date/Time Prepared: 5/18/2023 11:21 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 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 06400 I NTRAVENOUS THERAPY 64.00 0 64.00 06500 RESPIRATORY THERAPY 0 65 00 65 00 06600 PHYSI CAL THERAPY 66.00 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 69 00 06900 FLECTROCARDLOLOGY 0 69 00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 75.00 07698 HYPERBARIC OXYGEN THERAPY
07700 ALLOGENEIC STEM CELL ACQUISITION 76.98 76. 98 0 77.00 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 90.00 09000 CLI NI C 0 0 90.00 91.00 09100 EMERGENCY 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 94.00 95.00 09500 AMBULANCE SERVICES 0000 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 0 97.00 200.00 Subtotal (see instructions) 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

0

202.00

Net Charges (line 200 - line 201)

| NPATIENT ROUTINE SERVICE CAPITAL COSTS | Health Financial Systems | COMMUNITY HOSPITAL | OF NOBLE CTY, | INC | In Lie | u of Form CMS- | 2552-10 |
|--|--|--------------------|---------------|-----------|-----------|----------------|---------|
| To 12/31/2022 Date/Time Prepared: 5/18/2023 11:21 am Title XIX Hospital PPS 5/18/2023 11:21 am PPS To 12/31/2024 Total Patient PPS | APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAP | TAL COSTS | Provi der C | | | | |
| Capital Related Cost (From Wkst. B, Part II, col. 26) Col. 1 - Col. 2 - Col. 2 - Col. 3 / Col. 4 Col. 3 / Col. 3 / Col. 4 Col. 3 / Col. 4 Col. 2 - Col. 2 | | | | | | Date/Time Pre | |
| Cost Center Description | | | T: +1 | o VIV | Hooni tol | | 21 am_ |
| Related Cost (From Wiss) Related Cost (Col. 1 - Col. 26) Col. 3 / Col. 4) Related Cost (Col. 1 - Col. 26) Col. 26) Col. 26) Col. 26) Col. 26) Col. 26) Col. 27 Col. | Cost Center Description | Cani tal | | | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | oust defiter bescription | | | | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 | | | ., | | | • | |
| I.00 2.00 3.00 4.00 5.00 | | B, Part II, | | (col. 1 - | | , | |
| NPATIENT ROUTINE SERVICE COST CENTERS 547,765 0 547,765 7,384 74.18 30.00 31.00 ADULTS & PEDIATRICS 0 0 0 0 0 0.00 31.00 INPATIENT ROUTINE SERVICE COST CENTERS 547,765 0 547,765 7,384 74.18 30.00 CORONARY CARE UNIT 0 0 0 0 0 0.00 32.00 CORONARY CARE UNIT 0 0 0 0 0 0 0.00 33.00 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0.00 34.00 SUBPROVIDER - IPF 0 0 0 0 0 0 0.00 41.00 SUBPROVIDER - IPF 0 0 0 0 0 0 0.00 43.00 NURSERY 19,944 19,944 399 49,98 43.00 44.00 SKILLED NURSING FACILITY 0 0 0 0 0 0 0 0 0.00 45.00 NURSING FACILITY 0 0 0 0 0 0 0 0.00 45.00 OURSING FACILITY 0 0 0 0 0 0 0 0.00 45.00 OURSING FACILITY 0 0 0 0 0 0 0 0.00 45.00 OURSING FACILITY 0 0 0 0 0 0 0 0.00 45.00 OURSING FACILITY 0 0 0 0 0 0 0 0.00 45.00 OURSING FACILITY 0 0 0 0 0 0 0 0.00 45.00 OURSING FACILITY 0 0 0 0 0 0 0 0.00 45.00 OURSING FACILITY 0 0 0 0 0 0 0 0.00 45.00 OURSING FACILITY 0 0 0 0 0 0 0 0 0.00 45.00 OURSING FACILITY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | | | | | |
| 30. 00 ADULTS & PEDIATRICS 547,765 0 547,765 7,384 74.18 30.00 31. 00 INTENSI VE CARE UNIT 0 0 0 0 0 0 32. 00 CORONARY CARE UNIT 0 0 0 0 0 0 33. 00 BURN INTENSI VE CARE UNIT 0 0 0 0 0 0 0 40. 00 SUBROVIDER - IPF 0 0 0 0 0 0 0 41. 00 SUBPROVIDER - IRF 0 0 0 0 0 0 0 43. 00 NURSERY 19,944 19,944 3999 49.98 43.00 44. 00 SKILLED NURSING FACILITY 0 0 0 0 0 0 0 44. 00 TOST CENTER OF TABLE OF T | | 1. 00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| 31.00 INTENSI VE CARE UNIT 0 0 0 0 0 0 0 0 0 | | | | | | | |
| 32.00 CORONARY CARE UNIT 0 0 0 0 0 0 0 0 0 | | 547, 765 | 0 | 547, 76 | | | |
| 33.00 BURN INTENSIVE CARE UNIT 0 0 0 0 0.00 33.00 | | 0 | | | 0 0 | | |
| 34. 00 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 | | 0 | | | 0 | | |
| A0. 00 SUBPROVIDER - IPF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | 0 | | | 0 | | |
| 41.00 SUBPROVIDER - IRF 0 0 0 0 0 0 0 41.00 43.00 NURSERY 19,944 399 49,98 43.00 44.00 SKILLED NURSING FACILITY 0 0 0 0 0 45.00 NURSING FACILITY 0 0 0 0 0 200.00 Total (lines 30 through 199) 567,709 567,709 7,783 200.00 Cost Center Description Inpatient Program days Program Capital Cost (col. 5 x col. 6) | | 0 | | J | | | |
| 19,944 19,944 399 49.98 43.00 | | | | | | | |
| 44.00 SKILLED NURSING FACILITY 0 0 0 0 0 0 0 0 0 | | 10 044 | ٥ | 10.04 | ۷۱ ۷۱ | | |
| NURSING FACILITY | | 17, 744 | | 17, 74 | 0 0 | | |
| Total (lines 30 through 199) 567, 709 567, 709 7, 783 200.00 | | 0 | | | 0 | | |
| Inpatient | | 567, 709 | | 567.70 | 7. 783 | | |
| Capital Cost (col. 5 x col. 6) | | I npati ent | Inpatient | | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | Program days | Program | | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS 64 4,748 30.00 31.00 INTENSI VE CARE UNIT 0 0 0 31.00 32.00 CORONARY CARE UNIT 0 0 0 32.00 33.00 BURN INTENSI VE CARE UNIT 0 0 0 33.00 34.00 SURGICAL INTENSI VE CARE UNIT 0 0 0 34.00 40.00 SUBPROVI DER - I PF 0 0 0 41.00 50 50 50 50 50 50 50 | | | | | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS 64 4,748 30.00 31.00 INTENSIVE CARE UNIT 0 0 0 31.00 32.00 CORONARY CARE UNIT 0 0 0 32.00 33.00 BURN INTENSIVE CARE UNIT 0 0 0 33.00 34.00 SURGICAL INTENSIVE CARE UNIT 0 0 0 34.00 40.00 SUBPROVIDER - IPF 0 0 0 40.00 41.00 SUBPROVIDER - IRF 0 0 0 41.00 43.00 NURSERY 32 1,599 43.00 44.00 SKILLED NURSING FACILITY 0 0 0 44.00 45.00 NURSING FACILITY 0 0 0 0 0 0 0 0 0 | | | | | | | |
| 30. 00 ADULTS & PEDIATRICS 64 4, 748 30. 00 31. 00 INTENSIVE CARE UNIT 0 0 0 32. 00 CORONARY CARE UNIT 0 0 0 33. 00 BURN INTENSIVE CARE UNIT 0 0 0 34. 00 SURGICAL INTENSIVE CARE UNIT 0 0 0 40. 00 SUBPROVIDER - IPF 0 0 0 41. 00 SUBPROVIDER - IRF 0 0 0 43. 00 NURSERY 32 1, 599 43. 00 44. 00 SKILLED NURSING FACILITY 0 0 0 45. 00 NURSING FACILITY 0 0 0 45. 00 NURSING FACILITY 0 0 0 | LANDATI ENT. DOUTLAND OFFICE COOT, OFFITEDO | 6. 00 | 7. 00 | | | | |
| 31. 00 INTENSIVE CARE UNIT | | (4 | 4 740 | , | | | 20.00 |
| 32. 00 CORONARY CARE UNIT 0 0 0 33. 00 33. 00 BURN INTENSIVE CARE UNIT 0 0 0 34. 00 SUBGICAL INTENSIVE CARE UNIT 0 0 0 40. 00 SUBPROVIDER - IPF 0 0 0 41. 00 SUBPROVIDER - IRF 0 0 0 43. 00 NURSERY 32 1,599 44. 00 SKILLED NURSING FACILITY 0 0 0 45. 00 NURSING FACILITY 0 0 0 45. 00 NURSING FACILITY 0 0 0 | | 04 | 4, 748 | | | | |
| 33.00 BURN INTENSIVE CARE UNIT 0 0 34.00 34.00 40.00 SUBPROVIDER - IPF 0 0 0 40.00 41.00 SUBPROVIDER - IRF 0 0 0 41.00 43.00 NURSERY 32 1,599 43.00 SKILLED NURSING FACILITY 0 0 0 45.00 NURSING FACILITY 0 0 0 45.00 | | 0 | | | | | |
| 34. 00 SURGI CAL INTENSIVE CARE UNIT 0 0 40. 00 SUBPROVI DER - I PF 0 0 41. 00 SUBPROVI DER - I RF 0 0 43. 00 NURSERY 32 1, 599 44. 00 SKI LLED NURSI NG FACI LI TY 0 0 45. 00 NURSI NG FACI LI TY 0 0 45. 00 45. 00 | | | | | | | |
| 40. 00 SUBPROVI DER - I PF 0 0 40. 00 41. 00 SUBPROVI DER - I RF 0 0 41. 00 43. 00 NURSERY 32 1, 599 43. 00 44. 00 SKI LLED NURSI NG FACI LI TY 0 0 44. 00 45. 00 NURSI NG FACI LI TY 0 0 45. 00 | | | | | | | |
| 41. 00 SUBPROVI DER - I RF 0 0 41. 00 43. 00 NURSERY 32 1, 599 43. 00 44. 00 SKI LLED NURSI NG FACILITY 0 0 44. 00 45. 00 NURSI NG FACILITY 0 0 45. 00 | | 0 | | | | | |
| 43.00 NURSERY 32 1,599 43.00 44.00 SKILLED NURSING FACILITY 0 0 44.00 45.00 NURSING FACILITY 0 0 45.00 | | o | Ö | | | | |
| 45. 00 NURSING FACILITY 0 0 45. 00 | | 32 | 1, 599 |) | | | 43.00 |
| | 44.00 SKILLED NURSING FACILITY | o | 1 | 1 | | | 44.00 |
| 200.00 Total (lines 30 through 199) 96 6,347 200.00 | 45.00 NURSING FACILITY | 0 | 0 | | | | 45.00 |
| | 200.00 Total (lines 30 through 199) | 96 | 6, 347 | 1 | | | 200.00 |

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-0146 Peri od: Worksheet D From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/18/2023 11:21 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 388.348 27, 185, 280 0.014285 48.049 686 05100 RECOVERY ROOM 0.000000 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.030230 52.00 96, 307 3, 185, 835 0 0 52.00 05300 ANESTHESI OLOGY 0.000000 53.00 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 590, 655 54.00 39, 143, 357 0.015090 231, 520 3, 494 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 57 00 05700 CT SCAN 0 0.000000 0 57.00 Ω Ω 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 C 0.000000 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0 59.00 06000 LABORATORY 186, 019 39, 143, 357 0.004752 128, 961 60.00 613 60.00 06001 BLOOD LABORATORY 60.01 0.000000 0 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 0 0.000000 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63.00 0 C 0 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 64.00 06500 RESPIRATORY THERAPY 0.012185 1, 774 65.00 142, 189 11, 669, 628 145, 625 65.00 06600 PHYSI CAL THERAPY 100, 428 4, 059, 965 0.024736 1, 538 66.00 38 66.00 06700 OCCUPATI ONAL THERAPY 1, 442, 924 67.00 32, 777 0.022716 495 11 67.00 68.00 06800 SPEECH PATHOLOGY 14, 141 871, 346 0.016229 2,501 41 68.00 06900 ELECTROCARDI OLOGY 69.00 0.000000 0 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 Ω 70 00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 719, 328 98 71.00 18, 103 0.006657 14, 729 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 24, 417 2, 532, 679 0.009641 2, 381 23 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 220, 586 26, 140, 833 0.008438 91,507 772 73.00 07400 RENAL DIALYSIS 74 00 0.000000 74 00 0 0 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 0 0 75.00 07698 HYPERBARIC OXYGEN THERAPY 60, 662 4, 483, 523 0.013530 0 0 76.98 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0.000000 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0.000000 0 0 88.00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89.00 0 0 90.00 09000 CLI NI C 3, 081 233, 549 0.013192 0 90.00 0 09100 EMERGENCY 260,061 91.00 91.00 49, 957, 471 0.005206 136, 480 711 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 198, 364 6, 313, 254 0.031420 92.00 0 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 94.00 0.000000 0 09500 AMBULANCE SERVICES 95.00 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0.000000 0 0 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 0.000000 0 0 200.00 Total (lines 50 through 199) 2, 336, 138 219, 082, 329 803.786 8, 261 200. 00

| Health Financial Systems COMM | UNITY HOSPITAL | OF NOBLE CIY, | INC | In Lie | u of Form CMS-1 | 2552-10 |
|--|-----------------|----------------|------------------|---|----------------------|---------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P | ASS THROUGH COS | STS Provider C | F | reriod: rom 01/01/2022 o 12/31/2022 | Date/Time Pre | epared: |
| - | | T: +1 | e XIX | Hospi tal | 5/18/2023 11: PPS | 21 am |
| Cost Center Description | Nursi ng | Nursing | | Allied Health | All Other | |
| cost center bescription | Program | Program | Post-Stepdown | Cost | Medi cal | |
| | Post-Stepdown | | Adjustments | 0031 | Education | |
| | Adjustments | | Auj us tillerits | | Cost | |
| | 1A | 1.00 | 2A | 2.00 | 3. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | IA | 1.00 | ZA | 2.00 | 3.00 | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 0 | 0 | | 0 | 0 | 30.00 |
| 31. 00 03100 NTENSI VE CARE UNI T | | | | | 0 | 1 |
| 32. 00 03200 CORONARY CARE UNIT | | | | | 0 | |
| 33. 00 03300 BURN INTENSIVE CARE UNIT | | | • | | | |
| | | | | | | |
| 34. 00 03400 SURGI CAL INTENSI VE CARE UNIT | 0 | _ | | | 0 | |
| 40. 00 04000 SUBPROVI DER - I PF | 0 | 0 | 1 | | 0 | |
| 41. 00 04100 SUBPROVI DER - RF | 0 | 0 | 1 | | 0 | |
| 43. 00 04300 NURSERY | 0 | 0 | | | 0 | 1 |
| 44.00 04400 SKILLED NURSING FACILITY | 0 | 0 |) C | 0 | | 44.00 |
| 45.00 04500 NURSING FACILITY | 0 | 0 |) C | 0 | | 45. 00 |
| 200.00 Total (lines 30 through 199) | 0 | 0 |) C | 0 | 0 | 200.00 |
| Cost Center Description | Swi ng-Bed | Total Costs | Total Patient | Per Diem | I npati ent | |
| | Adjustment | (sum of cols. | Days | (col. 5 ÷ | Program Days | |
| | Amount (see | 1 through 3, | | col. 6) | | |
| | instructions) | minus col. 4) | | | | |
| | 4. 00 | 5.00 | 6. 00 | 7. 00 | 8. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | <u> </u> | <u> </u> | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 0 | 0 | 7, 384 | 0.00 | 64 | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | | 0 | | | 0 | 1 |
| 32. 00 03200 CORONARY CARE UNIT | | 0 | | | 0 | 1 |
| 33. 00 03300 BURN INTENSIVE CARE UNIT | | 0 | | | o o | |
| 34. 00 03400 SURGI CAL INTENSI VE CARE UNI T | | Ö | | | Ö | 1 |
| 40. 00 04000 SUBPROVI DER - PF | 0 | 0 | | | 0 | 1 |
| 41. 00 04100 SUBPROVI DER - RF | | 0 | 1 | | 0 | 1 |
| 43. 00 04300 NURSERY | | | | | 32 | |
| | | | | | • | |
| 44.00 04400 SKILLED NURSING FACILITY | | 0 | | | 0 | |
| 45. 00 04500 NURSING FACILITY | | 0 | l | | • | |
| 200.00 Total (lines 30 through 199) | | 0 | 7, 783 | | 96 | 200.00 |
| Cost Center Description | I npati ent | | | | | |
| | Program | | | | | |
| | Pass-Through | | | | | |
| | Cost (col. 7 | | | | | |
| | x col. 8) | | | | | |
| | 9. 00 | | - | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | _ | | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 0 | l . | | | | 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 SURGICAL INTENSIVE CARE UNIT | 0 | | | | | 34.00 |
| 40. 00 04000 SUBPROVI DER - 1 PF | 0 | | | | | 40.00 |
| 41. 00 04100 SUBPROVI DER - RF | 0 | | | | | 41.00 |
| 43. 00 04300 NURSERY | 0 | l . | | | | 43.00 |
| 44.00 04400 SKILLED NURSING FACILITY | | | | | | 44.00 |
| 45. 00 04500 NURSI NG FACILITY | | | | | | 45.00 |
| 200.00 Total (lines 30 through 199) | | | | | | 200.00 |
| | | | | | | |

 Heal th 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 01/01/2022 | Part IV | To | 12/31/2022 | Date/Time | Prepared: THROUGH COSTS

| | | | | | 10 12/31/2022 | 5/18/2023 11: | |
|--------|--|---------------|---------------|----------|---------------|---------------|--------|
| | | | Ti tl | e XIX | Hospi tal | PPS | |
| | Cost Center Description | Non Physician | Nursi ng | Nursi ng | Allied Health | Allied Health | |
| | | Anesthetist | Program | Program | Post-Stepdown | | |
| | | Cost | Post-Stepdown | | Adjustments | | |
| | | | Adjustments | | | | |
| | | 1. 00 | 2A | 2. 00 | 3A | 3. 00 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 | 05000 OPERATING ROOM | 0 | (| | 0 | | 50.00 |
| 51. 00 | 05100 RECOVERY ROOM | 0 | (| | 0 | | 51.00 |
| 52. 00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | |) | 0 | 1 | 52.00 |
| 53. 00 | 05300 ANESTHESI OLOGY | 0 | |) | 0 | ή | 53.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 0 | |) | 0 | ή " | 54.00 |
| 55. 00 | 05500 RADI OLOGY-THERAPEUTI C | 0 | |) | 0 | ή " | 55.00 |
| 56. 00 | 05600 RADI OI SOTOPE | 0 | |) | 0 | 1 | 56.00 |
| 57. 00 | 05700 CT SCAN | 0 | |) | 0 | 1 | 57.00 |
| 58. 00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0 | |) | 0 | | 58. 00 |
| 59. 00 | 05900 CARDI AC CATHETERI ZATI ON | 0 | (|) | 0 | ή | 59.00 |
| 60.00 | 06000 LABORATORY | 0 | (|) | 0 | | 60.00 |
| 60. 01 | 06001 BLOOD LABORATORY | 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 | 1 | 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 RESPI RATORY THERAPY | 0 | (|) | 0 | ή | 65. 00 |
| 66. 00 | 06600 PHYSI CAL THERAPY | 0 | (|) | 0 | 0 | 66. 00 |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY | 0 | (|) | 0 | ή | 67.00 |
| 68. 00 | 06800 SPEECH PATHOLOGY | 0 | (|) | 0 | ή | 68. 00 |
| 69. 00 | 06900 ELECTROCARDI OLOGY | 0 | (|) | 0 | 0 | 69. 00 |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 0 | (|) | 0 | 0 | 70.00 |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | (|) | 0 | ή | 71. 00 |
| 72. 00 | 07200 I MPL. DEV. CHARGED TO PATIENTS | 0 | (|) | 0 | 0 | 72. 00 |
| 73. 00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | (|) | 0 | 0 | 73. 00 |
| 74. 00 | 07400 RENAL DI ALYSI S | 0 | (| | 0 | 0 | 74. 00 |
| 75. 00 | 07500 ASC (NON-DISTINCT PART) | 0 | (| | 0 | 0 | 75. 00 |
| 76. 98 | 07698 HYPERBARI C OXYGEN THERAPY | 0 | (| Ί | 0 | | 76. 98 |
| 77. 00 | 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | (|) | 0 (| 0 | 77. 00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88. 00 | 08800 RURAL HEALTH CLINIC | 0 | ` | 1 | 0 | | 88. 00 |
| 89. 00 | 08900 FEDERALLY QUALIFIED HEALTH CENTER | 0 | |) | 0 | 1 | 89. 00 |
| 90. 00 | 09000 CLI NI C | 0 | | | 0 | 1 | 90.00 |
| 91. 00 | 09100 EMERGENCY | 0 | (|) | 0 | 1 | 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 | C | 7 | 0 | 0 | 94.00 |
| 95.00 | 09500 AMBULANCE SERVICES | _ | _ | | | _ | 95.00 |
| 96.00 | 09600 DURABLE MEDI CAL EQUI P-RENTED | 0 |) | 2 | 0 | | 96.00 |
| 97.00 | 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | (| <u>'</u> | U (| 0 | 97.00 |
| 200.00 | Total (lines 50 through 199) | 0 | (| ין | 0 0 |)J O | 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

| | | | | 1 | 0 12/31/2022 | 5/18/2023 11: | parea: 21 am |
|--------|--|------------|---------------|--------------|---------------|---------------|-----------------|
| | | | Ti tl | e XIX | Hospi tal | PPS | 21 (1111 |
| | Cost Center Description | All Other | Total Cost | Total | | Ratio of Cost | |
| | | Medi cal | (sum of cols. | Outpati ent | (from Wkst. | to Charges | |
| | | Educati on | 1, 2, 3, and | Cost (sum of | C, Part I, | (col. 5 ÷ | |
| | | Cost | 4) | col s. 2, 3, | col. 8) | col . 7) | |
| | | | , | and 4) | , | (see | |
| | | | | , | | instructions) | |
| | | 4. 00 | 5. 00 | 6. 00 | 7. 00 | 8. 00 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 | 05000 OPERATING ROOM | 0 | 0 | 0 | 27, 185, 280 | 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, 185, 835 | 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 | 39, 143, 357 | 0.000000 | 54.00 |
| 55.00 | 05500 RADI OLOGY-THERAPEUTI C | 0 | 0 | 0 | 0 | 0.000000 | 55.00 |
| 56.00 | 05600 RADI OI SOTOPE | 0 | 0 | 0 | 0 | 0.000000 | 56.00 |
| 57.00 | 05700 CT SCAN | 0 | 0 | 0 | 0 | 0.000000 | 57.00 |
| 58.00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0 | 0 | 0 | 0 | 0.000000 | 58.00 |
| 59.00 | 05900 CARDI AC CATHETERI ZATI ON | 0 | 0 | 0 | 0 | 0.000000 | 59.00 |
| 60.00 | 06000 LABORATORY | 0 | 0 | 0 | 39, 143, 357 | 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 | 11, 669, 628 | 0.000000 | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 0 | 0 | 0 | 4, 059, 965 | 0.000000 | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 0 | 0 | 0 | 1, 442, 924 | 0.000000 | 67.00 |
| 68.00 | 06800 SPEECH PATHOLOGY | 0 | 0 | 0 | 871, 346 | 0.000000 | 68.00 |
| 69. 00 | 06900 ELECTROCARDI OLOGY | 0 | 0 | 0 | 0 | 0.000000 | 69.00 |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | 0 | 0 | 0.000000 | 70.00 |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | 0 | 2, 719, 328 | 0. 000000 | 71.00 |
| 72.00 | 07200 I MPL. DEV. CHARGED TO PATIENTS | 0 | 0 | 0 | 2, 532, 679 | 0. 000000 | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | 0 | 26, 140, 833 | 0.000000 | 73.00 |
| 74.00 | 07400 RENAL DIALYSIS | 0 | 0 | 0 | 0 | 0. 000000 | 74.00 |
| 75.00 | 07500 ASC (NON-DISTINCT PART) | 0 | 0 | 0 | 0 | 0. 000000 | 75.00 |
| 76. 98 | 07698 HYPERBARI C OXYGEN THERAPY | 0 | 0 | | 4, 483, 523 | 0. 000000 | 76. 98 |
| 77. 00 | 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | 0 | 0 | 0 | 0.000000 | 77. 00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88. 00 | 08800 RURAL HEALTH CLINIC | 0 | 0 | | 0 | 0. 000000 | 88. 00 |
| 89. 00 | 08900 FEDERALLY QUALIFIED HEALTH CENTER | 0 | 0 | | 0 | 0. 000000 | 89. 00 |
| 90.00 | 09000 CLI NI C | 0 | 0 | · - | 233, 549 | 0. 000000 | 90.00 |
| 91. 00 | 09100 EMERGENCY | 0 | 0 | | 49, 957, 471 | 0. 000000 | 91.00 |
| 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 0 | 0 | 6, 313, 254 | 0. 000000 | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | -1 | _ | _ | - | 0.000 | |
| 94.00 | 09400 HOME PROGRAM DIALYSIS | 0 | 0 | 0 | 0 | 0. 000000 | 94.00 |
| 95.00 | 09500 AMBULANCE SERVICES | _ | _ | _ | _ | | 95.00 |
| 96.00 | 09600 DURABLE MEDI CAL EQUI P-RENTED | 0 | 0 | · · | 0 | 0. 000000 | 96.00 |
| 97.00 | 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | 0 | · - | 0 | 0. 000000 | 97.00 |
| 200.00 | Total (lines 50 through 199) | l Ol | 0 | 0 | 219, 082, 329 | | 200. 00 |
| | | | | | | | |

Heal th Financial Systems

COMMUNITY HOSPITAL OF NOBLE CTY, INC

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-0146

Period:
From 01/01/2022
To 12/31/2022

Part IV
Date/Time Prepared:
5/18/2023 11: 21 am

Program
Program
Program
Program
Program
Program
Program
Pass-Through
Pass-Through
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Pass-Through

| | | | | | | 5/18/2023 11: | zı allı |
|--------|--|---------------|-------------|---------------|-------------|---------------|---------|
| | | | Ti tl | e XIX | Hospi tal | PPS | |
| | Cost Center Description | Outpati ent | I npati ent | Inpati ent | Outpati ent | Outpati ent | |
| | ' | Ratio of Cost | Program | Program | Program | Program | |
| | | to Charges | Charges | Pass-Through | Charges | Pass-Through | |
| | | (col. 6 ÷ | onal goo | Costs (col. 8 | onal goo | 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 | 7.00 | 10.00 | 11.00 | 12.00 | 13.00 | |
| 50. 00 | 05000 OPERATING ROOM | 0. 000000 | 48, 049 | · C | 0 | 0 | 50.00 |
| 51. 00 | 1 1 | 1 | 40, 049 | 1 | | 0 | |
| | · · | 0.000000 | - | 1 | | _ | 51.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0. 000000 | 0 | 1 | _ | 0 | 52.00 |
| 53. 00 | 05300 ANESTHESI OLOGY | 0. 000000 | 0 | 1 | · · | 0 | 53.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 0. 000000 | 231, 520 | l . | - | 0 | 54.00 |
| 55. 00 | 05500 RADI OLOGY-THERAPEUTI C | 0. 000000 | 0 | 1 | - | 0 | 55. 00 |
| 56. 00 | 05600 RADI OI SOTOPE | 0. 000000 | 0 | C | 0 | 0 | 56. 00 |
| 57.00 | 05700 CT SCAN | 0. 000000 | 0 | C | 0 | 0 | 57.00 |
| 58.00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0. 000000 | 0 | C | 0 | 0 | 58.00 |
| 59.00 | 05900 CARDI AC CATHETERI ZATI ON | 0. 000000 | 0 | C | 0 | 0 | 59. 00 |
| 60.00 | 06000 LABORATORY | 0. 000000 | 128, 961 | | 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 | 63.00 |
| 64. 00 | | 0. 000000 | 0 | 1 | - | 0 | 64.00 |
| 65. 00 | 06500 RESPIRATORY THERAPY | 0. 000000 | 145, 625 | 1 | - | 0 | 65. 00 |
| | | | | | - | 0 | |
| 66.00 | 1 1 | 0.000000 | 1, 538 | 1 | - | | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 0. 000000 | 495 | 1 | - | 0 | 67.00 |
| 68. 00 | 06800 SPEECH PATHOLOGY | 0. 000000 | 2, 501 | 1 | - | 0 | 68.00 |
| 69. 00 | 06900 ELECTROCARDI OLOGY | 0. 000000 | 0 | 1 | | 0 | 69. 00 |
| 70. 00 | 07000 ELECTROENCEPHALOGRAPHY | 0. 000000 | 0 | 1 | - | 0 | 70.00 |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 000000 | 14, 729 | | 0 | 0 | 71. 00 |
| 72.00 | 07200 I MPL. DEV. CHARGED TO PATIENTS | 0. 000000 | 2, 381 | [C | 0 | 0 | 72.00 |
| 73.00 | | 0. 000000 | 91, 507 | [C | 0 | 0 | 73.00 |
| 74.00 | 07400 RENAL DI ALYSI S | 0. 000000 | 0 | C | 0 | 0 | 74.00 |
| 75.00 | 07500 ASC (NON-DISTINCT PART) | 0. 000000 | 0 | C | 0 | 0 | 75. 00 |
| 76. 98 | 07698 HYPERBARIC OXYGEN THERAPY | 0. 000000 | 0 | l c | 0 | 0 | 76. 98 |
| 77.00 | 07700 ALLOGENEIC STEM CELL ACQUISITION | 0. 000000 | 0 | l c | 0 | 0 | 77. 00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | - | |
| 88. 00 | 08800 RURAL HEALTH CLINIC | 0. 000000 | 0 | C | 0 | 0 | 88. 00 |
| 89. 00 | 08900 FEDERALLY QUALIFIED HEALTH CENTER | 0. 000000 | 0 | | | 0 | 89. 00 |
| 90.00 | 09000 CLINIC | 0. 000000 | 0 | 1 | - | Ö | 90.00 |
| 91. 00 | 09100 EMERGENCY | 0. 000000 | 136, 480 | 1 | | 0 | 91.00 |
| 91.00 | 1 | | 130, 460 | - | | 0 | |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 000000 | 0 | 1 | 1 0 | 0 | 92.00 |
| 04.00 | OTHER REIMBURSABLE COST CENTERS | 0.000000 | | | 1 0 | 0 | 04.00 |
| 94.00 | 09400 HOME PROGRAM DI ALYSIS | 0. 000000 | 0 | C | 0 | 0 | 94.00 |
| 95. 00 | 09500 AMBULANCE SERVI CES | | _ | | | | 95.00 |
| 96. 00 | 09600 DURABLE MEDI CAL EQUI P-RENTED | 0. 000000 | 0 | 1 | | 0 | 96. 00 |
| 97. 00 | 09700 DURABLE MEDICAL EQUIP-SOLD | 0. 000000 | 0 | C | | 0 | 97.00 |
| 200.00 | O Total (lines 50 through 199) | | 803, 786 | C | 0 | 0 | 200.00 |
| | | | | | | | |

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0146 Peri od: Worksheet D From 01/01/2022 Part V Date/Time Prepared: 12/31/2022 5/18/2023 11:21 am Title XIX Hospi tal PPS Charges Costs PPS Services Cost Center Description Cost to PPS Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) Services (see From Servi ces Services Not Worksheet C, 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. 167233 85, 183 50.00 05100 RECOVERY ROOM 0 0.000000 51.00 0 51.00 0 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0.473339 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.119007 0 704, 291 0 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 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 0 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 0.111263 0 489, 962 0 60.00 06001 BLOOD LABORATORY 0 60.01 0.000000 0 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0 61 00 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 06400 I NTRAVENOUS THERAPY 64.00 0.000000 0 64.00 0 06500 RESPIRATORY THERAPY 0 65 00 0 149731 0 428, 022 65 00 0 06600 PHYSI CAL THERAPY 0 66.00 0.373684 0 86, 823 0 66.00 06700 OCCUPATI ONAL THERAPY 0.562447 21, 772 0 67.00 0 52, 177 68.00 06800 SPEECH PATHOLOGY 0.401700 0 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 27, 365 0 71.00 0.137323 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 239627 0 89, 352 72.00 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 136, 369 0.202776 0 0 73.00 74.00 07400 RENAL DIALYSIS 0.000000 0 0 0 74.00 0 07500 ASC (NON-DISTINCT PART) 0 75.00 0.000000 0 0 0 75.00 07698 HYPERBARIC OXYGEN THERAPY 07700 ALLOGENEIC STEM CELL ACQUISITION 0 76.98 Ω 0 0 76.98 0 211225 77.00 0.000000 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00 89.00 90.00 09000 CLI NI C 0. 325289 0 0 90.00 91.00 09100 EMERGENCY 0.093522 0 762, 869 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 0. 511148 0 0 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0 94.00 95.00 09500 AMBULANCE SERVICES 0.380496 0 0 95.00 0 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0.000000 96.00 0 0 0

0.000000

0

0

2.884.185

2, 884, 185

0

0

0

0 97.00

200.00

201.00

0 202.00

09700 DURABLE MEDICAL EQUIP-SOLD

Only Charges

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

97.00

200.00

201.00

202.00

200.00

201.00

202.00

In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0146 Peri od: Worksheet D From 01/01/2022 Part V 12/31/2022 Date/Time Prepared: 5/18/2023 11:21 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 14, 245 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 0000000000000000000000000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 83, 816 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 54, 515 60.00 06001 BLOOD LABORATORY 60.01 C 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61 00 61 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 06400 INTRAVENOUS THERAPY 64.00 64.00 06500 RESPIRATORY THERAPY 65 00 64 088 65 00 06600 PHYSI CAL THERAPY 66.00 32, 444 66.00 06700 OCCUPATI ONAL THERAPY 12, 246 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 20, 960 68.00 69 00 06900 FLECTROCARDLOLOGY 69 00 0 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3, 758 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 21, 411 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 27, 652 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 75.00 07698 HYPERBARIC OXYGEN THERAPY
07700 ALLOGENEIC STEM CELL ACQUISITION 76.98 76. 98 0 77.00 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 90.00 09000 CLI NI C 90.00 91.00 09100 EMERGENCY 0 71, 345 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 94.00 95.00 09500 AMBULANCE SERVICES 0 0 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 97.00

0

406, 480

406, 480

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 | | Provi der CCN: 15-0146 | Peri od: From 01/01/2022 | Worksheet D-1 |
| | | | | Date/Time Prepared: 5/18/2023 11:21 am |
| | | Title XVIII | Hospi tal | PPS |

| | | | | 5/18/2023 11: | 21 am | |
|------------------|--|---------------------------|-------------------|---------------|--------|--|
| | | Title XVIII | Hospi tal | PPS | | |
| | Cost Center Description | | | 1. 00 | | |
| | PART I - ALL PROVIDER COMPONENTS | | <u> </u> | 1.00 | | |
| | I NPATI ENT DAYS | | | | 1 | |
| 1.00 | Inpatient days (including private room days and swing-bed days | rs, excluding newborn) | | 7, 384 | 1.00 | |
| 2.00 | Inpatient days (including private room days, excluding swing- | | | 7, 384 | 2.00 | |
| 3.00 | Private room days (excluding swing-bed and observation bed day | ys). If you have only pr | ivate room days, | 0 | 3.00 | |
| | do not complete this line. | | | | | |
| 4.00 | Semi-private room days (excluding swing-bed and observation b | | 04 . 6 . 11 | 4, 710 | 1 | |
| 5. 00 | Total swing-bed SNF type inpatient days (including private roll reporting 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 | nom days) after December | 31 of the cost | 0 | 6.00 | |
| 0.00 | reporting period (if calendar year, enter 0 on this line) | on days) at tel becember | 31 of the cost | O | 0.00 | |
| 7.00 | Total swing-bed NF type inpatient days (including private room | m days) through December | 31 of the cost | 0 | 7.00 | |
| | reporting period | 3 , 3 | | | | |
| 8.00 | Total swing-bed NF type inpatient days (including private room | m days) after December 3 | 31 of the cost | 0 | 8.00 | |
| | reporting period (if calendar year, enter 0 on this line) | | | | | |
| 9. 00 | Total inpatient days including private room days applicable to | o the Program (excluding | g swing-bed and | 1, 091 | 9. 00 | |
| 10. 00 | newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o | unly (including privato r | coom days) | 0 | 10.00 | |
| 10.00 | through December 31 of the cost reporting period (see instruc | | oon days) | U | 10.00 | |
| 11. 00 | | | room davs) 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 | e room days) | 0 | 12.00 | |
| | through December 31 of the cost reporting period | | | | | |
| 13. 00 | | | | 0 | 13.00 | |
| 14 00 | after December 31 of the cost reporting period (if calendar y | | | 0 | 14 00 | |
| 14. 00 15. 00 | | 0 | | | | |
| 16. 00 | 3 3 1 | 0 | 1 | | | |
| 10.00 | SWING BED ADJUSTMENT | | | J | 10.00 | |
| 17. 00 | | es through December 31 d | of the cost | 0. 00 | 17. 00 | |
| | reporting period | 9 | | | | |
| 18.00 | | es after December 31 of | the cost | 0. 00 | 18.00 | |
| 40.00 | reporting period | | 19.00 | | | |
| 19. 00 | 00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period | | | | | |
| 20. 00 | | | | | | |
| 20.00 | reporting period | | | | | |
| 21. 00 | | 8, 911, 085 | 21.00 | | | |
| 22.00 | j , | | | | | |
| | 5 x line 17) | | | | | |
| 23. 00 |] 3 | 31 of the cost reportin | ng period (line 6 | 0 | 23.00 | |
| 24.00 | x line 18) | - 21 -£ | (1: | 0 | 24 00 | |
| 24. 00 | Swing-bed cost applicable to NF type services through Decembe 7 x line 19) | er 31 of the cost reporti | ng period (iine | 0 | 24.00 | |
| 25. 00 | | 31 of the cost reporting | neriod (line 8 | 0 | 25. 00 | |
| 20.00 | x line 20) | or or the oper reperting | , por ou (11110 0 | Ü | 20.00 | |
| 26.00 | | | | 0 | 26.00 | |
| 27. 00 | General inpatient routine service cost net of swing-bed cost | (line 21 minus line 26) | | 8, 911, 085 | 27.00 | |
| | PRI VATE ROOM DI FFERENTI AL ADJUSTMENT | | | | | |
| | General inpatient routine service charges (excluding swing-be | d and observation bed ch | narges) | 0 | 1 | |
| 29. 00 30. 00 | | | | 0 | | |
| 31.00 | | - line 28) | | 0. 000000 | 1 | |
| 32. 00 | , | . 11116 20) | | 0. 00 | 1 | |
| 33. 00 | | | | 0. 00 | 1 | |
| 34.00 | | nus line 33)(see instruc | ctions) | 0.00 | 34.00 | |
| 35.00 | Average per diem private room cost differential (line 34 x li | | | 0. 00 | 1 | |
| 36.00 | | | | 0 | | |
| 37. 00 | | and private room cost di | fferential (line | 8, 911, 085 | 37.00 | |
| | 27 minus line 36) | | | | 1 | |
| | PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU | LISTMENTS | | | 1 | |
| 38. 00 | | | | 1, 206. 81 | 38.00 | |
| | | | | 1, 316, 630 | 1 | |
| | | | | | | |
| 40.00 | | | | 0 | 40.00 | |
| | | am (line 14 x line 35) | | | | |

| | | INITY HOSPITAL (| | | | u of Form CMS- | |
|------------------|---|------------------|----------------|----------------------|--|----------------------|------------------|
| COMPUT | ATION OF INPATIENT OPERATING COST | | Provider (| CCN: 15-0146 | Peri od: From 01/01/2022 To 12/31/2022 | Date/Time Pre | pared: |
| | | | Ti +I | e XVIII | Hospi tal | 5/18/2023 11: PPS | 21 am |
| | Cost Center Description | Total | Total | Average Per | | Program Cost | |
| | | Inpatient | Inpati ent | Diem (col. + col. 2) | 1 | (col. 3 x | |
| | | 1.00 | Days 2.00 | ÷ COI . 2) | 4.00 | col . 4) 5.00 | |
| 2.00 | NURSERY (title V & XIX only) | 0 | | 0. (| | | 42.00 |
| 13 00 | Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT | O | | 0.0 | 00 0 | 0 | 43.00 |
| 14. 00 | CORONARY CARE UNIT | 0 | | 0.0 | | | 1 |
| 15.00 | BURN INTENSIVE CARE UNIT | 0 | | 0. (| | | |
| 16.00 | SURGICAL INTENSIVE CARE UNIT | 0 | (| 0. (| 00 0 | 0 | 46. 00 47. 00 |
| 17. 00 | OTHER SPECIAL CARE (SPECIFY) Cost Center Description | | | | | | 47.00 |
| | · | | | | | 1. 00 | |
| 18. 00 18. 01 | Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisiti | · · | | t III line 10 |) column 1) | 1, 352, 726 0 | 1 |
| | Total Program inpatient costs (sum of lines | | | | , corumir i) | 2, 669, 356 | 1 |
| | PASS THROUGH COST ADJUSTMENTS | | | | | | |
| 0. 00 | Pass through costs applicable to Program inp | atient routine | services (fro | om Wkst. D, su | ım of Parts I and | 80, 930 | 50.00 |
| 1. 00 | Pass through costs applicable to Program inp | atient ancillar | y services (f | from Wkst. D, | sum of Parts II | 91, 027 | 51.00 |
| 2 00 | and IV) | EO and E1) | | | | 171, 957 | F2 00 |
| 2. 00 3. 00 | | | | | | | |
| | medical education costs (line 49 minus line | | | | | 2, 497, 399 | |
| 4 00 | TARGET AMOUNT AND LIMIT COMPUTATION Program discharges | | | | | 0 | 54.00 |
| 5. 00 | | | | | | | 55.00 |
| | Permanent adjustment amount per discharge | | | | | | 55. 01 |
| 5. 02 | | | | | | | 55.02 |
| 66.00 57.00 | | | | | | | 56. 00 57. 00 |
| 58. 00 | Bonus payment (see instructions) | g coot and to | . got amount (| (| | Ō | 1 |
| 9. 00 | Trended costs (lesser of line 53 ÷ line 54, | | the cost rep | porting period | l endi ng 1996, | 0. 00 | 59.00 |
| 0.00 | updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, | | m prior vear | cost report. | updated by the | 0. 00 | 60.00 |
| , , , , , | market basket) | | | | | 0.00 | 00.00 |
| 51. 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 | | | | | | |
| | enter zero. (see instructions) | | · · | • | | | |
| 52.00 | Relief payment (see instructions) Allowable Inpatient cost plus incentive paym | ent (see instru | ctions) | | | 0 | |
| 3. 00 | PROGRAM INPATIENT ROUTINE SWING BED COST | cit (see mistre | eti ons) | | | | 03.00 |
| 4. 00 | Medicare swing-bed SNF inpatient routine cos | ts through Dece | mber 31 of th | ne cost report | ing period (See | 0 | 64.00 |
| 55. 00 | <pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre> | ts after Decemb | er 31 of the | cost reportin | na period (See | 0 | 65.00 |
| , , , , | instructions)(title XVIII only) | | 0. 0. 0 | ооот торо | .g po ou (ooo | | 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 |
| 7. 00 | CAH, see instructions Title V or XIX swing-bed NF inpatient routin | e costs through | December 31 | of the cost r | eportina period | 0 | 67.00 |
| | (line 12 x line 19) | · · | | | | | |
| 8. 00 | Title V or XIX swing-bed NF inpatient routin (line 13 x line 20) | e costs after D | ecember 31 of | f the cost rep | orting period | 0 | 68.00 |
| 9. 00 | Total title V or XIX swing-bed NF inpatient | routine costs (| line 67 + lir | ne 68) | | 0 | 69.00 |
| | PART III - SKILLED NURSING FACILITY, OTHER N | | | | | | 70 00 |
| 0. 00 1. 00 | Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of | • | | • |) | | 70.00 |
| 2. 00 | Program routine service cost (line 9 x line | | 70 . 11116 |) | | | 72.00 |
| 3.00 | Medically necessary private room cost applic | able to Program | | | | | 73.00 |
| 4.00 5.00 | Total Program general inpatient routine serv Capital-related cost allocated to inpatient | | | * | Part II column | | 74. 00 75. 00 |
| 5.00 | 26, line 45) | . Satino Service | 55555 (110111 | or Roncet D, | . a. c. r., coruilli | | , 3. 00 |
| 76.00 | Per diem capital-related costs (line 75 ÷ li | | | | | | 76.00 |
| / ()() | Program capital-related costs (line 9 x line | 101 | | | | 1 | 77 00 |

77.00

78.00

79.00

80.00

81. 00 82. 00

83.00

84.00

85.00

86.00

2, 674 87. 00

1, 206. 81 88. 00

78.00

81.00

82. 00 83. 00

85.00

77.00 Program capital-related costs (line 9 x line 76)

87.00 Total observation bed days (see instructions)

Inpatient routine service cost (line 74 minus line 77)

Program inpatient ancillary services (see instructions)

PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)

Inpatient routine service cost per diem limitation
Inpatient routine service cost limitation (line 9 x line 81)

Reasonable inpatient routine service costs (see instructions)

Utilization review - physician compensation (see instructions)

Total Program inpatient operating costs (sum of lines 83 through 85)

79.00 Aggregate charges to beneficiaries for excess costs (from provider records)

80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)

| Health Financial Systems COMML | u of Form CMS-2 | 2552-10 | | | | |
|--|-----------------|--------------|----------------------------------|---------------|------------------|--------|
| COMPUTATION OF INPATIENT OPERATING COST | | | | Peri od: | Worksheet D-1 | |
| | | | From 01/01/2022 To 12/31/2022 | | pared: 21 am_ | |
| | | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | | | | | | |
| | | | | | 1. 00 | |
| 89.00 Observation bed cost (line 87 x line 88) (se | e instructions) |) | | | 3, 227, 010 | 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 | 547, 765 | 8, 911, 085 | 0. 06147 | 0 3, 227, 010 | 198, 364 | 90.00 |
| 91.00 Nursing Program cost | 0 | 8, 911, 085 | 0.00000 | 0 3, 227, 010 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 8, 911, 085 | 0.00000 | 0 3, 227, 010 | 0 | 92.00 |
| 93.00 All other Medical Education | o | 8, 911, 085 | 0. 00000 | 0 3, 227, 010 | 0 | 93. 00 |

| Health Financial Systems | COMMUNITY HOSPITAL OF | NOBLE CTY, INC | In Lieu | of Form CMS-2552-10 |
|---|-----------------------|-----------------------|-----------------------------|--|
| COMPUTATION OF INPATIENT OPERATING COST | | Provider CCN: 15-0146 | Peri od: From 01/01/2022 | Worksheet D-1 |
| | | | To 12/31/2022 | Date/Time Prepared: 5/18/2023 11:21 am |
| | | Title XIX | Hospi tal | PPS |

| | | | 10 12/31/2022 | 5/18/2023 11: | | |
|------------------|--|---------------------------|-------------------|------------------|----------------|--|
| | | Title XIX | Hospi tal | PPS | | |
| | Cost Center Description | | | | | |
| | DADT I DECLUDED COMPONENTO | | | 1. 00 | | |
| | PART I - ALL PROVIDER COMPONENTS | | | | | |
| 1. 00 | INPATIENT DAYS Inpatient days (including private room days and swing-bed day | (s. ovel udi na nowborn) | | 7, 384 | 1.00 | |
| 2. 00 | Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing- | | | 7, 384 | 2.00 | |
| 3. 00 | Private room days (excluding swing-bed and observation bed da | | rivate room days | 7, 304 | 3.00 | |
| 3.00 | do not complete this line. | iya). Ti you have only pi | Trvate room days, | J | 3.00 | |
| 4. 00 | Semi-private room days (excluding swing-bed and observation b | oed davs) | | 4, 710 | 4.00 | |
| 5. 00 | Total swing-bed SNF type inpatient days (including private ro | | er 31 of the cost | | 5.00 | |
| | reporting period | <i>y</i> , | | | | |
| 6. 00 | Total swing-bed SNF type inpatient days (including private ro | oom 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 | om days) through December | r 31 of the cost | 0 | 7.00 | |
| 0 00 | reporting period | da) -£t Db (| 21 -6 -1 | 0 | 0.00 | |
| 8. 00 | Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line) | om days) arter becember . | 31 of the cost | 0 | 8.00 | |
| 9. 00 | Total inpatient days including private room days applicable t | to the Program (excluding | a swing-bod and | 64 | 9.00 | |
| 7. 00 | newborn days) (see instructions) | the frogram (excruding | g swifig-bed and | 04 | 7.00 | |
| 10. 00 | Swing-bed SNF type inpatient days applicable to title XVIII o | only (including private i | room davs) | 0 | 10.00 | |
| | through December 31 of the cost reporting period (see instruc | | <i>,</i> | | | |
| 11. 00 | Swing-bed SNF type inpatient days applicable to title XVIII o | only (including private i | 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 | |
| 40.00 | through December 31 of the cost reporting period | V and Charles Brown and | | | 40.00 | |
| 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 Medically necessary private room days applicable to the Progr | | | 0 | 14.00 | |
| 15. 00 | Total nursery days (title V or XIX only) | all (excluding swing-bed | uays) | 399 | | |
| | Nursery days (title V or XIX only) | | | 32 | | |
| 10.00 | SWING BED ADJUSTMENT | | | 02 | 10.00 | |
| 17. 00 | Medicare rate for swing-bed SNF services applicable to service | ces through December 31 o | of the cost | 0.00 | 17.00 | |
| | reporting period | G | | | | |
| 18. 00 | Medicare rate for swing-bed SNF services applicable to servic | ces after December 31 of | the cost | 0. 00 | 18.00 | |
| | reporting period | | | | | |
| 19. 00 | Medicaid rate for swing-bed NF services applicable to service | es through December 31 of | f the cost | 0. 00 | 19.00 | |
| 20.00 | reporting period | | | 0.00 | 20.00 | |
| 20. 00 | Medicaid rate for swing-bed NF services applicable to service reporting period | es arter becember 31 or | the cost | 0. 00 | 20.00 | |
| 21. 00 | Total general inpatient routine service cost (see instruction | is) | | 8, 911, 085 | 21.00 | |
| 22. 00 | Swing-bed cost applicable to SNF type services through Decemb | | ting period (line | | 22.00 | |
| | 5 x line 17) | | 5 7 7 | | | |
| 23. 00 | Swing-bed cost applicable to SNF type services after December | 31 of the cost reportin | ng period (line é | 0 | 23.00 | |
| | x line 18) | | | | | |
| 24. 00 | Swing-bed cost applicable to NF type services through Decembe | er 31 of the cost reporti | ing period (line | 0 | 24.00 | |
| 25 00 | 7 x line 19) | 21 -6 | | 0 | 25 00 | |
| 25. 00 | Swing-bed cost applicable to NF type services after December x line 20) | 31 of the cost reporting | g period (iine 8 | 0 | 25.00 | |
| 26. 00 | Total swing-bed cost (see instructions) | | | 0 | 26.00 | |
| 27. 00 | | (line 21 minus line 26) | | 8, 911, 085 | | |
| 27.00 | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | (1116 21 111110 11110 20) | | 0,711,000 | 27.00 | |
| 28. 00 | General inpatient routine service charges (excluding swing-be | ed and observation bed ch | narges) | 0 | 28.00 | |
| 29. 00 | Private room charges (excluding swing-bed charges) | | - | 0 | 29.00 | |
| 30. 00 | Semi-private room charges (excluding swing-bed charges) | | | 0 | 30.00 | |
| 31. 00 | General inpatient routine service cost/charge ratio (line 27 | ÷ line 28) | | 0. 000000 | 31.00 | |
| 32.00 | Average private room per diem charge (line 29 ÷ line 3) | | | 0.00 | | |
| 33.00 | Average semi-private room per diem charge (line 30 ÷ line 4) | nue line 22) (con inst | stions) | 0.00 | | |
| 34.00 | Average per diem private room charge differential (line 32 mi | | LI 0115) | 0. 00 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 | 0 8, 911, 085 | 36.00 37.00 | |
| 27.00 | 27 minus line 36) | and private room cost u | Circital Cirling | 5, 711, 003 |] 57.50 | |
| | PART II - HOSPITAL AND SUBPROVIDERS ONLY | | | | 1 | |
| | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ | IUSTMENTS | | | 1 | |
| 38. 00 | Adjusted general inpatient routine service cost per diem (see | | | 1, 206. 81 | 38.00 | |
| 00 00 | Program general inpatient routine service cost (line 9 x line | | | 77, 236 | 39.00 | |
| 39. 00 | | | | _ | | |
| 40. 00 | Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39 | | | 0 77, 236 | 40.00 | |

| | Financial Systems CON ATION OF INPATIENT OPERATING COST | MUNITY HOSPITAL (| | I NC CN: 15-0146 | In Lie Period: | u of Form CMS-2 Worksheet D-1 | |
|------------------|--|-------------------|----------------|----------------------|----------------------------------|----------------------------------|------------------|
| COMPUT | ATTON OF INPATTENT OPERATING COST | | Provider C | CN. 13-0140 | From 01/01/2022 To 12/31/2022 | | |
| | | | | VIV | | 5/18/2023 11: | |
| | Cost Center Description | Total | Ti tl Total | e XIX Average Per | Hospital Program Days | PPS Program Cost | |
| | 555 55116. 5555. Pt. 51 | Inpatient | I npati ent | Diem (col. | | (col. 3 x | |
| | | 1.00 | Days 2.00 | ÷ col . 2) 3.00 | 4.00 | col . 4) 5.00 | |
| 42.00 | NURSERY (title V & XIX only) | 315, 480 | 399 | | | | 42.00 |
| 43. 00 | Intensive Care Type Inpatient Hospital Uni INTENSIVE CARE UNIT | ts ol | C | 0.0 | 00 00 | 0 | 43.00 |
| 44. 00 | CORONARY CARE UNIT | o o | C | • | | • | 44.00 |
| 45. 00 | BURN INTENSIVE CARE UNIT | 0 | C | | | | 45.00 |
| 46. 00 47. 00 | SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) | 0 | C | 0. (| 00 0 | 0 | 46. 00 47. 00 |
| 47.00 | Cost Center Description | | | | | | 47.00 |
| 49.00 | Program inpatient ancillary service cost (| Wkst D 2 col 3 |) Line 200) | | | 1. 00 107, 610 | 19.00 |
| 48. 00 48. 01 | Program inpatient cellular therapy acquisi | | | III, line 10 |), column 1) | 0 107,810 | 48. 01 |
| 49. 00 | Total Program inpatient costs (sum of line | | | | · | 210, 148 | 49. 00 |
| 50. 00 | PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program i | nnationt routino | sorvices (fro | m Wkst D si | um of Darte L and | 6, 347 | 50.00 |
| 30.00 | | npatrent routine | services (110 | III WKST. D, SC | iii or raits i aid | 0, 347 | 30.00 |
| 51. 00 | Pass through costs applicable to Program i and IV) | npatient ancillar | y services (f | rom Wkst. D, | sum of Parts II | 8, 261 | 51.00 |
| 52. 00 | Total Program excludable cost (sum of line | s 50 and 51) | | | | 14, 608 | 52.00 |
| 53. 00 | | | | | | | |
| | medical education costs (line 49 minus lin TARGET AMOUNT AND LIMIT COMPUTATION | e 52) | | | | | |
| 4. 00 | Program di scharges | 0 | 54.00 | | | | |
| 5.00 | Target amount per discharge | | 55.00 | | | | |
| 55. 01 55. 02 | Permanent adjustment amount per discharge Adjustment amount per discharge (contracto | 0. 00 0. 00 | | | | | |
| 56.00 | Target amount (line 54 x sum of lines 55, | 0.00 | 56.00 | | | | |
| 57.00 | Difference between adjusted inpatient oper | 0 | 57.00 | | | | |
| 58. 00 59. 00 | Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54 | or line 55 from | the cost rep | ortina period | l endina 1996 | 0.00 | 58. 00 59. 00 |
| | updated and compounded by the market baske | t) | • | 0 . | | | |
| 60. 00 | Expected costs (lesser of line 53 ÷ line 5 market basket) | 4, or line 55 fro | om prior year | cost report, | updated by the | 0.00 | 60.00 |
| 61. 00 | Continuous improvement bonus payment (if I | ine 53 ÷ line 54 | is less than | the lowest of | lines 55 plus | 0 | 61.00 |
| | 55.01, or line 59, or line 60, enter the L | | | | | | |
| | 53) are less than expected costs (lines 54 enter zero. (see instructions) | x 60), or 1 % of | the target a | mount (line 5 | 66), otherwise | | |
| | Relief payment (see instructions) | | | | | 0 | 62.00 |
| 63. 00 | Allowable Inpatient cost plus incentive pa PROGRAM INPATIENT ROUTINE SWING BED COST | yment (see instru | ıcti ons) | | | 0 | 63.00 |
| 64. 00 | Medicare swing-bed SNF inpatient routine c | osts through Dece | ember 31 of th | e cost report | ing period (See | 0 | 64.00 |
| 65. 00 | instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine c | osts after Decemb | or 21 of the | cost roportin | na ported (Soc | 0 | 65.00 |
| 03.00 | instructions)(title XVIII only) | usts after Decemb | der 31 of the | cost reportir | ig perrou (see | | 05.00 |
| 66. 00 | Total Medicare swing-bed SNF inpatient rou | tine 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 rout | ine costs through | December 31 | of the cost r | reporting period | 0 | 67. 00 |
| 07.00 | (line 12 x line 19) | · · | | | | | 07.00 |
| 68. 00 | Title V or XIX swing-bed NF inpatient rout (line 13 x line 20) | ine costs after [| ecember 31 of | the cost rep | orting period | 0 | 68. 00 |
| 69. 00 | Total title V or XIX swing-bed NF inpatien | t routine costs (| line 67 + lin | e 68) | | 0 | 69.00 |
| | PART III - SKILLED NURSING FACILITY, OTHER | NURSING FACILITY | , AND ICF/IID | ONLY | | | |
| 70. 00 71. 00 | Skilled nursing facility/other nursing fac Adjusted general inpatient routine service | • | | • | ') | | 70.00 71.00 |
| 72.00 | Program routine service cost (line 9 x lin | | THE 70 + TITLE | 2) | | | 72.00 |
| 73.00 | 00 Medically necessary private room cost applicable to Program (line 14 x line 35) | | | | | | |
| 74. 00 75. 00 | Total Program general inpatient routine se Capital-related cost allocated to inpatien | • | | • | Part II column | | 74. 00 75. 00 |
| 5.00 | 26, line 45) | t routine service | (110111 | WOI KSHEEL D, | rait II, COLUMNI | | , 3.00 |
| 76.00 | Per diem capital-related costs (line 75 ÷ | | | | | | 76.00 |
| | Program capital-related costs (line 9 x li Inpatient routine service cost (line 74 mi | · . | | | | | 77. 00 78. 00 |
| J. 00 | | nus iiio /// | | | | | |

Inpatient routine service cost (line 74 minus line 77)

79.00 Aggregate charges to beneficiaries for excess costs (from provider records)

80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)

78.00

79.00

80.00

81.00 82.00

| Health Financial Systems COMMU | u of Form CMS-2 | 2552-10 | | | | |
|--|-----------------|--------------|----------------------------------|---------------|---------------|--------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provi der CC | | Peri od: | Worksheet D-1 | |
| | | | From 01/01/2022 To 12/31/2022 | | | |
| | | Ti tl e | e XIX | Hospi tal | PPS | |
| Cost Center Description | | | | | | |
| | | | | | 1. 00 | |
| 89.00 Observation bed cost (line 87 x line 88) (se | e instructions) |) | | | 3, 227, 010 | 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 | 547, 765 | 8, 911, 085 | 0. 06147 | 0 3, 227, 010 | 198, 364 | 90.00 |
| 91.00 Nursing Program cost | 0 | 8, 911, 085 | 0.00000 | 0 3, 227, 010 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 8, 911, 085 | 0.00000 | 0 3, 227, 010 | 0 | 92.00 |
| 93.00 All other Medical Education | o | 8, 911, 085 | 0. 00000 | 3, 227, 010 | 0 | 93. 00 |

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

| INPATI ENT ANCILLARY SERVICE COST APPORTIONMENT | Health Financial Systems COMMUNITY HOSPITAL C | OF NOBLE CTY, IN | С | In Lie | u of Form CMS-2 | 2552-10 |
|--|--|------------------|------------|---------------|-----------------|----------|
| To Clast Center Description To Clast | | | : 15-0146 | Peri od: | | |
| Solition Cost Center Description Title XVIII Hospital Hospital To Charges Inpatient To Charges Inpatient To Charges Inpatient To Charges Inpatient | | | | | Dato/Timo Pro | narod: |
| New York Cost Center Description Repair to Cost To Charges To | | | | 10 12/31/2022 | | |
| INPATIENT BOUTLINE SERVICE COST CENTERS | | | | | | |
| NIPATE NOTIFIES SERVICE COST CENTERS 1.00 2.00 3.0 | Cost Center Description | | | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | To Charges | 3 | 9 | |
| INPATIENT ROUTINE SERVICE COST CENTERS 5.36, 5.38 30, 0.0 3.10 | | | | Charges | | |
| IMPATI ENT BOUTINE SERVICE COST CENTERS 30.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 32 | | | 1. 00 | 2.00 | | |
| 31.00 03100 INTENSIVE CARE UNIT 0 33.00 33.00 33.00 03200 CORROMAY CARE UNIT 0 33.00 33.00 33.00 03200 CORROMAY CARE UNIT 0 33.00 | INPATIENT ROUTINE SERVICE COST CENTERS | I | | | | |
| 32.00 03200 CORDUNARY CARE UNIT 0 33.00 33.00 3300 BURN INTERNIS VE CARE UNIT 0 33.00 33 | 30. 00 03000 ADULTS & PEDI ATRI CS | | | 536, 538 | | 30.00 |
| 33.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 040.00 04000 SUBFORVI DER - I-PF 0 0 44.00 040.00 04000 SUBFORVI DER - I-PF 0 0 44.00 040.00 04000 SUBFORVI DER - I-PF 0 0 44.00 040.00 04000 | 31.00 03100 INTENSIVE CARE UNIT | | | 0 | | 31.00 |
| 34. 00 03400 SURGICAL INTENSIVE CARE UNIT 0 04.00 04 | | | | 0 | | 1 |
| 40. 00 04000 SUBPROVI DER - I PF | | | | 0 | | |
| 1.00 0.100 SUBPROVI DER - I RF 34.00 3.00 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000 | | | | 0 | | • |
| A3. 00 A3.00 MJASSERY A5. 00 A3.00 A8.00 A3.00 A8.00 A8.00 A3.00 A8.00 A8.00 A3.00 A8.00 | | | | 0 | | 1 |
| MOCILLARY SERVICE COST CENTERS | | | | | | • |
| 50.00 | | | | | | 10.00 |
| S2200 OSCOOD OS | | | 0. 16723 | 3 252, 444 | 42, 217 | 50.00 |
| 53. 00 05300 ANESTHESI OLOGY 0.000000 0.0 0.53. 00 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000 | | | 0.00000 | 0 0 | 0 | 51.00 |
| 54. 00 05400 RADIOLOGY-DIAGNOSTIC 0.119007 1,948,570 231,893 54. 00 55. 00 05500 RADIOLOGY-DIAGNOSTIC 0.000000 0 0 55. 00 05500 RADIOLOGY-THERAPEUTIC 0.000000 0 0 55. 00 0570 015700 | | | 0. 47333 | 9 0 | 0 | 52.00 |
| 55. 00 05.00 05.00 05.00 05.00 05.00 05.50 05. | | | | | | 1 |
| 56.00 05600 RADIO I SOTOPE 0.000000 0 0 56.00 | | | | | | 1 |
| 57. 00 05700 05700 058 | | | | | | 1 |
| SB. 00 OSBOO MAGNETIC RESONANCE IMACI NC (MRI) | | | | | | 1 |
| 59.00 05900 05900 05000 0 0 0 0 0 0 0 | | | | | | 1 |
| 60.00 06000 LABORATORY 0.000000 0.000000 0.00000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000 | | | | | | 1 |
| 60.01 60.01 60.01 60.01 60.01 60.01 61.00 62.0 | | | | | _ | 1 |
| 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0 0.00000 0.00000 0.00000 0.00000 0.00000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000 | | | | | | |
| 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 0 0 62. 00 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 0 63. 00 64. 00 06400 INTRAVENOUS THERAPY 0.000000 0 0 64. 00 65. 00 06500 RESPI RATORY THERAPY 0.149731 1, 421, 369 212, 823 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.562447 25, 620 14, 410 67. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.562447 25, 620 14, 410 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.401700 29, 362 11, 795 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 0 0 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0.000000 0 0 69. 00 71. 00 07000 ELECTROCARDI OLOGY 0.000000 0 0 70. 00 72. 00 07000 IMPL. DEV. CHARGED TO PATIENTS 0.137323 182, 890 25, 115 71. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.239627 205, 445 49, 230 72. 00 74. 00 07400 RENLA DIALYSIS 0.000000 0 0 75. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 75. 00 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.000000 0 0 75. 00 77. 00 07700 LOGEMEIC STEM CELL ACQUISITION 0.000000 0 0 77. 00 79. 00 09000 CLINI C 0.000000 0 0 0 0 79. 00 09000 CLINI C 0.000000 0 0 0 79. 00 09000 CLINI C 0.000000 0 0 0 79. 00 09000 CLINI C 0.000000 0 0 0 79. 00 09000 CLINI C 0.000000 0 0 0 79. 00 09000 DEBRECANCY 0.000000 0 0 0 79. 00 09000 DEBRECANCY 0.000000 0 0 0 79. 00 09000 DIARBEE MEDI CAL EQUI P-RINTED 0.000000 0 0 0 79. 00 09000 DURABLE MEDI CAL EQUI P-RINTED 0.000000 0 0 0 79. 00 09000 DURABLE MEDI CAL EQUI P-RINTED 0.000000 0 0 0 79. 00 09000 DURABLE MEDI CAL EQUI P-RINTED 0.000000 0 0 0 79. 00 09000 DURABLE MEDI CAL EQUI P-RINTED 0.000000 0 0 0 79. 00 09000 DURABLE MEDI CAL EQUI P-RINTED 0.000000 0 0 0 70. 00 000000 0 0 0 0 70 | | | | | | 1 |
| 64. 00 06400 INTRAVENOUS THERAPY 0. 000000 0 0 64. 00 | | | | | 0 | 1 |
| 65.00 06500 RESPIRATORY THERAPY 0.149731 1,421,369 212,823 65.00 66.00 06600 06500 | 63.00 06300 BLOOD STORING, PROCESSING & TRANS. | | 0.00000 | 0 0 | 0 | 63.00 |
| 66.00 06600 PHYSI CAL THERAPY 0.373684 54, 168 20, 242 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.562447 25, 620 14, 410 67.00 69.00 06800 SPEECH PATHOLOGY 0.401700 29, 362 11, 470 67.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0.000000 0 0 | 64. 00 06400 I NTRAVENOUS THERAPY | | 0.00000 | 0 0 | 0 | 64.00 |
| 67.00 06700 0CCUPATI ONAL THERAPY 0.562447 25,620 14,410 67.00 68.00 06800 SPECCH PATHOLOGY 0.4017700 29,362 11,795 68.00 70.00 07000 ELECTROCARDI OLOGY 0.000000 0 0.900 0.000000 0 0.000000 0 0.000000 0 | | | | | | • |
| 68. 00 06800 SPEECH PATHOLOGY 0. 401700 29, 362 11, 795 68. 00 69. 00 0. 00000 0. 0 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000 | | | | | | 1 |
| 69. 00 06900 ELECTROCARDI OLOGY 0.000000 0 0 69. 00 70. 00 | | | | | | 1 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 70.00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.137323 182,890 25,115 71.00 72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 0.239627 205,445 49,230 72.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.202776 1,244,837 252,423 73.00 74. 00 07400 RENAL DIALYSIS 0.000000 0 0 74.00 75. 00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 75.00 76. 98 07698 HYPERBARI COXYGEN THERAPY 0.211225 0 0 76.98 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 0 0 77.00 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 77.00 99. 00 08900 CLINIC 0.325289 0 0 90.00 90. 00 09000 CLINIC 0.325289 0 0 90.00 91. 00 09100 EMERGENCY 0.511148 0 0 90.00 92. 00 09200 OSSERVATION BEDS (NON-DISTINCT PART) 0.511148 0 0 92.00 97. 00 09500 MBULANCE SERVI CES 95.00 96. 00 09500 MBULANCE SERVI CES 95.00 96. 00 09500 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 10,252,982 1,352,726 200.00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (Line 61) 0 0 00.00000 201. 00 00000 0 0 0 0.00000 201. 00 201. 00 0.00000 0 0 0.00000 0 0 | | | | | | 1 |
| 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 137323 182, 890 25, 115 71. 00 72. 00 72.00 1MPL. DEV. CHARGED TO PATIENTS 0. 239627 205, 445 49, 230 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 202776 1, 244, 837 252, 423 73. 00 74. 00 07400 RENAL DI ALYSIS 0. 000000 0 0 0 74. 00 075. 00 075. 00 ASC (NON-DISTINCT PART) 0. 000000 0 0 0 0 0 0 0 | | | | | | 1 |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 239627 205, 445 49, 230 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 202776 1, 244, 837 252, 423 73. 00 74. 00 7400 RENAL DI ALYSIS 0. 000000 0 0 74. 00 75. 00 07500 ASC (NON-DI STINCT PART) 0. 0000000 0 0 75. 00 07500 ASC (NON-DI STINCT PART) 0. 211225 0 0 0 76. 98 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0. 0000000 0 0 0 0 0 0 | | | | | | 1 |
| 73.00 | | | | | | 1 |
| 74.00 | | | | | | 1 |
| 76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0. 211225 0 0 0 76. 98 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SITION 0. 0000000 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 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 0 0 0 0 0 0 | 74. 00 07400 RENAL DI ALYSI S | | 0.00000 | | 0 | 74.00 |
| 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 0 0 0 0 0 0 0 | 75.00 07500 ASC (NON-DISTINCT PART) | | 0.00000 | 0 0 | 0 | 75. 00 |
| 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 89.00 | | | | | | 1 |
| 88. 00 | | | 0. 00000 | 0 0 | 0 | 77. 00 |
| 89. 00 | | | 0.0000 | | | 00.00 |
| 90. 00 09000 CLINIC 0. 325289 0 0 90. 00 91. 00 91. 00 09100 EMERGENCY 0. 094231 3, 012, 321 283, 854 91. 00 09200 095ERVATION BEDS (NON-DISTINCT PART) 0. 511148 0 0 0 92. 00 09500 AMBURSABLE COST CENTERS 0. 000000 0 0 94. 00 95. 00 09500 AMBURANCE SERVICES 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0. 000000 0 0 96. 00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0. 000000 0 0 97. 00 000000 0 0 0 0 0 0 | | | | | | |
| 91. 00 | | | | | | 1 |
| 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0.511148 0 0 0 0 0 0 0 0 0 | | | | | - | 1 |
| OTHER REIMBURSABLE COST CENTERS O.000000 O O.000000 O.0000000 O.000000 O.0000000 O.000000 O.0000000 O.000000 O.0000000 O.000000 O.0000000 O.0000000 O.0000000 O.0000000 O.0000000 O.0000000 O.0000000 O.0000000 O.000 | | | | | · | 1 |
| 94. 00 | | | 0.0 | <u> </u> | | 72.00 |
| 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 96. 00 97. 00 0.000000 0 97. 00 0.000000 0 97. 00 0.00000000 | | | 0. 00000 | 0 0 | 0 | 94.00 |
| 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 0 97. 00 200. 00 Total (sum of lines 50 through 94 and 96 through 98) 10, 252, 982 1, 352, 726 200. 00 201. 00 20 | | j | | | | 1 |
| 200.00 Total (sum of lines 50 through 94 and 96 through 98) 10, 252, 982 1, 352, 726 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 | | | | | | |
| 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 | | | 0. 00000 | | _ | • |
| | | | | 10, 252, 982 | | |
| 202.00 | | ges (line 61) | | 10, 252, 222 | | 1 |
| | zoz.ou Net charges (Time zou minus line zoi) | I | | 10, 252, 982 | | 1202. UU |

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

| Health Financial Systems COMMUNITY HOSPITAL OF | | | u or form CMS-2 | |
|---|-----------------------|-----------------|-----------------|--------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0146 | Peri od: | Worksheet D-3 | |
| | | From 01/01/2022 | | |
| | | To 12/31/2022 | | |
| | T | | 5/18/2023 11: | 21 am |
| | Title XIX | Hospi tal | PPS | |
| Cost Center Description | Ratio of Co | | I npati ent | |
| | To Charges | s Program | Program Costs | |
| | | Charges | (col. 1 x | |
| | | | col . 2) | |
| | 1. 00 | 2.00 | 3. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | <u>'</u> | | • | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | | 131, 307 | | 30.00 |
| 31. 00 03100 NTENSI VE CARE UNI T | | 101,007 | | 31.00 |
| 32. 00 03200 CORONARY CARE UNIT | | 0 | | 32.00 |
| | | 0 | | |
| | | 0 | | 33.00 |
| 34. 00 03400 SURGI CAL INTENSI VE CARE UNI T | | 0 | | 34.00 |
| 40. 00 04000 SUBPROVI DER - 1 PF | | 0 | | 40. 00 |
| 41. 00 04100 SUBPROVI DER - I RF | | 0 | | 41. 00 |
| 43. 00 04300 NURSERY | | 0 | | 43.00 |
| ANCILLARY SERVICE COST CENTERS | | | | |
| 50. 00 05000 OPERATING ROOM | 0. 1672 | 233 48, 049 | 8, 035 | 50.00 |
| 51. 00 05100 RECOVERY ROOM | 0.0000 | | 0 | 51.00 |
| 52. 00 O5200 DELIVERY ROOM & LABOR ROOM | 0. 4733 | | Ö | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0. 0000 | | 0 | 53.00 |
| | | | | |
| 54. 00 05400 RADI OLOGY - DI AGNOSTI C | 0. 1190 | | | 54.00 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0.0000 | | 0 | 55.00 |
| 56. 00 05600 RADI OI SOTOPE | 0.0000 | 000 | 0 | 56.00 |
| 57. 00 05700 CT SCAN | 0.0000 | 000 | 0 | 57.00 |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0.0000 | 000 | 0 | 58.00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | 0.0000 | 000 | 0 | 59.00 |
| 60. 00 06000 LABORATORY | 0. 1112 | | 14, 349 | 60.00 |
| 60. 01 06001 BLOOD LABORATORY | 0. 0000 | | 0 | 60. 01 |
| 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | 0. 0000 | | Ö | 61.00 |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | | | 0 | 62.00 |
| | 0.0000 | | | |
| 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. | 0.0000 | | 0 | 63.00 |
| 64. 00 06400 I NTRAVENOUS THERAPY | 0.0000 | | 0 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0. 1497 | 731 145, 625 | 21, 805 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0. 3736 | 1, 538 | 575 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0. 5624 | 495 | 278 | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 0. 4017 | 2, 501 | 1, 005 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0.0000 | | 0 | 69.00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 0. 0000 | | Ō | 70.00 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 1373 | | | 71.00 |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS | 0. 2396 | | 571 | 72.00 |
| | | | l e | |
| 73. 00 O7300 DRUGS CHARGED TO PATIENTS | 0. 2027 | | 18, 555 | 73.00 |
| 74. 00 07400 RENAL DI ALYSI S | 0.0000 | | 0 | 74.00 |
| 75. 00 07500 ASC (NON-DISTINCT PART) | 0.0000 | | 0 | 75. 00 |
| 76. 98 07698 HYPERBARI C OXYGEN THERAPY | 0. 2112 | 225 0 | 0 | 76. 98 |
| 77.00 O7700 ALLOGENEIC STEM CELL ACQUISITION | 0.0000 | 000 | 0 | 77.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | |
| 88. 00 08800 RURAL HEALTH CLINIC | 0.0000 | 000 | 0 | 88. 00 |
| 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER | 0.0000 | | l | 89.00 |
| 90. 00 09000 CLINIC | 0. 3252 | | | 90.00 |
| 91. 00 09100 EMERGENCY | 0. 0942 | | • | |
| | | | | |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 511 | 48 0 | 0 | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | |
| 94. 00 09400 HOME PROGRAM DIALYSIS | 0.0000 | 000 | 0 | 94.00 |
| 95. 00 09500 AMBULANCE SERVI CES | | | | 95.00 |
| 96. OO 09600 DURABLE MEDICAL EQUIP-RENTED | 0.0000 | 000 | 0 | 96.00 |
| 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD | 0.0000 | 000 | 0 | 97.00 |
| 200.00 Total (sum of lines 50 through 94 and 96 through 98) | | 803, 786 | 107, 610 | |
| 201.00 Less PBP Clinic Laboratory Services-Program only charges | (line 61) | 000,700 | | 201.00 |
| 202.00 Net charges (line 200 minus line 201) | (| 803, 786 | | 202.00 |
| 202.00 mot onargos (11110 200 IIII lius 11110 201) | ı | 1 003, 700 | ļ | 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 01/01/2022 Part A To 12/31/2022 Date/Time Prepared: 5/18/2023 11:21 am Title XVIII Hospi tal **PPS** 1.00 PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS 1.00 DRG Amounts Other than Outlier Payments 1.00 2, 158, 092 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 694, 382 1.02 instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1.03 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) 0 2.04 3.00 Managed Care Simulated Payments 0 3.00 23.44 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 13.00 Total allowable FTE count for the prior year. 0.00 13.00 14.00 Total allowable FTE count for the penultimate year if that 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 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 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 2.48 30.00 Percentage of Medicaid patient days (see instructions) 31.00 23.19 31.00 32 00 Sum of lines 30 and 31 25 67 32 00 33.00 Allowable disproportionate share percentage (see instructions) 10. 39 33. 00

| | Financial Systems COMMUNITY HOSPITAL ATION OF REIMBURSEMENT SETTLEMENT | OF NOBLE CTY, INC Provider CCN: 15-0146 | Period: | u of Form CMS-2 Worksheet E | 2552-10 |
|------------------|--|---|----------------------------------|------------------------------------|------------------|
| CALCUI | ATTON OF RETWINDORSEMENT SETTLEMENT | Trovider Con. 13-0140 | From 01/01/2022 To 12/31/2022 | Part A Date/Time Pre 5/18/2023 11: | pared: |
| | | Title XVIII | Hospi tal | PPS | 21 aiii |
| | | | | 1. 00 | |
| 34.00 | Disproportionate share adjustment (see instructions) | | | 74, 094 | 34.00 |
| | | | Prior to 10/1 1.00 | 0n/After 10/1 2.00 | |
| 35. 00 | Uncompensated Care Payment Adjustment Total uncompensated care amount (see instructions) | | 7 102 027 149 | 6, 874, 073, 457 | 35.00 |
| 35. 00 | Factor 3 (see instructions) | | 0. 000101647 | 0. 000108063 | |
| 35. 02 | Hospital UCP, including supplemental UCP (If line 34 is ze (see instructions) | ero, enter zero on this lir | re) 731, 049 | 742, 833 | 35. 02 |
| 35. 03 | | • | 546, 784 | 187, 235 | |
| 36.00 | Total UCP adjustment (sum of columns 1 and 2 on line 35.03 Additional payment for high percentage of ESRD beneficiary | | 734, 019 | | 36.00 |
| 40.00 | Total Medicare discharges (see instructions) | areenargee (rrines re time | 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 instr Divide line 41 by line 40 (if less than 10%, you do not qu | | 0.00 | | 41. 01 42. 00 |
| 43.00 | Total Medicare ESRD inpatient days (see instructions) | lairry for adjustment) | 0.00 | | 43.00 |
| 44.00 | Ratio of average length of stay to one week (line 43 divid days) | led by line 41 divided by 7 | 0.000000 | | 44.00 |
| 45. 00 | Average weekly cost for dialysis treatments (see instructi | , | 0. 00 | | 45.00 |
| 46.00 | Total additional payment (line 45 times line 44 times line | 41.01) | 0 | | 46.00 |
| 47. 00 48. 00 | Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH | l small rural hospitals | 3, 660, 587 4, 336, 699 | | 47. 00 48. 00 |
| | only. (see instructions) | , smarr rarar nospitars | 1, 555, 577 | | 10.00 |
| | | | | Amount 1.00 | |
| 49. 00 | Total payment for inpatient operating costs (see instructi | ons) | | 4, 167, 671 | 49.00 |
| 50.00 | Payment for inpatient program capital (from Wkst. L, Pt. I | • | e) | 1, 816 | 1 |
| 51.00 | | | | 0 | |
| 52. 00 53. 00 | Direct graduate medical education payment (from Wkst. E-4, Nursing and Allied Health Managed Care payment | line 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 | 54.01 |
| 55.00 | Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lin | e 69) | | 0 | 55.00 |
| 55. 01 56. 00 | Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see i | ntructions) | | 0 | 55. 01 56. 00 |
| 57. 00 | Routine service other pass through costs (from Wkst. D, Pt | | through 35). | 0 | 57.00 |
| 58.00 | Ancillary service other pass through costs from Wkst. D, P | t. IV, col. 11 line 200) | | 0 | 58.00 |
| 59. 00 60. 00 | Total (sum of amounts on lines 49 through 58) Primary payer payments | | | 4, 169, 487 0 | 59.00 60.00 |
| 61.00 | Total amount payable for program beneficiaries (line 59 mi | nus line 60) | | 4, 169, 487 | |
| 62.00 | Deductibles billed to program beneficiaries | , | | 426, 624 | |
| 63.00 | 1 3 | | | 6, 592 | |
| 65.00 | Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) | | | 48, 391 31, 454 | 1 |
| 66.00 | Allowable bad debts for dual eligible beneficiaries (see i | nstructions) | | 35, 529 | |
| 67. 00 | Subtotal (line 61 plus line 65 minus lines 62 and 63) | , | | 3, 767, 725 | |
| 68.00 | Credits received from manufacturers for replaced devices f | • • | | 0 | ı |
| 69. 00 70. 00 | Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | 6). (FOR SCH See INSTRUCTIO | ons) | 0 | 69.00 70.00 |
| 70. 50 | Rural Community Hospital Demonstration Project (§410A Demo | nstration) adjustment (see | instructions) | 0 | 70. 50 |
| 70. 75 | N95 respirator payment adjustment amount (see instructions | • | | 0 | 70. 75 |
| 70. 87 70. 88 | Demonstration payment adjustment amount before sequestrati SCH or MDH volume decrease adjustment (contractor use only | | | 0 | 70.87 70.88 |
| 70. 88 | Pioneer ACO demonstration payment adjustment amount (see i | | | Ü | 70.89 |
| 70. 90 | | | | 0 | |
| 70. 91 | HSP bonus payment HRR adjustment amount (see instructions) | | | -446 | |
| 70. 92 70. 93 | | | | 0 | |
| 10. 93 | , , | | | 0 | l l |
| 70. 94 | HRR adjustment amount (see instructions) | | | | |

| Health Financial Systems | COMMUNITY HOSPITAL OF NOBLE CTY, INC | In Lieu of Form CMS-2552-10 |
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| | ATION OF REIMBURSEMENT SETTLEMENT | Provi der C | CN: 15-0146 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Date/Time Pre 5/18/2023 11: | pared: |
|---------|--|--------------|------------------|---|--|---------|
| | | Title | XVIII | Hospi tal | PPS | |
| | | | FFY | (уууу) | Amount | |
| | | | | 0 | 1. 00 | |
| 70. 96 | Low volume adjustment for federal fiscal year (yyyy) (Enter in | n column 0 | | 2022 | 507, 489 | 70. 96 |
| 70. 97 | the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter in | | | 2023 | 119, 957 | 70. 97 |
| 70. 98 | the corresponding federal year for the period ending on or aft Low Volume Payment-3 | ter 10/1) | | | 0 | |
| | HAC adjustment amount (see instructions) | | | | 0 | |
| | Amount due provider (line 67 minus lines 68 plus/minus lines 6 | 59 & 70) | | | 4, 394, 725 | |
| | Sequestration adjustment (see instructions) | | | | 55, 374 0 | 1 |
| | Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM or CHART pass-throughs | | | | U | 71.02 |
| | Interim payments | | | | 4, 295, 919 | |
| | Interim payments-PARHM or CHART | | | | 4, 273, 717 | 72.00 |
| | Tentative settlement (for contractor use only) | | | | 0 | 1 |
| 73. 01 | Tentative settlement-PARHM or CHART (for contractor use only) | 1 | | | O | 73. 01 |
| 74. 00 | Balance due provider/program (line 71 minus lines 71.01, 71.02 | | | | 43, 432 | 1 |
| 74. 01 | 73) Balance due provider/program-PARHM or CHART (see instructions) | | | | | 74. 01 |
| | Protested amounts (nonallowable cost report items) in accordan | | | | 69, 275 | |
| 73.00 | CMS Pub. 15-2, chapter 1, §115.2 | ———— | | | 07, 273 | /3.00 |
| 00.00 | TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) | 6.0.00 | | | | 00.00 |
| 90. 00 | Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of plus 2.04 (see instructions) | OT 2. U3 | | | 0 | 90.00 |
| 91. 00 | Capital outlier from Wkst. L, Pt. I, line 2 | | | | 0 | 91.00 |
| | Operating outlier reconciliation adjustment amount (see instru | uctions) | | | 0 | 92.00 |
| | Capital outlier reconciliation adjustment amount (see instruct | | | | 0 | 93.00 |
| 94.00 | The rate used to calculate the time value of money (see instru | uctions) | | | 0.00 | 94.00 |
| 95.00 | Time value of money for operating expenses (see instructions) | | | | 0 | 95.00 |
| 96. 00 | Time value of money for capital related expenses (see instruct | tions) | | | 0 | 96.00 |
| | | | | Pri or to 10/1 1.00 | 0n/After 10/1 2.00 | |
| | HSP Bonus Payment Amount | | | 1.00 | 2.00 | |
| 100.00 | HSP bonus amount (see instructions) | | | 379, 271 | 127, 813 | 100.00 |
| | HVBP Adjustment for HSP Bonus Payment | | | | | |
| 101.00 | HVBP adjustment factor (see instructions) | | | 1. 0000000000 | 1. 0000000000 | 101.00 |
| 102.00 | HVBP adjustment amount for HSP bonus payment (see instructions | s) | | 0 | 0 | 102. 00 |
| | HRR Adjustment for HSP Bonus Payment | | | | | |
| | HRR adjustment factor (see instructions) | | | 0. 9997 | 0. 9974 | 1 |
| 104.00 | HRR adjustment amount for HSP bonus payment (see instructions) | | | -114 | -332 | 104. 00 |
| | Rural Community Hospital Demonstration Project (§410A Demonstr | | | | | |
| 200.00 | Is this the first year of the current 5-year demonstration per | riod under | the 21st | | | 200.00 |
| | Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement | | | | | - |
| 201 00 | Medicare inpatient service costs (from Wkst. D-1, Pt. II, line | 40) | | | | 201. 00 |
| | Medicare discharges (see instructions) | 5 47) | | | | 202.00 |
| | Case-mix adjustment factor (see instructions) | | | | | 203.00 |
| 200.00 | Computation of Demonstration Target Amount Limitation (N/A in | first year | of the curre | nt 5-vear demons | | 200.00 |
| | period) | iii St your | or the curre | are o year demons | | |
| 204.00 | Medicare target amount | | | | | 204.00 |
| 205.00 | Case-mix adjusted target amount (line 203 times line 204) | | | | | 205.00 |
| 206.00 | Medicare inpatient routine cost cap (line 202 times line 205) | | | | | 206.00 |
| | Adjustment to Medicare Part A Inpatient Reimbursement | | | | | 1 |
| | Program reimbursement under the §410A Demonstration (see instr | , | | | | 207. 00 |
| | Medicare Part A inpatient service costs (from Wkst. E, Pt. A, | line 59) | | | | 208.00 |
| | Adjustment to Medicare IPPS payments (see instructions) | | | | | 209. 00 |
| | Reserved for future use | | | | | 210.00 |
| 211. 00 | Total adjustment to Medicare IPPS payments (see instructions) | | | | | 211. 00 |
| 046 6- | Comparision of PPS versus Cost Reimbursement | 244) | | | | 1040 0- |
| | Total adjustment to Medicare Part A IPPS payments (from line 2 | 211) | | | | 212.00 |
| | Low-volume adjustment (see instructions) Net Medicare Part A LPPS adjustment (difference between PPS ar | nd coc+ rc!: | mburcoman+) | | | 213.00 |
| ∠18.00 | Net Medicare Part A IPPS adjustment (difference between PPS ar (line 212 minus line 213) (see instructions) | iu cost rell | ilibul Sellient) | | | 218. 00 |
| | (TITIO 212 IIII IIII 210) (SEE TIISTI UCTI UIIS) | | | 1 1 | | 1 |

| Health Financial Systems | COMMUNITY HOSPITAL OF | NOBLE CTY, INC | In Lieu | u of Form CMS-2552-10 |
|---|-----------------------|------------------------|--|--|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | | Provi der CCN: 15-0146 | Peri od: From 01/01/2022 To 12/31/2022 | Worksheet E Part B Date/Time Prepared: |

5/18/2023 11:21 am Title XVIII Hospi tal PPS 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, 350, 517 2.00 2.00 3.00 OPPS payments 4, 449, 975 3 00 4.00 Outlier payment (see instructions) 4.00 0 4.01 Outlier reconciliation amount (see instructions) 0 4.01 5.00 Enter the hospital specific payment to cost ratio (see instructions) 0.864 5.00 6.00 Line 2 times line 5 3, 758, 847 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) 8.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 9 00 9 00 0 10.00 Organ acquisitions 0 10.00 Total cost (sum of lines 1 and 10) (see instructions) 11.00 11.00 0 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 0 12.00 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 0 13.00 Total reasonable charges (sum of lines 12 and 13) 14.00 0 14.00 Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis 16.00 had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000) 17.00 0.000000 17.00 18.00 Total customary charges (see instructions) 0 18.00 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 0 19.00 instructions) 20 00 20 00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 instructions) 21.00 Lesser of cost or charges (see instructions) 21.00 0 22.00 Interns and residents (see instructions) 0 22.00 Cost of physicians' services in a teaching hospital (see instructions) 23.00 0 23.00 Total prospective payment (sum of lines 3, 4, 449, 975 24.00 4. 4.01. 8 and 9) 24.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 833, 271 25.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 26.00 26.00 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 3, 616, 704 27.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28.00 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00 0 30.00 Subtotal (sum of lines 27 through 29) 3, 616, 704 30.00 31.00 Primary payer payments 316 31.00 Subtotal (line 30 minus line 31) 32.00 3, 616, 388 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 67, 403 34.00 Adjusted reimbursable bad debts (see instructions) 43, 812 35.00 35.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 36.00 43,690 36,00 37.00 Subtotal (see instructions) 3,660,200 37.00 38.00 MSP-LCC reconciliation amount from PS&R 38.00 0 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39 00 39 00 39.50 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 39.97 39 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39 98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 3, 660, 200 40.00 Subtotal (see instructions) 40.00 40.01 Sequestration adjustment (see instructions) 46, 119 40.01 40 02 Demonstration payment adjustment amount after sequestration 0 40 02 40.03 Sequestration adjustment-PARHM or CHART pass-throughs 40.03 3, 653, 831 41.00 Interim payments 41.00 Interim payments-PARHM or CHART 41.01 41.01 42.00 Tentative settlement (for contractors use only) 0 42.00 Tentative settlement-PARHM or CHART (for contractor use only) 42.01 42.01 43.00 Balance due provider/program (see instructions) -39, 750 43.00 Balance due provider/program-PARHM (see instructions) 43.01 43.01 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 90.00 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 The rate used to calculate the Time Value of Money 0.00 92.00 Time Value of Money (see instructions) 93.00 0 94.00 Total (sum of lines 91 and 93) 0 94.00

| 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: From 01/01/2022 To 12/31/2022 | Worksheet E Part B Date/Time Pre 5/18/2023 11: | |
| | | Title XVIII | Hospi tal | PPS | |
| | | | | | |
| | | | | 1. 00 | |
| MEDICARE PART B ANCILLARY COSTS | | | | | |
| 200.00 Part B Combined Billed Days | | | | 0 | 200.00 |

Contractor

Number

1.00

NPR Date

(Mo/Day/Yr)

2.00

8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0146 Peri od: Worksheet E-1 From 01/01/2022 Part I 12/31/2022 Date/Time Prepared: 5/18/2023 11:21 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 4, 295, 919 1.00 Total interim payments paid to provider 3, 653, 831 1.00 Interim payments payable on individual bills, either 2 00 2 00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. write "NONE" or enter a zero List separately each retroactive lump sum adjustment 3.00 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 3.01 0 3.02 0 3.02 0 3 03 0 3 03 3.04 0 0 3.04 0 3.05 3.05 0 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 0 0 3.51 3.51 0 0 3.52 3.52 3 53 0 0 3 53 3.54 0 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 O 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4, 295, 919 3, 653, 831 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 5.50 0 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 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 43, 432 6.01 0 SETTLEMENT TO PROGRAM 6.02 39, 750 6.02 7.00 Total Medicare program liability (see instructions) 4, 339, 351 3, 614, 081 7.00

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: | | | | | |
| | | | From 01/01/2022 To 12/31/2022 | Date/Time Pr | | |
| | 5. | | | | | |
| | | Title XVIII | Hospi tal | PPS | | |
| | | | | | | |
| | | | | 1. 00 | | |
| | TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS | | | | | |
| | HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION | N | | | | |
| 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 | | | | | | |
| 3.00 | Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 | | | | 3.00 | |
| 4.00 | | | | | | |
| 5.00 | 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 | | | | | |
| 6.00 | 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 | | | | | |
| 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I | | | | | 7.00 | |
| | line 168 | | | | | |
| 8.00 | Calculation of the HIT incentive payment (see instructions) | | | | 8. 00 | |
| 9.00 | Sequestration adjustment amount (see instructions) | | | | 9.00 | |
| 10.00 | Calculation of the HIT incentive payment after sequestration | (see instructions) | | | 10.00 | |
| | INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH | | | | | |
| 30.00 | Initial/interim HIT payment adjustment (see instructions) | | | | 30.00 | |
| 31.00 | Other Adjustment (specify) | | | | 31.00 | |
| 22 00 | 00 Polance due provider (Line 9 (or Line 10) minus Line 20 and Line 21) (see instructions) | | | | | |

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

30. 00 31. 00 32. 00

| Heal th | Financial Systems C | OMMUNITY HOSPITAL OF | NOBLE CTY, INC | In Lie | u of Form CMS-2 | 552-10 |
|--|--|-----------------------|------------------------|----------------------------------|----------------------------------|--------|
| OUTLIE | ER RECONCILIATION AT TENTATIVE SETTLEMENT | | Provider CCN: 15-0146 | Peri od: | Worksheet E-5 | |
| | | | | From 01/01/2022 To 12/31/2022 | Date/Time Prep 5/18/2023 11:2 | |
| | | | Title XVIII | | PPS | |
| | | | | | | |
| | | | | | 1. 00 | |
| | TO BE COMPLETED BY CONTRACTOR | | | | | |
| 1.00 | Operating outlier amount from Wkst. E, P | t. 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 | e of money (see instr | ructions) | | 0.00 | 5.00 |
| 6.00 | Time value of money for operating expense | es (see instructions) | | | 0 | 6.00 |
| 7. 00 | Time value of money for capital related of | expenses (see instruc | ctions) | | o | 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)

Provider CCN: 15-0146

Period: Worksheet G
From 01/01/2022
To 12/31/2022 Date/Time Prepared: 5/18/2023 11:21 am

| —————————————————————————————————————— | | | | | 5/18/2023 11: | 21 am |
|--|--|---------------------------|----------------------|---------------|---------------|------------------|
| | | General Fund | Speci fi c | Endowment | Plant Fund | |
| | | 1.00 | Purpose Fund 2.00 | Fund 3. 00 | 4. 00 | |
| | CURRENT ASSETS | 1.00 | 2.00 | 0.00 | 1. 00 | |
| 1.00 | Cash on hand in banks | 27, 568 | 0 | 0 | 0 | 1.00 |
| 2.00 | Temporary investments | 0 | 0 | 0 | | 2.00 |
| 3.00 | Notes receivable | 0 | 0 | 0 | 0 | 3.00 |
| 4. 00 | Accounts receivable | 26, 141, 849 | 0 | 0 | 0 | 4.00 |
| 5. 00 6. 00 | Other receivable Allowances for uncollectible notes and accounts receivable | 17 227 040 | 0 | 0 | 0 | 5. 00 6. 00 |
| 7. 00 | Inventory | -17, 327, 840 363, 477 | 1 | 0 | 0 | 7.00 |
| 8. 00 | Prepaid expenses | 5, 122 | 1 | 0 | 0 | 8.00 |
| 9. 00 | Other current assets | 0 | Ö | 0 | 0 | 9.00 |
| 10.00 | Due from other funds | 38, 202, 632 | 0 | 0 | 0 | 10.00 |
| 11. 00 | Total current assets (sum of lines 1-10) | 47, 412, 808 | 0 | 0 | 0 | 11.00 |
| | FI XED ASSETS | T | TT | | | |
| 12.00 | Land | 755 202 | 0 | 0 | 0 | 12.00 |
| 13. 00 14. 00 | Land improvements | 755, 392 -664, 639 | 1 | 0 | 0 | 13. 00 14. 00 |
| 15. 00 | Accumulated depreciation Buildings | 4, 270, 602 | 1 | 0 | 0 | 15.00 |
| 16. 00 | Accumulated depreciation | -2, 590, 803 | 1 | 0 | 0 | 16.00 |
| 17. 00 | Leasehold improvements | 1, 476, 956 | l I | 0 | Ő | 17.00 |
| 18.00 | Accumulated depreciation | -890, 699 | 1 | 0 | 0 | 18.00 |
| 19. 00 | Fixed equipment | 180, 080 | 0 | 0 | 0 | 19.00 |
| 20.00 | Accumulated depreciation | -97, 944 | I | 0 | 0 | 20.00 |
| 21. 00 | Automobiles and trucks | 1, 319, 061 | 0 | 0 | 0 | 21.00 |
| 22. 00 | Accumulated depreciation | -898, 903 | | 0 | 0 | 22.00 |
| 23.00 | Maj or movable equipment | 11, 621, 750 | | 0 | 0 | 23. 00 24. 00 |
| 24. 00 25. 00 | Accumulated depreciation Minor equipment depreciable | -9, 591, 130 779, 650 | 1 | 0 | 0 | 25.00 |
| 26. 00 | Accumulated depreciation | -283, 649 | | 0 | 0 | 26.00 |
| 27. 00 | HIT designated Assets | 0 | Ö | 0 | ő | 27.00 |
| 28. 00 | Accumulated depreciation | 0 | 0 | 0 | 0 | 28. 00 |
| 29.00 | Mi nor equi pment-nondepreci abl e | 0 | 0 | 0 | 0 | 29. 00 |
| 30.00 | Total fixed assets (sum of lines 12-29) | 5, 385, 724 | 0 | 0 | 0 | 30.00 |
| | OTHER ASSETS | 1 | 1 0 | | | |
| 31.00 | Investments Penerits on Leases | 0 | 0 | 0 | 0 | 31. 00 32. 00 |
| 32. 00 33. 00 | Deposits on leases Due from owners/officers | | | 0 | 0 | 32.00 |
| 34. 00 | Other assets | 0 | Ö | 0 | 0 | 34.00 |
| 35. 00 | Total other assets (sum of lines 31-34) | 0 | Ö | 0 | 0 | 35.00 |
| 36.00 | Total assets (sum of lines 11, 30, and 35) | 52, 798, 532 | 0 | 0 | 0 | 36. 00 |
| | CURRENT LIABILITIES | | | | | |
| 37. 00 | Accounts payable | 1, 301, 679 | | 0 | | 37.00 |
| 38.00 | Salaries, wages, and fees payable | 1, 024, 009 | 0 | 0 | 0 | 38.00 |
| 39. 00 40. 00 | Payroll taxes payable Notes and Loans payable (short term) | 187, 626 | 0 | 0 | 0 | 39. 00 40. 00 |
| 41. 00 | Deferred income | 107,020 | | 0 | 0 | 41.00 |
| 42. 00 | Accel erated payments | | | Ü | Ĭ | 42.00 |
| 43. 00 | Due to other funds | 0 | 0 | 0 | 0 | 43.00 |
| 44.00 | Other current liabilities | 2, 626, 279 | 0 | 0 | 0 | 44.00 |
| 45.00 | Total current liabilities (sum of lines 37 thru 44) | 5, 139, 593 | 0 | 0 | 0 | 45. 00 |
| | LONG TERM LIABILITIES | 1 | 1 _1 | | | |
| 46. 00 | Mortgage payable | 402 244 | 0 | 0 | 0 | 46.00 |
| 47. 00 48. 00 | Notes payable Unsecured Loans | 402, 346 | 0 | 0 | 0 | 47. 00 48. 00 |
| 49. 00 | Other long term liabilities | | Ö | 0 | 0 | 49.00 |
| 50.00 | Total long term liabilities (sum of lines 46 thru 49) | 402, 346 | 1 | 0 | | 50.00 |
| 51.00 | Total liabilities (sum of lines 45 and 50) | 5, 541, 939 | 1 | 0 | | 51.00 |
| | CAPITAL ACCOUNTS | | | | | |
| 52.00 | General fund balance | 47, 256, 593 | | | | 52.00 |
| 53.00 | Specific purpose fund | ļ | 0 | | | 53.00 |
| 54.00 | Donor created - endowment fund balance - restricted | | | 0 | | 54.00 |
| 55.00 | Donor created - endowment fund balance - unrestricted | | | 0 | | 55.00 |
| 56. 00 57. 00 | Governing body created - endowment fund balance Plant fund balance - invested in plant | | | 0 | 0 | 56. 00 57. 00 |
| 58.00 | Plant fund balance - reserve for plant improvement, | | | | 0 | 58.00 |
| _ 5. 55 | replacement, and expansion | | | | | - 3. 33 |
| 59.00 | Total fund balances (sum of lines 52 thru 58) | 47, 256, 593 | 0 | 0 | 0 | 59.00 |
| 60.00 | Total liabilities and fund balances (sum of lines 51 and | 52, 798, 532 | 0 | 0 | 0 | 60.00 |
| | [59] | I | | | | l |
| | | | | | | |

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0146

| Peri od: | Worksheet G-1 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared:

| | | | | | 10 12/31/2 | 5/18/2023 1 | repared: 11:21 am |
|------------------|---|-----------|--------------------------|----------|--------------|-------------|----------------------|
| | | General | Fund | Speci al | Purpose Fund | Endowment | |
| | | | | | | Fund | |
| | | 1. 00 | 2. 00 | 3.00 | 4.00 | 5. 00 | |
| 1. 00 | Fund balances at beginning of period | 1.00 | 43, 267, 227 | 3.00 | 4.00 | 0 3.00 | 1.00 |
| 2.00 | Net income (loss) (from Wkst. G-3, line 29) | | 3, 048, 990 | | | o l | 2.00 |
| 3. 00 | Total (sum of line 1 and line 2) | | 46, 316, 217 | | | o | 3.00 |
| 4.00 | HO INTEREST EXPENSE | 562, 644 | | | 0 | | 0 4.00 |
| 5.00 | | O | | | 0 | | 0 5.00 |
| 6.00 | | 0 | | | 0 | | 0 6.00 |
| 7. 00 | | 0 | | | 0 | | 0 7.00 |
| 8. 00 | | 0 | | | 0 | | 0 8.00 |
| 9.00 | T-1-1 | 0 | F/O /44 | | 0 | | 0 9.00 |
| 10. 00 11. 00 | Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) | | 562, 644 46, 878, 861 | | | 0 | 10. 00 11. 00 |
| 12. 00 | ASSET TRANSFERS | -377, 732 | 40, 070, 001 | | 0 | ٩ | 0 12.00 |
| 13. 00 | ASSET TRANSFERS | -377, 732 | | | 0 | | 0 13.00 |
| 14. 00 | | | | | 0 | | 0 14.00 |
| 15. 00 | | o | | | 0 | | 0 15.00 |
| 16.00 | | o | | | 0 | | 0 16.00 |
| 17.00 | | o | | | 0 | | 0 17.00 |
| 18.00 | Total deductions (sum of lines 12-17) | | -377, 732 | | | 0 | 18. 00 |
| 19. 00 | Fund balance at end of period per balance | | 47, 256, 593 | | | 0 | 19. 00 |
| | sheet (line 11 minus line 18) | Endowment | DI ont | Fund | | | |
| | | Fund | Prant | Fund | | | |
| | | Turiu | | | | | |
| | | 6. 00 | 7.00 | 8. 00 | | | |
| 1.00 | Fund balances at beginning of period | 0 | | | 0 | | 1.00 |
| 2.00 | Net income (loss) (from Wkst. G-3, line 29) | | | | | | 2.00 |
| 3. 00 4. 00 | Total (sum of line 1 and line 2) HO INTEREST EXPENSE | 0 | 0 | | 0 | | 3. 00 4. 00 |
| 4. 00 5. 00 | HO INTEREST EXPENSE | | 0 | | | | 5.00 |
| 6. 00 | | | 0 | | | | 6.00 |
| 7. 00 | | | 0 | | | | 7.00 |
| 8. 00 | | | 0 | | | | 8.00 |
| 9.00 | | | 0 | | | | 9. 00 |
| 10.00 | Total additions (sum of line 4-9) | o | | | 0 | | 10.00 |
| 11.00 | Subtotal (line 3 plus line 10) | 0 | | | 0 | | 11. 00 |
| 12.00 | ASSET TRANSFERS | | 0 | | | | 12. 00 |
| 13.00 | | | 0 | • | | | 13. 00 |
| 14.00 | | | 0 | | | | 14.00 |
| 15.00 | | | 0 | | | | 15.00 |
| 16. 00 17. 00 | | | 0 | | | | 16. 00 17. 00 |
| 18.00 | Total deductions (sum of lines 12-17) | o | U | | 0 | | 18.00 |
| 19. 00 | Fund balance at end of period per balance | | | | 0 | | 19. 00 |
| 50 | sheet (line 11 minus line 18) | | | | | | |
| | | , | ' | | • | | • |

0

0 24.00

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-0146 Peri od: Worksheet G-2 From 01/01/2022 Parts I & II Date/Time Prepared: 12/31/2022 5/18/2023 11:21 am Cost Center Description I npati ent Outpati ent Total 1.00 2.00 3.00 PART I - PATIENT REVENUES General Inpatient Routine Services 1.00 Hospi tal 10, 723, 625 10, 723, 625 1.00 SUBPROVIDER - IPF 2.00 0 2.00 0 SUBPROVIDER - IRF 3.00 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 OTHER LONG TERM CARE 9.00 0 0 9.00 10.00 Total general inpatient care services (sum of lines 1-9) 10, 723, 625 10, 723, 625 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 14.00 SURGICAL INTENSIVE CARE UNIT 0 14.00 15.00 OTHER SPECIAL CARE (SPECIFY) 15.00 16.00 Total intensive care type inpatient hospital services (sum of lines 0 0 16.00 11-15)17.00 Total inpatient routine care services (sum of lines 10 and 16) 10, 723, 625 10, 723, 625 17.00 18.00 Ancillary services 40, 423, 425 40, 423, 425 18.00 Outpatient services 185, 114, 094 19.00 0 185, 114, 094 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 0 22.00 23. 00 AMBULANCE SERVICES 0 24, 123, 687 24, 123, 687 23.00

| 24. 10 CORF 0 0 25. 00 AMBULATORY SURGICAL CENTER (D. P.) 0 0 26. 00 HOSPICE 0 0 27. 00 OTHER (SPECIFY) 0 0 | 0 24. 10 0 25. 00 0 26. 00 0 27. 00 , 831 28. 00 |
|---|--|
| 26. 00 HOSPI CE 0 0 | 0 26.00 0 27.00 |
| | 0 27.00 |
| 27. 00 OTHER (SPECIFY) 0 0 | |
| | 831 28.00 |
| 28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 51,147,050 209,237,781 260,384 | |
| PART II - OPERATING EXPENSES | |
| 29. 00 Operating expenses (per Wkst. A, column 3, line 200) 64, 282, 728 | 29. 00 |
| 30.00 PROVISION FOR BAD DEBT 5, 409, 368 | 30.00 |
| 31.00 HOME OFFICE INTEREST EXPENSE 562,644 | 31.00 |
| 32.00 | 32.00 |
| 33. 00 | 33.00 |
| 34. 00 | 34.00 |
| 35. 00 | 35.00 |
| 36.00 Total additions (sum of lines 30-35) 5,972,012 | 36.00 |
| 37. 00 DEDUCT (SPECIFY) 0 0 | 37.00 |
| 38. 00 | 38.00 |
| 39. 00 | 39.00 |
| 40. 00 | 40.00 |
| 41. 00 | 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 to Wkst. G-3, line 4) | 43.00 |

24. 00 CMHC

| Health Financial Systems | COMMUNITY HOSPITAL OF | NOBLE CTY, INC | In Lie | u of Form CMS-2552-10 |
|------------------------------------|-----------------------|-----------------------|----------|-----------------------|
| STATEMENT OF REVENUES AND EXPENSES | | Provider CCN: 15-0146 | Peri od: | Worksheet G-3 |

| | Triancial Systems Common Triancial Systems | | III LI C | u or rorm cm3-2 | |
|--------|---|-------------|---------------|--------------------------------|--------|
| STATEM | STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-0146 Period: From 01/01/2022 | | | Worksheet G-3 | |
| | | | To 12/31/2022 | | pared: |
| | | | | 5/18/2023 11: | |
| | | | | | |
| | | | | 1. 00 | |
| 1. 00 | Total patient revenues (from Wkst. G-2, Part I, column 3, lir | | | 260, 384, 831 188, 947, 280 | 1.00 |
| 2.00 | Less contractual allowances and discounts on patients' accounts | | | | 2.00 |
| 3.00 | | | | 71, 437, 551 | 3.00 |
| 4.00 | Less total operating expenses (from Wkst. G-2, Part II, line 43) | | | 70, 254, 740 | 4. 00 |
| 5. 00 | Net income from service to patients (line 3 minus line 4) | | | 1, 182, 811 | 5.00 |
| | OTHER I NCOME | | | 1 | |
| 6. 00 | Contributions, donations, bequests, etc | | | 0 | 6. 00 |
| 7. 00 | Income from investments | | | 8, 340 | 1 |
| 8.00 | Revenues from telephone and other miscellaneous communication | ı servi ces | | 0 | 8. 00 |
| 9. 00 | Revenue from television and radio service | | | 0 | 9. 00 |
| | 00 Purchase discounts | | | 0 | 10.00 |
| | 00 Rebates and refunds of expenses | | | 0 | 11. 00 |
| | Parking lot receipts | | | 0 | 12.00 |
| | 00 Revenue from laundry and linen service | | | 0 | 13.00 |
| | No Revenue from meals sold to employees and guests | | | 231, 342 | |
| | 0 Revenue from rental of living quarters | | | 0 | |
| | 00 Revenue from sale of medical and surgical supplies to other than patients | | | 0 | 16. 00 |
| | 00 Revenue from sale of drugs to other than patients | | | 0 | 17. 00 |
| | 00 Revenue from sale of medical records and abstracts | | | 0 | 18. 00 |
| | 00 Tuition (fees, sale of textbooks, uniforms, etc.) | | | 0 | 19. 00 |
| | 00 Revenue from gifts, flowers, coffee shops, and canteen | | | 0 | 20.00 |
| | Rental of vending machines | | | 0 | 21.00 |
| | 0 Rental of hospital space | | | 0 | 22. 00 |
| 23.00 | Governmental appropriations | | | 0 | 23. 00 |
| 24.00 | EMS SUBSI DY | | | 595, 278 | 24.00 |
| 24.01 | OTHER REVENUE | | | 1, 031, 219 | 24. 01 |
| 24.50 | COVI D-19 PHE Fundi ng | | | 0 | 24.50 |
| | Total other income (sum of lines 6-24) | | | 1, 866, 179 | |
| 26.00 | Total (line 5 plus line 25) | | | 3, 048, 990 | 26. 00 |
| 27.00 | OTHER EXPENSES (SPECIFY) | | | 0 | 27. 00 |
| 28. 00 | Total other expenses (sum of line 27 and subscripts) | | | 0 | 28. 00 |
| 29. 00 | 00 Net income (or loss) for the period (line 26 minus line 28) | | | 3, 048, 990 | 29.00 |

| Heal th | Financial Systems | COMMUNITY HOSPITAL OF | NOBLE CTY, INC | In Lie | u of Form CMS-2 | 2552-10 |
|--------------------------------|---|----------------------------|--|--|-----------------|---------|
| CALCULATION OF CAPITAL PAYMENT | | Provider CCN: 15-0146 | Peri od: From 01/01/2022 To 12/31/2022 | Worksheet L Parts I-III Date/Time Pre 5/18/2023 11: | | |
| | | | Title XVIII | Hospi tal | PPS | |
| | | | | | | |
| | PART I - FULLY PROSPECTIVE METHOD | | | | 1. 00 | |
| | CAPITAL FEDERAL AMOUNT | | | | | 1 |
| 1. 00 | Capital DRG other than outlier | | | | 1, 816 | 1.00 |
| 1. 01 | Model 4 BPCI Capital DRG other tha | n outlier | | | 0 | 1.00 |
| 2. 00 | Capital DRG outlier payments | ar odti i ci | | | 0 | 2.00 |
| 2. 01 | Model 4 BPCI Capital DRG outlier p | avments | | | 0 | 2. 01 |
| 3. 00 | Total inpatient days divided by nu | | reporting period (see ins | structions) | 13. 16 | |
| 4. 00 | Number of interns & residents (see | | sharing harren (and and | | 0.00 | |
| 5. 00 | Indirect medical education percent | | | | 0.00 | |
| 6. 00 | Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and | | | 0 | 6.00 | |
| | 1.01) (see instructions) | | | | | |
| 7. 00 | 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 | Percentage of Medicaid patient day | s to total days (see instr | ructions) | | 0.00 | 8.00 |
| 9. 00 | Sum of Lines 7 and 8 | | | 0.00 | 9.00 | |
| | Allowable disproportionate share percentage (see instructions) | | | 0.00 | 10.00 | |
| 11.00 | Disproportionate share adjustment (see instructions) | | | 0 | 11.00 | |
| 12.00 | 2.00 Total prospective capital payments (see instructions) | | | 1, 816 | 12.00 | |
| | | | | | 1. 00 | |
| | PART II - PAYMENT UNDER REASONABLE | COST | | | 1.00 | |
| 1.00 | Program inpatient routine capital | cost (see instructions) | | | 0 | 1.00 |
| 2.00 | Program inpatient ancillary capital cost (see instructions) | | | | 0 | 2.00 |
| 3.00 | Total inpatient program capital cost (line 1 plus line 2) | | 0 | 3.00 | | |
| 4.00 | Capital cost payment factor (see instructions) | | | 0 | 4.00 | |
| 5. 00 | Total inpatient program capital co | st (line 3 x line 4) | | | 0 | 5.00 |
| | | | | | 1. 00 | |
| | PART III - COMPUTATION OF EXCEPTIO | N PAYMENTS | | | | |
| 1. 00 | Program inpatient capital costs (s | | | | 0 | 1.00 |
| 2.00 | Program inpatient capital costs fo | r extraordinary circumstar | nces (see instructions) | | 0 | 2.00 |
| 3.00 | Net program inpatient capital cost | | | | 0 | 3.00 |
| 4.00 | Applicable exception percentage (see instructions) | | | 0.00 | 4.00 | |

0

0

0

0

0

0

0

0

0 16.00

0 17.00

0.00

5.00

6.00

8.00

9. 00 10. 00

11.00

12.00

13.00

14.00

15.00

5.00

6.00

8.00

9.00

10.00

11.00

12.00

13.00

14.00

15.00

16.00

Capital cost for comparison to payments (line 3 x line 4)

(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)

Capital minimum payment level (line 5 plus line 7)

Worksheet L, Part III, line 14)

Percentage adjustment for extraordinary circumstances (see instructions)

Current year allowable operating and capital payment (see instructions)

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

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

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

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

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

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