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: 15-0035 Worksheet S Peri od: From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 6/22/2023 2:56 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 6/22/2023 2:56 pm use only ] Manually prepared cost report ] 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. [5] Cost Report Status 6. Date Received: 10. NPR Date: 11. Contractor's Vendor Code: 4
(2) Settled without Audit 8. [N] Initial Report for this Provider CCN 12. [0] If line 5, column 1 is 4: Enter 13. Settled with Audit 9. [N] Final Report for this Provider CCN 14. [N] Initial Report for this Provider CCN 15. [N] Final Report for this Provider CCN 16. NPR Date: 11. Contractor's Vendor Code: 4. In Contractor's V Contractor use only

number of times reopened = 0-9.

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

(3) Settled with Audit

(4) Reopened (5) Amended

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

CERTIFICATION BY 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 PORTER REGIONAL HOSPITAL (15-0035) 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	CHECKBOX	ELECTRONI C	
	1	2	SI GNATURE STATEMENT	
1			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			2
3	Signatory Title			3
4	Date			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						
1.00	HOSPI TAL	0	219, 588	-49, 458	0	0	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2.00
3.00	SUBPROVI DER - I RF	0	-74, 963	-67		0	3. 00
5.00	SWING BED - SNF	0	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6. 00
200.00	TOTAL	0	144, 625	-49, 525	0	0	200.00

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

Heal th	lealth Financial Systems PORTER REGIONAL HOSPITAL In Lieu of Form CMS-2552-10								2552-10		
	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provi d	ler CC	N: 15-		Peri od:		Workshe	et S-2	
							From 01/01/2022   Part   To 12/31/2022   Date/Time Prepa				nared·
									6/22/20		
	1.00	2.00		3. 00				1. 00			
1. 00	Hospital and Hospital Health Care Co Street: 85 EAST US HIGHWAY 6	mplex Address: PO Box:	_								1. 00
2.00	City: VALPARAISO	State: IN	Zip Code	e: 463	383	Count	y: PORTER				2.00
	1-1-1-J	Component Name	CCN	CBS		Provi der		Paymer	nt Syst	em (P,	
		·	Number	Numl	ber	Type	Certi fi ed		0, or		
		1.00	0.00		00	1.00	5.00	V	XVIII		
	Hospital and Hospital-Based Componen	1.00	2. 00	3. (	00	4. 00	5. 00	6. 00	7. 00	8. 00	
3. 00	Hospi tal	PORTER REGIONAL	150035	238	344	1	07/01/1966	N	Р	0	3. 00
		HOSPI TAL									
4.00	Subprovider - IPF										4. 00
5.00		PORTER REHAB UNIT	15T035	238	344	5	01/01/2009	N	P	0	5. 00
6. 00 7. 00	Subprovider - (Other) Swing Beds - SNF	PORTER SWING BEDS	15U035	238	244		01/01/2020	N	P	0	6. 00 7. 00
8. 00	Swing Beds - NF	I OKTEK SWING BEBS	130033	230	,44		0170172020	114	'		8.00
9.00	Hospi tal -Based SNF										9. 00
10.00	Hospital-Based NF										10. 00
11.00	Hospi tal -Based OLTC				l						11. 00
12. 00 13. 00	Hospi tal -Based HHA Separately Certified ASC										12. 00 13. 00
	Hospi tal -Based Hospi ce				ŀ						14. 00
15. 00	Hospital -Based Health Clinic - RHC				İ						15. 00
16.00	Hospital-Based Health Clinic - FQHC										16. 00
17. 00	Hospital-Based (CMHC) I				ŀ						17. 00
18. 00 19. 00	Renal Dialysis				ł						18. 00 19. 00
19.00	other						From:		То		19.00
							1. 00		2.0		
	Cost Reporting Period (mm/dd/yyyy)						01/01/20	022	12/31/	2022	20.00
21.00	Type of Control (see instructions)						4				21. 00
						1. 00	2. 00		3. C	00	
	Inpatient PPS Information										
22. 00	Does this facility qualify and is it					Υ	N				22. 00
	disproportionate share hospital adju: §412.106? In column 1, enter "Y" fo			(							
	facility subject to 42 CFR Section §										
	hospital?) In column 2, enter "Y" fo										
22. 01	Did this hospital receive interim UC					N	N				22. 01
	this cost reporting period? Enter in for the portion of the cost reporting										
	1. Enter in column 2, "Y" for yes or										
	cost reporting period occurring on o										
	instructions)										
22. 02	Is this a newly merged hospital that determined at cost report settlement			LIMP		N	N				22. 02
	1, "Y" for yes or "N" for no, for the			uiiiii							
	period prior to October 1. Enter in			no,							
	for the portion of the cost reporting										
22. 03	Did this hospital receive a geograph rural as a result of the OMB standard					N	N		N		22. 03
	adopted by CMS in FY2015? Enter in co										
	for the portion of the cost reporting	g period prior to Octobe	r 1. Ente								
	in column 2, "Y" for yes or "N" for										
	reporting period occurring on or after Does this hospital contain at least			ıc.							
	counted in accordance with 42 CFR 41.										
	yes or "N" for no.		-,								
22. 04	Did this hospital receive a geograph										22. 04
	rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in										
	for the portion of the cost reporting										
	in column 2, "Y" for yes or "N" for										
	reporting period occurring on or after	er October 1. (see instr	uctions)								
	Does this hospital contain at least										
	counted in accordance with 42 CFR 41, yes or "N" for no.	z. 105)? EHLEF IN COLUMN	ა, Y T	UI							
23. 00	Which method is used to determine Me	dicaid days on lines 24	and/or 25	5			3 N				23. 00
	below? In column 1, enter 1 if date	of admission, 2 if censu	s days, c	or 3							
	if date of discharge. Is the method			cost							
	reporting period different from the reporting period? In column 2, ente										
	,g po oa 111 ooi amii 2, - ciite				1		1	1			'

Health Financial Systems PORTER REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0035 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 6/22/2023 2:56 pm XVIII XIX 1. 00 2.00 3.00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I Ν 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. Y/N IMF Direct GME IME Direct GME 2. 00 3. 00 4.00 5.00 1 00 61.00 Did your hospital receive FTE slots under ACA Ν 0.00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61 03 Enter the base line FTE count for primary care 61 03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary 61.05 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 2.00 1.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0 00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01

during in this cost reporting period of HRSA THC program. (see instructions)

Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

63.00

Teaching Hospitals that Claim Residents in Nonprovider Settings

Woolth Financial Systems	DODTED	REGIONAL HOSPITAL		ln lio	u of Form CMS 1	0552 10
Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMP			CN: 15-0035 Pe	eri od:	u of Form CMS-2 Worksheet S-2	
				om 01/01/2022	Part I	pared:
		<u> </u>	Unwei ghted	Unwei ghted	Ratio (col. 1/	,
			FTEs Nonprovi der	FTEs in Hospital	(col. 1 + col. 2))	
			Si te	2.00	2.00	
Section 5504 of the ACA Base Yea	ur ETE Pasidants in No	onnrovider Settings	1.00	2.00	3.00	
period that begins on or after J			illi s base year	13 your cost i	epor tring	
64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in your of (column 1 divided by (column)	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter in	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0. 00	0. 000000	64. 00
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
	1. 00	2.00	Si te 3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63	1.00	2.00	0.00	0. 00		65.00
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	Unwei ghted	Ratio (col. 1/	
			FTĔs	FTEs in	(col. 1 + col.	
			Nonprovi der	Hospi tal	2))	
			Si te	2.00	2.00	
Section 5504 of the ACA Current	Vaar ETE Dasidants in	n Nonnrovider Settings	1.00	2.00	3.00	
beginning on or after July 1, 20		i Nonprovider Setting.	3LifeCtive ic	n cost reporti	ng perrous	
66.00 Enter in column 1 the number of		y care resident	0.00	0. 00	0. 000000	66. 00
FTEs attributable to rotations of						
Enter in column 2 the number of						
FTEs that trained in your hospit (column 1 divided by (column 1 +						
(cordini r drvrded by (cordini r r	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
	. 3	3 2222	FTEs	FTEs in	(col. 3 + col.	
			Nonprovi der	Hospi tal	4))	
			Si te			
(7.00 E.)	1. 00	2. 00	3.00	4. 00	5.00	<u> </u>
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0. 00	0. 000000	67.00

	Financial Systems PORTER REGIONAL HOSPITAL AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN:	F	In Period: From 01/01/2 To 12/31/2	1022 1022	of Form Workshee Part I Date/Tir 6/22/202	et S-2 me Pre	pared:		
					1. 0	0			
68. 00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-4907: For a cost reporting period beginning prior to October 1, 2022, did you obta MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final (August 10, 2022)?	ain permissi	on from your		N		68. 00		
			-	1. 00	2. 00	3. 00			
	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain	n an IPE suh	nrovi der2	N			70. 00		
71. 00	Enter "Y" for yes or "N" for no.  If line 70 is yes: Column 1: Did the facility have an approved GME teaching recent cost report filed on or before November 15, 2004? Enter "Y" for yes 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes (ourn 3: If column 2 is Y, indicate which program year began during this concept instructions)  Inpatient Rehabilitation Facility PPS	program in or "N" for n a new teac or "N" for	the most no. (see hi ng no.	IV.		0	71. 00		
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it cont	tain an IRF		Υ			75. 00		
76. 00	subprovider? Enter "Y" for yes and "N" for no.  If line 75 is yes: Column 1: Did the facility have an approved GME teaching recent cost reporting period ending on or before November 15, 2004? Enter "No. Column 2: Did this facility train residents in a new teaching program in CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If coindicate which program year began during this cost reporting period. (see in	y for yes o n accordance olumn 2 is Y	r "N" for with 42	N	N	0	76. 00		
					1. 0	0			
80. 00 81. 00	81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.								
85. 00 86. 00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter " Did this facility establish a new Other subprovider (excluded unit) under 42 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			10.	N		85. 00 86. 00		
87. 00	Is this hospital an extended neoplastic disease care hospital classified und 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	der section			N		87. 00		
			Approved n Permanen Adjustmen (Y/N)	nt	Number Appro Permar Adjustm 2.0	ved ent ents			
	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 89. (see instructions)  Column 2: Enter the number of approved permanent adjustments.				2.0		88. 00		
	V	Wkst. A Line No.	Effective I	Date	Appro Permar Adjusti Amount Discha	ment Ment Per			
89. 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	1. 00	2.00		3. 0		89. 00		
	on which the per discharge permanent adjustment approval was based.  Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge.  Column 3: Enter the amount of the approved permanent adjustment to the	0. 0				0	84.00		
	TEFRA target amount per discharge.		V		XI X	(			
	Title V and XIX Services		1. 00		2. 0	0			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Ente	er "Y" for	N		Υ		90. 00		
91.00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report $\epsilon$	either in	N		Υ		91. 00		
92.00	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification	n)? (see			N		92. 00		
	instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and )	XIX? Enter	N		N		93. 00		
94. 00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no i	in the	N		N		94. 00		
96. 00	applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no i	in the	0. 00 N		O. O	0	95. 00 96. 00		
	applicable column. If line 96 is "Y", enter the reduction percentage in the applicable column.		0. 00		0.00	0	97. 00		

116. 00

117. 00

118. 00

N

"N" for no.

116.00 Is this facility classified as a referral center? Enter "Y" for yes or

117.00 is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.

118.00|s the mal practice insurance a claims-made or occurrence policy? Enter 1

if the policy is claim-made. Enter 2 if the policy is occurrence.

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.

Health Financial Systems	PORTER REGION	NAL HOSPITAL		I	n Lieu	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC	CN: 15-0035	Peri od: From 01/01/ To 12/31/		Worksheet S- Part I Date/Time Pr 6/22/2023 2:	epared:
					-	1. 00	-
147.00 Was there a change in the statist	cal hasis? Enter "V" for	ves or "N" for	no			1.00 N	147. 00
148.00 Was there a change in the order of						N	148. 00
149.00 Was there a change to the simplif				or no.		N	149. 00
	<u> </u>	Part A	Part B		V	Title XIX	
		1.00	2.00	3.00		4. 00	
Does this facility contain a prov or charges? Enter "Y" for yes or							
155. 00 Hospi tal		N	N	N		N	155. 00
156.00 Subprovi der - IPF		N	N	N		N	156. 00
157. 00 Subprovi der – I RF		N	N	N		N	157. 00
158. 00 SUBPROVI DER							158. 00
159. 00 SNF		N	N N	N		N	159. 00
160.00 HOME HEALTH AGENCY 161.00 CMHC		N	l N l N	N N		N N	160. 00 161. 00
181. OUICWING			IN	11		IN	161.00
						1. 00	
Mul ti campus							
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has or	ne or more campu	uses in dif	ferent CBSAs?	'	N	165. 00
	Name	County			BSA	FTE/Campus	
	0	1. 00	2. 00	3. 00 4.	. 00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0. 0	00 166. 00
						1.00	4
Health Information Technology (HI	T) incentive in the Americ	can Recovery and	d Reinvestm	ent Act		1. 00	
167.00 Is this provider a meaningful use				CITE ACE		Υ	167. 00
168.00 If this provider is a CAH (line 10 reasonable cost incurred for the	05 is "Y") and is a meanir	ngful user (line		'), enter the	•		168. 00
168.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	not a meaningful user, doe	es this provider			'		168. 01
169.00 If this provider is a meaningful transition factor. (see instruction	user (line 167 is "Y") and				the	9. 9	99169.00
				Begi nni		Endi ng	
				1. 00	)	2. 00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	peginning date and ending	date for the re	eporting				170. 00
				1. 00	)	2. 00	
171.00 If line 167 is "Y", does this prosection 1876 Medicare cost plans "Y" for yes and "N" for no in column 2. (s	reported on Wkst. S-3, Pt. umn 1. If column 1 is yes,	I, line 2, col	. 6? Enter	N			0 171. 00

Health Financial Systems PORTER REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0035 Peri od: Worksheet S-2 From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 6/22/2023 2:56 pm Y/N Date 1. 00 2.00 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 1 00 Has the provider changed ownership immediately prior to the beginning of the cost N 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 2.00 Ν 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 Υ 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) Y/N Date Type 2.00 1.00 3.00 Financial Data and Reports
Column 1: Were the financial statements prepared by a Certified Public 4 00 4 00 N 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 5 00 5 00 Ν those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper. 1.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider 6.00 the legal operator of the program? 7 00 Are costs claimed for Allied Health Programs? If "Y" see instructions. 7 00 Were nursing programs and/or allied health programs approved and/or renewed during the N 8.00 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 Ν 9.00 program in the current cost report? If yes, see instructions.

Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 Ν 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved Ν 11.00 Teaching Program on Worksheet A? If yes, see instructions. Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting 13.00 Ν 13.00 period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions 15.00 Part B Y/N Y/N Date 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? Υ 03/23/2023 03/23/2023 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) 17.00 Was the cost report prepared using the PS&R Report for 17 00 N N 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) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed Ν Ν 18.00 but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Ν Ν 19.00 Report data for corrections of other PS&R Report information? If yes, see instructions.

Heal th	Financial Systems PORTER REGION	NAL HOSPITAL		In Lie	u of Form CMS-	-2552-10	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider 0	CN: 15-0035	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S-: Part II Date/Time Pro 6/22/2023 2:	epared:	
		Descr	iption	Y/N	Y/N		
00	1011 47 47 1		0	1.00	3. 00	100	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00	
		Y/N	Date	Y/N	Date		
		1.00	2. 00	3. 00	4. 00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00	
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS I	HOSPI TALS)				
	Capital Related Cost						
22. 00	Have assets been relifed for Medicare purposes? If yes, se		N	22. 00			
23. 00	Have changes occurred in the Medicare depreciation expense	ing the cost	N	23. 00			
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter-	porting period?	N	24. 00			
	If yes, see instructions						
25. 00	Have there been new capitalized leases entered into during	the cost repo	rting period?	If yes, see	N	25. 00	
26. 00	instructions.  Were assets subject to Sec. 2314 of DEFRA acquired during to	f yes, see	N	26. 00			
27. 00	instructions. Has the provider's capitalization policy changed during the	N	27. 00				
27.00	copy.	e cost reportin	ig perrou: II	yes, subili t	IV		
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit e	ntered into du	ring the cost	reporting	N	28. 00	
	period? If yes, see instructions.		· ·	. 0			
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		ebt Service F	eserve Fund)	N	29. 00	
30. 00	Has existing debt been replaced prior to its scheduled matinistructions.		debt? If yes	, see	N	30. 00	
31. 00	Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes	, see	N	31. 00	
	instructions. Purchased Services						
32. 00	Have changes or new agreements occurred in patient care se		ed through co	ntractual	Υ	32. 00	
33. 00	arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 approximately see instructions.		ng to competi	tive bidding? If	Υ	33. 00	
	Provi der-Based Physi ci ans						
34. 00	Were services furnished at the provider facility under an	arrangement wi	th provider-b	ased physicians?	Y	34. 00	
35. 00	If yes, see instructions.  If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see in		nts with the	provi der-based	Υ	35. 00	
	phrysicians during the cost reporting period: IT yes, see it	nstructions.		Y/N	Date		
				1. 00	2. 00		
0	Home Office Costs			1		٠	
36. 00 37. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	repared by the	home office?	Y		36. 00 37. 00	
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of	fice different	from that of	N	12/31/2021	38. 00	
	the provider? If yes, enter in column 2 the fiscal year en	d of the home	offi ce.				
39. 00	If line 36 is yes, did the provider render services to other see instructions.	er cnarn compor	ients? IT yes	, N		39. 00	
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00	
		1	. 00	2	00	_	
	Cost Report Preparer Contact Information			2.			
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	· ·					
42. 00	respectively. Enter the employer/company name of the cost report	COMMUNITY HEAL	_TH SYSTEMS			42. 00	
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-925-4333		VI CTORI A_ROMANI	KO@CHS. NET	43. 00	
	· · · · · · · · · · · · · · · · · · ·			1			

Health Financial Systems PORTER REGI	ONAL HOSPITAL	In Lie	u of Form CMS-2552	2-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0035	Peri od: From 01/01/2022 To 12/31/2022		
	3. 00			
Cost Report Preparer Contact Information				
41.00 Enter the first name, last name and the title/position	REVENUE MANAGER		41	1.00
held by the cost report preparer in columns 1, 2, and 3,				
respecti vel y.				
42.00 Enter the employer/company name of the cost report			42	2. 00
preparer.				
43.00 Enter the telephone number and email address of the cost			43	3. 00
report preparer in columns 1 and 2, respectively.				

 
 Heal th Financial
 Systems
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 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 | Peri od: | Worksheet S-3 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: Provider CCN: 15-0035

				Т	o 12/31/2022	Date/Time Prep 6/22/2023 2:50	
						I/P Days / 0/P	O pili
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Li ne No.		Avai I abl e			
		1.00	2.00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA				<u> </u>		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	153	62, 379	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7.00	Total Adults and Peds. (exclude observation		153	62, 379	0.00	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31.00				1	8. 00
8. 01	NEONATAL INTENSIVE CARE UNIT	31. 01	14	5, 110	0.00	0	8. 01
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00 13. 00	OTHER SPECIAL CARE (SPECIFY)	42.00				o	12. 00 13. 00
14. 00	NURSERY	43. 00	199	79, 169	0.00		14.00
15. 00	Total (see instructions) CAH visits		199	79, 109	0.00		15. 00
16. 00	SUBPROVIDER - IPF					U	16. 00
17. 00	SUBPROVIDER - I RF	41. 00	14	5, 110		o	17. 00
18. 00	SUBPROVI DER	41.00	14	3, 110		O I	18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27.00	Total (sum of lines 14-26)		213				27. 00
28.00	Observation Bed Days					0	28. 00
29.00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)		10	3, 650			32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges						33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	0	0		0	34. 00

| Period: | Worksheet S-3 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: | 6/22/2023 2:56 pm

					-	6/22/2023 2:5	6 pm
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA					•	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	17, 119	907	46, 652			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)	14, 998	8, 984				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO I RF Subprovi der	586	346	0.40			4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	203	0	243			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF	17 222	0	47, 005			6.00
7. 00	Total Adults and Peds. (exclude observation	17, 322	907	46, 895			7. 00
9 00	beds) (see instructions) INTENSIVE CARE UNIT	2, 037	207	5, 987			8. 00
8. 00 8. 01	NEONATAL INTENSIVE CARE UNIT	2,037	48	2, 354			8. 01
9. 00	CORONARY CARE UNIT	o <sub>l</sub>	40	2, 334			9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		1, 102	2, 511			13. 00
14. 00	Total (see instructions)	19, 359	2, 264	57, 747		1, 150. 73	1
15. 00	CAH visits	0	2, 20 1	0,7,7.17		1, 100.70	15. 00
16. 00	SUBPROVIDER - IPF		1	_			16. 00
17. 00	SUBPROVIDER - IRF	2, 696	64	4, 173	0.00	16. 98	
18. 00	SUBPROVI DER	·		·			18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			11			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C			
27. 00	,		_		0. 00	1, 167. 71	
28. 00	Observation Bed Days		0	5, 753			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			575			30.00
31.00	Employee discount days - IRF		200	65			31.00
32.00	Labor & delivery days (see instructions)	0	222	583			32.00
32. 01	Total ancillary labor & delivery room			656	1		32. 01
33 UU	outpatient days (see instructions) LTCH non-covered days	0					33. 00
	LTCH non-covered days LTCH site neutral days and discharges	0					33. 00
	Temporary Expansion COVID-19 PHE Acute Care	0	o	C			34. 00
54.00	Temporary Expansion Covid 17 The Acute Care	Ч	Ч	C	11	I	1 37.00

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: 
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 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provider CCN: 15-0035

				10	) 12/31/2022	Date/IIMe Pre    6/22/2023 2:50	
		Full Time Equivalents		Di sch	arges	0, 22, 2020 2. 0	<u> Б</u>
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	3, 703	1, 737	11, 088	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2. 00	for the portion of LDP room available beds) HMO and other (see instructions)			2, 252			2. 00
3.00	HMO IPF Subprovider			2, 252	0		3.00
4. 00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF				o <sub>l</sub>		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
8. 01	NEONATAL INTENSIVE CARE UNIT						8. 01
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	0	3, 703	1, 737	11, 088	14. 00
15. 00	CAH visits						15. 00
16.00	SUBPROVI DER - I PF	0.00		050	0.4	205	16.00
17. 00	SUBPROVIDER - I RF	0. 00	0	250	36	395	17. 00
18. 00 19. 00	SUBPROVI DER						18. 00 19. 00
20. 00	SKILLED NURSING FACILITY NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33. 00	LTCH non-covered days			О			33. 00
33. 00	LTCH site neutral days and discharges			0			33. 00
	Temporary Expansi on COVID-19 PHE Acute Care						34. 00
2 30	1 - 1 - 3	1		1	ı	l	

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0035

					To	12/31/2022	Date/Time Prep 6/22/2023 2:56	
		Wkst. A Line	Amount Reported	Reclassificati		Paid Hours Related to	Average Hourly Wage (col. 4 ÷	
		Number	керог геа	on of Salaries (from Wkst.	Salaries (col.2 ± col.	Salaries in	col. 5)	
		1. 00	2. 00	A-6) 3. 00	3) 4.00	<u>col . 4</u> 5. 00	6.00	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	3. 00	0.00	
1. 00	SALARIES Total salaries (see	200.00	92, 233, 719		92, 233, 719	2, 428, 841. 00	37. 97	1. 00
	instructions)	200.00			,			
2.00	Non-physician anesthetist Part A		0	C	0	0. 00	0. 00	2. 00
3.00	Non-physician anesthetist Part		0	C	0	0. 00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		386, 121	d	386, 121	1, 683. 00	229. 42	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0	0	1	0. 00 0. 00	1 1	4. 01 5. 00
6. 00	Physician-Part B Non-physician-Part B for		0	О	0	0.00	0. 00	6. 00
7. 00	hospital-based RHC and FQHC services Interns & residents (in an	21. 00	0	0	0	0. 00	0. 00	7. 00
7. 00	approved program) Contracted interns and	21.00	0		0	0.00		7. 01
	residents (in an approved programs)							
8. 00	Home office and/or related organization personnel	44.00	0	C	0	0.00		8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	1, 426, 860	0	-	0. 00 35, 475. 00	0. 00 40. 22	9. 00 10. 00
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient		24, 321, 346	O	24, 321, 346	186, 407. 00	130. 47	11. 00
12. 00	Care Contract Labor: Top Level		273, 478	C	273, 478	3, 152. 00	86. 76	12. 00
	management and other management and administrative services							
13. 00	Contract Labor: Physician-Part A - Administrative		339, 913	C	339, 913	2, 406. 00	141. 28	13. 00
14. 00	Home office and/or related organization salaries and		0	C	0	0.00	0. 00	14. 00
14. 01	wage-related costs Home office salaries		8, 287, 172	0	8, 287, 172	143, 517. 00	57 74	14. 01
14. 02	Related organization salaries		0, 207, 172	o o	0, 207, 172	0.00	0. 00	14. 02
15. 00	Home office: Physician Part A - Administrative		0	O	0	0. 00	0.00	15. 00
16. 00	Home office and Contract		0	C	0	0.00	0. 00	16. 00
16. 01	Physicians Part A - Teaching Home office Physicians Part A		0	C	0	0. 00	0.00	16. 01
14 02	- Teaching Home office contract		0	0	0	0.00	0.00	16. 02
10. 02	Physicians Part A - Teaching				o o	0.00	0.00	10. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		24, 361, 004		24, 361, 004			17. 00
18. 00	instructions) Wage-related costs (other)		,		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			18. 00
19. 00	(see instructions) Excluded areas		376, 156	0	376, 156			19. 00
20. 00	Non-physician anesthetist Part		0	O	0			20. 00
21. 00	Non-physician anesthetist Part		0	C	0			21. 00
22. 00	Physician Part A - Administrative		24, 758	C	24, 758			22. 00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0	0	0			22. 01 23. 00
24.00	Wage-related costs (RHC/FQHC)		0					24.00
25. 00	Interns & residents (in an approved program)		0	0	0			25. 00
25. 50	Home office wage-related		1, 474, 191	О	1, 474, 191			25. 50
25. 51	(core) Related organization		0	0	o			25. 51
25. 52	wage-related (core) Home office: Physician Part A		0					25. 52
∠J. J∠	- Administrative - wage-related (core)		U					20.02

					To	o 12/31/2022	Date/Time Prep 6/22/2023 2:50	
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE							
26. 00	Employee Benefits Department	4. 00	482, 652	0	482, 652	·		
27. 00	Administrative & General	5. 00	9, 161, 893	-269, 920		·		
28. 00	Administrative & General under		504, 984	0	504, 984	12, 384. 00	40. 78	28.00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00		29. 00
30. 00	Operation of Plant	7. 00	2, 260, 457	0	2, 260, 457			
31. 00	Laundry & Linen Service	8. 00	4, 320	0	4, 320			
32. 00	Housekeepi ng	9. 00	81, 778	0	81, 778	·		
33. 00	Housekeeping under contract		2, 941, 957	0	2, 941, 957	125, 596. 98	23. 42	33.00
	(see instructions)							
34. 00	Di etary	10. 00	94, 253	-46, 480	·	·		34.00
35. 00	Di etary under contract (see		1, 797, 789	0	1, 797, 789	69, 468. 00	25. 88	35. 00
	instructions)		_					
36. 00	Cafeteri a	11. 00	0	46, 480	46, 480	·		
37. 00	Maintenance of Personnel	12. 00	0	0	0	0.00		
38. 00	Nursing Administration	13. 00	4, 251, 920	269, 920				
39. 00	Central Services and Supply	14. 00	981, 535	0	981, 535	·		
40. 00	Pharmacy	15. 00	2, 990, 400	0	2, 990, 400	·		40.00
41. 00	Medical Records & Medical	16. 00	897, 612	0	897, 612	32, 769. 00	27. 39	41. 00
	Records Li brary							
42. 00	Soci al Servi ce	17. 00	917, 596	0	917, 596	·		42.00
43. 00	Other General Service	18. 00	0	0	0	0.00	0. 00	43.00

					'	0 12/01/2022	6/22/2023 2: 50	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	$(col.2 \pm col.$	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		97, 478, 449	0	97, 478, 449	2, 636, 289. 98	36. 98	1.00
	instructions)							
2.00	Excluded area salaries (see		1, 426, 860	0	1, 426, 860	35, 475. 00	40. 22	2.00
	instructions)							
3.00	Subtotal salaries (line 1		96, 051, 589	0	96, 051, 589	2, 600, 814. 98	36. 93	3.00
	minus line 2)							
4.00	Subtotal other wages & related		33, 221, 909	0	33, 221, 909	335, 482. 00	99. 03	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		25, 859, 953	0	25, 859, 953	0.00	26. 92	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		155, 133, 451	0	155, 133, 451	2, 936, 296. 98	52. 83	6. 00
7.00	Total overhead cost (see		27, 369, 146	0	27, 369, 146	903, 906. 98	30. 28	7. 00
	instructions)							

Health Financial Systems	PORTER REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-003	
		From 01/01/2022   Part IV
		To 12/21/2022 Data/Time Propagate

	To 12/31/2023	2 Date/Time Pre 6/22/2023 2:5	
		Amount	D PIII
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	1, 881, 141	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	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	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	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)	15, 106, 915	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	141, 398	10. 00
11. 00	Life Insurance (If employee is owner or beneficiary)	41, 869	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)	187, 451	
14. 00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00	'Workers' Compensation Insurance	579, 620	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumulative portion)		
47.00	TAXES	5 040 07/	4- 00
17. 00	FICA-Employers Portion Only	5, 343, 076	
18. 00	Medicare Taxes - Employers Portion Only	1, 249, 590	18. 00
19. 00	Unemployment Insurance	0	19.00
20. 00	State or Federal Unemployment Taxes OTHER	230, 858	20. 00
21 00		-1 0	21 00
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))	0	21. 00
22. 00	Day Care Cost and Allowances	0	22. 00
23. 00	Tuition Reimbursement	0	23. 00
24. 00		24, 761, 918	
24.00	Part B - Other than Core Related Cost	24, 701, 910	24.00
25 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
25.00	Totale mod replace soots (or contr)	I	20.00

Health Financial Systems	PORTER REGIONAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	F	eriod: rom 01/01/2022 o 12/31/2022	Worksheet S-3 Part V Date/Time Prep 6/22/2023 2:50	pared:
Cost Center Description		Contract Labor	Benefit Cost	
		1. 00	2. 00	
PART V - Contract Labor and Benefit Cost				

		07 227 2020 2.0	O PIII
Cost Center Description	Contract Labor	Benefit Cost	
	1. 00	2. 00	
PART V - Contract Labor and Benefit Cost			
Hospital and Hospital-Based Component Identification:			
Total facility's contract labor and benefit cost	24, 321, 346	24, 761, 918	1. 00
Hospi tal	24, 321, 346	24, 761, 918	2. 00
SUBPROVI DER - I PF			3. 00
SUBPROVI DER - I RF	0	0	4. 00
Subprovider - (Other)	0	0	5. 00
Swing Beds - SNF	0	0	6. 00
Swing Beds - NF	0	0	7. 00
SKILLED NURSING FACILITY			8. 00
NURSING FACILITY			9. 00
OTHER LONG TERM CARE I			10.00
Hospi tal -Based HHA			11. 00
AMBULATORY SURGICAL CENTER (D. P. ) I			12.00
Hospi tal -Based Hospi ce			13. 00
Hospital-Based Health Clinic RHC			14. 00
Hospital-Based Health Clinic FQHC			15. 00
Hospi tal -Based-CMHC			16. 00
RENAL DIALYSIS I	0	0	17. 00
Other	0	0	18. 00
	PART V - Contract Labor and Benefit Cost Hospital and Hospital-Based Component Identification: Total facility's contract labor and benefit cost Hospital SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER - IRF Subprovider - (Other) Swing Beds - SNF Swing Beds - NF SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE I Hospital-Based HHA AMBULATORY SURGICAL CENTER (D.P.) I Hospital-Based Hospice Hospital-Based Health Clinic RHC Hospital-Based Health Clinic FOHC Hospital-Based-CMHC RENAL DIALYSIS I	PART V - Contract Labor and Benefit Cost Hospital and Hospital-Based Component Identification:  Total facility's contract labor and benefit cost  Usubprovi Der - IPF SUBPROVI DER - IPF SUBPROVI DER - IRF Subprovi der - (Other) Swing Beds - SNF SKILLED NURSING FACILITY NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE I Hospital-Based HHA AMBULATORY SURGICAL CENTER (D. P. ) I Hospital-Based Health Clinic RHC Hospital-Based Health Clinic FQHC Hospital-Based-CMHC RENAL DIALYSIS I  O 1.00  1.	Cost Center Description  PART V - Contract Labor and Benefit Cost  Hospital and Hospital - Based Component Identification:  Total facility's contract Labor and benefit cost  Bubprovider - IPF Subprovider - (Other) Swing Beds - SNF Swing Beds - SNF SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE I Hospital - Based Heal th Clinic RHC Hospital - Based Heal th Clinic FOHC Hospital - Based - CMHC RENAL DIALYSIS I  Contract Labor Benefit Cost 1.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2

HUNPI	Financial Systems PORTER REGIONAL HOSPI			u of Form CMS-2	
	TAL UNCOMPENSATED AND INDIGENT CARE DATA Prov	vider CCN: 15-0035	Peri od: From 01/01/2022	Worksheet S-10	)
			To 12/31/2022		pared: 6 pm
				1. 00	
	Uncompensated and indigent care cost computation				
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided	ed by line 202 colum	n 8)	0. 125575	1. 00
2. 00	Medicaid (see instructions for each line)  Net revenue from Medicaid		49, 989, 491	2. 00	
3. 00	Did you receive DSH or supplemental payments from Medicaid?		Υ Υ	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental	ai d?	Y	4. 00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from I	Medi cai d		0	5. 00
6.00	Medicaid charges			344, 363, 272	
7. 00 8. 00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program (line	a 7 minus sum of li	nes 2 and 5: if	43, 243, 418 0	7. 00 8. 00
0.00	<pre>&lt; zero then enter zero)</pre>	ie / iiii iius suiii oi iii	nes 2 and 5, 11	l	0.00
	Children's Health Insurance Program (CHIP) (see instructions for ea	ach line)			
9.00	Net revenue from stand-alone CHIP			0	9. 00
10.00	Stand-alone CHIP charges			385	
11. 00 12. 00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (line	e 11 minus line 0.	if / zero then	48	11. 00 12. 00
12.00	enter zero)	ic ii iii iid3 i iiic 7,	TT \ ZCTO then		12.00
	Other state or local government indigent care program (see instruc-				
13.00	Net revenue from state or local indigent care program (Not included				13.00
14. 00	Charges for patients covered under state or local indigent care pro-	ogram (Not included	lin lines 6 or	0	14. 00
15. 00	State or local indigent care program cost (line 1 times line 14)			o	15. 00
16. 00	Difference between net revenue and costs for state or local indiger	nt care program (li	ne 15 minus line	0	
	13; if < zero then enter zero)				
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)	nd state/local indi	gent care program	is (see	
17. 00	Private grants, donations, or endowment income restricted to funding			0	
18.00	Government grants, appropriations or transfers for support of hospi		(£ 1!	0	
19. 00	Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)	idi gent care program	is (sum or lines	48	19. 00
	10/ 12 did 10/	Uni nsured	Insured	<b>-</b>	
		patients	pati ents	Total (col. 1	
				+ col . 2)	
	Uncomposed to (coo instructions for each line)	1.00	2. 00		
20. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility		2. 00	+ col . 2) 3.00	20, 00
20. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions)		2. 00	+ col . 2) 3.00	20. 00
	Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts	ty 15, 692, 7	2. 00	+ col . 2) 3. 00 15, 793, 517	
20. 00	Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions)	ty 15, 692, 7	2. 00 776 100, 741 520 100, 741	+ col . 2) 3.00 15, 793, 517 2, 071, 361	21. 00
	Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off	ty 15, 692, 7	2. 00 776 100, 741 520 100, 741	+ col . 2) 3.00 15, 793, 517 2, 071, 361	21. 00
21. 00	Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions)	ty 15, 692, 7	2. 00 776 100, 741 520 100, 741 060 0	+ col . 2) 3.00 15,793,517 2,071,361 24,060	21. 00 22. 00
21. 00 22. 00	Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care	ty 15, 692, 7 (see 1, 970, 6	2. 00 776 100, 741 520 100, 741 060 0	+ col. 2) 3.00 15,793,517 2,071,361 24,060 2,047,301	21. 00 22. 00
21. 00 22. 00 23. 00	Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)	ty 15, 692, 7 (see 1, 970, 6 as 24, 0 1, 946, 5	2. 00 776 100, 741 620 100, 741 660 0 660 100, 741	+ col. 2) 3.00 15,793,517 2,071,361 24,060 2,047,301	21. 00 22. 00 23. 00
21. 00 22. 00 23. 00	Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient day	ty 15, 692, 7 (see 1, 970, 6 as 24, 0 1, 946, 5	2. 00 776 100, 741 620 100, 741 660 0 660 100, 741	+ col. 2) 3.00 15,793,517 2,071,361 24,060 2,047,301	21. 00 22. 00
21. 00 22. 00 23. 00 24. 00	Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)	ty 15,692,7 (see 1,970,6 as 24,0 1,946,5 lays beyond a length	2.00  776 100, 741  920 100, 741  960 0  9660 100, 741	+ col. 2) 3.00 15,793,517 2,071,361 24,060 2,047,301	21. 00 22. 00 23. 00 24. 00
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00	Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient di imposed on patients covered by Medicaid or other indigent care proi If line 24 is yes, enter the charges for patient days beyond the instay limit Total bad debt expense for the entire hospital complex (see instructions)	ty 15,692,7 (see 1,970,6 as 24,0 1,946,5 ays beyond a length gram? ndigent care progra	2.00  776 100, 741  920 100, 741  960 0  9660 100, 741	+ col. 2) 3.00  15, 793, 517 2, 071, 361 24, 060 2, 047, 301  1.00 N 0 12, 220, 305	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00	Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient dimposed on patients covered by Medicaid or other indigent care profif line 24 is yes, enter the charges for patient days beyond the instay limit Total bad debt expense for the entire hospital complex (see instrumed and complex is the complex of the entire hospital complex (see	ty 15,692,7 (see 1,970,6 (as 24,0 1,946,5 (asys beyond a length ogram? ndigent care programations) (see instructions)	2.00  776 100, 741  920 100, 741  960 0  9660 100, 741	+ col. 2) 3.00  15, 793, 517 2, 071, 361 24, 060 2, 047, 301  1.00 N 0 12, 220, 305 380, 519	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01	Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient dimposed on patients covered by Medicaid or other indigent care proof of line 24 is yes, enter the charges for patient days beyond the install bad debt expense for the entire hospital complex (see instrumedicare reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see	ty 15,692,7 (see 1,970,6 (as 24,0 1,946,5 (asys beyond a length ogram? ndigent care programations) (see instructions)	2.00  776 100, 741  920 100, 741  960 0  9660 100, 741	+ col. 2) 3.00  15, 793, 517 2, 071, 361 24, 060 2, 047, 301  1.00 N 0 12, 220, 305 380, 519 585, 413	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00	Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient dimposed on patients covered by Medicaid or other indigent care proof of line 24 is yes, enter the charges for patient days beyond the instay limit Total bad debt expense for the entire hospital complex (see instructions)  Medicare allowable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	ty 15,692,7 (see 1,970,6 as 24,0 1,946,5 lays beyond a length gram? ndigent care programetions) lee instructions)	2.00  776 100,741  920 100,741  960 0  9660 100,741  9 of stay limit  9 m's length of	+ col. 2) 3.00  15, 793, 517 2, 071, 361 24, 060 2, 047, 301  1.00 N 0 12, 220, 305 380, 519 585, 413 11, 634, 892	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01	Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient dimposed on patients covered by Medicaid or other indigent care proof of line 24 is yes, enter the charges for patient days beyond the install bad debt expense for the entire hospital complex (see instrumedicare reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see	ty 15,692,7 (see 1,970,6 as 24,0 1,946,5 lays beyond a length gram? ndigent care programetions) lee instructions)	2.00  776 100,741  920 100,741  960 0  9660 100,741  9 of stay limit  9 m's length of	+ col. 2) 3.00  15, 793, 517 2, 071, 361 24, 060 2, 047, 301  1.00 N 0 12, 220, 305 380, 519 585, 413	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00

Heal th	Financial Systems	PORTER REGIONA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der C	CN: 15-0035 P	eri od:	Worksheet A	
					rom 01/01/2022	D 1 (T' D	
				1	o 12/31/2022		
	Coot Conton Decemintion	Colorios	O+box	Total (ool 1	Dool ooo! fi oo+!	6/22/2023 2:50	o piii
	Cost Center Description	Sal ari es	0ther		Reclassificati	Reclassified	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col. 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		-54, 742, 509	-54, 742, 509	6, 160, 443	-48, 582, 066	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		10, 264, 378	10, 264, 378	1, 213, 660	11, 478, 038	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	482, 652	260, 900	743, 552	18, 195, 105	18, 938, 657	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	9, 161, 893	91, 311, 882				
7. 00	00700 OPERATION OF PLANT	2, 260, 457	5, 526, 915			14, 138, 407	
8.00	00800 LAUNDRY & LINEN SERVICE	4, 320	1, 356, 158			1, 360, 478	1
9. 00	00900 HOUSEKEEPI NG	81, 778	5, 066, 404			5, 141, 471	1
10.00	01000 DI ETARY	94, 253	5, 393, 715			2, 678, 400	
		94, 203		1			
11.00	01100 CAFETERI A	4 054 000	0	1	,		
13. 00	01300 NURSI NG ADMI NI STRATI ON	4, 251, 920	558, 444			5, 070, 165	
14. 00	01400 CENTRAL SERVICES & SUPPLY	981, 535	26, 492, 630			2, 096, 568	
15. 00	01500 PHARMACY	2, 990, 400	34, 100, 913				
16. 00	01600 MEDICAL RECORDS & LIBRARY	897, 612	1, 354, 789			2, 252, 401	
17. 00	01700 SOCI AL SERVI CE	917, 596	689, 783	1, 607, 379	0	1, 607, 379	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	16, 900, 350	16, 675, 075	33, 575, 425	-201, 585	33, 373, 840	30. 00
31.00	03100 INTENSIVE CARE UNIT	6, 178, 954	8, 589, 106	14, 768, 060	-207, 758	14, 560, 302	31. 00
31.01	03101 NEONATAL INTENSIVE CARE UNIT	1, 742, 554	1, 072, 986	2, 815, 540	-28, 172	2, 787, 368	31. 01
41.00	04100 SUBPROVI DER - I RF	1, 424, 523	573, 046			1, 970, 404	
43. 00	04300 NURSERY	670	90, 117				
10.00	ANCI LLARY SERVI CE COST CENTERS	070	70, 117	70, 707	20, 107	07,000	10.00
50.00	05000 OPERATING ROOM	8, 692, 962	11, 108, 721	19, 801, 683	-2, 799, 216	17, 002, 467	50.00
51. 00	05100 RECOVERY ROOM	0,072,702	11, 100, 721	1	-2, 799, 210	17,002,407	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2 240 252	699, 713		-113, 720		
	05300 ANESTHESI OLOGY	2, 269, 252					
53.00		0 755 050	2, 870, 147			2, 870, 147	
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 755, 850	4, 566, 381	13, 322, 231	-2, 091, 800	11, 230, 431	
54. 01	05401 ULTRASOUND	0	0	0	0	0	
56. 00	05600 RADI OI SOTOPE	0	0	0	0	0	
57. 00	05700 CT SCAN	0	0	0	0	0	
58. 00	05800  MRI	0	0	0	0	0	
60.00	06000 LABORATORY	5, 648, 048	7, 576, 261				
65. 00	06500 RESPI RATORY THERAPY	2, 152, 056	2, 328, 930	4, 480, 986	-392, 536	4, 088, 450	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 961, 551	407, 498	2, 369, 049	-33, 469	2, 335, 580	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	896, 543	223, 538	1, 120, 081	-2, 648	1, 117, 433	67. 00
68.00	06800 SPEECH PATHOLOGY	649, 986	165, 799	815, 785	-48, 628	767, 157	68. 00
69.00	06900 ELECTROCARDI OLOGY	4, 190, 706	2, 985, 607	7, 176, 313	-769, 050	6, 407, 263	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0		3, 526, 132	3, 526, 132	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	20, 804, 273	20, 804, 273	
	07300 DRUGS CHARGED TO PATIENTS	127, 437	69, 705	197, 142			
74. 00	07400 RENAL DIALYSIS	180, 471	765, 625			937, 794	
	03950 ANCI LLARY	100, 171	700,020			0	
	03610 SLEEP LAB	0	0	0	o		76. 01
	03951 WOUND CARE	770 104	729, 703	1			
		770, 106	129, 103	1, 499, 009	-1, 645	1, 498, 164	
77. 00	07700 ALLOGENEI C HSCT ACQUISITION	U <sub>I</sub>		<u> </u>	U U	0	77. 00
00 00	OUTPATIENT SERVICE COST CENTERS	ما					00.00
90.00	09000 CLI NI C	7 5 4 0 4 7	7 200 (00	44 070 (05	F ( 004	0	
	09100 EMERGENCY	7, 564, 947	7, 308, 688	14, 873, 635	-56, 824	14, 816, 811	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS	-		_		_	
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		92, 231, 382	196, 441, 048	288, 672, 430	0	288, 672, 430	1118.00
	NONREI MBURSABLE COST CENTERS			1			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 337	468	1	0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
	19201 OTHER NONREI MBURSABLE	0	0	l 0	0		192. 01
	07950 NONREI MBURSABLE	0	0	0	0		194. 00
	07951   MARKETI NG	0	0	0	0	0	194. 01
	07952 SENI OR CI RCLE	0	0	0	o		194. 02
	07953 NONREIMB - REGENCY LTC	О	0	0	o	0	194. 03
	07954 VACANT UNFINISHED AREA	О	0	0	ol		194. 04
200.00		92, 233, 719	196, 441, 516	288, 675, 235	0	288, 675, 235	
					,		•

Heal th	Financial Systems	PORTER REGION	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CCN	: 15-0035	Peri od:	Worksheet A	
					From 01/01/2022 To 12/31/2022	Date/Time Pre	nared:
					10 12/31/2022	6/22/2023 2:5	
	Cost Center Description	Adjustments	Net Expenses				
			For Allocation				
	GENERAL SERVICE COST CENTERS	6. 00	7. 00				
1.00	00100 CAP REL COSTS-BLDG & FIXT	53, 949, 493	5, 367, 427				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	629, 626					2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	18, 938, 657				4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-4, 968, 345	72, 991, 112				5.00
7.00	00700 OPERATION OF PLANT	-226, 500	13, 911, 907				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	1, 360, 478				8. 00
9.00	00900 HOUSEKEEPI NG	0	5, 141, 471				9.00
10.00	01000 DI ETARY	0	2, 678, 400				10.00
11.00	01100 CAFETERI A	1 554	2, 605, 906				11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	1, 556 0	5, 071, 721 2, 096, 568				13. 00 14. 00
15. 00	01500 PHARMACY	0	3, 324, 557				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	2, 252, 401				16. 00
17. 00	01700 SOCIAL SERVICE	0	· · · · · · · · · · · · · · · · · · ·				17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		, , , , , ,				
30.00	03000 ADULTS & PEDI ATRI CS	-1, 731, 911	31, 641, 929				30.00
31.00	03100 INTENSIVE CARE UNIT	-2, 920, 626	11, 639, 676				31.00
31. 01	03101 NEONATAL INTENSIVE CARE UNIT	-755, 400	· · · · · · · · · · · · · · · · · · ·				31. 01
41.00	04100 SUBPROVI DER - I RF	0					41.00
43. 00	04300 NURSERY	0	67, 380				43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	-1, 453, 760	15, 548, 707				50.00
51.00	05100 RECOVERY ROOM	-1, 455, 760	15, 546, 707				51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	-105, 183					52.00
53.00	05300 ANESTHESI OLOGY	-2, 850, 966	· · · · · · · · · · · · · · · · · · ·				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-376, 918	10, 853, 513				54.00
54. 01	05401 ULTRASOUND	0	0				54. 01
56. 00	05600 RADI OI SOTOPE	0	0				56. 00
57. 00	05700 CT SCAN	0	0				57. 00
58. 00 60. 00	05800   MRI	-606	12, 712, 625				58. 00 60. 00
65. 00	06500 RESPI RATORY THERAPY	-606	4, 088, 450				65. 00
66. 00	06600 PHYSI CAL THERAPY	0	2, 335, 580				66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	1, 117, 433				67. 00
68. 00	06800 SPEECH PATHOLOGY	0	767, 157				68. 00
69. 00	06900 ELECTROCARDI OLOGY	-246, 850	6, 160, 413				69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	3, 526, 132				71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	20, 804, 273				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	32, 872, 740				73.00
74. 00 76. 00	07400 RENAL DI ALYSI S 03950 ANCI LLARY	0	937, 794				74. 00 76. 00
76. 00	03610 SLEEP LAB		0				76.00
76. 03	03951 WOUND CARE						76. 03
	07700 ALLOGENEIC HSCT ACQUISITION	0	1 1 1 1				77. 00
	OUTPATIENT SERVICE COST CENTERS	'	'				
	09000  CLI NI C	0	0				90.00
	09100 EMERGENCY	-4, 025, 949	10, 790, 862				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
400.00	OTHER REIMBURSABLE COST CENTERS						100.00
102.00	10200   OPIOI	0	0				102. 00
118. 00		34, 917, 661	323, 590, 091				118. 00
110.00	NONREI MBURSABLE COST CENTERS	34, 717, 001	323, 370, 071				1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2, 805				190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0				192. 00
	19201 OTHER NONREI MBURSABLE	0	0				192. 01
	07950 NONREI MBURSABLE	0	0				194. 00
	07951 MARKETI NG	0	0				194. 01
	07952 SENI OR CI RCLE	0	0				194. 02
	07953 NONREIMB - REGENCY LTC	0	0				194. 03
	07954 VACANT UNFINISHED AREA	0	0				194. 04
200.00	TOTAL (SUM OF LINES 118 through 199)	34, 917, 661	323, 592, 896				200. 00

Health Financial Systems RECLASSIFICATIONS | Period: | Worksheet A-6 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: 6/22/2023 2:56 pm Provider CCN: 15-0035

					6/22/2023 2	: 56 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2.00	3.00	4. 00	5. 00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	18, 202, 673		1.00
1.00	O DELL'ARCHITE	— — <del></del>	- — — <del>ŏ</del>	18, 202, 673		1.00
	C - RENTAL AND LEASE EXPENSES		<u> </u>	10, 202, 010		
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	3, 072, 078		1.00
2. 00	CAP REL COSTS-BUBB & TTAT	2. 00	o	1, 102, 048		2. 00
	•					1
3.00	ADMINISTRATIVE & GENERAL	5.00	0	129, 085		3. 00
4.00	EMERGENCY	91. 00	0	28, 280		4. 00
5.00	OPERATION OF PLANT	7. 00	0	74, 616		5. 00
6.00		0. 00	0	0		6. 00
7. 00		0. 00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11. 00		0.00	o	0		11. 00
12.00		0.00	o	0		12. 00
13.00		0.00	O	0		13. 00
.0.00		— — <del></del>	- — <del>-</del> -	4, 406, 107		10.00
	D - OTHER CAPITAL COSTS		<u> </u>	1, 100, 107		
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	526, 514		1.00
2. 00	CAP REL COSTS-BLDG & FIXT	1.00	o	2, 561, 851		2. 00
3. 00	CAP REL COSTS-MVBLE EQUIP		0	111, 612		3. 00
	O DEDALIDO AND MALNIFENANCE O	0070	0	3, 199, 977		$\perp$
	E - REPAIRS AND MAINTENANCE C		-			
1. 00	OPERATION OF PLANT	7. 00	0	5, 510, 060		1. 00
2.00	HOUSEKEEPI NG	9. 00	0	395		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	o	0		5. 00
6.00		0.00	o	0		6. 00
7. 00		0.00	O	0		7. 00
8. 00		0.00	o	0		8. 00
9. 00		0.00	o	0		9. 00
10. 00		0.00	0	0		1
				-		10.00
11.00		0.00	0	0		11.00
12. 00		0.00	0	0		12. 00
13.00		0.00	0	0		13. 00
14. 00		0. 00	0	0		14. 00
15.00		0.00	0	0		15. 00
16.00		0.00	0	0		16. 00
17.00		0.00	0	0		17. 00
18. 00		0.00	O	0		18. 00
19. 00		0.00	0	0		19. 00
. ,		— — <del></del>		5, 510, 455		17.00
	F - CHIEF NURSING OFFICER COS	Т	<u> </u>	0,010,100		
1.00	NURSI NG ADMI NI STRATI ON	13.00	269, 920	0		1.00
1.00	norsing Administration		269, 920	<u> </u>		1.00
	C MEDICAL SUDDILLES		207, 720	U		$\overline{}$
1 00	G - MEDICAL SUPPLIES	74 00	اء	0.507.400		1 00
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	3, 526, 132		1. 00
0.0-	PATI ENT		_	00 00 / ==		
2. 00	I MPL. DEV. CHARGED TO	72. 00	0	20, 804, 273		2. 00
	PATI ENTS					
3.00	OPERATING ROOM	5000	•_	55 <u>8, 1</u> 39		3. 00
	0		0	24, 888, 544		
	H - COST OF DRUGS/IV SOLUTION					
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	32, 735, 891		1. 00
				32, 735, 891		1
	M - DIETARY COSTS TO CAFETERI	A				
1.00	CAFETERI A	11.00	46, 480	2, 559, 426		1.00
50	0	— — ····° <del>y</del>	46, 480	2, 559, 426		100
	P - NON-CAPI TALI ZED EQUI PMENT		70, 400	2, 557, 420		
1 00	OPERATION OF PLANT	7. 00	0	744 250		1 00
1.00	OFERATION OF PLANT			766, 359		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3. 00
4.00		0. 00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	O	0		8. 00
9.00		0.00	O	0		9. 00
10.00		0.00	Ö	0		10.00
11. 00		0.00	o	0		11.00
12. 00		0.00	ő	0		12. 00
13. 00		0.00	o	0		13. 00
	I	0.00	9	٥	l	1 .3.00

Health Financial Systems RECLASSIFICATIONS PORTER REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 | Period: | Worksheet A-6 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: 6/22/2023 2:56 pm Provider CCN: 15-0035

					6/22/2023 2:56 pm
		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3. 00	4.00	5. 00	
14. 00		0.00	0	0	14. 00
15. 00		0.00	0	0	15. 00
16. 00		0.00	0	0	16. 00
17. 00		0.00	0	0	17. 00
18. 00		0.00	0	0	18. 00
19. 00		0.00	0	0	19. 00
20. 00		0.00	0	0	20.00
21. 00		0.00	0	0	21. 00
22. 00		0.00	0	0	22. 00
23. 00		0.00	0	0	23. 00
24. 00		0.00	0	0	24. 00
[	TOTALS		0	766, 359	
500.00	Grand Total: Increases		316, 400	92, 269, 432	500.00

Peri od: Worksheet ...
From 01/01/2022
To 12/31/2022 Date/Ti me Prepared: 6/22/2023 2:56 pm

		Decreases				0/22/2023 2.	T piii
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6.00	7. 00	8.00	9. 00	10.00		
	A - EMPLOYEE BENEFITS		0.00				
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	18, 202, 673	0		1.00
				18, 202, 673			
	C - RENTAL AND LEASE EXPENSES	;	· · · · · · · · · · · · · · · · · · ·	-, -, -			1
1.00	DI ETARY	10.00	0	12, 251	10		1. 00
2.00	CENTRAL SERVICES & SUPPLY	14.00	o	202	10		2. 00
3.00	PHARMACY	15. 00	o	872, 260	o		3. 00
4.00	ADULTS & PEDIATRICS	30.00	ol	121, 605	ol		4. 00
5. 00	INTENSIVE CARE UNIT	31.00	0	119, 157	o		5. 00
6. 00	SPEECH PATHOLOGY	68. 00	0	45, 761	ol		6. 00
7. 00	OPERATING ROOM	50.00	0	1, 557, 415	l ol		7. 00
8. 00	LABORATORY	60.00	0	257, 575	0		8. 00
9. 00	RESPIRATORY THERAPY	65. 00	0	325, 654	0		9. 00
10.00	ELECTROCARDI OLOGY	69.00	0	199, 993	0		10.00
	1	1	0	·	0		1
11. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	848, 689	0		11. 00
12.00	SUBPROVI DER – I RF	41.00	0	22, 665	0		12.00
13. 00	PHYSICAL THERAPY	6600		22, 880	0		13. 00
	0		0	4, 406, 107			_
4 00	D - OTHER CAPITAL COSTS	- aal		0 100 077	4.01		4
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	3, 199, 977	12		1. 00
2.00		0.00	0	0	13		2. 00
3.00		0.00	•	0	12		3. 00
	0		0	3, 199, 977			_
	E - REPAIRS AND MAINTENANCE C	OSTS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 380	0		1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	886, 682	0		2. 00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	60, 293	0		3. 00
4.00	DI ETARY	10.00	0	173, 063	0		4. 00
5.00	CENTRAL SERVICES & SUPPLY	14.00	o	302, 434	o		5. 00
6.00	PHARMACY	15. 00	o	157, 633	ol		6. 00
7.00	ADULTS & PEDIATRICS	30.00	ol	6, 346	ol		7. 00
8.00	INTENSIVE CARE UNIT	31.00	0	64, 741	o		8. 00
9. 00	NEONATAL INTENSIVE CARE UNIT	31. 01	ol	19, 659	ol		9. 00
10.00	NURSERY	43. 00	0	20, 134	o		10.00
11. 00	OPERATING ROOM	50.00	0	1, 623, 620	ol		11. 00
12. 00	EMERGENCY	91.00	0	58, 343	o o		12. 00
13. 00	DELIVERY ROOM & LABOR ROOM	52.00	0	80, 066	o		13. 00
14. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 204, 148	0		14. 00
15. 00	LABORATORY	1	0	233, 168	o		15. 00
	1	60.00	0	·	0		1
16.00	RESPIRATORY THERAPY	65. 00	0	60, 602	0		16.00
17. 00	SPEECH PATHOLOGY	68.00	0	1, 984	0		17. 00
18.00	ELECTROCARDI OLOGY	69.00	0	555, 167	0		18. 00
19. 00	PHYSI CAL THERAPY	6600		992	0		19. 00
	0		0	5, 510, 455			_
	F - CHIEF NURSING OFFICER COS				_1		4
1.00	ADMI NI STRATI VE & GENERAL		269, 920	$ \frac{0}{0}$	0		1. 00
	0		269, 920	0			_
	G - MEDICAL SUPPLIES						4
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	24, 888, 544			1. 00
2.00		0.00	0	0	0		2. 00
3.00		0.00	0	0	0		3. 00
	0		0	24, 888, 544			
	H - COST OF DRUGS/IV SOLUTION	IS					
1.00	PHARMACY	1500		32, 735, 891	o		1. 00
				32, 735, 891			1
	M - DIETARY COSTS TO CAFETERI	A					
1.00	DI ETARY	10.00	46, 480	2, 559, 426	0		1. 00
			46, 480	2, 559, 426			1
	P - NON-CAPITALIZED EQUIPMENT	•					П
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	84, 151	0		1. 00
2.00	CENTRAL SERVICES & SUPPLY	14.00	o	186, 417	o		2. 00
3.00	ADULTS & PEDIATRICS	30.00	ō	73, 634	o		3. 00
4. 00	OPERATING ROOM	50.00	ŏ	176, 320	l ol		4. 00
5. 00	DELIVERY ROOM & LABOR ROOM	52.00	o o	33, 654	l ol		5. 00
6. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	38, 963	0		6. 00
7. 00	LABORATORY	60.00		20, 335	o		7. 00
8. 00	PHYSI CAL THERAPY	66.00		20, 333 9, 597	0		8. 00
	1	69.00			0		9. 00
9.00	ELECTROCARDI OLOGY	l l		13, 890			1
10.00	SUBPROVI DER - I RF	41.00		4, 500			10.00
11. 00	NURSERY	43.00		3, 273	0		11. 00
12.00	EMERGENCY	91.00	O	26, 761	0		12.00
13.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	O	6, 188	0		13. 00
14.00	HOUSEKEEPI NG	9.00	0	7, 106	0		14.00
15. 00	DI ETARY	10. 00	0	18, 348	0		15. 00

Health Financial Systems RECLASSIFICATIONS PORTER REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 | Period: | Worksheet A-6 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: 6/22/2023 2:56 pm Provider CCN: 15-0035

						6/22/2023 2: 5	o pm
		Decreases					ı
	Cost Center Line # S		Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
16. 00	NURSING ADMINISTRATION	13. 00	0	10, 119	0		16. 00
17.00	PHARMACY	15. 00	0	972	2 0		17. 00
18.00	INTENSIVE CARE UNIT	31.00	0	23, 860	0		18. 00
19.00	NEONATAL INTENSIVE CARE UNIT	31. 01	0	8, 513	0		19. 00
20.00	RESPIRATORY THERAPY	65. 00	0	6, 280	0		20. 00
21.00	OCCUPATIONAL THERAPY	67. 00	0	2, 648	0		21. 00
22. 00	SPEECH PATHOLOGY	68. 00	0	883	0		22. 00
23.00	RENAL DIALYSIS	74. 00	0	8, 302	2 0		23. 00
24.00	WOUND CARE	76. 03	0	1, 645	0		24. 00
	TOTALS		0	766, 359			l
500.00	Grand Total: Decreases		316, 400	92, 269, 432			500. 00

				Ť	o 12/31/2022	Date/Time Prep 6/22/2023 2:50	
			<u> </u>	Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
1.00	Land	2, 949, 373	0	C	0	0	1. 00
2.00	Land Improvements	3, 714, 722	613, 430	C	613, 430	124, 430	2. 00
3.00	Buildings and Fixtures	166, 662, 282	79, 821	C	79, 821	0	3. 00
4.00	Building Improvements	9, 039, 270	3, 175, 413	C	3, 175, 413	48, 317	4. 00
5.00	Fixed Equipment	7, 231, 864	264, 276	C	264, 276	14, 100	5. 00
6.00	Movable Equipment	68, 148, 971	5, 368, 921	C	5, 368, 921	3, 468, 072	6. 00
7.00	HIT designated Assets	17, 083, 251	0	C	0	91, 951	7. 00
8.00	Subtotal (sum of lines 1-7)	274, 829, 733	9, 501, 861	C	9, 501, 861	3, 746, 870	8. 00
9.00	Reconciling Items	0	0	C	0	0	9. 00
10.00	Total (line 8 minus line 9)	274, 829, 733	9, 501, 861	C	9, 501, 861	3, 746, 870	10.00
		Endi ng Bal ance	Fully				
			Depreciated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	2, 949, 373	0				1. 00
2.00	Land Improvements	4, 203, 722	0				2. 00
3.00	Buildings and Fixtures	166, 742, 103	0				3. 00
4.00	Building Improvements	12, 166, 366	0				4. 00
5.00	Fixed Equipment	7, 482, 040	0				5. 00
6.00	Movable Equipment	70, 049, 820	0				6. 00
7.00	HIT designated Assets	16, 991, 300	0				7. 00
8.00	Subtotal (sum of lines 1-7)	280, 584, 724	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	280, 584, 724	o				10. 00

Heal th	Financial Systems	PORTER REGION	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-0035	Peri od:	Worksheet A-7	
					From 01/01/2022 To 12/31/2022		nared:
					10 12/31/2022	6/22/2023 2:5	6 pm
			Sl	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	instructions)	
		9. 00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORL	KSHEET A, COLUM	N 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FLXT	-54, 742, 509	0		0 0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	10, 264, 378	0	)	0	0	2.00
3.00	Total (sum of lines 1-2)	-44, 478, 131	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	·	Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	-54, 742, 509				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	10, 264, 378	8			2. 00
3.00	Total (sum of lines 1-2)	0	-44, 478, 131				3. 00

Heal th	n Financial Systems	PORTER REGION	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet A-7 Part III Date/Time Pre 6/22/2023 2:50	pared:
		COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	<u> Б.</u>
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col			
		1. 00	2.00	2) 3, 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		2.00	3.00	4.00	3.00	
1.00	CAP REL COSTS-BLDG & FLXT	186, 061, 563	С	186, 061, 56	3 0. 663121	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	94, 523, 161	0	94, 523, 16	1 0. 336879	0	2. 00
3.00	Total (sum of lines 1-2)	280, 584, 724		280, 584, 72			3. 00
		ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
		/ 00	d Costs	through 7)	0.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	6.00	7. 00	8. 00	9. 00	10. 00	
1. 00	CAP REL COSTS-BLDG & FLXT	I		1	0 -54, 419, 657	2, 377, 049	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0			0 10, 894, 004		2.00
3.00	Total (sum of lines 1-2)	0		i	0 -43, 525, 653		3. 00
			Sl	JMMARY OF CAPI		-, -, -, -	
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
		11.00	10.00	10.00	instructions)	45.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	11.00	12. 00	13.00	14. 00	15. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	54, 321, 670	526, 514	2, 561, 85	1 0	5, 367, 427	1. 00
2.00	CAP REL COSTS-MUBLE EQUIP	0 34, 321, 070			0 0		2.00
3.00	Total (sum of lines 1-2)	54, 321, 670		1			
				, , , , , , , , , ,	-1	, , , , , , , , , ,	

					o 12/31/2022	Date/Time Prep 6/22/2023 2:56	
				Expense Classification on		0/22/2023 2.30	o piii
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	<u>,                                      </u>	1.00	2. 00	3.00	4. 00	5. 00	
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1. 00
2. 00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by	В	40E 020	CAP REL COSTS-BLDG & FIXT	1.00		6. 00
	suppliers (chapter 8)	Ь	-095, 029	CAP REL CUSTS-BLDG & FIXT			
7. 00	Tel ephone services (pay stations excluded) (chapter 21)		0		0.00	0	7. 00
8.00	Television and radio service (chapter 21)	А	-226, 500	OPERATION OF PLANT	7. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -14, 530, 349		0.00	0	9. 00 10. 00
	adj ustment			RADI OLOGY-DI AGNOSTI C	F4 00		
11. 00	Sale of scrap, waste, etc. (chapter 23)	В			54.00	0	11. 00
12. 00	Related organization transactions (chapter 10)	A-8-1	58, 606, 758			0	
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests		0		0. 00 0. 00		13. 00 14. 00
15. 00	Rental of quarters to employee and others		0		0.00	О	15. 00
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0.00	0	17. 00
18. 00	patients Sale of medical records and		0		0.00	0	18. 00
19. 00	abstracts Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
20. 00	books, etc.) Vending machines		0		0.00	0	20. 00
21. 00	Income from imposition of interest, finance or penalty		0		0.00	o	21. 00
22. 00	overpayments and borrowings to		0		0.00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	COSTS-BLDG & FLXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00	•	29. 00 30. 00
30.00	therapy costs in excess of	A-0-3	U	OCCUPATIONAL THERAPT	67.00		30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see instructions)	A	-5, 820	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32. 00
	Depreciation and Interest TRAINING REVENUE	В	1 556	NURSING ADMINISTRATION	13. 00		33. 00
	1 IN INC. NEVENOE	ا ت	1, 550	P.S. STRO ABMINISTRATION	13.00	<u>ા</u> બ	

					0 12/31/2022	6/22/2023 2:50	
				Expense Classification on	Worksheet A	072272020 2.0	O PIII
				To/From Which the Amount is			
					,		
					_		
	Cost Center Description	Basis/Code (2)		Cost Center		Wkst. A-7 Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
33. 01	MISC. NON PATIENT REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	-	33. 01
33. 02	NON-ALLOWABLE LEGAL FEES	A		ADMINISTRATIVE & GENERAL	5. 00		33. 02
33. 03	INTERNS ANDRESIDENTS COST	A	-12, 141	ADMINISTRATIVE & GENERAL	5. 00	0	33. 03
33. 05	PATIENT TV DEPRECIATION	A	-1, 580	CAP REL COSTS-MVBLE EQUIP	2.00	9	33. 05
33. 06	MARKETI NG	A	-391, 643	ADMINISTRATIVE & GENERAL	5. 00	0	33. 06
33. 07	PHYSICIAN RECRUITING	A	-245, 014	ADMINISTRATIVE & GENERAL	5. 00	0	33. 07
33. 08	LOBBYING EXPENSE IN	A	-17, 115	ADMINISTRATIVE & GENERAL	5. 00	0	33. 08
	ASSOCIATION DUES						
33. 11	MI NORI TY I NTEREST	A	-7, 547, 606	ADMINISTRATIVE & GENERAL	5. 00	0	33. 11
33. 12	CHARI TY	A	-8, 300	ADMINISTRATIVE & GENERAL	5. 00	0	33. 12
33. 16	SENI OR CIRCLE	A	-1, 105	ADMINISTRATIVE & GENERAL	5. 00	0	33. 16
33. 17	COMMUNITY PROGRAMS	A	-20, 917	ADMINISTRATIVE & GENERAL	5. 00	0	33. 17
50.00	TOTAL (sum of lines 1 thru 49)		34, 917, 661				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

- (1) Description all chapter references in this column pertain to CMS Pub. 15-1. (2) Basis for adjustment (see instructions).

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

  B. Amount Received if cost cannot be determined.

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

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

				10 12/31/2022	6/22/2023 2:50	
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount	<u> </u>
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
1.00		CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	298, 108	0	1.00
2.00	2. 00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	626, 044	0	2.00
3.00	5. 00	ADMINISTRATIVE & GENERAL	NON-CAPITAL HOME OFFICE COST	11, 652, 350	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	Capital-Related Interest	729, 098	0	4. 00
4.01		CAP REL COSTS-BLDG & FIXT	PASI Capital Costs - Bldg &	24, 744		4. 01
4.02		CAP REL COSTS-MVBLE EQUIP	PASI Capital Costs - Moveabl	5, 162		4. 02
4.03		ADMINISTRATIVE & GENERAL	PASI Operating Costs	1, 765, 059		4. 03
4.04		ADMINISTRATIVE & GENERAL	Shared Service Center Alloca	6, 282, 547		4. 04
4.08		ADMINISTRATIVE & GENERAL	Malpractice Costs	1, 469, 337		4. 08
4. 09		CAP REL COSTS-BLDG & FIXT	Interest Expense	0	-53, 592, 572	4. 09
4. 10		ADMINISTRATIVE & GENERAL	Management Fees	0	7, 482, 897	4. 10
4. 11		ADMINISTRATIVE & GENERAL	401K Fees	0	4, 900	4. 11
4. 12	1	ADMINISTRATIVE & GENERAL	Audi t Fees	0	129, 679	4. 12
4. 13	1	ADMINISTRATIVE & GENERAL	Corporate Overhead Allocatio	0	2, 661, 413	4. 13
4. 14		ADMINISTRATIVE & GENERAL	HIIM Allocation	0	1, 182, 684	4. 14
4. 15		ADMINISTRATIVE & GENERAL	Contract Management	0	258, 295	4. 15
4. 16		ADMINISTRATIVE & GENERAL	PASI Lien Unit Collection Fe		138, 193	4. 16
5.00	TOTALS (sum of lines 1-4).			22, 852, 449	-35, 754, 309	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.

1103 110 0	been posted to worksheet A,	cor anno r anazor 2, tric anioar	it arrowabic 3ii	oura be marcated in cordilli 4	or this part.	
				Related Organization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	
	1. 00	2. 00	3.00	4. 00	5. 00	
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

rembursement under title Aviii.		
6. 00 B	0. 00 CHS	100.00 6.00
7. 00	0.00	0.00 7.00
8. 00	0.00	0.00 8.00
9. 00	0.00	0.00 9.00
10. 00	0.00	0.00 10.00
100.00 G. Other (financial or		100.00
non-financial) specify:		

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

					6/22/2023 2: 50	<u>6 pm</u>
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6. 00	7. 00				
	A. COSTS INCUR	RED AND ADJUSTM	ENTS REQUIRED AS A RESULT OF T	RANSACTIONS WITH RELATED O	RGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:				
1.00	298, 108	9				1.00
2.00	626, 044	9				2.00
3.00	11, 652, 350	0				3.00
4.00	729, 098	11				4.00
4.01	24, 744	. 9				4. 01
4.02	5, 162	9				4. 02
4.03	492, 354	0				4.03
4.04	3, 363, 225	0				4.04
4.08	-318, 838	0				4. 08
4.09	53, 592, 572	11				4. 09
4. 10	-7, 482, 897	o			1	4. 10
4. 11	-4, 900	o			1	4. 11
4. 12	-129, 679	o			1	4. 12
4. 13	-2, 661, 413				1	4. 13
4.14	-1, 182, 684				1	4. 14
4. 15	-258, 295					4. 15
4. 16	-138, 193					4. 16
5.00	58, 606, 758					5. 00
	•					

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

Related Organization(s)					
and/or Home Office					
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.

i ei iiibui	Termidul Sement under title AVIII.						
	HOME OFFICE		6. 00				
7.00			7.00				
8.00			8.00				
9.00			9.00				
10.00		10	10.00				
100.00		100	00.00				

- (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.
- $\hbox{\it C. Provider has financial interest in corporation, partnership, or other organization.}\\$
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

| Period: | Worksheet A-8-2 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0035

						To 12/31/2022	Date/Time Prepared: 6/22/2023 2:56 pm	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
					·		Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00		ADULTS & PEDIATRICS	1, 726, 091	1, 726, 091		1		
2.00		INTENSIVE CARE UNIT	2, 920, 626			0		
3.00		NEONATAL INTENSIVE CARE UNIT	755, 400			0	0	
4.00		OPERATING ROOM	1, 453, 760			0	0	
5. 00		DELIVERY ROOM & LABOR ROOM	105, 183			0	0	0.00
6.00	53. 00 ANESTHESI OLOGY		2, 850, 966				0	
7.00	54. 00 RADI OLOGY-DI AGNOSTI C		376, 918				0	
8.00	69. 00 ELECTROCARDI OLOGY		246, 850				0	
9.00	60. 00 LABORATORY		606	•			0	,, ,,
10.00		ADMINISTRATIVE & GENERAL EMERGENCY	68, 000				0	
11. 00 200. 00	91.00	EMERGENCY	4, 025, 949 14, 530, 349			) U	0	
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
	WKSt. A LITTE #	I denti fi er	Li mi t		Memberships &		of Malpractice	
		ruentiffei	Limit	Li mi t	Continuing	Share of col.	Insurance	
					Education	12	Trisur unce	
	1. 00	2.00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00	30.00	ADULTS & PEDIATRICS	0	(	) C	0	0	1. 00
2.00	31. 00	INTENSIVE CARE UNIT	0	(	o c	0	0	2. 00
3.00	31. 01 NEONATAL INTENSIVE CARE UNIT		0	(	o c	0	0	3. 00
4.00	50.00 OPERATING ROOM		0	(	) c	0	0	4. 00
5.00	52.00 DELIVERY ROOM & LABOR ROOM		0	(	) c	0	0	5. 00
6.00	53. 00 ANESTHESI OLOGY		0	(	) c	0	0	
7. 00	54. 00 RADI OLOGY-DI AGNOSTI C		0	(	) C	0	0	
8.00		ELECTROCARDI OLOGY	0	(	0	0	0	
9. 00		LABORATORY	0	(	0	0	0	,
10.00		ADMINISTRATIVE & GENERAL	0	(	0	0	0	
11. 00	91.00	EMERGENCY	0	(			0	
200.00	MI . A	0 1 0 1 (D)	0	(		·	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provider Component	Adjusted RCE	RCE	Adjustment		
		Identi fi er	Share of col.	Limit	Di sal I owance			
			14					
	1.00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADULTS & PEDIATRICS	0					1. 00
2.00		INTENSIVE CARE UNIT	0			1	•	2. 00
3.00	31. 01 NEONATAL INTENSIVE CARE UNIT		0		ol c	755, 400		3. 00
4.00	50. 00 OPERATI NG ROOM		0		ol c	1, 453, 760		4.00
5.00	52. OO DELIVERY ROOM & LABOR ROOM		0	(	o c	105, 183		5. 00
6.00	53. 00 ANESTHESI OLOGY		0	(	) c	2, 850, 966		6. 00
7.00	54. 00 RADI OLOGY-DI AGNOSTI C		0	(	) c	376, 918		7. 00
8.00	69. 00 ELECTROCARDI OLOGY		0	(	) c	246, 850	)	8. 00
9.00		LABORATORY	0	1	) C	606	•	9. 00
10.00		ADMINISTRATIVE & GENERAL	0		) C	68, 000	•	10.00
11. 00	91. 00	EMERGENCY	0		1	1,,	•	11. 00
200.00			0	(	O  C	14, 530, 349	1	200. 00

	Financial Systems	PURIER REGIONA				u oi foill cws-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der Co		Peri od:	Worksheet B	
					rom 01/01/2022	Part I	
					o 12/31/2022	Date/Time Prep	
						6/22/2023 2: 5	6 pm
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	<b>'</b>	for Cost			BENEFITS		
		Allocation			DEPARTMENT		
		(from Wkst A					
		col . 7)					
		0	1.00	2.00	4. 00	4A	
	GENERAL SERVICE COST CENTERS			•	<u> </u>		
1.00	00100 CAP REL COSTS-BLDG & FIXT	5, 367, 427	5, 367, 427				1.00
			3,307,427	1			
2.00	00200 CAP REL COSTS-MVBLE EQUIP	12, 107, 664		12, 107, 664			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	18, 938, 657	21, 844	49, 275	19, 009, 776		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	72, 991, 112	269, 815	608, 640	1, 842, 319	75, 711, 886	5.00
7.00	00700 OPERATION OF PLANT	13, 911, 907	1, 469, 267	l		19, 163, 839	7. 00
							•
8.00	00800 LAUNDRY & LINEN SERVICE	1, 360, 478	7, 827	l		1, 386, 856	
9.00	00900 HOUSEKEEPI NG	5, 141, 471	50, 573	114, 082	16, 944	5, 323, 070	9. 00
10.00	01000 DI ETARY	2, 678, 400	159, 654	360, 142	9, 898	3, 208, 094	10.00
11.00	01100 CAFETERI A	2, 605, 906	. 0	1		2, 615, 536	
	01300 NURSING ADMINISTRATION		ū				
13. 00		5, 071, 721	31, 571	1		6, 111, 384	
14.00	01400 CENTRAL SERVICES & SUPPLY	2, 096, 568	107, 590	242, 699	203, 363	2, 650, 220	14. 00
15. 00	O1500 PHARMACY	3, 324, 557	60, 595	136, 688	619, 578	4, 141, 418	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	2, 252, 401	20, 960	47, 280	185, 975	2, 506, 616	
17. 00	01700 SOCIAL SERVICE	1, 607, 379	2, 407	1		1, 805, 332	
17.00		1,007,379	2, 407	3, 430	190, 110	1, 600, 332	17.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	T					ļ
30. 00	03000 ADULTS & PEDIATRICS	31, 641, 929	843, 440	1, 902, 603	3, 501, 531	37, 889, 503	30.00
31.00	03100 INTENSIVE CARE UNIT	11, 639, 676	159, 564	359, 939	1, 280, 211	13, 439, 390	31.00
31. 01	03101 NEONATAL INTENSIVE CARE UNIT	2, 031, 968	61, 684	1		2, 593, 834	ı
				1			
41. 00	04100 SUBPROVI DER - I RF	1, 970, 404	108, 548	l		2, 618, 957	
43.00	04300 NURSERY	67, 380	19, 560	44, 122	2 139	131, 201	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	15, 548, 707	536, 405	1, 210, 004	1, 801, 086	19, 096, 202	50.00
51. 00	05100 RECOVERY ROOM	0	000, 100	1,210,001		0	1
				1	1		
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 750, 062	106, 763	240, 834	470, 164	3, 567, 823	52. 00
53.00	05300 ANESTHESI OLOGY	19, 181	9, 260	20, 888	3  O	49, 329	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	10, 853, 513	352, 581	795, 342	1, 814, 116	13, 815, 552	54.00
54. 01	05401 ULTRASOUND	10,000,010	002,001	1 ,,0,0,2	1, 01.1, 1.10	0	1
		0	0				
56.00	05600  RADI 0I SOTOPE	이	0		) 이	0	
57.00	05700 CT SCAN	0	0	(	0	0	57.00
58.00	05800 MRI	l ol	0	1	ol ol	0	58. 00
60. 00	06000 LABORATORY	12, 712, 625	112, 315	253, 355	1, 170, 213		•
				l		14, 248, 508	
65. 00	06500 RESPI RATORY THERAPY	4, 088, 450	26, 085	58, 842	445, 882	4, 619, 259	65.00
66. 00	06600 PHYSI CAL THERAPY	2, 335, 580	146, 767	331, 072	406, 412	3, 219, 831	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 117, 433	0	) (	185, 754	1, 303, 187	67.00
68. 00	06800 SPEECH PATHOLOGY	767, 157	0			901, 827	
	l I		044 500	1			
69. 00	06900 ELECTROCARDI OLOGY	6, 160, 413	246, 538	556, 133	868, 268	7, 831, 352	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 526, 132	0	(	0	3, 526, 132	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	20, 804, 273	0	) c	ol ol	20, 804, 273	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	32, 872, 740	0		26, 404	32, 899, 144	1
	1 1		F 207	1			1
	07400 RENAL DI ALYSI S	937, 794	5, 387	12, 152	37, 392	992, 725	
76. 00	03950 ANCI LLARY	0	0	(	0	0	76. 00
76. 01	03610 SLEEP LAB	0	0	(	0	0	76. 01
76. 03	03951 WOUND CARE	1, 498, 164	56, 149	126, 659	159, 557	1, 840, 529	76. 03
	07700 ALLOGENEIC HSCT ACQUISITION	1, 1,0, 101	00, ,	1 .20,007	107,007	0	1
77.00		<u> </u>		1	)  0	- 0	17.00
	OUTPATIENT SERVICE COST CENTERS					_	
90. 00	09000 CLI NI C	0	0	(	0	0	90.00
91.00	09100 EMERGENCY	10, 790, 862	374, 278	844, 284	1, 567, 374	13, 576, 798	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		•			0	1
72.00	OTHER REIMBURSABLE COST CENTERS				1		72.00
100 00					\ \		100 00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	1	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	323, 590, 091	5, 367, 427	12, 107, 664	19, 009, 292	323, 589, 607	118. 00
	NONREI MBURSABLE COST CENTERS						
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 805	0		484	3 280	190. 00
		2,005	^	1			
	19200 PHYSI CI ANS' PRI VATE OFFI CES	l ol	0				192. 00
	19201 OTHER NONREI MBURSABLE	0	0	(			192. 01
194.00	07950 NONREI MBURSABLE	l ol	0	(	ol ol	0	194. 00
	07951 MARKETI NG	ام	n		ol ol		194. 01
	07952 SENI OR CI RCLE	ا م	^	,	ا ا		194. 02
		اً م	0	]	(		
	07953 NONREIMB - REGENCY LTC	이	0	ή (	0		194. 03
194. 04	07954 VACANT UNFINISHED AREA	j ol	0	(	) 0		194. 04
200.00				İ			200.00
201.00			^	,	ار		201. 00
	1 1 9	222 502 221	U	10 407	10 000 77		
202.00	TOTAL (sum lines 118 through 201)	323, 592, 896	5, 367, 427	12, 107, 664	19, 009, 776	323, 592, 896	1202.00

Provider CCN: 15-0035

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 01/01/2022 | Part |
| To 12/31/2022 | Date/Time Prepared: 6/22/2023 2:56 pm

				'	0 12/31/2022	6/22/2023 2:5	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5. 00	7. 00	8. 00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	75, 711, 886	05 047 4/5				5. 00
7.00	00700 OPERATION OF PLANT	5, 853, 326	25, 017, 165	1			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	423, 596	54, 294				8. 00
9.00	00900 HOUSEKEEPI NG	1, 625, 857	350, 812	1	., = ,	F (22 007	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	979, 867 798, 879	1, 107, 469 0	1	328, 467	5, 623, 897 0	10. 00 11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 866, 637	218, 995	1	64, 952	0	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	809, 473	746, 321	7, 670		0	14.00
15. 00	01500 PHARMACY	1, 264, 938	420, 327			0	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	765, 611	145, 391	0	l '	0	16.00
17. 00	01700 SOCIAL SERVICE	551, 413	16, 697	1	l '	0	17. 00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	001, 110	10, 077		1, 702		17.00
30. 00	03000 ADULTS & PEDI ATRI CS	11, 572, 918	5, 850, 618	657, 192	1, 735, 247	3, 216, 569	30.00
31. 00	03100 I NTENSI VE CARE UNI T	4, 104, 874	1, 106, 845	1		346, 650	31.00
31. 01	03101 NEONATAL INTENSIVE CARE UNIT	792, 250	427, 881	1	126, 906	30, 267	31. 01
41. 00	04100 SUBPROVI DER - I RF	799, 924	752, 966	1		324, 813	•
43.00	04300 NURSERY	40, 074	135, 679	1		0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	5, 832, 668	3, 720, 870	227, 219	1, 103, 580	3, 453	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 089, 742	740, 585	48, 717		84, 834	52. 00
53.00	05300 ANESTHESI OLOGY	15, 067	64, 233		19, 051	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 219, 767	2, 445, 747	187, 812	725, 389	3, 809	54.00
54. 01	05401 ULTRASOUND	0	0	0	0	0	54. 01
56. 00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	05800 MRI	0	0	0	0	0	58. 00
60.00	06000 LABORATORY	4, 352, 007	779, 091	1		0	60.00
65. 00	06500 RESPI RATORY THERAPY	1, 410, 888	180, 943	1	,	0	65. 00
66.00	06600 PHYSI CAL THERAPY	983, 452	1, 018, 077		301, 953	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	398, 040	0	0	0	0	67. 00 68. 00
68. 00 69. 00	06900 ELECTROCARDI OLOGY	275, 450	1 710 140	117 514	F07 220	44, 055	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 391, 977 1, 077, 008	1, 710, 160	117, 514	507, 220	44, 055	71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	6, 354, 374	0		0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	10, 048, 583	0		0	0	73.00
74. 00	07400 RENAL DIALYSIS	303, 214	37, 370		11, 084	0	74.00
76. 00	03950 ANCI LLARY	000, 214	37, 370		11,004	0	76.00
76. 01	03610 SLEEP LAB	0	0	0	0	0	76. 01
76. 03	03951 WOUND CARE	562, 164	389, 488	53, 240	115, 519	0	76. 03
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS			'	- 1		
90.00	09000 CLI NI C	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	4, 146, 843	2, 596, 306	340, 933	770, 043	189, 906	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	9 /	75, 710, 881	25, 017, 165	1, 864, 746	7, 299, 739	4, 244, 356	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 005	0		· ·		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		· ·	1, 379, 541	
	19201 OTHER NONREI MBURSABLE	0	0	0	0		192. 01
	07950 NONREI MBURSABLE	0	0	0	0		194. 00
	07951 MARKETI NG	0	0	0	0		194. 01
	207952 SENI OR CI RCLE		0	] 0	0		194. 02
	3 O 7 9 5 3 NONREI MB - REGENCY LTC		0	0			194. 03
	07954 VACANT UNFI NI SHED AREA	0	0	1 0	이	0	194. 04
200.00			^	] _		^	200. 00 201. 00
201. 00 202. 00		75, 711, 886	25, 017, 165	1, 864, 746	7, 299, 739		
∠∪∠. ∪(	TOTAL (Sum TITIES TTO CHI OUGH 201)	1 ,3, , , , , , , , , , , , , , , , , ,	23,017,103	1, 004, 740	1,277,139	5,023,097	<sub>1</sub> 202.00

Provider CCN: 15-0035

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 01/01/2022 | Part |
| To 12/31/2022 | Date/Time Prepared: 6/22/2023 2:56 pm

			10	12/31/2022	6/22/2023 2:5	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
·		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVI CE COST CENTERS						1 00
1.00   00100   CAP REL COSTS-BLDG & FLXT 2.00   00200   CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00   00500 ADMI NI STRATI VE & GENERAL						5.00
7. 00   00700   OPERATION OF PLANT						7. 00
8. 00   00800   LAUNDRY & LI NEN SERVI CE						8.00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00   01100   CAFETERI A	3, 414, 415					11. 00
13.00 01300 NURSING ADMINISTRATION	176, 935	8, 438, 903				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	80, 241	o	4, 515, 278			14. 00
15. 00 01500 PHARMACY	100, 878	0	0	6, 052, 227		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	55, 846	0	627	0	3, 517, 213	16. 00
17. 00 01700 SOCIAL SERVICE	47, 372	0	527	0	0	17. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	659, 093	2, 794, 304	182, 349	0	263, 507	30.00
31. 00   03100   INTENSIVE CARE UNIT	219, 732	1, 146, 853	75, 473	0	51, 622	31.00
31. 01   03101   NEONATAL   INTENSIVE CARE UNIT	64, 072	379, 374	14, 810	0	19, 199	31. 01
41. 00   04100   SUBPROVI DER - I RF 43. 00   04300   NURSERY	60, 207	195, 015	9, 243	0	18, 624	41.00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS	31, 912	149	8, 022	U	6, 663	43. 00
50. 00 05000 OPERATI NG ROOM	382, 590	1, 208, 974	449, 963	ol	618, 475	50.00
51. 00   05100   RECOVERY   ROOM	0 0	1, 200, 7, 4	447, 703	Ö	010, 473	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	119, 989	389, 574	37, 256	ol	25. 045	52. 00
53. 00   05300   ANESTHESI OLOGY	0	0	2, 203	ō	40, 225	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	370, 074	315, 620	133, 316	o	440, 679	54.00
54. 01   05401   ULTRASOUND	0	0	0	o	0	54. 01
56. 00   05600   RADI 0I SOTOPE	0	0	0	O	0	56. 00
57. 00   05700   CT   SCAN	0	0	0	0	0	57. 00
58. 00   05800   MRI	0	0	0	0	0	58. 00
60. 00   06000   LABORATORY	324, 510	0	524, 139	0	389, 297	60.00
65. 00 06500 RESPI RATORY THERAPY	76, 093	0	47, 082	0	91, 025	65. 00
66. 00   06600   PHYSI CAL THERAPY	89, 425	0	2, 680	0	35, 098	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	38, 826	0	362	0	23, 186	67.00
68. 00   06800   SPEECH   PATHOLOGY   69. 00   06900   ELECTROCARDI OLOGY	26, 203	75	101 93, 929	U	9, 209	68. 00
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT	179, 133 0	423, 236 0	404, 906	0	300, 013 74, 353	69. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	2, 388, 968	0	276, 962	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	3, 333		2, 300, 700	6, 052, 227	495, 081	73. 00
74. 00 07400 RENAL DI ALYSI S	3, 546	18, 101	6, 367	0, 032, 227	6, 380	74.00
76. 00 03950 ANCI LLARY	0,0.0	0	0	ol	0, 333	76. 00
76. 01   03610   SLEEP LAB	0	o	0	ō	0	76. 01
76. 03   03951   WOUND CARE	36, 273	153, 831	17, 280	o	12, 076	76. 03
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	o	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00   09000   CLI NI C	0	· · · · · · · · · · · · · · · · · · ·		0		
91. 00   09100   EMERGENCY	267, 884	1, 413, 797	115, 675	0	320, 494	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS		ا	-	al		
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS	2 414 147	8, 438, 903	4 515 270	/ OE2 227	3, 517, 213	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	3, 414, 167	8, 438, 903	4, 515, 278	6, 052, 227	3, 517, 213	1118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	248	٥	0	٥		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	240	0	0	0		190.00
192. 01 19201 OTHER NONREI MBURSABLE	0		0	0	0	192. 01
194. 00 07950 NONREI MBURSABLE	0	0	0	Ö		194. 00
194. 01 07951 MARKETI NG	0		0	ol Ol		194. 00
194. 02 07952 SENI OR CI RCLE	0	l ol	0	ol		194. 02
194. 03 07953 NONREI MB - REGENCY LTC	0	ol	Ö	ol		194. 03
194. 04 07954 VACANT UNFI NI SHED AREA	0	ol	Ō	o		194. 04
200.00 Cross Foot Adjustments		[				200. 00
201.00 Negative Cost Centers	0	o	0	o		201. 00
202.00 TOTAL (sum lines 118 through 201)	3, 414, 415	8, 438, 903	4, 515, 278	6, 052, 227	3, 517, 213	202. 00

Health Financial Systems	PORTER REGIONAL	HOSPI TAL		In Lie	u of Form CMS-2552-1
COST ALLOCATION - GENERAL SERVICE COSTS		Provider Co	F	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part I Date/Time Prepared: 6/22/2023 2:56 pm
Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	072272023 2. 30 ріп
	17. 00	24. 00	25. 00	26. 00	
GENERAL SERVICE COST CENTERS					4 0
1.00   00100   CAP REL COSTS-BLDG & FIXT   2.00   00200   CAP REL COSTS-MVBLE EQUIP   4.00   00400   EMPLOYEE BENEFITS DEPARTMENT   5.00   00500   ADMINISTRATIVE & GENERAL   7.00   00700   OPERATION OF PLANT   8.00   00800   LAUNDRY & LINEN SERVICE   9.00   00900   HOUSEKEEPING   10.00   01000   DIETARY   11.00   01100   CAFETERIA   13.00   01300   NURSING ADMINISTRATION   14.00   01400   CENTRAL SERVICES & SUPPLY   15.00   01600   MEDICAL RECORDS & LIBRARY   17.00   01700   SOCIAL SERVICE   INPATIENT ROUTINE SERVICE   COST CENTERS	2, 426, 293				1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00
30. 00 03000 ADULTS & PEDI ATRI CS	1, 835, 230	66, 656, 530		66, 656, 530	30.00
31.00 03100 INTENSIVE CARE UNIT	235, 521	21, 192, 871	1		31.00
31. 01   03101   NEONATAL INTENSIVE CARE UNIT	92, 603	4, 560, 797	1		31. 01
41. 00   04100   SUBPROVI DER -   1 RF 43. 00   04300   NURSERY	164, 160 98, 779	5, 214, 637 503, 941			41. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	70,777	500,711		000,711	10.00
50. 00 05000 OPERATING ROOM	0	32, 643, 994	(	32, 643, 994	50.00
51. 00   05100   RECOVERY ROOM	0	0			51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM 53. 00   05300   ANESTHESI OLOGY	0	6, 323, 216			52.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0	190, 108 22, 657, 765			53. 00 54. 00
54. 01   05401   ULTRASOUND	0	0 22,037,703		0	54. 01
56. 00   05600 RADI 0I SOTOPE	0	0	o c	0	56. 00
57. 00   05700   CT   SCAN	0	0	C		57. 00
58. 00   05800   MRI	0	0 040 7//		_	58.00
60. 00   06000   LABORATORY 65. 00   06500   RESPI RATORY   THERAPY	0	20, 848, 766 6, 478, 956	l .	20, 848, 766 6, 478, 956	60. 00 65. 00
66. 00   06600 PHYSI CAL THERAPY	0	5, 658, 967	l .		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 763, 601	l .		67. 00
68.00 06800 SPEECH PATHOLOGY	0	1, 212, 865		., ,	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	13, 598, 589			69.00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT 72.00   07200   IMPL. DEV. CHARGED TO PATIENTS	0	5, 082, 399 29, 824, 577	1		71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		49, 498, 368	l .		73.00
74.00 07400 RENAL DIALYSIS	0	1, 378, 787	1		74.00
76. 00   03950   ANCI LLARY	0	0	C	0	'
76. 01   03610   SLEEP LAB	0	0			76. 01
76. 03   03951   WOUND CARE 77. 00   07700   ALLOGENEI C   HSCT   ACQUI SI TI ON	0	3, 180, 400	C	3, 180, 400	76. 03 77. 00
OUTPATIENT SERVICE COST CENTERS	J 0			,	77.00
90. 00 09000 CLI NI C	0	0	(	0	90.00
91. 00   09100   EMERGENCY	0	23, 738, 679	1		· · · · · · · · · · · · · · · · · · ·
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART				)	92. 00
OTHER REIMBURSABLE COST CENTERS  102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0		0	102. 00
SPECIAL PURPOSE COST CENTERS				,	102.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 426, 293	322, 208, 813	(	322, 208, 813	118. 00
NONREI MBURSABLE COST CENTERS	1		1		400.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	4, 542 1, 379, 541		1	190. 00   192. 00
192. 01 19201 OTHER NONREI MBURSABLE		0			192. 01
194. 00 07950 NONREI MBURSABLE	0	0	d	0	194. 00
194. 01 07951 MARKETI NG	0	0	(	0	194. 01
194. 02 07952 SENI OR CI RCLE	0	0		0	194. 02
194. 03 07953 NONREIMB - REGENCY LTC 194. 04 07954 VACANT UNFINISHED AREA		0		0	194. 03   194. 04
200.00 Cross Foot Adjustments		0		0	200. 00
201.00 Negative Cost Centers	0	0		o o	201. 00
202.00 TOTAL (sum lines 118 through 201)	2, 426, 293	323, 592, 896	(	323, 592, 896	202.00

| 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 Provider CCN: 15-0035

					To	12/31/2022	Date/Time Pre 6/22/2023 2:5	
				CAPI TAL REI	LATED COSTS		0/22/2023 2.3	O pili
				57.1 7 77.E T.E.	2.1125 00010			
		Cost Center Description	Di rectl y	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
			Assigned New				BENEFI TS	
			Capi tal Rel ated Costs				DEPARTMENT	
			0	1. 00	2. 00	2A	4. 00	
	GENER	AL SERVICE COST CENTERS	, u	11.00	2.00			
1.00		CAP REL COSTS-BLDG & FIXT						1.00
2.00		CAP REL COSTS-MVBLE EQUIP						2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	0	21, 844		71, 119	71, 119	4. 00
5.00		ADMINISTRATIVE & GENERAL	0	269, 815		878, 455	6, 891	5.00
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	0	1, 469, 267 7, 827		4, 783, 590 25, 483	1, 752 3	7. 00 8. 00
9. 00		HOUSEKEEPING	0	50, 573		164, 655	63	•
10.00	1	DI ETARY	0	159, 654		519, 796	37	10.00
11. 00		CAFETERI A	0	0		0	36	•
13.00	01300	NURSING ADMINISTRATION	0	31, 571	71, 216	102, 787	3, 504	13. 00
14. 00		CENTRAL SERVICES & SUPPLY	0	107, 590		350, 289	761	14. 00
15. 00	1	PHARMACY	0	60, 595		197, 283	2, 318	1
16.00		MEDICAL RECORDS & LIBRARY	0	20, 960		68, 240	696	1
17. 00		SOCIAL SERVICE LENT ROUTINE SERVICE COST CENTERS	U	2, 407	5, 430	7, 837	711	17. 00
30. 00		ADULTS & PEDIATRICS	0	843, 440	1, 902, 603	2, 746, 043	13, 108	30.00
31. 00	1	INTENSIVE CARE UNIT	i o	159, 564		519, 503	4, 789	•
31. 01		NEONATAL INTENSIVE CARE UNIT	0	61, 684		200, 828	1, 350	1
41.00		SUBPROVIDER - IRF	0	108, 548	244, 860	353, 408	1, 104	41.00
43.00		NURSERY	0	19, 560	44, 122	63, 682	1	43. 00
F0 00		LARY SERVICE COST CENTERS	1 0	F0/ 40F	1 010 001	4 747 400	, 707	50.00
50. 00 51. 00		OPERATING ROOM RECOVERY ROOM	0	536, 405 0		1, 746, 409	6, 737 0	50. 00 51. 00
52. 00	4	DELIVERY ROOM & LABOR ROOM	0	106, 763		347, 597	1, 759	ł
53. 00		ANESTHESI OLOGY	0	9, 260		30, 148	1, 737	53.00
54. 00		RADI OLOGY-DI AGNOSTI C	0	352, 581		1, 147, 923	6, 786	ł
54. 01	05401	ULTRASOUND	0	0	0	0	0	54. 01
56.00		RADI OI SOTOPE	0	0	0	0	0	
57. 00		CT SCAN	0	0	0	0	0	57. 00
58.00	05800		0	112 215	0	0	0	58. 00
60. 00 65. 00		LABORATORY RESPI RATORY THERAPY	0	112, 315 26, 085		365, 670 84, 927	4, 377 1, 668	60. 00 65. 00
66. 00		PHYSI CAL THERAPY	0	146, 767		477, 839	1, 520	•
67. 00		OCCUPATI ONAL THERAPY	0	0		477,037	695	1
68. 00		SPEECH PATHOLOGY	0	0	0	Ö	504	•
69. 00		ELECTROCARDI OLOGY	0	246, 538	556, 133	802, 671	3, 248	69. 00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73. 00 74. 00		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	0	5, 387	12 152	17, 539	99 140	
74.00	1	ANCI LLARY	0	5, 387 	12, 152	17, 539	0	76.00
76. 00		SLEEP LAB	0	0	0	0	0	•
		WOUND CARE	0	56, 149	126, 659	182, 808	597	
		ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	
		TIENT SERVICE COST CENTERS						
		CLI NI C	0	0		0	0	
91. 00 92. 00		EMERGENCY	0	374, 278	844, 284	1, 218, 562	5, 863	
92.00		OBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS				U <sub>I</sub>		92. 00
102.00		OPLOID TREATMENT PROGRAM	0	0	0	o	0	102. 00
.02.00		AL PURPOSE COST CENTERS			<u> </u>	<u> </u>		102.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5, 367, 427	12, 107, 664	17, 475, 091	71, 117	118. 00
		MBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1	0		190.00
		PHYSICIANS' PRIVATE OFFICES OTHER NONREIMBURSABLE	0	0	0	0		192. 00 192. 01
		NONREI MBURSABLE	0	0	0	0		194. 00
	1	MARKETI NG		n		o o		194. 00
		SENI OR CI RCLE	Ö	Ö	l ő	o		194. 02
		NONREIMB - REGENCY LTC	0	0	0	o	0	194. 03
		VACANT UNFINISHED AREA	0	0	0	o	0	194. 04
200.00		Cross Foot Adjustments		_		O	_	200.00
201.00		Negative Cost Centers		0	12 107 44	17 475 001		201. 00
202. 00	וי	TOTAL (sum lines 118 through 201)	0	5, 367, 427	12, 107, 664	17, 475, 091	71, 119	<sub> </sub> ∠∪∠. UU

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0035

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

6/22/2023 2:56 pm Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 885, 346 5 00 5 00 7.00 00700 OPERATION OF PLANT 68, 453 4, 853, 795 7.00 00800 LAUNDRY & LINEN SERVICE 4, 954 40, 974 8.00 10, 534 8.00 9.00 00900 HOUSEKEEPI NG 19,014 68, 064 251, 796 9.00 0 01000 DI ETARY 0 757, 492 10.00 10.00 11, 459 214, 870 11, 330 01100 CAFETERI A 9, 343 0 0 11.00 11.00 13 00 01300 NURSING ADMINISTRATION 21,830 42, 489 0 2, 240 0 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 9.467 144, 800 7,635 14 00 169 0 15.00 01500 PHARMACY 14, 793 81, 551 0 4, 300 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 8, 954 28, 209 0 1, 487 0 16.00 01700 SOCIAL SERVICE 6, 449 3, 240 17.00 17.00 0 171 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 135, 255 1, 135, 130 14, 439 59, 856 433, 244 30.00 03100 INTENSIVE CARE UNIT 214, 748 31.00 48,006 3,024 11, 324 46, 691 31.00 4, 077 03101 NEONATAL INTENSIVE CARE UNIT 4, 377 9.265 83, 017 431 31.01 31.01 04100 SUBPROVIDER - IRF 41.00 9, 355 146, 089 1,042 7.703 43, 750 41.00 04300 NURSERY 43.00 43.00 469 26, 324 247 1, 388 0 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 68, 212 721, 918 4, 993 38,067 465 50.00 05100 RECOVERY ROOM 51.00 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 12, 744 52.00 143, 687 1,070 7,577 11, 426 52.00 05300 ANESTHESI OLOGY 176 12, 462 53.00 53.00 657 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 49.349 474, 520 4, 127 25, 021 513 54.00 54.01 05401 ULTRASOUND 54.01 0 C C 0 05600 RADI OI SOTOPE 56.00 0 0 0 0 56.00 57.00 05700 CT SCAN 0 0 ol 57.00 0 0 05800 MRI 58.00 0 0 0 0 58.00 60.00 06000 LABORATORY 50, 896 151, 158 3 7,971 0 60.00 06500 RESPIRATORY THERAPY 65.00 16,500 35, 106 0 1,851 0 65.00 66 00 06600 PHYSI CAL THERAPY 11 501 197, 526 186 10.416 66 00 0 06700 OCCUPATIONAL THERAPY 67.00 4,655 0 0 67.00 06800 SPEECH PATHOLOGY 3, 221 0 68.00 68.00 C 69.00 06900 ELECTROCARDI OLOGY 27.974 331.803 2.582 17, 496 5.934 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 12, 595 71.00 C 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 74, 313 C 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 117, 516 0 0 0 73.00 74 00 07400 RENAL DIALYSIS 3 546 0 382 74 00 7.250 0 03950 ANCI LLARY 76.00 0 0 0 76.00  $\Gamma$ 03610 SLEEP LAB 76.01 76.01 0 76.03 03951 WOUND CARE 1, 170 3, 985 0 76.03 6,574 75. 568 07700 ALLOGENEIC HSCT ACQUISITION 77 00 77.00 0 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 91.00 09100 EMERGENCY 48, 496 503, 732 7, 491 26, 562 25, 579 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102, 00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 251, 796 571, 679 118. 00 118.00 885, 334 4, 853, 795 40, 974 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 12 0 0 190. 00 185, 813 192. 00 0 0 0 0 οĺ 192. 01 19201 OTHER NONREI MBURSABLE 0 0 0 192. 01 194. 00 07950 NONREI MBURSABLE 0 0 0 0 0 194.00 0 0 0 194. 01 194. 01 07951 MARKETI NG 0 0 0 194. 02 07952 SENI OR CIRCLE 0 194, 02 0 0 194. 03 07953 NONREIMB - REGENCY LTC 0 C 0 0 0 194. 03 194. 04 07954 VACANT UNFINISHED AREA 0 0 0 0 194. 04 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 TOTAL (sum lines 118 through 201) 757, 492 202. 00 202.00 885, 346 4, 853, 795 40, 974 251, 796

Provider CCN: 15-0035

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared:

				10	12/31/2022	Date/lime Pre 6/22/2023 2:5	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	O piii
		21.11.21.21.11.1	ADMI NI STRATI ON	SERVICES &		RECORDS &	
				SUPPLY		LI BRARY	
		11. 00	13. 00	14. 00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPING						9.00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A	9, 379					11. 00
13. 00	01300 NURSING ADMINISTRATION	486	1				13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	220	1	513, 341			14. 00
15.00	01500 PHARMACY	277		0	300, 522		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	153	o	71	o	107, 810	16. 00
17. 00	01700 SOCIAL SERVICE	130	0	60	0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1, 809	1	20, 731	0	8, 072	30. 00
31. 00	03100 INTENSIVE CARE UNIT	604		8, 580	0	1, 581	31. 00
31. 01	03101 NEONATAL INTENSIVE CARE UNIT	176		1, 684	0	588	31. 01
41. 00	04100 SUBPROVI DER - I RF	165		1, 051	0	571	41.00
43. 00	04300 NURSERY	88	3	912	0	204	43. 00
EO 00	ANCILLARY SERVICE COST CENTERS	1 051	24 022	E1 1E/	ol	19, 009	
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	1, 051 0		51, 156 0	0	19, 009	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	330	1 -1	4, 236	0	767	52.00
53. 00	05300 ANESTHESI OLOGY	0	0,002	250	Ö	1, 232	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 017	6, 483	15, 157	ol	13, 500	54.00
54. 01	05401 ULTRASOUND	0		0	Ö	0	54. 01
56.00	05600 RADI OI SOTOPE	0	o	0	О	0	56. 00
57.00	05700 CT SCAN	0	o	0	О	0	57. 00
58.00	05800 MRI	0	0	0	0	0	58. 00
60.00	06000 LABORATORY	891	0	59, 589	0	11, 926	60.00
65.00	06500 RESPI RATORY THERAPY	209	1	5, 353	0	2, 789	65. 00
66. 00	06600 PHYSI CAL THERAPY	246	1	305	0	1, 075	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	107	1	41	0	710	67. 00
68. 00	06800 SPEECH PATHOLOGY	72	1	12	0	282	68. 00
69. 00	06900 ELECTROCARDI OLOGY	492 0	1	10, 679	0	9, 191	69.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	1	46, 034 271, 600	0	2, 278 8, 485	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0		271,000	300, 522	15, 167	73.00
74. 00	07400 RENAL DIALYSIS	10	372	724	300, 322	195	74.00
76. 00	03950 ANCI LLARY	0		0	Ö	0	76. 00
76. 01	03610 SLEEP LAB	0	o	0	o	0	76. 01
76. 03	03951 WOUND CARE	100	3, 160	1, 965	o	370	76. 03
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	o	0	o	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	1		0		
	09100 EMERGENCY	736	29, 040	13, 151	0	9, 818	91. 00
92. 00							92. 00
100.00	OTHER REIMBURSABLE COST CENTERS	0		0	ما	0	100.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	) 0	0	0	0	102. 00
110 0	SPECIAL PURPOSE COST CENTERS	0.270	172 224	E12 2/1	200 E22	107 010	110 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	9, 378	173, 336	513, 341	300, 522	107, 810	1118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1	0	0	ol	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	1	0	Ö		192. 00
	1 19201 OTHER NONREIMBURSABLE	0	ol	0	o		192. 01
194.00	07950 NONREI MBURSABLE	0	o	0	O	0	194. 00
	1 07951 MARKETI NG	0	o  o	0	o		194. 01
	2 07952 SENI OR CI RCLE	0	0	0	0		194. 02
	3 07953 NONREIMB - REGENCY LTC	0	0	0	0		194. 03
	4 07954 VACANT UNFI NI SHED AREA	0	이	0	0	0	194. 04
200.00		_	, ,			_	200. 00
201.00		9, 379	172 224	U E10 041	300 533		201.00
202.00	p   TOTAL (Sum TITIES TTO LIMOUGH 201)	7,379	9 173, 336	513, 341	300, 522	107, 610	1202. UU

Cost Center Description   SOCIAL SERVICE   Subtotal   Intern & Total   Residents Cost & Post   Stepdown   Adjustments   Stepdown   Adjustments   Stepdown   Adjustments   Stepdown   Adjustments   Stepdown   S	1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 17. 00
17. 00	2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00
1.00   00100   CAP REL COSTS-BLDG & FIXT	2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00
2.00   00200   CAP REL COSTS-MVBLE EQUIP 4.00   00400   EMPLOYEE BENEFITS DEPARTMENT 5.00   00500   ADMINISTRATIVE & GENERAL	2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00
	7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00
7. 00   00700   OPERATI ON OF PLANT	9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00
8. 00   00800   LAUNDRY & LI NEN SERVI CE 9. 00   00900   HOUSEKEEPI NG 10. 00   01000   DI ETARY	11. 00 13. 00 14. 00 15. 00 16. 00
10. 00   01000   DI ETARY 11. 00   01100   CAFETERI A	14. 00 15. 00 16. 00
13. 00 01300 NURSI NG ADMINI STRATI ON	15. 00 16. 00
14. 00   01400   CENTRAL SERVI CES & SUPPLY 15. 00   01500   PHARMACY	16.00
16. 00   01600   MEDI CAL RECORDS & LI BRARY	17 ∩∩
17. 00 01700 SOCI AL SERVI CE 18, 598	17.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS   14,068   4,639,147   0   4,639,147   30.00   03000   ADULTS & PEDI ATRI CS   14,068   4,639,147   0   4,639,147	30. 00
30. 00   03000   ADULTS & PEDI ATRI CS   14, 068   4, 639, 147   0   4, 639, 147   31. 00   03100   I NTENSI VE CARE UNI T   1, 805   884, 212   0   884, 212	31. 00
31. 01   03101   NEONATAL   NTENSI VE CARE UNIT 710 314, 296 0 314, 296	31. 01
41. 00   04100   SUBPROVI DER - I RF   1, 258   569, 502   0   569, 502   43. 00   04300   NURSERY   757   94. 075   0   94. 075	41. 00
43. 00   04300   NURSERY   757   94, 075   0   94, 075   ANCI LLARY SERVI CE COST CENTERS	43. 00
50. 00   05000   OPERATI NG ROOM   0   2, 682, 850   0   2, 682, 850	50.00
51. 00   05100   RECOVERY ROOM   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	51. 00 52. 00
52. 00   05200   DELI VERY ROOM & LABOR ROOM   0   539, 195   0   539, 195   53. 00   05300   ANESTHESI OLOGY   0   44, 925   0   44, 925	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 0 1, 744, 396 0 1, 744, 396	54.00
54. 01   05401   ULTRASOUND   0   0   0   0   0   0   0   0   0	54. 01
56. 00   05600   RADI 0I SOTOPE   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	56. 00 57. 00
58. 00   05800   MRI   0   0   0   0	58.00
60. 00   06000   LABORATORY   0   652, 481   0   652, 481   65. 00   06500   RESPI RATORY THERAPY   0   148, 403   0   148, 403	60. 00 65. 00
66. 00   06600   PHYSI CAL THERAPY	66. 00
67. 00   06700   OCCUPATI ONAL THERAPY   0   6, 208   0   6, 208	67. 00
68. 00   06800   SPEECH PATHOLOGY   0   4, 093   0   4, 093   69. 00   06900   ELECTROCARDI OLOGY   0   1, 220, 763   0   1, 220, 763	68. 00 69. 00
71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 60, 907 0 60, 907	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 354, 398 0 354, 398	72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   433, 313   0   433, 313   74. 00   07400   RENAL DIALYSIS   0   30, 158   0   30, 158	73. 00 74. 00
74. 00   07400   RENAL DI ALYSI S	74. 00 76. 00
76. 01   03610   SLEEP LAB   0   0   0	76. 01
76. 03   03951   WOUND CARE 0 276, 297 0 276, 297 77. 00   07700   ALLOGENEI C HSCT ACQUISITION 0 0 0	76. 03 77. 00
OUTPATIENT SERVICE COST CENTERS	77.00
90. 00 09000 CLI NI C 0 0 0	90.00
91. 00   09100   EMERGENCY	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS	<del>9</del> 2.00
102. 00 10200 OPI 0I D TREATMENT PROGRAM 0 0 0 0	102. 00
	118. 00
NONREI MBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 15 0 15	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 185, 813 0 185, 813	192. 00
	192. 01
	194. 00 194. 01
194. 02 07952 SENI OR CI RCLE 0 0 0 0	194. 02
	194. 03
	194. 04 200. 00
201.00   Negative Cost Centers   0   0   0	201. 00
202.00 TOTAL (sum lines 118 through 201) 18,598 17,475,091 0 17,475,091	202. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0035 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 6/22/2023 2:56 pm CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE (SQUARE FEET) (SQUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5A 5. 00 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 655, 573 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 655, 573 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 2,668 91, 751, 067 4.00 2,668 00500 ADMINISTRATIVE & GENERAL 5 00 32, 955 32, 955 8, 891, 973 -75, 711, 886 247, 881, 010 5 00 7.00 00700 OPERATION OF PLANT 179, 455 179, 455 2, 260, 457 19, 163, 839 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 956 956 4, 320 1, 386, 856 8.00 0 00900 HOUSEKEEPI NG 6, 177 6, 177 81,778 5, 323, 070 9.00 9.00 01000 DI ETARY 10.00 47, 773 3, 208, 094 10 00 19,500 19, 500 11.00 01100 CAFETERI A 46, 480 0 2, 615, 536 11.00 01300 NURSING ADMINISTRATION 3, 856 4, 521, 840 13.00 3,856 0 6, 111, 384 13.00 01400 CENTRAL SERVICES & SUPPLY 13, 141 13, 141 981, 535 2, 650, 220 14.00 14.00 7.401 7, 401 15.00 01500 PHARMACY 2, 990, 400 4, 141, 418 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 2,560 2, 560 897, 612 0 2, 506, 616 16.00 01700 SOCIAL SERVICE 17.00 294 294 917, 596 1, 805, 332 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 103, 017 103, 017 16, 900, 350 0 37, 889, 503 30.00 19, 489 03100 INTENSIVE CARE UNIT 19, 489 6, 178, 954 0 13, 439, 390 31.00 31.00 31.01 03101 NEONATAL INTENSIVE CARE UNIT 7,534 7, 534 1, 742, 554 0 2, 593, 834 31.01 04100 SUBPROVIDER - IRF 0 13, 258 13, 258 1, 424, 523 2, 618, 957 41.00 41.00 04300 NURSERY 670 43.00 2, 389 2, 389 131, 201 43.00 ANCILLARY SERVICE COST CENTERS 19, 096, 202 50.00 05000 OPERATING ROOM 65, 516 65, 516 8, 692, 962 50.00 51.00 05100 RECOVERY ROOM 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 13,040 13,040 2, 269, 252 0 3, 567, 823 52.00 05300 ANESTHESI OLOGY 0 53.00 1, 131 1, 131 49, 329 53.00 0 13, 815, 552 54.00 05400 RADI OLOGY-DI AGNOSTI C 43,064 43, 064 8, 755, 850 54.00 54.01 05401 ULTRASOUND 0 0 0 54.01 05600 RADI OI SOTOPE 56.00 0 0 0 0 0 0 0 0 0 0 0 0 56.00 57.00 05700 CT SCAN 0 0 57.00 05800 MRI 58.00 58 00 60.00 06000 LABORATORY 13, 718 13, 718 5, 648, 048 14, 248, 508 60.00 06500 RESPIRATORY THERAPY 2, 152, 056 4, 619, 259 65.00 3, 186 3, 186 65.00 06600 PHYSI CAL THERAPY 17, 926 17, 926 1, 961, 551 3, 219, 831 66.00 66.00 06700 OCCUPATIONAL THERAPY 896, 543 1, 303, 187 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 649, 986 901, 827 68.00 69.00 06900 ELECTROCARDI OLOGY 30, 112 30, 112 4, 190, 706 7, 831, 352 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 3, 526, 132 71 00 C 0 71 00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 C  $\cap$ 20, 804, 273 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 127, 437 32, 899, 144 73.00 07400 RENAL DIALYSIS 0 74.00 658 658 180, 471 992, 725 74.00 03950 ANCI LLARY 76 00 76 00 0 C 0 76.01 03610 SLEEP LAB 0 0 0 76.01 03951 WOUND CARE 6,858 770, 106 0 1, 840, 529 76.03 6,858 76.03 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 45, 714 45, 714 91.00 09100 EMERGENCY 7, 564, 947 13, 576, 798 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPIOID TREATMENT PROGRAM 0 0 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 91, 748, 730 655, 573 655, 573 -75, 711, 886 247, 877, 721 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 3, 289 190. 00 2, 337 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 192.00 0 0 192. 01 19201 OTHER NONREI MBURSABLE 0 0 192.01 0 0 194. 00 07950 NONREI MBURSABLE 0 0 0 194.00 0 194. 01 07951 MARKETI NG 0 194. 01 0 0 194. 02 07952 SENI OR CIRCLE 0 0 194. 02 0 194. 03 07953 NONREIMB - REGENCY LTC 0 0 0 0 194. 03 C 194. 04 07954 VACANT UNFINISHED AREA 0 194.04 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 201.00 202.00 Cost to be allocated (per Wkst. B, 5, 367, 427 12, 107, 664 19, 009, 776 75, 711, 886 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 8. 187383 18. 468827 0.207189 0. 305436 203. 00 885, 346 204. 00 Cost to be allocated (per Wkst. B, 204 00 71, 119

Part II)

Health Financial Systems	;	PORTER REGION	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS			Provi der CO		Peri od:	Worksheet B-1	
					From 01/01/2022 Fo 12/31/2022	Date/Time Pre 6/22/2023 2:5	pared: 6 pm
		CAPITAL REL	LATED COSTS				
Cost Center	Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
				(GROSS SALARI ES)		,	
		1. 00	2. 00	4. 00	5A	5. 00	
205.00 Unit cost mu	ultiplier (Wkst. B, Part			0. 00077!	5	0. 003572	205. 00
1 1 1 1 1 1	ment amount to be allocated B-2)						206. 00
207.00 NAHE unit co	ost multiplier (Wkst. D, nd IV)						207. 00

		cial Systems TON - STATISTICAL BASIS	PORTER REGIONA	AL HOSPITAL Provider CO		eri od:	u of Form CMS-: Worksheet B-1	
						rom 01/01/2022 o 12/31/2022	Date/Time Pre	pared:
		Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	6/22/2023 2: 5 CAFETERI A	6 pm
		oost scritch bescription		LINEN SERVICE (POUNDS OF		(MEALS SERVED)	(FTE'S)	
			7.00	<u>LAUNDR)</u> 8. 00	9. 00	10.00	11. 00	
	GENERA	AL SERVICE COST CENTERS	7.00	0.00	7.00	10.00	11.00	
1.00		CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5.00		ADMINISTRATIVE & GENERAL						5. 00
7.00	1 .	OPERATION OF PLANT	440, 495	4 5/4 775				7. 00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	956 6, 177	1, 561, 775 0	433, 362			8. 00 9. 00
10.00		DI ETARY	19, 500	0	19, 500			10.00
		CAFETERI A	o	0	0	0	96, 295	ł
		NURSI NG ADMINI STRATI ON	3, 856	0	3, 856	0	4, 990	ı
		CENTRAL SERVICES & SUPPLY PHARMACY	13, 141 7, 401	6, 424 0	13, 141 7, 401	0	2, 263 2, 845	14. 00 15. 00
		MEDICAL RECORDS & LIBRARY	2, 560	0	2, 560			ł
17. 00		SOCIAL SERVICE	294	0	294	0	1, 336	17. 00
30. 00		ADULTS & PEDIATRICS	103, 016	550, 415	103, 016	126, 677	18, 588	30.00
31. 00		INTENSIVE CARE UNIT	19, 489	115, 269				31.00
		NEONATAL INTENSIVE CARE UNIT	7, 534	16, 416			1, 807	31. 01
		SUBPROVI DER – I RF NURSERY	13, 258 2, 389	39, 702 9, 398	13, 258 2, 389			
43.00		LARY SERVICE COST CENTERS	2, 304	7, 370	2, 309	O O	700	43.00
	05000	OPERATING ROOM	65, 516	190, 302	65, 516	136	10, 790	50. 00
		RECOVERY ROOM	0	0	0	_	_	51.00
		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	13, 040 1, 131	40, 802 0	13, 040 1, 131		3, 384 0	52. 00 53. 00
54. 00		RADI OLOGY-DI AGNOSTI C	43, 064	157, 298				•
		ULTRASOUND	o	0	0	0	0	54. 01
		RADI OI SOTOPE CT SCAN	0	0	0	0	0	56. 00 57. 00
	05800			0		0	0	58.00
60.00	06000	LABORATORY	13, 718	119	13, 718	0	9, 152	1
		RESPI RATORY THERAPY	3, 186	0	3, 186		2, 146	1
66. 00 67. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	17, 926	7, 078 0	17, 926 0	0	2, 522 1, 095	1
		SPEECH PATHOLOGY	o o	0	Ö	0	739	68. 00
69. 00	06900	ELECTROCARDI OLOGY	30, 112	98, 421	30, 112	1, 735		1
		MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
	1 1	DRUGS CHARGED TO PATTENTS	0	0		0	94	73.00
		RENAL DIALYSIS	658	0	658		100	
	1	ANCI LLARY	0	0		_		76. 00
		SLEEP LAB WOUND CARE	0 6, 858	0 44, 590				76. 01 76. 03
		ALLOGENEIC HSCT ACQUISITION	0	0	0	0		77. 00
00.00		TIENT SERVICE COST CENTERS	1					00.00
		CLI NI C EMERGENCY	45, 715	285, 541	45, 715	0 7, 479		l
		OBSERVATION BEDS (NON-DISTINCT PART	43,713	203, 341	45,715	7, 477	7,333	92.00
		REIMBURSABLE COST CENTERS						
102. 00		OPIOID TREATMENT PROGRAM AL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)	440, 495	1, 561, 775	433, 362	167, 154	96, 288	118. 00
	NONRE	MBURSABLE COST CENTERS		.,,	,	,		
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
		PHYSICIANS' PRIVATE OFFICES OTHER NONREIMBURSABLE	0	0	0	54, 330		192. 00 192. 01
		NONREI MBURSABLE	l o	0	Ö	0		194. 00
		MARKETI NG	0	0	0	0		194. 01
		SENIOR CIRCLE NONREIMB - REGENCY LTC	0	0	0	0		194. 02 194. 03
		VACANT UNFINISHED AREA		0		0		194. 03
200.00		Cross Foot Adjustments						200. 00
201.00	1 .	Negative Cost Centers	05 047 4/5	4 0/4 74/	7 000 700	F (00 007	0 444 445	201. 00
202. 00		Cost to be allocated (per Wkst. B, Part I)	25, 017, 165	1, 864, 746	7, 299, 739	5, 623, 897	3, 414, 415	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	56. 793301	1. 193991	16. 844437	25. 391888	35. 457864	203. 00
204.00		Cost to be allocated (per Wkst. B,	4, 853, 795	40, 974	251, 796	757, 492	9, 379	204. 00
205.00		Part II) Unit cost multiplier (Wkst. B, Part	11. 018956	0. 026236	0. 581029	3. 420075	0. 097399	205. 00
		II)		1. 020200		1233,0		

Health Finan	cial Systems	PORTER REGION	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCAT	TION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
					From 01/01/2022 To 12/31/2022		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	(FTE' S)	
		(SQUARE FEET)	(POUNDS OF				
			LAUNDR)				
		7. 00	8. 00	9. 00	10.00	11. 00	
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)						

-	LLOCATION - STATISTICAL BASIS	TORTER REGIONA	Provider CO	CN: 15-0035 P	eri od:	Worksheet B-1	
		I wygorno I	OENTE M	Т	rom 01/01/2022 o 12/31/2022	Date/Time Pre 6/22/2023 2:5	
	Cost Center Description	NURSI NG ADMI NI STRATI ON (NURSI NG WA	CENTRAL SERVI CES & SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	RECORDS &	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		GES)	REQUIS.)		CHARGES)	,	
	GENERAL SERVICE COST CENTERS	13. 00	14. 00	15. 00	16. 00	17. 00	
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00	OO100 CAP REL COSTS-BLDG & FIXT O0200 CAP REL COSTS-BLDG & FIXT O0400 EMPLOYEE BENEFITS DEPARTMENT O0500 ADMINISTRATIVE & GENERAL O0700 OPERATION OF PLANT O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING O1000 DIETARY O1100 CAFETERIA O1300 NURSING ADMINISTRATION O1400 CENTRAL SERVICES & SUPPLY O1500 PHARMACY O1600 MEDICAL RECORDS & LIBRARY O1700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	37, 905, 068 0 0 0 0	39, 321, 285 0 5, 461 4, 591	32, 810, 095 0	2, 565, 859, 559		1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00
30. 00	03000 ADULTS & PEDIATRICS	12, 551, 235	1, 587, 992	0	192, 200, 265	46, 652	30.00
31. 00 31. 01 41. 00 43. 00	03100 INTENSIVE CARE UNIT 03101 NEONATAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04300 NURSERY ANCILLARY SERVICE COST CENTERS	5, 151, 316 1, 704, 034 875, 950 670	657, 255 128, 974 80, 489 69, 861	0	14, 003, 672 13, 584, 103	2, 354 4, 173	31. 01 41. 00
50. 00	05000 OPERATING ROOM	5, 430, 347	3, 918, 510	0	451, 536, 217	0	50.00
51. 00 52. 00 53. 00 54. 00 54. 01	05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND	0 1, 749, 847 0 1, 417, 669 0	0 324, 441 19, 182 1, 160, 985 0	0 0	0 18, 267, 851 29, 339, 936	0 0 0 0	51. 00 52. 00
56. 00 57. 00 58. 00 60. 00 65. 00 66. 00	05600 RADI OI SOTOPE 05700 CT SCAN 05800 MRI 06000 LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0 0 0 0 0	0 0 0 4, 564, 481 410, 016 23, 336	0	66, 393, 036	0	
67. 00 68. 00 69. 00 71. 00 72. 00 73. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 339 1,901,047 0 0	3, 152 882 817, 982 3, 526, 132 20, 804, 273 0	000000000000000000000000000000000000000	16, 911, 672 6, 716, 844 218, 827, 753 54, 232, 416 202, 014, 937	0 0 0 0	67. 00 68. 00 69. 00 71. 00 72. 00 73. 00
	07400 RENAL DI ALYSI S 03950 ANCI LLARY 03610 SLEEP LAB	81, 302 0 0	55, 447 0 0		0	0 0 0	
76. 03 77. 00	03951 WOUND CARE 07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	690, 964	150, 487 0	0		0	76. 03 77. 00
90. 00 91. 00 92. 00	09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0 6, 350, 348	0 1, 007, 356	0		0	90. 00 91. 00 92. 00
102.00	OTHER REIMBURSABLE COST CENTERS 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
118. 00	SPECIAL PURPOSE COST CENTERS	37, 905, 068	39, 321, 285	32, 810, 095	2, 565, 859, 559		
192. 00 192. 01	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 OTHER NONREIMBURSABLE	0 0	0	0	0	0	190. 00 192. 00 192. 01
194. 01 194. 02	07950 NONREI MBURSABLE 07951 MARKETI NG 07952 SENI OR CIRCLE 07953 NONREI MB - REGENCY LTC	0 0	0 0 0	0 0	0 0	0	194. 00 194. 01 194. 02 194. 03
	07954 VACANT UNFINISHED AREA Cross Foot Adjustments	O	0	0	0	0	194. 04 200. 00 201. 00
202.00	Cost to be allocated (per Wkst. B, Part I)	8, 438, 903	4, 515, 278			2, 426, 293 39. 338700	
204.00	Cost to be allocated (per Wkst. B, Part II)	0. 222633 173, 336 0. 004573	0. 114830 513, 341 0. 013055	300, 522	107, 810	18, 598	204. 00
	II)	3. 30 107 3	3. 3 10000	0.307107	3. 300042	3. 501007	

Heal th Fina	ncial Systems	PORTER REGIONA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2022 To 12/31/2022		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUIS.)	LI BRARY	(TOTAL PATIENT	
		(NURSING WA	(COSTED		(GROSS	DAYS)	
		GES)	REQUIS.)		CHARGES)	·	
		13.00	14.00	15. 00	16.00	17. 00	
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	PORTER REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0035	Period: Worksheet C From 01/01/2022 Part I
		To 12/31/2022 Date/Time Prepared

			-	To 12/31/2022	Date/Time Pre 6/22/2023 2:5	
		Title	XVIII	Hospi tal	PPS	о рііі
		11 210	7,0111	Costs	110	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS	66, 656, 530		66, 656, 530	0	66, 656, 530	30. 00
31. 00   03100   NTENSI VE CARE UNI T	21, 192, 871		21, 192, 87		21, 192, 871	
31. 01 03101 NEONATAL INTENSIVE CARE UNIT	4, 560, 797		4, 560, 79		4, 560, 797	
41. 00   04100   SUBPROVI DER -   RF	5, 214, 637		5, 214, 63		5, 214, 637	
43. 00   04300   NURSERY	503, 941		503, 94		503, 941	
ANCI LLARY SERVI CE COST CENTERS	303, 741		303, 74	·   · · · · · · · · · · · · · · · · · ·	303, 741	43.00
50. 00 05000 OPERATING ROOM	32, 643, 994		32, 643, 994	1 0	32, 643, 994	50.00
51. 00   05100   RECOVERY   ROOM	02,010,771		02,010,77		02,010,771	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	6, 323, 216		6, 323, 210	-	6, 323, 216	
53. 00   05300   ANESTHESI OLOGY	190, 108		190, 108		190, 108	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	22, 657, 765		22, 657, 76!		22, 657, 765	
54. 01   05401   ULTRASOUND	22,007,700		22,007,700		0	1
56. 00   05600   RADI 01 SOTOPE	0		ì		0	
57. 00   05700   CT   SCAN	0		ì		0	1
58. 00   05800   MRI	0		ì		0	58. 00
60. 00 06000 LABORATORY	20, 848, 766		20, 848, 766		20, 848, 766	
65. 00 06500 RESPIRATORY THERAPY	6, 478, 956	0			6, 478, 956	
66. 00   06600   PHYSI CAL THERAPY	5, 658, 967	0	5, 658, 96		5, 658, 967	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 763, 601	0	1, 763, 60		1, 763, 601	67. 00
68. 00 06800 SPEECH PATHOLOGY	1, 212, 865	0	1, 212, 86!		1, 212, 865	
69. 00 06900 ELECTROCARDI OLOGY	13, 598, 589	·	13, 598, 589		13, 598, 589	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5, 082, 399		5, 082, 39		5, 082, 399	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	29, 824, 577		29, 824, 57		29, 824, 577	
73. 00 07300 DRUGS CHARGED TO PATIENTS	49, 498, 368		49, 498, 368		49, 498, 368	
74. 00 07400 RENAL DIALYSIS	1, 378, 787		1, 378, 78		1, 378, 787	1
76. 00 03950 ANCI LLARY	1, 370, 707		1, 370, 70	1	1, 370, 707	1
76. 01 03610 SLEEP LAB	0		ì		0	1
76. 03   03951   WOUND CARE	3, 180, 400		3, 180, 400	1 1	3, 180, 400	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0, 100, 100		0, 100, 100		0, 100, 100	
OUTPATIENT SERVICE COST CENTERS			· · · · · · · · · · · · · · · · · · ·	۷		77.00
90. 00 09000 CLINI C	0		(	o	0	90.00
91. 00   09100   EMERGENCY	23, 738, 679		23, 738, 67		23, 738, 679	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	7, 317, 528		7, 317, 528		7, 317, 528	
OTHER REIMBURSABLE COST CENTERS	7,017,020		7,017,020	اا	7,017,020	72.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0		(		0	102. 00
200.00 Subtotal (see instructions)	329, 526, 341	0			329, 526, 341	
201.00 Less Observation Beds	7, 317, 528	_	7, 317, 528		7, 317, 528	
202.00 Total (see instructions)	322, 208, 813				322, 208, 813	
(222)	,,, 0.0	ı	,,, 0	٦ ١	, ,,, , 0.0	, .=

			ļi	o 12/31/2022	Date/Time Pre 6/22/2023 2:5	
		Title	XVIII	Hospi tal	PPS	
·		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
			ĺ		Rati o	
	6.00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	174, 226, 017		174, 226, 017	7		30. 00
31.00 03100 INTENSIVE CARE UNIT	37, 652, 944		37, 652, 944	Į.		31. 00
31.01 03101 NEONATAL INTENSIVE CARE UNIT	14, 003, 672		14, 003, 672	2		31. 01
41. 00   04100   SUBPROVI DER -   I RF	13, 584, 103		13, 584, 103	3		41. 00
43. 00   04300 NURSERY	4, 860, 240		4, 860, 240			43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	182, 152, 733	269, 383, 484	451, 536, 217	0. 072295	0.000000	50. 00
51.00   05100   RECOVERY ROOM	o	0	(	0. 000000	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	18, 169, 322	98, 529	18, 267, 85°	0. 346139	0.000000	52. 00
53. 00   05300   ANESTHESI OLOGY	11, 516, 127	17, 823, 809			0.000000	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	78, 740, 253	242, 688, 766	321, 429, 019	0. 070491	0.000000	54.00
54. 01   05401   ULTRASOUND	o	0	(	0. 000000	0.000000	54. 01
56. 00   05600   RADI 0I SOTOPE	o	0	(	0. 000000	0.000000	56. 00
57. 00 05700 CT SCAN	o	0	(	0. 000000	0.000000	57. 00
58. 00   05800   MRI	o	0	(	0. 000000	0.000000	58. 00
60. 00   06000   LABORATORY	126, 168, 283	157, 782, 556	283, 950, 839	0.073424	0.000000	60.00
65. 00 06500 RESPIRATORY THERAPY	63, 013, 264	3, 379, 772	66, 393, 036	0. 097585	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	17, 905, 931	7, 694, 488	25, 600, 419	0. 221050	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	15, 364, 369	1, 547, 303	16, 911, 672	0. 104283	0.000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	5, 097, 722	1, 619, 122	6, 716, 844	0. 180571	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	89, 669, 990	129, 157, 763		0. 062143	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	28, 368, 860	25, 863, 556			0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	115, 232, 423	86, 782, 514	202, 014, 937	0. 147636	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	87, 533, 627	273, 575, 602	361, 109, 229	0. 137073	0.000000	73. 00
74. 00   07400   RENAL DI ALYSI S	4, 522, 142	131, 201	4, 653, 343	0. 296300	0.000000	74. 00
76. 00 03950 ANCI LLARY	0	0	(	0. 000000	0.000000	76. 00
76. 01 03610 SLEEP LAB	0	0	(	0. 000000	0.000000	76. 01
76. 03 03951 WOUND CARE	718, 715	8, 089, 634	8, 808, 349	0. 361067	0.000000	76. 03
77.00 07700 ALLOGENEIC HSCT ACQUISITION	o	0	(	0. 000000	0.000000	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	(	0.000000	0.000000	90.00
91. 00 09100 EMERGENCY	74, 966, 162	158, 800, 313	233, 766, 475		0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	7, 231, 307	10, 742, 941			0.000000	92.00
OTHER REIMBURSABLE COST CENTERS			,			
102.00 10200 OPI OI D TREATMENT PROGRAM	O	0	(			102. 00
200.00 Subtotal (see instructions)	1, 170, 698, 206	1, 395, 161, 353	2, 565, 859, 559			200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	1, 170, 698, 206	1, 395, 161, 353	2, 565, 859, 559	p		202. 00

Health Financial Systems	PORTER REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0035	Peri od: Worksheet C Part I To 12/31/2022 Date/Ti me Prepared: 6/22/2023 2:56 pm

INPATI ENT ROUTI NE SERVI CE COST CENTERS   11.00	6 pm
INPATI ENT ROUTI NE SERVI CE COST CENTERS	<u>- p</u>
INPATI ENT ROUTINE SERVICE COST CENTERS	
INPATI ENT ROUTI NE SERVI CE COST CENTERS	
30. 00   03000   ADULTS & PEDIATRICS   31. 00   03101   NTENSIVE CARE UNIT   31. 01   03101   NEONATAL INTENSIVE CARE UNIT   41. 00   04100   SUBPROVIDER - IRF   04300   NURSERY   ANCILLARY SERVICE COST CENTERS	
31. 00	
31. 01 03101 NEONATAL INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - I RF 50. 00 04300 NURSERY ANCILLARY SERVICE COST CENTERS 50. 00 05000 PERATI NG ROOM 0. 000000 52. 00 05200 DELI VERY ROOM 0. 346139 53. 00 05300 ANESTHESI OLOGY 0. 006479 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 070491 54. 01 05401 ULTRASOUND 0. 000000 56. 00 05600 RADI OLOGY-DI AGNOSTI C 0. 000000 56. 00 05600 RADI OLOGY-DI AGNOSTI C 0. 000000 57. 00 05700 CT SCAN 0. 000000 58. 00 05800 MRI 0. 000000 58. 00 05800 MRI 0. 000000 59. 00 05800 MRI 0. 0000000 59. 00 05800 MRI 0. 000000 59. 000000 59. 0000000 59. 000000 59. 000000 59. 000000 59. 0000000 59. 0000000 59. 00	30.00
41.00	31.00
43. 00	31. 01
ANCILLARY SERVICE COST CENTERS	41.00
50. 00         05000 OPERATING ROOM         0. 072295           51. 00         05100 RECOVERY ROOM         0. 000000           52. 00         05200 DELIVERY ROOM & LABOR ROOM         0. 346139           53. 00         05300 ANESTHESI OLOGY         0. 006479           54. 00         05400 RADI OLOGY-DI AGNOSTI C         0. 070491           54. 01         05401 ULTRASOUND         0. 000000           56. 00         05600 RADI OI SOTOPE         0. 000000           57. 00         05700 CT SCAN         0. 000000           58. 00         05800 MRI         0. 000000           60. 00         06500 RESPI RATORY THERAPY         0. 073424           65. 00         06500 PHYSI CAL THERAPY         0. 221050           67. 00         06700 PHYSI CAL THERAPY         0. 104283           68. 00         06800 SPEECH PATHOLOGY         0. 180571           69. 00         06900 ELECTROCARDI OLOGY         0. 180571           69. 00         07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT         0. 093715           72. 00         07200 I MPL. DEV. CHARGED TO PATI ENTS         0. 147636           73. 00         07300 RURGS CHARGED TO PATI ENTS         0. 147636           76. 01         03950 ANCI LLARY         0. 000000           76. 01	43.00
50. 00         05000 OPERATING ROOM         0. 072295           51. 00         05100 RECOVERY ROOM         0. 000000           52. 00 05200 DELIVERY ROOM & LABOR ROOM         0. 346139           53. 00 05300 ANESTHESI OLOGY         0. 006479           54. 00 05400 RADI OLOGY-DI AGNOSTI C         0. 070491           56. 00 05600 RADI OLOGY-DI AGNOSTI C         0. 000000           57. 00 05700 CT SCAN         0. 000000           58. 00 05800 MRI         0. 000000           60. 00 05600 RESPI RATORY THERAPY         0. 073424           65. 00 06600 PHYSI CAL THERAPY         0. 0773424           66. 00 06600 PHYSI CAL THERAPY         0. 221050           67. 00 06700 OCCUPATI ONAL THERAPY         0. 104283           68. 00 06800 SPEECH PATHOLOGY         0. 180571           69. 00 06900 ELECTROCARDI OLOGY         0. 162143           71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT         0. 062143           72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS         0. 147636           73. 00 07300 DRUGS CHARGED TO PATI ENTS         0. 147636           76. 01 03950 ANCI LLARY         0. 000000           76. 01 03610 SLEEP LAB         0. 000000           76. 01 03951 WOUND CARE         0. 361067	1
52. 00   05200   DELI VERY ROOM & LABOR ROOM   0. 346139   53. 00   05300   ANESTHESI OLOGY   0. 006479   54. 01   05401   ULTRASOUND   0. 000000   56. 00   05600   RADI OLOGY-DI AGNOSTI C   0. 000000   57. 00   05700   CT SCAN   0. 000000   58. 00   05800   MRI   0. 000000   60. 00   06000   LABORATORY   0. 073424   65. 00   06500   RESPI RATORY THERAPY   0. 097585   66. 00   06600   PHYSI CAL THERAPY   0. 221050   67. 00   06700   0CCUPATI ONAL THERAPY   0. 104283   68. 00   06800   SPEECH PATHOLOGY   0. 180571   69. 00   06900   ELECTROCARDI OLOGY   0. 062143   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0. 093715   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENT   0. 147636   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 137073   74. 00   07400   RENAL DI ALYSI S   0. 296300   76. 01   03610   SLEEP LAB   0. 000000   76. 03   03951   WOUND CARE   0. 361067	50.00
53. 00       05300       ANESTHESI OLOGY       0.006479         54. 00       054001       RADI OLOGY-DI AGNOSTI C       0.070491         54. 01       05401       ULTRASOUND       0.000000         56. 00       05600       RADI OI SOTOPE       0.000000         57. 00       05700       CT SCAN       0.000000         68. 00       06000       LABORATORY       0.00000         65. 00       06500       RESPI RATORY THERAPY       0.073424         66. 00       06600       PHYSI CAL THERAPY       0.221050         67. 00       06700       OCCUPATI ONAL THERAPY       0.104283         68. 00       06800       SPEECH PATHOLOGY       0.180571         69. 00       06900       ELECTROCARDI OLOGY       0.062143         71. 00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.147636         72. 00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.147636         73. 00       07300       RENAL DI ALYSI S       0.296300         76. 01       03610       SLEEP LAB       0.000000         76. 01       03610       SLEEP LAB       0.000000         76. 01       03951       WOUND CARE       0.361067 <td>51.00</td>	51.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C   0. 070491   54. 01   05401   ULTRASOUND   0. 000000   57. 00   05600   RADI OI SOTOPE   0. 000000   58. 00   05800   MRI   0. 000000   60. 00   06600   LABORATORY   0. 073424   65. 00   06500   RESPI RATORY THERAPY   0. 097585   66. 00   06600   PHYSI CAL THERAPY   0. 221050   67. 00   06700   0CCUPATI ONAL THERAPY   0. 104283   68. 00   06800   SPEECH PATHOLOGY   0. 180571   69. 00   06900   ELECTROCARDI OLOGY   0. 062143   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0. 093715   72. 00   07200   TIMPL. DEV. CHARGED TO PATI ENTS   0. 147636   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 137073   74. 00   07400   RENAL DI ALLYSI S   0. 296300   76. 01   03610   SLEEP LAB   0. 000000   76. 01   03610   SLEEP LAB   0. 000000   76. 03   03951   WOUND CARE   0. 361067	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C   0. 070491   54. 01   05401   ULTRASOUND   0. 000000   57. 00   05600   RADI OI SOTOPE   0. 000000   58. 00   05800   MRI   0. 000000   60. 00   06600   LABORATORY   0. 073424   65. 00   06500   RESPI RATORY THERAPY   0. 097585   66. 00   06600   PHYSI CAL THERAPY   0. 221050   67. 00   06700   0CCUPATI ONAL THERAPY   0. 104283   68. 00   06800   SPEECH PATHOLOGY   0. 180571   69. 00   06900   ELECTROCARDI OLOGY   0. 062143   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0. 093715   72. 00   07200   TIMPL. DEV. CHARGED TO PATI ENTS   0. 147636   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 137073   74. 00   07400   RENAL DI ALLYSI S   0. 296300   76. 01   03610   SLEEP LAB   0. 000000   76. 01   03610   SLEEP LAB   0. 000000   76. 03   03951   WOUND CARE   0. 361067	53.00
54. 01       05401       ULTRASOUND       0.000000         56. 00       05600       RADI OI SOTOPE       0.000000         57. 00       05700       CT SCAN       0.000000         68. 00       06800       MRI       0.000000         65. 00       06500       RESPI RATORY THERAPY       0.073424         66. 00       06600       PHYSI CAL THERAPY       0.221050         67. 00       06700       0CCUPATI ONAL THERAPY       0.104283         68. 00       06800       SPEECH PATHOLOGY       0.180571         69. 00       06900       ELECTROCARDI OLOGY       0.062143         71. 00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0.093715         72. 00       07200       I MPL. DEV. CHARGED TO PATI ENTS       0.147636         73. 00       07300       DRUGS CHARGED TO PATI ENTS       0.137073         74. 00       07400       RENAL DI ALYSI S       0.296300         76. 00       03950       ANCI LLARY       0.000000         76. 01       03610       SLEEP LAB       0.000000         76. 02       03951       WOUND CARE       0.361067	54.00
56. 00       05600   RADI OI SOTOPE       0.000000         57. 00       05700   CT SCAN       0.000000         58. 00       05800   MRI       0.000000         60. 00   C6000   LABORATORY       0.073424         65. 00   06500   RESPI RATORY THERAPY       0.097585         66. 00   06600   PHYSI CAL THERAPY       0.221050         67. 00   06700   OCCUPATI ONAL THERAPY       0.104283         68. 00   06800   SPEECH PATHOLOGY       0.180571         69. 00   06900   ELECTROCARDI OLOGY       0.062143         71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.093715         72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS       0.147636         73. 00   07300   DRUGS CHARGED TO PATI ENTS       0.137073         74. 00   07400   RENAL DI ALYSI S       0.296300         76. 01   03610   SLEEP LAB       0.000000         76. 01   03610   SLEEP LAB       0.000000         76. 03   03951   WOUND CARE       0.361067	54. 01
57. 00	56. 00
58. 00   05800   MRI   0. 000000   0. 073424   0. 0734	57. 00
60. 00   06000   CABORATORY   0. 073424   0. 097585   0. 06600   PHYSI CAL THERAPY   0. 221050   06700   06700   06000   PATHERAPY   0. 104283   0. 08800   08800   SPECH PATHOLOGY   0. 108571   0. 062143   0. 07100   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0. 093715   0. 147636   0. 137073   0. 07300   DRUGS CHARGED TO PATI ENTS   0. 137073   0. 07400   DRUGS CHARGED TO PATI ENTS   0. 137073   0. 07400   RENAL DI ALYSI S   0. 296300   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000	58. 00
65. 00	60.00
66. 00   06600   PHYSI CAL THERAPY   0. 221050   67. 00   06700   06CUPATI ONAL THERAPY   0. 104283   68. 00   06800   SPEECH PATHOLOGY   0. 180571   69. 00   06900   ELECTROCARDI OLOGY   0. 062143   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT   0. 093715   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 147636   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 137073   74. 00   07400   RENAL DI ALYSI S   0. 296300   76. 00   03950   ANCI LLARY   0. 000000   76. 01   03610   SLEEP LAB   0. 000000   76. 03   03951   WOUND CARE   0. 361067	65. 00
67. 00	66. 00
68. 00	67. 00
69. 00   06900   ELECTROCARDI OLOGY   0. 062143   71. 00   70700   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0. 093715   72. 00   7300   7300   DRUGS CHARGED TO PATI ENTS   0. 147636   73. 00   7300   7400   RENAL DI ALYSI S   0. 296300   76. 00   03950   ANCI LLARY   0. 000000   76. 01   03610   SLEEP LAB   0. 000000   0. 361067	68. 00
71. 00	69.00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 147636   07300   07400	71.00
73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 137073   0. 296300   0. 03950   ANCI LLARY   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000	72.00
74. 00   07400   RENAL DI ALYSI S   0. 296300   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000	73.00
76. 00   03950   ANCI LLARY	74.00
76. 01   03610   SLEEP LAB	76.00
	76. 01
77. 00   07700   ALLOGENEI C HSCT ACQUISITION   0.000000	76. 03
	77.00
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLI NI C 0. 000000	90.00
91. 00   09100   EMERGENCY   0. 101549	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.407112	92.00
OTHER REIMBURSABLE COST CENTERS	1
102. 00 10200 OPI OI D TREATMENT PROGRAM	102. 00
200.00 Subtotal (see instructions)	200. 00
201.00 Less Observation Beds	201. 00
202.00 Total (see instructions)	202. 00

Health Financial Systems	PORTER REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0035	Peri od: Worksheet C
		From 01/01/2022   Part I
		To 12/21/2022   Dota/Time December

			T	o 12/31/2022	Date/Time Pre 6/22/2023 2:5	pared: 6 pm
		Ti tl	e XIX	Hospi tal	Cost	<u> </u>
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	66, 656, 530		66, 656, 530	ام	66, 656, 530	30.00
31. 00   03100   NTENSI VE CARE UNI T	21, 192, 871		21, 192, 871	٥	21, 192, 871	31. 00
31. 01   03101   NEONATAL   INTENSIVE CARE UNIT	4, 560, 797		4, 560, 797	٥	4, 560, 797	31. 01
41. 00   04100   SUBPROVI DER -   RF	5, 214, 637		5, 214, 637		5, 214, 637	41. 00
43. 00   04300   NURSERY	503, 941		503, 941	٥	503, 941	43. 00
ANCI LLARY SERVI CE COST CENTERS	000,711		000,711	<u>ا</u>	000, 711	10.00
50. 00   05000   OPERATING ROOM	32, 643, 994		32, 643, 994	O	32, 643, 994	50. 00
51. 00   05100   RECOVERY ROOM	0	•	0	ol	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 323, 216	•	6, 323, 216	ol	6, 323, 216	52. 00
53. 00 05300 ANESTHESI OLOGY	190, 108		190, 108		190, 108	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	22, 657, 765		22, 657, 765	o	22, 657, 765	54.00
54. 01 05401 ULTRASOUND	0		0	o	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0		0	o	0	56. 00
57. 00 05700 CT SCAN	0		0	o	0	57. 00
58. 00 05800 MRI	0		0	o	0	58. 00
60. 00   06000   LABORATORY	20, 848, 766		20, 848, 766	o	20, 848, 766	60.00
65. 00 06500 RESPIRATORY THERAPY	6, 478, 956	0	6, 478, 956	o	6, 478, 956	65. 00
66. 00 06600 PHYSI CAL THERAPY	5, 658, 967	0	5, 658, 967	o	5, 658, 967	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 763, 601	0	1, 763, 601	o	1, 763, 601	67. 00
68. 00 06800 SPEECH PATHOLOGY	1, 212, 865	0	1, 212, 865	o	1, 212, 865	68. 00
69. 00 06900 ELECTROCARDI OLOGY	13, 598, 589		13, 598, 589	o	13, 598, 589	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5, 082, 399		5, 082, 399	o	5, 082, 399	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	29, 824, 577		29, 824, 577	o	29, 824, 577	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	49, 498, 368		49, 498, 368	o	49, 498, 368	73. 00
74.00 07400 RENAL DIALYSIS	1, 378, 787		1, 378, 787	o	1, 378, 787	74. 00
76. 00   03950   ANCI LLARY	0		0	0	0	76. 00
76. 01   03610   SLEEP LAB	0		0	0	0	76. 01
76. 03   03951   WOUND CARE	3, 180, 400		3, 180, 400	0	3, 180, 400	76. 03
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00   09000   CLI NI C	0		0	0	0	90.00
91. 00   09100   EMERGENCY	23, 738, 679		23, 738, 679		23, 738, 679	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	7, 317, 528		7, 317, 528		7, 317, 528	92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPLOID TREATMENT PROGRAM	0					102. 00
200.00 Subtotal (see instructions)	329, 526, 341	0			329, 526, 341	
201.00 Less Observation Beds	7, 317, 528		7, 317, 528		7, 317, 528	
202.00   Total (see instructions)	322, 208, 813	0	322, 208, 813	0	322, 208, 813	202. 00

				To 12/31/2022	Date/Time Pre 6/22/2023 2:5	
		Ti tl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Rati o	I npati ent	
					Ratio	
	6. 00	7.00	8. 00	9. 00	10. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	174, 226, 017		174, 226, 01	7	I	30.00
31.00   03100   INTENSIVE CARE UNIT	37, 652, 944		37, 652, 94	4	I	31.00
31.01  03101 NEONATAL INTENSIVE CARE UNIT	14, 003, 672		14, 003, 67	2	I	31. 01
41. 00   04100   SUBPROVI DER -   RF	13, 584, 103		13, 584, 10	3	I	41.00
43. 00   04300 NURSERY	4, 860, 240		4, 860, 24	O	1	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	182, 152, 733	269, 383, 484	451, 536, 21	7 0. 072295	0. 000000	50. 00
51.00   05100   RECOVERY ROOM	0	0		0.000000	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	18, 169, 322	98, 529	18, 267, 85	0. 346139	0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	11, 516, 127	17, 823, 809	29, 339, 93	6 0. 006479	0.000000	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	78, 740, 253	242, 688, 766	321, 429, 01	9 0. 070491	0.000000	54.00
54. 01   05401   ULTRASOUND	0	0		0.000000	0.000000	54. 01
56. 00   05600   RADI 0I SOTOPE	0	0		0.000000	0.000000	56.00
57. 00  05700 CT SCAN	0	0		0.000000	0.000000	57. 00
58. 00   05800   MRI	0	0		0.000000	0.000000	58. 00
60. 00   06000   LABORATORY	126, 168, 283	157, 782, 556	283, 950, 83	9 0. 073424	0.000000	60.00
65. 00 06500 RESPIRATORY THERAPY	63, 013, 264	3, 379, 772	66, 393, 03	6 0. 097585	0.000000	65. 00
66. 00   06600 PHYSI CAL THERAPY	17, 905, 931	7, 694, 488	25, 600, 41	9 0. 221050	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	15, 364, 369	1, 547, 303	16, 911, 67	0. 104283	0.000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	5, 097, 722	1, 619, 122	6, 716, 84	4 0. 180571	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	89, 669, 990	129, 157, 763	218, 827, 75	0. 062143	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	28, 368, 860	25, 863, 556	54, 232, 41	6 0. 093715	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	115, 232, 423	86, 782, 514	202, 014, 93	7 0. 147636	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	87, 533, 627	273, 575, 602	361, 109, 22	9 0. 137073	0.000000	73. 00
74. 00 07400 RENAL DIALYSIS	4, 522, 142	131, 201		0. 296300	0.000000	74. 00
76. 00 03950 ANCI LLARY	0	0		0.000000	0.000000	76. 00
76. 01 03610 SLEEP LAB	o	0		0. 000000	0. 000000	76. 01
76. 03   03951   WOUND CARE	718, 715	8, 089, 634	8, 808, 34		0. 000000	76. 03
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	, ,	0. 000000	0.000000	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0.000000	0.000000	90.00
91. 00 09100 EMERGENCY	74, 966, 162	158, 800, 313	233, 766, 47			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	7, 231, 307	10, 742, 941			0. 000000	
OTHER REIMBURSABLE COST CENTERS	.,	,,				
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0		0		102. 00
200.00 Subtotal (see instructions)	1, 170, 698, 206	1, 395, 161, 353	2, 565, 859, 55	9	I	200. 00
201.00 Less Observation Beds	., ., 5, 5, 5, 200	., 2,0, .0., 000	_, 555, 557, 66		I	201.00
202.00 Total (see instructions)	1, 170, 698, 206	1 395 161 353	2 565 859 55	9	I	202. 00
	., ., ., ., ., ., 200	., 2,0, .0., 000	_, _, 000, 007, 00	-1		1_32.00

Health Financial Systems	PORTER REGIONAL H	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0035	From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared:

				10 12/31/2022	6/22/2023 2:5	
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient		<u> </u>		
	<b>'</b>	Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS					30.00
31.00	03100 INTENSIVE CARE UNIT					31.00
31. 01	03101 NEONATAL INTENSIVE CARE UNIT					31. 01
41.00	04100 SUBPROVI DER - I RF					41.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 000000				50.00
51.00	05100 RECOVERY ROOM	0. 000000				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53.00	05300 ANESTHESI OLOGY	0. 000000				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
54. 01	05401 ULTRASOUND	0. 000000				54. 01
56.00	05600 RADI OI SOTOPE	0. 000000				56.00
57.00	05700 CT SCAN	0. 000000				57.00
58. 00	05800 MRI	0. 000000				58. 00
	06000 LABORATORY	0. 000000				60.00
65. 00	06500 RESPIRATORY THERAPY	0. 000000				65.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000				66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000				68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000				69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
74.00	07400 RENAL DIALYSIS	0. 000000				74.00
76.00	03950 ANCI LLARY	0. 000000				76. 00
76. 01	03610 SLEEP LAB	0. 000000				76. 01
76. 03	03951 WOUND CARE	0. 000000				76. 03
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000				77. 00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	0. 000000				90.00
91.00	09100 EMERGENCY	0. 000000				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
	OTHER REIMBURSABLE COST CENTERS					
102.00	10200 OPI OI D TREATMENT PROGRAM					102. 00
200.00	Subtotal (see instructions)					200.00
201.00						201.00
202.00						202.00
		,				•

	Financial Systems	PORTER REGION	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL (		Provider Co	<u> </u>	Period: From 01/01/2022 To 12/31/2022	Date/Time Prep 6/22/2023 2:50	pared: 6 pm
				XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal Rel ated Cost	Swing Bed Adjustment	Reduced Capital	Total Patient Days	Per Diem (col. 3 / col. 4)	
		(from Wkst. B,	riaj ao emorre	Related Cost		0 , 00,	
		Part II, col.		(col. 1 - col.			
		26)		2)			
		1.00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>			<u>"</u>		
30.00	ADULTS & PEDI ATRI CS	4, 639, 147	0	4, 639, 14	7 52, 405	88. 52	30. 00
31.00	INTENSIVE CARE UNIT	884, 212		884, 21	2 5, 987	147. 69	31.00
31. 01	NEONATAL INTENSIVE CARE UNIT	314, 296		314, 29	6 2, 354	133. 52	31. 01
41.00	SUBPROVI DER - I RF	569, 502	0	569, 50	2 4, 173	136. 47	41. 00
43.00	NURSERY	94, 075		94, 07		37. 47	43.00
200.00	Total (lines 30 through 199)	6, 501, 232		6, 501, 23	2 67, 430		200. 00
	Cost Center Description	I npati ent	I npati ent				
		Program days	Program				
			Capital Cost				
			(col. 5 x col.				
		/ 00	6)				
	INPATIENT ROUTINE SERVICE COST CENTERS	6.00	7. 00				
30. 00	ADULTS & PEDIATRICS	17, 119	1, 515, 374				30.00
31. 00	INTENSIVE CARE UNIT	2, 037					31. 00
31. 00	NEONATAL INTENSIVE CARE UNIT	2,037	300, 645	1			31.00
41. 00	SUBPROVIDER - IRF	2, 696		1			41. 00
	NURSERY	2,090	307, 723	1			43.00
	Total (lines 30 through 199)	21, 852	-	1			200. 00

Heal th Financial	Systems	PO	ORTER REGION	AL H	OSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTI ONMENT OF	INPATIENT ANCILLARY SERVICE CA	APITAL C	OSTS	F	Provi der C	CN: 15-0035	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part II Date/Time Pre 6/22/2023 2:5	
					Titl∈	e XVIII	Hospi tal	PPS	
Cost	Center Description	(fr	lated Cost	(froi Par	m Wkst. C,	Ratio of Cos to Charges (col. 1 ÷ co	Program	Capital Costs (column 3 x column 4)	

							0/22/2023 2.3	ο μιι
					XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Tota	I Charges	Ratio of Cos	t Inpatient	Capital Costs	
			(fro	m Wkst. C,	to Charges	Program	(column 3 x	
			Par	t I, col.	(col. 1 + col	. Charges	column 4)	
		Part II, col.		8)	2)			
		26)						
		1.00		2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2, 682, 850	4	51, 536, 217	0. 00594	57, 915, 967	344, 137	50.00
51.00	05100 RECOVERY ROOM	0	)	0	0.00000	00 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	539, 195		18, 267, 851	0. 0295	31, 906	942	52.00
53.00	05300 ANESTHESI OLOGY	44, 925		29, 339, 936	0. 00153	3, 226, 232	4, 939	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 744, 396	3	21, 429, 019	0. 00542	28, 905, 999	156, 873	54.00
54. 01	05401 ULTRASOUND	0		0	0. 00000	00	0	54. 01
56.00	05600 RADI OI SOTOPE	0		0	0. 00000	00 0	0	56. 00
57.00	05700 CT SCAN	0		0	0. 00000	00 0	0	57. 00
58.00	05800 MRI	0		0	0. 00000	00 0	0	58. 00
60.00	06000 LABORATORY	652, 481	2	83, 950, 839	0. 00229	98 43, 171, 788	99, 209	60.00
65.00	06500 RESPIRATORY THERAPY	148, 403		66, 393, 036	0.00223	23, 714, 345	53, 002	65. 00
66.00	06600 PHYSI CAL THERAPY	700, 614		25, 600, 419	0. 02736	5, 323, 377	145, 685	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	6, 208		16, 911, 672	0.00036	4, 467, 116	1, 639	67. 00
68. 00	06800 SPEECH PATHOLOGY	4, 093		6, 716, 844		1, 398, 356	852	68. 00
69.00	06900 ELECTROCARDI OLOGY	1, 220, 763	2	18, 827, 753	0. 0055	79 35, 078, 141	195, 701	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	60, 907		54, 232, 416	0. 00112	9, 861, 672	11, 075	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	354, 398		02, 014, 937				
73.00		433, 313		61, 109, 229				
74.00		30, 158		4, 653, 343				
76. 00		0		0	0. 00000		0	76. 00
76. 01	03610 SLEEP LAB	0		0	0. 00000		0	76. 01
76. 03		276, 297	·	8, 808, 349			6, 953	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0		0	0. 00000		0	77. 00
	OUTPATIENT SERVICE COST CENTERS							
90.00		0		0	0.00000	00 0	0	90.00
	09100 EMERGENCY	1, 889, 030	2	33, 766, 475			218, 352	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	509, 285		17, 974, 248				
200.00		11, 297, 316				316, 246, 994		
	-		, -, 0	, , 500	1	1 = :=: = :=! ***	.,,	

Health Financial Systems	PORTER REGIONA	AI HOSPITAI		In lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P		S Provider CO		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part III Date/Time Pre 6/22/2023 2:5	pared:
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 31. 01   03101   NEONATAL INTENSIVE CARE UNIT 41. 00   04100   SUBPROVIDER - IRF	0 0	0 0 0		0 0 0	0 0 0	31. 00 31. 01
	0	0		0		41.00
43.00   04300   NURSERY 200.00   Total (lines 30 through 199)	0	0		0	0	200.00
200.00 Total (lines 30 through 199)  Cost Center Description	Swi ng-Bed	Total Costs	Total Dotion	Per Diem (col.	Inpati ent	200.00
cost center bescription	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,	Days	3 ÷ COI. 0)	Frogram Days	
		minus col. 4)				
	4. 00	5.00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	0.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	52, 40	5 0.00	17, 119	30.00
31. 00 03100 I NTENSI VE CARE UNI T		0	5, 98			
31. 01   03101 NEONATAL INTENSIVE CARE UNIT		0	2, 35			31. 01
41. 00   04100   SUBPROVI DER -   RF	o	0	4, 17	0.00	2, 696	41.00
43. 00 04300 NURSERY		0	2, 51	0.00	0	43.00
200.00 Total (lines 30 through 199)		0	67, 43	0	21, 852	200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 31. 01   03101   NEONATAL INTENSIVE CARE UNIT 41. 00   04100   SUBPROVIDER - IRF 43. 00   04300   NURSERY	0 0 0 0					30. 00 31. 00 31. 01 41. 00 43. 00
43.00 04300 NUKSERY 200.00 Total (lines 30 through 199)						200.00
200.00   10tal (11100 00 through 177)	١					1200.00

Health Financial Systems	PORTER REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0035	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2022	Part IV

THROUGH COSTS 12/31/2022 Date/Time Prepared: 6/22/2023 2:56 pm Title XVIII Hospi tal Nursi ng Cost Center Description Non Physician Nursi ng Allied Health Allied Health Anestheti st Post-Stepdown Program Program Post-Stepdown Cost Adjustments Adjustments 1.00 ЗА 3.00 2A 2.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 50.00 0 51.00 05100 RECOVERY ROOM 0 51.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 53.00 05300 ANESTHESI OLOGY 0 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 54.00 0 05401 ULTRASOUND 54.01 54.01 0 0 56.00 05600 RADI OI SOTOPE 0 0 56.00 57.00 05700 CT SCAN 0 0 57.00 01 58.00 05800 MRI 0 0 58.00 06000 LABORATORY 0 60.00 0 60.00 65.00 06500 RESPIRATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 0 0 66.00 0 66.00 06700 OCCUPATI ONAL THERAPY 0 0 0 67.00 67.00 06800 SPEECH PATHOLOGY 68.00 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 71.00 71 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72.00 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 07400 RENAL DIALYSIS 0 74.00 74.00 0 76. 00 03950 ANCI LLARY 0 0 76.00 Ω 03610 SLEEP LAB 0 76.01 0 0 76.01 03951 WOUND CARE 0 0 76.03 76. 03 0 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0 ol 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 0 90.00 09100 EMERGENCY 0 0 0 0 0 0 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 Ω Total (lines 50 through 199) 200.00 0 0 200. 00

Heal th	Financial Systems	PORTER REGION	AI HOSPITAI		In lie	eu of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS		S Provider CO		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Pre 6/22/2023 2:5	pared:
				XVIII	Hospi tal	PPS	
	Cost Center Description	AII Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	(from Wkst. C,	(col. 5 ÷ col. 7) (see	
		4.00	5. 00	6, 00	7. 00	instructions) 8.00	
	ANCILLARY SERVICE COST CENTERS	4.00	5.00	0.00	7.00	8.00	
50. 00	05000 OPERATING ROOM	1 0	0		0 451, 536, 217	0.000000	50.00
	05100 RECOVERY ROOM	0	0		0 101, 000, 217		
	05200 DELIVERY ROOM & LABOR ROOM	0	Ö		0 18, 267, 851	0. 000000	
53.00	05300 ANESTHESI OLOGY	0	0		0 29, 339, 936		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 321, 429, 019	0.000000	54.00
54. 01	05401 ULTRASOUND	0	0		0 0	0.000000	54. 01
56.00	05600 RADI 0I S0T0PE	0	0		0 0	0.000000	56. 00
57.00	05700 CT SCAN	0	0		0 0	0.000000	57. 00
58.00	05800 MRI	0	0		0 0	0.000000	58. 00
	06000 LABORATORY	0	0		0 283, 950, 839		
65.00	06500 RESPI RATORY THERAPY	0	0		0 66, 393, 036	0.000000	65. 00
	06600 PHYSI CAL THERAPY	0	0		0 25, 600, 419		
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 16, 911, 672		
68. 00	06800 SPEECH PATHOLOGY	0	0		0 6, 716, 844		
	06900 ELECTROCARDI OLOGY	0	0		0 218, 827, 753		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 54, 232, 416		
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 202, 014, 937		
	07300 DRUGS CHARGED TO PATIENTS	0	0	1	0 361, 109, 229		
	07400 RENAL DI ALYSI S	0	0		0 4, 653, 343		
	03950 ANCI LLARY	0	0		0	0.000000	
	03610 SLEEP LAB	0	0		0 000 0	0.000000	
76. 03	03951 WOUND CARE	0	0		0 8, 808, 349		
//. 00	07700 ALLOGENEI C HSCT ACQUI SI TI ON	0	0		U  0	0.000000	77. 00

0 0 0

0 0 0

0 0 233, 766, 475 0 17, 974, 248 0 2, 321, 532, 583

 0. 000000
 90. 00

 0. 000000
 91. 00

 0. 000000
 92. 00

200. 00

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

76. 01 03610 SLEEP LAB
76. 03 03951 WOUND CARE
77. 00 07700 ALLOGENEIC HSCT ACQUISITION
OUTPATIENT SERVICE COST CENTERS

92. 00 | 09200 | 085ERVATION BEDS (NON-DISTINCT PART 200. 00 | Total (lines 50 through 199)

llool +b	Financial Customs	PORTER REGIONA	I HOSDITAL		المانا	u of Form CMS-2	DEE2 10
APPORT	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS		Provider CC		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Pre 6/22/2023 2:5	pared:
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)		Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9. 00	10.00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	57, 915, 967		0 71, 646, 433		50.00
51. 00	05100 RECOVERY ROOM	0. 000000	0		0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	31, 906		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000	3, 226, 232		0 4, 551, 297	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	28, 905, 999		0 61, 083, 901	0	54. 00
54. 01	05401 ULTRASOUND	0. 000000	0		0	0	54. 01
56. 00	05600 RADI OI SOTOPE	0. 000000	0		0	0	56. 00
57. 00	05700 CT SCAN	0. 000000	0		0	0	57. 00
58. 00	05800 MRI	0. 000000	0		0	0	58. 00
60.00	06000 LABORATORY	0. 000000	43, 171, 788		0 16, 920, 169	0	60. 00
65.00	06500 RESPI RATORY THERAPY	0. 000000	23, 714, 345		0 738, 208	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	5, 323, 377		0 207, 524	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	4, 467, 116		0 65, 886	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	1, 398, 356		0 10, 984	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	35, 078, 141		0 45, 752, 645	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	9, 861, 672		0 6, 540, 126	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	43, 401, 244		0 32, 442, 468	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	28, 127, 846		0 95, 574, 819	0	73. 00
74.00	07400 RENAL DIALYSIS	0. 000000	1, 947, 737		0 72, 116	0	74. 00
76. 00	03950 ANCI LLARY	0. 000000	0		0	0	76. 00
76. 01	03610 SLEEP LAB	0. 000000	0		0 0	0	76. 01
76. 03	03951 WOUND CARE	0. 000000	221, 672		0 1, 946, 622	0	76. 03
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77. 00

0.000000

0. 000000 0. 000000

27, 020, 426 2, 433, 170

316, 246, 994

22, 068, 556 2, 006, 282

361, 628, 036

0 0 0

0

90.00

0 91.00 0 92.00 0 200.00

77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON OUTPATIENT SERVI CE COST CENTERS
90. 00 09000 CLI NI C

91.00 | 09100 | EMERGENCY 92.00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART 200.00 | Total (lines 50 through 199)

From 01/01/2022 Part V Date/Time Prepared: 12/31/2022 6/22/2023 2:56 pm Title XVIII Hospi tal Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.072295 71, 646, 433 0 5, 179, 679 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52 00 0.346139 52 00 0 0 53.00 05300 ANESTHESI OLOGY 0.006479 4, 551, 297 0 29, 488 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.070491 61, 083, 901 5, 306 4, 305, 865 54.00 54. 01 05401 ULTRASOUND 0.000000 0 C 0 Ω 54 01 05600 RADI OI SOTOPE 56.00 0.000000 C 0 0 56.00 57.00 05700 CT SCAN 0.000000 0 0 57.00 05800 MRI 58.00 0.000000 0 0 58.00 0 16, 920, 169 06000 LABORATORY 1, 242, 346 18, 693 60 00 0.073424 60 00 65.00 06500 RESPIRATORY THERAPY 0.097585 738, 208 0 72,038 65.00 06600 PHYSI CAL THERAPY 0. 221050 207, 524 0 0 45, 873 66.00 66.00 0 06700 OCCUPATIONAL THERAPY 0.104283 65, 886 0 67.00 67.00 6,871 0 1, 983 06800 SPEECH PATHOLOGY 68 00 0.180571 10, 984 68 00 69.00 06900 ELECTROCARDI OLOGY 0.062143 45, 752, 645 0 0 2, 843, 207 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.093715 6, 540, 126 612, 908 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.147636 32, 442, 468 0 ol 4, 789, 676 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 533, 302 73.00 0.137073 95, 574, 819 13, 100, 727 73.00 74.00 07400 RENAL DIALYSIS 0. 296300 72, 116 21, 368 74.00 03950 ANCI LLARY 0 76.00 76.00 0.000000 0 03610 SLEEP LAB 0 76.01 0.000000 0 76.01 0 0 03951 WOUND CARE 0 702, 861 76.03 0.361067 1, 946, 622 76.03 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 77.00 77.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 90.00 0 0 0 22, 068, 556 91.00 09100 EMERGENCY 0.101549 0 0 2, 241, 040 91.00 92.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.407112 2,006,282 816, 781 200.00 Subtotal (see instructions) 361, 628, 036 23, 999 533, 302 36, 012, 711 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

361, 628, 036

23, 999

533, 302

36, 012, 711 202. 00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	PORTER REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0035	Peri od: From 01/01/2022	Worksheet D Part V Date (Time Droppered)

				To 12/31/2022	Date/Time Pre 6/22/2023 2:5	
		Title	XVIII	Hospi tal	PPS	JO PIII
	Cos					
Cost Center Description	Cost Reimbursed Services Subject To	Cost Reimbursed Services Not Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
ANOLUL ARV OFRIGO COOT OFFITERS	6.00	7. 00				
ANCILLARY SERVICE COST CENTERS		0	I			
50. 00   05000   OPERATING ROOM	0	0				50.00
51. 00 05100 RECOVERY ROOM	0	0				51.00
52.00   05200   DELI VERY ROOM & LABOR ROOM 53.00   05300   ANESTHESI OLOGY	0	0				52. 00 53. 00
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY - DI AGNOSTI C	0 374	0				54.00
54. 01   05401   ULTRASOUND	3/4	0				54. 00
56. 00   05600   RADI OI SOTOPE	0	0				56. 00
57. 00   05700 CT SCAN	0	0				57. 00
58. 00   05800   MRI	0	0				58. 00
60. 00 06000 LABORATORY	1, 373	0				60.00
65. 00 06500 RESPIRATORY THERAPY	1, 3, 5	0				65. 00
66. 00   06600   PHYSI CAL THERAPY	0	0	l .			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	73, 101				73. 00
74.00 07400 RENAL DIALYSIS	0	0				74.00
76. 00  03950 ANCI LLARY	0	0				76. 00
76. 01  03610   SLEEP LAB	0	0				76. 01
76. 03  03951 WOUND CARE	0	0				76. 03
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0				77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0				90.00
91. 00   09100   EMERGENCY	0	0				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92. 00
200.00 Subtotal (see instructions)	1, 747	73, 101				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges 202.00 Net Charges (line 200 - line 201)	1, 747	73, 101				202. 00

Health Financial Systems	PORTER REGIONA				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE O	CAPITAL COSTS	Provi der C		Peri od:	Worksheet D	
		Component		From 01/01/2022 To 12/31/2022	Part II Date/Time Pre	narod:
		Component	CCN. 13-1033	10 12/31/2022	6/22/2023 2:5	
		Title	XVIII	Subprovi der -	PPS	<u> </u>
				IRF		
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	Inpati ent	Capital Costs	
·	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	2, 682, 850	451, 536, 217		·	263	
51.00   05100   RECOVERY ROOM	0	0			0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	539, 195	18, 267, 851			0	52. 00
53. 00   05300   ANESTHESI OLOGY	44, 925	29, 339, 936				53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 744, 396	321, 429, 019			1, 772	
54. 01   05401   ULTRASOUND	0	0	0.00000		0	
56. 00   05600   RADI OI SOTOPE	0	0	0.00000		0	56. 00
57.00  05700 CT SCAN	0	0	0.00000		0	57. 00
58. 00   05800   MRI	0	0	0.00000		0	58. 00
60. 00   06000   LABORATORY	652, 481	283, 950, 839			4, 182	
65. 00 06500 RESPIRATORY THERAPY	148, 403	66, 393, 036				65. 00
66. 00   06600 PHYSI CAL THERAPY	700, 614	25, 600, 419			76, 369	
67. 00 06700 OCCUPATI ONAL THERAPY	6, 208	16, 911, 672				
68.00 06800 SPEECH PATHOLOGY	4, 093	6, 716, 844				68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 220, 763	218, 827, 753				
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN		54, 232, 416				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	354, 398	202, 014, 937		·		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	433, 313	361, 109, 229				1
74. 00   07400   RENAL DI ALYSI S	30, 158	4, 653, 343			510	
76. 00   03950   ANCI LLARY	0	0	0.00000		0	
76. 01   03610   SLEEP LAB	0	0	0.00000		0	76. 01
76. 03   03951   WOUND CARE	276, 297	8, 808, 349			109	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.00000	0 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	1 0.0000			
91. 00   09100   EMERGENCY	1, 889, 030			·	358	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR		17, 974, 248			0	
200.00   Total (lines 50 through 199)	10, 788, 031	2, 321, 532, 583		10, 340, 048	87, 281	200. 00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE	PORTER REGION		CN. 1E 002E	Do	In Lie	u of Form CMS-2 Worksheet D	2552-10
THROUGH COSTS	RVICE UTHER PAS:		CCN: 15-0035		om 01/01/2022	Part IV	pared:
		Title	xVIII	S	Subprovi der -	PPS	о рііі
Cost Center Description		Program Post-Stepdown Adjustments			Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2. 00		3A	3. 00	
ANCILLARY SERVICE COST CENTERS							
50. 00   05000   OPERATI NG ROOM	0			0	0	0	50. 00
51.00   05100   RECOVERY ROOM	0	0		0	0	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54. 00
54. 01   05401   ULTRASOUND	0	0		0	0	0	54. 01
56. 00   05600   RADI 0I SOTOPE	0	0		0	0	0	56. 00
57. 00  05700 CT SCAN	0	0		0	0	0	57. 00
58. 00   05800   MRI	0	0		0	0	0	58. 00
60. 00  06000  LABORATORY	0	0		0	0	0	60. 00
65. 00  06500 RESPIRATORY THERAPY	0	0		0	0	0	65. 00
66. 00  06600 PHYSI CAL THERAPY	0	0		0	0	0	66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67. 00
68. 00   06800   SPEECH PATHOLOGY	0	0		0	0	0	68. 00
69. 00  06900   ELECTROCARDI OLOGY	0	0		0	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72. 00
73.00   07300   DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73. 00
74. 00   07400   RENAL DI ALYSI S	0	0		0	0	0	74.00
76. 00  03950  ANCI LLARY	0	0		0	0	0	76. 00
76. 01  03610  SLEEP LAB	0	0		0	0	0	76. 01
76. 03  03951 WOUND CARE	0	0		0	0	0	76. 03
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	_						
90. 00  09000   CLI NI C	0	0		0	0	0	90. 00
91. 00   09100   EMERGENCY	0	0		0	0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0		0	92. 00
200.00   Total (lines 50 through 199)	0	0	1	0	0	0	200. 00

Haalah Firansial Customs	DODTED DECLON	AL LIOCDI TAL		1 11-	6 F OMC (	2552 10
Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	PORTER REGION		ON. 1E 002E	Period:	u of Form CMS-2 Worksheet D	2552-10
THROUGH COSTS	WICE UINER PASS	s Provider C	UN. 13-0033	From 01/01/2022	Part IV	
THROUGH COSTS		Component		To 12/31/2022	Date/Time Pre 6/22/2023 2:5	pared: 6 pm
		Title	: XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of			
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see instructions)	
	4.00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
50. 00 05000 OPERATING ROOM	0	0		0 451, 536, 217	0.000000	50.00
51. 00   05100   RECOVERY   ROOM	0			0 0	0. 000000	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 18, 267, 851	0. 000000	
53. 00 05300 ANESTHESI OLOGY	0	0		0 29, 339, 936	0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0 321, 429, 019	0. 000000	
54. 01   05401   ULTRASOUND	0	0		0 0	0.000000	
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 MRI	0	0		0 0	0.000000	58. 00
60. 00   06000   LABORATORY	0	0		0 283, 950, 839	0.000000	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0 66, 393, 036	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 25, 600, 419	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 16, 911, 672	0.000000	67. 00
68. 00   06800   SPEECH PATHOLOGY	0	0		0 6, 716, 844	0.000000	
69. 00  06900   ELECTROCARDI OLOGY	0	0		0 218, 827, 753	0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 54, 232, 416	0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 202, 014, 937	0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 361, 109, 229	0. 000000	
74. 00   07400   RENAL DI ALYSI S	0	0		0 4, 653, 343	0. 000000	
76. 00 03950 ANCI LLARY	0	0		0	0. 000000	
76. 01 03610 SLEEP LAB	0	0		0 0	0. 000000	
76. 03   03951   WOUND CARE	0	0	•	0 8, 808, 349	0. 000000	
77. 00 07700 ALLOGENEI C HSCT ACQUISITION	0	0		0 0	0. 000000	77. 00
OUTPATIENT SERVICE COST CENTERS		0	1		0.000000	00.00
90. 00   09000   CLI NI C 91. 00   09100   EMERGENCY	0			0 0 233, 766, 475	0. 000000 0. 000000	
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART	0	0	•	0 233, 766, 475 0 17, 974, 248		
200.00 Total (lines 50 through 199)	0	-		0 2, 321, 532, 583		200.00
200.00   Total (Titles 50 till ough 199)	1	٠ ٠	1	U <sub>1</sub> 2, 321, 332, 303	I	1200.00

Health Financial Systems  PORTER REGIONAL HOSPITAL  APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS  Provider CCN: 15-0035 Component CCN: 15-T035  Component CCN: 15-T035  Title XVIII  Cost Center Description  Period: From 01/01/2022 Date/Time Prepared: 6/22/2023 2:56 pm  PPS  Title XVIII  Cost Center Description  Outpatient Ratio of Cost To 12/31/2022 Date/Time Prepared: 6/22/2023 2:56 pm  PPS  Inpatient Program Progr
THROUGH COSTS  Component CCN: 15-T035  Title XVIII  Cost Center Description  Outpatient Ratio of Cost Program Pass-Through  Cost Charges  Ratio of Cost Charges  Ratio of Cost Charges  Ratio of Cost Charges  Component CCN: 15-T035  To 01/01/2022 Date/Time Prepared: 6/22/2023 2: 56 pm  PPS  IRF  Outpatient Program Program Program Program Program Program Program Pass-Through  Program Pass-Through  Pass-Through
Component CCN: 15-T035 To 12/31/2022 Date/Time Prepared: 6/22/2023 2: 56 pm  Title XVIII Subprovider - PPS  IRF  Cost Center Description Outpatient Ratio of Cost Program Program Program Program Program Program Program Program Program Pass-Through Charges Pass-Through
Title XVIII Subprovider - PPS  Cost Center Description Outpatient Ratio of Cost Program Program Program Program Program Program Program Program Pass-Through Charges Pass-Through
Title XVIII Subprovider - PPS IRF  Cost Center Description Outpatient Ratio of Cost Program Program Program Program Program Program Pass-Through Charges Pass-Through
Cost Center Description  Outpatient   Inpatient   Inpatient   Outpatient   Outpatient   Program
Ratio of Cost   Program   Pass-Through   Pass-Through   Pass-Through   Pass-Through   Program
Ratio of Cost   Program   Pass-Through   Pass-Through   Pass-Through   Pass-Through   Program
$ (\operatorname{col}. 6 \div \operatorname{col}. $ $ (\operatorname{Costs} (\operatorname{col}. 8) $ $ (\operatorname{Costs} (\operatorname{col}. 9) $
7) x col. 10) x col. 12)
9.00 10.00 11.00 12.00 13.00
ANCILLARY SERVICE COST CENTERS
50. 00   05000   0PERATI NG ROOM   0. 000000   44, 313   0   0   50. 00
51. 00   05100   RECOVERY ROOM   0. 000000   0   0   51. 00
52. 00   05200   DELIVERY ROOM & LABOR ROOM   0. 000000   0   0   52. 00
53. 00   05300   ANESTHESI OLOGY
54. 00   05400  RADI 0LOGY-DI AGNOSTI C   0. 000000  326, 512  0  0  54. 00
54. 01   05401   ULTRASOUND   0. 000000   0   0   54. 01
56. 00   05600  RADI 01 SOTOPE   0. 000000  0  0  0  56. 00
57. 00   05700  CT SCAN   0. 000000  0  0  0  57. 00
58. 00   05800   MRI   0. 000000   0   0   0   58. 00
60. 00   06000  LABORATORY
65. 00   06500   RESPI RATORY THERAPY
66. 00   06600  PHYSI CAL THERAPY 0. 000000  2, 790, 551  0  0  66. 00
67. 00   06700  0CCUPATI ONAL THERAPY 0. 000000  2, 941, 901  0  0  67. 00
68. 00   06800   SPEECH PATHOLOGY   0. 000000   560, 335   0   0   68. 00
69. 00   06900  ELECTROCARDI OLOGY   0. 000000  49, 927  0  0  69. 00
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   0. 000000   2, 044   0   0   71. 00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 000000   3, 279   0   0   72. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 000000   1, 673, 593   0   0   73. 00
74. 00   07400   RENAL DI ALYSI S   0. 000000   78, 672   0   0   74. 00
76. 00   03950  ANCI LLARY   0. 000000  0  0  0  76. 00
76. 01   03610  SLEEP LAB   0. 000000  0   0   0   76. 01
76. 03   03951  WOUND CARE   0. 000000  3, 480  0  0  76. 03
77. 00   07700   ALLOGENEI C   HSCT   ACQUI SI TI ON   0. 000000   0   0   0   77. 00
OUTPATIENT SERVICE COST CENTERS
90. 00   09000   CLI NI C   0. 000000   0   0   0   90. 00
91. 00   09100   EMERGENCY   0. 000000   44, 334   0   104   0   91. 00
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART   0.000000   0   0   0   92. 00
200.00   Total (lines 50 through 199)   10,340,048   0   104   0   200.00

Hoal th	Financial Systems	PORTER REGIONA	AI HOSDITAI		In lie	eu of Form CMS-:	2552_10
	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provi der Co	CN: 15-0035	Peri od:	Worksheet D	2332-10
			Component		From 01/01/2022 To 12/31/2022		
			Title	XVIII	Subprovider - IRF	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subj ect To		
				Ded. & Coins.			
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCI LLARY SERVI CE COST CENTERS	, ,					
50.00	05000 OPERATING ROOM	0. 072295	0		0	-	
51.00	05100 RECOVERY ROOM	0. 000000	0		0	•	
	05200 DELIVERY ROOM & LABOR ROOM	0. 346139	0		0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0. 006479	0		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 070491	0		0	0	54. 00
54. 01	05401 ULTRASOUND	0. 000000	0		0	0	54. 01
56.00	05600  RADI 0I SOTOPE	0. 000000	0		0	0	56. 00
57.00	05700  CT SCAN	0. 000000	0		0	0	57. 00
58.00	05800 MRI	0. 000000	0		0	0	58. 00
60.00	06000 LABORATORY	0. 073424	0		0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 097585	0		0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 221050	0		0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 104283	0		0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 180571	0		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 062143	0		0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 093715	0		0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 147636	0		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 137073	0		0 1, 072	0	73. 00
74.00	07400 RENAL DIALYSIS	0. 296300	0		0	0	74.00
76.00	03950 ANCI LLARY	0. 000000	0		0	0	76. 00
76. 01	03610 SLEEP LAB	0. 000000	0		0	0	76. 01
76. 03	03951 WOUND CARE	0. 361067	0		0 0	0	76. 03
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000	0		0 0	0	1 ,0.00
	09100 EMERGENCY	0. 101549	104		0		
02 00	00200 OPSEDVATION PEDS (NON DISTINCT DADT	0 407112	0	I		1 0	02 00

0. 407112

0 0 0

1, 072

1, 072

0 92.00 11 200.00 201.00

11 202. 00

104

104

92.00 200. 00 201. 00

202.00

09200 OBSERVATION BEDS (NON-DISTINCT PART
0 Subtotal (see instructions)
0 Less PBP Clinic Lab. Services-Program
Only Charges
0 Net Charges (line 200 - line 201)

Health Financial Systems	PORTER REGIONAL				u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICE	S AND VACCINE COST	Provider CCN: Component CCN:		Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Pre 6/22/2023 2:5	epared:
		Title XV	П	Subprovi der - I RF	PPS	<u> 50 р</u>
	Cost	s		TIM		
Cost Center Description	Subject To Ded. & Coins. D	Cost Reimbursed Services Not Subject To ed. & Coins. (see inst.) 7.00				
ANCILLARY SERVICE COST CENTERS	0.00	7.00				
50. 00	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				50. 00 51. 00 52. 00 53. 00 54. 01 56. 00 57. 00 58. 00 66. 00 66. 00 67. 00 68. 00
69. 00   06900   ELECTROCARDI OLOGY   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI EN	O O O O O O O O O O O O O O O O O O O	0 0 0 147 0 0 0				69. 00 71. 00 72. 00 73. 00 74. 00 76. 00 76. 01 76. 03 77. 00
90. 00	0 0 0	0				90. 00 91. 00

0 147

147

92. 00 200. 00 201. 00

202. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0035 Worksheet D From 01/01/2022 Part V Date/Time Prepared: 12/31/2022 6/22/2023 2:56 pm Title XIX Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) 3.00 (see inst.) 1.00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.072295 29, 109, 196 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0.346139 0 35, 706 52 00 0 05300 ANESTHESI OLOGY 0 53.00 0.006479 0 1, 995, 786 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.070491 35, 598, 464 0 54.00 54. 01 05401 ULTRASOUND 0.000000 0 0 54.01 0 0 05600 RADI OI SOTOPE 0 0 56.00 0.000000 0 0 56.00 57.00 05700 CT SCAN 0.000000 0 0 57.00 05800 MRI 0 58.00 0.000000 0 0 0 58.00 0 22, 620, 665 06000 LABORATORY 0.073424 0 60 00 60 00 0 65.00 06500 RESPIRATORY THERAPY 0.097585 0 628, 055 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 221050 649, 115 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.104283 140, 171 67.00 0 0 68.00 06800 SPEECH PATHOLOGY 0 0.180571 184, 107 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.062143 0 0 9, 636, 305 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.093715 2, 422, 640 71.00 71.00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.147636 0 0 4, 270, 223 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0. 137073 0 0 30, 453, 559 73.00 0 73.00 74.00 07400 RENAL DIALYSIS 0. 296300 3, 278 0 74.00 03950 ANCI LLARY 0.000000 0 0 76.00 76.00 0 0 0 03610 SLEEP LAB 76. 01 0.000000 0 0 76.01 03951 WOUND CARE Ω 939, 081 76.03 0.361067 Ω 76.03 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 0.000000 0 0 09100 EMERGENCY 51, 150, 192 91.00 91.00 0.101549 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.407112 1, 820, 561 92.00 0 200.00 Subtotal (see instructions) 0 191, 657, 104 0 200.00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00 Only Charges

191, 657, 104

0 202.00

202.00

Net Charges (line 200 - line 201)

				From 01/01/2022 To 12/31/2022	Part V Date/Time Pre 6/22/2023 2:5	
	Title XI		e XIX	Hospi tal	Cost	
	Costs					
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.) 6.00	(see inst.) 7.00	-			
ANCILLARY SERVICE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATING ROOM	0	2, 104, 449	1			50.00
51. 00   05100   RECOVERY ROOM	0		1			51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	12, 359	,			52. 00
53. 00 05300 ANESTHESI OLOGY	0	12, 931				53. 00
54. 00   05400 RADI OLOGY-DI AGNOSTI C	0	2, 509, 371				54.00
54. 01 05401 ULTRASOUND	0	0	)			54. 01
56. 00 05600 RADI OI SOTOPE	0	0	)			56. 00
57.00 05700 CT SCAN	0	0	)			57. 00
58. 00   05800   MRI	0	0	)			58. 00
60. 00   06000   LABORATORY	0	1, 660, 900				60.00
65. 00 06500 RESPIRATORY THERAPY	0	61, 289				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	143, 487				66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	0	14, 617				67. 00
68. 00   06800   SPEECH PATHOLOGY	0	33, 244				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	598, 829				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	227, 038				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	630, 439	1			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	.,,				73. 00
74. 00   07400   RENAL DI ALYSI S	0	971				74. 00
76. 00   03950   ANCI LLARY	0	0	1			76. 00
76. 01   03610   SLEEP LAB	0		1			76. 01
76. 03   03951   WOUND CARE	0		1			76. 03
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON	0	0	1			77. 00
90. 00 09000 CLINIC	0	0				90.00
91. 00   09100  EMERGENCY		1	1			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
200.00 Subtotal (see instructions)						200.00
201.00 Less PBP Clinic Lab. Services-Program		10, 430, 779				201.00
Only Charges						201.00
202.00   Net Charges (line 200 - line 201)	0	18, 458, 779				202. 00

Health Financial Systems	PORTER REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0035	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Pre 6/22/2023 2:5	
	Title XVIII	Hospi tal	PPS	
Cost Contar Deceriation				

		T: 11 20011		6/22/2023 2:5	6 pm
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			52, 648	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-l Private room days (excluding swing-bed and observation bed day	52, 405 0	2. 00 3. 00		
3.00	do not complete this line.	U	3.00		
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		46, 652	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	243	5. 00		
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	om days) after December :	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
7.00	reporting period	" days) till bagil becelliber	or or the cost	Ŭ	7.00
8.00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 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	swi ng-bed and	17, 119	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII on	alv (including private r	nom days)	203	10. 00
10.00	through December 31 of the cost reporting period (see instruc-		Join days)	200	10.00
11. 00					11. 00
40.00	December 31 of the cost reporting period (if calendar year, en				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	x only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	X only (including private	e room davs)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye				
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	days)	0	14. 00
15.00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
10.00	reporting period	a through Dagambar 21 of	the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	ne cost	0.00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions			66, 656, 530	
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)	er 31 of the cost report	ng period (line	0	22. 00
23. 00					23. 00
	x line 18)				
24. 00			0	24. 00	
25. 00	7 x line 19)	31 of the cost reporting	period (line 8	0	25. 00
23.00	O   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)				23.00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		66, 656, 530	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	d and observation had sh	argos)	0	20 00
28.00	Private room charges (excluding swing-bed charges)	a and observation bed ch	arges)	0	28. 00 29. 00
30. 00	Semi -private room charges (excluding swing-bed charges)			Ö	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)	1: 22) ( :+	h:)	0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 mil Average per diem private room cost differential (line 34 x li		(ions)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	16 31)		0.00	36. 00
37. 00	· · · · · · · · · · · · · · · · · · ·				
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTUENTO			
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			1 271 05	38. 00
38. 00 39. 00	Program general inpatient routine service cost per diem (see	*		1, 271. 95 21, 774, 512	
40. 00	Medically necessary private room cost applicable to the Progra	•		21, 774, 312	40. 00
41.00	OO Total Program general inpatient routine service cost (line 39 + line 40)				41. 00

Heal th	Financial Systems PC	ORTER REGIONAL	. HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Provi der CO	CN: 15-0035	Peri od: From 01/01/2022	Worksheet D-1	
					To 12/31/2022	Date/Time Pre 6/22/2023 2:5	
	Cost Center Description	Total	Ti tl e Total	XVIII Average Per	Hospital Program Days	PPS Program Cost	
		atient Cost		Diem (col. 1		(col. 3 x col.	
		1. 00	2. 00	<u>col. 2)</u> 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	00 0	0	42. 00
43. 00	INTENSIVE CARE UNIT	21, 192, 871	5, 987	3, 539. 8	2, 037	7, 210, 593	43. 00
43. 01 44. 00	NEONATAL INTENSIVE CARE UNIT CORONARY CARE UNIT	4, 560, 797	2, 354	1, 937. 4	17 O	0	43. 01 44. 00
45.00	BURN INTENSIVE CARE UNIT						45.00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
177.00	Cost Center Description					1. 00	17.00
48. 00	Program inpatient ancillary service cost (Wkst.					31, 394, 507	1
48. 01 49. 00	Program inpatient cellular therapy acquisition of Total Program inpatient costs (sum of lines 41				column 1)	0 60, 379, 612	
	PASS THROUGH COST ADJUSTMENTS	,	•	•			1
50. 00	Pass through costs applicable to Program inpatie	ent routine se	ervices (from	Wkst. D, sum	n of Parts I and	1, 816, 219	50.00
51. 00	Pass through costs applicable to Program inpation and IV)	ent ancillary	services (fr	om Wkst. D, s	sum of Parts II	1, 430, 802	51.00
52. 00	Total Program excludable cost (sum of lines 50 a	,				3, 247, 021	52. 00
53. 00	Total Program inpatient operating cost excluding medical education costs (line 49 minus line 52)	g capital rela	ated, non-phy	sician anesth	netist, and	57, 132, 591	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00 55. 00	Program discharges Target amount per discharge					0 0.00	
55. 01	Permanent adjustment amount per discharge					0.00	
55. 02 56. 00	Adjustment amount per discharge (contractor use Target amount (line 54 x sum of lines 55, 55.01,					0. 00 0	
57.00	Difference between adjusted inpatient operating		get amount (I	ine 56 minus	line 53)	0	57.00
58. 00 59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54, or l	ine 55 from 1	the cost repo	rtina period	endi na 1996.	0 0. 00	
	updated and compounded by the market basket)		·	0.			
60. 00	Expected costs (lesser of line 53 ÷ line 54, or market basket)			•		0.00	
61. 00	Continuous improvement bonus payment (if line 55.55.01, or line 59, or line 60, enter the lesser 53) are less than expected costs (lines 54 x 60)	of 50% of the	e amount by w	hich operatir	ng costs (line	0	61.00
62. 00	enter zero. (see instructions) Relief payment (see instructions)		-			0	62.00
63. 00	Allowable Inpatient cost plus incentive payment PROGRAM INPATIENT ROUTINE SWING BED COST	(see instruct	tions)			0	
64. 00	Medicare swing-bed SNF inpatient routine costs	through Decemb	oer 31 of the	cost reporti	ng period (See	0	64.00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs a</pre>	after December	31 of the c	ost reporting	period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine or </pre>	costs (line 64	l plus line 6	5)(title XVII	I only); for	0	66.00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routine or		·		•	0	67. 00
	(line 12 x line 19)	· ·					
68. 00	Title V or XIX swing-bed NF inpatient routine co (line 13 x line 20)	osts after Dec	cember 31 of	the cost repo	orting period	0	68.00
69. 00	Total title V or XIX swing-bed NF inpatient rou- PART III - SKILLED NURSING FACILITY, OTHER NURSI	NG FACILITY,	AND ICF/IID	ONLY		0	
70. 00 71. 00	Skilled nursing facility/other nursing facility, Adjusted general inpatient routine service cost						70.00
72. 00	Program routine service cost (line 9 x line 71)						72.00
73. 00 74. 00	Medically necessary private room cost applicable Total Program general inpatient routine service			ne 35)			73.00
75. 00	Capital-related cost allocated to inpatient rou			orksheet B, F	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ line 2	2)					76.00
77. 00	Program capital-related costs (line 9 x line 76)	)					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minus li Aggregate charges to beneficiaries for excess co		ovi der record	s)			78. 00 79. 00
80.00	Total Program routine service costs for comparis	son to the cos			nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limitati Inpatient routine service cost limitation (line						81. 00 82. 00
83.00	Reasonable inpatient routine service costs (see	instructions)	)				83.00
84. 00 85. 00	Program inpatient ancillary services (see instruutilization review - physician compensation (see		:)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum of						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THE Total observation bed days (see instructions)	IROUGH COST				5, 753	87. 00
87.00							, 0,.00

Health Financial Systems	PORTER REGION	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022	Date/Time Prep 6/22/2023 2:50	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)				7, 317, 528	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	4, 639, 147	66, 656, 530	0. 06959	7, 317, 528	509, 285	90. 00
91.00 Nursing Program cost	0	66, 656, 530	0. 00000	7, 317, 528	0	91.00
92.00 Allied health cost	0	66, 656, 530	0. 00000	7, 317, 528	0	92.00
93.00 All other Medical Education	0	66, 656, 530	0. 00000	0 7, 317, 528	0	93. 00

Health Financial Systems	PORTER REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0035		Worksheet D-1
	Component CCN: 15-T035	From 01/01/2022 To 12/31/2022	
	Title XVIII	Subprovi der -	PPS

		litle XVIII	I RF	PPS	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		4, 173	1. 00
2.00	Inpatient days (including private room days, excluding swing-	<i>y</i> ,		4, 173	
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	ivate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation by	ed days)		4, 173	4. 00
5.00	Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost	4, 173	5. 00
	reporting period	<i>y-,</i> g		_	
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)	m daya) thraugh Dagambar	21 of the cost	0	7 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	ii days) through beceiiber	31 Of the Cost	0	7. 00
8.00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 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	swing-bed and	2, 696	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	alv (including private r	nom davs)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)		oom days)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, el				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	x only (including privat	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including private	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye				
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT			0	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
	reporting period	_			
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
17.00	reporting period	s through becomed or or	the cost	0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20. 00
21 00	reporting period	- >		F 214 (27	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instruction: Swing-bed cost applicable to SNF type services through December		ing period (line	5, 214, 637 0	21. 00 22. 00
22.00	5 x line 17)	or or the cost report	ing period (inic	O	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24.00	x line 18)	- 21 -6 +1+	(1:	0	24.00
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1 = 19$	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December :	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)	. 0			
	Total swing-bed cost (see instructions)	(line 21 minus line 24)		0 5, 214, 637	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		5, 214, 637	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
29. 00				0	29. 00
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ 11 ne 28)		0. 000000 0. 00	31. 00 32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34. 00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x li	ne 31)		0. 00	•
36.00	Private room cost differential adjustment (line 3 x line 35)	and anticota access and	eforonticl (I:	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	rrerential (line	5, 214, 637	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see	,		1, 249. 61	
39.00	Program general inpatient routine service cost (line 9 x line			3, 368, 949	
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39)			0 3, 368, 949	
11.00	1.5ta Sgram general impatront routine service cost (inte 37		'	5, 500, 747	1 00

	Financial Systems ATION OF INPATIENT OPERATING COST	PORTER REGIONAL	Provider CCN: 1	E 003E	Peri od:	u of Form CMS-2 Worksheet D-1	
UMPUT	ATION OF INPATIENT OPERATING COST		Component CCN:		Ferrod: From 01/01/2022 To 12/31/2022	Date/Time Pre 6/22/2023 2:5	pare
			Title XVI	11	Subprovi der -	PPS	о рііі
	Cost Center Description	Total Inpatient Costli	npatient Days Diem		Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	3. 00	4. 00	<u>4)</u> 5. 00	
2. 00	NURSERY (title V & XIX only)	0	0	0.00			42.
2 00	Intensive Care Type Inpatient Hospital Unit: INTENSIVE CARE UNIT	0	ol	0.00	0 0	0	   43.
4. 00	NEONATAL INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0	0.00		0	
6. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 47.
	Cost Center Description					1 00	
8. 00	Program inpatient ancillary service cost (W	kst D-3 col 3	line 200)			1. 00 1, 446, 937	48.
8. 01 9. 00	Program inpatient cellular therapy acquisit Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	ion cost (Workshe	et D-6, Part III,		column 1)	4, 815, 886	48.
0. 00	Pass through costs applicable to Program in	patient routine s	ervices (from Wks	t. D, sum	of Parts I and	367, 923	50.
1. 00	<pre>III) Pass through costs applicable to Program in and IV)</pre>	patient ancillary	services (from W	kst. D, sı	um of Parts II	87, 281	51.
2. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost excl		ated non-nhysici	an anesthe	etist and	455, 204 4, 360, 682	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION					.,,	
4. 00	Program discharges					0	54
5. 00	Target amount per discharge					0.00	55
5. 01	Permanent adjustment amount per discharge					0.00	
. 02	Adjustment amount per discharge (contractor					0.00	
. 00	Target amount (line 54 x sum of lines 55, 5 Difference between adjusted inpatient opera		net amount (lino	56 minus I	ine 53)	0	56
	Bonus payment (see instructions)	ting cost and tary	get amount (Time	oo iiii iius i	THE 33)	0	
9. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost reportin	a period e	endi na 1996	0.00	
). 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the					0.00	
1. 00	market basket) Continuous improvement bonus payment (ifli 55.01, or line 59, or line 60, enter the le 53) are less than expected costs (lines 54	sser of 50% of the	e amount by which	operating	g costs (line	0	61
2. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62
3. 00	Allowable Inpatient cost plus incentive pay PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instruc	tions)			0	63
. 00	Medicare swing-bed SNF inpatient routine co	sts through Decemb	per 31 of the cos	t reportir	ng period (See	0	64
. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co	sts after Decembe	31 of the cost	reporti ng	period (See	0	65
. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient rout CAH, see instructions</pre>	ine costs (line 6	1 plus line 65)(t	itle XVIII	only); for	0	66
. 00	Title V or XIX swing-bed NF inpatient routi (line 12 x line 19)	ne costs through I	December 31 of th	e cost rep	porting period	0	67
3. 00	Title V or XIX swing-bed NF inpatient routi (line 13 x line 20)	ne costs after De	cember 31 of the	cost repor	rting period	0	68
9. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER I	NURSING FACILITY,	AND ICF/IID ONLY			0	
0. 00 1. 00	Skilled nursing facility/other nursing faci Adjusted general inpatient routine service	-		(IIne 37)			70
	Program routine service cost (line 9 x line		10 70 7 TINE 2)				72
	Medically necessary private room cost appli		(line 14 x line 3	5)			73
	Total Program general inpatient routine ser			•			74
	Capital-related cost allocated to inpatient 26, line 45)		costs (from Works	heet B, Pa	art II, column		75
. 00	Per diem capital-related costs (line 75 ÷ 1 Program capital-related costs (line 9 x lin						76
3. 00	Inpatient routine service cost (line 74 min						78
	Aggregate charges to beneficiaries for exce	,	ovi der records)				79
0. 00			· .	ne 78 minu	us line 79)		80
1. 00	1 .						81
2. 00	Inpatient routine service cost limitation (						82
3. 00	Reasonable inpatient routine service costs	•	)				83
4. 00	Program inpatient ancillary services (see i	,	-)				84
	Utilization review - physician compensation						85
5.00	Total Program innations operating costs (cu						
5. 00 5. 00	Total Program inpatient operating costs (su PART IV - COMPUTATION OF OBSERVATION BED PA:		ough 65)				1 0.

Health Financial Systems	PORTER REGION	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		· ·	CCN: 15-T035	From 01/01/2022 To 12/31/2022		
		Title	XVIII	Subprovider - IRF	PPS	
Cost Center Description						
					1. 00	
88.00 Adjusted general inpatient routine cost per of	diem (line 27 ÷	line 2)			0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see	e instructions)				0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
				,	4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH O	COST					
90.00 Capital -related cost	569, 502	5, 214, 637	0. 10921	2 0	0	90.00
91.00 Nursing Program cost	o	5, 214, 637	0.00000	0	0	91.00
92.00 Allied health cost	o	5, 214, 637	0.00000	0	i ol	92.00
93.00 All other Medical Education	o	5, 214, 637		0 0	o	93.00

Health Financial Systems	PORTER REGIONAL HOS	SPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Pro	rovider CCN:	15-0035	Peri od: From 01/01/2022	Worksheet D-1	
				To 12/31/2022	Date/Time Prep 6/22/2023 2:56	
		Title >	(I X	Hospi tal	Cost	
Cost Center Description						

		Title XIX	Hospi tal	6/22/2023 2:5 Cost	6 pm
	Cost Center Description	THE WAY	1.0001 (4.		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			52, 648	1. 00
2.00	Inpatient days (including private room days, excluding swing-	<i>3</i> ,	vata naam dava	52, 405	2.00
3.00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		46, 652	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	31 of the cost	243	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December (	21 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	on days) at tel becember .	or or 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
0.00	reporting period		1 -6 +1+		0.00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	m days) after becember 3	or the cost	0	8. 00
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swi ng-bed and	907	9. 00
	newborn days) (see instructions)			_	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruc-		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, en	nter O on this line)	<i>y</i> ,		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	X only (including private	e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI.	X only (including private	e room days)	0	13. 00
10.00	after December 31 of the cost reporting period (if calendar ye			Ŭ	10.00
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	days)	0	14. 00
15.00	Total nursery days (title V or XIX only)			2, 511	
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			1, 102	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0.00	18. 00
19. 00	Medicald rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
	reporting period	G			
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	5)		66, 656, 530	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)	·			
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		66, 656, 530	
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT				
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d and observation bed cha	arges)	0	
30.00	Semi -private room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	•
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	aug line 22) (eee inctrue	ti ono)	0.00	•
34. 00 35. 00	Average per diem private room charge differential (line 32 mil Average per diem private room cost differential (line 34 x li		11 0115)	0. 00 0. 00	34. 00 35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	'/		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	66, 656, 530	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMFNTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 271. 95	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		1, 153, 659	39. 00
40.00	Medically necessary private room cost applicable to the Program general inpatient routine service cost (Line 20)			1 152 650	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ ITHE 40)		1, 153, 659	41.00

	Financial Systems	PORTER REGIONA	_		In Lie	u of Form CMS-:	2552-10
COMPU	TATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2022	Worksheet D-1	
					Го 12/31/2022	Date/Time Pre 6/22/2023 2:5	6 pm
	Cost Center Description	Total	Ti tl e	Average Per	Hospital Program Days	Cost Program Cost	
		Inpatient Cost		Diem (col. 1 -	3	(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	503, 941	2, 511	200. 69		221, 160	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	21, 192, 871	5, 987	3, 539. 8	1 207	732, 741	43. 00
43. 01	NEONATAL INTENSIVE CARE UNIT	4, 560, 797	2, 354	1, 937. 4		92, 999	1
44. 00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wks					12, 111, 844	
48. 01 49. 00	Program inpatient cellular therapy acquisition Total Program inpatient costs (sum of lines 4	•			column 1)	0 14, 312, 403	
	PASS THROUGH COST ADJUSTMENTS	<u> </u>	•	•			1
50. 00	Pass through costs applicable to Program inpa	itient routine s	ervices (from	Wkst. D, sum	of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inpa	itient ancillary	services (fro	om Wkst. D, su	um of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines 5	(0 and 51)				0	52. 00
53. 00	Total Program inpatient operating cost exclude	,	ated, non-phys	sician anesthe	etist, and	0	
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	(2)					-
54. 00	Program di scharges					0	54.00
55.00	Target amount per discharge					0.00	1
55. 01 55. 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor u	ise only)				0. 00 0. 00	
56.00	Target amount (line 54 x sum of lines 55, 55.	01, and 55.02)			. 50)	0	
57. 00 58. 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and tar	get amount (li	ine 56 minus I	ine 53)	0	
59. 00	Trended costs (lesser of line 53 ÷ line 54, c	or line 55 from	the cost repor	rting period e	endi ng 1996,	0.00	1
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	or line 55 from	prior year co	ost report, up	odated by the	0. 00	60.00
61. 00	market basket) Continuous improvement bonus payment (if line				,	0	
01.00	55.01, or line 59, or line 60, enter the less $53$ ) are less than expected costs (lines $54$ x	er of 50% of th	e amount by wh	nich operating	costs (line	0	01.00
62. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62. 00
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	s through Decem	ber 31 of the	cost reportir	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost</pre>	s after Decembe	r 31 of the co	nst renorting	neriod (See	0	65. 00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routin CAH, see instructions		•		•	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	costs through	December 31 of	f the cost rep	oorting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	costs after De	cember 31 of	the cost repor	rting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70.00	Skilled nursing facility/other nursing facili	ty/ICF/IID rout	ine service co	ost (line 37)			70.00
71. 00 72. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line 7	,	ne 70 ÷ line 2	2)			71.00
73. 00	Medically necessary private room cost applica	ble to Program	•	ne 35)			73. 00
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r			orksheet B Pa	art II column		74. 00 75. 00
	26, line 45)			5. Ronoot 2, 10			
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus	line 77)					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				ıs line 70)		79. 00 80. 00
81. 00	Inpatient routine service costs for compa		St Tim tati Off	CITIE 10 IIIIII	45 IIIIG <i>17]</i>		81. 00
82. 00 83. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s	,					82. 00 83. 00
84. 00	Program inpatient ancillary services (see ins		,				84.00
85.00	Utilization review - physician compensation (	see instruction					85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ougn 85)				86. 00
87. 00	Total observation bed days (see instructions)		line 2)				87.00
88. 00	Adjusted general inpatient routine cost per d	ireni (irne 27 ÷	111le 2)			1, 271. 95	<u> </u> σσ. υθ

Health Financial Systems	PORTER REGION	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022	Date/Time Prep 6/22/2023 2:56	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (see	e instructions)				7, 317, 528	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	4, 639, 147	66, 656, 530	0. 06959	7, 317, 528	509, 285	90.00
91.00 Nursing Program cost	0	66, 656, 530	0. 00000	7, 317, 528	ol	91.00
92.00 Allied health cost	0	66, 656, 530	0. 00000	7, 317, 528	0	92.00
93.00 All other Medical Education	0	66, 656, 530	0. 00000	0 7, 317, 528	0	93. 00

Health Financial Systems	PORTER REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0035	Peri od: From 01/01/2022	Worksheet D-1
	Component CCN: 15-T035		Date/Time Prepared: 6/22/2023 2:56 pm
	Title XIX	Subprovi der -	Cost

		II tie xix	I RF	COST	
	Cost Center Description		-		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		4, 173	1.00
2.00	Inpatient days (including private room days, excluding swing-b			4, 173	
3. 00	Private room days (excluding swing-bed and observation bed day	(s). If you have only pri	vate room days,	0	3. 00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		4, 173	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
	reporting period			_	
6.00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after December 3	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
	reporting period	, .,			
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 31	of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (eycluding	swing_hed and	64	9. 00
7. 00	newborn days) (see instructions)	the rrogram (excruding	Swifig-bed and	04	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11 00	through December 31 of the cost reporting period (see instruct				11 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)	oom days) arter	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
	through December 31 of the cost reporting period				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ve			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra	· · · · · · · · · · · · · · · · · · ·	<i>'</i>	0	14. 00
15. 00	Total nursery days (title V or XIX only)	(ener daring eniring bed e	,		15. 00
16. 00	Nursery days (title V or XIX only)			1, 102	16. 00
47.00	SWING BED ADJUSTMENT			2.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0.00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions			5, 214, 637	
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)	er 31 of the cost reporti	ng period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	R1 of the cost reporting	neriod (line 8	0	25. 00
23.00	x line 20)	or the cost reporting	perrou (rriie o	١	23.00
26. 00	Total swing-bed cost (see instructions)			0	
27. 00	General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		5, 214, 637	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation bed cha	rges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)	and executation sed end	900)	Ö	
30.00	Semi -private room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 =	- line 28)		0. 000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
34. 00	Average per diem private room charge differential (line 32 mir	ous line 33)(see instruct	ions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin	, ,		0. 00	1
36.00	Private room cost differential adjustment (line 3 x line 35)	•		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	5, 214, 637	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 249. 61	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			79, 975	
40.00	Medically necessary private room cost applicable to the Program general inpatient routine service cost (Line 20)			70 075	
41. 00	Total Program general inpatient routine service cost (line 39	+ 11116 40)	ļ	79, 975	41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	PORTER REGION	Provider CCN:		Peri od:	worksheet D-1	
			Component CCI		From 01/01/2022 To 12/31/2022	Date/Time Prep 6/22/2023 2:50	
			Title	XIX	Subprovi der - I RF	Cost	
	Cost Center Description	·	Inpatient Days Di	col . 2)		Program Cost (col. 3 x col. 4)	
2. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00 0 0	5. 00 0	42
	Intensive Care Type Inpatient Hospital Units						
3. 00 3. 01	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	0	0	0. 00 0. 00			
	CORONARY CARE UNIT				]		44
	BURN INTENSIVE CARE UNIT				ļ		45
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)				ļ		46
	Cost Center Description						Ë
3. 00	Program inpatient ancillary service cost (Wks	st D-3 col 3	line 200)			1. 00 198, 293	48
	Program inpatient cellular therapy acquisition			I, line 10,	column 1)	0	1
0. 00	Total Program inpatient costs (sum of lines	41 through 48.0	1)(see instructi	ons)		278, 268	49
0. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inpa	atient routine	services (from W	/kst. D. sum	of Parts L and	0	50
			`				
. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services (from	Wkst. D, su	um of Parts II	0	51
2. 00	Total Program excludable cost (sum of lines 5	50 and 51)				o	52
. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line 5	ding capital re	lated, non-physi	cian anesthe	etist, and	0	53
00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54
	Target amount per discharge					0.00	
	Permanent adjustment amount per discharge				ļ	0.00	
. 02 . 00	Adjustment amount per discharge (contractor u Target amount (line 54 x sum of lines 55, 55.					0.00	1
	Difference between adjusted inpatient operati		raet amount (lin	e 56 minus l	line 53)		
. 00	Bonus payment (see instructions)	· ·			, i	0	
. 00	Trended costs (lesser of line 53 ÷ line 54, of updated and compounded by the market basket)	or line 55 from	the cost report	ing period e	endi ng 1996,	0.00	59
. 00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 fro	m prior year cos	t report, up	pdated by the	0.00	60
. 00	Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x enter zero. (see instructions)	ser of 50% of t	he amount by whi	ch operating	g costs (line	0	61
	Relief payment (see instructions)					0	
. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63
. 00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of the c	ost reportin	ng period (See	0	64
. 00	instructions) (title XVIII only)	ts after Decemb	or 21 of the cos	t roporting	pariod (Saa	0	65
. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	ts after beceilib	el 31 01 the cos	t reporting	perrou (see	١	
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 65)	(title XVIII	l only); for	0	66
. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 of	the cost rep	porting period	0	67
. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after D	ecember 31 of th	e cost repor	rting period	0	68
. 00	Total title V or XIX swing-bed NF inpatient r					0	69
0. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili						70
	Adjusted general inpatient routine service co	-		,			71
	Program routine service cost (line 9 x line 7		(lino 14 v li	) 2E)			72
. 00	Medically necessary private room cost applica Total Program general inpatient routine servi			30 <i>)</i>			73
	Capital-related cost allocated to inpatient r 26, line 45)	•		ksheet B, Pa	art II, column		75
. 00	Per diem capital-related costs (line 75 ÷ lir Program capital-related costs (line 9 x line						76
. 00	arrangu caurar-relateu cusis UTDE 9 X ITDE						77
. 00	Inpatient routine service cost (line 74 minus	s iine //)					79
6. 00 6. 00 7. 00 8. 00 9. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess	s costs (from p	· · · · · · · · · · · · · · · · · · ·				80
5. 00 6. 00 7. 00 8. 00 9. 00 9. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess Total Program routine service costs for compa	s costs (from p arison to the c	· · · · · · · · · · · · · · · · · · ·		us line 79)		
5. 00 7. 00 8. 00 9. 00 9. 00 9. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess Total Program routine service costs for compa Inpatient routine service cost per diem limit	s costs (from p arison to the c tation	ost limitation (		us line 79)		81
5. 00 7. 00 8. 00 9. 00 9. 00 1. 00 2. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess Total Program routine service costs for compa	s costs (from parison to the c tation ine 9 x line 81	ost limitation (		us line 79)		
5. 00 7. 00 8. 00 9. 00 9. 00 1. 00 2. 00 8. 00 4. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess Total Program routine service costs for compainpatient routine service cost per diem limit Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (services (see inservices (see inservices))	s costs (from parison to the ctation ine 9 x line 81 see instruction structions)	ost limitation ( ) s)		us line 79)		81 82 83 84
5. 00 7. 00 8. 00 9. 00 9. 00 1. 00 2. 00 8. 00 4. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess Total Program routine service costs for compainpatient routine service cost per diem limit Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s	s costs (from parison to the cation in a screen and see instructions) (see instructions)	ost limitation ( ) s) ns)		us line 79)		82 82 83

Health Financial Systems	PORTER REGION	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		'	CCN: 15-T035	From 01/01/2022 To 12/31/2022	6/22/2023 2:56	
		Ti tl	e XIX	Subprovider - IRF	Cost	
Cost Center Description						
					1.00	
88.00 Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see	e instructions)				0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	569, 502	5, 214, 637	0. 10921	2 0	0	90.00
91.00 Nursing Program cost	0	5, 214, 637	0.00000	0	0	91.00
92.00 Allied health cost	0	5, 214, 637	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	5, 214, 637	0.00000	0 0	0	93.00

Health Financial Systems INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	PORTER REGIONAL		CN: 15-0035	Peri od:	u of Form CMS-2 Worksheet D-3	
THE ATTEMPT AND LEARLY SERVICE GOST ATTORTONIMENT		rrovider	.c.v. 13 0033	From 01/01/2022 To 12/31/2022		pared:
		Ti tl	e XVIII	Hospi tal	PPS	-
Cost Center Description		,	Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS				61, 750, 860		30.00
31. 00 03100 INTENSIVE CARE UNIT				12, 509, 426		31.00
31. 01 03101 NEONATAL INTENSIVE CARE UNIT				0		31. 01
41. 00   04100   SUBPROVI DER -   RF				0		41.00
43. 00   04300   NURSERY						43. 00
ANCI LLARY SERVI CE COST CENTERS  50, 00 05000 OPERATI NG ROOM			0. 07229	95 57, 915, 967	4, 187, 035	50.00
51. 00   05100   RECOVERY ROOM			0.00000		4, 167, 033	
52. 00   05200   DELIVERY ROOM & LABOR ROOM			0. 34613			
53. 00   05300   ANESTHESI OLOGY			0. 00647		20, 903	
54. 00   05400   RADI OLOGY-DI AGNOSTI C			0. 07049			
54. 01   05400   NADI 0E001-DI AGNOSTITO			0.00000		2,037,013	
56. 00   05600   RADI 0I SOTOPE			0.00000		0	
57. 00   05700 CT SCAN			0.00000		0	
58. 00   05800   MRI			0.00000		0	
60. 00   06000   LABORATORY			0. 07342		_	
65. 00 06500 RESPIRATORY THERAPY			0. 09758			
66. 00 06600 PHYSI CAL THERAPY			0. 22105		1, 176, 732	
67. 00 06700 OCCUPATI ONAL THERAPY			0. 10428			
68. 00 06800 SPEECH PATHOLOGY			0. 18057			
69. 00 06900 ELECTROCARDI OLOGY			0. 06214		2, 179, 861	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0. 09371		924, 187	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 14763			
73. 00 07300 DRUGS CHARGED TO PATIENTS			0. 13707			
74. 00 07400 RENAL DIALYSIS			0. 29630		577, 114	
76. 00 03950 ANCI LLARY			0. 00000		0	
76. 01   03610   SLEEP LAB			0. 00000		Ö	
76. 03   03951   WOUND CARE			0. 36106		80, 038	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION			0. 00000		0	
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C			0.00000	00 0	0	90.00
01 00 00100 EMERCENCY			0 1015/	10 27 020 426	2 7/3 807	01 00

0. 000000 0. 101549

0. 407112

27, 020, 426 2, 433, 170

316, 246, 994

316, 246, 994

2, 743, 897

990, 573

31, 394, 507 200. 00 201. 00

91.00

92.00

202. 00

91.00

200. 00 201. 00

202.00

09100 EMERGENCY

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges (line 61)

PATIENT ANCILLARY SERVICE COST APPORTIONMENT			Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Pre	pare
	Title	e XVIII	Subprovi der -	6/22/2023 2: 5 PPS	6 pr
Cost Center Description		Ratio of Cos	IRF t Inpatient	Inpatient	
cost center bescription		To Charges	Program	Program Costs	
		l ro onar ges	9	(col. 1 x col.	
			3	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1	•		
. 00 03000 ADULTS & PEDIATRICS					T 30
.00 03100 INTENSIVE CARE UNIT					31
.01 03101 NEONATAL INTENSIVE CARE UNIT					31
. 00   04100   SUBPROVI DER - I RF			8, 630, 027		41
. 00   04300   NURSERY					43
ANCILLARY SERVICE COST CENTERS					
.00 05000 OPERATING ROOM		0. 07229	95 44, 313	3, 204	50
.00   05100   RECOVERY ROOM		0.00000	00	0	51
.00   05200   DELIVERY ROOM & LABOR ROOM		0. 34613		0	52
. 00   05300   ANESTHESI OLOGY		0. 00647	1, 074	7	53
. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 07049	326, 512	23, 016	54
. 01  05401 ULTRASOUND		0.00000	00	0	54
. 00   05600   RADI 0I SOTOPE		0.00000		0	56
.00  05700 CT SCAN		0.00000		0	1 ~ '
.00   05800   MRI		0.00000		0	
. 00   06000   LABORATORY		0. 07342		133, 628	
00 06500 RESPI RATORY THERAPY		0. 09758		8	
00 06600 PHYSI CAL THERAPY		0. 22105		616, 851	
.00 06700 OCCUPATI ONAL THERAPY		0. 10428		306, 790	
00 06800 SPEECH PATHOLOGY		0. 18057		101, 180	
00 06900 ELECTROCARDI OLOGY		0. 06214		3, 103	
. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT		0. 09371		192	
00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 14763		484	
00 07300 DRUGS CHARGED TO PATIENTS		0. 13707		229, 404	
00 07400 RENAL DIALYSIS		0. 29630		23, 311	
. 00   03950   ANCI LLARY		0.00000		0	
.01   03610   SLEEP LAB .03   03951   WOUND CARE		0.00000		1 257	
		0. 36106		1, 257	
.00   07700   ALLOGENEI C HSCT ACQUISITION   OUTPATIENT SERVICE COST CENTERS		0.00000	00 0	0	77
. 00   O9000   CLINIC		0.00000		0	90
. 00   09100   EMERGENCY		0. 00000		4, 502	
.00   09100  EMERGENCY .00   09200  OBSERVATION BEDS (NON-DISTINCT PART		0. 10154		4, 502	1
0.00 Total (sum of lines 50 through 94 and 96 through 9	0)	0.40/11	10, 340, 048		
1.00 Less PBP Clinic Laboratory Services-Program only c			10, 340, 048	1, 440, 937	201
L. MALEST LEGGE FOR CLITTIC LANGEAUDI V SELVICES-FLOUI AIII ONI V C	norues utile of	1	· U		120

Health Financial Systems	PORTER REGIONAL				eu of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C		Peri od:	Worksheet D-3	
		Component	CCN: 15-U035	From 01/01/2022 To 12/31/2022		
		Ti tl e	e XVIII	Swing Beds - SNF		
Cost Center Description			Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.22	2)	
LADATI ENT. DOUTLAGE CEDALOE COCT. CENTERO			1.00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS						20.00
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   NTENSIVE CARE UNIT						30.00
31. 01   03100  INTENSIVE CARE UNIT						31.00
41. 00   04100   SUBPROVI DER -   RF						41.00
43. 00   04300   NURSERY						43.00
ANCILLARY SERVICE COST CENTERS			1			43.00
50. 00 05000 OPERATING ROOM			0. 07229	95 0	0	50.00
51. 00   05100   RECOVERY   ROOM			0.00000		1	
52. 00 05200 DELIVERY ROOM & LABOR ROOM			0. 34613	-	1	
53. 00   05300   ANESTHESI OLOGY			0.00647		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 07049		73	
54. 01   05401 ULTRASOUND			0.00000		l	1
56. 00 05600 RADI 0I SOTOPE			0.00000	00	0	56. 00
57. 00 05700 CT SCAN			0.00000	00	0	57. 00
58. 00   05800   MRI			0.00000	00	0	58. 00
60. 00   06000   LABORATORY			0. 07342	77, 344	5, 679	60.00
65. 00 06500 RESPIRATORY THERAPY			0. 09758	128, 980	12, 587	65.00
66. 00   06600   PHYSI CAL THERAPY			0. 22105	74, 273	16, 418	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY			0. 10428	82, 644	8, 618	67. 00
68.00 06800 SPEECH PATHOLOGY			0. 18057	1, 426	257	68. 00
69. 00   06900   ELECTROCARDI OLOGY			0. 06214	13 2, 899	180	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0. 09371		1, 160	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 14763			
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 13707	78, 986	10, 827	73. 00
74.00   07400   RENAL DIALYSIS			0. 29630		0	74. 00
76. 00   03950   ANCI LLARY			0.00000		0	
76. 01   03610   SLEEP LAB			0.00000		0	76. 01
76. 03   03951   WOUND CARE			0. 36106			76. 03
77.00 07700 ALLOGENEIC HSCT ACQUISITION			0.00000	00 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS				. al -	_	
90. 00 09000 CLI NI C			0.00000			
91. 00  09100 FMERGENCY			0 10154	19 0	1 0	91 00

0. 000000 0. 101549

0. 407112

0

459, 969

459, 969

91.00 0

202. 00

0 92.00

55, 799 200. 00 201. 00

91. 00 09100 EMERGENCY

200. 00 201. 00

202.00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges (line 61)

Health Financial Systems PORTER	REGIONAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CO		Peri od:	Worksheet D-3	
			From 01/01/2022 To 12/31/2022	Date/Time Pre	
			To 12/31/2022	6/22/2023 2:50	
	Ti tl	e XIX	Hospi tal	Cost	<u>Б</u>
Cost Center Description		Ratio of Cos		Inpati ent	
,		To Charges	Program	Program Costs	
				(col. 1 x col.	
			The state of the s	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00   03000   ADULTS & PEDI ATRI CS			23, 246, 989	1	30.00
31.00   03100   INTENSIVE CARE UNIT			5, 372, 750		31. 00
31.01  03101 NEONATAL INTENSIVE CARE UNIT			6, 518, 128		31. 01
41. 00   04100   SUBPROVI DER - I RF			0		41. 00
43. 00 04300 NURSERY			1, 560, 882		43.00
ANCILLARY SERVICE COST CENTERS		,			
50. 00   05000   OPERATING ROOM		0. 07229		1, 539, 409	50.00
51. 00   05100   RECOVERY ROOM		0.00000		0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 34613			52.00
53. 00   05300   ANESTHESI OLOGY		0. 00647		11, 184	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 07049		774, 004	54.00
54. 01   05401   ULTRASOUND		0.00000		0	54. 01
56. 00   05600   RADI 0I SOTOPE		0. 00000		0	56.00
57. 00   05700   CT   SCAN		0. 00000		0	57. 00
58. 00   05800   MRI		0.00000		0	58. 00
60. 00   06000   LABORATORY		0. 07342			60.00
65. 00 06500 RESPI RATORY THERAPY		0. 09758		828, 628	
66. 00 06600 PHYSI CAL THERAPY		0. 22105			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 10428			67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 18057			68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 06214			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 09371			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 14763		888, 540	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 13707			73. 00
74. 00 07400 RENAL DI ALYSI S		0. 29630		122, 503	74.00
76. 00   03950   ANCI LLARY		0. 00000		0	76. 00
76. 01   03610   SLEEP LAB		0. 00000		0	76. 01
76. 03   03951   WOUND CARE		0. 36106		64, 434	

0.000000

0.000000

0. 101549

0. 407112

11, 855, 980 1, 056, 349

111, 962, 064

111, 962, 064

90.00

91.00

92.00

201. 00

202. 00

0 77.00

0

1, 203, 963

430, 052

12, 111, 844 200. 00

07700 ALLOGENEIC HSCT ACQUISITION

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges (line 61)

OUTPATIENT SERVICE COST CENTERS

77.00

90.00

200.00

201.00

202.00

09000 CLI NI C

91. 00 09100 EMERGENCY

I NPATI I	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0035	Peri od:	Worksheet D-3	
		Component	CCN: 15-T035	From 01/01/2022 To 12/31/2022	Date/Time Pre	narec
		·			6/22/2023 2:5	
		Ti tl	e XIX	Subprovi der - I RF	Cost	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program Charges	Program Costs (col. 1 x col.	
				Charges	2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				<b>I</b>	
	03000 ADULTS & PEDIATRICS					30.
	03100 INTENSIVE CARE UNIT 03101 NEONATAL INTENSIVE CARE UNIT					31. 31.
	04100 SUBPROVIDER - I RF			1, 211, 993		41.
	04300 NURSERY			1, 211, 773		43.
	ANCILLARY SERVICE COST CENTERS					
50. 00	05000 OPERATING ROOM		0. 0722	95 0	0	50.
	05100 RECOVERY ROOM		0.0000	00 0	0	51.
	05200 DELIVERY ROOM & LABOR ROOM		0. 3461		0	
	05300 ANESTHESI OLOGY		0.0064		0	
	05400  RADI OLOGY-DI AGNOSTI C 05401  ULTRASOUND		0.0704		3, 005	
	05600 RADI OI SOTOPE		0. 0000 0. 0000		0	
	05700 CT SCAN		0.0000		0	
	05800 MRI		0.0000		o o	
0. 00	06000 LABORATORY		0.0734		21, 308	60.
	06500 RESPI RATORY THERAPY		0. 0975		0	
	06600 PHYSI CAL THERAPY		0. 2210		89, 837	1
	06700 OCCUPATI ONAL THERAPY		0. 1042		42, 469	
	06800 SPEECH PATHOLOGY		0. 1805		10, 602	
	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 0621 0. 0937		117	1
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 0437		28, 788	1
	07300 DRUGS CHARGED TO PATIENTS		0. 1370		449	1
	07400 RENAL DIALYSIS		0. 2963		0	1
76. 00	03950 ANCI LLARY		0.0000	00 0	0	76.
	03610 SLEEP LAB		0.0000		0	1
	03951 WOUND CARE		0. 3610		471	
	07700 ALLOGENEI C HSCT ACQUI SI TI ON		0.0000	00 0	0	77.
	OUTPATIENT SERVICE COST CENTERS  09000 CLINIC		0.0000	00	0	90.
	09100 EMERGENCY		0.0000		1, 247	
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 1013		1, 247	1
200.00			3. 1071	1, 418, 950	198, 293	
201. 00	Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0	1,75,270	201.
202.00		. ,		1, 418, 950		202.

	Financial Systems	PORTER REGIONAL				u of Form CMS-	
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT		Provider C	CN: 15-0035	Peri od:	Worksheet D-3	
			Component	CCN: 15-U035	From 01/01/2022 To 12/31/2022	Date/Time Pre 6/22/2023 2:5	
			Ti tl	e XIX	Swing Beds - SNF		
	Cost Center Description			Ratio of Cos		Inpati ent	
				To Charges	Program	Program Costs	
					Charges	(col. 1 x col.	
						2)	
				1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS						30.00
	03100 I NTENSI VE CARE UNIT						31.00
31. 01	03101 NEONATAL INTENSIVE CARE UNIT						31. 01
41.00	04100 SUBPROVI DER - I RF						41.00
43.00	04300 NURSERY						43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM			0. 0722		0	00.00
51.00	05100 RECOVERY ROOM			0.00000		0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM			0. 3461		0	
53.00	05300 ANESTHESI OLOGY			0.0064		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C			0. 07049		0	
54. 01	05401 ULTRASOUND			0.00000	00	0	54. 01
56.00	05600 RADI 0I SOTOPE			0.00000		0	
57.00	05700 CT SCAN			0.00000		0	
58.00	05800 MRI			0.00000	00	0	58. 00
60.00	06000 LABORATORY			0. 07342		0	60.00
65.00	06500 RESPI RATORY THERAPY			0. 09758	35 0	0	65.00
66.00	06600 PHYSI CAL THERAPY			0. 2210		0	
67.00	06700 OCCUPATI ONAL THERAPY			0. 10428		0	
68.00	06800 SPEECH PATHOLOGY			0. 1805	71 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY			0. 0621	43 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0. 0937	15 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS			0. 1476	36 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS			0. 1370	73 0	0	73.00
74.00	07400 RENAL DIALYSIS			0. 29630	00	0	74.00
76.00	03950 ANCI LLARY			0.00000	00	0	76. 00
76. 01	03610 SLEEP LAB			0.00000	00	0	76. 01
76. 03	03951 WOUND CARE			0. 3610	67 0	0	76. 03
77.00	07700 ALLOGENEIC HSCT ACQUISITION			0.00000	00	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C			0.00000	00 0	0	90.00
91.00	09100 EMERGENCY			0. 1015	49 0	0	91.00

0. 000000 0. 101549

0. 407112

0 91.00

92.00

0 200. 00 201. 00 202. 00

91.00

200. 00 201. 00 202.00

09100 EMERGENCY

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

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

Marx a		Title XVIII Hospital	6/22/2023 2: 50 PPS	о рііі
New York   New York				
1.00   1.00		DADT A LADATIFAT HOODITAL CEDITORS LADO	1. 00	
1.01   1866 amounts other than outlier payments for discharges occurring on or after October 1 (see   31, 163, 64)   1.01	1 00		0	1 00
Dist amounts of ther than outli in payment for Model 4 BPCI for discharges occurring prior to October   10,997,407   1.02		DRG amounts other than outlier payments for discharges occurring prior to October 1 (see		
1.03   1.03	1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see	10, 597, 407	1. 02
Descriptor   Security Control	1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October	0	1. 03
2.00   Out   represents for dischariges (see instructions)	1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after	0	1. 04
2.02   2.03   Outlier payment for discharges cocurring prior to October 1 (see instructions)   891,25   2.03		Outlier payments for discharges. (see instructions)	_	
2.03   Out   employments for oil schariges occurring on or after October 1 (see instructions)   140,86   2.04   Out   employments for oil schariges occurring on or after October 1 (see instructions)   240,86   2.04   Out   oil oil oil own of scharides occurring on or after October 1 (see instructions)   280,65   4,00   Oil oil oil oil oil oil oil oil oil oil o				
2.04   Outlier payments for discharges occurring on or after October 1 (see instructions)   26,199,204   3.00			-	
Second Second				
Indirect Medical Education Adjustment	3.00	Managed Care Simulated Payments	26, 199, 204	3. 00
FTF count for all opathic and esteopathic programs for the most recent cost reporting period ending on or before 12/31/1996, (see instructions)   0.00   5.00	4.00		208. 65	4. 00
or before 12/3/17/96, (see Instructions) 5. 01 FTE count for quali Fing hospitals under \$131 of the CAA 2021 (see Instructions) 6. 00 FTE count for all opathic 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 I initiation adjustment after the cap-building window closed under \$127 of 0.00 6.00 new programs in accordance with 42 CFR 413, 79(e) 7. 01 MMS Section 422 ceduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(v)(8)(1) 0.00 7.00 cost report straddles July 1, 2011 then see Instructions. 7. 02 AG \$503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(v)(8)(2) If the 0.00 7.01 cost report straddles July 1, 2011 then see Instructions of track programs in 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 all opathic and osteopathic programs for 1998), and 67 FR 50069 (August 1, 2002) (see Instructions) 8. 01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost 1998), and 67 FR 50069 (August 1, 2002) 8. 02 In amount of increase if the hospital was awarded FTE cap slots under § 5506 of the ACA. (see Instructions) 8. 03 In the amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see 0.00 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 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see 0.00 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 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see 0.00 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 The amount	Г 00		0.00	F 00
FTE cap adjustment for qualifying hospitals under \$131 of the CAA 2021 (see instructions)	5.00		0.00	5.00
new programs in accordance with 42 CFR 413.79(c) 6.26 Rural track programs FTE cap lith tatton adjustment after the cap-building window closed under \$127 of the CAA 2021 (see instructions) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(1) 7.01 ACA\$ \$503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the Company of th	5. 01	· · · · · · · · · · · · · · · · · · ·	0.00	5. 01
Rural track program FTE cap limitation adjustment after the cap-building window closed under \$172 or the CAB 2021 (See Instructions)   0.00   6.26	6.00		0.00	6. 00
the CAA 2021 (see Instructions) 7.00 MA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(1) 7.01 ACA \$503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the 7.02 ACA \$503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the 7.03 ACA \$503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the 7.04 Acq \$503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(iv)(B)(2) If the 7.05 ACQ \$100 track programs of the Cap as specified under 42 CFR \$412.105(f)(iv)(B)(2) If the 7.06 Acq sustained (increase or decrease) to the FIE count for all opathic and osteopathic programs for and 57 FR 49075 (August 10, 2022) (see instructions) 8.07 Acq sustained (increase if the Nos) 120 (20 (4 A13.79(c)(2)(iv)), 46 FR 26340 (Mey 12, 10) (Mey 1	. 2.		0.00	( )(
MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see Instructions.   0.00   7.01	0. 20		0.00	0. 20
cost report straddles July 1, 2011 then see instructions.  7. 02 Ajustment (increase or decrease) to the hospital's rural track programs FTE limitation(s) for rural 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 affiliated programs in accordance with 42 FCR 413,75(b), 413,79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).  8.01 The amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.  8.02 The amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.  8.03 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions).  8.04 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions).  8.05 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 minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions).  8.00 FTE count for allopathic and osteopathic programs in the current year from your records.  9.00 Current year all lowable FTE (see instructions).  9.00 Current year all owable FTE count for the prior year.  9.00 Sum of lines 12 through 14 divided by 3.  9.00 Sum of lines 12 through 14 divided by 3.  9.00 Sum of lines 12 through 14 divided by 3.  9.00 Sum of lines 12 through 14 divided by 3.  9.00 Option year residents displaced by program or hospital closure.  9.00 Ajustment for residents displaced by program or hospital closure.  9.00 Option year resident to bed ratio (line 18 divided by line 4).  9.00 Option year resident to bed ratio (see instructions).  9.00 Option year resident to bed ratio (see instructions).  10.00 FTE count for	7. 00		0. 00	7. 00
Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track for Medicare (ABL 6711ilated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	7. 01		0.00	7. 01
track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 8F FR 49075 (August 10, 0202) (see instructions)  8.00 Adjustment (Increase or decrease) to the FIE count for allopathic and osteopathic programs for considerable in the 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).  8.01 The amount of Increase if the hospital was awarded FIE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see Instructions.  8.02 The amount of Increase if the hospital was awarded FIE cap slots under § 5506 of ACA. (see instructions)  8.11 The amount of Increase if the hospital was awarded FIE cap slots under \$126 of the CAA 2021 (see one of the seed of the cost instructions)  9.00 Sun of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)  10.00 FIE count for allopathic and osteopathic programs in the current year from your records  10.00 Total allowable FIE count for the prior year.  10.00 Total allowable FIE count for the prior year.  10.00 Total allowable FIE count for the prior year.  10.00 Total allowable FIE count for the prior year.  10.00 Total allowable FIE count for the prior year.  10.00 Adjustment for residents in initial years of the program (see instructions)  10.00 Adjustment for residents in initial years of the program (see instructions)  10.00 Adjustment for residents in initial years of the program (see instructions)  10.00 Adjustment for residents in initial years of the program (see instructions)  10.00 Adjustment for resident to bed ratio (line 18 divided by line 4).  10.00 Adjustment for residents in initial years of the program of hospital seed by program of hospital seed by program of hospital seed by program of hospital seed by program of hospital seed by program of hospital seed by program of hospital seed by program of hospital seed b	7.00		0.00	7 00
and 87 FR 49075 (August 10. 2022) (see instructions) 8.00 All ustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for 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). 8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2001, see instructions. 8.02 The amount of increase if the hospital was awarded FTE cap slots under § 5506 of ACA. (see instructions) 8.11 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA. 2021 (see 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 under § 5506 of ACA. (see 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 under \$10.00 plus in sline 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 10.00 Current year allowable FTE (see instructions) 11.00 Current year allowable FTE (see instructions) 12.00 Current year allowable FTE (see instructions) 13.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, 0.00 11.00	7.02		0.00	7. 02
Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 RE340 (May 12. 1998), and 67 FR 50069 (August 1, 2002).				
1998), and 67 FR 50069 (August 1, 2002).	8.00		0.00	8. 00
8. 01   The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.   8. 02   The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)   The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)   The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)   The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)   The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)   The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)   The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)   The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)   The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions) and 7.01, plus or minute increase				
Report straddles July 1, 2011, see instructions.   0.00	0 01		0.00	0 01
B. 02	0.01		0.00	0.01
8. 21   The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions)	8.02		0.00	8. 02
Instructions				
minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)   TEE count for all opathic and osteopathic programs in the current year from your records   0.00   10.00   11.00   12.00   12.00   12.00   12.00   12.00   13.00   13.00   10.00   12.00   13.00   10.000   10.	8. 21		0.00	8. 21
10.00   FTE count for all'opathic and osteopathic programs in the current year from your records   0.00   10	9. 00		0.00	9. 00
12.00   Current year allowable FTE (see instructions)   12.00   13.00   10.00   13.00   13.00   14.00   10.01   10.00   14.00   10.00   14.00   10.00   10.00   14.00   10.00   10.00   14.00   10.00   10.00   14.00   10.00   10.00   14.00   10.00   10.00   10.00   14.00   10.0	10.00		0. 00	10. 00
13.00   Total allowable FTE count for the prior year.   0.00   13.00   14.00   15.00   15.00   16.00   16.00   17.00   16.00   17.00   18.00   19.00				
14.00       Total all lowable FTE count for the penul timate year if that year ended on or after September 30, 1997, otherwise enter zero.       0.00       14.00         15.00       Sum of lines 12 through 14 divided by 3.       0.00       15.00         16.00       Adj ustment for residents in initial years of the program (see instructions)       0.00       16.00         17.00       Adj ustment for residents displaced by program or hospital closure       0.00       17.00         18.00       Adj usted rolling average FTE count       0.00       18.00         19.00       Current year resident to bed ratio (see instructions)       0.0000000       19.00         20.00       Prior year resident to bed ratio (see instructions)       0.0000000       20.00         21.00       Enter the lesser of lines 19 or 20 (see instructions)       0.000000       20.00         22.01       IME payment adj ustment (see instructions)       0.000000       22.00         22.01       IME payment adj ustment - Managed Care (see instructions)       0.000000       22.00         23.00       Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA       0.000000       23.00         25.00       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see       0.00       25.00         26.00       Resident to bed ratio (divide line 25 b				
otherwise enter zero.    Sum of lines 12 through 14 divided by 3.   0.00   15.00   16.00   17.00   Adjustment for residents in initial years of the program (see instructions)   0.00   16.00   17.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   18.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   18.00   18.00   18.00   18.00   19.00   18.00   18.00   19.00		' 3		
15.00   Sum of lines 12 through 14 divided by 3.   0.00   15.00   16.00   16.00   Adjustment for residents in initial years of the program (see instructions)   0.00   16.00   17.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   18.00   Adjusted rolling average FTE count   0.00   18.00   19.00   0.	14.00		0.00	14.00
17. 00	15.00	Sum of lines 12 through 14 divided by 3.		
18.00       Adjusted rolling average FTE count       0.00       18.00         19.00       Current year resident to bed ratio (line 18 divided by line 4).       0.000000       19.00         20.00       Prior year resident to bed ratio (see instructions)       0.000000       21.00         21.00       Enter the lesser of lines 19 or 20 (see instructions)       0.000000       21.00         22.01       IME payment adjustment (see instructions)       0.000000       22.00         1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA       0.000000       22.01         23.00       Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105       0.00       23.00         24.00       IME FTE Resident Count Over Cap (see instructions)       0.00       24.00         25.00       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see       0.00       25.00         26.00       Resident to bed ratio (divide line 25 by line 4)       0.000000       26.00         27.00       IME payments adjustment factor. (see instructions)       0.000000       27.00         28.00       IME add-on adjustment amount - Managed Care (see instructions)       0.000000       27.00         28.01       IME add-on adjustment amount - Managed Care (see instructions)       0.29.00				
19.00   Current year resident to bed ratio (line 18 divided by line 4).   0.000000   19.00   20.00   Prior year resident to bed ratio (see instructions)   0.000000   20.00   20.00   20.00   Enter the lesser of lines 19 or 20 (see instructions)   0.000000   21.00   1ME payment adjustment (see Instructions)   0.2000   22.00   1ME payment adjustment (see Instructions)   0.2000   22.00   1ME payment adjustment - Managed Care (see instructions)   0.000000   22.00   1ME payment adjustment - Managed Care (see instructions)   0.000000   22.00   1ME resident Call Education Adjustment for the Add-on for § 422 of the MMA   23.00   (f)(1)(iv)(C).   24.00   1ME FTE Resident Count Over Cap (see instructions)   0.00   24.00   25.00   1ME payment adjustment and osteopathic lime FTE resident cap slots under 42 CFR 412.105   0.00   24.00   25.00   1 f the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see   0.00   25.00   1 f the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see   0.000000   26.00   26.00   1 ME payments adjustment factor. (see instructions)   0.000000   26.00   28.00   1 ME add-on adjustment amount (see instructions)   0.000000   28.00   28.00   1 ME add-on adjustment amount (see instructions)   0.000000   28.00   29.00   2				
20.00   Prior year resident to bed ratio (see instructions)   0.000000   20.00   21.00   Enter the lesser of lines 19 or 20 (see instructions)   0.000000   21.00   22.00   IME payment adjustment (see instructions)   0.22.00   IME payment adjustment - Managed Care (see instructions)   0.22.01   IME payment adjustment - Managed Care (see instructions)   0.22.01   IME payment adjustment for the Add-on for § 422 of the MMA   23.00   Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA   24.00   IME FTE Resident Count Over Cap (see instructions)   0.00   24.00   IME FTE Resident Count Over Cap (see instructions)   0.00   25.00   If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see   0.00   25.00   Instructions)   0.000000   26.00   27.00   IME payments adjustment factor. (see instructions)   0.000000   27.00   28.00   IME add-on adjustment amount (see instructions)   0.000000   27.00   28.00   IME add-on adjustment amount (see instructions)   0.000000   29.00   29.00   Total IME payment (sum of lines 22 and 28)   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.00000000		, , , , , , , , , , , , , , , , , , , ,		
21.00   Enter the lesser of lines 19 or 20 (see instructions)   0.000000   21.00     22.00   IME payment adjustment (see instructions)   0   22.00     1ME payment adjustment - Managed Care (see instructions)   0   22.01     1 mid rect Medical Education Adjustment for the Add-on for § 422 of the MMA     23.00   Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA     23.00   IME FTE Resident Count Over Cap (see instructions)   0.00     24.00   IME FTE Resident Count Over Cap (see instructions)   0.00   24.00     25.00   If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)   0.000000     26.00   Resident to bed ratio (divide line 25 by line 4)   0.000000   25.00     27.00   IME payments adjustment factor. (see instructions)   0.000000   27.00     28.01   IME add-on adjustment amount (see instructions)   0.28.00     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     29.01   Total IME payment - Managed Care (sum of lines 22.01 and 28.01)   0.29.01     Disproportionate Share Adjustment   0.000000   0.000000     20.00   0.000000   0.000000   0.000000   0.000000     20.00   0.000000   0.000000   0.000000   0.000000     20.00   0.000000   0.000000   0.000000   0.000000     20.00   0.000000   0.000000   0.000000   0.000000   0.000000     20.00   0.0000000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000				
IME payment adjustment - Managed Care (see instructions)   0   1ndi rect 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) .   0   1ME FTE Resident Count Over Cap (see instructions)   0.00   24.00   1f the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see   0.00   25.00   instructions)   0.000000   26.00   27.00   1ME payments adjustment factor. (see instructions)   0.000000   27.00   1ME payments adjustment factor. (see instructions)   0.000000   27.00   28.01   1ME add-on adjustment amount (see instructions)   0.28.01   1ME add-on adjustment amount - Managed Care (see instructions)   0.28.01   29.00   29.01   2	21. 00		0. 000000	21. 00
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 If the amount on line 24 is greater than -0-, 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 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME payments adjustment amount (see instructions) 0.000000 27.00 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 Total IME payment (sum of lines 22 and 28) 0.29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0.29.01 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 2.82 30.00 31.00 Percentage of Medicaid patient days (see instructions) 22.37 32.00				
Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105  (f)(1)(iv)(C).  24.00 IME FTE Resident Count Over Cap (see instructions)  1f the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  29.00 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  20.00 Sum of lines 30 and 31  20.00 Sum of lines 30 and 31	22. 01		0	22. 01
(f)(1)(iv)(C).  24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days (see instructions)  20.00 Sum of lines 30 and 31  20.00 Sum of lines 30 and 31	23 00		0.00	23 00
24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount (see instructions) 29.00 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.00 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Sum of lines 30 and 31  24.00 24.00 25.00 0.000000 26.00 26.00 26.00 0.000000 27.00 27.00 0.000000 27.00 28.01 0.000000 27.00 28.01 0.000000 27.00 28.01 0.000000 27.00 29.01 0.0000000 27.00 29.01 0.000000000000000000000000000000000	23.00		0.00	23.00
instructions	24.00	IME FTE Resident Count Over Cap (see instructions)	0. 00	24. 00
26.00       Resident to bed ratio (divide line 25 by line 4)       0.000000       26.00         27.00       IME payments adjustment factor. (see instructions)       0.000000       27.00         28.00       IME add-on adjustment amount (see instructions)       0       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         29.01       Disproportionate Share Adjustment       0       29.01         30.00       Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)       2.82       30.00         31.00       Percentage of Medicaid patient days (see instructions)       19.55       31.00         32.00       Sum of lines 30 and 31       22.37       32.00	25. 00		0. 00	25. 00
27.00       IME payments adjustment factor. (see instructions)       0.000000       27.00         28.00       IME add-on adjustment amount (see instructions)       0.28.00         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         29.01       Total IME payment - Managed Care (sum of lines 22.01 and 28.01)       0.00         Disproportionate Share Adjustment       29.01         30.00       Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)       2.82       30.00         31.00       Percentage of Medicaid patient days (see instructions)       19.55       31.00         32.00       Sum of lines 30 and 31       22.37       32.00	24 00		0.00000	24 00
28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.00 Sum of lines 30 and 31  20.00 Sum of lines 30 and 31				
28.01 IME add-on adjustment amount - Managed Care (see instructions)  7				
29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31. 00 Percentage of Medicaid patient days (see instructions)  32. 00 Sum of lines 30 and 31	28. 01		0	28. 01
Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of lines 30 and 31  22.37 32.00				
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of lines 30 and 31  22.37 32.00	29. 01		0	29. 01
31.00       Percentage of Medicaid patient days (see instructions)       19.55       31.00         32.00       Sum of lines 30 and 31       22.37       32.00	30 00		2 82	30 00
32.00 Sum of lines 30 and 31 22.37 32.00				
33 00 [Allowable disproportionate share percentage (see instructions)		Sum of lines 30 and 31	22. 37	32. 00
	33.00	Allowable disproportionate share percentage (see instructions)	7. 67	
34.00   Disproportionate share adjustment (see instructions)   800,764   34.00	34. UU	prisprioportronate share augustiment (see Enstructions)	800, /64	34.00

	Financial Systems PORTER REGION ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0035	Peri od:	worksheet E	2002-10
			From 01/01/2022 To 12/31/2022	Part A Date/Time Prep 6/22/2023 2:50	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1 1.00	0n/After 10/1 2.00	
	Uncompensated Care Payment Adjustment		1.00	2.00	
35. 00	Total uncompensated care amount (see instructions)			6, 874, 403, 459	•
35. 01 35. 02	Factor 3 (see instructions) Hospital UCP, including supplemental UCP (If line 34 is zer (see instructions)	ro, enter zero on this line	0. 000133205 958, 012	0. 000122773 843, 991	35. 01 35. 02
35. 03 36. 00	Pro rata share of the hospital UCP, including supplemental Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	, i	716, 540 929, 272	212, 732	35. 03 36. 00
40. 00	Additional payment for high percentage of ESRD beneficiary Total Medicare discharges (see instructions)	discharges (lines 40 throu	gh 46) 0		40.00
41. 00	Total ESRD Medicare discharges (see instructions)		0		41. 00
41. 01	Total ESRD Medicare covered and paid discharges (see instru		0		41. 01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qua	alify for adjustment)	0.00		42.00
43. 00 44. 00	Total Medicare ESRD inpatient days (see instructions) Ratio of average length of stay to one week (line 43 divide days)	ed by line 41 divided by 7	0. 000000		43. 00 44. 00
45. 00	Average weekly cost for dialysis treatments (see instruction	ons)	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, only. (see instructions)	small rural hospitals	44, 523, 054 0		47. 00 48. 00
	John y. (See Thisti detroils)			Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instruction	•		44, 523, 054	ł
50. 00 51. 00	Payment for inpatient program capital (from Wkst. L, Pt. I			3, 206, 559 0	50. 00 51. 00
52. 00	Exception payment for inpatient program capital (Wkst. L, F Direct graduate medical education payment (from Wkst. E-4,			0	52.00
53.00	Nursing and Allied Health Managed Care payment	,		0	53. 00
54.00	Special add-on payments for new technologies			198, 438	ı
54. 01 55. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	54. 01 55. 00
55. 01	Cellular therapy acquisition cost (see instructions)			0	55. 01
56. 00	Cost of physicians' services in a teaching hospital (see in	•		0	56. 00
57. 00 58. 00	Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt		hrough 35).	0	57. 00 58. 00
59. 00	Total (sum of amounts on lines 49 through 58)	IV, cor. II IIIle 200)		47, 928, 051	59.00
60.00	Primary payer payments			23, 902	
61.00	Total amount payable for program beneficiaries (line 59 min	nus line 60)		47, 904, 149	1
62. 00 63. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			4, 017, 464 210, 903	•
64.00	Allowable bad debts (see instructions)			238, 703	1
65. 00	Adjusted reimbursable bad debts (see instructions)			155, 157	•
66.00	,	nstructions)		64, 152 43, 830, 939	
67. 00 68. 00		or applicable to MS-DRGs (s	ee instructions)	43, 830, 939	68.00
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96			0	69. 00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70. 50 70. 75	Rural Community Hospital Demonstration Project (§410A Demon N95 respirator payment adjustment amount (see instructions)		instructions)	0	70. 50 70. 75
70. 73	Demonstration payment adjustment amount before sequestration			0	70. 87
70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	70. 88
70. 89 70. 90	Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions)			0	70. 89 70. 90
70. 90 70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	70. 90
70. 92	Bundled Model 1 discount amount (see instructions)			0	ı
70. 93 70. 94	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			0	70. 93
	INDU AGUICTMONT AMOUNT (COO INSTRUCTIONS)			-138, 168	70. 94

Health F	Financial Systems POR	TER REGIONAL	ΗΛΟΡΙ ΤΔΙ		Inlie	u of Form CMS-	2552_10
	TION OF REIMBURSEMENT SETTLEMENT	TER REGIONAL	Provider CO	CN: 15-0035	Peri od:	Worksheet E	2552 10
					From 01/01/2022 To 12/31/2022		
			Title	XVIII	Hospi tal	PPS	о ріп
				FFY	(уууу)	Amount	
					0	1. 00	
	Low volume adjustment for federal fiscal year (yy the corresponding federal year for the period pric		column 0		0	0	70. 96
70. 97 L	Low volume adjustment for federal fiscal year (yy the corresponding federal year for the period end	yy) (Enter ir			0	0	70. 97
	Low Volume Payment-3	9	,			0	70. 98
70. 99 H	HAC adjustment amount (see instructions)					0	70. 99
	Amount due provider (line 67 minus lines 68 plus/	minus lines 6	9 & 70)			43, 692, 771	71.00
71. 01   9	Sequestration adjustment (see instructions)					550, 529	71. 01
71. 02	Demonstration payment adjustment amount after sequ	uestrati on				0	71. 02
71. 03	Sequestration adjustment-PARHM or CHART pass-thro	ughs					71. 03
72. 00 I	Interim payments					42, 922, 654	72.00
72. 01 I	Interim payments-PARHM or CHART						72. 01
73.00	Tentative settlement (for contractor use only)					0	73.00
	Tentative settlement-PARHM or CHART (for contrac						73. 01
	Balance due provider/program (line 71 minus lines 73)	71. 01, 71. 02	2, 72, and			219, 588	74.00
	Balance due provider/program-PARHM or CHART (see i						74. 01
	Protested amounts (nonallowable cost report items; CMS Pub. 15-2, chapter 1, §115.2	) in accordar	nce with			5, 074, 105	75.00
Т	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96	6)					
	Operating outlier amount from Wkst. E, Pt. A, line	e 2, or sum o	of 2.03			0	90.00
	plus 2.04 (see instructions)						
	Capital outlier from Wkst. L, Pt. I, line 2					0	1
	Operating outlier reconciliation adjustment amoun					0	1 /
	Capital outlier reconciliation adjustment amount					0	1
	The rate used to calculate the time value of money	, ,	icti ons)			0.00	
	Time value of money for operating expenses (see in					0	
96. 00	Time value of money for capital related expenses	(see Instruct	Tons)		Prior to 10/1	0 /After 10/1	96.00
					1.00	0n/After 10/1 2.00	
Н	ISP Bonus Payment Amount						
100.00 F	HSP bonus amount (see instructions)				0	0	100. 00
H	HVBP Adjustment for HSP Bonus Payment						1
101.00 F	HVBP adjustment factor (see instructions)				0. 0000000000	0.0000000000	101. 00
	HVBP adjustment amount for HSP bonus payment (see	instructions	5)		0	0	102. 00
	HRR Adjustment for HSP Bonus Payment						
	HRR adjustment factor (see instructions)				0.0000		103. 00
	HRR adjustment amount for HSP bonus payment (see				0	0	∐104. 00
	Rural Community Hospital Demonstration Project (§4						
	Is this the first year of the current 5-year demon		iod under t	he 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no	0.					1
	Cost Reimbursement	5	10)				l
	Medicare inpatient service costs (from Wkst. D-1,	Pt. II, line	9 49)				201. 00
	Medicare discharges (see instructions)						202. 00
	Case-mix adjustment factor (see instructions)		61 .	6.11			203. 00
	Computation of Demonstration Target Amount Limitations	tion (N/A in	Tirst year	of the currer	ητ 5-year demonst	ration	
p	peri od)						

plus 2.04 (see instructions)			I	l
91.00   Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00 Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00 Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00 The rate used to calculate the time value of money (see instructions)			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 instructions)			0	96.00
		Prior to 10/1	On/After 10/1	
		1. 00	2. 00	
HSP Bonus Payment Amount				
100.00 HSP bonus amount (see instructions)		0	0	100. 00
HVBP Adjustment for HSP Bonus Payment				
101.00 HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102. 00
HRR Adjustment for HSP Bonus Payment				1
103.00 HRR adjustment factor (see instructions)		0.0000	0.0000	103. 00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus	stment			
200.00 Is this the first year of the current 5-year demonstration period under t	he 21st			200. 00
Century Cures Act? Enter "Y" for yes or "N" for no.			I	
Cost Reimbursement				
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201. 00
202.00 Medicare discharges (see instructions)			I	202.00
203.00 Case-mix adjustment factor (see instructions)			I	203.00
Computation of Demonstration Target Amount Limitation (N/A in first year	of the current	5-year demonst	ration	
peri od)				
204.00 Medi care target amount				204. 00
205.00 Case-mix adjusted target amount (line 203 times line 204)			I	205.00
206.00 Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00 Program reimbursement under the §410A Demonstration (see instructions)				207. 00
208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			I	208.00
209.00 Adjustment to Medicare IPPS payments (see instructions)			I	209.00
210.00 Reserved for future use			I	210.00
211.00 Total adjustment to Medicare IPPS payments (see instructions)			I	211.00
Comparision of PPS versus Cost Reimbursement				
212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)				212. 00
213.00 Low-volume adjustment (see instructions)			I	213.00
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reim	bursement)		I	218.00
(line 212 minus line 213) (see instructions)	•		I	

Health Financial Systems	PORTER REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-003	35

	71.11.20			6/22/2023 2:5	6 pm
	Title XV		Hospi tal	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			74, 848	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			36, 012, 711	2.00
3. 00 4. 00	OPPS payments Outlier payment (see instructions)			35, 389, 844 68, 340	3. 00 4. 00
4. 00	Outlier reconciliation amount (see instructions)			08, 340	4. 00
5. 00	Enter the hospital specific payment to cost ratio (see instructions)			0.000	5. 00
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, li	ne 200		0	9.00
10.00	Organ acquisitions			74 040	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			74, 848	11. 00
	Reasonable charges				
12. 00	Ancillary service charges			557, 301	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			557, 301	14. 00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for payment for ser			0	ı
16. 00	Amounts that would have been realized from patients liable for payment for so	ervices o	n a chargebasis	0	16. 00
17. 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)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			557, 301	
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 e.	xceeds Li	ne 11) (see	482, 453	
	instructions)		(000	,	
20.00	Excess of reasonable cost over customary charges (complete only if line 11 e.	xceeds li	ne 18) (see	0	20. 00
	instructions)				
21. 00	Lesser of cost or charges (see instructions)			74, 848	
22. 00 23. 00	Interns and residents (see instructions)			0 0	22. 00 23. 00
24. 00	Cost of physicians' services in a teaching hospital (see instructions) Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			35, 458, 184	•
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			33, 430, 104	24.00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)			53, 336	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH,	see instr	uctions)	5, 870, 725	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	29, 608, 971	27. 00
	instructions)				
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0	28. 00
29. 00 30. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00 30. 00
31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			29, 608, 971 7, 914	
32. 00	Subtotal (line 30 minus line 31)			29, 601, 057	ł
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			= 1, 22., 22.	
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34.00	Allowable bad debts (see instructions)			335, 170	34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)			217, 861	•
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			201, 138 29, 818, 918	
37. 00 38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			29, 818, 918	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)			0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced devices (see	e instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			29, 818, 942	40.00
40. 01	Sequestration adjustment (see instructions)			375, 718	•
40. 02 40. 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM or CHART pass-throughs			0	40. 02 40. 03
41. 00	Interim payments			29, 492, 682	
41. 01	Interim payments-PARHM or CHART			27, 172, 002	41. 01
42.00	Tentative settlement (for contractors use only)			0	42. 00
42. 01	Tentative settlement-PARHM or CHART (for contractor use only)				42. 01
43.00	Balance due provider/program (see instructions)			-49, 458	ı
43. 01	Balance due provider/program-PARHM (see instructions)	. 15 ^	abantar 1	_	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pul	o. 15-2,	unapter 1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)			Ö	91.00
92. 00	The rate used to calculate the Time Value of Money			0.00	
93. 00	Time Value of Money (see instructions)			0	93. 00
94. 00	Total (sum of lines 91 and 93)			0	94. 00

Health Financial Systems	PORTER REGIONAL	HOSPI TAL	In Lie	u of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Peri od:	Worksheet E	
			From 01/01/2022		
			To 12/31/2022	Date/Time Pr	epared:
				6/22/2023 2:	56 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					0 200. 00

Health Financial Systems	PORTER REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0035	Peri od: From 01/01/2022	Worksheet E Part B
	Component CCN: 15-T035	To 12/31/2022	Date/Time Prepared: 6/22/2023 2:56 pm
	Title XVIII	Subprovi der -	PPS

		litle XVIII	Subprovi der -	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
. 00	Medical and other services (see instructions)			147	
00	Medical and other services reimbursed under OPPS (see instructi	ons)		11	
00	OPPS payments Outlier payment (see instructions)			39 0	
01	Outlier reconciliation amount (see instructions)			0	
00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0.000	
00	Line 2 times line 5			0	
00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
00 00	Transitional corridor payment (see instructions)  Ancillary service other pass through costs from Wkst. D, Pt. IV	/ col 13 line 200		0	
.00	Organ acquisitions	, cor. 13, Trile 200		0	1
00	Total cost (sum of lines 1 and 10) (see instructions)			147	1
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges			4 070	١.,
. 00	Ancillary service charges  Organ acquisition charges (from Wkst D. 4 Dt III col. 4 Lin	20, 40)		1, 072	1
. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Iir Total reasonable charges (sum of lines 12 and 13)	e 69)		0 1, 072	
00	Customary charges			1,072	'¬
. 00	Aggregate amount actually collected from patients liable for pa	yment for services on	a charge basis	0	15
. 00	Amounts that would have been realized from patients liable for		n a chargebasis	0	16
00	had such payment been made in accordance with 42 CFR §413.13(e)			0. 000000	
00	Ratio of line 15 to line 16 (not to exceed 1.000000)  Total customary charges (see instructions)			1, 072	1
00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	925	
	instructions)		, (222		
. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20
00	instructions)			1.47	1
. 00 . 00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			147 0	1
. 00	Cost of physicians' services in a teaching hospital (see instru	actions)		0	
. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	,		39	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
. 00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	
. 00	Deductibles and Coinsurance amounts relating to amount on line	•		0	
. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plinstructions)	us the sum of filles 22	and 23] (See	186	27
. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28
. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29
. 00	Subtotal (sum of lines 27 through 29)			186	
. 00	Primary payer payments			0	1
. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	5)		186	32
00	Composite rate ESRD (from Wkst. I-5, line 11)	3)		0	33
	Allowable bad debts (see instructions)			0	34
00	Adjusted reimbursable bad debts (see instructions)			0	
	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		0	
	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			186	38
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
50	Pioneer ACO demonstration payment adjustment (see instructions)				39
. 75	N95 respirator payment adjustment amount (see instructions)			0	39
97	Demonstration payment adjustment amount before sequestration			0	
98	Partial or full credits received from manufacturers for replace	d devices (see instruc	tions)	0	
99 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 186	1
01	Sequestration adjustment (see instructions)			2	
02	Demonstration payment adjustment amount after sequestration			0	
03	Sequestration adjustment-PARHM or CHART pass-throughs				40
00	Interim payments			251	
01	Interim payments-PARHM or CHART  Tentative settlement (for centractors use only)				4
00 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM or CHART (for contractor use only)		}	0	42
00	Balance due provider/program (see instructions)			-67	
01	Balance due provider/program-PARHM (see instructions)			0,	43
00	Protested amounts (nonallowable cost report items) in accordance §115.2	e with CMS Pub. 15-2,	chapter 1,	0	
	TO BE COMPLETED BY CONTRACTOR				
. 00	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0. 00	
. 00 . 00	Time Value of Money (see instructions)			0	93

Health Financial Systems	PORTER REGIONAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0035	Peri od:	Worksheet E	
			From 01/01/2022		
		Component CCN: 15-T035	To 12/31/2022		
				6/22/2023 2:5	6 pm
		Title XVIII	Subprovi der -	PPS	
			IRF		
				1.00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					200. 00

| Period: | Worksheet E-1 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: | 6/22/2023 2:56 pm Health Financial Systems POR ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0035

					6/22/2023 2:56	5 pm
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		42, 922, 654	1	29, 492, 682	1. 00
2.00	Interim payments payable on individual bills, either		(		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			1	0	3. 01
3. 02	ADJUSTIMENTS TO TROVIDER					3. 02
3. 02						3. 02
3. 04						3. 04
3. 05						3. 05
3.03	Provider to Program			7		3. 03
3. 50	ADJUSTMENTS TO PROGRAM		(		0	3. 50
3. 51	7. DOG THE TO THOUSE WITH				l ő	3. 51
3. 52					l ol	3. 52
3. 53					0	3. 53
3. 54			(		o	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				o	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		42, 922, 654	1	29, 492, 682	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR			_		
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	I	1	J		
5. 01	TENTATI VE TO PROVI DER		(		0	5. 01
5. 02			(		0	5. 02
5. 03	Dravi dan ta Dragnam			<u>/ </u>	0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM				1 0	5. 50
5. 50	ILIVIALIVE TO FROORAW					5. 50
5. 51						5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines					5. 99
5. //	5. 50-5. 98)		`			3. 77
6.00	Determined net settlement amount (balance due) based on					6. 00
5. 55	the cost report. (1)					5. 00
6. 01	SETTLEMENT TO PROVIDER		219, 588	3	0	6. 01
6. 02	SETTLEMENT TO PROGRAM				49, 458	6. 02
7. 00	Total Medicare program liability (see instructions)		43, 142, 242	2	29, 443, 224	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
			)	1. 00	2. 00	
8.00	Name of Contractor					8. 00

		Title	XVIII	Subprovi der - I RF	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4.00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		5, 006, 955 C		251	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment 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. 00
3.01	ADJUSTMENTS TO PROVIDER		C		0	3. 01
3.02			C	)	0	3. 02
3.03			C	)	0	3. 03
3.04			C	)	0	3.04
3.05			C		0	3. 05
	Provider to Program					
3. 50	ADJUSTMENTS TO PROGRAM		C		0	3. 50
3. 51			C		0	3. 51
3. 52			0		0	3. 52
3. 53 3. 54			C		0 0	3. 53
3. 54	Subtotal (sum of lines 2 01 2 40 minus sum of lines		0		0	3. 54 3. 99
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		U		١	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		5, 006, 955		251	4. 00
	appropri ate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
E 04	Program to Provider					E 04
5. 01 5. 02	TENTATI VE TO PROVI DER		C		0 0	5. 01 5. 02
5. 02			O			5. 02
3.03	Provider to Program			1	0	5. 05
5. 50	TENTATI VE TO PROGRAM		C	)	0	5. 50
5. 51			C	)	0	5. 51
5. 52			C	)	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		С		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVI DER		C		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		74, 963		67	6. 02
7. 00	Total Medicare program liability (see instructions)		4, 931, 992		184	7. 00
		,		Contractor Number	NPR Date (Mo/Day/Yr)	
8. 00	Name of Contractor	(	J	1. 00	2. 00	8. 00
6.00	Name of Contractor			1	ı l	0.00

		'			6/22/2023 2:50	6 pm
				Swing Beds - SNF		
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		114, 63	30	0	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER			O	0	3. 01
3. 01	ADJUSTMENTS TO PROVIDER			0		3. 01
3. 02				0		3. 02
3. 03				0		3. 03
3. 05				0		3. 05
5.05	Provider to Program			O <sub>I</sub>		3.03
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				0	l ol	3. 51
3. 52				0	0	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	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		114, 63	30	0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after		I		I	5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	0	5. 02
5.03				0	0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
4 01	the cost report. (1)				0	6. 01
6. 01 6. 02	SETTLEMENT TO PROVI DER SETTLEMENT TO PROGRAM			0	0	6. 01
6. 02 7. 00	Total Medicare program liability (see instructions)		114, 63	-		7. 00
7.00	Total medicale program frability (see instructions)		114, 03	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2.00	
8. 00	Name of Contractor					8. 00
				•		

Heal th	Financial Systems PORTER REGIONA	AL HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0035	Peri od: From 01/01/2022	Worksheet E-1	
			To 12/31/2022		
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				1
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				4
1. 00	Total hospital discharges as defined in AARA §4102 from Wks	t. S-3, Pt. I col. 15 line	2 14		1. 00
2.00	Medicare days (see instructions)				2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days (see instructions)				4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3				6. 00
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	n (see instructions)			10. 00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)				30. 00
	Other Adjustment (specify)				31. 00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruction	ns)		32. 00

		Component CCN: 15-U035	To 12/31/2022	Date/Time Pre 6/22/2023 2:5	
		Title XVIII	Swing Beds - SNF		<u> </u>
			Part A	Part B	
	COMPUTATION OF MET COOT OF COMPTED CERTIFICATION		1. 00	2. 00	
1 00	COMPUTATION OF NET COST OF COVERED SERVICES		120 702	0	1 00
1. 00 2. 00	Inpatient routine services - swing bed-SNF (see instructions) Inpatient routine services - swing bed-NF (see instructions)		130, 792	1	1. 00 2. 00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	· A and sum of Wkst D	0	0	3.00
0.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swin				0.00
	instructions)	3			
3.01	Nursing and allied health payment-PARHM or CHART (see instruct	i ons)			3. 01
4.00	Per diem cost for interns and residents not in approved teachi	ng program (see		0.00	4. 00
	instructions)				
5.00	Program days	vatruati ana)	203	0	5.00
6. 00 7. 00	Interns and residents not in approved teaching program (see in Utilization review - physician compensation - SNF optional met		0		6. 00 7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	illod offi y	130, 792	0	8.00
9. 00	Primary payer payments (see instructions)		130, 772	Ö	9.00
10. 00	Subtotal (line 8 minus line 9)		130, 792	1	10.00
11. 00	Deductibles billed to program patients (exclude amounts applic	able to physician	0	0	11. 00
	professional services)	, 3			
12.00	Subtotal (line 10 minus line 11)		130, 792	0	12. 00
13. 00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	14, 588	0	13. 00
	for physician professional services)				
14.00	80% of Part B costs (line 12 x 80%)		444.004	0	14.00
15.00	Subtotal (see instructions)		116, 204		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16. 50 16. 55	Pioneer ACO demonstration payment adjustment (see instructions Rural community hospital demonstration project (§410A Demonstr	•	0		16. 50 16. 55
10. 55	adjustment (see instructions)	atron) payment	0		10. 55
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
17. 00	Allowable bad debts (see instructions)		0	l o	17. 00
17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
18.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	0	0	18. 00
19.00	Total (see instructions)		116, 204	0	19. 00
19. 01	Sequestration adjustment (see instructions)		1, 574	0	19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	19. 02
19. 03	Sequestration adjustment-PARHM or CHART pass-throughs				19. 03
19. 25	Sequestration for non-claims based amounts (see instructions)		0	0	19. 25
20.00	Interim payments		114, 630	0	20.00
20. 01	Interim payments-PARHM or CHART				20. 01
21. 00 21. 01	Tentative settlement (for contractor use only)		0	0	21. 00 21. 01
22. 00	Tentative settlement-PARHM or CHART (for contractor use only) Balance due provider/program (line 19 minus lines 19.01, 19.02	10 25 20 and 21)	0	0	22.00
22. 00	Balance due provider/program-PARHM or CHART (see instructions)	•	0		22. 00
23. 00	Protested amounts (nonallowable cost report items) in accordan		0	0	23. 00
20.00	chapter 1, §115.2				20.00
	Rural Community Hospital Demonstration Project (§410A Demonstr	ation) Adjustment			
200.00	Is this the first year of the current 5-year demonstration per	iod under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement			T	
201.00	Medicare swing-bed SNF inpatient routine service costs (from W	/kst. D-1, Pt. II, line			201. 00
202.00	66 (title XVIII hospital))  Medicare swing-bed SNF inpatient ancillary service costs (from	Wkst D 2 col 2 lin			202. 00
202.00	200 (title XVIII swing-bed SNF))	I WKSt. D-3, COI. 3, IIII	e		202.00
203.00	Total (sum of lines 201 and 202)				203. 00
	Medicare swing-bed SNF discharges (see instructions)				204. 00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demonst		
	peri od)				
	Medicare swing-bed SNF target amount				205. 00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti			<u> </u>	206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				
	Program reimbursement under the §410A Demonstration (see instr				207. 00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	t, col. 1, sum of lines	1		208. 00
200.00	and 3)  Adjustment to Medicare swing bod SNE DDS navments (see instruc	etions)			200 00
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc   Reserved for future use	, ci oiis)			209. 00 210. 00
210.00	Comparision of PPS versus Cost Reimbursement				JE 10.00
215 00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	209 plus line 210) (see			215. 00
	instructions)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
			*		-

		Component CCN: 15-U035	To 12/31/2022	Date/Time Pre 6/22/2023 2:5	
		Title XIX	Swing Beds - SNF		, о р
			Part A	Part B	
	COMPUTATION OF MET COOT OF COMPTED CEDIA OF		1. 00	2. 00	
1 00	COMPUTATION OF NET COST OF COVERED SERVICES		0		1 00
1. 00 2. 00	Inpatient routine services - swing bed-SNF (see instructions) Inpatient routine services - swing bed-NF (see instructions)		0	1	1.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	· A and sum of Wkst D			3.00
0.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swir				0.00
	instructions)	.g zou pass t sug, see			
3.01	Nursing and allied health payment-PARHM or CHART (see instruct	i ons)			3. 01
4.00	Per diem cost for interns and residents not in approved teachi	ng program (see	0.00		4. 00
	instructions)				
5.00	Program days		0		5.00
6. 00 7. 00	Interns and residents not in approved teaching program (see ir Utilization review - physician compensation - SNF optional met	STructions)	0		6. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	.nod only	0		8.00
9. 00	Primary payer payments (see instructions)		0		9.00
10. 00	Subtotal (line 8 minus line 9)		0		10.00
11. 00	Deductibles billed to program patients (exclude amounts applic	cable to physician	0	l	11.00
	professional services)				
12.00	Subtotal (line 10 minus line 11)		0		12. 00
13.00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	0		13.00
	for physician professional services)				
14. 00	80% of Part B costs (line 12 x 80%)		0		14. 00
15. 00	Subtotal (see instructions)		0		15. 00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`	0		16.00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions	•			16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstradjustment (see instructions)	atron) payment			16. 55
16. 99	Demonstration payment adjustment amount before sequestration		0		16. 99
17. 00	Allowable bad debts (see instructions)		o o	l	17. 00
17. 01	Adjusted reimbursable bad debts (see instructions)		0		17. 01
18.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	0		18. 00
19.00	Total (see instructions)		0		19. 00
19. 01	Sequestration adjustment (see instructions)		0		19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		0		19. 02
19. 03	Sequestration adjustment-PARHM or CHART pass-throughs				19. 03
19. 25	Sequestration for non-claims based amounts (see instructions)		0		19. 25
20.00	Interim payments		0		20.00
20. 01	Interim payments-PARHM or CHART				20. 01
21. 00 21. 01	Tentative settlement (for contractor use only) Tentative settlement-PARHM or CHART (for contractor use only)		0		21.00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.02	2 19 25 20 and 21)	0		22. 00
22. 01	Balance due provider/program-PARHM or CHART (see instructions)	· · · · · · · · · · · · · · · · · · ·			22. 01
23. 00	Protested amounts (nonallowable cost report items) in accordan		0		23. 00
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstr	ration) Adjustment			
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.				-
201 00	Cost Reimbursement	West D 1 Dt II line		Γ	201 00
201.00	Medicare swing-bed SNF inpatient routine service costs (from W  66 (title XVIII hospital))	IKSt. D-1, Pt. 11, Time			201. 00
202 00	Medicare swing-bed SNF inpatient ancillary service costs (from	n Wkst D_3 col 3 lin	10		202. 00
202.00	200 (title XVIII swing-bed SNF))	, mot. b o, cor. o, rrr			202.00
203.00	Total (sum of lines 201 and 202)				203. 00
	Medicare swing-bed SNF discharges (see instructions)				204.00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demonst	trati on	
	peri od)				
	Medicare swing-bed SNF target amount				205. 00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti				206. 00
207.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				207 00
	Program reimbursement under the §410A Demonstration (see instr	•	1		207. 00
200. U	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2  and 3)	., cor. r, sum or rifles	1		208. 00
209. 00	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ctions)			209. 00
	Reserved for future use	· · · · · · · · · · · · · · · · · · ·			210. 00
	Comparision of PPS versus Cost Reimbursement				1
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	209 plus line 210) (see			215. 00
	instructions)				

Health Financial Systems	PORTER REGIONAL HOSPITAL	In Lie	eu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-00		Worksheet E-3
		From 01/01/2022	
	Component CCN: 15-TC	35 To 12/31/2022	Date/Time Prepared:
			6/22/2023 2:56 pm
	Title XVIII	Subprovi der -	PPS
		. LDE	I

	IRF		
		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS	11.00	
1.00	Net Federal PPS Payment (see instructions)	4, 856, 875	1. C
. 00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0066	2.0
. 00	Inpatient Rehabilitation LIP Payments (see instructions)	153, 963	3.0
. 00	Outlier Payments	41, 552	4.0
. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5. C
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0. 00	5. C
. 00	New Teaching program adjustment. (see instructions)	0.00	6. C
. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7. C
. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0. 00	8. 0
. 00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.0
0. 00	Average Daily Census (see instructions)	11. 432877	
1. 00	Teaching Adjustment Factor (see instructions)	0.000000	
2. 00	Teaching Adjustment (see instructions)	0	12. 0
3. 00	Total PPS Payment (see instructions)	5, 052, 390	
4. 00	Nursing and Allied Health Managed Care payments (see instruction)	0	14. (
5. 00	Organ acqui si ti on (DO NOT USE THIS LINE)	ĭ	15. (
5. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	16. (
7. 00	Subtotal (see instructions)	5, 052, 390	
3. 00	Primary payer payments	0, 002, 070	18.
9. 00	Subtotal (line 17 less line 18).	5, 052, 390	
0.00	Deducti bl es	31, 120	1
1. 00	Subtotal (line 19 minus line 20)	5, 021, 270	
2. 00	Coi nsurance	33, 843	
3. 00	Subtotal (line 21 minus line 22)	4, 987, 427	
4. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	11, 540	
5. 00	Adjusted reimbursable bad debts (see instructions)	7, 501	25. (
6. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	8, 943	
7. 00	Subtotal (sum of lines 23 and 25)	4, 994, 928	
3. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	4, 774, 720	28. (
9. 00	Other pass through costs (see instructions)	ő	29.
0. 00	Outlier payments reconciliation	ő	30. (
1. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ő	31. (
1. 50	Pioneer ACO demonstration payment adjustment (see instructions)	ő	31. !
1. 98	Recovery of accelerated depreciation.	ő	31.
1. 99	Demonstration payment adjustment amount before sequestration	ő	31.
2. 00	Total amount payable to the provider (see instructions)	4, 994, 928	
2. 01	Sequestration adjustment (see instructions)	62, 936	1
2. 02	Demonstration adjustment amount after sequestration	02, 730	32. (
3. 00	Interim payments	5, 006, 955	
4. 00	Tentative settlement (for contractor use only)	0,000,733	34.
5. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-74, 963	
5. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	4, 371	36.
3. 00	§115. 2	4, 371	30. (
	TO BE COMPLETED BY CONTRACTOR	44 550	F .
0.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	41, 552	
1.00	Outlier reconciliation adjustment amount (see instructions)	0 00	51. (
2.00	The rate used to calculate the Time Value of Money	0.00	
3. 00	Time Value of Money (see instructions)	0	53. (
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19		
9. 00 9. 01	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0. 000000	
	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0. 000000	

Health Financial Systems	PORTER REGIONAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0035	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Pre 6/22/2023 2:5	pared:
	Title XIX	Hospi tal	Cost	
		Innationt	Outpationt	

			10 12/31/2022	6/22/2023 2:5	
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR XI	SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		14, 312, 403		1.00
2.00	Medical and other services			18, 458, 779	2.00
3.00	Organ acquisition (certified transplant programs only)		o		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		14, 312, 403	18, 458, 779	4.00
5.00	Inpatient primary payer payments		0		5.00
6. 00	Outpatient primary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		14, 312, 403	18, 458, 779	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		1		
	Reasonabl e Charges				İ
8.00	Routi ne servi ce charges		1, 211, 993		8.00
9.00	Ancillary service charges		111, 962, 064	191, 657, 104	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		o		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		113, 174, 057	191, 657, 104	ł
	CUSTOMARY CHARGES			, , , , , , , , , , , , , , , , , , , ,	
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
	basis	3			
14.00	Amounts that would have been realized from patients liable for	payment for services on	o	0	14. 00
	a charge basis had such payment been made in accordance with	12 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15. 00
16.00	Total customary charges (see instructions)		113, 174, 057	191, 657, 104	16. 00
17. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	98, 861, 654	173, 198, 325	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instr		0	0	20. 00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		14, 312, 403	18, 458, 779	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide			
22. 00	Other than outlier payments		0	0	22. 00
23. 00	Outlier payments		0	0	23. 00
24.00	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		14 212 402	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		14, 312, 403	18, 458, 779	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT  Excess of reasonable cost (from line 18)			0	20.00
30.00	, ,		14 212 402		30.00
31. 00 32. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles	1	14, 312, 403	18, 458, 779 0	31. 00 32. 00
32.00	Coinsurance		0	0	32.00
			0	0	
34. 00 35. 00	Allowable bad debts (see instructions)		0	Ü	34. 00 35. 00
36. 00	Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 22)	14 212 402	18, 458, 779	36.00
37. 00	SETTLEMENT ADJUSTMENT	1 33)	14, 312, 403 -14, 312, 403	-18, 458, 779	
			-14, 312, 403	-10, 450, 779	
38. 00 39. 00	Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst. E-4)		0	0	38. 00 39. 00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41. 00	Interim payments			0	41. 00
	Balance due provider/program (line 40 minus line 41)		0	0	41.00
42. 00 43. 00	Protested amounts (nonallowable cost report items) in accordance to the state of th	aco with CMS Dub 1E 2		0	•
43.00	chapter 1, §115.2	ICE WI III CINIS PUD 10-2,	١	U	43. 00
	Jonaptor 1, 3113.2		1 I		I

Health Financial Systems	PORTER REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0035		Worksheet E-3
		From 01/01/2022	
	Component CCN: 15-T035	To 12/31/2022	
			6/22/2023 2:56 pm
	Title XIX	Subprovi der -	Cost
		IDE	

		II tie xix	I RF	COST	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR XI)		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	020 FOR 111220 FOR M.	. 02 020		
1.00	Inpatient hospital/SNF/NF services		278, 268		1. 00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant programs only)		o	-	3. 00
4. 00	Subtotal (sum of lines 1, 2 and 3)		278, 268	0	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		278, 268	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		<u> </u>		
	Reasonabl e Charges				
8.00	Routi ne servi ce charges		0		8. 00
9.00	Ancillary service charges		1, 418, 950	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		1, 418, 950	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for s	services on a charge	0	0	13.00
	basis				
14.00	Amounts that would have been realized from patients liable for ;	payment for services on	0	0	14.00
	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0. 000000	15.00
16. 00	Total customary charges (see instructions)		1, 418, 950	0	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	1, 140, 682	0	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
40.00	16) (see instructions)				40.00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instruc		0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		278, 268	0	21. 00
22. 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co Other than outlier payments	mipreted for PPS provide	0	0	22. 00
23. 00	Outlier payments			0	23. 00
24. 00	Program capital payments			U	24. 00
25. 00	Capital exception payments (see instructions)				25. 00
26. 00	Routine and Ancillary service other pass through costs			0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)			Ö	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)			0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		278, 268	0	29. 00
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		270,200	Ü	27.00
30.00	Excess of reasonable cost (from line 18)		0	0	30. 00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		278, 268	0	31. 00
32. 00	Deducti bl es		0	0	32. 00
33.00	Coinsurance		0	0	33. 00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	33)	278, 268	0	36.00
37.00	SETTLEMENT ADJUSTMENT		-278, 268	0	37.00
38. 00	Subtotal (line 36 ± line 37)		0	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				

Heal th	Financial Systems PORTER RI	EGIONAL HOSPITAL	In Lie	u of Form CMS-2	552-10
OUTLI E	R RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0035	Peri od:	Worksheet E-5	
			From 01/01/2022 To 12/31/2022	Date/Time Prep 6/22/2023 2:56	
		Title XVIII		PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2,	or sum of 2.03 plus 2.04 (see i	nstructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00	Operating outlier reconciliation adjustment amount (se	e instructions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see	instructions)		0	4.00
5.00	The rate used to calculate the time value of money (see	e instructions)		0.00	5.00
6.00	Time value of money for operating expenses (see instru	ctions)		0	6.00
7.00	Time value of money for capital related expenses (see	instructions)		0	7.00

Health Financial Systems PORTER REG BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provi der CCN: 15-0035

Peri od: Worksheet G
From 01/01/2022
To 12/31/2022 Date/Ti me Prepared: 6/22/2023 2:56 pm

OH y)					6/22/2023 2:5	6 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2. 00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-71, 307		_		1.00
2.00	Temporary investments	0	0	_		2.00
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	72, 747, 375	0	_	0	3. 00 4. 00
5.00	Other recei vable	72, 747, 373		0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-9, 947, 597	1	0	Ö	6.00
7.00	Inventory	11, 621, 160		0	0	7. 00
8.00	Prepai d expenses	4, 254, 701	0	0	0	8. 00
9.00	Other current assets	111, 762		_	0	9. 00
10.00	Due from other funds	0	0		0	10.00
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	78, 716, 094	. 0	0	0	11. 00
12. 00	Land	11, 543, 687	'l o	0	0	12. 00
13. 00	Land improvements	5, 523, 538	1	_	-	13.00
14. 00	Accumul ated depreciation	-3, 151, 236	1	_		14. 00
15.00	Bui I di ngs	191, 897, 013	1	0	0	15. 00
16. 00	Accumulated depreciation	-46, 782, 588	0	0	0	16. 00
17. 00	Leasehold improvements	11, 950, 829	1	_	0	17. 00
18. 00	Accumulated depreciation	-4, 544, 819	1	_	0	18.00
19.00	Fixed equipment	7, 485, 941	1	_	0	19.00
20. 00 21. 00	Accumulated depreciation Automobiles and trucks	-6, 315, 843 313, 309		_	0	20.00
22. 00	Accumulated depreciation	-242, 508	1	_	0	22.00
23. 00	Major movable equipment	53, 385, 682	1	0	Ö	23. 00
24. 00	Accumulated depreciation	-45, 960, 015	1	Ō	Ō	24. 00
25.00	Mi nor equi pment depreci abl e	16, 685, 604		0	0	25. 00
26. 00	Accumulated depreciation	-15, 006, 529	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	_	0	28. 00
29. 00	Mi nor equipment-nondepreciable	174 702 045	0	_	1	29. 00 30. 00
30. 00	Total fixed assets (sum of lines 12-29)  OTHER ASSETS	176, 782, 065	0	0	0	30.00
31. 00	Investments	1 0	0	0	0	31.00
32. 00	Deposits on Leases	0	Ö	Ō	1	32. 00
33.00	Due from owners/officers	0	0	0	0	33. 00
34.00	Other assets	16, 142, 809	0	0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	16, 142, 809	1	_	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	271, 640, 968	0	0	0	36. 00
37. 00	CURRENT LIABILITIES Accounts payable	12, 281, 413	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	12, 856, 534		_	1	38.00
39. 00	Payrol Laxes payable	959, 625	•	0	Ö	39.00
40. 00	Notes and Loans payable (short term)	3, 513, 604	1	Ō	Ō	40. 00
41.00	Deferred income	0	0	0	0	41. 00
42.00	Accel erated payments	0	)			42. 00
43.00	Due to other funds	-467, 690, 563		0	0	43. 00
44. 00	Other current liabilities	3, 618, 842	1	_	0	44. 00
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	-434, 460, 545	0	0	0	45. 00
46. 00	Mortgage payable	1 0	0	0	0	46. 00
47. 00	Notes payable		o o	_	1	47. 00
48. 00	Unsecured Loans	0	0	0	l	48. 00
49.00	Other long term liabilities	25, 837, 415	0	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	25, 837, 415				50. 00
51. 00	Total liabilities (sum of lines 45 and 50)	-408, 623, 130	) 0	0	0	51.00
F2 00	CAPI TAL ACCOUNTS	/00 0/4 000				
52. 00 53. 00	General fund balance Specific purpose fund	680, 264, 098	0			52. 00 53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			Ö		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant		1		0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
FO 00	replacement, and expansion	/00 0/4 000		_	_	F0.00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	680, 264, 098 271, 640, 968	1	0	0	59. 00 60. 00
00.00	[59]	211,040,968	,			00.00
	1/	1	1	I	1	ı

Provider CCN: 15-0035

					То	12/31/2022	Date/Time Prep 6/22/2023 2:56	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	у ріп
	I <del></del>	1.00	2. 00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		594, 433, 421			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		85, 830, 677					2.00
3.00	Total (sum of line 1 and line 2)		680, 264, 098			0	0	3. 00
4. 00 5. 00	Additions (credit adjustments) (specify)	0			0		0	4. 00 5. 00
6.00					0		0	6. 00
7. 00					0		0	7. 00
8. 00					0		0	8. 00
9. 00					0		0	9. 00
10.00	Total additions (sum of line 4-9)		0		Ŭ	0	Ĭ	10. 00
11. 00	Subtotal (line 3 plus line 10)		680, 264, 098			0		11. 00
12. 00	Deductions (debit adjustments) (specify)	0	000, 20 1, 070		0	J	0	12. 00
13. 00	, (, (, (, /, /, /, /	o			0		ol	13. 00
14. 00		o			0		ol	14. 00
15.00		o			0		o	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)		0			0		18.00
19. 00	Fund balance at end of period per balance		680, 264, 098			0		19.00
	sheet (line 11 minus line 18)		51	L				
		Endowment Fund	PI ant	Funa				
		6.00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0.00	7.00	0.00	0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)	1			-			2. 00
3.00	Total (sum of line 1 and line 2)	o			0			3. 00
4.00	Additions (credit adjustments) (specify)		0					4.00
5.00			0					5.00
6.00			0					6.00
7.00			0					7.00
8.00			0					8.00
9.00			0					9. 00
10. 00	Total additions (sum of line 4-9)	0			0			10. 00
11. 00	Subtotal (line 3 plus line 10)	0			0			11. 00
12. 00	Deductions (debit adjustments) (specify)		0					12. 00
13.00			0					13.00
14.00			0					14.00
15.00			0					15. 00
16.00			0					16.00
17. 00 18. 00	Total deductions (sum of lines 12-17)		O		0			17. 00 18. 00
19.00	Fund balance at end of period per balance				0			19. 00
17.00	sheet (line 11 minus line 18)	"			U			17.00
	10.000 (1.1.0 11 111100 11110 10)	1		I			1	

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0035

			Т	0 12/31/2022	Date/Time Prep 6/22/2023 2:50	
	Cost Center Description		Inpati ent	Outpati ent	Total	<u> </u>
			1, 00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		179, 052, 841		179, 052, 841	1. 00
2.00	SUBPROVI DER - I PF		,,		,,	2. 00
3. 00	SUBPROVIDER - IRF		13, 584, 103		13, 584, 103	3. 00
4. 00	SUBPROVI DER		, ,		, ,	4. 00
5.00	Swing bed - SNF		0		0	5. 00
6.00	Swing bed - NF		0		0	6. 00
7.00	SKILLED NURSING FACILITY					7. 00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9. 00
10.00	Total general inpatient care services (sum of lines 1-9)		192, 636, 944		192, 636, 944	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT		37, 652, 944		37, 652, 944	11.00
11. 01	NEONATAL INTENSIVE CARE UNIT		14, 003, 672		14, 003, 672	11. 01
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of I	ines	51, 656, 616		51, 656, 616	16.00
	11-15)					
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		244, 293, 560		244, 293, 560	17.00
18. 00	Ancillary services		844, 046, 122		2, 069, 664, 221	18.00
19. 00	Outpati ent servi ces		82, 197, 469	169, 543, 254	251, 740, 723	
20.00	RURAL HEALTH CLINIC		0	0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21. 00
22. 00	HOME HEALTH AGENCY					22. 00
23. 00	AMBULANCE SERVICES					23. 00
24. 00	CMHC					24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )					25. 00
26. 00	HOSPICE			_		26. 00
27. 00	INPATIENT CONTRACTED HOSPICE		161, 055		161, 055	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to 2 to 2 to 2 to 2 to 2 to 2 to 2 to	to Wkst.	1, 170, 698, 206	1, 395, 161, 353	2, 565, 859, 559	28. 00
	G-3, line 1)					
20.00	PART II - OPERATING EXPENSES			200 (75 225		20.00
29. 00 30. 00	Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY)		0	288, 675, 235		29. 00 30. 00
31. 00	ADD (SPECIFI)		0			31. 00
32.00			0			32.00
33. 00			0			33. 00
34. 00			0			34. 00
35. 00			0			35. 00
36. 00	Total additions (sum of lines 30-35)		Ü	0		36. 00
37. 00	DEDUCT (SPECIFY)		0	U		37. 00
38. 00	DEDUCT (SECTED)		0			38. 00
39. 00			0			39. 00
40. 00			0			40. 00
41. 00			0			41. 00
42. 00	Total deductions (sum of lines 37-41)		0	n		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		288, 675, 235		43. 00
	to Wkst. G-3, line 4)			, 0, 0, 200		
		1		'	!	

Heal th Financial Systems	llool +b	Financial Systems	DODTED DECLONAL II	OCDI TAI	la lio	u of Form CMC 3	DEE2 10
Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)   1.00   1							
1.00					From 01/01/2022	Date/Time Pre	pared:
1.00						0,22,2020 2.0	<u>р</u>
2.00   Less contractual allowances and discounts on patients' accounts   2, 195, 230, 761   2.00   370, 628, 798   3.00   300, 628, 798   300, 628, 798						1. 00	
3.00   Net patient revenues (line 1 minus line 2)   288, 678, 788   3.00   288, 677, 235   4.00   288, 675, 235   4.00   288, 675, 235   4.00   288, 675, 235   4.00   288, 675, 235   4.00   288, 675, 235   4.00   288, 675, 235   4.00   288, 675, 235   4.00   288, 675, 235   4.00   288, 675, 235   4.00   288, 675, 235   4.00   288, 675, 235   4.00   288, 675, 235   4.00   288, 677, 235   4.00   288, 675, 235   4.00   288, 675, 235   4.00   288, 677, 235   4.00   288, 677, 235   4.00   288, 677, 235   4.00   288, 677, 235   4.00   288, 677, 235   4.00   288, 677, 235   4.00   288, 677, 235   4.00   288, 677, 248, 248, 248, 248, 248, 248, 248, 248	1.00	Total patient revenues (from Wkst. G-2, Part	I, column 3, line	28)		2, 565, 859, 559	1. 00
4.00   Less total operating expenses (from Wkst. G-2, Part II, line 43)   288, 675, 235   4.00   Not income from service to patients (line 3 minus line 4)   81, 953, 563   5.00   OTHER INCOME	2.00		patients' accounts	5		2, 195, 230, 761	2. 00
Net income from service to patients (line 3 minus line 4)	3.00					370, 628, 798	3. 00
OTHER INCOME         Contributions, donations, bequests, etc         0         6.00           7.00         Income from investments         0         7.00           8.00         Revenues from tel eyision and radio service         0         9.00           9.00         Revenue from tel eyision and radio service         0         9.00           10.00         Purchase discounts         0         10.00           11.00         Rebates and refunds of expenses         0         11.00           12.00         Parking lot receipts         0         12.00           13.00         Revenue from laundry and linen service         0         13.00           14.00         Revenue from laundry and linen service         0         13.00           15.00         Revenue from laundry and linen service         0         13.00           14.00         Revenue from laundry and linen service         0         13.00           15.00         Revenue from laundry and linen service         0         13.00           16.00         Revenue from laundry and linen service         0         14.00           15.00         Revenue from laundry and linen service         0         15.00           16.00         Revenue from meals sold to employees and guests         0         16.00<	4.00			3)			
6.00         Contributions, donations, bequests, etc         0         6.00           7.00         Income from investments         0         7.00           8.00         Revenues from telephone and other miscellaneous communication services         0         8.00           9.00         Revenue from television and radio service         0         9.00           10.00         Purchase discounts         0         10.00           11.00         Rebates and refunds of expenses         0         11.00           11.00         Rebates and refunds of expenses         0         12.00           13.00         Revenue from I laundry and I inen service         0         12.00           13.00         Revenue from I laundry and I inen service         0         12.00           14.00         Revenue from laundry and I inen service         0         12.00           15.00         Revenue from meals sold to employees and guests         0         14.00           16.00         Revenue from sale of durgh of the employees and guests         0         15.00           16.00         Revenue from sale of fliving quarters         0         15.00           17.00         Revenue from sale of fliving quarters         0         15.00           18.00         Revenue from sale of fliving to	5.00		minus line 4)			81, 953, 563	5. 00
7.00       Income from investments       0       7.00         8.00       Revenues from telephone and other miscellaneous communication services       0       8.00         9.00       Revenue from television and radio service       0       9.00         10.00       Purchase discounts       0       10.00         11.00       Rebates and refunds of expenses       0       11.00         12.00       Parking lot receipts       0       12.00         13.00       Revenue from laundry and linen service       0       13.00         14.00       Revenue from meals sold to employees and guests       0       14.00         15.00       Revenue from rental of living quarters       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       15.00         18.00       Revenue from sale of medical necords and abstracts       0       17.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         24.50 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
8.00       Revenues from telephone and other miscellaneous communication services       0       8.00         9.00       Revenue from television and radio service       0       9.00         10.00       Purchase discounts       0       10.00         11.00       Rebates and refunds of expenses       0       11.00         12.00       Parking lot receipts       0       12.00         13.00       Revenue from laundry and linen service       0       13.00         14.00       Revenue from meals sold to employees and guests       0       13.00         15.00       Revenue from rental of living quarters       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of medical records and abstracts       0       17.00         18.00       Revenue from sale of medical records and abstracts       0       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of hospital space       0       22.00         22.00       Rental of hospital space       0       22.00						- 1	
9.00       Revenue from television and radio service       0       9.00         10.00       Purchase discounts       0       10.00         11.00       Rebates and refunds of expenses       0       11.00         12.00       Parking lot receipts       0       12.00         13.00       Revenue from laundry and linen service       0       13.00         14.00       Revenue from laundry and linen service       0       13.00         15.00       Revenue from meals sold to employees and guests       0       14.00         15.00       Revenue from rental of living quarters       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of drugs to other than patients       0       17.00         18.00       Revenue from sale of fugges to other than patients       0       17.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       18.00         19.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         20.00       Rental of boospital space       0       21.00         22.00       Rental of hospital space       0       22.00         24.50						- 1	
10.00   Purchase discounts   0   10.00   11.00   Rebates and refunds of expenses   0   11.00   12.00   Parking lot receipts   0   12.00   13.00   13.00   Revenue from laundry and linen service   0   13.00   14.00   Revenue from meals sold to employees and guests   0   14.00   15.00   Revenue from rental of living quarters   0   15.00   16.00   Revenue from sale of medical and surgical supplies to other than patients   0   15.00   17.00   Revenue from sale of drugs to other than patients   0   17.00   18.00   19.00   Revenue from sale of medical records and abstracts   0   18.00   19.00   10.00   1			ous communication s	servi ces		- 1	
11. 00       Rebates and refunds of expenses       0       11. 00         12. 00       Parking lot receipts       0       12. 00         13. 00       Revenue from laundry and linen service       0       13. 00         14. 00       Revenue from meals sold to employees and guests       0       14. 00         15. 00       Revenue from rental of living quarters       0       14. 00         16. 00       Revenue from sale of medical and surgical supplies to other than patients       0       16. 00         17. 00       Revenue from sale of medical records and abstracts       0       17. 00         18. 00       Revenue from sale of medical records and abstracts       0       18. 00         19. 00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19. 00         20. 00       Revenue from gifts, flowers, coffee shops, and canteen       0       20. 00         21. 00       Rental of vending machines       0       21. 00         22. 00       Rental of hospital space       0       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 00       OTHER INCOME       806, 472       24. 00         25. 00       Total other income (sum of lines 6-24)       3, 877, 114       25. 00						0	
12.00						0	
13.00       Revenue from laundry and linen service       0       13.00         14.00       Revenue from meals sold to employees and guests       0       14.00         15.00       Revenue from rental of living quarters       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of medical records and abstracts       0       17.00         18.00       Revenue from sale of medical records and abstracts       0       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER INCOME       806, 472       24.00         25.00       Total other income (sum of lines 6-24)       3, 877, 114       25.00         26.00       Total (line 5 plus line 25)       85, 830, 677       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00						0	
14.00       Revenue from meals sold to employees and guests       0       14.00         15.00       Revenue from rental of living quarters       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of drugs to other than patients       0       17.00         18.00       Revenue from sale of medical records and abstracts       0       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER INCOME       806, 472       24.00         25.00       Total other income (sum of lines 6-24)       3, 877, 114       25.00         25.00       Total (line 5 plus line 25)       85, 830, 677       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td></td>						0	
15.00 Revenue from rental of living quarters 16.00 Revenue from sale of medical and surgical supplies to other than patients 17.00 Revenue from sale of drugs to other than patients 19.00 Revenue from sale of medical records and abstracts 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 19.00 Revenue from gifts, flowers, coffee shops, and canteen 20.00 Revenue from gifts, flowers, coffee shops, and canteen 21.00 Rental of vending machines 22.00 Rental of hospital space 23.00 Governmental appropriations 24.00 OTHER INCOME 25.00 Total other income (sum of lines 6-24) 26.00 Total (line 5 plus line 25) 27.00 OTHER EXPENSES (SPECIFY) 28.00 Total other expenses (sum of line 27 and subscripts)  15.00 16.00 16.00 17.00 18.00 19.00 19.00 20.00	13.00	Revenue from Laundry and Linen service				0	13.00
16.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of drugs to other than patients       0       17.00         18.00       Revenue from sale of medical records and abstracts       0       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER INCOME       806, 472       24.00         24.50       COVID-19 PHE Funding       3, 070, 642       24.50         25.00       Total other income (sum of lines 6-24)       3, 877, 114       25.00         26.00       Total (line 5 plus line 25)       85, 830, 677       26.00         27.00       OTHER EXPENSES (SPECIFY)       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00	14.00	Revenue from meals sold to employees and gues	sts			0	14.00
17. 00       Revenue from sale of drugs to other than patients       0       17. 00         18. 00       Revenue from sale of medical records and abstracts       0       18. 00         19. 00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19. 00         20. 00       Revenue from gifts, flowers, coffee shops, and canteen       0       20. 00         21. 00       Rental of vending machines       0       21. 00         22. 00       Rental of hospital space       0       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 00       OTHER INCOME       806, 472       24. 00         24. 50       COVI D-19 PHE Funding       3, 070, 642       24. 50         25. 00       Total other income (sum of lines 6-24)       3, 877, 114       25. 00         26. 00       Total (line 5 plus line 25)       85, 830, 677       26. 00         27. 00       OTHER EXPENSES (SPECI FY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00						0	15.00
18.00       Revenue from sale of medical records and abstracts       0       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER INCOME       806, 472       24.00         25.00       Total other income (sum of lines 6-24)       3, 877, 114       25.00         26.00       Total (line 5 plus line 25)       85, 830, 677       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00				n patients		0	16.00
19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER INCOME       806, 472       24.00         25.00       Total other income (sum of lines 6-24)       3, 877, 114       25.00         26.00       Total (line 5 plus line 25)       85, 830, 677       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00						0	17.00
20. 00       Revenue from gifts, flowers, coffee shops, and canteen       0       20. 00         21. 00       Rental of vending machines       0       21. 00         22. 00       Rental of hospital space       0       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 00       OTHER INCOME       806, 472       24. 00         25. 00       Total other income (sum of lines 6-24)       3, 877, 114       25. 00         26. 00       Total (line 5 plus line 25)       85, 830, 677       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00							
21. 00       Rental of vending machines       0       21. 00         22. 00       Rental of hospital space       0       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 00       OTHER INCOME       806, 472       24. 00         24. 50       COVI D-19 PHE Funding       3, 070, 642       24. 50         25. 00       Total other income (sum of lines 6-24)       3, 877, 114       25. 00         26. 00       Total (line 5 plus line 25)       85, 830, 677       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00	19. 00	Tuition (fees, sale of textbooks, uniforms, e	etc.)			0	19.00
22. 00       Rental of hospital space       0       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 00       OTHER INCOME       806, 472       24. 00         24. 50       COVI D-19 PHE Funding       3, 070, 642       24. 50         25. 00       Total other income (sum of lines 6-24)       3, 877, 114       25. 00         26. 00       Total (line 5 plus line 25)       85, 830, 677       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00	20.00	Revenue from gifts, flowers, coffee shops, an	nd canteen			0	20.00
23. 00 Governmental appropriations 24. 00 OTHER INCOME 24. 50 COVID-19 PHE Funding 25. 00 Total other income (sum of lines 6-24) 26. 00 Total (line 5 plus line 25) 27. 00 OTHER EXPENSES (SPECIFY) 28. 00 Total other expenses (sum of line 27 and subscripts)  0 23. 00 806, 472 24. 00 3, 070, 642 24. 50 3, 877, 114 25. 00 85, 830, 677 26. 00 0 27. 00 28. 00 Total other expenses (sum of line 27 and subscripts)	21. 00	Rental of vending machines				0	21.00
24. 00       OTHER I NCOME       806, 472       24. 00         24. 50       COVI D-19 PHE Funding       3, 070, 642       24. 50         25. 00       Total other income (sum of lines 6-24)       3, 877, 114       25. 00         26. 00       Total (line 5 plus line 25)       85, 830, 677       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0 27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0 28. 00	22. 00	Rental of hospital space				0	22. 00
24. 50       COVI D-19 PHE Funding       3, 070, 642       24. 50         25. 00       Total other income (sum of lines 6-24)       3, 877, 114       25. 00         26. 00       Total (line 5 plus line 25)       85, 830, 677       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0 27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0 28. 00	23.00	Governmental appropriations				0	23. 00
25. 00       Total other income (sum of lines 6-24)       3, 877, 114   25. 00         26. 00       Total (line 5 plus line 25)       85, 830, 677   26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0 27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0 28. 00	24.00	OTHER I NCOME				806, 472	24.00
26. 00       Total (line 5 plus line 25)       85, 830, 677       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0 27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0 28. 00	24. 50	COVI D-19 PHE Fundi ng				3, 070, 642	24. 50
27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00	25.00	Total other income (sum of lines 6-24)				3, 877, 114	25. 00
28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00	26.00	Total (line 5 plus line 25)				85, 830, 677	26.00
	27.00	OTHER EXPENSES (SPECIFY)				0	27. 00
20 00 Not income (or loss) for the period (line 26 minus line 29)	28. 00	Total other expenses (sum of line 27 and subs	scri pts)			0	28. 00
27. 00   Net Thomas (01 1055) 101 the period (11he 20 iii hus 11he 20)   85, 830, 877   29. 00	29. 00	Net income (or loss) for the period (line 26	minus line 28)			85, 830, 677	29. 00

CAL CIT	<i>y</i>	NAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
3.12001	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0035	Peri od: From 01/01/2022 To 12/31/2022	Worksheet L Parts I-III Date/Time Pre 6/22/2023 2:50	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			3, 163, 973	1. 00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			42, 586	2. 00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3. 00 4. 00	Total inpatient days divided by number of days in the cost Number of interns & residents (see instructions)	reporting period (see inst	ructions)	153. 84 0. 00	3. 00 4. 00
5.00	Indirect medical education percentage (see instructions)			0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by	the sum of lines 1 and 1 01	columns 1 and	0.00	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	0.00	7. 00
	30) (see instructions)				
8.00	Percentage of Medicaid patient days to total days (see ins	tructions)		0.00	8.00
9. 00 10. 00	Sum of lines 7 and 8	anal		0. 00 0. 00	9. 00 10. 00
11. 00	Allowable disproportionate share percentage (see instruction Disproportionate share adjustment (see instructions)	ons)		0.00	11.00
12. 00				3, 206, 559	
	Trotal prospective depictal payments (ass that detrone)			0,200,007	12.00
	T			1. 00	
4 00	PART II - PAYMENT UNDER REASONABLE COST			0	4 00
1.00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions)	`		0	1. 00 2. 00
3.00	Total inpatient program capital cost (see Instructions,	)		0	3.00
4.00	Capital cost payment factor (see instructions)			0	4. 00
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1. 00	
1. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS  Program inpatient capital costs (see instructions)			1.00	1, 00
	PART III - COMPUTATION OF EXCEPTION PAYMENTS  Program inpatient capital costs (see instructions)  Program inpatient capital costs for extraordinary circumsta	ances (see instructions)			
2.00	Program inpatient capital costs (see instructions)	ances (see instructions)		0	2. 00
2. 00 3. 00 4. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)	ances (see instructions)		0 0 0 0.00	2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)	, ,		0 0 0 0.00	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see	instructions)		0 0 0 0.00 0	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina	instructions)	:line 6)	0 0 0 0.00 0.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7)	instructions) ary circumstances (line 2 x	:line 6)	0 0 0 0.00 0 0.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinary capital minimum payment level for extraordinary capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicable)	instructions) ary circumstances (line 2 x plicable)	ŕ	0 0 0 0.00 0 0.00 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7)	instructions) ary circumstances (line 2 x plicable) o capital payments (line 8	less line 9)	0 0 0 0.00 0 0.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinary capital minimum payment level for extraordinary current year capital payments (from Part I, line 12, as apple Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	instructions) ary circumstances (line 2 x plicable) o capital payments (line 8 r capital payment (from pri	less line 9) or year	0 0 0 0.00 0 0.00 0	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as apple current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, en	instructions) ary circumstances (line 2 x plicable) o capital payments (line 8 r capital payment (from pri payments (line 10 plus lir ter the amount on this line	less line 9) or year ne 11)	0 0 0 0.00 0 0.00 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinary capital minimum payment level for extraordinary capital minimum payment level for extraordinary capital minimum payment level for extraordinary capital minimum payment level for extraordinary capital minimum payment level for extraordinary capital minimum payment level for extraordinary capital minimum payment level for extraordinary capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, encarryover of accumulated capital minimum payment level over	instructions) ary circumstances (line 2 x plicable) o capital payments (line 8 r capital payment (from pri payments (line 10 plus lir ter the amount on this line	less line 9) or year ne 11)	0 0 0 0.00 0 0.00 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinary capital minimum payment level for extraordinary capital minimum payment level for extraordinary capital minimum payment level for extraordinary capital minimum payment level for extraordinary capital minimum payment level for extraordinary capital minimum payment level for extraordinary capital minimum payment level for extraordinary capital minimum payment level for extraordinary capital minimum payment level over worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, encapital minimum payment level over (if line 12 is negative, enter the amount on this line)	instructions) ary circumstances (line 2 x plicable) o capital payments (line 8 r capital payment (from pri payments (line 10 plus line ter the amount on this line r capital payment for the f	less line 9) or year ne 11)	0 0 0 0.00 0 0.00 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinary capital minimum payment level for extraordinary capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app Current year comparison of capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, encapt carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see instructions)	instructions) ary circumstances (line 2 x plicable) o capital payments (line 8 r capital payment (from pri payments (line 10 plus line ter the amount on this line r capital payment for the f instructions)	less line 9) or year ne 11)	0 0 0 0.00 0 0.00 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00