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PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PORTER MEMORIAL HOSPITAL (15-0035) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 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.

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

| (Si gned) | | | |
|-----------|------------|-----------------|----------------|
| | Officer or | Admi ni strator | of Provider(s) |
| | | | |
| | | | |
| Title | | | |
| 11116 | | | |
| | | | |
| | | | |
| Date | | | |

| | | Title | XVIII | | | |
|-------------------------------|---------|----------|----------|-------|-----------|--------|
| Cost Center Description | Title V | Part A | Part B | HIT | Title XIX | |
| | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| PART III - SETTLEMENT SUMMARY | | | | | | |
| 1.00 Hospi tal | 0 | 562, 806 | -58, 417 | 0 | 0 | 1.00 |
| 2.00 Subprovi der - IPF | 0 | 0 | 0 | | 0 | 2.00 |
| 3.00 Subprovider - IRF | 0 | 81, 105 | -146 | | 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 | 643, 911 | -58, 563 | 0 | 0 | 200.00 |

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

Health Financial Systems PORTER MEMORIAL 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 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/28/2021 4:36 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 85 EAST US HIGHWAY 6 1.00 PO Box: 1.00 State: IN 2.00 City: VALPARAISO Zi p Code: 46383 County: PORTER 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)

/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 PORTER MEMORIAL 150035 23844 07/01/1966 Ν 0 3.00 HOSPI TAI Subprovi der - IPF 4.00 4.00 Subprovi der - IRF PORTER REHAB UNIT 15T035 23844 01/01/2009 Ρ 0 5.00 Ν 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF PORTER SWING BEDS 15U035 23844 Р 0 01/01/2020 N 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2020 12/31/2020 20.00 21.00 Type of Control (see instructions) 21.00 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR \$412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22. 01 Did this hospital receive interim uncompensated care payments for this 22.01 Ν Ν cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care Ν Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after Did this hospital receive a geographic reclassification from urban to 22.03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for

| reporting period different from the method used in t | reporting period different from the method used in the prior cost | | | | | | |
|---|---|------------|------------|--------------|------------|------------|-------|
| reporting period? In column 2, enter "Y" for yes or | "N" for no |). | | | | | |
| | In-State | In-State | Out-of | Out-of | Medi cai d | 0ther | |
| | Medi cai d | Medi cai d | State | State | HMO days | Medi cai d | |
| | paid days | eligible | Medi cai d | Medi cai d | | days | |
| | | unpai d | paid days | el i gi bl e | | | |
| | | days | | unpai d | | | |
| | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | 6. 00 | |
| 24.00 If this provider is an IPPS hospital, enter the | 1, 584 | 487 | 39 | 28 | 7, 713 | 238 | 24.00 |
| in-state Medicaid paid days in column 1, in-state | | | | | | | |
| Medicaid eligible unpaid days in column 2, | | | | | | | |
| out-of-state Medicaid paid days in column 3, | | | | | | | |
| out-of-state Medicaid eligible unpaid days in column | | | | | | | |
| 4, Medicaid HMO paid and eligible but unpaid days in | | | | | | | |
| column 5, and other Medicaid days in column 6. | | | | | | | |
| | | | | | | | |

Ν

23.00

yes or "N" for no.

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25

below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost

Health Financial Systems PORTER MEMORIAL 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 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/28/2021 4:36 pm In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days eligible Medi cai d Medi cai d days unpai d pai d days el i gi bl e days unpai d 1.00 2. 00 3.00 4. 00 5. 00 6. 00 25.00 If this provider is an IRF, enter the in-state 50 25, 00 361 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 27.00 enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 36.00 of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37 00 37 00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38 00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38 00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume N N 39 00 hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for 40 00 Ν Ν no in column 2, for discharges on or after October 1. (see instructions) XVIII 1.00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance 45.00 Ν Υ Ν with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. 47.00 | Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. Ν Ν 47.00 Ν 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N Ν N 48.00 Teaching Hospitals 56.00 Is this a hospital involved in training residents in approved GME programs? 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), MA 56.00 GME payment reduction? Enter "Y" for yes or "N" for no in column 2. 57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved 57.00 GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as Ν 58.00 defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Qualification Y/N Line # Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for Ν 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 adjustement? Enter "Y" for yes or "N" for no in column 2.

Health Financial Systems PORTER MEM HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA PORTER MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

| | | Y/N | IME | Direct GME | I ME | Direct GME | |
|--------|---|---------|-------------------|--------------------|-----------------------|-----------------------------|--------|
| | | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| 61. 00 | Did your hospital receive FTE slots under ACA | N | | | 0. 00 | | 61.00 |
| | section 5503? Enter "Y" for yes or "N" for no in | | | | | | |
| 61 01 | column 1. (see instructions) Enter the average number of unweighted primary care | | | | | | 61. 01 |
| 01.01 | FTEs from the hospital's 3 most recent cost reports | | | | | | 01.01 |
| | 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 | | | | | | |
| 61 04 | instructions) Enter the number of unweighted primary care/or | | | | | | 61. 04 |
| 01.04 | surgery allopathic and/or osteopathic FTEs in the | | | | | | 01.04 |
| | current cost reporting period. (see instructions). | | | | | | |
| 61. 05 | Enter the difference between the baseline primary | | | | | | 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) | | | | | | |
| | | Pro | ogram Name | Program Code | Unweighted | Unweighted | |
| | | | | | IME FTE Count | Direct GME FTE Count | |
| | | | 1. 00 | 2.00 | 3. 00 | 4. 00 | |
| 61. 10 | Of the FTEs in line 61.05, specify each new program | | | | 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 Sei | rvi ces | Admi ni strati or | n (HRSA) | | 1.00 | |
| 62.00 | Enter the number of FTE residents that your hospital | trai ne | d in this cost | | iod for which | 0.00 | 62.00 |
| (2.25 | your hospital received HRSA PCRE funding (see instruc | | | t (TUO) ! ! ! | | 0.00 | (0.01 |
| 62. 01 | Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC productions. | | | | your nospitai | 0.00 | 62. 01 |
| | Teaching Hospitals that Claim Residents in Nonprovide | | | 113) | | | |
| 63.00 | Has your facility trained residents in nonprovider se | ettings | during this c | | | N | 63. 00 |
| | "Y" for yes or "N" for no in column 1. If yes, comple | ete lin | es 64 through | | | | |
| | | | | Unweighted FTEs | Unweighted FTEs in | Ratio (col. 1/ (col. 1 + | |
| | | | | Nonprovider | Hospi tal | col. 2)) | |
| | | | | Si te | nospi tui | 001. 2)) | |
| | | | | 1. 00 | 2. 00 | 3. 00 | |
| | Section 5504 of the ACA Base Year FTE Residents in No | • | | This base year | is your cost | reporti ng | |
| 44.00 | period that begins on or after July 1, 2009 and before | | | 0.00 | 0.00 | 0.000000 | 44.00 |
| 04.00 | Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor | | | 0.00 | 0.00 | 0. 000000 | 04.00 |
| | resident FTEs attributable to rotations occurring in | | | | | | |
| | settings. Enter in column 2 the number of unweighted | d non-p | rimary care | | | | |
| | resident FTEs that trained in your hospital. Enter in | | | | | | |
| | of (column 1 divided by (column 1 + column 2)). (see | instru | CTIONS) | I | | | I |

Health Financial Systems PORTER MEMORIAL 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 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/28/2021 4:36 pm Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs 3/ (col. 3 + FTEs in col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if li is yes, or your facility 0.000000 65.00 0.00 0. 00 if line 63 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col . 1 + col . 2)) FTEs in FTFs Nonprovi der Hospi tal Si te 1.00 2. 00 3. 00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs FTEs in 3/(col. 3 +Nonprovi der col. 4)) Hospi tal Si te 1. 00 2.00 3. 00 4. 00 5.00 67.00 Enter in column 1, the program 0. 00 0. 00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in

| | 4)). (see instructions) | | | | | | | | |
|-------|-----------------------------------|-----------------------|-----------------------|----------------|------------|------|------|-------|-------|
| | | | | | | | | | |
| | | | | | | 1.00 | 2.00 | 3. 00 | |
| | Inpatient Psychiatric Facility F | PPS | | | | | | | |
| 70.00 | Is this facility an Inpatient Ps | sychiatric Facility (| IPF), or does it cont | ain an IPF sub | provi der? | N | | | 70.00 |
| | Enter "Y" for yes or "N" for no |). | | | | | | | |
| 71.00 | If line 70 is yes: Column 1: Dic | I the facility have a | n approved GME teachi | ng program in | the most | | | 0 | 71.00 |
| | recent cost report filed on or b | oefore November 15, 2 | 004? Enter "Y" for y | es or "N" for | no. (see | | | | |
| | 42 CFR 412. 424(d)(1)(iii)(c)) Co | olumn 2: Did this fac | ility train residents | in a new teac | hi ng | | | | |
| | program in accordance with 42 CF | R 412.424 (d)(1)(iii |)(D)? Enter "Y" for y | es or "N" for | no. | | | | |
| | Column 3: If column 2 is Y, indi | cate which program y | ear began during this | cost reportin | g period. | | | | |
| | (see instructions) | | | | | | | | |
| | Inpatient Rehabilitation Facilit | ty PPS | | | | | | | |
| 75.00 | Is this facility an Inpatient Re | | y (IRF), or does it c | ontain an IRF | | Y | | | 75.00 |
| | subprovider? Enter "Y" for yes | and "N" for no. | | | | | | | |
| | | | | | | | | | |

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

106. 00

107.00

108.00

Ν

Ν

Ν

106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment

Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?

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

107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)

Enter "Y" for yes or "N" for no in column 2. (see instructions)

for outpatient services? (see instructions)

131.00

131.00 If this is a Medicare certified intestinal transplant center, enter the certification

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

| Health Financial Systems | PORTER MEMOR | I AL HOSPI TAL | | _ | In Lie | u of Form CMS- | -2552-10 |
|--|--|-----------------------|-----------------|------------------|------------------------|--|--------------------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLE | X IDENTIFICATION DATA | Provi der CC | N: 15-0035 | | 1/01/2020 2/31/2020 | Worksheet S- Part I Date/Time Pr 7/28/2021 4: | epared: |
| | | | | | 1. 00 | 2. 00 | |
| 132.00 If this is a Medicare certified is in column 1 and termination date, | | | cation dat | | 1.00 | 2.00 | 132. 00 |
| 133.00 Removed and reserved 134.00 If this is an organ procurement or and termination date, if applicable | | the OPO number i | n column 1 | | | | 133. 00 134. 00 |
| All Providers 140.00 Are there any related organization chapter 10? Enter "Y" for yes or 'are claimed, enter in column 2 the | 'N" for no in column 1. I | f yes, and home | office cos | ts | Y | HB1848 | 140. 00 |
| 1.00 If this facility is part of a cha | | 00 Ilines 141 thro | ugh 143 the | name an | 3.00 nd address | of the home | |
| office and enter the home office of the Name: CHS/COMMUNITY HEALTH SYSTEM | MS Contractor's Name: W | ISCONSIN PHYSICI | AN Contrac | tor's Nu | mber: 5228 | 30 | 141. 00 |
| 142.00 Street: 4000 MERIDIAN BLVD 143.00 City: FRANKLIN | PO Box: State: T | ERVI CES | Zip Cod | 0: | 3706 | .7 | 142. 00 143. 00 |
| 143. OUCL LY. FRANKLIN | State. I | IV | ZIP COU | е. | 3700 | | 143.00 |
| 144.00 Are provider based physicians' co | sts included in Worksheet | A? | | | | 1. 00 Y | 144.00 |
| | | | | | 1. 00 | 2.00 | + |
| 145.00 If costs for renal services are clinpatient services only? Enter "Y" no, does the dialysis facility in spines to the dialysis facility in t | ' for yes or "N" for no i clude Medicare utilizatio | n column 1. If o | column 1 is | | Υ | | 145. 00 |
| period? Enter "Y" for yes or "N" 146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o | gy changed from the previ n column 1. (See CMS Pub. | | | lf | N | | 146. 00 |
| | | | | | | 1. 00 | |
| 147.00 Was there a change in the statisti 148.00 Was there a change in the order of | cal basis? Enter "Y" for | yes or "N" for | no. | | | N N | 147. 00 148. 00 |
| 149.00 Was there a change to the simplifi | | | | or no. | | N N | 149. 00 |
| | | Part A 1.00 | Part B 2,00 | Т | itle V 3.00 | Title XIX 4.00 | |
| Does this facility contain a provior charges? Enter "Y" for yes or | | n exemption fro | m the appli | | f the low | er of costs | |
| 155. 00 Hospi tal | N TOT THE TOT CUCH COMPC | N | N | . (366) | N | N | 155. 00 |
| 156.00 Subprovi der - IPF 157.00 Subprovi der - IRF | | N N | N N | | N N | N N | 156. 00 157. 00 |
| 157. 00 Subprovider - TRF 158. 00 SUBPROVI DER | | IN IN | IN | | IN | į įv | 158. 00 |
| 159. 00 SNF | | N | N | | N | N | 159. 00 |
| 160.00 HOME HEALTH AGENCY | | N | N N | | N | N | 160.00 |
| 161. 00 CMHC | | | IV | | N | 1. 00 | 161.00 |
| Multicampus | | | | | | | |
| 165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. | ampus hospital that has o | ne or more campu | | | BSAs? | N | 165. 00 |
| | Name 0 | County 1.00 | State Z 2.00 | i p Code 3.00 | 4. 00 | FTE/Campus 5.00 | - |
| 166.00 f 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) | | | | | | | 0166.00 |
| | | | | | | 1.00 | |
| Health Information Technology (HI 167.00 s this provider a meaningful use | | | | ent Act | | Y | 167. 00 |
| 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H | 05 is "Y") and is a meani | ngful user (line | | "), ente | r the | ' | 168. 00 |
| 168.01 If this provider is a CAH and is rexception under §413.70(a)(6)(ii) | not a meaningful user, do | es this provider | | | dshi p | | 168. 01 |
| 169.00 If this provider is a meaningful utransition factor. (see instruction | user (line 167 is "Y") an | | | | enter the | 9.9 | 9169. 00 |

| Health Financial Systems | PORTER MEMORIAL | HOSPI TAL | In Lie | u of Form CMS- | 2552-10 |
|---|--|-----------|-----------------|----------------|---------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX II | AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0035 | | | | ! |
| | | | From 01/01/2020 | | |
| | | | To 12/31/2020 | Date/Time Pre | pared: |
| | | | | 7/28/2021 4: 3 | 6 pm |
| | | | Begi nni ng | Endi ng | |
| | | | 1. 00 | 2. 00 | |
| 170.00 Enter in columns 1 and 2 the EHR begi period respectively (mm/dd/yyyy) | | | 170. 00 | | |
| | | | | | |
| | | | 1. 00 | 2. 00 | |
| 171.00 If line 167 is "Y", does this provide | | | N | C | 171. 00 |
| section 1876 Medicare cost plans repo | | | | | |
| "Y" for yes and "N" for no in column | on | | | | |
| 1876 Medicare days in column 2. (see | | | | | |
| 1 | | | | | |

| | Financial Systems PORTER MEMORIA | | | | u of Form CMS | |
|---------|--|----------------|---------------|---|---------------------|--------|
| HOSPI T | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provi der C | CN: 15-0035 | Period: From 01/01/2020 To 12/31/2020 | | |
| | | | | Y/N | 7/28/2021 4: | 36 pm |
| | | | | 1.00 | 2. 00 | |
| | General Instruction: Enter Y for all YES responses. Enter N | for all NO re | esponses. Ent | | | |
| | mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS | | | | | |
| | Provider Organization and Operation | | | | | |
| 1. 00 | Has the provider changed ownership immediately prior to the | | | N | | 1.00 |
| | reporting period? If yes, enter the date of the change in c | olumn 2. (see | 1 | | V//I | |
| | | | 1.00 | 2. 00 | V/I 3. 00 | |
| 2. 00 | Has the provider terminated participation in the Medicare P | | N | | | 2.00 |
| | yes, enter in column 2 the date of termination and in column | n 3, "V" for | | | | |
| 3. 00 | voluntary or "I" for involuntary. Is the provider involved in business transactions, includin | a management | Y | | | 3.00 |
| | contracts, with individuals or entities (e.g., chain home o | | | | | |
| | or medical supply companies) that are related to the provid | | | | | |
| | officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe | | | | | |
| | relationships? (see instructions) | 7 31 111 1 41 | | | | |
| | | | Y/N | Туре | Date | |
| | Financial Data and Reports | | 1.00 | 2. 00 | 3. 00 | |
| 4. 00 | Column 1: Were the financial statements prepared by a Cert | ified Public | N | | | 4.00 |
| | Accountant? Column 2: If yes, enter "A" for Audited, "C" f | | | | | |
| | or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions. | ilable in | | | | |
| 5. 00 | Are the cost report total expenses and total revenues diffe | rent from | N | | | 5.00 |
| | those on the filed financial statements? If yes, submit rec | | | | | |
| | | | | Y/N 1. 00 | Legal Oper. 2.00 | |
| | Approved Educational Activities | | | 1.00 | 2.00 | |
| 6. 00 | Column 1: Are costs claimed for nursing school? Column 2: | If yes, is the | he provider i | s Y | Y | 6. 00 |
| 7. 00 | the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in | structions | | Υ | | 7. 00 |
| 8. 00 | Were nursing school and/or allied health programs approved | | d during the | N | | 8.00 |
| | cost reporting period? If yes, see instructions. | | | n N | | |
| 9. 00 | Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction | | 9. 00 | | | |
| 10.00 | Was an approved Intern and Resident GME program initiated o | | the current | N | | 10.00 |
| | cost reporting period? If yes, see instructions. | | | | | |
| 11. 00 | Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions. | & R in an App | proved | N | | 11.00 |
| | reaching frogram on worksheet A: 11 yes, see first detrons. | | | | Y/N | |
| | | | | | 1. 00 | |
| 12 00 | Bad Debts Is the provider seeking reimbursement for bad debts? If yes | eoo Instruc | tions | | Y | 12.00 |
| | If line 12 is yes, did the provider's bad debt collection p | | | cost reporting | l 'N | 13.00 |
| | period? If yes, submit copy. | , , | <u> </u> | | | |
| 14. 00 | If line 12 is yes, were patient deductibles and/or co-payme | nts waived? I | f yes, see ir | nstructi ons. | N N | 14. 00 |
| 15. 00 | Bed Complement Did total beds available change from the prior cost reporti | na period? If | ves. see ins | structions. | Y | 15.00 |
| | | Par | t A | Par | t B | |
| | | Y/N 1,00 | Date | Y/N | Date | |
| | PS&R Data | 1. 00 | 2.00 | 3. 00 | 4. 00 | |
| 16. 00 | Was the cost report prepared using the PS&R Report only? | Υ | 04/15/2021 | Y | 04/15/2021 | 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 | N | | N | | 17. 00 |
| | totals and the provider's records for allocation? If | | | | | |
| | either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) | | | | | |
| 18. 00 | If line 16 or 17 is yes, were adjustments made to PS&R | N | | N | | 18. 00 |
| | Report data for additional claims that have been billed | | | | | |
| | but are not included on the PS&R Report used to file this cost report? If yes, see instructions. | | | | | |
| | | NI. | | N | | 19.00 |
| 19. 00 | If line 16 or 17 is yes, were adjustments made to PS&R | N | | IN | | |
| 19. 00 | Report data for corrections of other PS&R Report linformation? If yes, see instructions. | IN | | 14 | | 17.00 |

| Health Financial Systems PORTER MEMORIAL HOS | SPI TAL | In Lie | u of Form CMS- | -2552-10 | | | | |
|--|---|--------------------------|-------------------------|--------------|--|--|--|--|
| | Provi der CCN: 15-0035 Peri od From (To | | Worksheet S- Part II | 2 epared: | | | | |
| | Description | Y/N | Y/N | | | | | |
| 20 00 16 1 - 1/ - 17 17 17 17 17 17 17 17 17 17 17 17 17 | 0 | 1.00 | 3. 00 | 20.00 | | | | |
| 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 | | | | | |
| | . 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 (EXCEPT CH | I LDRENS HOSPI TALS) | | | | | | | |
| Capital Related Cost | | | | | | | | |
| 22.00 Have assets been relifed for Medicare purposes? If yes, see inst | | 1 - 2 10 1 | N | 22.00 | | | | |
| 23.00 Have changes occurred in the Medicare depreciation expense due t reporting period? If yes, see instructions. | o appraisais made (| during the cost | N | 23. 00 | | | | |
| 24.00 Were new leases and/or amendments to existing leases entered int lf yes, see instructions | o during this cost | reporting period? | N | 24. 00 | | | | |
| 25.00 Have there been new capitalized leases entered into during the clinstructions. | ost reporting peri | od? If yes, see | N | 25. 00 | | | | |
| 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cosinstructions. | t reporting period | ? If yes, see | N | 26. 00 | | | | |
| 27.00 Has the provider's capitalization policy changed during the cost copy. | reporting period? | If yes, submit | N | 27. 00 | | | | |
| Interest Expense Were new loans, mortgage agreements or letters of credit entered | into during the c | ost reporting | N | 28. 00 | | | | |
| period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond | N | 29. 00 | | | | | | |
| | | | | | | | | |
| | .00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see | | | | | | | |
| Purchased Services 32.00 Have changes or new agreements occurred in patient care services | | | | | | | | |
| arrangements with suppliers of services? If yes, see instruction 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied | S. | | Y | 32.00 | | | | |
| no, see instructions. | per tarming to comp | eti ti ve bi ddi iig: Ti | ' | 33.00 | | | | |
| Provider-Based Physicians 34.00 Are services furnished at the provider facility under an arrange | ment with provider | -based physicians? | Υ | 34.00 | | | | |
| If yes, see instructions. | • | . , | | | | | | |
| 35.00 If line 34 is yes, were there new agreements or amended existing physicians during the cost reporting period? If yes, see instruc | | · . | Υ | 35. 00 | | | | |
| | | Y/N 1,00 | Date | | | | | |
| Home Office Costs | | 1. 00 | 2. 00 | | | | | |
| 36.00 Were home office costs claimed on the cost report? | | Υ | | 36.00 | | | | |
| 37.00 If line 36 is yes, has a home office cost statement been prepare | d by the home offi | | | 37. 00 | | | | |
| If yes, see instructions. 38.00 If line 36 is yes , was the fiscal year end of the home office d | | of N | 12/31/2019 | 38. 00 | | | | |
| the provider? If yes, enter in column 2 the fiscal year end of t 39.00 If line 36 is yes, did the provider render services to other cha | | yes, N | | 39. 00 | | | | |
| see instructions. 40.00 If line 36 is yes, did the provider render services to the home | office? If yes, s | ee N | | 40.00 | | | | |
| i nstructi ons. | | | | | | | | |
| | 1.00 | 2. | 00 | | | | | |
| Cost Report Preparer Contact Information | | | | | | | | |
| 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. | er the first name, last name and the title/position d by the cost report preparer in columns 1, 2, and 3, | | | | | | | |
| | NITY HEALTH SYSTEMS | ; | | 42.00 | | | | |
| | 25-4333 | VI CTORI A_ROMAN | KO@CHS. NET | 43.00 | | | | |

| Heal th | Financial Systems | PORTER MEMOR | I AL HOS | SPI TAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---------|--|----------------|----------|-------------|---|---|--|---------|
| HOSPI T | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT Q | UESTI ONNAI RE | Pr | rovider CCN | | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II Date/Time Pre 7/28/2021 4:3 | pared: |
| | | | | 3.00 |) | _ | | |
| | Cost Report Preparer Contact Information | | | 3.00 | , | | | |
| 41. 00 | Enter the first name, last name and the time held by the cost report preparer in columns respectively. | | REVEN | JE MANAGER | | | | 41.00 |
| 42. 00 | Enter the employer/company name of the cost preparer. | t report | | | | | | 42. 00 |
| 43. 00 | Enter the telephone number and email address report preparer in columns 1 and 2, respect | | | | | | | 43.00 |

Heal th Financial SystemsPORTERHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 01/01/2020 | Part I | Date/Time | Prepared: | Provi der CCN: 15-0035

| | | | | | T | o 12/31/2020 | Date/Time Pre 7/28/2021 4:3 | |
|------------------|--|-------------|------|---------|--------------|--------------|--------------------------------|------------------|
| | | | | | | | 1/P Days / | O piii |
| | | | | | | | 0/P Visits / | |
| | | | | | | | Tri ps | |
| | Component | Worksheet A | No. | of Beds | Bed Days | CAH Hours | Title V | |
| | | Line Number | | | Avai I abl e | | | |
| | | 1. 00 | | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| 1. 00 | Hospital Adults & Peds. (columns 5, 6, 7 and | 30. 00 | | 192 | 70, 272 | 0. 00 | 0 | 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) | | | | | | | 2 00 |
| 2.00 | HMO and other (see instructions) | | | | | | | 2.00 3.00 |
| 3. 00 4. 00 | HMO IPF Subprovider HMO IRF Subprovider | | | | | | | 4.00 |
| 5. 00 | Hospital Adults & Peds. Swing Bed SNF | | | | | | 0 | |
| 6. 00 | Hospital Adults & Peds. Swing Bed NF | | | | | | 0 | |
| 7. 00 | Total Adults and Peds. (exclude observation | | | 192 | 70, 272 | 0. 00 | 0 | |
| 7.00 | beds) (see instructions) | | | 1/2 | 10,212 | 0.00 | O | 7.00 |
| 8. 00 | INTENSIVE CARE UNIT | 31. 00 | | 32 | 11, 712 | 0. 00 | 0 | 8.00 |
| 8. 01 | NEONATAL INTENSIVE CARE UNIT | 31. 01 | 1 | 14 | 5, 124 | 0. 00 | 0 | |
| 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 | 43.00 | ol . | | | | 0 | 13.00 |
| 14.00 | Total (see instructions) | | | 238 | 87, 108 | 0. 00 | 0 | 14.00 |
| 15.00 | CAH visits | | | | | | 0 | |
| 16. 00 | SUBPROVIDER - IPF | | | | | | | 16.00 |
| 17. 00 | SUBPROVI DER - I RF | 41. 00 | 1 | 14 | 5, 124 | | 0 | |
| 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 |
| 22. 00 23. 00 | HOME HEALTH AGENCY | | | | | | | 23.00 |
| 24.00 | AMBULATORY SURGICAL CENTER (D. P.) HOSPICE | | | | | | | 24.00 |
| 24. 00 | HOSPICE (non-distinct part) | 30.00 | | | | | | 24.00 |
| 25. 00 | CMHC - CMHC | 30.00 | 1 | | | | | 25.00 |
| 26. 00 | RURAL HEALTH CLINIC | | | | | | | 26.00 |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER | 89. 00 | | | | | 0 | |
| 27. 00 | Total (sum of lines 14-26) | 071.00 | | 252 | | | · · | 27. 00 |
| 28. 00 | Observation Bed Days | | | | | | 0 | |
| 29.00 | Ambul ance Trips | | | | | | | 29. 00 |
| 30.00 | Employee discount days (see instruction) | | | İ | | | | 30.00 |
| 31.00 | Employee discount days - IRF | | | | | | | 31.00 |
| 32.00 | Labor & delivery days (see instructions) | | | 0 | 0 | | | 32.00 |
| 32. 01 | Total ancillary labor & delivery room | | | | | | | 32. 01 |
| | outpatient days (see instructions) | | | | | | | |
| 33.00 | LTCH non-covered days | | | | | | | 33.00 |
| 33. 01 | LTCH site neutral days and discharges | | l | ļ | | | | 33. 01 |

Provi der CCN: 15-0035

Peri od: Worksheet S-3 From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared: 7/28/2021 4:36 pm

| | | 1 (0 0 | / O /D) // - ! - | / エ : | 5 11 F | <u> 7/28/2021 4: 3</u> | 6 pm |
|------------------|--|-------------|---------------------|-----------|---------------|-----------------------------|------------------|
| | | 1/P Days | / O/P Visits | / Irips | Full lime E | Equi val ents | |
| | | | | | | | |
| | Component | Title XVIII | Title XIX | Total All | Total Interns | Employees On | |
| | Component | IIII AVIII | II LIE XIX | Patients | & Residents | Payrol I | |
| | | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | |
| 1. 00 | Hospital Adults & Peds. (columns 5, 6, 7 and | 16, 536 | 1, 126 | 43, 228 | | 10.00 | 1.00 |
| 1.00 | 8 exclude Swing Bed, Observation Bed and | 10,000 | 1, 120 | 10, 220 | | | 1.00 |
| | Hospice days) (see instructions for col. 2 | | | | | | |
| | for the portion of LDP room available beds) | | | | | | |
| 2.00 | HMO and other (see instructions) | 11, 381 | 7, 352 | | | | 2.00 |
| 3.00 | HMO IPF Subprovider | 0 | 0 | | | | 3.00 |
| 4.00 | HMO IRF Subprovider | 386 | 361 | | | | 4.00 |
| 5.00 | Hospital Adults & Peds. Swing Bed SNF | o | 0 | 0 | | | 5.00 |
| 6.00 | Hospital Adults & Peds. Swing Bed NF | | o | 0 | | | 6.00 |
| 7.00 | Total Adults and Peds. (exclude observation | 16, 536 | 1, 126 | 43, 228 | | | 7.00 |
| | beds) (see instructions) | | | | | | |
| 8.00 | INTENSIVE CARE UNIT | 1, 998 | 60 | 5, 535 | | | 8. 00 |
| 8. 01 | NEONATAL INTENSIVE CARE UNIT | 0 | 207 | 2, 996 | | | 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 | | 1, 106 | 2, 400 | | | 13. 00 |
| 14. 00 | Total (see instructions) | 18, 534 | 2, 499 | 54, 159 | 0. 00 | 1, 343. 99 | |
| 15. 00 | CAH visits | 0 | 0 | 0 | | | 15.00 |
| 16.00 | SUBPROVIDER - I PF | | | | | | 16.00 |
| 17. 00 | SUBPROVIDER - IRF | 1, 946 | 69 | 3, 182 | 0. 00 | 15. 37 | 17.00 |
| 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 24. 10 | HOSPICE (non distinct nont) | | | 0 | | | 24. 00 24. 10 |
| 25. 00 | HOSPICE (non-distinct part) CMHC - CMHC | | | U | | | 25.00 |
| 26. 00 | RURAL HEALTH CLINIC | | | | | | 26.00 |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER | 0 | o | 0 | 0. 00 | 0.00 | |
| 27. 00 | Total (sum of lines 14-26) | o o | o _l | 0 | 0.00 | | |
| 28. 00 | Observation Bed Days | | 0 | 3, 984 | 0.00 | 1, 337. 30 | 28.00 |
| 29. 00 | Ambulance Trips | 0 | Ÿ. | 3, 704 | | | 29.00 |
| 30.00 | Employee discount days (see instruction) | ١ | | 0 | | | 30.00 |
| 31. 00 | Employee discount days (see Thisti detroit) | | | 0 | | | 31.00 |
| 32. 00 | Labor & delivery days (see instructions) | 0 | 238 | 594 | | | 32.00 |
| 32. 01 | Total ancillary labor & delivery room | | 200 | 0 | | | 32. 01 |
| 02.01 | outpatient days (see instructions) | | | O | | | 32.01 |
| 33. 00 | LTCH non-covered days | o | | | | | 33.00 |
| | LTCH site neutral days and discharges | o | | | | | 33. 01 |
| | , | · | ļ | | ! | • | |

Peri od: Worksheet S-3 From 01/01/2020 Part I To 12/31/2020 Date/Ti me Prepared: 7/38/2021 4:36 pm

| | | | | | | 7/28/2021 4: 3 | 6 pm |
|--------|---|---------------|---------|-------------|-----------|----------------|------------------|
| | | Full Time | | Di sch | arges | | |
| | | Equi val ents | | | | | |
| | Component | Nonpai d | Title V | Title XVIII | Title XIX | Total All | |
| | | Workers | | | | Pati ents | |
| | | 11. 00 | 12. 00 | 13. 00 | 14. 00 | 15. 00 | |
| 1.00 | Hospital Adults & Peds. (columns 5, 6, 7 and | | C | 3, 485 | 1, 606 | 10, 555 | 1.00 |
| | 8 exclude Swing Bed, Observation Bed and | | | | | | |
| | Hospice days) (see instructions for col. 2 | | | | | | |
| | for the portion of LDP room available beds) | | | | | | |
| 2. 00 | HMO and other (see instructions) | | | 1, 644 | 0 | | 2.00 |
| 3. 00 | HMO I PF Subprovi der | | | | 0 | | 3.00 |
| 4. 00 | HMO IRF Subprovider | | | | 0 | | 4.00 |
| 5. 00 | Hospital Adults & Peds. Swing Bed SNF | | | | | | 5.00 |
| 6. 00 | Hospital Adults & Peds. Swing Bed NF | | | | | | 6.00 |
| 7. 00 | Total Adults and Peds. (exclude observation | | | | | | 7. 00 |
| | 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 | C | 3, 485 | 1, 606 | 10, 555 | 1 |
| 15.00 | CAH visits | | | | | | 15.00 |
| 16. 00 | SUBPROVI DER - I PF | | _ | | | | 16.00 |
| 17. 00 | SUBPROVI DER - I RF | 0. 00 | C | 185 | 35 | 297 | 1 |
| 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) | | | | | | 24. 10 |
| 25. 00 | CMHC - CMHC | | | | | | 25.00 |
| 26.00 | RURAL HEALTH CLINIC | 0.00 | | | | | 26.00 |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER | 0.00 | | | | | 26. 25 |
| 27. 00 | Total (sum of lines 14-26) | 0. 00 | | | | | 27.00 |
| 28. 00 | Observation Bed Days | | | | | | 28.00 |
| 29. 00 | Ambul ance Trips | | | | | | 29.00 |
| 30.00 | Employee discount days (see instruction) | | | | | | 30.00 |
| 31.00 | Employee discount days - IRF | | | | | | 31.00 |
| 32.00 | Labor & delivery days (see instructions) | | | | | | 32.00 |
| 32. 01 | Total ancillary labor & delivery room | | | | | | 32. 01 |
| 22 00 | outpatient days (see instructions) LTCH non-covered days | | | | | | 22.00 |
| 33. 00 | | | | | | | |
| 22 ∩1 | LTCH site neutral days and discharges | | | 0 | | | 33. 00 33. 01 |

| | Financial Systems | | PORTER MEMORI | | | | u of Form CMS-2 | |
|------------------|---|------------------------|--------------------|--|---|---|--|------------------|
| HOSPI T | AL WAGE INDEX INFORMATION | | | Provi der C | F | eriod: rom 01/01/2020 o 12/31/2020 | | pared: |
| | | Wkst. A Line Number | Amount Reported | Reclassificat ion of Salaries (from Wkst. | Adjusted Salaries (col.2 ± col. 3) | Paid Hours Related to Salaries in col. 4 | Average Hourly Wage (col. 4 ÷ col. 5) | |
| | | 1. 00 | 2. 00 | A-6) 3. 00 | 4.00 | 5. 00 | 6. 00 | |
| | PART II - WAGE DATA | | | | • | | | |
| 1. 00 | SALARIES Total salaries (see | 200.00 | 86, 169, 618 | О | 86, 169, 618 | 2, 827, 464. 00 | 30. 48 | 1.00 |
| 2. 00 | instructions) Non-physician anesthetist Part | | 0 | 0 | 0 | 0. 00 | 0. 00 | 2.00 |
| 2.00 | A and an estiletist Part | | o l | O | , | 0.00 | 0.00 | 2.00 |
| 3. 00 | Non-physician anesthetist Part | | 0 | 0 | 0 | 0. 00 | 0. 00 | 3. 00 |
| 4. 00 | Physician-Part A - Administrative | | 323, 167 | 0 | 323, 167 | 1, 631. 00 | 198. 14 | 4. 00 |
| 4. 01 | Physicians - Part A - Teaching | | 0 | 0 | 1 | 0. 00 | 0.00 | |
| 5. 00 | Physician and Non Physician-Part B | | 0 | 0 | 0 | 0. 00 | 0. 00 | 5.00 |
| 6. 00 | Non-physician-Part B for hospital-based RHC and FQHC services | | 0 | 0 | 0 | 0. 00 | 0.00 | 6. 00 |
| 7. 00 | Interns & residents (in an | 21. 00 | 0 | 0 | 0 | 0. 00 | 0. 00 | 7. 00 |
| 7. 01 | approved program) Contracted interns and residents (in an approved | | 0 | O | 0 | 0. 00 | 0.00 | 7. 01 |
| 8. 00 | programs) Home office and/or related organization personnel | | 0 | 0 | 0 | 0. 00 | 0. 00 | 8. 00 |
| 9.00 | SNF | 44.00 | 0 | 0 | 0 | 0.00 | 0.00 | |
| 10. 00 | Excluded area salaries (see instructions) | | 1, 154, 540 | 0 | 1, 154, 540 | 36, 831. 00 | 31. 35 | 10.00 |
| 11. 00 | OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient | | 4, 710, 036 | 0 | 4, 710, 036 | 56, 292. 00 | 83. 67 | 11. 00 |
| 12. 00 | Care Contract Labor: Top Level | | 6, 450 | 0 | 6, 450 | 171. 00 | 37. 72 | 12.00 |
| | management and other management and administrative services | | | | | | | |
| 13. 00 | Contract Labor: Physician-Part A - Administrative | | 344, 909 | 0 | 344, 909 | 2, 366. 00 | 145. 78 | 13. 00 |
| 14. 00 | Home office and/or related organization salaries and | | 0 | 0 | 0 | 0. 00 | 0. 00 | 14. 00 |
| 14. 01 | wage-related costs Home office salaries | | 10, 461, 963 | 0 | 10, 461, 963 | 328, 770. 00 | 31. 82 | 14. 01 |
| 14. 02 15. 00 | Related organization salaries Home office: Physician Part A | | 0 | 0 | 0 | 0. 00 0. 00 | 0. 00 0. 00 | |
| 15.00 | - Administrative | | U | O | , | 0.00 | | |
| 16. 00 | Home office and Contract Physicians Part A - Teaching | | 0 | 0 | 0 | 0. 00 | 0. 00 | 16.00 |
| 16. 01 | Home office Physicians Part A | | 0 | 0 | 0 | 0. 00 | 0.00 | 16. 01 |
| 16. 02 | - Teaching Home office contract | | 0 | 0 | 0 | 0. 00 | 0. 00 | 16. 02 |
| | Physicians Part A - Teaching WAGE-RELATED COSTS | | | | | | | |
| 17. 00 | Wage-related costs (core) (see | | 22, 059, 792 | O | 22, 059, 792 | | | 17. 00 |
| 18. 00 | instructions) Wage-related costs (other) | | | | | | | 18. 00 |
| 19. 00 | (see instructions) Excluded areas | | 306, 912 | 0 | 306, 912 | | | 19. 00 |
| 20. 00 | Non-physician anesthetist Part | | 0 | 0 | 0 | | | 20.00 |
| 21. 00 | Non-physician anesthetist Part | | 0 | 0 | 0 | | | 21.00 |
| 22. 00 | Physician Part A - Administrative | | 26, 394 | 0 | 26, 394 | | | 22.00 |
| 22. 01 | Physician Part A - Teaching | | 0 | 0 | 0 | | | 22. 01 |
| 23. 00 24. 00 | Physician Part B Wage-related costs (RHC/FQHC) | | 0 | 0 | 0 | | | 23. 00 24. 00 |
| 25. 00 | Interns & residents (in an | | 0 | 0 | 0 | | | 25.00 |
| 25. 50 | approved program) Home office wage-related | | 2, 298, 755 | 0 | 2, 298, 755 | | | 25. 50 |
| 25. 51 | (core) Related organization | | 0 | 0 | 0 | | | 25. 51 |
| 25. 52 | wage-related (core) Home office: Physician Part A | | 0 | 0 | 0 | | | 25. 52 |
| | - Administrative - wage-related (core) | | | | | | | |
| | | | | | | | | |

| Heal th | Financial Systems | | PORTER MEMORI | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|-------------------|--------------------------------|--------------|---------------|-----------------------|--------------|---|-----------------|---------|
| HOSPI T | AL WAGE INDEX INFORMATION | | | Provi der Co | | Period: From 01/01/2020 To 12/31/2020 | | pared: |
| | | Wkst. A Line | Amount | Reclassificat | | Paid Hours | Average | |
| | | Number | Reported | i on of Sal ari es | Sal ari es | Related to | Hourly Wage | |
| | | | | | (col.2 ± col | | (col. 4 ÷ | |
| | | | | (from Wkst. A-6) | 3) | col. 4 | col . 5) | |
| | | 1. 00 | 2. 00 | 3. 00 | 4.00 | 5. 00 | 6. 00 | |
| 25. 53 | Home office: Physicians Part A | | 2.00 | 0.00 | 1.00 | 0 | 0.00 | 25. 53 |
| | - Teaching - wage-related | | _ | _ | | | | |
| | (core) | | | | | | | |
| | OVERHEAD COSTS - DIRECT SALARI | ES | | | | | | |
| 26. 00 | Employee Benefits Department | 4. 00 | | | 383, 10 | | | |
| 27. 00 | Administrative & General | 5. 00 | 11, 318, 928 | | | | l | |
| 28. 00 | Administrative & General under | 1 | 356, 267 | 0 | 356, 26 | 18, 665. 00 | 19. 09 | 28. 00 |
| | contract (see inst.) | | | | | | | |
| 29. 00 | Maintenance & Repairs | 6. 00 | 0 | 0 | | 0.00 | | 29. 00 |
| 30.00 | Operation of Plant | 7. 00 | 2, 123, 745 | | 2, 123, 74 | | l | |
| 31. 00 | Laundry & Linen Service | 8.00 | 132, 121 | | 132, 12 | | l | |
| 32. 00 | Housekeepi ng | 9.00 | 1, 433, 613 | | 1, 433, 61 | | l . | |
| 33. 00 | Housekeepi ng under contract | | 531, 771 | 0 | 531, 77 | 14, 954. 00 | 35. 56 | 33. 00 |
| 24.00 | (see instructions) | 10.00 | 1 705 054 | 002 022 | 700 4 | 10 771 00 | 15.00 | 24.00 |
| 34.00 | Di etary | 10.00 | 1, 725, 354 | · | | | l . | 34.00 |
| 35. 00 | Dietary under contract (see | | 313, 303 | 0 | 313, 30 | 5, 949. 86 | 52. 66 | 35. 00 |
| 36. 00 | i nstructi ons) Cafeteri a | 11.00 | 0 | 992, 932 | 992, 93 | 66, 119. 00 | 15.02 | 36. 00 |
| 37. 00 | Maintenance of Personnel | 12.00 | 0 | 772, 732 | 772, 7 | 0 0, 119.00 | l | |
| 38. 00 | Nursing Administration | 13.00 | 3, 533, 448 | 221, 992 | 3, 755, 44 | | | |
| 39. 00 | Central Services and Supply | 14.00 | 780, 252 | | 780, 25 | · | l . | 39.00 |
| 40. 00 | Pharmacy | 15.00 | 2, 805, 619 | | 2, 805, 6 | | | 40.00 |
| 41. 00 | Medical Records & Medical | 16.00 | 565, 182 | | 565, 18 | | l | 41.00 |
| - 1.00 | Records Library | 10.00 | 303, 102 | | 303, 10 | 27, 101. 00 | 20.03 | 71.00 |
| 42.00 | Social Service | 17.00 | 1, 376, 422 | 0 | 1, 376, 42 | 22 37, 970. 00 | 36. 25 | 42. 00 |
| | Other General Service | 18. 00 | | l o | .,, | 0 0.00 | l | 43.00 |
| | 1 | | | | ' | , | | |

| Health Financial Systems | PORTER MEMORIAL HOSPITAL | 1 | n Lieu of Form CMS-2552-10 |
|---------------------------------|--------------------------|----------|----------------------------|
| HOSPITAL WAGE INDEX INFORMATION | Provi der CCN: 15-0035 | Peri od: | Worksheet S-3 |

| нозы | AL WAGE INDEX INFORMATION | | | Provider C | | From 01/01/2020 To 12/31/2020 | Part III Date/Time Prep 7/28/2021 4:30 | |
|-------|--------------------------------|-------------|---------------|------------------|--------------|----------------------------------|--|-------|
| | | Worksheet A | Amount | Recl assi fi cat | Adj usted | Pai d Hours | Average | |
| | | Line Number | Reported | ion of | Sal ari es | Related to | Hourly Wage | |
| | | | | Sal ari es | (col.2 ± col | . Salaries in | (col. 4 ÷ | |
| | | | | (from | 3) | col. 4 | col. 5) | |
| | | | | Worksheet | | | | |
| | | | | A-6) | | | | |
| | | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | 6. 00 | |
| | PART III - HOSPITAL WAGE INDEX | SUMMARY | | | | | | |
| 1.00 | Net salaries (see | | 87, 370, 959 | 0 | 87, 370, 95 | 59 2, 867, 032. 86 | 30. 47 | 1.00 |
| | instructions) | | | | | | | |
| 2. 00 | Excluded area salaries (see | | 1, 154, 540 | 0 | 1, 154, 54 | 36, 831. 00 | 31. 35 | 2.00 |
| | instructions) | | | | | | | |
| 3.00 | Subtotal salaries (line 1 | | 86, 216, 419 | 0 | 86, 216, 41 | 9 2, 830, 201. 86 | 30. 46 | 3.00 |
| | minus line 2) | | | | | | | |
| 4. 00 | Subtotal other wages & related | | 15, 523, 358 | 0 | 15, 523, 35 | 387, 599. 00 | 40. 05 | 4. 00 |
| | costs (see inst.) | | | | | | | |
| 5. 00 | Subtotal wage-related costs | | 24, 384, 941 | 0 | 24, 384, 94 | 0.00 | 28. 28 | 5.00 |
| | (see inst.) | | | | | | | |
| 6. 00 | Total (sum of lines 3 thru 5) | | 126, 124, 718 | | 126, 124, 71 | | | |
| 7. 00 | Total overhead cost (see | | 27, 379, 134 | 0 | 27, 379, 13 | 1, 035, 929. 86 | 26. 43 | 7. 00 |
| | instructions) | | | | | | | |
| | | | | | | | | |

| Health Financial Systems | PORTER MEMORIAL HOSPITAL | In Lieu | u of Form CMS-2552-10 |
|-----------------------------|--------------------------|-----------------|-----------------------------------|
| HOSPITAL WAGE RELATED COSTS | Provi der CCN: 15-0035 | | Worksheet S-3 |
| | | From 01/01/2020 | Part V Date/Time Prepared: |

| | To 12/31/2020 | Date/Time Prep 7/28/2021 4:30 | |
|--------|---|----------------------------------|--------|
| | | Amount | |
| | | Reported | |
| | | 1. 00 | |
| | PART IV - WAGE RELATED COSTS | | |
| | Part A - Core List | | |
| | RETI REMENT COST | | |
| 1.00 | 401K Employer Contributions | 1, 688, 013 | 1.00 |
| 2.00 | Tax Sheltered Annuity (TSA) Employer Contribution | o | 2.00 |
| 3.00 | Nonqualified Defined Benefit Plan Cost (see instructions) | ol | 3.00 |
| 4.00 | Qualified Defined Benefit Plan Cost (see instructions) | ol | 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) | 13, 321, 610 | 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 | 193, 287 | 10.00 |
| 11.00 | Life Insurance (If employee is owner or beneficiary) | 67, 608 | 11.00 |
| 12.00 | Accident Insurance (If employee is owner or beneficiary) | 4, 692 | 12.00 |
| 13.00 | Disability Insurance (If employee is owner or beneficiary) | 207, 176 | 13.00 |
| 14.00 | Long-Term Care Insurance (If employee is owner or beneficiary) | o | 14.00 |
| 15.00 | 'Workers' Compensation Insurance | 1, 052, 379 | 15.00 |
| 16.00 | Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. | 0 | 16.00 |
| | Non cumulative portion) | | |
| | TAXES | | l |
| 17.00 | FICA-Employers Portion Only | 4, 587, 639 | 17.00 |
| 18.00 | Medicare Taxes - Employers Portion Only | 1, 072, 915 | |
| 19. 00 | Unempl oyment Insurance | 0 | 19.00 |
| 20.00 | State or Federal Unemployment Taxes | 197, 778 | 20.00 |
| | OTHER | | l |
| 21.00 | Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see | 0 | 21.00 |
| | instructions)) | | l |
| 22.00 | Day Care Cost and Allowances | 0 | 22.00 |
| 23.00 | Tuition Reimbursement | 0 | 23.00 |
| 24.00 | Total Wage Related cost (Sum of lines 1 -23) | 22, 393, 097 | 24.00 |
| | Part B - Other than Core Related Cost | | l |
| 25.00 | OTHER WAGE RELATED COSTS (SPECIFY) | ı İ | 25. 00 |
| | | | |

| Health Financial Systems | PORTER MEMORIAL HOSPITAL | In Lie | u of Form CMS-2552-10 |
|--|--------------------------|--|---|
| HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provi der CCN: 15-0035 | Peri od: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part V Date/Time Prepared: 7/28/2021 4:36 pm |

| | | 10 12/31/2020 | 7/28/2021 4: 3 | |
|--------|---|---------------|----------------|-------|
| | Cost Center Description | Contract | Benefit Cost | |
| | | Labor | | |
| | | 1. 00 | 2.00 | |
| | PART V - Contract Labor and Benefit Cost | | | |
| | Hospital and Hospital-Based Component Identification: | | | |
| 1.00 | Total facility's contract labor and benefit cost | 4, 710, 036 | 22, 393, 097 | 1.00 |
| 2.00 | Hospi tal | 4, 710, 036 | 22, 393, 097 | 2.00 |
| 3.00 | Subprovi der - I PF | | | 3.00 |
| 4.00 | Subprovi der - I RF | 0 | 0 | 4.00 |
| 5.00 | Subprovi der - (Other) | 0 | 0 | 5.00 |
| 6.00 | Swing Beds - SNF | 0 | 0 | 6.00 |
| 7.00 | Swing Beds - NF | 0 | 0 | 7.00 |
| 8.00 | Hospi tal -Based SNF | | | 8.00 |
| 9.00 | Hospi tal -Based NF | | | 9.00 |
| 10.00 | Hospi tal -Based OLTC | | | 10.00 |
| 11. 00 | Hospi tal -Based HHA | | | 11.00 |
| 12. 00 | Separately Certified ASC | | | 12.00 |
| 13. 00 | Hospi tal -Based Hospi ce | | | 13.00 |
| 14. 00 | Hospital-Based Health Clinic RHC | | | 14.00 |
| 15. 00 | Hospital-Based Health Clinic FQHC | | | 15.00 |
| 16.00 | Hospi tal -Based-CMHC | | | 16.00 |
| 17. 00 | Renal Di al ysi s | 0 | 0 | 17.00 |
| 18. 00 | Other | 0 | 0 | 18.00 |

| | Financial Systems PORTER MEMORIAL H | | | | u of Form CMS-2 | |
|---------|--|----------------|----------------|----------------------------------|-----------------|-------|
| HOSPI 1 | AL UNCOMPENSATED AND INDIGENT CARE DATA | Provi der CO | CN: 15-0035 | Peri od: | Worksheet S-1 | 0 |
| | | | | From 01/01/2020 To 12/31/2020 | Date/Time Pre | nared |
| | | | | | 7/28/2021 4: 3 | 6 pm |
| | | | | | 1. 00 | |
| | Uncompensated and indigent care cost computation | | | | | |
| . 00 | Cost to charge ratio (Worksheet C, Part I line 202 column 3 div | vided by Li | ne 202 colum | n 8) | 0. 122385 | 1.0 |
| | Medicaid (see instructions for each line) | | | | | |
| . 00 | Net revenue from Medicaid | | | | 40, 302, 628 | • |
| . 00 | Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplemen | tal naumant | to from Modic | ol dO | Y | 3. C |
| . 00 | If line 4 is no, then enter DSH and/or supplemental payments fi | | | ai u r | 0 | 1 |
| . 00 | Medicaid charges | on wearcar | u | | 252, 876, 526 | |
| . 00 | Medicaid cost (line 1 times line 6) | | | | 30, 948, 294 | |
| . 00 | Difference between net revenue and costs for Medicaid program | (line 7 mir | nus sum of li | nes 2 and 5; if | 0 | 1 |
| | < zero then enter zero) | | | | | |
| | Children's Health Insurance Program (CHIP) (see instructions for | or each lir | ne) | | | |
| . 00 | Net revenue from stand-alone CHIP | | | | 0 | |
| 1.00 | Stand-alone CHIP charges | | | | 5, 844 | 1 |
| 2. 00 | Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP | (line 11 mi | nus line 0 | if / zero then | 715 | 12.0 |
| 2.00 | enter zero) | (11110 11 1111 | nus iine 7, | TT \ Zero then | 713 | 12.0 |
| | Other state or local government indigent care program (see inst | ructions f | or each line |) | | |
| 3. 00 | Net revenue from state or local indigent care program (Not incl | | | | 0 | 13. (|
| 4. 00 | | e program (| (Not included | in lines 6 or | 0 | 14. (|
| | 10) | | | | _ | |
| 5.00 | State or local indigent care program cost (line 1 times line 1 | , | | 15! | 0 | |
| 6. 00 | Difference between net revenue and costs for state or local inc 13; if < zero then enter zero) | argent care | e program (11 | ne 15 minus iine | 0 | 16.0 |
| | Grants, donations and total unreimbursed cost for Medicaid, CHI | P and stat | e/Local indi | gent care progra | ıms (see | |
| 7 00 | instructions for each line) | | | | 0 | 177 |
| | Private grants, donations, or endowment income restricted to for Government grants, appropriations or transfers for support of I | | | | 0 | |
| 9. 00 | Total unreimbursed cost for Medicaid , CHIP and state and local | | | s (sum of lines | | 19.0 |
| | 8, 12 and 16) | 9 | p9 | | | |
| | | | Uni nsured | Insured | Total (col. 1 | |
| | | | pati ents | pati ents | + col . 2) | |
| | Uncompensated Care (see instructions for each line) | | 1. 00 | 2. 00 | 3. 00 | |
| 0.00 | | cility | 14, 144, 29 | 95 32, 920 | 14, 177, 215 | 20.0 |
| | (see instructions) | | | | | l |
| 1. 00 | Cost of patients approved for charity care and uninsured discou | unts (see | 1, 731, 0 | 32, 920 | 1, 763, 970 | 21.0 |
| 2. 00 | instructions) Payments received from patients for amounts previously written | off as | 38, 70 | 51 0 | 38, 761 | 22.0 |
| 2.00 | charity care | UII as | 30, 70 | | 36, 701 | 22.0 |
| 3. 00 | Cost of charity care (line 21 minus line 22) | | 1, 692, 28 | 32, 920 | 1, 725, 209 | 23.0 |
| | | | | | | |
| | | | | | 1. 00 | |
| 4. 00 | Does the amount on line 20 column 2, include charges for patien | | ond a Length | of stay limit | N | 24.0 |
| E 00 | imposed on patients covered by Medicaid or other indigent care | | t care progra | m's longth of | 0 | 25 (|
| 5. 00 | <pre>If line 24 is yes, enter the charges for patient days beyond tl stay limit</pre> | ie i nui geni | care progra | m 3 rengtii 0i | 0 | 25.0 |
| 6. 00 | Total bad debt expense for the entire hospital complex (see in | structions |) | | 19, 611, 894 | 26.0 |
| 7. 00 | Medicare reimbursable bad debts for the entire hospital complex | | | | 525, 638 | 1 |
| 7. 01 | Medicare allowable bad debts for the entire hospital complex (| • | | | 808, 675 | |
| 8. 00 | Non-Medicare bad debt expense (see instructions) | | • | | 18, 803, 219 | 28.0 |
| 9. 00 | Cost of non-Medicare and non-reimbursable Medicare bad debt exp | oense (see | i nstructi ons | () | 2, 584, 269 | |
| 30.00 | Cost of uncompensated care (line 23 column 3 plus line 29) | | | | 4, 309, 478 | 30.0 |
| | Total unreimbursed and uncompensated care cost (line 19 plus li | | | | 4, 310, 193 | |

| | Financial Systems SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O | PORTER MEMORIA | L HOSPITAL Provider CO | CN: 15-0035 F | In Lie | u of Form CMS-: Worksheet A | 2552-10 |
|------------------|---|-------------------------|------------------------------|----------------|--------------------------------|-----------------------------------|--------------------|
| | | | | F | rom 01/01/2020 o 12/31/2020 | Date/Time Pre | |
| | Cost Center Description | Sal ari es | 0ther | Total (col. 1 | Recl assi fi cat | 7/28/2021 4: 3 Recl assi fi ed | o piii |
| | · | | | + col. 2) | i ons (See | Tri al Bal ance | |
| | | | | | A-6) | (col. 3 +- col. 4) | |
| | | 1. 00 | 2.00 | 3. 00 | 4.00 | 5. 00 | |
| | GENERAL SERVICE COST CENTERS | | | | | | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP | | 1, 051, 470 | | | 5, 882, 598 | 1.00 |
| 2. 00 4. 00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | 383, 109 | 9, 821, 355 213, 788 | | | 11, 221, 377 17, 202, 368 | 2.00 4.00 |
| 5. 00 | 00500 ADMI NI STRATI VE & GENERAL | 11, 318, 928 | 48, 152, 449 | | | 38, 401, 314 | 5.00 |
| 7. 00 | 00700 OPERATION OF PLANT | 2, 123, 745 | 6, 898, 287 | | | 13, 284, 624 | 7.00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | 132, 121 | 1, 251, 520 | | | 1, 383, 641 | 8. 00 |
| 9. 00 | 00900 HOUSEKEEPI NG | 1, 433, 613 | 1, 808, 355 | | | 3, 241, 359 | 9. 00 |
| 10.00 | 01000 DI ETARY | 1, 725, 354 | 1, 374, 247 | 3, 099, 601 | | 1, 274, 579 | |
| 11.00 | 01100 CAFETERI A | 0 | 0 | 0 225 (2) | ., . = . , . = . | 1, 727, 927 | 1 |
| 13.00 | 01300 NURSI NG ADMI NI STRATI ON | 3, 533, 448 | 402, 186 | | | 4, 157, 626 | |
| 14. 00 15. 00 | 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY | 780, 252 2, 805, 619 | 20, 605, 199 31, 141, 269 | | | 1, 903, 466 2, 970, 801 | |
| 16. 00 | 01600 MEDICAL RECORDS & LIBRARY | 565, 182 | 1, 066, 987 | 1, 632, 169 | | 1, 632, 169 | 1 |
| 17. 00 | 01700 SOCIAL SERVICE | 1, 376, 422 | 272, 711 | | | 1, 649, 133 | 1 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | .,, | | ., ., ., ., ., | | ., | |
| 30.00 | 03000 ADULTS & PEDIATRICS | 15, 672, 764 | 5, 261, 744 | | | 20, 060, 255 | 30.00 |
| 31.00 | 03100 NTENSI VE CARE UNI T | 4, 889, 307 | 3, 959, 916 | | | 8, 777, 435 | |
| 31. 01 | 03101 NEONATAL INTENSIVE CARE UNIT | 1, 695, 081 | 1, 035, 803 | | | 2, 709, 586 | |
| 41.00 | 04100 SUBPROVI DER - I RF 04300 NURSERY | 1, 097, 197 | 250, 569 | | | 1, 348, 212 | 1 |
| 43. 00 | ANCI LLARY SERVI CE COST CENTERS | 5, 339 | 71, 659 | 76, 998 | 585, 537 | 662, 535 | 43.00 |
| 50. 00 | 05000 OPERATING ROOM | 5, 315, 203 | 11, 086, 813 | 16, 402, 016 | 1, 499, 210 | 17, 901, 226 | 50.00 |
| 51. 00 | 05100 RECOVERY ROOM | 2, 252, 057 | 359, 937 | | | 0 | 51.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 1, 888, 967 | 670, 133 | | | 2, 652, 761 | ı |
| 53.00 | 05300 ANESTHESI OLOGY | 0 | 3, 634, 192 | 3, 634, 192 | 0 | 3, 634, 192 | |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 5, 791, 152 | 2, 515, 709 | | | 9, 123, 593 | |
| 54. 01 | 05401 ULTRASOUND | 369, 915 | 70, 127 | 440, 042 | | 0 | |
| 56.00 | 05600 RADI OI SOTOPE | 304, 760 | 533, 637 | 838, 397 | | 0 | 56.00 |
| 57. 00 58. 00 | 05700 CT SCAN 05800 MRI | 497, 407 | 250, 772 187, 731 | | | 0 | 57. 00 58. 00 |
| 60.00 | 06000 LABORATORY | 208, 112 5, 210, 879 | 6, 120, 862 | | | 10, 987, 097 | • |
| 65. 00 | 06500 RESPIRATORY THERAPY | 1, 713, 717 | 826, 263 | | | 2, 437, 501 | |
| 66. 00 | 06600 PHYSI CAL THERAPY | 1, 768, 833 | 298, 307 | 2, 067, 140 | | 2, 067, 140 | 1 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 669, 949 | 49, 270 | | | 719, 219 | |
| 68. 00 | 06800 SPEECH PATHOLOGY | 647, 198 | 77, 483 | | | 723, 981 | |
| 69. 00 | 06900 ELECTROCARDI OLOGY | 3, 345, 619 | 5, 314, 759 | | | 8, 348, 041 | |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0 | 0 | | , | 893, 470 | 1 |
| 72. 00 73. 00 | 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS | 126, 959 | 3, 048 | 130, 007 | 17, 671, 905 29, 879, 001 | 17, 671, 905 30, 009, 008 | |
| 74.00 | 07400 RENAL DIALYSIS | 120, 737 | 658, 068 | 658, 068 | | 658, 068 | |
| 76. 00 | 03950 ANCI LLARY | 0 | 030, 000 | 030,000 | | 030, 000 | ı |
| | 03610 SLEEP LAB | 224, 228 | 48, 094 | 272, 322 | -272, 322 | 0 | 76. 01 |
| 76. 03 | 03951 WOUND CARE | 848, 329 | 740, 983 | | | 1, 589, 172 | 76. 03 |
| | OUTPATIENT SERVICE COST CENTERS | | - | | | | |
| 90.00 | 09000 CLI NI C 09100 EMERGENCY | 0 | 0 5 700 7/1 | 11 000 071 | | 0 | |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART | 5, 391, 510 | 5, 700, 761 | 11, 092, 271 | -100, 912 | 10, 991, 359 | 91.00 |
| 92.00 | SPECIAL PURPOSE COST CENTERS | | | | | | 72.00 |
| 118.00 | | 86, 112, 275 | 173, 786, 463 | 259, 898, 738 | 0 | 259, 898, 738 | 118.00 |
| | NONREI MBURSABLE COST CENTERS | | | | | | |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 57, 343 | 4, 123 | | | | 190. 00 |
| | 19200 PHYSICIANS' PRIVATE OFFICES | 0 | 180 | | | | 192.00 |
| | 19201 OTHER NONREI MBURSABLE | 0 | 0 | | | | 192. 01 |
| | 07950 NONREI MBURSABLE 07951 MARKETI NG | 0 | 0 | | _ | | 194. 00 194. 01 |
| | 07951 MARKETTING 07952 SENI OR CIRCLE | 0 | 0 | | | | 194.01 |
| | 07953 NONREIMB - REGENCY LTC | 0 | 0 | | | | 194. 02 |
| | 07954 VACANT UNFINISHED AREA | o | Ö | | o o | | 194. 04 |
| 200.00 | | 86, 169, 618 | 173, 790, 766 | 259, 960, 384 | | 259, 960, 384 | |
| | | | | | · | | |

 Health Financial
 Systems
 PORTER MEM

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 15-0035 Peri od:

| | | | | | 10 12/31/ | 7/28/2021 4: | |
|-----------------|---|-------------------|----------------------------|---|-----------|--------------|------------------|
| | Cost Center Description | Adjustments | Net Expenses | | | | J |
| | · | (See A-8) | For | | | | |
| | | | Allocation | | | | |
| | | 6. 00 | 7. 00 | | | | |
| | GENERAL SERVICE COST CENTERS | | | T | | | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FLXT | 765, 547 | 6, 648, 145 | 1 | | | 1.00 |
| 2.00 | 00200 CAP REL COSTS-MVBLE EQUIP | -701, 812 | 10, 519, 565 | • | | | 2.00 |
| 4. 00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | -4, 872 | 17, 197, 496 | • | | | 4.00 |
| 5.00 | 00500 ADMI NI STRATI VE & GENERAL | 22, 872, 139 | 61, 273, 453 | | | | 5.00 |
| 7. 00 | 00700 OPERATION OF PLANT | -277, 877 | 13, 006, 747 | | | | 7.00 |
| 8. 00 9. 00 | 00800 LAUNDRY & LI NEN SERVI CE | 0 | 1, 383, 641 | | | | 8.00 |
| 9. 00 10. 00 | 00900 HOUSEKEEPI NG 01000 DI ETARY | 0 | 3, 241, 359 1, 274, 579 | • | | | 9.00 |
| | 01100 CAFETERI A | 0 | 1, 727, 927 | | | | 11.00 |
| | 01300 NURSING ADMINISTRATION | -10, 657 | 4, 146, 969 | | | | 13.00 |
| | 01400 CENTRAL SERVICES & SUPPLY | 0,037 | 1, 903, 466 | | | | 14.00 |
| | 01500 PHARMACY | o o | 2, 970, 801 | | | | 15. 00 |
| | 01600 MEDICAL RECORDS & LIBRARY | 0 | 1, 632, 169 | | | | 16.00 |
| | 01700 SOCIAL SERVICE | 0 | 1, 649, 133 | 1 | | | 17. 00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | , , | ' | | | |
| 30.00 | 03000 ADULTS & PEDIATRICS | -1, 656, 091 | 18, 404, 164 | | | | 30.00 |
| 31.00 | 03100 INTENSIVE CARE UNIT | -2, 651, 180 | 6, 126, 255 | | | | 31.00 |
| 31.01 | 03101 NEONATAL INTENSIVE CARE UNIT | -755, 400 | 1, 954, 186 | | | | 31.01 |
| 41.00 | 04100 SUBPROVI DER - I RF | 0 | 1, 348, 212 | | | | 41.00 |
| 43.00 | 04300 NURSERY | 0 | 662, 535 | | | | 43.00 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| | 05000 OPERATING ROOM | -4, 802, 637 | 13, 098, 589 | | | | 50.00 |
| | 05100 RECOVERY ROOM | 0 | 0 | | | | 51.00 |
| | 05200 DELIVERY ROOM & LABOR ROOM | -201, 675 | 2, 451, 086 | i | | | 52.00 |
| | 05300 ANESTHESI OLOGY | -3, 586, 459 | 47, 733 | | | | 53.00 |
| | 05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND | -276, 972 | 8, 846, 621 | | | | 54.00 |
| | 05600 RADI OI SOTOPE | 0 | 0 | | | | 54. 01 56. 00 |
| | 05700 CT SCAN | 0 | 0 | • | | | 57.00 |
| 58. 00 | 05800 MRI | 0 | 0 | | | | 58.00 |
| | 06000 LABORATORY | 0 | 10, 987, 097 | | | | 60.00 |
| 65. 00 | 06500 RESPIRATORY THERAPY | o o | 2, 437, 501 | | | | 65.00 |
| | 06600 PHYSI CAL THERAPY | o O | 2, 067, 140 | | | | 66.00 |
| | 06700 OCCUPATI ONAL THERAPY | 0 | 719, 219 | 1 | | | 67.00 |
| | 06800 SPEECH PATHOLOGY | 0 | 723, 981 | | | | 68. 00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | -3, 644, 990 | 4, 703, 051 | | | | 69. 00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0 | 893, 470 | | | | 71.00 |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 17, 671, 905 | | | | 72. 00 |
| | 07300 DRUGS CHARGED TO PATIENTS | 0 | 30, 009, 008 | | | | 73. 00 |
| | 07400 RENAL DI ALYSI S | 0 | 658, 068 | | | | 74.00 |
| | 03950 ANCI LLARY | 0 | 0 | | | | 76.00 |
| | 03610 SLEEP LAB | 0 | 0 | | | | 76. 01 |
| 76. 03 | 03951 WOUND CARE | -19, 800 | 1, 569, 372 | | | | 76. 03 |
| 00 00 | OUTPATIENT SERVICE COST CENTERS 09000 CLINIC | 0 | | | | | - 00 00 |
| | 09100 EMERGENCY | 0 -3, 464, 882 | | | | | 90.00 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART | -3, 404, 002 | 7, 526, 477 | | | | 91.00 |
| 72.00 | SPECIAL PURPOSE COST CENTERS | | | | | | 72.00 |
| 118. 00 | | 1, 582, 382 | 261, 481, 120 | | | | 118.00 |
| 110.00 | NONREI MBURSABLE COST CENTERS | 1, 302, 302 | 201, 401, 120 | | | | 1110.00 |
| 190.00 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 61, 466 | | | | 190. 00 |
| | 19200 PHYSICIANS' PRIVATE OFFICES | Ö | 180 | | | | 192.00 |
| | 19201 OTHER NONREI MBURSABLE | Ö | 0 | | | | 192. 01 |
| | 07950 NONREI MBURSABLE | 0 | 0 | | | | 194.00 |
| | 07951 MARKETI NG | o | 0 | • | | | 194. 01 |
| 194. 02 | 07952 SENIOR CIRCLE | 0 | 0 | | | | 194. 02 |
| 194. 03 | 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) | 1, 582, 382 | 261, 542, 766 | | | | 200.00 |
| | | | | | | | |

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0035

| | | | | | 10 | '2021 4: 36 pm |
|------------------|---|--------------------|-------------------|----------------------------|----|------------------|
| | Cost Center | I ncreases Li ne # | Sal ary | Other | | |
| | 2. 00 | 3.00 | 4. 00 | 5. 00 | | |
| 1. 00 | A - EMPLOYEE BENEFITS EMPLOYEE BENEFITS DEPARTMENT | 4.00 | 0 | 16, 607, 501 | | 1.00 |
| 1.00 | 0 | 4.00 | | 16, 607, 501 | | 1.00 |
| 4 00 | C - RENTAL AND LEASE EXPENSES | | ما | 4 0/7 700 | | 1.00 |
| 1. 00 2. 00 | CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP | 1. 00 2. 00 | 0 | 1, 867, 728 1, 254, 875 | | 1.00 |
| 3. 00 | SUBPROVI DER - I RF | 41. 00 | Ö | 446 | | 3.00 |
| 4. 00 | | 0. 00 | 0 | 0 | | 4.00 |
| 5. 00 6. 00 | | 0. 00 0. 00 | 0 | 0 | | 5. 00 6. 00 |
| 7. 00 | | 0.00 | o | o | | 7. 00 |
| 8.00 | | 0. 00 | o | 0 | | 8. 00 |
| 9. 00 10. 00 | | 0. 00 0. 00 | 0 | 0 | | 9.00 |
| 11. 00 | | 0.00 | o | 0 | | 11.00 |
| 12.00 | | 0. 00 | O | 0 | | 12. 00 |
| 13.00 | | 0. 00 0. 00 | 0 | 0 | | 13.00 |
| 14. 00 15. 00 | | 0.00 | 0 | 0 | | 14. 00 15. 00 |
| 16.00 | | 0. 00 | О | 0 | | 16.00 |
| 17. 00 | | 0.00 | • | 0 | | 17. 00 |
| | D - OTHER CAPITAL COSTS | | 0 | 3, 123, 049 | | |
| 1.00 | CAP REL COSTS-BLDG & FIXT | 1. 00 | 0 | 337, 287 | | 1.00 |
| 2. 00 3. 00 | CAP REL COSTS MARIE FOLLO | 1. 00 2. 00 | 0 | 2, 626, 113 145, 147 | | 2. 00 3. 00 |
| 3.00 | CAP REL COSTS-MVBLE EQUIP 0 | | | 3, 108, 547 | | 3.00 |
| | E - REPAIRS AND MAINTENANCE C | | | | | |
| 1. 00 2. 00 | OPERATION OF PLANT DRUGS CHARGED TO PATIENTS | 7. 00 73. 00 | 0 | 4, 358, 752 5, 984 | | 1.00 |
| 3. 00 | BROOS SIMMOLD TO TATTEMES | 0.00 | Ö | 0 | | 3. 00 |
| 4.00 | | 0.00 | 0 | 0 | | 4.00 |
| 5. 00 6. 00 | | 0. 00 0. 00 | 0 | 0 | | 5. 00 6. 00 |
| 7. 00 | | 0. 00 | Ö | Ö | | 7. 00 |
| 8. 00 | | 0. 00 | 0 | 0 | | 8. 00 |
| 9. 00 10. 00 | | 0. 00 0. 00 | 0 | 0 | | 9.00 |
| 11. 00 | | 0. 00 | Ö | Ö | | 11.00 |
| 12.00 | | 0.00 | 0 | 0 | | 12.00 |
| 13. 00 14. 00 | | 0. 00 0. 00 | 0 | 0 | | 13.00 |
| 15. 00 | | 0. 00 | Ö | Ö | | 15. 00 |
| 16.00 | | 0.00 | 0 | 0 | | 16.00 |
| 17. 00 18. 00 | | 0. 00 0. 00 | 0 | 0 | | 17. 00 18. 00 |
| 19. 00 | | 0. 00 | ō | 0 | | 19. 00 |
| 20.00 | | 0.00 | 0 | 0 | | 20.00 |
| 21. 00 22. 00 | | 0. 00 0. 00 | 0 | 0 | | 21. 00 22. 00 |
| 23. 00 | | 0.00 | 0_ | 0 | | 23. 00 |
| | O F - CHIEF NURSING OFFICER COS | TT . | 0 | 4, 364, 736 | | |
| 1. 00 | NURSI NG ADMI NI STRATI ON | 13. 00 | 221, 992 | 0 | | 1.00 |
| | 0 | | 221, 992 | | | |
| 1. 00 | G - MEDICAL SUPPLIES MEDICAL SUPPLIES CHARGED TO | 71. 00 | O | 893, 470 | | 1.00 |
| 1.00 | PATI ENT | 71.00 | ٩ | | | 1.00 |
| 2. 00 | IMPL. DEV. CHARGED TO PATIENTS | 72. 00 | 0 | 17, 671, 905 | | 2. 00 |
| 3. 00 | OPERATING ROOM | 50.00 | o | 563, 172 | | 3.00 |
| | 0 | | | 19, 128, 547 | | |
| 1. 00 | H - COST OF DRUGS/IV SOLUTION DRUGS CHARGED TO PATIENTS | 73. 00 | 0 | 29, 873, 017 | | 1.00 |
| 1.00 | 0 | 73.00 | | 29, 873, 017 | | 1.00 |
| 4.66 | I - LABOR AND DELIVERY COSTS | | | /= 000° | | |
| 1. 00 2. 00 | ADULTS & PEDIATRICS NURSERY | 30. 00 43. 00 | 0 540, 342 | 65, 828 62, 480 | | 1.00 |
| 3. 00 | DELIVERY ROOM & LABOR ROOM | 52.00 | 31 <u>5, 1</u> 82 | 0 | | 3. 00 |
| | 0 | | 855, 524 | 128, 308 | | |
| 1. 00 | K - RECOVERY ROOM OPERATING ROOM | 50.00 | 2, 252, 057 | 359, 689 | | 1.00 |
| 55 | 0 | | 2, 252, 057 | 359, 689 | | 1.30 |
| | · | · | | * | | |

| Heal th | Health Financial Systems | | | IAL HOSPITAL | | In Lieu of Form CMS-2552-10 | | | |
|---------|------------------------------|-----------|-------------|--------------|--------------|----------------------------------|--------------|------------------|--|
| RECLAS | SI FI CATI ONS | | | Provi der (| CCN: 15-0035 | Peri od: | Worksheet A- | 6 | |
| | | | | | | From 01/01/2020 To 12/31/2020 | | epared: 36 pm | |
| | | Increases | | | | | | | |
| | Cost Center | Li ne # | Sal ary | 0ther | | | | | |
| | 2. 00 | 3. 00 | 4. 00 | 5. 00 | | | | | |
| | L - OTHER RADIOLOGY COST | | | | | | | | |
| 1.00 | RADI OLOGY-DI AGNOSTI C | 54.00 | 1, 380, 194 | 695, 387 | | | | 1.00 | |
| 2.00 | | 0.00 | o | 0 | | | | 2.00 | |
| 3.00 | | 0.00 | o | 0 | | | | 3.00 | |
| 4.00 | | 0.00 | o | 0 | | | | 4.00 | |
| | 0 — — — — — | | 1, 380, 194 | 695, 387 | | | | İ | |
| | M - DIETARY COSTS TO CAFETER | İΑ | , | | | | | 1 | |
| 1.00 | CAFETERI A | 11. 00 | 992, 932 | 734, 995 | | | | 1.00 | |
| | 0 = = = = = | | 992, 932 | 734, 995 | | | | | |
| | O - SLEEP LAB COSTS TO EKG | | , | | | | | 1 | |
| 1.00 | ELECTROCARDI OLOGY | 69. 00 | 224, 228 | 45, 575 | | | | 1.00 | |
| | 0 — — — — — | | 224, 228 | 45, 575 | | | | İ | |

224, 228 224, 228 5, 926, 927

45, 575 45, 575 78, 169, 351

500.00

500.00 Grand Total: Increases

Provider CCN: 15-0035

Peri od: From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/28/2021 4:36 pm

| COSE CONTROL COSE CONTROL COSE COSE COSE COSE COSE COSE COSE COSE COSE COSE COSE COSE COSE COSE COSE COSE COSE COSE COSE COSE COSE COSE COSE | | Decreases | | | | | 7/28/2021 4: | 36 pm |
|--|--------|--|--------|------------|--------------|-------------------|--------------|--------|
| A | | Cost Center | | Salary | Other | Wkst 1-7 Pof | | |
| A _ FMPC OVER PRIVET IS | | | | | | | | |
| ALBAN IN STRATIVE & GERESOL 5.00 0 16,697,591 0 1.00 | | | 7.00 | 0.00 | 7. 00 | 10.00 | | |
| 0 | 1.00 | | 5. 00 | 0 | 16, 607, 501 | 0 | | 1.00 |
| DOD ADMINISTRATIVE & CENERAL 5.00 0 616, 685 10 2.0 | | | | | | | | |
| 2 00 OPERATION OF PLANT 7.00 0 99,160 10 2.00 3.00 DETAIN 0.00 1.150 0 3.00 DETAIN 0.00 0 12,150 0 3.00 DETAIN 0.00 0 12,150 0 3.00 0 3.00 DETAIN 0.00 0 12,150 0 3.00 0 1 | | C - RENTAL AND LEASE EXPENSES | S | | | | | |
| 3 0.0 DI ETARY 10 DI ETARY 10 DI SEEP LAB 10 DI SEEP LAB 10 DI STITRAL SERVICES & SUPPLY 11 0.0 0 0 13, 159 0 0 4.0 10 0 DI STITRAL SERVICES & SUPPLY 11 0.0 0 0 0 78, 288 0 0 7.7 10 MOUNTS & PEDIATRICS 30 0.0 0 0 78, 288 0 0 7.7 10 MOUNTS & PEDIATRICS 30 0.0 0 0 78, 288 0 0 9.7 10 0 MOUNTS & PEDIATRICS 30 0.0 0 0 78, 288 0 0 9.7 10 0 0 0 800 MITHAN 97 (CART WIN 1 | 1.00 | l . | | • | 616, 885 | | | 4 |
| A - 0.0 SLEEP LAS | | l . | | • | | | | 1 |
| 5.00 CENTRAL SERVICES & SUPPLY | | l control of the cont | | | | | | |
| HABMACY | | l control of the cont | | | | | | 4 |
| 7.00 ADULTS & PEDIATRICS | | | | - 1 | | | | 1 |
| B.00 | | l control of the cont | | • | | | | |
| 9.00 SECOVERY ROOM 51.00 0 248 0 9.00 11.00 DEFAIT NG ROOM 50.00 0 122,2064 0 11.00 11.00 DEFAIT NG ROOM 60.00 0 122,2064 0 11.00 11.00 DEFAIT NG ROOM 65.00 0 0 17.00 11.00 DEFAIT NG ROOM 65.00 0 0 17.00 11.00 DEFAIT NG ROOM 65.00 0 0 17.00 11.00 DELECTROX CARDOLLOSY 69.00 0 31.90 0 11.00 DELECTROX CARDOLLOSY 69.00 0 31.90 0 11.00 DELECTROX CARDOLLOSY 69.00 0 31.90 0 11.00 DELECTROX CARDOLLOSY 69.00 0 0 15.00 11.00 DELECTROX CARDOLLOSY 69.00 0 0 15.00 11.00 DELECTROX CARDOLLOSY 69.00 0 0 15.00 11.00 DELECTROX CARDOLLOSY 69.00 0 0 15.00 11.00 DELECTROX CARDOLLOSY 69.00 0 0 15.00 11.00 DELECTROX CARDOLLOSY 69.00 0 0 15.00 11.00 DELECTROX CARDOLLOSY 69.00 0 0 0 15.00 11.00 DELECTROX CARDOLLOSY 69.00 0 0 0 15.00 11.00 DELECTROX CARDOLLOSY 69.00 0 0 0 15.00 11.00 DELECTROX CARDOLLOSY 69.00 0 0 0 15.00 12.00 DELECTROX CARDOLLOSY 69.00 0 0 0 15.00 12.00 DELECTROX CARDOLLOSY 69.00 0 0 0 0 0 0 12.00 DELECTROX CARDOLLOSY 69.00 0 0 0 0 0 0 0 0 12.00 DELECTROX CARDOLLOSY 69.00 0 0 0 0 0 0 0 0 0 | | | | - 1 | | | | |
| 10.00 OPERATING ROOM | | l control of the cont | | | | | | |
| 11.00 ABORATORY 60.00 0 122, 304 0 11.00 13.00 ELECTROCARDIOLOGY 69.00 0 34, 340 0 13.00 14.00 CT. SCAM 0 15.00 0 15.00 15.00 FAIR REPRIVEY 66.00 0 34, 340 0 13.00 15.00 FAIR REPRIVEY 91.00 0 77, 180 0 15.00 17.00 SALVERS 0 0 0 77, 180 0 15.00 17.00 SALVERS 0 0 0 0 77, 180 0 15.00 17.00 DEL TORNO & LABOR ROOM 52.00 0 501, 858 0 17.00 17.00 DEL TORNO & LABOR ROOM 52.00 0 3.123, 047 10.00 DEL TORNO & CONTROL & CONTRO | | l . | | - 1 | | | | 1 |
| 12.00 RESPIRATIONY HIERARY | | l . | 1 | - 1 | | | | 1 |
| 13.00 ELECTROCABID LOGY 69.00 0 34,340 0 13.00 15.00 14.00 15.00 ENERGENCY 91.00 0 79,180 0 15.00 16.00 16.00 ENERGENCY 91.00 0 79,180 0 15.00 17.00 RADI DICKY-DI | | l control of the cont | 1 | - 1 | | | | |
| 15.00 EMERCENCY 91.00 0 79,180 0 15.00 16.00 17.00 | 13.00 | ELECTROCARDI OLOGY | 69. 00 | О | | | | 13.00 |
| 1.00 DELI VERY ROOM & LABOR ROOM 52,00 0 1,499 0 17.00 RADIOLOGY-DI ANDISTIC 54,00 0 3,123,049 1 1.00 | 14.00 | CT SCAN | 57.00 | O | 1, 500 | 0 | | 14.00 |
| 17. 00 ADD IOLOSY-DIAGNOSTIC | 15.00 | EMERGENCY | 91.00 | 0 | 79, 180 | 0 | | 15.00 |
| 1.00 | | | 1 | 0 | | | | 1 |
| D - OTHER CAPITAL COSTS | 17. 00 | RADI OLOGY-DI AGNOSTI C | 54.00 | | | | | 17. 00 |
| 1.00 | | | | 0 | 3, 123, 049 | | | |
| 2.00 3.00 0 0 0.00 0 0.00 0 0.3.106.547 1.00 E-REPAIRS AND MAINTENANCE COSTS EMPLOYEE BENEFITS DEPARTMENT 4.00 0 0.00 0 0.515.38 0 0 0.00 0 0.50 0 0.50 0 0.50 0 0.50 0 0.50 0 0.50 0 0.50 0 0.50 0 0.50 0 0.50 0 0.50 0 0.50 0 0.50 0 0.50 0 0.50 0 0.50 0 0.50 0 0.50 0 0.50 0 0 0 | 4 00 | | F 00 | | 0 400 547 | 4.0 | | 4 00 |
| 3.00 | | ADMINISTRATIVE & GENERAL | | | | | | |
| Color Colo | | | | | 0 | | | |
| Color | 3.00 | | | | | — — ¹² | | 3.00 |
| 1.00 | | F - REPAIRS AND MAINTENANCE (| L L | <u> </u> | 3, 100, 547 | | | - |
| 2.00 ADMINISTRATIVE & GENERAL 5.00 0 515,138 0 2.00 4.00 DIETARY 10.00 0 683,936 0 4.00 4.00 DIETARY 10.00 0 83,936 0 6.00 5.00 CENTRAL SERVICES & SUPPLY 14.00 0 308,660 0 5.00 6.00 PHARMACY 15.00 0 182,232 0 6.00 8.00 INTENSIVE CARE UNIT 31.00 0 9,830 0 8.00 8.00 INTENSIVE CARE UNIT 31.00 0 9,830 0 8.00 10.00 NURSERY 43.00 0 17,285 0 10.00 10.00 NURSERY 43.00 0 17,285 0 10.00 10.10 OPERATING ROOM 50.00 0 12,128,933 0 11.00 12.00 EMERGENCY 91.00 0 12,128,933 0 11.00 12.00 EMERGENCY 91.00 0 12,128,933 0 11.00 13.00 ELIVERY ROOM 52.00 0 91,1774 0 12.00 14.00 RADIOLOGY-DIAGNOSTIC 54.00 0 756,991 0 14.00 16.00 RADIOLOGY-DIAGNOSTIC 54.00 0 756,991 0 14.00 16.00 RADIOLOGY-DIAGNOSTIC 54.00 0 756,991 0 14.00 16.00 RADIOLOGY-DIAGNOSTIC 54.00 0 756,991 0 14.00 17.00 CT SCAN 57.00 0 12,203 0 15.00 18.00 RADIOLOGY-DIAGNOSTIC 54.00 0 756,991 0 14.00 17.00 CT SCAN 57.00 0 12,203 0 15.00 18.00 RADIOLOGY-DIAGNOSTIC 54.00 0 756,991 0 14.00 17.00 CT SCAN 57.00 0 12,203 0 15.00 18.00 RADIOLOGY-DIAGNOSTIC 54.00 0 15,947,900 15.00 17.00 CT SCAN 57.00 0 12,203 0 15.00 18.00 RADIOLOGY-DIAGNOSTIC 54.00 0 15,947,900 0 15.00 18.00 RADIOLOGY-DIAGNOSTIC 55.00 0 15,947,900 0 12,000 19.00 LABORATORY 65.00 0 12,301 0 10.00 19.00 LABORATORY 65.00 0 12,301 0 10.00 19.00 LABORATORY 65.00 0 12,301 0 10.00 10.00 ROUND CARE 76.03 0 140 0 22,238 0 10.00 10.00 ROUND CARE 76.03 0 140 0 22,238 0 10.00 10.00 ROUND CARE 76.03 0 140 0 0 22,238 0 10.00 10.00 ROUND CARE 76.03 0 140 0 0 22,200 10.00 RESPIRATORY THERAPY 65.00 0 12,301 0 0 0.00 10.00 ROUND CARE 76.03 0 140 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 1 00 | | | 0 | 2 030 | 0 | | 1 00 |
| 3.00 HOUSEKEEPING 9.00 0 609 0 3.3.00 4.00 15TARY 10.00 0 83.936 0 4.00 15TARY 10.00 0 83.936 0 5.00 4.00 15TARY 10.00 0 83.936 0 5.00 6.00 PHARMACY 15.00 0 182.232 0 6.00 9.00 7.00 6.00 PHARMACY 15.00 0 182.232 0 7.00 6.00 PHARMACY 15.00 0 182.232 0 7.00 9.00 9.00 9.00 9.00 9.00 9.00 9. | | l . | | | | | | 4 |
| 5.00 CENTRAL SERVICES & SUPPLY 14.00 0 308, 660 0 0 5.00 0 6.00 0 7.00 0 0 182, 232 0 0 0 0 7.00 0 0 0 0 0 0 0 0 0 | | l . | | • | | | | 1 |
| 6.00 PHARMACY | | | 10.00 | О | 83, 936 | 0 | | 4.00 |
| 7. 00 ADULTS & PEDIATRICS 30.00 0 5.6.29 0 8.00 1.7.00 8.00 1.7.185N VE CARE UNIT 31.00 0 9.830 0 8.00 1.7.00 1.7.00 NINTENSI VE CARE UNIT 31.01 0 21.298 0 9.00 10.00 NEONATAL INTENSIVE CARE UNIT 31.01 0 21.298 0 9.00 11.00 NINTENSIVE CARE UNIT 31.01 0 21.298 0 9.00 11.00 NINTENSIVE CARE UNIT 31.01 0 21.298 0 9.00 11.00 PERATING ROOM 50.00 0 1.218.933 0 11.00 11.00 PERATING ROOM 50.00 0 1.218.933 0 11.00 11.00 PERATING ROOM 50.00 0 91.774 0 13.00 11.00 PERATING ROOM 52.00 0 91.774 0 13.00 PERATING ROOM 52.00 0 91.774 0 13.00 PERATING ROOM 52.00 0 91.774 0 13.00 PERATING ROOM 52.00 0 91.774 0 13.00 PERATING ROOM 54.01 0 25.667 0 15.00 PERATING ROOM 54.01 0 25.667 0 15.00 PERATING ROOM 54.01 0 25.667 0 15.00 PERATING ROOM 54.01 0 25.667 0 15.00 PERATING ROOM 54.01 0 25.667 0 15.00 PERATING ROOM 54.01 0 25.667 0 15.00 PERATING ROOM 55.00 0 121.023 0 17.00 PERATING ROOM 55.00 0 121.023 0 17.00 PERATING ROOM 55.00 0 121.023 0 17.00 PERATING ROOM 55.00 0 121.023 0 17.00 PERATING ROOM 55.00 0 121.023 0 17.00 PERATING ROOM 55.00 0 122.00 PERATING ROOM 55.00 0 122.00 PERATING ROOM 55.00 0 122.00 PERATING ROOM 55.00 0 122.00 PERATING ROOM 55.00 0 122.00 PERATING ROOM 55.00 0 122.00 PERATING ROOM 55.00 0 19.128.547 0 0 22.00 PERATING ROOM 55.00 0 19.128.547 0 0 22.00 PERATING ROOM 55.00 0 221.00 PERATING ROOM 55.00 0 221.00 PERATING ROOM 55.00 0 19.128.547 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 5.00 | CENTRAL SERVICES & SUPPLY | 14.00 | o | 308, 660 | 0 | | 5.00 |
| 8. 00 NTENSIVE CARE UNIT 31. 00 0 9.800 0 0 0 0 0 0 0 0 0 | 6.00 | l control of the cont | | 0 | 182, 232 | | | 6.00 |
| 9. 00 NEONATAL INTENSIVE CARE UNIT 31. 01 0 21. 298 0 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 11. 00 | | | | - 1 | | | | |
| 10.00 NURSERY | | l control of the cont | | -1 | | 1 | | |
| 11.00 OPERATING ROOM | | l control of the cont | 1 | | | | | 1 |
| 12. 00 | | l . | 1 | | | | | 1 |
| 13. 00 DELI VERY ROOM & LABOR ROOM 52. 00 0 91,774 0 13. 00 14. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 756, 991 0 14. 00 15. 00 ULTRASOUND 54. 01 0 25, 067 0 15. 00 16. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 39, 889 0 16. 00 17. 00 CT SCAN 57. 00 0 121, 023 0 17. 00 18. 00 MRI 58. 00 0 159, 401 0 18. 00 19. 00 LABORATORY 60. 00 0 222, 338 0 19. 00 20. 00 RESPIRATORY THERAPY 65. 00 0 12, 301 0 20. 00 21. 00 WOUND CARE 76. 03 0 140 0 21. 00 22. 00 SEECH PATHOLOGY 68. 00 0 700 0 22. 00 23. 00 ELECTROCARDI OLOGY 69. 00 0 547, 800 0 0 ELECTROCARDI OLOGY 69. 00 0 4, 364, 736 F - CHIEF NURSI NG OFFI CER COST 14. 00 0 221, 992 0 0 G - MEDI CAL SUPPLIES 14. 00 0 19, 128, 547 0 0 2. 00 3. 00 0 0 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 1. 00 0 | | | 1 | - 1 | | 1 | | 1 |
| 14, 00 | | l control of the cont | | | | | | 1 |
| 15.00 U.TRASQUIND | | l control of the cont | | - 1 | | | | |
| 16. 00 RADI OI SOTOPE 56. 00 0 39, 889 0 16. 00 17. 00 CT SCAN 57. 00 0 121, 023 0 17. 00 18. 00 MRI 58. 00 0 159, 401 0 18. 00 19. 00 LABORATORY 60. 00 0 222, 338 0 19. 00 20. 00 RESPI RATORY THERAPY 65. 00 0 12, 301 0 20. 00 21. 00 WOUND CARE 76. 03 0 140 0 21. 00 22. 00 SPECH PATHOLOGY 68. 00 0 700 0 22. 00 23. 00 ELECTROCARDI OLOGY 69. 00 0 547, 800 0 1. 00 G - MEDI CAL SUPPLIES 1. 00 G - MEDI CAL SUPPLIES 1. 00 CENTRAL SERVI CES & SUPPLY 14. 00 0 19, 128, 547 0 2.00 3. 00 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 | | | | | | | | |
| 17. 00 CT SCAN 57. 00 0 121, 023 0 17. 00 18. 00 MRI 58. 00 0 159, 401 0 18. 00 19. 00 LABORATORY 60. 00 0 222, 338 0 19. 00 20. 00 21. 00 0 22. 00 21. 00 0 0 22. 00 21. 00 0 22. 00 21. 00 0 22. 00 21. 00 0 0 22. 00 22. 00 23. 00 25. 00 0 0 0 0 23. 00 0 0 0 23. 00 0 0 0 0 0 0 0 0 0 | | l control of the cont | | | | | | |
| 19. 00 LABORATORY 60. 00 0 222, 338 0 20. 00 20. 00 RESPIRATORY THERAPY 65. 00 0 12, 301 0 20. 00 21. 00 WOUND CARE 76. 03 0 140 0 21. 00 22. 00 SPEECH PATHOLOGY 68. 00 0 700 0 22. 00 23. 00 ELI VERY ROOM EAGURE 5. 00 0 12, 301 0 0 22. 00 24. 00 SPEECH PATHOLOGY 69. 00 0 547, 800 0 0 23. 00 F - CHI EF NURSI NG OFFI CER COST | | l control of the cont | | o | | | | |
| 20. 00 RESPIRATORY THERAPY 65. 00 0 12, 301 0 20. 00 21. 00 WOUND CARE 76. 03 0 140 0 21. 00 22. 00 SPECCH PATHOLOGY 68. 00 0 700 0 22. 00 23. 00 ELECTROCARDI OLOGY 69. 00 0 547, 800 0 23. 00 | 18.00 | MRI | 58. 00 | О | 159, 401 | 0 | | 18. 00 |
| 21. 00 WOUND CARE 76. 03 0 140 0 22. 00 22. 00 SPEECH PATHOLOGY 68. 00 0 700 0 22. 00 23. 00 ELECTROCARDI OLOGY 69. 00 0 547, 800 0 F - CHI EF NURSI NG OFFI CER COST 1. 00 ADMIN ISTRATI VE & GENERAL 5. 00 221, 992 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 19.00 | LABORATORY | 60.00 | 0 | 222, 338 | 0 | | 19.00 |
| 22. 00 SPEECH PATHOLOGY 68. 00 0 700 0 22. 00 23. 00 ELECTROCARDI OLOGY 69. 00 0 547, 800 0 F - CHI EF NURSI NG OFFI CER COST 1. 00 ADMIN IN STRATI VE & GENERAL 5. 00 221, 992 0 0 0 G - MEDI CAL SUPPLIES | 20.00 | RESPI RATORY THERAPY | 65. 00 | 0 | 12, 301 | 0 | | 20.00 |
| 23. 00 ELECTROCARDI OLOGY 69. 00 0 547, 800 0 23. 00 | | | | 1 | | | | |
| The correction of the correc | | | | 0 | | | | |
| Tool F - CHI EF NURSI NG OFFI CER COST ADMI NI STRATI VE & GENERAL 5.00 221, 992 0 0 0 0 0 0 0 0 0 | 23. 00 | ELECTROCARDI OLOGY | 69.00 | 0 | | | | 23.00 |
| 1. 00 ADMI NI STRATI VE & GENERAL 5. 00 221, 992 0 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | O CHIEF NUDCING OFFICED COL | | 0 | 4, 364, 736 | | | - |
| Central Supplies | 1 00 | | | 221 002 | 0 | | | 1 00 |
| 1. 00 CENTRAL SERVICES & SUPPLY 14. 00 0 19, 128, 547 0 0 2. 00 0 0 0 0 0 0 0 0 0 | 1.00 | O GENERAL _ | 5.00 | | | | | 1.00 |
| 1. 00 CENTRAL SERVI CES & SUPPLY 14. 00 0 19, 128, 547 0 0 2. 00 3. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | G - MEDICAL SUPPLIES | | 221, 772 | U | | | - |
| 2.00 3.00 0 | 1 00 | | 14 00 | O | 19 128 547 | 0 | | 1 00 |
| 3. 00 O | | Service Services a Server | | | 0 | 1 | | |
| 1.00 No. | | | | ol | 0 | | | |
| 1. 00 PHARMACY | | | | o | 19, 128, 547 | | | |
| 0 | | H - COST OF DRUGS/IV SOLUTION | NS | <u> </u> | | | | 1 |
| 1 - LABOR AND DELIVERY COSTS | 1.00 | PHARMACY | 1500 | | | | | 1.00 |
| 1. 00 ADULTS & PEDIATRICS 30. 00 855, 524 0 0 0 2. 00 2. 00 3. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | 0 | | 0 | 29, 873, 017 | | | |
| 2. 00 3. 00 DELI VERY ROOM & LABOR ROOM 52. 00 0 128, 308 0 2. 00 0 0 0 0 0 0 3. 00 K - RECOVERY ROOM 51. 00 2, 252, 057 359, 689 0 1. 00 | | | | | | | | 4 |
| 3. 00 0 0 0 0 0 3. 00 K - RECOVERY ROOM 51. 00 2, 252, 057 359, 689 0 1. 00 | | l control of the cont | | | | | | |
| 0 855, 524 128, 308 | | DELIVERY ROOM & LABOR ROOM | | 0 | 128, 308 | | | |
| K - RECOVERY ROOM 1. 00 RECOVERY ROOM 51. 00 2, 252, 057 359, 689 0 1. 00 | 3.00 | | | | 0 | | | 3.00 |
| 1. 00 RECOVERY ROOM 51. 00 2, 252, 057 359, 689 0 | | N DECOVEDA BOOM | | 855, 524 | 128, 308 | | | - |
| | 1 00 | | 51 00 | 2 252 057 | 350 690 | 0 | | 1 00 |
| | 1.00 | | | | | | | 1.00 |
| | | 1 | ı | , ===, 55, | , 00, | ı | | 1 |

Heal th Financial Systems PORTER MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 15-0035 Period: From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/28/2021 4: 36 pm

| | | | | | | 7/28/2021 4: | 36 pm |
|--------|-------------------------------|-----------|-------------|--------------|---------------|--------------|--------|
| | | Decreases | | | | | |
| | Cost Center | Li ne # | Sal ary | 0ther | Wkst. A-7 Ref | | |
| | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | | |
| | L - OTHER RADIOLOGY COST | | | | | | |
| 1.00 | ULTRASOUND | 54. 01 | 369, 915 | 45, 060 | (| 0 | 1.00 |
| 2.00 | RADI OI SOTOPE | 56. 00 | 304, 760 | 493, 748 | (| 0 | 2.00 |
| 3.00 | CT SCAN | 57. 00 | 497, 407 | 128, 249 | (| 0 | 3.00 |
| 4.00 | MRI | 58. 00 | 208, 112 | 28, 330 | | <u>o</u> | 4.00 |
| | 0 | | 1, 380, 194 | 695, 387 | | | |
| | M - DIETARY COSTS TO CAFETERI | A | | | | | |
| 1.00 | DI ETARY | 10. 00 | 992, 932 | 734, 995 | (| <u>o</u> | 1.00 |
| | 0 | | 992, 932 | 734, 995 | | | |
| | O - SLEEP LAB COSTS TO EKG | | | | | | |
| 1.00 | SLEEP LAB | 76. 01 | 224, 228 | 45, 575 | (| | 1.00 |
| | 0 | | 224, 228 | 45, 575 | | | |
| 500.00 | Grand Total: Decreases | | 5, 926, 927 | 78, 169, 351 | | | 500.00 |

RECONCILIATION OF CAPITAL COSTS CENTERS

Provi der CCN: 15-0035

Peri od: Worksheet A-7 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020

7/28/2021 4:36 pm Acqui si ti ons Begi nni ng Disposals and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4.00 5.00 1.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 2, 949, 373 Land 1.00 0 2.00 Land Improvements 3, 506, 326 97, 462 97, 462 86, 037 2.00 3.00 3, 998 3.00 Buildings and Fixtures 166, 692, 824 3, 998 37, 458 4.00 Building Improvements 7, 691, 790 726, 216 0 726, 216 40, 391 4.00 Fi xed Equi pment 6, 892, 126 283, 013 283, 013 5.00 0 232, 319 5.00 73, 106, 355 1, 982, 956 0 6.00 Movable Equipment 1, 982, 956 4, 376, 690 6.00 0 7.00 HIT designated Assets 17, 491, 954 204, 048 7.00 8.00 Subtotal (sum of lines 1-7) 278, 330, 748 3, 093, 645 0 3, 093, 645 4, 976, 943 8.00 9.00 Reconciling Items 0 9.00 278, 330, 748 3, 093, 645 4, 9<u>76, 943</u> Total (line 8 minus line 9) 3, 093, 645 10.00 10.00 O Endi ng Ful I y Bal ance Depreciated Assets 6. 00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 2, 949, 373 0 1.00 0 2.00 Land Improvements 3, 517, 751 2.00 166, 659, 364 3.00 Buildings and Fixtures 0 3.00 4.00 Building Improvements 8, 377, 615 0 4.00 5.00 Fixed Equipment 6, 942, 820 0 5.00 70, 712, 621 0 6.00 Movable Equipment 6.00 17, 287, 906 HIT designated Assets 0 7.00 7.00 8.00 Subtotal (sum of lines 1-7) 276, 447, 450 0 8.00 Reconciling Items 9.00 0 9.00 10.00 Total (line 8 minus line 9) 276, 447, 450 0 10.00

| Heal th | Financial Systems | PORTER MEMORI | AL HOSPITAL | | In Lieu of Form CMS-2552-10 | | | |
|---------|--|-----------------|-----------------|---------------|---|--------------------------|--------|--|
| RECONG | RECONCILIATION OF CAPITAL COSTS CENTERS | | Provi der C | CN: 15-0035 | Period: From 01/01/2020 To 12/31/2020 | | pared: | |
| | | | SL | JMMARY OF CAP | TAL | 772072021 1.0 | O piii | |
| | Cost Center Description | Depreciation | Lease | Interest | Insurance (see instructions) | Taxes (see instructions) | | |
| | | 9. 00 | 10. 00 | 11. 00 | 12. 00 | 13. 00 | | |
| | PART II - RECONCILIATION OF AMOUNTS FROM WOR | KSHEET A, COLU | MN 2, LINES 1 a | and 2 | | | | |
| 1.00 | CAP REL COSTS-BLDG & FLXT | 1, 051, 470 | 0 | | 0 0 | 0 | 1.00 | |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | 9, 821, 355 | 0 | | 0 0 | 0 | 2.00 | |
| 3.00 | Total (sum of lines 1-2) | 10, 872, 825 | 0 | | 0 0 | ol | 3.00 | |
| | | SUMMARY 0 | F CAPITAL | | | | | |
| | Cost Center Description | Other | Total (1) | | | | | |
| | | Capi tal -Relat | (sum of cols. | | | | | |
| | | ed Costs (see | 9 through 14) | | | | | |
| | | instructions) | | | | | | |
| | | 14. 00 | 15. 00 | | | | | |
| | PART II - RECONCILIATION OF AMOUNTS FROM WOR | KSHEET A, COLU | MN 2, LINES 1 a | and 2 | | | | |
| 1.00 | CAP REL COSTS-BLDG & FIXT | 0 | 1, 051, 470 | | | | 1.00 | |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | 0 | 9, 821, 355 | | | | 2.00 | |
| 3. 00 | Total (sum of lines 1-2) | 0 | 10, 872, 825 | | | | 3.00 | |

| Heal th | n Financial Systems | PORTER MEMORI | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---------|--|-----------------------------|------------------|------------------|---|-----------------|---------|
| RECON | CILIATION OF CAPITAL COSTS CENTERS | | Provi der C | | Period: From 01/01/2020 To 12/31/2020 | | pared: |
| | | COMI | PUTATION OF RA | TIOS | ALLOCATION OF | OTHER CAPITAL | |
| | Cost Center Description | Gross Assets | Capi tal i zed | Gross Assets | • | Insurance | |
| | | | Leases | for Ratio | instructions) | | |
| | | | | (col. 1 - | | | |
| | | 1. 00 | 2.00 | col . 2) 3.00 | 4.00 | 5. 00 | |
| | PART III - RECONCILIATION OF CAPITAL COSTS C | | 2.00 | 3.00 | 4.00 | 5.00 | |
| 1. 00 | CAP REL COSTS-BLDG & FLXT | 181, 504, 103 | 0 | 181, 504, 10 | 0. 656559 | 0 | 1.00 |
| 2. 00 | CAP REL COSTS-MVBLE EQUIP | 94, 943, 347 | | 1 | | | 2.00 |
| 3.00 | Total (sum of lines 1-2) | 276, 447, 450 | 0 | 276, 447, 45 | 1. 000000 | 0 | 3.00 |
| | | ALLOCATION OF OTHER CAPITAL | | | SUMMARY C | F CAPITAL | |
| | Cost Center Description | Taxes | 0ther | Total (sum o | f Depreciation | Lease | |
| | | | Capi tal -Rel at | | | | |
| | | | ed Costs | through 7) | | | |
| | DART III DECONOLILATION OF CARLEY COOTS | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10. 00 | |
| 1. 00 | PART III - RECONCILIATION OF CAPITAL COSTS C | ENTERS | 0 | ı | 0 1, 087, 919 | 1 0/7 700 | 1.00 |
| 2. 00 | CAP REL COSTS-BLUG & FIXT | 0 | 0 | | 0 1, 087, 919 | | 2.00 |
| 3. 00 | Total (sum of lines 1-2) | 0 | | | 0 10, 207, 462 | | 3.00 |
| 3.00 | Total (Suil of Titles 1-2) | 0 | SI | JMMARY OF CAPI | | 3, 122, 003 | 3.00 |
| | | | | | | | |
| | Cost Center Description | Interest | Insurance | Taxes (see | 0ther | Total (2) | |
| | | | (see | instructions | | | |
| | | | instructions) | | ed Costs (see | 9 through 14) | |
| | | 11 00 | 10.00 | 10.00 | instructions) | 45.00 | |
| | PART III - RECONCILIATION OF CAPITAL COSTS C | 11.00 | 12. 00 | 13.00 | 14. 00 | 15. 00 | |
| 1. 00 | CAP REL COSTS-BLDG & FIXT | 729, 098 | 337, 287 | 2, 626, 11 | 3 0 | 6, 648, 145 | 1.00 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | 727,070 | 1 | | 0 0 | | 2.00 |
| 3. 00 | Total (sum of lines 1-2) | 729, 098 | | 1 | - | , , | |
| | | | | | • | | • |

| Period: | Worksheet A-8 | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared: Provi der CCN: 15-0035

| | | | | To | 12/31/2020 | Date/Time Pre 7/28/2021 4:3 | |
|------------------|---|--------------|---------------|-----------------------------|----------------|--------------------------------|------------------|
| | | | | Expense Classification on | | 772072021 4. 3 | о рііі |
| | | | | To/From Which the Amount is | to be Adjusted | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | Cost Center Description | Basi s/Code | Amount | Cost Center | Li ne # | Wkst. A-7 | |
| | | (2) 1. 00 | 2. 00 | 3.00 | 4. 00 | Ref. 5. 00 | |
| 1. 00 | Investment income - CAP REL | | 0 | CAP REL COSTS-BLDG & FIXT | 1. 00 | 0 | 1.00 |
| 2.00 | COSTS-BLDG & FIXT (chapter 2) 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 |
| | (chapter 2) | | 0 | | | 0 | |
| 4. 00 | Trade, quantity, and time discounts (chapter 8) | | U | | 0. 00 | 0 | 4.00 |
| 5. 00 | Refunds and rebates of expenses (chapter 8) | | 0 | | 0. 00 | 0 | 5. 00 |
| 6.00 | Rental of provider space by | | 0 | | 0. 00 | 0 | 6. 00 |
| 7. 00 | suppliers (chapter 8) Telephone services (pay | А | -80, 275 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 7. 00 |
| | stations excluded) (chapter 21) | | | | | | |
| 8. 00 | Television and radio service | А | -277, 877 | OPERATION OF PLANT | 7. 00 | 0 | 8. 00 |
| 9. 00 | (chapter 21) Parking Lot (chapter 21) | | 0 | | 0. 00 | 0 | 9. 00 |
| 10.00 | Provi der-based physi ci an | A-8-2 | -21, 060, 086 | | | 0 | 10.00 |
| 11. 00 | adjustment Sale of scrap, waste, etc. | В | 0 | RADI OLOGY-DI AGNOSTI C | 54. 00 | 0 | 11. 00 |
| 12. 00 | (chapter 23) Related organization | A-8-1 | 27, 530, 881 | | | 0 | 12. 00 |
| | transactions (chapter 10) | | | | 0.00 | | |
| 13. 00 14. 00 | Laundry and linen service Cafeteria-employees and guests | | 0 | | 0. 00 0. 00 | 0 | 13. 00 14. 00 |
| 15. 00 | Rental of quarters to employee and others | | 0 | | 0.00 | 0 | 15. 00 |
| 16. 00 | Sale of medical and surgical | | 0 | | 0. 00 | 0 | 16. 00 |
| | supplies to other than patients | | | | | | |
| 17. 00 | Sale of drugs to other than patients | | 0 | | 0. 00 | 0 | 17. 00 |
| 18. 00 | Sale of medical records and | | 0 | | 0. 00 | 0 | 18. 00 |
| 19. 00 | abstracts Nursing and allied health | | 0 | | 0. 00 | 0 | 19. 00 |
| | education (tuition, fees, books, etc.) | | | | | | |
| 20. 00 | Vending machines | | 0 | | 0. 00 | 0 | |
| 21. 00 | Income from imposition of interest, finance or penalty | | 0 | | 0. 00 | 0 | 21. 00 |
| 22.00 | charges (chapter 21) | | | | 0.00 | | 22.00 |
| 22. 00 | Interest expense on Medicare overpayments and borrowings to | | 0 | | 0. 00 | 0 | 22. 00 |
| 23. 00 | repay Medicare overpayments Adjustment for respiratory | A-8-3 | 0 | RESPIRATORY THERAPY | 65. 00 | | 23. 00 |
| 20.00 | therapy costs in excess of | Α σ σ | · · | REST FIGURE THE TOTAL T | 66. 66 | | 20.00 |
| 24. 00 | limitation (chapter 14) Adjustment for physical | A-8-3 | 0 | PHYSI CAL THERAPY | 66. 00 | | 24. 00 |
| | therapy costs in excess of limitation (chapter 14) | | | | | | |
| 25. 00 | Utilization review - | | 0 | *** Cost Center Deleted *** | 114. 00 | | 25. 00 |
| | physicians' compensation (chapter 21) | | | | | | |
| 26. 00 | Depreciation - CAP REL COSTS-BLDG & FIXT | А | -337, 741 | CAP REL COSTS-BLDG & FIXT | 1. 00 | 9 | 26. 00 |
| 27. 00 | Depreciation - CAP REL | А | -1, 033, 261 | CAP REL COSTS-MVBLE EQUIP | 2. 00 | 9 | 27. 00 |
| 28. 00 | COSTS-MVBLE EQUIP Non-physician Anesthetist | | 0 | *** Cost Center Deleted *** | 19. 00 | | 28. 00 |
| 29. 00 | Physicians' assistant | | 0 | | 0. 00 | 0 | 29. 00 |
| 30. 00 | Adjustment for occupational therapy costs in excess of | A-8-3 | 0 | OCCUPATI ONAL THERAPY | 67. 00 | | 30. 00 |
| 30. 99 | limitation (chapter 14) Hospice (non-distinct) (see | | Λ | ADULTS & PEDIATRICS | 30. 00 | | 30. 99 |
| 55. 77 | instructions) | | O | | 33. 00 | | 33. , , |
| | | | | | | | |

1, 582, 382

50.00

- | column 6, line 200.) | (1) Description all chapter references in this column pertain to CMS Pub. 15-1.
- (2) Basis for adjustment (see instructions).

TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A,

50.00

- 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.

OFFICE COSTS

From 01/01/2020

| OFFICE | C0S1S | | | To 12/31/2020 | | epared: 86 pm |
|--------|-------------------------------|-------------------------------|-------------------------------|-----------------|----------------|------------------|
| | Li ne No. | Cost Center | Expense Items | Amount of | Amount | |
| | | | ' | Allowable Cost | Included in | |
| | | | | | Wks. A, column | |
| | | | | | 5 | |
| | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | A. COSTS INCURRED AND ADJUSTI | MENTS REQUIRED AS A RESULT OF | TRANSACTIONS WITH RELATED O | RGANIZATIONS OF | CLAIMED HOME | |
| | OFFICE COSTS: | | | | | |
| 1.00 | 1.00 | CAP REL COSTS-BLDG & FIXT | NEW CAPITAL - BUILDING & FIX | 303, 643 | 0 | 1.00 |
| 2.00 | 2.00 | CAP REL COSTS-MVBLE EQUIP | NEW CAPITAL - MOVABLE EQUIPM | 327, 126 | 0 | 2.00 |
| 3.00 | 5. 00 | ADMINISTRATIVE & GENERAL | NON-CAPITAL HOME OFFICE COST | 9, 249, 617 | 0 | 3.00 |
| 4.00 | 1.00 | CAP REL COSTS-BLDG & FIXT | Capital-Related Interest | 729, 098 | 0 | 4.00 |
| 4. 01 | 1.00 | CAP REL COSTS-BLDG & FIXT | PASI Capital Costs - Bldg & | 70, 547 | 0 | 4.01 |
| 4. 02 | 2. 00 | CAP REL COSTS-MVBLE EQUIP | PASI Capital Costs - Moveabl | 8, 778 | o | 4.02 |
| 4.03 | 5. 00 | ADMINISTRATIVE & GENERAL | PASI Operating Costs | 1, 983, 465 | 1, 413, 514 | 4.03 |
| 4.04 | 5. 00 | ADMINISTRATIVE & GENERAL | Shared Service Center Alloca | 5, 501, 672 | 2, 886, 208 | 4.04 |
| 4. 08 | 5. 00 | ADMINISTRATIVE & GENERAL | Malpractice Costs | 968, 887 | 2, 076, 047 | 4.08 |
| 4.09 | 5. 00 | ADMINISTRATIVE & GENERAL | Interest Expense | 0 | -25, 123, 849 | 4.09 |
| 4. 10 | 5. 00 | ADMINISTRATIVE & GENERAL | Management Fees | 0 | 6, 456, 186 | 4. 10 |
| 4. 11 | 5. 00 | ADMINISTRATIVE & GENERAL | 401K Fees | 0 | 6, 756 | 4. 11 |
| 4. 12 | 5. 00 | ADMINISTRATIVE & GENERAL | Audi t Fees | 0 | 130, 301 | 4. 12 |
| 4. 13 | 5. 00 | ADMINISTRATIVE & GENERAL | Corporate Overhead Allocatio | 0 | 2, 679, 823 | 4. 13 |
| 4. 14 | 5. 00 | ADMINISTRATIVE & GENERAL | HIIM Allocation | 0 | 875, 262 | 4.14 |
| 4. 15 | 5. 00 | ADMINISTRATIVE & GENERAL | Contract Management | 0 | 79, 633 | 4. 15 |
| 4. 16 | 5. 00 | ADMINISTRATIVE & GENERAL | PASI Lien Unit Collection Fe | 0 | 132, 071 | 4. 16 |
| 5.00 | TOTALS (sum of lines 1-4). | | | 19, 142, 833 | -8, 388, 048 | 5.00 |
| | Transfer column 6, line 5 to | | | | | |
| | Worksheet A-8, column 2, | | | | | |
| | line 12. | | | | | |
| * The | amounts on Lines 1 4 (and sub | eccinte ac appropriata) ara | transformed in detail to Work | choot A colum | n 4 lines es | |

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 1101 | been posted to worksheet A, | cor anno r ana/or 2, the anioa | iit dirowabic 3i | iodi di be i ildi cated i il coi dilli | + or this part. | |
|-----------|------------------------------|--------------------------------|------------------|--|-----------------|---|
| | | | | Related Organization(s) and/ | or Home Office | |
| | | | | | | l |
| | | | | | | l |
| | | | | | | |
| | Symbol (1) | Name | Percentage of | Name | Percentage of | |
| | • | | Ownershi p | | Ownershi p | |
| | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | B. INTERRELATIONSHIP TO RELA | TED ORGANIZATION(S) AND/OR HO | 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.

| | Comonit under this Aires | | | |
|--------|--------------------------|----------------|----|--------|
| 6. 00 | В | 0.00 CHS 100.0 | 00 | 6. 00 |
| 7.00 | | 0.00 | 00 | 7.00 |
| 8.00 | | 0.00 | 00 | 8.00 |
| 9.00 | | 0.00 | 00 | 9.00 |
| 10.00 | | 0.00 | 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.
- Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

| | | | | | То | 12/31/2020 | Date/Time Pr 7/28/2021 4: | epared: 36 pm |
|-------|----------------|-----------------|-----------------------------------|-----------------------|-----------|----------------|------------------------------|------------------|
| | Net | Wkst. A-7 Ref. | | | | | 77 207 2021 1. | Jo piii |
| | Adjustments | | | | | | | |
| | (col. 4 minus | | | | | | | |
| | col. 5)* | | | | | | | |
| | 6. 00 | 7. 00 | | | | | | |
| | A. COSTS INCUR | RED AND ADJUSTI | MENTS REQUIRED AS A RESULT OF THE | RANSACTIONS WITH RELA | ATED ORGA | NI ZATI ONS OR | CLAIMED HOME | |
| | OFFICE COSTS: | | | | | | | |
| 1.00 | 303, 643 | 9 | | | | | | 1.00 |
| 2.00 | 327, 126 | | | | | | | 2.00 |
| 3.00 | 9, 249, 617 | 0 | | | | | | 3.00 |
| 4.00 | 729, 098 | 11 | | | | | | 4.00 |
| 4. 01 | 70, 547 | 9 | | | | | | 4. 01 |
| 4.02 | 8, 778 | 9 | | | | | | 4. 02 |
| 4.03 | 569, 951 | 0 | | | | | | 4. 03 |
| 4.04 | 2, 615, 464 | 0 | | | | | | 4. 04 |
| 4.08 | -1, 107, 160 | 0 | | | | | | 4. 08 |
| 4.09 | 25, 123, 849 | 11 | | | | | | 4. 09 |
| 4. 10 | -6, 456, 186 | 0 | | | | | | 4. 10 |
| 4. 11 | -6, 756 | 0 | | | | | | 4. 11 |
| 4. 12 | -130, 301 | 0 | | | | | | 4. 12 |
| 4. 13 | -2, 679, 823 | 0 | | | | | | 4. 13 |
| 4.14 | -875, 262 | 0 | | | | | | 4. 14 |
| 4. 15 | -79, 633 | 0 | | | | | | 4. 15 |
| 4. 16 | -132, 071 | 0 | | | | | | 4. 16 |
| 5. 00 | 27, 530, 881 | | | | | | | 5. 00 |
| * The | amounts on lin | as 1_4 (and sub | oscrints as annronriate) are tra | insferred in detail t | o Worksh | aat A column | 6 lines as | |

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 RELA | TED ORGANIZATION(S) AND/OR HOME OFFICE: | |
| | | | |

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

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

| 6. 00 | HOME OFFICE | 6.00 |
|--------------------------|--------------|--------------|
| | INOME OFFICE | |
| 7.00 | | 7.00 |
| 8.00 | | 8.00 9.00 |
| 9.00 | | 9.00 |
| 8. 00 9. 00 10. 00 | | 10.00 |
| 100.00 | | 100.00 |

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

Provider CCN: 15-0035

| | | | | | | | o 12/31/2020 | Date/Time Pro 7/28/2021 4:3 | |
|--------|----------------|------------------------------|----------------|--------------|----------------|----|---------------|--------------------------------|--------|
| | Wkst. A Line # | Cost Center/Physician | Total | Professi ona | l 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, 656, 091 | 1, 656, 0 | | 0 | C | 0 | 1.00 |
| 2.00 | 31. 00 | INTENSIVE CARE UNIT | 2, 651, 180 | 2, 651, 1 | 80 | 0 | C | 0 | 2.00 |
| 3.00 | 31. 01 | NEONATAL INTENSIVE CARE UNIT | 755, 400 | 755, 4 | 00 | 0 | C | 0 | 3.00 |
| 4.00 | 50.00 | OPERATING ROOM | 4, 802, 637 | 4, 802, 6 | 37 | 0 | C | 0 | 4.00 |
| 5.00 | 52. 00 | DELIVERY ROOM & LABOR ROOM | 201, 675 | 201, 6 | 75 | 0 | C | 0 | 5.00 |
| 6.00 | 53. 00 | ANESTHESI OLOGY | 3, 586, 459 | 3, 586, 4 | 59 | 0 | C | 0 | 6.00 |
| 7.00 | 54.00 | RADI OLOGY-DI AGNOSTI C | 276, 972 | 276, 9 | 72 | 0 | C | 0 | 7. 00 |
| 8.00 | 69. 00 | ELECTROCARDI OLOGY | 3, 644, 990 | 3, 644, 9 | 90 | 0 | C | 0 | 8. 00 |
| 9.00 | | WOUND CARE | 19, 800 | 19, 8 | 00 | 0 | C | 0 | 9. 00 |
| 10.00 | 91. 00 | EMERGENCY | 3, 464, 882 | 3, 464, 8 | 82 | 0 | C | 0 | 10.00 |
| 200.00 | | | 21, 060, 086 | | | 0 | | 0 | 200.00 |
| | Wkst. A Line # | | Unadjusted RCE | | | | Provi der | Physician Cost | |
| | | I denti fi er | Li mi t | | CE Memberships | | Component | of Malpractice | |
| | | | | Limit | Conti nui n | | Share of col. | Insurance | |
| | | | | | Educati or | 1 | 12 | | |
| 1.00 | 1. 00 | 2.00 | 8. 00 | 9. 00 | 12.00 | | 13. 00 | 14.00 | 1 00 |
| 1.00 | | ADULTS & PEDIATRICS | 0 | | 0 | 0 | C | | |
| 2.00 | | INTENSIVE CARE UNIT | 0 | | 0 | 0 | C | | |
| 3.00 | | NEONATAL INTENSIVE CARE UNIT | | | - | 0 | C | 0 | 3.00 |
| 4.00 | | OPERATING ROOM | 0 | | 0 | 0 | C | 0 | 4.00 |
| 5.00 | | DELIVERY ROOM & LABOR ROOM | 0 | | 0 | 0 | C | 0 | 5.00 |
| 6.00 | | ANESTHESI OLOGY | 0 | | 0 | 0 | C | 0 | |
| 7.00 | | RADI OLOGY-DI AGNOSTI C | 0 | | 0 | 0 | C | 0 | |
| 8. 00 | | ELECTROCARDI OLOGY | 0 | | 0 | 0 | C | 0 | |
| 9.00 | | WOUND CARE | 0 | | 0 | 0 | C | 0 | 9.00 |
| 10.00 | 91.00 | EMERGENCY | 0 | | 0 | 0 | C | 0 | |
| 200.00 | Wkst. A Line # | Cost Center/Physician | Provi der | Adjusted RC | O RCE | -0 | Adi ustmant | 0 | 200.00 |
| | WKSt. A LINE # | I denti fi er | Component | Limit | Di sal Lowan | | Adjustment | | |
| | | ruentiffer | Share of col. | LIIIII | Di Sai i Owali | | | | |
| | | | 14 | | | | | | |
| | 1.00 | 2.00 | 15. 00 | 16. 00 | 17. 00 | | 18. 00 | | |
| 1. 00 | | ADULTS & PEDIATRICS | 0 | 10.00 | 0 | 0 | 1, 656, 091 | | 1, 00 |
| 2. 00 | | INTENSIVE CARE UNIT | 0 | | Ö | o | 2, 651, 180 | • | 2.00 |
| 3. 00 | | NEONATAL INTENSIVE CARE UNIT | 0 | | 0 | o | 755, 400 | | 3.00 |
| 4. 00 | | OPERATING ROOM | Ö | | Ö | o | 4, 802, 637 | | 4.00 |
| 5. 00 | | DELIVERY ROOM & LABOR ROOM | 0 | | 0 | o | 201, 675 | | 5.00 |
| 6. 00 | | ANESTHESI OLOGY | 0 | | 0 | o | 3, 586, 459 | | 6. 00 |
| 7. 00 | | RADI OLOGY-DI AGNOSTI C | 0 | | o | o | 276, 972 | | 7. 00 |
| 8. 00 | | ELECTROCARDI OLOGY | Ö | | Ö | o | 3, 644, 990 | • | 8.00 |
| 9. 00 | | WOUND CARE | Ö | | Ö | ol | 19, 800 | • | 9. 00 |
| 10.00 | | EMERGENCY | Ö | | Ö | ol | 3, 464, 882 | • | 10.00 |
| 200.00 | | | Ö | | Ö | 0 | 21, 060, 086 | • | 200.00 |
| | | 1 | | ' | 1 | | . , | • | |

| Period: | Worksheet B | From 01/01/2020 | Part | To | 12/31/2020 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0035

| | | | | | 12/31/2020 | Date/Time Pre | pared: | |
|-------------------------|-------|--|----------------------------|---------------------|---------------|----------------------------|-----------------------------|--------------------|
| | | | CAPI TAL REL | ATED COSTS | | 7/28/2021 4: 3 | 6 pm | |
| | | | | | | | | |
| Cost Center Description | | | Net Expenses | BLDG & FIXT | MVBLE EQUIP | EMPLOYEE | Subtotal | |
| | | | for Cost Allocation | | | BENEFITS DEPARTMENT | | |
| | | | (from Wkst A | | | DEI / II (I III E I I I I | | |
| | | | col. 7) | | | | | |
| | OFNED | AL CERVILOE COCT OFFITERS | 0 | 1. 00 | 2.00 | 4. 00 | 4A | |
| 1. 00 | | AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT | 6, 648, 145 | 6, 648, 145 | | 1 | | 1.00 |
| 2. 00 | | CAP REL COSTS-MVBLE EQUIP | 10, 519, 565 | 0,040,143 | 10, 519, 565 | | | 2.00 |
| 4. 00 | | EMPLOYEE BENEFITS DEPARTMENT | 17, 197, 496 | 22, 531 | | 17, 255, 679 | | 4. 00 |
| 5.00 | | ADMINISTRATIVE & GENERAL | 61, 273, 453 | 278, 306 | | 2, 232, 115 | 64, 224, 247 | 5.00 |
| 7.00 | | OPERATION OF PLANT | 13, 006, 747 | 1, 534, 956 | | 427, 185 | 17, 397, 693 | 7.00 |
| 8. 00 9. 00 | | LAUNDRY & LINEN SERVICE HOUSEKEEPING | 1, 383, 641 3, 241, 359 | 8, 073 52, 165 | | 26, 576 288, 367 | 1, 431, 065 3, 664, 433 | 8. 00 9. 00 |
| 10.00 | 1 | DI ETARY | 3, 241, 339 1, 274, 579 | | | 147, 324 | 1, 847, 156 | |
| 11. 00 | | CAFETERI A | 1, 727, 927 | 0 | | 199, 725 | 1, 927, 652 | |
| 13.00 | 01300 | NURSING ADMINISTRATION | 4, 146, 969 | 29, 127 | 46, 088 | 755, 395 | 4, 977, 579 | 13.00 |
| 14. 00 | | CENTRAL SERVICES & SUPPLY | 1, 903, 466 | 114, 413 | | 156, 945 | 2, 355, 864 | |
| 15.00 | | PHARMACY | 2, 970, 801 | 62, 764 | | 564, 342 | 3, 697, 220 | 15.00 |
| 16. 00 17. 00 | | MEDICAL RECORDS & LIBRARY SOCIAL SERVICE | 1, 632, 169 1, 649, 133 | 21, 619 2, 483 | | 113, 685 276, 863 | 1, 801, 682 1, 932, 408 | 16. 00 17. 00 |
| 17.00 | | IENT ROUTINE SERVICE COST CENTERS | 1,047,133 | 2, 403 | 5, 727 | 270, 003 | 1, 732, 400 | 17.00 |
| 30.00 | | ADULTS & PEDIATRICS | 18, 404, 164 | 869, 974 | 1, 376, 587 | 2, 980, 426 | 23, 631, 151 | 30.00 |
| 31. 00 | | INTENSIVE CARE UNIT | 6, 126, 255 | 164, 585 | | 983, 469 | 7, 534, 737 | |
| 31. 01 | | NEONATAL INTENSIVE CARE UNIT | 1, 954, 186 | | | 340, 960 | 2, 459, 447 | |
| 41. 00 43. 00 | | SUBPROVI DER - I RF NURSERY | 1, 348, 212 | 111, 964 20, 175 | | 220, 698 | 1, 858, 039 | |
| 43.00 | | LARY SERVICE COST CENTERS | 662, 535 | 20, 175 | 31, 924 | 109, 762 | 824, 396 | 43.00 |
| 50.00 | 05000 | OPERATING ROOM | 13, 098, 589 | 553, 285 | 875, 480 | 1, 522, 132 | 16, 049, 486 | 50.00 |
| 51.00 | | RECOVERY ROOM | 0 | 0 | | 0 | 0 | 51.00 |
| 52.00 | | DELIVERY ROOM & LABOR ROOM | 2, 451, 086 | 110, 123 | | 443, 358 | 3, 178, 818 | |
| 53. 00 54. 00 | | ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C | 47, 733 8, 846, 621 | 9, 551 368, 938 | | 1, 442, 495 | 72, 397 11, 241, 837 | 53. 00 54. 00 |
| 54. 01 | | ULTRASOUND | 0, 040, 021 | 0 | | 0 | 0 | 54. 01 |
| 56.00 | 05600 | RADI OI SOTOPE | 0 | 0 | 0 | o | 0 | 56.00 |
| 57.00 | | CT SCAN | 0 | 0 | · | 0 | 0 | 57.00 |
| 58. 00 60. 00 | 05800 | MRI LABORATORY | 0 10, 987, 097 | 120 502 | 0 190, 674 | 0 1, 048, 153 | 12 244 424 | 58. 00 60. 00 |
| 65.00 | 1 | RESPIRATORY THERAPY | 2, 437, 501 | 120, 502 26, 906 | | 344, 709 | 12, 346, 426 2, 851, 690 | |
| 66. 00 | | PHYSI CAL THERAPY | 2, 067, 140 | 151, 386 | | 355, 795 | 2, 813, 863 | |
| 67.00 | | OCCUPATI ONAL THERAPY | 719, 219 | 0 | | 134, 758 | 853, 977 | |
| 68. 00 | | SPEECH PATHOLOGY | 723, 981 | 0 | · | 130, 182 | 854, 163 | |
| 69.00 | | ELECTROCARDI OLOGY | 4, 703, 051 | 254, 297 | | 718, 064 | 6, 077, 794 | |
| 71. 00 72. 00 | | MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS | 893, 470 17, 671, 905 | 0 | 0 | 0 | 893, 470 17, 671, 905 | |
| 73. 00 | 07300 | DRUGS CHARGED TO PATIENTS | 30, 009, 008 | 0 | Ö | 25, 537 | 30, 034, 545 | |
| 74.00 | | RENAL DIALYSIS | 658, 068 | 5, 557 | 8, 793 | 0 | 672, 418 | |
| 76. 00 | 1 | ANCI LLARY | 0 | 0 | 0 | 0 | 0 | 76. 00 |
| | | SLEEP LAB | 1 5/0 272 | 0 57.01/ | 01 (42 | 170 (20 | 1 000 5/0 | |
| 76. 03 | | WOUND CARE TIENT SERVICE COST CENTERS | 1, 569, 372 | 57, 916 | 91, 642 | 170, 639 | 1, 889, 569 | 76. 03 |
| 90.00 | | CLINIC | 0 | 0 | 0 | 0 | 0 | 90.00 |
| 91.00 | | EMERGENCY | 7, 526, 477 | 386, 056 | 610, 869 | 1, 084, 486 | 9, 607, 888 | 91.00 |
| 92.00 | | OBSERVATION BEDS (NON-DISTINCT PART | | | | | 0 | 92.00 |
| 118. 00 | | AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) | 261, 481, 120 | 5, 565, 955 | 8, 807, 184 | 17, 244, 145 | 258, 675, 015 | 110 00 |
| 110.00 | | IMBURSABLE COST CENTERS | 201, 401, 120 | 5, 505, 755 | 8, 807, 184 | 17, 244, 145 | 238, 073, 013 | 1110.00 |
| 190.00 | 19000 | GIFT, FLOWER, COFFEE SHOP & CANTEEN | 61, 466 | 8, 133 | 12, 868 | 11, 534 | 94, 001 | 190. 00 |
| 192.00 | 19200 | PHYSICIANS' PRIVATE OFFICES | 180 | 946, 630 | 1, 497, 881 | 0 | 2, 444, 691 | |
| | 1 | OTHER NONREI MBURSABLE | 0 | 0 | 1 | 0 | | 192. 01 194. 00 |
| | | NONREI MBURSABLE MARKETI NG | 0 | 0 | 0 | 0 | | 194.00 |
| | | SENI OR CI RCLE | 0 | Ö | Ö | ő | | 194. 02 |
| | | NONREIMB - REGENCY LTC | 0 | 127, 427 | 201, 632 | o | 329, 059 | 194. 03 |
| | | VACANT UNFINISHED AREA | 0 | 0 | 0 | O | | 194. 04 |
| 200. 00 201. 00 | 1 | Cross Foot Adjustments Negative Cost Centers | | | | | | 200. 00 201. 00 |
| 201.00 | 1 | TOTAL (sum lines 118 through 201) | 261, 542, 766 | 6, 648, 145 | 10, 519, 565 | 17, 255, 679 | 261, 542, 766 | |
| _02.00 | 1 | 1.1.1.2 (0a 1.1.00 110 till 0agil 201) | 201,012,700 | 3, 5 10, 145 | . 5, 517, 505 | , 200, 017 | 20.,012,700 | |

Peri od: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared: 7/28/2021 4:36 pm

| | | | | | | 7/28/2021 4:3 | 6 pm |
|--------------|---|------------------|--------------|---|---------------|---------------|------------------|
| | Cost Center Description | ADMI NI STRATI V | OPERATION OF | LAUNDRY & | HOUSEKEEPI NG | DI ETARY | |
| | | E & GENERAL | PLANT | LINEN SERVICE | | | |
| | | 5. 00 | 7. 00 | 8. 00 | 9. 00 | 10. 00 | |
| | IERAL SERVI CE COST CENTERS | | | | | | |
| | 00 CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| | 200 CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| 4. 00 004 | OO EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4. 00 |
| | OOO ADMINISTRATIVE & GENERAL | 64, 224, 247 | | | | | 5.00 |
| | OO OPERATION OF PLANT | 5, 662, 688 | | | | | 7. 00 |
| | 300 LAUNDRY & LINEN SERVICE | 465, 790 | 38, 334 | 1, 935, 189 | | | 8. 00 |
| | POO HOUSEKEEPI NG | 1, 192, 718 | 247, 689 | | 5, 104, 840 | | 9. 00 |
| | 000 DI ETARY | 601, 222 | 781, 923 | 0 | 175, 267 | 3, 405, 568 | 10.00 |
| | 00 CAFETERI A | 627, 422 | 0 | 0 | 0 | 0 | 11.00 |
| 13. 00 013 | 800 NURSING ADMINISTRATION | 1, 620, 127 | 138, 300 | | 31, 000 | 0 | 13.00 |
| 14. 00 014 | OO CENTRAL SERVICES & SUPPLY | 766, 798 | 543, 256 | 8, 363 | 121, 770 | 0 | 14.00 |
| | OO PHARMACY | 1, 203, 390 | 298, 013 | 0 | 66, 799 | 0 | 15.00 |
| 16. 00 016 | 000 MEDICAL RECORDS & LIBRARY | 586, 420 | 102, 652 | 0 | 23, 009 | 0 | 16.00 |
| 17. 00 017 | 700 SOCIAL SERVICE | 628, 970 | 11, 789 | 0 | 2, 642 | 0 | 17.00 |
| I NP | PATIENT ROUTINE SERVICE COST CENTERS | | | · | | | |
| 30.00 030 | 000 ADULTS & PEDIATRICS | 7, 691, 585 | 4, 130, 797 | 709, 013 | 925, 912 | 2, 053, 700 | 30.00 |
| 31. 00 031 | 00 INTENSIVE CARE UNIT | 2, 452, 444 | 781, 482 | 148, 268 | 175, 168 | 145, 758 | 31.00 |
| 31. 01 031 | 01 NEONATAL INTENSIVE CARE UNIT | 800, 513 | 302, 103 | 21, 199 | 67, 716 | 20, 229 | 31.01 |
| 41.00 041 | 00 SUBPROVI DER - I RF | 604, 764 | 531, 627 | 32, 966 | 119, 163 | 163, 286 | 41.00 |
| 43.00 043 | NURSERY | 268, 329 | 95, 796 | | 21, 472 | 0 | 43.00 |
| | ILLARY SERVICE COST CENTERS | | | | · . | | |
| | 000 OPERATING ROOM | 5, 223, 867 | 2, 627, 100 | 235, 390 | 588, 861 | 4, 059 | 50.00 |
| | 00 RECOVERY ROOM | 0 | 0 | 0 | 0 | 0 | 51.00 |
| | 200 DELIVERY ROOM & LABOR ROOM | 1, 034, 658 | 522, 886 | 52, 496 | 117, 204 | 56, 987 | 52.00 |
| | 300 ANESTHESI OLOGY | 23, 564 | 45, 352 | | 10, 165 | 0 | 53.00 |
| | 100 RADI OLOGY-DI AGNOSTI C | 3, 659, 049 | 1, 751, 787 | | 392, 661 | 1, 964 | 54.00 |
| | 101 ULTRASOUND | 0,007,017 | 1,701,707 | 107, 020 | 072, 001 | 0 | 54. 01 |
| | 000 RADI OI SOTOPE | 0 | Ö | ol o | 0 | 0 | 56.00 |
| | 700 CT SCAN | 0 | | | 0 | 0 | 57.00 |
| | BOO MRI | 0 | | | 0 | 0 | 58.00 |
| | 000 LABORATORY | 4, 018, 576 | 572, 167 | 1 " | 128, 250 | 0 | 60.00 |
| | 000 RESPI RATORY THERAPY | 928, 182 | 127, 754 | | 28, 636 | 0 | 65.00 |
| | 000 PHYSI CAL THERAPY | 915, 870 | 718, 807 | | 161, 120 | 0 | 66.00 |
| | 700 OCCUPATI ONAL THERAPY | 277, 957 | /10,00/ | 10, 025 | 101, 120 | 0 | 67.00 |
| | 300 SPEECH PATHOLOGY | 278, 017 | | | 0 | 0 | 68.00 |
| | PATROLOGY COO ELECTROCARDI OLOGY | | 1 207 440 | 125, 979 | 270, 648 | 32, 618 | 69.00 |
| | 00 MEDICAL SUPPLIES CHARGED TO PATIENT | 1, 978, 231 | 1, 207, 449 | 125, 979 | 270, 648 | 32,018 | |
| | 200 IMPL. DEV. CHARGED TO PATIENTS | 290, 811 | | | 0 | 0 | 71. 00 72. 00 |
| | OO DRUGS CHARGED TO PATIENTS | 5, 751, 940 | | | 0 | 0 | |
| | | 9, 775, 824 | 2/ 205 | | - O14 | - | 73.00 |
| | 100 RENAL DIALYSIS | 218, 862 | 26, 385 | | 5, 914 | 0 | 74.00 |
| | 250 ANCI LLARY | 0 | 0 | | 0 | 0 | 76.00 |
| | o10 SLEEP LAB | 0 | 07.000 | 0 | 0 | 0 | 76. 01 |
| | P51 WOUND CARE | 615, 026 | 274, 996 | 56, 085 | 61, 640 | 0 | 76. 03 |
| | PATIENT SERVICE COST CENTERS | | | | ام | | |
| | 000 CLINIC | 0 | 0 | 0 | 0 | 0 | 90.00 |
| | OO EMERGENCY | 3, 127, 223 | 1, 833, 067 | 335, 381 | 410, 879 | 95, 824 | 91.00 |
| | 200 OBSERVATION BEDS (NON-DISTINCT PART | | | | | | 92. 00 |
| | CLAL PURPOSE COST CENTERS | | | | | | |
| 118. 00 | SUBTOTALS (SUM OF LINES 1 through 117) | 63, 290, 837 | 17, 711, 511 | 1, 935, 189 | 3, 905, 896 | 2, 574, 425 | 118. 00 |
| | IREI MBURSABLE COST CENTERS | | | | | | |
| | 000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 30, 596 | | | 8, 655 | | 190. 00 |
| | 200 PHYSICIANS' PRIVATE OFFICES | 795, 710 | 4, 494, 770 | 0 | 1, 007, 499 | 587, 433 | |
| 192. 01 192 | 201 OTHER NONREI MBURSABLE | 0 | 0 | 0 | 0 | 0 | 192. 01 |
| | P50 NONREI MBURSABLE | 0 | 0 | 0 | 0 | | 194. 00 |
| | 951 MARKETI NG | 0 | 0 | 0 | 0 | | 194. 01 |
| 194. 02 079 | 952 SENIOR CIRCLE | 0 | 0 | 0 | o | | 194. 02 |
| 194. 03 079 | NONREIMB - REGENCY LTC | 107, 104 | 815, 485 | 0 | 182, 790 | 243, 710 | 194. 03 |
| | 754 VACANT UNFINISHED AREA | 0 | 0 | ol | o | | 194.04 |
| 200.00 | Cross Foot Adjustments | | | | آ ا | _ | 200.00 |
| 201. 00 | Negative Cost Centers | 0 | n | ol ol | o | 0 | 201.00 |
| 202.00 | TOTAL (sum lines 118 through 201) | 64, 224, 247 | 23, 060, 381 | 1, 935, 189 | 5, 104, 840 | | |
| 1 | (| | | , | ., , | .,, | |

Peri od: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Ti me Prepared:

| | | | 10 | 12/31/2020 | 7/28/2021 4: 3 | |
|---|--------------------|-----------------------------------|----------------------------------|-------------|-----------------------------------|------------------|
| Cost Center Description | CAFETERI A | NURSI NG ADMI NI STRATI O N | CENTRAL SERVI CES & SUPPLY | PHARMACY | MEDI CAL RECORDS & LI BRARY | <u>у</u> р |
| | 11. 00 | 13. 00 | 14.00 | 15. 00 | 16.00 | |
| GENERAL SERVICE COST CENTERS | 11.00 | 10.00 | 11.00 | 10.00 | 10.00 | |
| 1. 00 O0100 CAP REL COSTS-BLDG & FLXT | | | | | | 1.00 |
| 2. 00 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| 5. 00 00500 ADMINISTRATIVE & GENERAL | | | | | | 5.00 |
| 7.00 00700 OPERATION OF PLANT | | | | | | 7.00 |
| 8.00 00800 LAUNDRY & LINEN SERVICE | | | | | | 8.00 |
| 9. 00 00900 HOUSEKEEPI NG | | | | | | 9.00 |
| 10. 00 01000 DI ETARY | | | | | | 10.00 |
| 11. 00 01100 CAFETERI A | 2, 555, 074 | | | | | 11.00 |
| 13.00 01300 NURSING ADMINISTRATION | 115, 913 | 6, 882, 919 | | | | 13.00 |
| 14.00 01400 CENTRAL SERVICES & SUPPLY | 56, 943 | 238 | 3, 853, 232 | | | 14.00 |
| 15. 00 01500 PHARMACY | 71, 996 | 190 | 0 | 5, 337, 608 | | 15.00 |
| 16.00 01600 MEDICAL RECORDS & LIBRARY | 33, 020 | 8, 821 | 701 | 0 | 2, 556, 305 | 16.00 |
| 17.00 01700 SOCIAL SERVICE | 46, 249 | 173, 454 | 602 | 0 | 0 | 17. 00 |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS | 594, 387 | 2, 573, 160 | 183, 117 | 0 | 194, 682 | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | 159, 450 | 775, 679 | 78, 219 | 0 | 39, 236 | 31.00 |
| 31. 01 03101 NEONATAL NTENSI VE CARE UNIT | 53, 294 | 307, 004 | 16, 743 | 0 | 21, 467 | 31. 01 |
| 41. 00 04100 SUBPROVI DER - I RF | 38, 950 | 162, 341 | 7, 407 | 0 | 11, 746 | 41.00 |
| 43. 00 04300 NURSERY | 20, 476 | 664 | 6, 590 | 0 | 5, 276 | 43.00 |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 276, 680 | 983, 725 | 422, 625 | 0 | 439, 808 | 50.00 |
| 51. 00 05100 RECOVERY ROOM | 0 | 0 | 0 | 0 | 0 | 51.00 |
| 52. 00 05200 DELI VERY ROOM & LABOR ROOM | 82, 665 | | 30, 659 | 0 | 21, 312 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0 | 0 | 5, 803 | 0 | 27, 567 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 254, 836 | 258, 877 | 125, 300 | 0 | 308, 668 | |
| 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 | 240 402 | 1 ((2 | 4E7 01E | 0 | 204 445 | 58.00 |
| 60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY | 240, 492 | | 457, 015 | 0 | 294, 465 | 1 |
| 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY | 62, 417 60, 592 | 2,044 | 52, 988 3, 401 | 0 | 62, 606 27, 380 | 65. 00 66. 00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 22, 808 | | 3, 401 | 0 | 15, 273 | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 18, 727 | 0 | , | 0 | 6, 915 | 1 |
| 69. 00 06900 ELECTROCARDI OLOGY | 121, 336 | 306, 080 | 82, 392 | 0 | 215, 077 | 69.00 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 121, 330 | 0 | 99, 801 | 0 | 50, 668 | 71.00 |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | o o | 2, 167, 115 | 0 | 195, 934 | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 2, 534 | 110 | 2, 107, 110 | 5, 337, 608 | 366, 541 | 73.00 |
| 74. 00 07400 RENAL DI ALYSI S | 2, 334 | 110 | 0 | 0, 337, 000 | 5, 192 | 74.00 |
| 76. 00 03950 ANCI LLARY | 0 | o o | 0 | 0 | 0, 172 | 76.00 |
| 76. 01 03610 SLEEP LAB | 0 | 0 | 0 | 0 | 0 | 76. 01 |
| 76. 03 03951 WOUND CARE | 28, 053 | 144, 979 | 18, 403 | 0 | 15, 804 | 76. 03 |
| OUTPATIENT SERVICE COST CENTERS | ., | | | - ' | ., | |
| 90. 00 09000 CLI NI C | 0 | 0 | 0 | 0 | 684 | 90.00 |
| 91. 00 09100 EMERGENCY | 187, 326 | 899, 694 | 94, 344 | 0 | 230, 004 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | | | | | | 92.00 |
| SPECIAL PURPOSE COST CENTERS | | | | · | | |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) | 2, 549, 144 | 6, 882, 919 | 3, 853, 232 | 5, 337, 608 | 2, 556, 305 | 118. 00 |
| NONREI MBURSABLE COST CENTERS | | | | | | |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 5, 930 | 0 | 0 | 0 | 0 | 190. 00 |
| 192.00 19200 PHYSICIANS' PRIVATE OFFICES | 0 | 0 | 0 | 0 | | 192. 00 |
| 192. 01 19201 OTHER NONREI MBURSABLE | 0 | 0 | 0 | 0 | 0 | 192. 01 |
| 194. 00 07950 NONREI MBURSABLE | 0 | 0 | 0 | 0 | | 194. 00 |
| 194. 01 07951 MARKETI NG | 0 | 0 | 0 | 0 | | 194. 01 |
| 194. 02 07952 SENI OR CI RCLE | 0 | 0 | 0 | 0 | | 194. 02 |
| 194. 03 07953 NONREI MB - REGENCY LTC | 0 | 0 | 0 | 0 | | 194. 03 |
| 194. 04 07954 VACANT UNFI NI SHED AREA | 0 | 0 | 0 | 0 | 0 | 194. 04 |
| 200.00 Cross Foot Adjustments | | | | | | 200.00 |
| 201.00 Negative Cost Centers | 0 | 0 | 0 | 0 | | 201.00 |
| 202.00 TOTAL (sum lines 118 through 201) | 2, 555, 074 | 6, 882, 919 | 3, 853, 232 | 5, 337, 608 | 2, 556, 305 | 202.00 |
| | | | | | | |

| | | | | | | 7/28/2021 4:36 pm |
|---------|---|-------------|---------------|-------------|---------------|-------------------|
| | Cost Center Description | SOCI AL | Subtotal | Intern & | Total | |
| | · | SERVI CE | | Resi dents | | |
| | | | | Cost & Post | | |
| | | | | Stepdown | | |
| | | | | Adjustments | | |
| | | 17. 00 | 24. 00 | 25. 00 | 26. 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 | 00700 OPERATION OF PLANT | | | | | 7.00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | | | | | 8.00 |
| 9.00 | 00900 HOUSEKEEPI NG | | | | | 9.00 |
| 10.00 | 01000 DI ETARY | | | | | 10.00 |
| 11. 00 | 01100 CAFETERI A | | | | | 11.00 |
| 13.00 | 01300 NURSI NG ADMI NI STRATI ON | | | | | 13.00 |
| 14.00 | 01400 CENTRAL SERVICES & SUPPLY | | | | | 14.00 |
| 15.00 | 01500 PHARMACY | | | | | 15. 00 |
| 16.00 | 01600 MEDICAL RECORDS & LIBRARY | | | | | 16.00 |
| 17.00 | 01700 SOCIAL SERVICE | 2, 796, 114 | | | | 17. 00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | |
| 30.00 | 03000 ADULTS & PEDIATRICS | 2, 108, 054 | 44, 795, 558 | 0 | 44, 795, 558 | 30.00 |
| 31.00 | 03100 INTENSIVE CARE UNIT | 269, 851 | 12, 560, 292 | 0 | 12, 560, 292 | 31.00 |
| 31. 01 | 03101 NEONATAL INTENSIVE CARE UNIT | 146, 066 | 4, 215, 781 | 0 | 4, 215, 781 | 31.01 |
| 41.00 | 04100 SUBPROVI DER - I RF | 155, 134 | 3, 685, 423 | 0 | 3, 685, 423 | 41.00 |
| 43.00 | 04300 NURSERY | 117, 009 | 1, 372, 218 | 0 | 1, 372, 218 | 43.00 |
| | ANCILLARY SERVICE COST CENTERS | | | | | |
| 50.00 | 05000 OPERATING ROOM | 0 | 26, 851, 601 | 0 | 26, 851, 601 | 50.00 |
| 51.00 | 05100 RECOVERY ROOM | 0 | 0 | 0 | 0 | 51.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | O | 5, 381, 882 | 0 | 5, 381, 882 | 52.00 |
| 53.00 | 05300 ANESTHESI OLOGY | 0 | 184, 848 | 0 | 184, 848 | 53.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | O | 18, 182, 604 | 0 | 18, 182, 604 | 54.00 |
| 54.01 | 05401 ULTRASOUND | O | 0 | 0 | 0 | 54. 01 |
| 56.00 | 05600 RADI OI SOTOPE | O | 0 | 0 | 0 | 56.00 |
| 57.00 | 05700 CT SCAN | O | 0 | 0 | 0 | 57.00 |
| 58.00 | 05800 MRI | O | 0 | 0 | 0 | 58.00 |
| 60.00 | 06000 LABORATORY | O | 18, 059, 242 | 0 | 18, 059, 242 | 60.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | O | 4, 116, 317 | 0 | 4, 116, 317 | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | O | 4, 711, 058 | 0 | 4, 711, 058 | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | O | 1, 170, 022 | | 1, 170, 022 | 67.00 |
| 68.00 | 06800 SPEECH PATHOLOGY | O | 1, 157, 822 | 0 | 1, 157, 822 | 68. 00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | o | 10, 417, 604 | | 10, 417, 604 | 69.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | o | 1, 334, 750 | | 1, 334, 750 | 71.00 |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 25, 786, 894 | 0 | 25, 786, 894 | 72. 00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | o | 45, 517, 162 | | 45, 517, 162 | 73.00 |
| 74.00 | 07400 RENAL DIALYSIS | o | 928, 771 | 0 | 928, 771 | 74.00 |
| 76. 00 | 03950 ANCI LLARY | o | 0 | 0 | 0 | 76.00 |
| 76. 01 | 03610 SLEEP LAB | o | 0 | 0 | 0 | 76. 01 |
| 76. 03 | 03951 WOUND CARE | o | 3, 104, 555 | 0 | 3, 104, 555 | 76. 03 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | |
| 90.00 | 09000 CLI NI C | 0 | 684 | 0 | 684 | 90.00 |
| 91.00 | 09100 EMERGENCY | O | 16, 821, 630 | 0 | 16, 821, 630 | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART | | | 0 | | 92.00 |
| | SPECIAL PURPOSE COST CENTERS | | | | | |
| 118.00 | SUBTOTALS (SUM OF LINES 1 through 117) | 2, 796, 114 | 250, 356, 718 | 0 | 250, 356, 718 | 118.00 |
| | NONREI MBURSABLE COST CENTERS | | | | | |
| 190.00 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 177, 797 | 0 | 177, 797 | 190. 00 |
| 192.00 | 19200 PHYSICIANS' PRIVATE OFFICES | 0 | 9, 330, 103 | 0 | 9, 330, 103 | 192. 00 |
| 192. 01 | 19201 OTHER NONREI MBURSABLE | O | 0 | 0 | 0 | 192. 01 |
| 194.00 | 07950 NONREI MBURSABLE | O | 0 | 0 | 0 | 194. 00 |
| 194. 01 | 07951 MARKETI NG | O | 0 | 0 | 0 | 194. 01 |
| 194. 02 | 07952 SENIOR CIRCLE | 0 | 0 | 0 | 0 | 194. 02 |
| 194. 03 | 07953 NONREIMB - REGENCY LTC | o | 1, 678, 148 | 0 | 1, 678, 148 | 194. 03 |
| 194. 04 | 07954 VACANT UNFINISHED AREA | o | 0 | 0 | 0 | 194. 04 |
| 200.00 | Cross Foot Adjustments | | 0 | 0 | 0 | 200. 00 |
| 201.00 | Negative Cost Centers | 0 | 0 | 0 | 0 | 201.00 |
| 202.00 | | 2, 796, 114 | 261, 542, 766 | 0 | 261, 542, 766 | |
| | | | | . ' | | • |

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS | Peri od: | Worksheet B | From 01/01/2020 | Part I I | To 12/31/2020 | Date/Time Prepared: Provi der CCN: 15-0035

| | | | | Id | 12/31/2020 | 7/28/2021 4:3 | |
|---------|---|---------------|--------------|--------------|--------------|---------------|---------|
| | | | CAPI TAL REI | LATED COSTS | | 172072021 4.3 | O piii |
| | | | | | | | |
| | Cost Center Description | Di rectly | BLDG & FIXT | MVBLE EQUIP | Subtotal | EMPLOYEE | |
| | • | Assigned New | | | | BENEFI TS | |
| | | Capi tal | | | | DEPARTMENT | |
| | | Related Costs | | | | | |
| | | 0 | 1. 00 | 2.00 | 2A | 4. 00 | |
| | GENERAL SERVICE COST CENTERS | | | | | | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FLXT | | | | | | 1.00 |
| 2.00 | 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| 4. 00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | 0 | 22, 531 | 35, 652 | 58, 183 | 58, 183 | 4.00 |
| 5. 00 | 00500 ADMINISTRATIVE & GENERAL | 0 | 278, 306 | 440, 373 | 718, 679 | 7, 524 | 5.00 |
| 7. 00 | 00700 OPERATION OF PLANT | 0 | 1, 534, 956 | 2, 428, 805 | 3, 963, 761 | 1, 440 | 7. 00 |
| 8. 00 | 00800 LAUNDRY & LINEN SERVICE | 0 | 8, 073 | 12, 775 | 20, 848 | 90 | 8. 00 |
| 9.00 | 00900 HOUSEKEEPI NG | 0 | 52, 165 | 82, 542 | 134, 707 | 972 | 9. 00 |
| 10.00 | 01000 DI ETARY | 0 | 164, 678 | 260, 575 | 425, 253 | 497 | 10.00 |
| 11.00 | 01100 CAFETERI A | 0 | 0 | 0 | 0 | 673 | 11.00 |
| 13.00 | 01300 NURSING ADMINISTRATION | 0 | 29, 127 | 46, 088 | 75, 215 | 2, 546 | 13.00 |
| 14. 00 | 01400 CENTRAL SERVICES & SUPPLY | 0 | 114, 413 | 181, 040 | 295, 453 | 529 | 14.00 |
| 15. 00 | 01500 PHARMACY | 0 | 62, 764 | 99, 313 | 162, 077 | 1, 902 | 15.00 |
| 16.00 | 01600 MEDICAL RECORDS & LIBRARY | 0 | 21, 619 | 34, 209 | 55, 828 | 383 | 16.00 |
| 17. 00 | 01700 SOCIAL SERVICE | 0 | 2, 483 | 3, 929 | 6, 412 | 933 | 17.00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 | 03000 ADULTS & PEDIATRICS | 0 | 869, 974 | 1, 376, 587 | 2, 246, 561 | 10, 067 | 30.00 |
| 31.00 | 03100 INTENSIVE CARE UNIT | 0 | 164, 585 | 260, 428 | 425, 013 | 3, 315 | 31.00 |
| | 03101 NEONATAL INTENSIVE CARE UNIT | 0 | 63, 625 | 100, 676 | 164, 301 | 1, 149 | 31.01 |
| 41.00 | 04100 SUBPROVI DER - I RF | 0 | 111, 964 | 177, 165 | 289, 129 | 744 | 41.00 |
| 43.00 | 04300 NURSERY | 0 | 20, 175 | 31, 924 | 52, 099 | 370 | 43.00 |
| 7 | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 | 05000 OPERATING ROOM | 0 | 553, 285 | 875, 480 | 1, 428, 765 | 5, 131 | 50.00 |
| 51.00 | 05100 RECOVERY ROOM | 0 | 0 | 0 | 0 | 0 | 51.00 |
| | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 110, 123 | 174, 251 | 284, 374 | 1, 494 | 52.00 |
| | 05300 ANESTHESI OLOGY | 0 | 9, 551 | 15, 113 | 24, 664 | 0 | 53.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 0 | 368, 938 | 583, 783 | 952, 721 | 4, 862 | 54.00 |
| 54. 01 | 05401 ULTRASOUND | 0 | 0 | 0 | 0 | 0 | 54.01 |
| 56.00 | 05600 RADI 0I S0T0PE | 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 | 120, 502 | 190, 674 | 311, 176 | 3, 533 | 60.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 0 | 26, 906 | 42, 574 | 69, 480 | 1, 162 | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 0 | 151, 386 | 239, 542 | 390, 928 | 1, 199 | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 0 | 0 | 0 | 0 | 454 | 67.00 |
| 68. 00 | 06800 SPEECH PATHOLOGY | 0 | 0 | 0 | 0 | 439 | 68. 00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0 | 254, 297 | 402, 382 | 656, 679 | 2, 420 | 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 | 86 | 73.00 |
| | 07400 RENAL DIALYSIS | 0 | 5, 557 | 8, 793 | 14, 350 | 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 |
| | 03951 WOUND CARE | 0 | 57, 916 | 91, 642 | 149, 558 | 575 | 76. 03 |
| (| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90.00 | 09000 CLI NI C | 0 | 0 | 0 | 0 | 0 | 90.00 |
| | 09100 EMERGENCY | 0 | 386, 056 | 610, 869 | 996, 925 | 3, 655 | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART | | | | 0 | | 92.00 |
| [| SPECIAL PURPOSE COST CENTERS | | | | | | |
| 118.00 | SUBTOTALS (SUM OF LINES 1 through 117) | 0 | 5, 565, 955 | 8, 807, 184 | 14, 373, 139 | 58, 144 | 118. 00 |
| | VONREI MBURSABLE COST CENTERS | | | | | | |
| 190.00 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 8, 133 | 12, 868 | 21, 001 | | 190. 00 |
| 192. 00 | 19200 PHYSICIANS' PRIVATE OFFICES | 0 | 946, 630 | 1, 497, 881 | 2, 444, 511 | | 192.00 |
| 192. 01 | 19201 OTHER NONREI MBURSABLE | 0 | 0 | 0 | 0 | 0 | 192. 01 |
| 194. 00 | 07950 NONREI MBURSABLE | 0 | 0 | 0 | 0 | | 194. 00 |
| 194. 01 | 07951 MARKETI NG | 0 | 0 | 0 | 0 | | 194. 01 |
| | 07952 SENI OR CIRCLE | 0 | 0 | 0 | 0 | | 194. 02 |
| 194. 03 | 07953 NONREIMB - REGENCY LTC | 0 | 127, 427 | 201, 632 | 329, 059 | | 194. 03 |
| 194. 04 | 07954 VACANT UNFINISHED AREA | 0 | 0 | 0 | 0 | | 194. 04 |
| 200.00 | Cross Foot Adjustments | | | | 0 | | 200. 00 |
| 201.00 | Negative Cost Centers | | 0 | 0 | 0 | | 201. 00 |
| 202.00 | TOTAL (sum lines 118 through 201) | 0 | 6, 648, 145 | 10, 519, 565 | 17, 167, 710 | | |
| ' | • | | | · · | ' | | |

| Peri od: | Worksheet B | From 01/01/2020 | Part | I | To 12/31/2020 | Date/Time Prepared:

| | | | | 10 | 0 12/31/2020 | Date/Time Pre 7/28/2021 4:3 | |
|------------------|---|-------------------|--------------------|---------------|------------------|--------------------------------|------------------|
| | Cost Center Description | ADMI NI STRATI V | OPERATION OF | LAUNDRY & | HOUSEKEEPI NG | DI ETARY | Орііі |
| | oost conten bescriptron | E & GENERAL | PLANT | LINEN SERVICE | HOUSEKEELTING | JI E ITHE | |
| | | 5. 00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | |
| | GENERAL SERVICE COST CENTERS | | | | | | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FIXT | | | | | I | 1. 00 |
| 2.00 | 00200 CAP REL COSTS-MVBLE EQUIP | | | | | I | 2.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | I | 4. 00 |
| 5. 00 | 00500 ADMINISTRATIVE & GENERAL | 726, 203 | | | | I | 5. 00 |
| 7. 00 | 00700 OPERATION OF PLANT | 64, 024 | 4, 029, 225 | | | I | 7. 00 |
| 8. 00 | 00800 LAUNDRY & LINEN SERVICE | 5, 266 | 6, 698 | | | I | 8. 00 |
| 9.00 | 00900 HOUSEKEEPI NG | 13, 485 | 43, 277 | 0 | 192, 441 | | 9.00 |
| 10.00 | 01000 DI ETARY | 6, 798 | 136, 621 | 0 | 6, 607 | 575, 776 | 1 |
| 11.00 | 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON | 7, 094 | 0 | | 1 140 | 0 | 11. 00 13. 00 |
| 13. 00 14. 00 | 01400 CENTRAL SERVICES & SUPPLY | 18, 317 8, 670 | 24, 164 94, 920 | 1 | 1, 169 4, 590 | 0 | |
| 15. 00 | 01500 PHARMACY | 13, 606 | 52, 070 | 1 | 2, 518 | 0 | 15. 00 |
| 16. 00 | 01600 MEDICAL RECORDS & LIBRARY | 6, 630 | 17, 936 | 1 | 2, 516 867 | 0 | 16.00 |
| 17. 00 | 01700 SOCIAL SERVICE | 7, 111 | 2, 060 | 1 | 100 | 0 | 17. 00 |
| 17.00 | INPATIENT ROUTINE SERVICE COST CENTERS | 7, 111 | 2,000 | 1 0 | 100 | | 17.00 |
| 30.00 | 03000 ADULTS & PEDI ATRI CS | 86, 963 | 721, 753 | 12, 055 | 34, 905 | 347, 216 | 30.00 |
| 31. 00 | 03100 INTENSIVE CARE UNIT | 27, 728 | 136, 544 | | 6, 603 | 24, 643 | 1 |
| 31. 01 | 03101 NEONATAL INTENSIVE CARE UNIT | 9, 051 | 52, 785 | | 2, 553 | 3, 420 | 1 |
| 41.00 | 04100 SUBPROVI DER - I RF | 6, 838 | 92, 889 | | 4, 492 | 27, 607 | 41.00 |
| 43.00 | 04300 NURSERY | 3, 034 | 16, 738 | 208 | 809 | 0 | 43.00 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 | 05000 OPERATING ROOM | 59, 062 | 459, 020 | 4, 002 | 22, 199 | 686 | 50.00 |
| 51. 00 | 05100 RECOVERY ROOM | 0 | 0 | _ | 0 | 0 | 51.00 |
| 52. 00 | 05200 DELIVERY ROOM & LABOR ROOM | 11, 698 | 91, 361 | 893 | 4, 418 | 9, 635 | 1 |
| 53. 00 | 05300 ANESTHESI OLOGY | 266 | 7, 924 | 0 | 383 | 0 | 53.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 41, 370 | 306, 081 | 3, 190 | 14, 802 | 332 | 1 |
| 54. 01 | 05401 ULTRASOUND | 0 | 0 | | 0 | 0 | 54.01 |
| 56. 00 57. 00 | 05600 RADI OI SOTOPE | 0 | 0 | 0 | 0 | 0 | 56.00 |
| 58.00 | 05700 CT SCAN 05800 MRI | 0 | 0 | 0 | 0 | 0 | 57. 00 58. 00 |
| 60.00 | 06000 LABORATORY | 45, 435 | 99, 972 | _ | 4, 835 | 0 | 60.00 |
| 65. 00 | 06500 RESPIRATORY THERAPY | 10, 494 | 22, 322 | | 1, 080 | 0 | 65.00 |
| 66. 00 | 06600 PHYSI CAL THERAPY | 10, 355 | 125, 594 | 1 | 6, 074 | 0 | 66.00 |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY | 3, 143 | 0 | | 0 | Ö | 67.00 |
| 68. 00 | 06800 SPEECH PATHOLOGY | 3, 143 | 0 | | o | 0 | 68.00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 22, 366 | 210, 972 | 2, 142 | 10, 203 | 5, 515 | 1 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 3, 288 | 0 | 0 | O | 0 | 71.00 |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENTS | 65, 033 | 0 | 0 | o | 0 | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 110, 597 | 0 | 0 | 0 | 0 | 73. 00 |
| 74.00 | 07400 RENAL DI ALYSI S | 2, 474 | 4, 610 | 0 | 223 | 0 | 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 | 6, 954 | 48, 049 | 954 | 2, 324 | 0 | 76. 03 |
| 00.00 | OUTPATIENT SERVICE COST CENTERS | | 0 | 1 0 | ٥ | | 00.00 |
| 90.00 | 09000 CLINIC | 0 | 220 202 | _ | 15 400 | 14 201 | |
| 91.00 | O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART | 35, 357 | 320, 283 | 5, 702 | 15, 489 | 16, 201 | 91.00 |
| 92.00 | SPECIAL PURPOSE COST CENTERS | | | | | | 92.00 |
| 118. 00 | | 715, 650 | 3, 094, 643 | 32, 902 | 147, 243 | 435, 255 | 118 00 |
| 110.00 | NONREI MBURSABLE COST CENTERS | 713,030 | 3, 074, 043 | 32, 702 | 147, 243 | 433, 233 | 1110.00 |
| 190 00 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 346 | 6, 747 | 0 | 326 | 0 | 190. 00 |
| | 19200 PHYSI CI ANS' PRI VATE OFFI CES | 8, 996 | 785, 349 | | | | 192.00 |
| | 19201 OTHER NONREI MBURSABLE | 0 | 0 | Ō | 0 | | 192. 01 |
| | 07950 NONREI MBURSABLE | 0 | 0 | o | O | | 194.00 |
| | 07951 MARKETI NG | 0 | 0 | 0 | 0 | 0 | 194. 01 |
| 194. 02 | 07952 SENIOR CIRCLE | 0 | 0 | 0 | o | 0 | 194. 02 |
| 194. 03 | 07953 NONREIMB - REGENCY LTC | 1, 211 | 142, 486 | 0 | 6, 891 | 41, 204 | 194. 03 |
| | 07954 VACANT UNFINISHED AREA | 0 | 0 | 0 | 0 | 0 | 194. 04 |
| 200.00 | | | | | | I | 200. 00 |
| 201.00 | 1 1 0 | 0 | 0 | 0 | 0 | | 201.00 |
| 202.00 | TOTAL (sum lines 118 through 201) | 726, 203 | 4, 029, 225 | 32, 902 | 192, 441 | 575, 776 | 202.00 |
| | | | | | | | |

| Peri od: | Worksheet B | From 01/01/2020 | Part I I | To 12/31/2020 | Date/Time Prepared:

| | | | 10 | 12/31/2020 | 7/28/2021 4:3 | pareu: 6 nm |
|--|------------|---|------------|------------|----------------|------------------|
| Cost Center Description | CAFETERI A | NURSI NG | CENTRAL | PHARMACY | MEDI CAL | <u> </u> |
| | | ADMI NI STRATI O | SERVICES & | | RECORDS & | |
| | | N | SUPPLY | | LI BRARY | |
| | 11. 00 | 13. 00 | 14. 00 | 15. 00 | 16. 00 | |
| GENERAL SERVI CE COST CENTERS | 1 | 1 | | | | 1 00 |
| 1. 00 00100 CAP REL COSTS-BLDG & FLXT 2. 00 00200 CAP REL COSTS-MVBLE EQULP | | | | | | 1.00 |
| 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT | | - | | 1 | | 2. 00 4. 00 |
| 5. 00 00500 ADMINISTRATIVE & GENERAL | | | | | | 5.00 |
| 7. 00 O0700 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 | 7, 767 | 1 | | | | 11.00 |
| 13.00 O1300 NURSING ADMINISTRATION | 352 | | | | | 13.00 |
| 14.00 01400 CENTRAL SERVICES & SUPPLY | 173 | 1 | 404, 481 | | | 14.00 |
| 15. 00 01500 PHARMACY | 219 | 1 | 0 | 232, 395 | 04 074 | 15.00 |
| 16. 00 01600 MEDI CAL RECORDS & LI BRARY | 100 | 1 | 74 | 0 | 81, 974 | 16.00 |
| 17. 00 01700 SOCIAL SERVICE | 141 | 3, 069 | 63 | 0 | 0 | 17. 00 |
| 30. 00 03000 ADULTS & PEDIATRICS | 1, 808 | 45, 517 | 19, 223 | ol | 6, 230 | 30.00 |
| 31. 00 03100 NTENSI VE CARE UNI T | 485 | | 8, 211 | 0 | 1, 256 | 31.00 |
| 31. 01 03101 NEONATAL NTENSI VE CARE UNIT | 162 | | 1, 758 | 0 | 687 | 31.00 |
| 41. 00 04100 SUBPROVI DER - RF | 118 | | 778 | o o | 376 | 41.00 |
| 43. 00 04300 NURSERY | 62 | | 692 | o | 169 | 43.00 |
| ANCILLARY SERVICE COST CENTERS | <u>'</u> | | | ' | | |
| 50. 00 05000 OPERATING ROOM | 841 | 17, 404 | 44, 365 | 0 | 14, 247 | 50.00 |
| 51.00 05100 RECOVERY ROOM | C | 1 | 0 | 0 | 0 | 51.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 251 | 1 | 3, 218 | 0 | 682 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0 | - | 609 | 0 | 882 | 53.00 |
| 54. 00 05400 RADI OLOGY - DI AGNOSTI C | 775 | | 13, 153 | 0 | 9, 877 | 54.00 |
| 54. 01 05401 ULTRASOUND 56. 00 05600 RADI OI SOTOPE | C | - | 0 | 0 | 0 | 54. 01 56. 00 |
| 57. 00 05700 CT SCAN | | - | 0 | 0 | 0 | 57.00 |
| 58. 00 05800 MRI | | | 0 | 0 | 0 | 58.00 |
| 60. 00 06000 LABORATORY | 731 | | 47, 975 | o | 9, 423 | 60.00 |
| 65. 00 06500 RESPIRATORY THERAPY | 190 | | 5, 562 | 0 | 2, 003 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 184 | 0 | 357 | 0 | 876 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 69 | | 1 | 0 | 489 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 57 | 1 | 0 | 0 | 221 | 68. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 369 | | 8, 649 | 0 | 6, 882 | 69. 00 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | C | | 10, 477 | 0 | 1, 621 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS | C | 0 | 227, 480 | 222 205 | 6, 270 | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DI ALYSI S | 8 | 2 | 0 | 232, 395 | 11, 729 166 | 73. 00 74. 00 |
| 74. 00 07400 RENAL DIALTSIS 76. 00 03950 ANCI LLARY | | | 0 | 0 | 0 | 76.00 |
| 76. 01 03610 SLEEP LAB | | | 0 | 0 | 0 | 76. 01 |
| 76. 03 03951 WOUND CARE | 85 | | 1, 932 | o | 506 | 76. 03 |
| OUTPATIENT SERVICE COST CENTERS | | , | | - | | |
| 90. 00 09000 CLI NI C | C | | 0 | 0 | 22 | 90.00 |
| 91. 00 09100 EMERGENCY | 569 | 15, 917 | 9, 904 | 0 | 7, 360 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | | | | | | 92.00 |
| SPECIAL PURPOSE COST CENTERS | | | | | | |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) | 7, 749 | 121, 763 | 404, 481 | 232, 395 | 81, 974 | 118.00 |
| NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 10 | ol | 0 | 0 | 0 | 190. 00 |
| 192.00 19200 PHYSI CLANS' PRI VATE OFFICES | 18 | 1 | 0 | o | | 190.00 |
| 192. 01 19201 OTHER NONREI MBURSABLE | | 1 | 0 | 0 | | 192.00 |
| 194. 00 07950 NONREI MBURSABLE | Ö | 1 | Ö | o | | 194.00 |
| 194. 01 07951 MARKETI NG | i c | 1 | 0 | ől | | 194. 01 |
| 194. 02 07952 SENI OR CIRCLE | | ol | 0 | o | | 194. 02 |
| 194.03 07953 NONREIMB - REGENCY LTC | C | o o | 0 | О | | 194. 03 |
| 194.04 07954 VACANT UNFINISHED AREA | C | 0 | 0 | 0 | 0 | 194. 04 |
| 200.00 Cross Foot Adjustments | 1 | | | | | 200. 00 |
| 201.00 Negative Cost Centers | C | 0 | 0 | 0 | | 201.00 |
| 202.00 TOTAL (sum lines 118 through 201) | 7, 767 | 121, 763 | 404, 481 | 232, 395 | 81, 974 | 202.00 |
| | | | | | | |

| | | | | To | om 01/01/2020 12/31/2020 | Date/Time Prepared: |
|---|--|---|--|---|---|--|
| | Cost Center Description | SOCI AL SERVI CE | Subtotal | Intern & Residents Cost & Post Stepdown Adjustments | Total | 7/28/2021 4:36 pm |
| | | 17. 00 | 24. 00 | 25.00 | 26. 00 | |
| | NERAL SERVICE COST CENTERS | | | | | |
| 2. 00 00 4. 00 00 5. 00 00 7. 00 00 8. 00 00 9. 00 01 11. 00 01 13. 00 01 14. 00 01 15. 00 01 16. 00 01 17. 00 01 | 0100 CAP REL COSTS-BLDG & FIXT 0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING 000 DIETARY 100 CAFETERIA 300 NURSING ADMINISTRATION 400 CENTRAL SERVICES & SUPPLY 500 PHARMACY 600 MEDICAL RECORDS & LIBRARY 700 SOCIAL SERVICE | 19, 889 | | | | 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 |
| | 3000 ADULTS & PEDIATRICS | 14, 996 | 3, 547, 294 | 0 | 3, 547, 294 | 30.00 |
| 31. 00 03 31. 01 03 41. 00 04 43. 00 04 | 3100 INTENSIVE CARE UNIT 3101 NEONATAL INTENSIVE CARE UNIT 1100 SUBPROVIDER - IRF 1300 NURSERY | 1, 919 1, 039 1, 103 832 | 651, 961 242, 696 427, 506 75, 025 | 0 0 0 0 | 651, 961 242, 696 427, 506 75, 025 | 31. 00 31. 01 41. 00 43. 00 |
| | ICILLARY SERVICE COST CENTERS | O | 2 055 722 | 0 | 2 055 722 | 50.00 |
| 51. 00 05 52. 00 05 53. 00 05 54. 01 05 56. 00 05 57. 00 05 58. 00 06 65. 00 06 65. 00 06 67. 00 06 69. 00 07 72. 00 07 73. 00 07 74. 00 07 76. 01 03 76. 01 03 76. 01 03 76. 01 03 90. 00 09 | OOOO OPERATING ROOM OFERATING ROOM OFFI OFERATION OFFI OFERATION OFFI OFFI OFFI OFFI OFFI OFFI OFFI O | 0 | 2, 055, 722 0 413, 052 34, 728 1, 351, 743 0 0 0 523, 112 112, 329 535, 737 4, 156 3, 860 931, 612 15, 386 298, 783 354, 817 21, 823 0 213, 502 | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 2, 055, 722 0 413, 052 34, 728 1, 351, 743 0 0 0 523, 112 112, 329 535, 737 4, 156 3, 860 931, 612 15, 386 298, 783 354, 817 21, 823 0 0 213, 502 | 50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 56. 00 57. 00 58. 00 60. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 76. 01 76. 03 |
| 91. 00 09 | 2100 EMERGENCY | o | 1, 427, 362 | 0 | 1, 427, 362 | 91.00 |
| SP | 2000 OBSERVATION BEDS (NON-DISTINCT PART PECIAL PURPOSE COST CENTERS | L | | - | | 92.00 |
| 118. 00 NO | SUBTOTALS (SUM OF LINES 1 through 117) NREIMBURSABLE COST CENTERS | 19, 889 | 13, 242, 228 | 0 | 13, 242, 228 | 118. 00 |
| 190. 00 19 192. 00 19 192. 01 19 194. 00 07 194. 01 07 194. 02 07 194. 03 07 | 10000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 10200 PHYSICIANS' PRIVATE OFFICES 10201 OTHER NONREIMBURSABLE 10950 NONREIMBURSABLE 10951 MARKETING 10952 SENIOR CIRCLE 10953 NONREIMB - REGENCY LTC 10954 VACANT UNFINISHED AREA 10954 Cross Foot Adjustments 1005 Negative Cost Centers 1007 TOTAL (sum lines 118 through 201) | 0 0 0 0 0 0 0 0 0 | 28, 477 3, 376, 154 0 0 0 0 520, 851 0 0 0 17, 167, 710 | 0 0 0 0 0 0 0 0 | 28, 477 3, 376, 154 0 0 0 0 520, 851 0 0 0 17, 167, 710 | 190. 00 192. 00 192. 01 194. 00 194. 01 194. 02 194. 03 194. 04 200. 00 201. 00 202. 00 |

| | Financial Systems ALLOCATION - STATISTICAL BASIS | PORTER MEMORI | AL HOSPITAL Provider CO | | eri od: | u of Form CMS-2 Worksheet B-1 | |
|--------------------|--|------------------------------|------------------------------|--|--------------------------------|---|--------------------|
| | | | | T. | rom 01/01/2020 o 12/31/2020 | Date/Time Pre 7/28/2021 4:3 | |
| | | CAPI TAL REI | LATED COSTS | | | 1/28/2021 4.3 | O DIII |
| | Cost Center Description | BLDG & FLXT (SQUARE FEET) | MVBLE EQUIP (SQUARE FEET) | EMPLOYEE BENEFITS DEPARTMENT (GROSS | Reconciliatio n | ADMINISTRATIV E & GENERAL (ACCUM. COST) | |
| | | 1. 00 | 2.00 | SALARI ES) | 5A | 5. 00 | |
| | GENERAL SERVICE COST CENTERS | 1.00 | 2.00 | 4.00 | 5A | 5.00 | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FIXT | 787, 225 | 1 | | | | 1.00 |
| | 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT | 2, 668 | 787, 225 2, 668 | 85, 786, 509 | | | 2.00 4.00 |
| 5. 00 | 00500 ADMINISTRATIVE & GENERAL | 32, 955 | | 11, 096, 936 | -64, 224, 247 | 197, 318, 519 | 5.00 |
| | 00700 OPERATION OF PLANT | 181, 758 | | | 0 | 17, 397, 693 | 7.00 |
| | 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG | 956 6, 177 | 1 | 132, 121 1, 433, 613 | 0 | 1, 431, 065 3, 664, 433 | 8. 00 9. 00 |
| 10.00 | 01000 DI ETARY | 19, 500 | | 732, 422 | 0 | 1, 847, 156 | 1 |
| | 01100 CAFETERI A | 0 | 0 | 992, 932 | 0 | 1, 927, 652 | 11.00 |
| | 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY | 3, 449 13, 548 | | 3, 755, 440 780, 252 | 0 | 4, 977, 579 2, 355, 864 | 13. 00 14. 00 |
| 15.00 | 01500 PHARMACY | 7, 432 | | 2, 805, 619 | 0 | 3, 697, 220 | 15. 00 |
| | 01600 MEDICAL RECORDS & LIBRARY | 2, 560 | | 565, 182 | | 1, 801, 682 | 16.00 |
| | 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS | 294 | 294 | 1, 376, 422 | 0 | 1, 932, 408 | 17. 00 |
| 30.00 | 03000 ADULTS & PEDIATRICS | 103, 016 | | | 0 | | |
| | 03100 INTENSIVE CARE UNIT 03101 NEONATAL INTENSIVE CARE UNIT | 19, 489 7, 534 | | 4, 889, 307 1, 695, 081 | 0 | 7, 534, 737 2, 459, 447 | 31. 00 31. 01 |
| 41. 00 | 04100 SUBPROVIDER - IRF | 13, 258 | | | 0 | 1, 858, 039 | 41.00 |
| | 04300 NURSERY | 2, 389 | | 545, 681 | 0 | 824, 396 | 43.00 |
| 50. 00 | ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM | 65, 516 | 65, 516 | 7, 567, 260 | 0 | 16, 049, 486 | 50.00 |
| | 05100 RECOVERY ROOM | 03, 310 | 03,310 | 7, 307, 200 | 0 | 0 10,047,400 | 51.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 13, 040 | | 2, 204, 149 | 0 | 3, 178, 818 | 52.00 |
| | 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C | 1, 131 43, 687 | 1, 131 43, 687 | 0 7, 171, 346 | 0 | 72, 397 11, 241, 837 | 53. 00 54. 00 |
| | 05401 ULTRASOUND | 43,007 | 43,007 | 7, 171, 340 | 0 | 0 11, 241, 037 | 54. 01 |
| | 05600 RADI OI SOTOPE | 0 | 0 | 0 | 0 | 0 | 56.00 |
| | 05700 CT SCAN 05800 MRI | 0 | 0 | 0 | 0 | 0 | 57. 00 58. 00 |
| 60.00 | 06000 LABORATORY | 14, 269 | - | 5, 210, 879 | 0 | 12, 346, 426 | 60.00 |
| | 06500 RESPI RATORY THERAPY | 3, 186 | | 1, 713, 717 | 0 | 2, 851, 690 | |
| | 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY | 17, 926 0 | | 1, 768, 833 669, 949 | 0 | 2, 813, 863 853, 977 | 66. 00 67. 00 |
| | | 0 | O | 647, 198 | 0 | 854, 163 | |
| | 06900 ELECTROCARDI OLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 30, 112 | | 3, 569, 847 | 0 | 6, 077, 794 | |
| | 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 893, 470 17, 671, 905 | 1 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | | 126, 959 | 0 | 30, 034, 545 | 73. 00 |
| | 07400 RENAL DI ALYSI S 03950 ANCI LLARY | 658 | | 0 | 0 | 672, 418 0 | 74. 00 76. 00 |
| | 03610 SLEEP LAB | 0 | 0 | 0 | 0 | 0 | 76.00 |
| 76. 03 | 03951 WOUND CARE | 6, 858 | 6, 858 | 848, 329 | 0 | 1, 889, 569 | 76. 03 |
| | OUTPATIENT SERVICE COST CENTERS 09000 CLINIC | 0 | O | 0 | 0 | 0 | 90.00 |
| 91.00 | 09100 EMERGENCY | 45, 714 | | 5, 391, 510 | | 9, 607, 888 | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART | | | | | | 92.00 |
| 118. 00 | SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 11 | 7) 659, 080 | 659, 080 | 85, 729, 166 | -64, 224, 247 | 194, 450, 768 |] 118. 00 |
| | NONREI MBURSABLE COST CENTERS | | | | | | |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES | 963 112, 093 | 1 | 57, 343 0 | 0 | 94, 001 2, 444, 691 | |
| | 19201 OTHER NONREIMBURSABLE | 112,043 | 112,093 | 0 | 0 | | 192.00 |
| 194.00 | 07950 NONREI MBURSABLE | 0 | 0 | 0 | 0 | | 194. 00 |
| | 07951 MARKETI NG 2 07952 SENI OR CI RCLE | 0 | 0 | 0 | 0 | | 194. 01 194. 02 |
| | 3 07953 NONREIMB - REGENCY LTC | 15, 089 | 15, 089 | 0 | 0 | 329, 059 | 1 |
| | 07954 VACANT UNFI NI SHED AREA | 0 | 0 | 0 | 0 | 0 | 194. 04 |
| 200. 00 201. 00 | | | | | | | 200. 00 201. 00 |
| 201.00 | | 6, 648, 145 | 10, 519, 565 | 17, 255, 679 | | 64, 224, 247 | |
| | Part I) | 0.445000 | 40.07007 | | | | |
| 203. 00 204. 00 | | 8. 445038 | 13. 362844 | 0. 201147 58, 183 | | 0. 325485 726, 203 | |
| | Part II) | | | | | | |
| 205. 00 | Unit cost multiplier (Wkst. B, Part | | | 0. 000678 | | 0. 003680 | 205. 00 |
| | | 1 | ' | | | ı | • |

| Health Financial Systems | PORTER MEMORI | PORTER MEMORIAL HOSPITAL | | | In Lieu of Form CMS-2552-10 | | | |
|---|------------------------------|------------------------------|---|----------------------------------|---|---------|--|--|
| COST ALLOCATION - STATISTICAL BASIS | | Provi der Co | | Peri od: | Worksheet B-1 | | | |
| | | | | From 01/01/2020 To 12/31/2020 | | | | |
| | CAPI TAL REL | LATED COSTS | | | | | | |
| Cost Center Description | BLDG & FIXT (SQUARE FEET) | MVBLE EQUIP (SQUARE FEET) | EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES) | Reconciliatio n | ADMINISTRATIV E & GENERAL (ACCUM. COST) | | | |
| | 1. 00 | 2. 00 | 4.00 | 5A | 5. 00 | | | |
| 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) | | | | | | 206. 00 | | |
| 207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV) | | | | | | 207. 00 | | |

| | Financial Systems | PORTER MEMORI | | ON 45 0005 5 | | u of Form CMS-1 | |
|--------------------|---|-------------------|---------------|---------------------|----------------------------|------------------------------|--------------------|
| COST | ALLOCATION - STATISTICAL BASIS | | Provi der C | CN: 15-0035 F | Period: From 01/01/2020 | Worksheet B-1 | |
| | | | | Τ | o 12/31/2020 | | |
| | Cost Center Description | OPERATION OF | LAUNDRY & | HOUSEKEEPI NG | DI ETARY | 7/28/2021 4: 3 CAFETERI A | o pm |
| | coot conto. Bood. Pt. o | PLANT | LINEN SERVICE | | (MEALS | (FTE' S) | |
| | | (SQUARE FEET) | (POUNDS OF | , | SERVED) | | |
| | | | LAUNDR) | | | | |
| | CENEDAL CEDVICE COCT CENTEDS | 7. 00 | 8. 00 | 9. 00 | 10.00 | 11. 00 | |
| 1. 00 | GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT | 1 | | | | | 1.00 |
| 2. 00 | 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| 5.00 | 00500 ADMINISTRATIVE & GENERAL | | | | | | 5.00 |
| 7.00 | 00700 OPERATION OF PLANT | 575, 092 | 1 | | | | 7.00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | 956 | 1 | | | | 8.00 |
| 9. 00 10. 00 | 00900 HOUSEKEEPI NG 01000 DI ETARY | 6, 177 19, 500 | 1 | 567, 959 19, 500 | | | 9.00 |
| 11.00 | 01100 CAFETERI A | 17, 500 | l . | 19, 500 | | 100, 825 | 1 |
| 13. 00 | 01300 NURSING ADMINISTRATION | 3, 449 | 1 | 3, 449 | ol ol | 4, 574 | 1 |
| 14.00 | 01400 CENTRAL SERVICES & SUPPLY | 13, 548 | 1 | | | 2, 247 | 1 |
| 15.00 | 01500 PHARMACY | 7, 432 | 0 | 7, 432 | 0 | 2, 841 | 15.00 |
| 16. 00 | 01600 MEDICAL RECORDS & LIBRARY | 2, 560 | | 2, 560 | | 1, 303 | 1 |
| 17. 00 | 01700 SOCIAL SERVICE | 294 | . 0 | 294 | l 0 | 1, 825 | 17.00 |
| 30. 00 | INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS | 103, 016 | 315, 299 | 103, 016 | 125, 484 | 23, 455 | 30.00 |
| 31.00 | 03100 I NTENSI VE CARE UNI T | 19, 489 | 1 | • | | 6, 292 | |
| 31. 01 | 03101 NEONATAL INTENSIVE CARE UNIT | 7, 534 | 1 | | | 2, 103 | 1 |
| 41.00 | 04100 SUBPROVI DER - I RF | 13, 258 | | | | 1, 537 | 1 |
| 43.00 | 04300 NURSERY | 2, 389 | 5, 430 | 2, 389 | 0 | 808 | 43.00 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 | 05000 OPERATING ROOM 05100 RECOVERY ROOM | 65, 516 | • | 65, 516 | | 10, 918 | |
| 51. 00 52. 00 | 05200 DELIVERY ROOM & LABOR ROOM | 13, 040 | - | - | 1 | 0 3, 262 | |
| 53.00 | 05300 ANESTHESI OLOGY | 1, 131 | • | 1, 131 | | 0, 202 | |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 43, 687 | 1 | 43, 687 | | 10, 056 | |
| 54.01 | 05401 ULTRASOUND | 0 | 0 | C | o | 0 | 54. 01 |
| 56.00 | 05600 RADI OI SOTOPE | 0 | 0 | C | 0 | 0 | 56.00 |
| 57.00 | 05700 CT SCAN | 0 | 0 | C | 0 | 0 | |
| 58.00 | 05800 MRI | 0 | 0 | 14.00 | 0 | 0 | |
| 60. 00 65. 00 | 06000 LABORATORY 06500 RESPI RATORY THERAPY | 14, 269 3, 186 | | 14, 269 3, 186 | | 9, 490 2, 463 | |
| 66.00 | 06600 PHYSI CAL THERAPY | 17, 926 | | | | 2, 463 | |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 17, 720 | | 17, 720 | | 900 | 1 |
| 68.00 | 06800 SPEECH PATHOLOGY | 0 | 0 | d | o | 739 | 1 |
| 69. 00 | 06900 ELECTROCARDI OLOGY | 30, 112 | 56, 023 | 30, 112 | 1, 993 | 4, 788 | 69.00 |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0 | 0 | C | 1 | 0 | |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS | 0 | 1 | | | 0 | 1 |
| 73. 00 74. 00 | 07400 RENAL DIALYSIS | 658 | 1 | 658 | | 100 0 | 1 |
| 76.00 | 03950 ANCI LLARY | 030 | 1 | 1 | 1 | 0 | |
| | 03610 SLEEP LAB | 0 | 1 | | | 0 | |
| 76. 03 | 03951 WOUND CARE | 6, 858 | 24, 941 | 6, 858 | 0 | 1, 107 | 76. 03 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90.00 | 09000 CLINIC | 0 | 0 | | 0 | 0 | |
| 91.00 | 09100 EMERGENCY | 45, 714 | 149, 144 | 45, 714 | 5, 855 | 7, 392 | |
| 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS | | | | | | 92.00 |
| 118.00 | | 441, 699 | 860, 580 | 434, 566 | 157, 301 | 100, 591 | 118.00 |
| | NONREI MBURSABLE COST CENTERS | 111/077 | 1 000,000 | 1017000 | , | 100/071 | 1 |
| 190.00 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 963 | 0 | | | 234 | 190.00 |
| | 19200 PHYSICIANS' PRIVATE OFFICES | 112, 093 | 0 | 112, 093 | 35, 893 | | 192.00 |
| | 19201 OTHER NONREI MBURSABLE | 0 | 0 | C | 0 | | 192. 01 |
| | 07950 NONREI MBURSABLE | 0 | 0 | | 0 | | 194.00 |
| | 07951 MARKETI NG 07952 SENI OR CI RCLE | 0 | | | | | 194. 01 194. 02 |
| | 307953 NONREIMB - REGENCY LTC | 20, 337 | | 20, 337 | 14, 891 | | 194. 02 |
| | 07954 VACANT UNFINISHED AREA | 20,007 | Ö | 20,007 | 0 | | 194. 04 |
| 200.00 | | | | | | | 200.00 |
| 201.00 | Negative Cost Centers | | | | | | 201.00 |
| 202.00 | | 23, 060, 381 | 1, 935, 189 | 5, 104, 840 | 3, 405, 568 | 2, 555, 074 | 202.00 |
| 000 00 | Part I) | 40.000505 | 0.040700 | 0.000046 | 1/ 0//005 | 05 044/74 | 000 00 |
| 203. 00 204. 00 | | 1 | 1 | | 1 | 25. 341671 7. 767 | 1 |
| 204. UC | Part II) | 4, 029, 225 | 32, 902 | 192, 441 | 575, 776 | 1, 101 | 204.00 |
| 205.00 | | 7. 006227 | 0. 038232 | 0. 338829 | 2. 767023 | 0. 077034 | 205.00 |
| | | | | | | | |
| 206.00 | | 1 | | | | | 206.00 |
| 207.00 | (per Wkst. B-2) | | | | | | 207 66 |
| 207.00 | | | | 1 | | | 207. 00 |
| | Parts III and IV) | | | | | | 1 |

| COST ALLO | OCATION - STATISTICAL BASIS | | Provi der CC | | Peri od: From 01/01/2020 To 12/31/2020 | Worksheet B-1 Date/Time Pre | |
|--|--|---|--|---------------------------------|--|--|---|
| | Cost Center Description | NURSI NG ADMI NI STRATI O N (NURSI NG WA GES) | CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.) | PHARMACY (COSTED REQUIS.) | MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) | 7/28/2021 4: 3 SOCI AL SERVI CE (TI ME SPENT) | |
| | | 13. 00 | 14. 00 | 15. 00 | 16.00 | 17. 00 | |
| 1. 00 00° 2. 00 00° 4. 00 00° 5. 00 00° 8. 00 00° 9. 00 01° 11. 00 01° 13. 00 01° 14. 00 014 15. 00 018 16. 00 011 17. 00 011 | NERAL SERVICE COST CENTERS 100 CAP REL COSTS-BLDG & FIXT 200 CAP REL COSTS-BLDG & FIXT 200 CAP REL COSTS-MYBLE EQUIP 400 EMPLOYEE BENEFITS DEPARTMENT 500 ADMINISTRATIVE & GENERAL 700 OPERATION OF PLANT 800 LAUNDRY & LINEN SERVICE 900 HOUSEKEEPING 000 DIETARY 100 CAFETERIA 300 NURSING ADMINISTRATION 400 CENTRAL SERVICES & SUPPLY 500 PHARMACY 600 MEDICAL RECORDS & LIBRARY 700 SOCIAL SERVICE | 35, 761, 720 1, 238 985 45, 829 901, 219 | 31, 556, 774 0 5, 743 4, 933 | 29, 901, 01 | 4 0 2, 045, 655, 946 0 0 | 57, 352 | 1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 16. 00 |
| | 000 ADULTS & PEDIATRICS | 13, 369, 411 | 1, 499, 672 | | 0 155, 745, 607 | 43, 239 | 30.00 |
| 31. 01 03° 41. 00 04° 43. 00 04° | 100 INTENSIVE CARE UNIT 101 NEONATAL INTENSIVE CARE UNIT 100 SUBPROVIDER - IRF 300 NURSERY CILLARY SERVICE COST CENTERS | 4, 030, 214 1, 595, 109 843, 478 3, 449 | 640, 584 137, 121 60, 657 53, 966 | | 0 31, 388, 985 0 17, 173, 909 0 9, 396, 446 0 4, 220, 904 | 5, 535 2, 996 3, 182 2, 400 | 31. 01 41. 00 |
| | OOO OPERATING ROOM | 5, 111, 165 | 3, 461, 160 | | 0 352, 459, 306 | 0 | 50.00 |
| 51. 00 05 ² 52. 00 05 ² 53. 00 05 ² 54. 00 05 ⁴ 54. 01 05 ⁴ 56. 00 05 ⁶ | 100 RECOVERY ROOM 200 DELIVERY ROOM & LABOR ROOM 300 ANESTHESI OLOGY 400 RADI OLOGY-DI AGNOSTI C 401 ULTRASOUND 600 RADI OI SOTOPE 700 CT SCAN | 0 1, 476, 611 0 1, 345, 054 0 | 0 251, 088 47, 524 1, 026, 168 0 0 | | 0 0 17, 049, 324 0 22, 053, 901 0 246, 934, 136 0 0 0 | 0 0 0 0 0 0 | 51.00 52.00 53.00 54.00 54.01 56.00 |
| 58. 00 058 60. 00 066 65. 00 066 66. 00 066 67. 00 068 | 800 MRI 000 LABORATORY 500 RESPI RATORY THERAPY 600 PHYSI CAL THERAPY 700 OCCUPATI ONAL THERAPY 800 SPEECH PATHOLOGY | 8, 633 10, 618 0 0 | 3, 742, 800 433, 953 27, 853 55 0 | | 0 0 0 0 235, 571, 722 0 50, 084, 589 0 21, 904, 089 0 12, 218, 686 0 5, 531, 618 | 0 0 0 0 0 | 58. 00 60. 00 65. 00 66. 00 67. 00 68. 00 |
| 71. 00 07 72. 00 07 73. 00 07 74. 00 07 76. 00 03 76. 01 03 | 900 ELECTROCARDIOLOGY 100 MEDICAL SUPPLIES CHARGED TO PATIENT 200 IMPL. DEV. CHARGED TO PATIENTS 300 DRUGS CHARGED TO PATIENTS 400 RENAL DIALYSIS 950 ANCILLARY 610 SLEEP LAB 951 WOUND CARE | 1, 590, 305 0 0 573 0 0 0 753, 270 | 674, 764 817, 341 17, 748, 034 0 0 0 0 150, 714 | 29, 901, 01 | 0 172, 061, 452 0 40, 534, 670 0 156, 747, 533 4 293, 232, 584 0 4, 153, 477 0 0 0 0 12, 643, 189 | 0 0 0 0 0 0 | 71. 00 72. 00 73. 00 74. 00 76. 00 76. 0 |
| 90. 00 090 91. 00 091 | TPATIENT SERVICE COST CENTERS 000 CLINIC 100 EMERGENCY | 0 4, 674, 559 | 0 772, 644 | | 0 546, 852 0 184, 002, 967 | 0 | 91.00 |
| 118. 00 | 200 OBSERVATION BEDS (NON-DISTINCT PART ECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) | 35, 761, 720 | 31, 556, 774 | 29, 901, 01 | 4 2, 045, 655, 946 | 57, 352 | 92.00 |
| 190. 00 190 192. 00 192 192. 01 192 194. 00 070 194. 01 070 194. 02 070 194. 03 070 | NREIMBURSABLE COST CENTERS OOO GIFT, FLOWER, COFFEE SHOP & CANTEEN 200 PHYSICIANS' PRIVATE OFFICES OTHER NONREIMBURSABLE 950 NONREIMBURSABLE 951 MARKETING 952 SENIOR CIRCLE 953 NONREIMB - REGENCY LTC 954 VACANT UNFINISHED AREA Cross Foot Adjustments | 0 0 0 0 0 0 0 | 0 0 0 0 0 0 0 | | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 0 0 0 0 | 190. 00 192. 00 192. 01 194. 00 194. 01 194. 02 194. 03 194. 04 200. 00 |
| 201. 00 202. 00 | Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) | 6, 882, 919 | 3, 853, 232 | 5, 337, 60 | 2, 556, 305 | 2, 796, 114 | 201.00 |
| 203. 00 204. 00 | Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, | 0. 192466 121, 763 | 0. 122105 404, 481 | 0. 17850 232, 39 | | 48. 753557 19, 889 | |
| 205. 00 | Part II) Unit cost multiplier (Wkst. B, Part II) NAME adjustment amount to be allocated | 0. 003405 | 0. 012818 | 0. 00777 | 0. 000040 | 0. 346788 | |
| 206. 00 | NAHE adjustment amount to be allocated (per Wkst. B-2) | | | | | | 206. 00 |

| Health Financial Systems | PORTER MEMORI | PORTER MEMORIAL HOSPITAL | | | In Lieu of Form CMS-2552-10 | | | |
|--|------------------|--------------------------|-------------|-----------------|-----------------------------|--------|--|--|
| COST ALLOCATION - STATISTICAL BASIS | | Provi der C | CN: 15-0035 | Peri od: | Worksheet B-1 | | | |
| | | | | From 01/01/2020 | | | | |
| | | | | To 12/31/2020 | Date/Time Pre 7/28/2021 4:3 | | | |
| Cost Center Description | NURSI NG | CENTRAL | PHARMACY | MEDI CAL | SOCI AL | | | |
| | ADMI NI STRATI O | SERVICES & | (COSTED | RECORDS & | SERVI CE | | | |
| | N | SUPPLY | REQUI S.) | LI BRARY | (TIME SPENT) | | | |
| | (NURSING WA | (COSTED | | (GROSS | | | | |
| | GES) | REQUIS.) | | CHARGES) | | | | |
| | 13. 00 | 14. 00 | 15.00 | 16. 00 | 17. 00 | | | |
| 207.00 NAHE unit cost multiplier (Wkst. D, | | | | | | 207.00 | | |
| Parts III and IV) | | | | | | | | |

| Health Financial Systems | PORTER MEMORIAL 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 01/01/2020 Part I To 12/31/2020 Date/Time Prepared: |

| | | | | | Го 12/31/2020 | Date/Time Pre 7/28/2021 4:3 | pared: 6 pm |
|--------|---|---------------|---------------|-------------------------|-----------------|-----------------------------|----------------|
| | | | Title | XVIII | Hospi tal | PPS | |
| | | | | | Costs | | |
| | Cost Center Description | Total Cost | Therapy Limit | Total Costs | RCE | Total Costs | |
| | | (from Wkst. | Adj . | | Di sal I owance | | |
| | | B, Part I, | , | | | | |
| | | col . 26) | | | | | |
| | | 1.00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 | 03000 ADULTS & PEDIATRICS | 44, 795, 558 | | 44, 795, 55 | 3 0 | 44, 795, 558 | 30.00 |
| 31.00 | 03100 INTENSIVE CARE UNIT | 12, 560, 292 | | 12, 560, 29 | 2 0 | 12, 560, 292 | 31.00 |
| 31. 01 | 03101 NEONATAL INTENSIVE CARE UNIT | 4, 215, 781 | | 4, 215, 78 | 1 0 | 4, 215, 781 | 31.01 |
| 41.00 | 04100 SUBPROVI DER - I RF | 3, 685, 423 | | 3, 685, 42 | 3 0 | 3, 685, 423 | 41.00 |
| 43.00 | 04300 NURSERY | 1, 372, 218 | | 1, 372, 21 | 3 0 | 1, 372, 218 | 43.00 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 | 05000 OPERATING ROOM | 26, 851, 601 | | 26, 851, 60 | 1 0 | 26, 851, 601 | 50.00 |
| 51.00 | 05100 RECOVERY ROOM | 0 | | (| 0 | 0 | 51.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 5, 381, 882 | | 5, 381, 88 | 2 0 | 5, 381, 882 | 52.00 |
| 53.00 | 05300 ANESTHESI OLOGY | 184, 848 | | 184, 84 | 3 0 | 184, 848 | 53.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 18, 182, 604 | | 18, 182, 60 | 4 0 | 18, 182, 604 | 54.00 |
| 54.01 | 05401 ULTRASOUND | 0 | | (| 0 | 0 | 54.01 |
| 56.00 | 05600 RADI OI SOTOPE | 0 | | (| 0 | 0 | 56.00 |
| 57.00 | 05700 CT SCAN | 0 | | (| 0 | 0 | 57.00 |
| 58.00 | 05800 MRI | 0 | | (| 0 | 0 | 58. 00 |
| 60.00 | 06000 LABORATORY | 18, 059, 242 | | 18, 059, 24 | 2 0 | 18, 059, 242 | 60.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 4, 116, 317 | 0 | 4, 116, 31 | 7 0 | 4, 116, 317 | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 4, 711, 058 | 0 | 4, 711, 05 | 3 0 | 4, 711, 058 | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 1, 170, 022 | 0 | 1, 170, 02 | 2 0 | 1, 170, 022 | 67.00 |
| 68. 00 | 06800 SPEECH PATHOLOGY | 1, 157, 822 | 0 | 1, 157, 82 | 2 0 | 1, 157, 822 | |
| 69.00 | 06900 ELECTROCARDI OLOGY | 10, 417, 604 | | 10, 417, 60 | | 10, 417, 604 | |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 1, 334, 750 | | 1, 334, 75 | | 1, 334, 750 | |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENTS | 25, 786, 894 | | 25, 786, 89 | | 25, 786, 894 | |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 45, 517, 162 | | 45, 517, 16 | 2 0 | 45, 517, 162 | |
| 74.00 | 07400 RENAL DIALYSIS | 928, 771 | | 928, 77 | 1 0 | 928, 771 | 74.00 |
| 76.00 | 03950 ANCI LLARY | 0 | | (| 0 | 0 | 76.00 |
| 76. 01 | 03610 SLEEP LAB | 0 | | (| 0 | 0 | 76. 01 |
| 76. 03 | 03951 WOUND CARE | 3, 104, 555 | | 3, 104, 55 | 5 0 | 3, 104, 555 | 76. 03 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90.00 | 09000 CLI NI C | 684 | | 68 | | | |
| | 09100 EMERGENCY | 16, 821, 630 | | 16, 821, 63 | | 16, 821, 630 | |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART | 3, 780, 099 | | 3, 780, 09 ⁶ | | 3, 780, 099 | |
| 200.00 | | 254, 136, 817 | 0 | | | 254, 136, 817 | |
| 201.00 | 1 | 3, 780, 099 | | 3, 780, 09 | | 3, 780, 099 | |
| 202.00 | Total (see instructions) | 250, 356, 718 | 0 | 250, 356, 71 | 0 | 250, 356, 718 | 202. 00 |
| | | | | | | | |

| | | | | -rom 01/01/2020 Γο 12/31/2020 | Part I Date/Time Pre 7/28/2021 4:3 | |
|---|---------------|------------------|------------------|---|--|---------|
| | | Title | XVIII | Hospi tal | PPS | |
| | | Charges | | | | |
| Cost Center Description | I npati ent | Outpati ent | | Cost or Other | TEFRA | |
| | | | + col. 7) | Ratio | I npati ent | |
| | | | | | Ratio | |
| | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | 1 | | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 141, 248, 855 | | 141, 248, 85 | | | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | 31, 388, 985 | | 31, 388, 98! | | | 31.00 |
| 31.01 03101 NEONATAL INTENSIVE CARE UNIT | 17, 173, 909 | | 17, 173, 90 | | | 31. 01 |
| 41. 00 04100 SUBPROVI DER - I RF | 9, 396, 446 | | 9, 396, 44 | | | 41.00 |
| 43. 00 04300 NURSERY | 4, 220, 904 | | 4, 220, 90 | 1 | | 43.00 |
| ANCILLARY SERVICE COST CENTERS | | | | , | | |
| 50.00 05000 OPERATING ROOM | 139, 166, 973 | 213, 292, 333 | | | 0. 000000 | 50.00 |
| 51. 00 05100 RECOVERY ROOM | 0 | 0 | | 0. 000000 | 0. 000000 | 51.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 16, 921, 983 | 127, 341 | 17, 049, 32 | | 0. 000000 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 9, 048, 295 | 13, 005, 606 | | | 0. 000000 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 59, 189, 117 | 187, 745, 019 | 246, 934, 136 | | 0. 000000 | 54.00 |
| 54. 01 05401 ULTRASOUND | 0 | 0 | | 0. 000000 | 0.000000 | 54. 01 |
| 56. 00 05600 RADI 0I SOTOPE | 0 | 0 | | 0.00000 | 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 | 105, 575, 010 | 129, 996, 712 | 235, 571, 72 | | 0.000000 | 60.00 |
| 65. 00 06500 RESPIRATORY THERAPY | 48, 020, 548 | 2, 064, 041 | 50, 084, 589 | | 0.000000 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 14, 658, 922 | 7, 245, 167 | | | 0.000000 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 10, 761, 355 | 1, 457, 331 | | | 0.000000 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 3, 877, 762 | 1, 653, 856 | 5, 531, 618 | 0. 209310 | 0.000000 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 64, 607, 379 | 107, 454, 073 | 172, 061, 45 | 0. 060546 | 0.000000 | 69.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 21, 600, 254 | 18, 934, 416 | 40, 534, 670 | 0. 032929 | 0.000000 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 91, 200, 350 | 65, 547, 183 | 156, 747, 53 | 0. 164512 | 0.000000 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 72, 492, 504 | 220, 740, 080 | 293, 232, 58 | 0. 155225 | 0.000000 | 73.00 |
| 74. 00 07400 RENAL DI ALYSI S | 4, 077, 806 | 75, 671 | 4, 153, 47 | | 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 | 409, 788 | 12, 233, 401 | 12, 643, 189 | 0. 245552 | 0.000000 | 76. 03 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90. 00 09000 CLI NI C | 0 | 546, 852 | 546, 85 | | 0.000000 | 90.00 |
| 91. 00 09100 EMERGENCY | 68, 038, 381 | 115, 964, 586 | | | 0.000000 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 5, 639, 834 | 8, 856, 918 | | | 0.000000 | 92.00 |
| 200.00 Subtotal (see instructions) | 938, 715, 360 | 1, 106, 940, 586 | 2, 045, 655, 946 | <u> </u> | | 200. 00 |
| 201.00 Less Observation Beds | | | | | | 201. 00 |
| 202.00 Total (see instructions) | 938, 715, 360 | 1, 106, 940, 586 | 2, 045, 655, 94 | 5 | | 202. 00 |
| | | | | | | |

| Health Financial Systems | PORTER MEMORIAL HOSPITAL | | In Lie | u of Form CMS-2552-10 |
|--|--------------------------|-------------|--|---|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CC | CN: 15-0035 | Peri od: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/28/2021 4:36 pm |

| | | | | To 12/31/2020 | 7/28/2021 4:3 | |
|---------|--|---------------|-------------|---------------|---------------|---------|
| | | | Title XVIII | Hospi tal | PPS | 50 piii |
| | Cost Center Description | PPS Inpatient | | <u> </u> | | |
| | · | Ratio | | | | |
| | | 11. 00 | | | | |
| | IPATIENT ROUTINE SERVICE COST CENTERS | | | | | |
| | 3000 ADULTS & PEDIATRICS | | | | | 30.00 |
| | 3100 INTENSIVE CARE UNIT | | | | | 31.00 |
| | 3101 NEONATAL INTENSIVE CARE UNIT | | | | | 31.01 |
| | 1100 SUBPROVI DER - I RF | | | | | 41.00 |
| | 1300 NURSERY | | | | | 43.00 |
| | ICI LLARY SERVI CE COST CENTERS | | | | | |
| | OOOO OPERATING ROOM | 0. 076184 | | | | 50.00 |
| | 5100 RECOVERY ROOM | 0. 000000 | | | | 51.00 |
| | 5200 DELIVERY ROOM & LABOR ROOM | 0. 315665 | | | | 52.00 |
| 1 | 300 ANESTHESI OLOGY | 0. 008382 | | | | 53.00 |
| | 7400 RADI OLOGY-DI AGNOSTI C | 0. 073633 | | | | 54.00 |
| | 5401 ULTRASOUND | 0. 000000 | | | | 54. 01 |
| | 6600 RADI OI SOTOPE | 0. 000000 | | | | 56. 00 |
| | 5700 CT SCAN | 0. 000000 | | | | 57.00 |
| | 5800 MRI | 0. 000000 | | | | 58. 00 |
| | 5000 LABORATORY | 0. 076661 | | | | 60.00 |
| | 5500 RESPI RATORY THERAPY | 0. 082187 | | | | 65.00 |
| | 6600 PHYSI CAL THERAPY | 0. 215077 | | | | 66.00 |
| | 5700 OCCUPATI ONAL THERAPY | 0. 095757 | | | | 67.00 |
| | SPEECH PATHOLOGY | 0. 209310 | | | | 68.00 |
| | 900 ELECTROCARDI OLOGY | 0. 060546 | | | | 69. 00 |
| | 7100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0. 032929 | | | | 71.00 |
| | 7200 IMPL. DEV. CHARGED TO PATIENTS | 0. 164512 | | | | 72.00 |
| | 7300 DRUGS CHARGED TO PATIENTS | 0. 155225 | | | | 73.00 |
| | 7400 RENAL DI ALYSI S | 0. 223613 | | | | 74.00 |
| 1 | 3950 ANCI LLARY | 0. 000000 | | | | 76. 00 |
| | 3610 SLEEP LAB | 0. 000000 | | | | 76. 01 |
| | 3951 WOUND CARE | 0. 245552 | | | | 76. 03 |
| | ITPATIENT SERVICE COST CENTERS | | | | | |
| | POOO CLINIC | 0. 001251 | | | | 90.00 |
| | P100 EMERGENCY | 0. 091420 | | | | 91.00 |
| | 0200 OBSERVATION BEDS (NON-DISTINCT PART | 0. 260755 | | | | 92.00 |
| 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 MEMORIAL HOSPITAL | In Lieu of Form CMS-2552-10 |
|--|--------------------------|---|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 15-0035 | Period: Worksheet C From 01/01/2020 Part I |
| | | To 12/31/2020 Date/Time Prepared |

| | | | Τ̈́ | o 12/31/2020 | Date/Time Pre 7/28/2021 4:3 | |
|---|---------------|---------------|--------------|-----------------|-----------------------------|----------|
| | | Ti tl | e XIX | Hospi tal | Cost | <u> </u> |
| | | | | Costs | | |
| Cost Center Description | Total Cost | Therapy Limit | Total Costs | RCE | Total Costs | |
| , | (from Wkst. | Adi . | | Di sal I owance | | |
| | B, Part I, | , | | | | |
| | col . 26) | | | | | |
| | 1.00 | 2.00 | 3.00 | 4. 00 | 5. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS | 44, 795, 558 | | 44, 795, 558 | 0 | 44, 795, 558 | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | 12, 560, 292 | | 12, 560, 292 | | 12, 560, 292 | 31.00 |
| 31.01 03101 NEONATAL INTENSIVE CARE UNIT | 4, 215, 781 | | 4, 215, 781 | 0 | 4, 215, 781 | 31.01 |
| 41. 00 04100 SUBPROVI DER - I RF | 3, 685, 423 | | 3, 685, 423 | 0 | 3, 685, 423 | 41.00 |
| 43. 00 04300 NURSERY | 1, 372, 218 | | 1, 372, 218 | 0 | 1, 372, 218 | 43.00 |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50. 00 05000 OPERATING ROOM | 26, 851, 601 | | 26, 851, 601 | 0 | 26, 851, 601 | 50.00 |
| 51.00 05100 RECOVERY ROOM | 0 | | C | 0 | | 51.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 5, 381, 882 | | 5, 381, 882 | 0 | 5, 381, 882 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 184, 848 | | 184, 848 | 0 | 184, 848 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 18, 182, 604 | | 18, 182, 604 | 0 | 18, 182, 604 | 54.00 |
| 54. 01 05401 ULTRASOUND | 0 | | | 0 | 0 | 54. 01 |
| 56. 00 05600 RADI 0I SOTOPE | o | | l | 0 | 0 | 56.00 |
| 57. 00 05700 CT SCAN | o | | | 0 | 0 | 57.00 |
| 58. 00 05800 MRI | o | | | 0 | 0 | 58.00 |
| 60. 00 06000 LABORATORY | 18, 059, 242 | | 18, 059, 242 | 0 | 18, 059, 242 | 60.00 |
| 65. 00 06500 RESPIRATORY THERAPY | 4, 116, 317 | 0 | 4, 116, 317 | 0 | 4, 116, 317 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 4, 711, 058 | 0 | 4, 711, 058 | 0 | 4, 711, 058 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 1, 170, 022 | 0 | 1, 170, 022 | 0 | 1, 170, 022 | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 1, 157, 822 | 0 | 1, 157, 822 | 0 | 1, 157, 822 | 68. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 10, 417, 604 | | 10, 417, 604 | | | |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 1, 334, 750 | | 1, 334, 750 | | 1, 334, 750 | |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 25, 786, 894 | | 25, 786, 894 | | | |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 45, 517, 162 | | 45, 517, 162 | | 45, 517, 162 | |
| 74.00 07400 RENAL DIALYSIS | 928, 771 | | 928, 771 | | 928, 771 | |
| 76. 00 03950 ANCI LLARY | ol | | l | 0 | | 76.00 |
| 76. 01 03610 SLEEP LAB | ol | | | 0 | 0 | 76. 01 |
| 76. 03 03951 WOUND CARE | 3, 104, 555 | | 3, 104, 555 | 0 | 3, 104, 555 | |
| OUTPATIENT SERVICE COST CENTERS | ., .,, | | | | ., ., | |
| 90. 00 09000 CLI NI C | 684 | | 684 | . 0 | 684 | 90.00 |
| 91. 00 09100 EMERGENCY | 16, 821, 630 | | 16, 821, 630 | 0 | 16, 821, 630 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 3, 780, 099 | | 3, 780, 099 | | 3, 780, 099 | |
| 200.00 Subtotal (see instructions) | 254, 136, 817 | 0 | | | | |
| 201.00 Less Observation Beds | 3, 780, 099 | | 3, 780, 099 | | 3, 780, 099 | |
| 202.00 Total (see instructions) | 250, 356, 718 | 0 | | | | |
| 1 | | | | | | |

| | | | | Fo 12/31/2020 | Date/Time Pre 7/28/2021 4:30 | |
|--|-----------------------------|------------------|------------------|---------------|---------------------------------|------------------|
| | | 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) | Ratio | I npati ent | |
| | | | | | Ratio | |
| | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | , | | | , | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 141, 248, 855 | | 141, 248, 85 | | | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | 31, 388, 985 | | 31, 388, 985 | | | 31.00 |
| 31. 01 03101 NEONATAL INTENSIVE CARE UNIT | 17, 173, 909 | | 17, 173, 90 | | | 31.01 |
| 41. 00 04100 SUBPROVI DER - RF | 9, 396, 446 | | 9, 396, 440 | | | 41.00 |
| 43. 00 04300 NURSERY | 4, 220, 904 | | 4, 220, 90 | 1 | | 43. 00 |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50. 00 05000 OPERATI NG ROOM | 139, 166, 973 | 213, 292, 333 | | | 0. 000000 | 50.00 |
| 51. 00 05100 RECOVERY ROOM | 0 | 0 | 1 | 0.000000 | 0. 000000 | 51.00 |
| 52. 00 05200 DELI VERY ROOM & LABOR ROOM | 16, 921, 983 | 127, 341 | 17, 049, 324 | | 0. 000000 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 9, 048, 295 | 13, 005, 606 | | | 0. 000000 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 59, 189, 117 | 187, 745, 019 | 246, 934, 136 | | 0. 000000 | 54.00 |
| 54. 01 05401 ULTRASOUND | 0 | 0 | (| 0. 000000 | 0. 000000 | 54. 01 |
| 56. 00 05600 RADI 01 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 | 105 575 010 | 100 007 710 | 005 574 70 | 0.000000 | 0.000000 | 58.00 |
| 60. 00 06000 LABORATORY | 105, 575, 010 | 129, 996, 712 | | | 0. 000000 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 48, 020, 548 | 2, 064, 041 | | | 0. 000000 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 14, 658, 922 | 7, 245, 167 | | | 0. 000000 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 10, 761, 355 | 1, 457, 331 | | | 0.000000 | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 3, 877, 762 | 1, 653, 856 | | | 0.000000 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 64, 607, 379 | 107, 454, 073 | | | 0.000000 | 69.00 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 21, 600, 254 | 18, 934, 416 | | I | 0.000000 | 71.00 |
| 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS | 91, 200, 350 | 65, 547, 183 | | | 0. 000000 0. 000000 | 72. 00 73. 00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DI ALYSI S | 72, 492, 504 4, 077, 806 | 220, 740, 080 | | | 0. 000000 | 74.00 |
| 74. 00 07400 RENAL DI ALYSIS 76. 00 03950 ANCI LLARY | 4,077,806 | 75, 671 0 | | | 0. 000000 | 76.00 |
| 76. 00 03930 ANCTELARY 76. 01 03610 SLEEP LAB | 0 | 0 | 9 | 0. 000000 | 0. 000000 | 76.00 |
| | 409, 788 | 12, 233, 401 | 12, 643, 189 | | 0. 000000 | 76.01 |
| 76. 03 03951 WOUND CARE OUTPATIENT SERVICE COST CENTERS | 409, 788 | 12, 233, 401 | 12, 043, 18 | 0. 245552 | 0.000000 | 76.03 |
| 90. 00 09000 CLINIC | l ol | 546, 852 | 546, 852 | 0. 001251 | 0. 000000 | 90.00 |
| 91. 00 09100 EMERGENCY | 68, 038, 381 | 115, 964, 586 | | | 0. 000000 | 91.00 |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 5, 639, 834 | 8, 856, 918 | | | 0. 000000 | 91.00 |
| 200.00 Subtotal (see instructions) | | 1, 106, 940, 586 | | | | 200.00 |
| 201.00 Less Observation Beds | 730, / 13, 300 | 1, 100, 940, 580 | 2, 043, 033, 940 | | | 200.00 |
| 202.00 Total (see instructions) | 020 715 240 | 1, 106, 940, 586 | 2 045 655 044 | | | 201.00 |
| 202.00 TOTAL (SEE THISTINGTIONS) | 730, / 13, 300 | 1, 100, 940, 580 | 2, 045, 055, 940 | 기 | | ZUZ. UU |

| Health Financial Systems | PORTER MEMORIAL | HOSPI TAL | In Lie | u of Form CMS-2 | 2552-10 |
|--|-----------------|------------------------|-----------------|---|---------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | | Provi der CCN: 15-0035 | From 01/01/2020 | Worksheet C Part I Date/Time Prep 7/28/2021 4:30 | |
| | | Title XIX | Hospi tal | Cost | |
| Cost Center Description | PPS Inpatient | | | | |

| | | | 10 12/31/2020 | 7/28/2021 4:36 pm |
|---|---------------|-----------|---------------|--------------------|
| | | Title XIX | Hospi tal | Cost |
| Cost Center Description | PPS Inpatient | | | |
| | Ratio | | | |
| | 11. 00 | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS | | | | 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 01 SOTOPE | 0. 000000 | | | 56.00 |
| 57. 00 05700 CT SCAN | 0. 000000 | | | 57.00 |
| 58. 00 05800 MRI | 0. 000000 | | | 58.00 |
| 60. 00 06000 LABORATORY | 0. 000000 | | | 60.00 |
| 65. 00 06500 RESPI RATORY 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 I MPL. DEV. CHARGED TO PATIENTS | 0. 000000 | | | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 0. 000000 | | | 73.00 |
| 74. 00 07400 RENAL DI ALYSI S | 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 |
| OUTPATIENT SERVICE COST CENTERS | 0.000000 | | | 00.00 |
| 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 |
| 200.00 Subtotal (see instructions) 201.00 Less Observation Beds | | | | 200. 00 201. 00 |
| | | | | l |
| 202.00 Total (see instructions) | 1 | | | 202.00 |

| Heal th | Financial Systems | PORTER MEMORI | AL_HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---------|--|---------------|--------------|--------------|---|-----------------------------|---------|
| APPORT | IONMENT OF INPATIENT ROUTINE SERVICE CAPITAL | COSTS | Provider C | | Period: From 01/01/2020 To 12/31/2020 | Date/Time Pre 7/28/2021 4:3 | |
| | | | Title | XVIII | Hospi tal | PPS | |
| | Cost Center Description | Capi tal | Swing Bed | Reduced | Total Patient | Per Diem | |
| | | Related Cost | Adjustment | Capi tal | Days | (col. 3 / | |
| | | (from Wkst. | | Related Cost | | col. 4) | |
| | | B, Part II, | | (col. 1 - | | | |
| | | col. 26) | | col. 2) | | | |
| | | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 | ADULTS & PEDIATRICS | 3, 547, 294 | 0 | 3, 547, 29 | | 75. 14 | |
| 31. 00 | INTENSIVE CARE UNIT | 651, 961 | | 651, 96° | | 117. 79 | |
| 31. 01 | NEONATAL INTENSIVE CARE UNIT | 242, 696 | | 242, 69 | | | 31. 01 |
| 41.00 | SUBPROVI DER - I RF | 427, 506 | | 427, 50 | • | 134. 35 | |
| | NURSERY | 75, 025 | | 75, 02! | • | 31. 26 | |
| 200.00 | Total (lines 30 through 199) | 4, 944, 482 | | 4, 944, 48 | 2 61, 325 | | 200. 00 |
| | Cost Center Description | I npati ent | I npati ent | | | | |
| | | Program days | Program | | | | |
| | | | Capital Cost | | | | |
| | | | (col. 5 x | | | | |
| | | | col. 6) | | | | |
| | | 6. 00 | 7. 00 | | | | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | 1 | | 1 | | | |
| 30.00 | ADULTS & PEDIATRICS | 16, 536 | | | | | 30.00 |
| 31.00 | INTENSIVE CARE UNIT | 1, 998 | | | | | 31.00 |
| 31. 01 | NEONATAL INTENSIVE CARE UNIT | 0 | 0 | 1 | | | 31. 01 |
| 41.00 | SUBPROVIDER - IRF | 1, 946 | | 1 | | | 41.00 |
| 43.00 | NURSERY | 0 | 0 | | | | 43.00 |
| 200.00 | Total (lines 30 through 199) | 20, 480 | 1, 739, 304 | | | | 200. 00 |

| Health Financial Systems | PORTER MEMORI | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|--|---------------|------------------|--------------|----------------------------------|-----------------------------|----------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT | AL COSTS | Provi der Co | | Peri od: | Worksheet D | |
| | | | | From 01/01/2020 To 12/31/2020 | Part II | narad. |
| | | | | To 12/31/2020 | Date/Time Pre 7/28/2021 4:3 | |
| | | Title | XVIII | Hospi tal | PPS | <u> </u> |
| Cost Center Description | Capi tal | Total Charges | Ratio of Cos | | Capital Costs | |
| | Related Cost | (from Wkst. | to Charges | Program | (column 3 x | |
| | (from Wkst. | C, Part I, | (col. 1 ÷ | Charges | column 4) | |
| | B, Part II, | col. 8) | col. 2) | | | |
| | col. 26) | | | | | |
| | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 2, 055, 722 | | 0. 00583 | | 265, 766 | |
| 51.00 05100 RECOVERY ROOM | 0 | _ | 0. 00000 | | 0 | 51.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 413, 052 | | | · · | 387 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 34, 728 | | 0. 00157 | | 3, 827 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 1, 351, 743 | 246, 934, 136 | | | 129, 627 | 54.00 |
| 54. 01 05401 ULTRASOUND | 0 | 0 | 0. 00000 | 0 | 0 | 54. 01 |
| 56. 00 05600 RADI 0I SOTOPE | 0 | 0 | 0. 00000 | | 0 | 56.00 |
| 57.00 05700 CT SCAN | 0 | 0 | 0. 00000 | 0 | 0 | 57.00 |
| 58. 00 05800 MRI | 0 | 0 | 0. 00000 | | 0 | 58. 00 |
| 60. 00 06000 LABORATORY | 523, 112 | 235, 571, 722 | 0. 00222 | 1 38, 080, 916 | 84, 578 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 112, 329 | 50, 084, 589 | 0. 00224 | 3 20, 261, 800 | 45, 447 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 535, 737 | 21, 904, 089 | 0. 02445 | 8 4, 687, 939 | 114, 658 | 66. 00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 4, 156 | | | 0 3, 338, 777 | 1, 135 | |
| 68.00 06800 SPEECH PATHOLOGY | 3, 860 | 5, 531, 618 | 0. 00069 | 8 1, 250, 422 | 873 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 931, 612 | 172, 061, 452 | 0. 00541 | 4 26, 003, 880 | 140, 785 | 69.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 15, 386 | 40, 534, 670 | 0. 00038 | 7, 458, 940 | 2, 834 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 298, 783 | 156, 747, 533 | 0. 00190 | 6 36, 860, 586 | 70, 256 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 354, 817 | 293, 232, 584 | 0. 00121 | 0 24, 005, 548 | 29, 047 | 73.00 |
| 74.00 07400 RENAL DIALYSIS | 21, 823 | 4, 153, 477 | 0. 00525 | 4 1, 979, 620 | 10, 401 | 74.00 |
| 76. 00 03950 ANCI LLARY | 0 | 0 | 0. 00000 | o o | 0 | 76.00 |
| 76. 01 03610 SLEEP LAB | 0 | 0 | 0. 00000 | o o | 0 | 76. 01 |
| 76. 03 03951 WOUND CARE | 213, 502 | 12, 643, 189 | 0. 01688 | 7 94, 681 | 1, 599 | 76. 03 |
| OUTPATIENT SERVICE COST CENTERS | * | | | | | |
| 90. 00 09000 CLI NI C | 22 | 546, 852 | 0.00004 | 0 0 | 0 | 90.00 |
| 91. 00 09100 EMERGENCY | 1, 427, 362 | | | | 200, 004 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 299, 342 | | | | 45, 503 | 92.00 |
| 200.00 Total (lines 50 through 199) | 8, 597, 088 | 1, 842, 226, 847 | | 263, 699, 054 | | |

| Health Financial Systems | PORTER MEMORI | AL HOSPITAL | | In Lie | u of Form CMS-: | 2552-10 |
|---|--|--|---|--|---|----------------------------------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA | ASS THROUGH COS | | | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part III | pared: |
| | | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | Nursing School Post-Stepdown Adjustments | Nursi ng School | Allied Healt Post-Stepdow Adjustments | n 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 43. 00 04300 NURSERY 200. 00 Total (Lines 30 through 199) | 0 0 0 | 0 0 0 0 | | 0 0 0 0 0 0 0 0 0 0 0 0 | 0 0 0 0 | 31. 00 31. 01 41. 00 |
| Cost Center Description | Swi ng-Bed | Total Costs | Total Patien | - | Inpati ent | 200.00 |
| Cost Center Description | Adjustment Amount (see | (sum of cols. 1 through 3, minus col. 4) | Days | (col. 5 ÷ col. 6) | Program Days | |
| | 4. 00 | 5. 00 | 6.00 | 7. 00 | 8. 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 200. 00 Total (Lines 30 through 199) | 0 | 0 0 0 0 0 | 5, 53 2, 99 3, 18 2, 40 | 0. 00 06 0. 00 02 0. 00 00 0. 00 | 0 1, 946 0 | 31. 00 31. 01 41. 00 |
| Cost Center Description | Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 | 0 | ₁ 01, 32 | <u>√</u> | 20, 400 | 250.00 |
| 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 SUBPROVI DER - IRF | 0 0 0 | | | | | 30.00 31.00 31.01 41.00 |
| 43.00 04300 NURSERY 200.00 Total (lines 30 through 199) | 0 | | | | | 43. 00 200. 00 |

| Peri od: | Worksheet D | From 01/01/2020 | Part IV | To | 12/31/2020 | Date/Time | Prepared: THROUGH COSTS

| | | | | 10 12/31/2020 | 7/28/2021 4: 3 | |
|--|---------------|---------------|----------|---------------|----------------|---------|
| | | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | Non Physician | Nursi ng | Nursi ng | Allied Health | Allied Health | |
| | Anesthetist | School | School | Post-Stepdown | | |
| | Cost | Post-Stepdown | | Adjustments | | |
| | | Adjustments | | | | |
| | 1. 00 | 2A | 2. 00 | 3A | 3. 00 | |
| ANCILLARY SERVICE COST CENTERS | | | | | | 1 |
| 50. 00 05000 OPERATI NG ROOM | 0 | 0 | 1 | 0 | 0 | |
| 51. 00 05100 RECOVERY ROOM | 0 | 0 | 1 | 0 | 0 | 51.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | | 0 | 0 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0 | 0 | | 0 | 0 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | | 0 | 0 | 54.00 |
| 54. 01 05401 ULTRASOUND | 0 | 0 | | 0 | 0 | 54. 01 |
| 56. 00 05600 RADI 0I SOTOPE | 0 | 0 | | 0 | 0 | 56. 00 |
| 57. 00 05700 CT SCAN | 0 | 0 | | 0 | 0 | 07.00 |
| 58. 00 05800 MRI | 0 | 0 | | 0 | 0 | |
| 60. 00 06000 LABORATORY | 0 | 0 | | 0 | 0 | |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 0 | | 0 | 0 | 00.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 0 | | 0 | 0 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0 | 0 | | 0 | 0 | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 0 | 0 | | 0 | 0 | 68. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | | 0 | 0 | 69.00 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0 | 0 | | 0 | 0 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 0 | | 0 | 0 | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | 0 | 0 | |
| 74. 00 07400 RENAL DI ALYSI S | 0 | 0 | | 0 | 0 | |
| 76. 00 03950 ANCI LLARY | 0 | 0 | | 0 | 0 | |
| 76. 01 03610 SLEEP LAB | 0 | 0 | | 0 | 0 | |
| 76. 03 03951 WOUND CARE | 0 | 0 | (| 0 | 0 | 76. 03 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | 1 |
| 90. 00 09000 CLI NI C | 0 | 0 | | 0 | 0 | |
| 91. 00 09100 EMERGENCY | 0 | 0 | 1 | 0 | 0 | |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0 | | | O C | 0 | 1 |
| 200.00 Total (lines 50 through 199) | 0 | 0 | 1 | 0 | 0 | 200. 00 |

| Health Financial Systems | PORTER MEMORIAL HOSPITAL | In Lieu of Form CMS-2552-1 | 0 |
|---------------------------------------|--|-----------------------------|---|
| APPORTIONMENT OF INPATIENT/OUTPATIENT | ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0035 | | _ |
| | | From 01/01/2020 Dorst 11/ | |

From 01/01/2020 | Part IV To 12/31/2020 | Date/Time Prepared: THROUGH COSTS 7/28/2021 4:36 pm Title XVIII Hospi tal All Other Ratio of Cost Cost Center Description Total Cost Total Total Charges to Charges Medi cal (sum of cols. Outpati ent (from Wkst. (col. 5 ÷ Educati on 1, 2, 3, and Cost (sum of C, Part I, 4) Cost col s. 2, 3, col. 8) col. 7) and 4) (see instructions) 4. 00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 352, 459, 306 0.000000 50.00 05100 RECOVERY ROOM 0 0 0.000000 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 17, 049, 324 52.00 52.00 0 53. 00 | 05300 | ANESTHESI OLOGY 0 0 22, 053, 901 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 246, 934, 136 0.000000 54.00 54.01 05401 ULTRASOUND 0 0.000000 54.01 0 56.00 05600 RADI OI SOTOPE 0 0 0.000000 56.00 57.00 05700 CT SCAN 0 0 0.000000 57.00 58.00 05800 MRI 0.000000 58.00 0 60.00 06000 LABORATORY 0 235, 571, 722 0.000000 60.00 06500 RESPIRATORY THERAPY 0 0 50, 084, 589 0.000000 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 21, 904, 089 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 12, 218, 686 0.000000 67.00 67.00 06800 SPEECH PATHOLOGY 0.000000 68 00 5, 531, 618 68 00 69.00 06900 ELECTROCARDI OLOGY 0 172, 061, 452 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 40, 534, 670 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 156, 747, 533 72.00 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0.000000 73 00 0 293, 232, 584 73 00 07400 RENAL DIALYSIS 0 74.00 0 4, 153, 477 0.000000 74.00 76. 00 03950 ANCI LLARY 0.000000 76.00 03610 SLEEP LAB 76. 01 0 0 0.000000 76.01 03951 WOUND CARE O 12, 643, 189 0.000000 76.03 0 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0.000000 90.00 0 546, 852 91. 00 09100 EMERGENCY 0 0 184, 002, 967 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0.000000 0 14, 496, 752 92.00 0 200.00 Total (lines 50 through 199) 0 1, 842, 226, 847 200.00

| Health Financial Systems | PORTER MEMORIAL | HOSPI TAL | In Lieu | ı of Form CMS-2552-10 |
|---|--------------------------------|---|--|--|
| APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS | ANCI LLARY SERVI CE OTHER PASS | Provider CCN: 15-0035 | Peri od: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/28/2021 4:36 pm |
| | | T' 11 . \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ | 11 | 20 |

| | | | To | 12/31/2020 | Date/Time Pre 7/28/2021 4:3 | |
|---|---------------|---------------|---------------|---------------|-----------------------------|----------|
| | | Title | XVIII | Hospi tal | PPS | <u> </u> |
| Cost Center Description | Outpati ent | I npati ent | I npati ent | Outpati ent | Outpati ent | |
| | Ratio of Cost | Program | Program | Program | Program | |
| | to Charges | Charges | Pass-Through | Charges | Pass-Through | |
| | (col. 6 ÷ | | Costs (col. 8 | - | Costs (col. 9 | |
| | col. 7) | | x col. 10) | | x col. 12) | |
| | 9. 00 | 10. 00 | 11. 00 | 12.00 | 13. 00 | |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 05000 OPERATI NG ROOM | 0. 000000 | 45, 562, 476 | 0 | 61, 362, 870 | 0 | 50.00 |
| 51.00 05100 RECOVERY ROOM | 0. 000000 | 0 | 0 | 0 | 0 | 51.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0. 000000 | 15, 965 | 0 | 0 | 0 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0. 000000 | 2, 429, 700 | 0 | 3, 412, 432 | 0 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0. 000000 | 23, 680, 456 | 0 | 51, 445, 884 | 0 | 54.00 |
| 54. 01 05401 ULTRASOUND | 0. 000000 | 0 | 0 | 0 | 0 | 54.01 |
| 56. 00 05600 RADI 0I SOTOPE | 0. 000000 | 0 | 0 | 0 | 0 | 56.00 |
| 57. 00 05700 CT SCAN | 0. 000000 | 0 | 0 | 0 | 0 | 57.00 |
| 58. 00 05800 MRI | 0. 000000 | 0 | 0 | 0 | 0 | 58.00 |
| 60. 00 06000 LABORATORY | 0. 000000 | 38, 080, 916 | 0 | 14, 595, 147 | 0 | 60.00 |
| 65. 00 06500 RESPIRATORY THERAPY | 0. 000000 | 20, 261, 800 | 0 | 635, 972 | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0. 000000 | 4, 687, 939 | 0 | 122, 300 | 0 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0. 000000 | 3, 338, 777 | 0 | 48, 285 | 0 | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 0. 000000 | 1, 250, 422 | 0 | 12, 546 | 0 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0. 000000 | 26, 003, 880 | 0 | 41, 355, 801 | 0 | 69.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0. 000000 | 7, 458, 940 | 0 | 4, 597, 391 | 0 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 0. 000000 | 36, 860, 586 | 0 | 23, 532, 920 | 0 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0. 000000 | 24, 005, 548 | 0 | 87, 943, 595 | 0 | 73.00 |
| 74. 00 07400 RENAL DIALYSIS | 0. 000000 | 1, 979, 620 | 0 | 66, 985 | 0 | 74.00 |
| 76. 00 03950 ANCI LLARY | 0. 000000 | 0 | 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 | 94, 681 | 0 | 4, 579, 290 | 0 | 76. 03 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90. 00 09000 CLI NI C | 0. 000000 | 0 | 0 | 0 | 0 | 90.00 |
| 91. 00 09100 EMERGENCY | 0. 000000 | 25, 783, 704 | 0 | 18, 695, 316 | 0 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0. 000000 | 2, 203, 644 | 0 | 2, 283, 342 | 0 | 92.00 |
| 200.00 Total (lines 50 through 199) | | 263, 699, 054 | 0 | 314, 690, 076 | 0 | 200. 00 |

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-0035 Worksheet D From 01/01/2020 Part V 12/31/2020 Date/Time Prepared: 7/28/2021 4:36 pm Title XVIII Hospi tal PPS Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, Subject To Subject To inst.) Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 40, 478 0.076184 61, 362, 870 4, 674, 869 50.00 05100 RECOVERY ROOM 0.000000 51.00 0 0 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0. 315665 0 52.00 53.00 05300 ANESTHESI OLOGY 0.008382 3, 412, 432 0 28,603 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.073633 51, 445, 884 0 0 3, 788, 115 54.00 0 05401 ULTRASOUND 54.01 0.000000 0 54.01 C Ω 0 56.00 05600 RADI OI SOTOPE 0.000000 C 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 0 14, 595, 147 06000 LABORATORY 1, 118, 879 60.00 0.076661 21, 311 60.00 65.00 06500 RESPIRATORY THERAPY 0.082187 635, 972 0 52, 269 65.00 06600 PHYSI CAL THERAPY 122, 300 0 o 66.00 0.215077 26, 304 66.00 0 06700 OCCUPATIONAL THERAPY 0.095757 0 67 00 48 285 4 624 67 00 68.00 06800 SPEECH PATHOLOGY 0.209310 12, 546 0 2,626 68.00 69.00 06900 ELECTROCARDI OLOGY 0.060546 41, 355, 801 0 2, 503, 928 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.032929 4, 597, 391 0 0 151, 387 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72 00 0 164512 23, 532, 920 0 3, 871, 448 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.155225 87, 943, 595 0 133, 317 13, 651, 045 73.00 74.00 07400 RENAL DIALYSIS 0. 223613 66, 985 14, 979 74.00 76.00 03950 ANCI LLARY 0.000000 0 0 ol 0 76.00 03610 SLEEP LAB 0.000000 0 0 76.01 0 76.01 03951 WOUND CARE 76.03 0. 245552 4, 579, 290 5, 500 1, 124, 454 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.001251 90.00 6,681 0 0. 091420 1, 709, 126 91.00 09100 EMERGENCY 18, 695, 316 465 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 260755 2, 283, 342 0 595, 393 92.00 200.00 Subtotal (see instructions) 314, 690, 076 73, 970 133, 782 33, 318, 049 200.00 Less PBP Clinic Lab. Services-Program 201.00 201. 00

314, 690, 076

73, 970

133, 782

33, 318, 049 202. 00

Only Charges

202.00

Net Charges (line 200 - line 201)

| Health Financial Systems | ; ; | PORTER MEMORIAL | HOSPI TAL | In Lieu | of Form CMS-2552-10 |
|---------------------------|--------------------------|------------------|------------------------|--|--|
| APPORTI ONMENT OF MEDICAL | _, OTHER HEALTH SERVICES | AND VACCINE COST | Provi der CCN: 15-0035 | Peri od: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: |

| | | | | From 01/01/2020 To 12/31/2020 | Part V Date/Time Pre | anarad: |
|---|---------------|---------------|-------|----------------------------------|--------------------------|---------|
| | | | | 10 12/31/2020 | 7/28/2021 4:3 | 36 pm |
| | | Title | XVIII | Hospi tal | PPS | |
| | Cos | sts | | | | |
| Cost Center Description | Cost | Cost | | | | |
| | Rei mbursed | Rei mbursed | | | | |
| | Servi ces | Services Not | | | | |
| | Subject To | Subject To | | | | |
| | Ded. & Coins. | Ded. & Coins. | | | | |
| | (see inst.) | (see inst.) | | | | |
| | 6. 00 | 7. 00 | | | | |
| ANCILLARY SERVICE COST CENTERS | | _ | 1 | | | |
| 50. 00 05000 OPERATING ROOM | 3, 084 | l | 1 | | | 50.00 |
| 51.00 05100 RECOVERY ROOM | 0 | 1 | 1 | | | 51.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | ł | | | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0 | 0 | ł | | | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | ł | | | 54.00 |
| 54. 01 05401 ULTRASOUND | 0 | 0 | 1 | | | 54. 01 |
| 56. 00 05600 RADI OI SOTOPE | 0 | 0 | 1 | | | 56.00 |
| 57.00 05700 CT SCAN | 0 | 0 | 1 | | | 57.00 |
| 58. 00 05800 MRI | 0 | 0 | l . | | | 58. 00 |
| 60. 00 06000 LABORATORY | 1, 634 | ł | 1 | | | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 0 | 1 | | | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 0 | 1 | | | 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 | 20, 694 | 1 | | | 73.00 |
| 74. 00 07400 RENAL DI ALYSI S | 0 | 0 | ł | | | 74.00 |
| 76. 00 03950 ANCI LLARY | 0 | 0 | • | | | 76.00 |
| 76. 01 03610 SLEEP LAB | 0 | 0 | 1 | | | 76. 01 |
| 76. 03 03951 WOUND CARE | 1, 351 | 0 | | | | 76. 03 |
| OUTPATIENT SERVICE COST CENTERS | | | I | | | 00.00 |
| 90. 00 09000 CLI NI C | 8 | 0 | 1 | | | 90.00 |
| 91. 00 09100 EMERGENCY | | 43 | | | | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0 | 0 | 1 | | | 92.00 |
| 200.00 Subtotal (see instructions) | 6, 077 | 20, 737 | | | | 200.00 |
| 201.00 Less PBP Clinic Lab. Services-Program | 0 | | | | | 201. 00 |
| Only Charges (Line 200 Line 201) | 4 077 | 20 727 | | | | 202 00 |
| 202.00 Net Charges (line 200 - line 201) | 6, 077 | 20, 737 | I | | | 202. 00 |

| Health Financial Systems | PORTER MEMORI | | | | u of Form CMS-2 | 2552-10 |
|---|---------------|------------------|--------------|----------------------------------|-----------------|---------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA | AL COSTS | Provi der C | CN: 15-0035 | Peri od: | Worksheet D | |
| | | Component | CCN: 15-T035 | From 01/01/2020 To 12/31/2020 | | narod: |
| | | Component | CCN. 13-1033 | 10 12/31/2020 | 7/28/2021 4: 3 | |
| | | Title | XVIII | Subprovi der - | PPS | |
| | | | | I RF | | |
| Cost Center Description | Capi tal | Total Charges | Ratio of Cos | t Inpatient | Capital Costs | |
| | Related Cost | (from Wkst. | to Charges | Program | (column 3 x | |
| | (from Wkst. | C, Part I, | (col. 1 ÷ | Charges | column 4) | |
| | B, Part II, | col. 8) | col. 2) | | | |
| | col . 26) | | | | | |
| | 1. 00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 2, 055, 722 | | | | | 50.00 |
| 51.00 05100 RECOVERY ROOM | 0 | | 0.0000 | | _ | 51.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 413, 052 | | | | 0 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 34, 728 | | | | | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 1, 351, 743 | 246, 934, 136 | | | | 54.00 |
| 54. 01 05401 ULTRASOUND | 0 | 0 | 0. 00000 | | 0 | 54. 01 |
| 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 | 523, 112 | | | | | 60.00 |
| 65. 00 06500 RESPIRATORY THERAPY | 112, 329 | | | | | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 535, 737 | | | | | 66. 00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 4, 156 | | | | | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 3, 860 | | | | | 68. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 931, 612 | | | | | 69. 00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 15, 386 | | | | | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 298, 783 | | | | | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 354, 817 | | | | | |
| 74. 00 07400 RENAL DI ALYSI S | 21, 823 | 4, 153, 477 | | | | |
| 76. 00 03950 ANCI LLARY | 0 | 0 | 0. 00000 | | 0 | 76. 00 |
| 76. 01 03610 SLEEP LAB | 0 | 0 | 0. 00000 | | 0 | 76. 01 |
| 76. 03 03951 WOUND CARE | 213, 502 | 12, 643, 189 | 0. 01688 | 1, 950 | 33 | 76. 03 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90. 00 09000 CLI NI C | 22 | | | | | 90.00 |
| 91. 00 09100 EMERGENCY | 1, 427, 362 | | | | 64 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0 | 14, 496, 752 | l . | | 0 | 92.00 |
| 200.00 Total (lines 50 through 199) | 8, 297, 746 | 1, 842, 226, 847 | l | 6, 526, 200 | 50, 029 | 200. 00 |

| Health Financial Systems | PORTER MEMORI | | | | ieu of Form CMS- | 2552-10 |
|--|--------------------------------------|--|-----------------------------|--|---|----------------------------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS | RVICE OTHER PAS | | CN: 15-0035 CCN: 15-T035 | Period: From 01/01/20 To 12/31/20 | | epared: |
| | | Title | XVIII | Subprovi der I RF | | - P.III |
| Cost Center Description | Non Physician Anesthetist Cost | School Post-Stepdown Adjustments | Nursi ng School | Allied Heal Post-Stepdon Adjustments | 6 | |
| ANOLI LADV CERVI OF COCT OFFITERS | 1. 00 | 2A | 2. 00 | 3A | 3. 00 | - |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50. 00 05000 0PERATI NG ROOM 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 0 0 0 0 | 0 0 0 | | 0 0 0 0 | 0 0 0 0 0 0 0 0 0 | 51.00 52.00 53.00 |
| 54. 01 05401 ULTRASOUND 56. 00 05600 RADI OI SOTOPE 57. 00 05700 CT SCAN 58. 00 05800 MRI | 0 0 0 | 0 0 0 | | 0 0 0 | 0 0 0 0 0 0 | 56. 00 57. 00 |
| 60. 00 | 0 | 0 | | 0 0 0 | 0 | 60. 00 65. 00 66. 00 |
| 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT | 0 0 | 0 0 | | 0 0 | 0 0 0 | 68. 00 69. 00 |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DI ALYSI S 76. 00 03950 ANCI LLARY | 0 0 0 | 0 0 | | 0 0 0 | 0 0 0 0 0 0 | 73. 00 74. 00 |
| 76. 01 03930 ANCIELARY 76. 01 03610 SLEEP LAB 76. 03 03951 WOUND CARE OUTPATIENT SERVICE COST CENTERS | 0 0 | 0 0 | | 0 0 | 0 0 0 | 76. 01 |
| 90. 00 | 0 0 0 0 | 0 | | 0 0 0 0 | 0 | 91.00 |

| Health Financial Customs | PORTER MEMORI | AL HOSDITAL | | ln lio | u of Form CMS-2 | DEED 10 |
|--|----------------|---------------|--------------|----------------------------------|-----------------|----------------|
| Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER | | | CN: 1E 002E | Period: | Worksheet D | 2552-10 |
| THROUGH COSTS | VICE UTHER PAS | | | From 01/01/2020 To 12/31/2020 | Part IV | pared: 6 pm |
| | | Title | · XVIII | Subprovi der - | PPS | • |
| | | T | | I RF | | |
| Cost Center Description | All Other | Total Cost | Total | Total Charges | | |
| | Medi cal | (sum of cols. | Outpati ent | (from Wkst. | to Charges | |
| | Educati on | 1, 2, 3, and | Cost (sum of | | (col. 5 ÷ | |
| | Cost | 4) | col s. 2, 3, | col. 8) | col. 7) | |
| | | | and 4) | | (see | |
| | | | | | instructions) | |
| | 4. 00 | 5. 00 | 6. 00 | 7. 00 | 8. 00 | |
| ANCILLARY SERVICE COST CENTERS | _1 | | T | | | |
| 50. 00 05000 OPERATI NG ROOM | 0 | | | 0 352, 459, 306 | 0. 000000 | |
| 51. 00 05100 RECOVERY ROOM | 0 | 0 | | 0 0 | 0. 000000 | |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | | 0 17, 049, 324 | 0. 000000 | |
| 53. 00 05300 ANESTHESI OLOGY | 0 | 0 | | 0 22, 053, 901 | 0. 000000 | |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | | 0 246, 934, 136 | 0. 000000 | |
| 54. 01 05401 ULTRASOUND | 0 | 0 | | 0 | 0. 000000 | |
| 56. 00 05600 RADI 0I SOTOPE | 0 | 0 | | 0 | 0. 000000 | |
| 57. 00 05700 CT SCAN | 0 | 0 | | 0 | 0.000000 | |
| 58. 00 05800 MRI | 0 | 0 | | 0 | 0.000000 | |
| 60. 00 06000 LABORATORY | 0 | 0 | | 0 235, 571, 722 | 0.000000 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 0 | | 0 50, 084, 589 | 0.000000 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 0 | | 0 21, 904, 089 | 0.000000 | |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0 | 0 | | 0 12, 218, 686 | 0.000000 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 0 | | 0 5, 531, 618 | 0.000000 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | | 0 172, 061, 452 | 0.000000 | 69.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0 | 0 | | 0 40, 534, 670 | 0.000000 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 0 | | 0 156, 747, 533 | 0.000000 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | 0 293, 232, 584 | 0.000000 | 73.00 |
| 74.00 07400 RENAL DIALYSIS | 0 | 0 | | 0 4, 153, 477 | 0.000000 | 74.00 |
| 76. 00 03950 ANCI LLARY | 0 | 0 | | 0 | 0.000000 | 76.00 |
| 76. 01 03610 SLEEP LAB | o | 0 | | 0 | 0.000000 | 76. 01 |
| 76. 03 03951 WOUND CARE | o | 0 | | 0 12, 643, 189 | 0.000000 | 76. 03 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90. 00 09000 CLI NI C | 0 | 0 | | 0 546, 852 | 0.000000 | 90.00 |
| 91. 00 09100 EMERGENCY | 0 | 0 | | 0 184, 002, 967 | 0.000000 | 91.00 |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0 | 0 | | 0 14, 496, 752 | 0.000000 | 92.00 |
| 200.00 Total (lines 50 through 199) | 0 | 0 | | 0 1, 842, 226, 847 | | 200. 00 |
| | . ' | • | • | • | | • |

| Health Financial Systems | PORTER MEMORIAL | HOSPI TAL | | | u of Form CMS-2 | 2552-10 |
|--|-------------------|------------------|--------------|-----------------|-----------------------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE | ERVICE OTHER PASS | Provi der Co | CN: 15-0035 | Peri od: | Worksheet D | |
| THROUGH COSTS | | | 00N 45 T005 | From 01/01/2020 | | |
| | | component | CCN: 15-T035 | To 12/31/2020 | Date/Time Pre 7/28/2021 4:3 | |
| | | Title | XVIII | Subprovi der - | PPS | о рііі |
| | | 11 11 0 | 7,4111 | IRF | 110 | |
| Cost Center Description | Outpati ent | I npati ent | I npati ent | Outpati ent | Outpati ent | |
| | Ratio of Cost | Program | Program | Program | Program | |
| | to Charges | Charges | Pass-Through | n Charges | Pass-Through | |
| | (col. 6 ÷ | , and the second | Costs (col. | 8 | Costs (col. 9 | |
| | col. 7) | | x col. 10) | | x col. 12) | |
| | 9. 00 | 10. 00 | 11. 00 | 12.00 | 13.00 | |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 0. 000000 | 19, 439 | | 0 | 0 | |
| 51.00 05100 RECOVERY ROOM | 0. 000000 | 0 | | 0 | 0 | |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0. 000000 | 0 | | 0 | 0 | |
| 53. 00 05300 ANESTHESI OLOGY | 0. 000000 | 1, 071 | | 0 0 | 0 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0. 000000 | 191, 275 | | 0 | 0 | 54.00 |
| 54. 01 05401 ULTRASOUND | 0. 000000 | 0 | | 0 | 0 | |
| 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 | 0. 000000 | 1, 229, 516 | | 0 | 0 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0. 000000 | 2, 329 | | 0 | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0. 000000 | 1, 771, 429 | | 0 | 0 | 66.00 |
| 67. 00 06700 0CCUPATI ONAL THERAPY | 0. 000000 | 1, 876, 665 | | 0 | 0 | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 0. 000000 | 425, 184 | | 0 | 0 | |
| 69. 00 06900 ELECTROCARDI OLOGY | 0. 000000 | 54, 919 | | 0 | 0 | |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0. 000000 | 740 | | 0 | 0 | |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 0. 000000 | 1, 518 | | 0 | 0 | 72.00 |
| 73.00 O7300 DRUGS CHARGED TO PATIENTS | 0. 000000 | 859, 474 | | 0 | 0 | |
| 74.00 07400 RENAL DIALYSIS | 0. 000000 | 82, 460 | | 0 | 0 | |
| 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 | 1, 950 | | 0 0 | 0 | 76. 03 |
| OUTPAȚI ENT SERVI CE COST CENTERS | | | | | | |
| 90. 00 09000 CLI NI C | 0. 000000 | 0 | | 0 | - | |
| 91. 00 09100 EMERGENCY | 0. 000000 | 8, 231 | | 0 651 | 0 | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0. 000000 | 0 | | 0 | 0 | |
| 200.00 Total (lines 50 through 199) | | 6, 526, 200 | l | 0 651 | 0 | 200. 00 |

| | Financial Systems | PORTER MEMORI | | ON 45 0005 | | u of Form CMS-2 | 2552-10 |
|---------|--|---------------|----------------|--------------|-----------------------------|--------------------------------|----------------|
| APPORTI | ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | VACCINE COST | Provi der C | CN: 15-0035 | Peri od: From 01/01/2020 | Worksheet D Part V | |
| | | | Component | CCN: 15-T035 | To 12/31/2020 | Date/Time Pre 7/28/2021 4:3 | pared: 6 pm |
| | | | Title | : XVIII | Subprovi der - I RF | PPS | |
| | | | | Charges | | Costs | |
| | Cost Center Description | Cost to | PPS | Cost | Cost | PPS Services | |
| | | Charge Ratio | Rei mbursed | Rei mbursed | Rei mbursed | (see inst.) | |
| | | From | Servi ces (see | Servi ces | Services Not | | |
| | | Worksheet C, | inst.) | Subject To | Subject To | | |
| | | Part I, col. | | Ded. & Coins | | | |
| | | 9 | 2.00 | (see inst.) | | F 00 | |
| | ANCILLARY SERVICE COST CENTERS | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | 05000 OPERATING ROOM | 0. 076184 | 0 | 1 | 0 0 | 0 | 50.00 |
| | 05100 RECOVERY ROOM | 0. 000000 | | | 0 0 | 0 | |
| | 05200 DELIVERY ROOM & LABOR ROOM | 0. 315665 | | | 0 | 0 | 52.00 |
| | 05300 ANESTHESI OLOGY | 0. 008382 | | | | 0 | 53.00 |
| | 05400 RADI OLOGY-DI AGNOSTI C | 0. 073633 | | | 0 | 0 | 54.00 |
| | 05401 ULTRASOUND | 0. 000000 | | | 0 0 | 0 | 54. 01 |
| | 05600 RADI OI SOTOPE | 0. 000000 | 1 0 | | 0 0 | Ö | 56.00 |
| | 05700 CT SCAN | 0. 000000 | 0 | | 0 0 | 0 | 57.00 |
| | 05800 MRI | 0. 000000 | 0 | | 0 0 | 0 | 58.00 |
| | 06000 LABORATORY | 0. 076661 | l o | | 0 0 | 0 | 60.00 |
| | 06500 RESPIRATORY THERAPY | 0. 082187 | 0 | | 0 0 | 0 | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 0. 215077 | l o | | 0 0 | 0 | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 0. 095757 | 0 | | 0 0 | 0 | 67.00 |
| 68.00 | 06800 SPEECH PATHOLOGY | 0. 209310 | 0 | | 0 0 | 0 | 68.00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0. 060546 | 0 | | 0 0 | 0 | 69.00 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0. 032929 | 0 | | 0 0 | 0 | 71.00 |
| | 07200 IMPL. DEV. CHARGED TO PATIENTS | 0. 164512 | 0 | | 0 0 | 0 | 72.00 |
| | 07300 DRUGS CHARGED TO PATIENTS | 0. 155225 | 0 | | 0 3, 297 | 0 | |
| | 07400 RENAL DI ALYSI S | 0. 223613 | 0 | | 0 | 0 | |
| | 03950 ANCI LLARY | 0. 000000 | 0 | | 0 | 0 | |
| | 03610 SLEEP LAB | 0. 000000 | 0 | | 0 | 0 | 76. 01 |
| | 03951 WOUND CARE | 0. 245552 | 0 | | 0 0 | 0 | 76. 03 |
| | OUTPATIENT SERVICE COST CENTERS | | | T | | | |
| | 09000 CLI NI C | 0. 001251 | 0 | | 0 0 | 0 | |
| | 09100 EMERGENCY | 0. 091420 | | | 0 0 | 60 | |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0. 260755 | | | 0 | 0 | |
| 200.00 | Subtotal (see instructions) | | 651 | | 0 3, 297 | 60 | 200.00 |
| 201.00 | Less PBP Clinic Lab. Services-Program | | | | 0 | | 201. 00 |
| | Only Charges | | I | 1 | | 1 | I |

651

60 202.00

202.00

Only Charges Net Charges (line 200 - line 201)

| APPORTI ONMEN | IT OF MEDICAL, OTHER HEALTH SERVICES AND | VACCINE COST | Provider Component (| CN: 15-0035 CCN: 15-T035 | Peri od: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Pre 7/28/2021 4:3 | epared: 36 pm |
|--|---|--|---|-----------------------------|--|---|--|
| | | | Title | XVIII | Subprovi der - I RF | PPS | |
| | | Cos | | | | | |
| | Cost Center Description | (see inst.) | Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) | | | | |
| ANCLLI | _ARY SERVICE COST CENTERS | 6. 00 | 7. 00 | | | | |
| 50. 00 05000 51. 00 05100 52. 00 05200 53. 00 05300 54. 00 05400 54. 01 05401 56. 00 05600 57. 00 05700 58. 00 06500 66. 00 06600 66. 00 06600 66. 00 06600 67. 00 06700 68. 00 06900 71. 00 07100 72. 00 07200 73. 00 07300 74. 00 07400 76. 00 03950 | OPERATING ROOM RECOVERY ROOM RECOVERY ROOM & LABOR ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C ULTRASOUND RADI OI SOTOPE CT SCAN MRI LABORATORY RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH PATHOLOGY ELECTROCARDI OLOGY MEDI CAL SUPPLI ES CHARGED TO PATI ENT IMPL. DEV. CHARGED TO PATI ENTS DRUGS CHARGED TO PATI ENTS RENAL DI ALYSI S ANCI LLARY | 0 0 0 0 0 0 0 0 0 0 0 0 | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | | 50. 00 51. 00 52. 00 53. 00 54. 00 54. 00 57. 00 58. 00 60. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 |
| 76. 03 03951 | SLEEP LAB WOUND CARE | 0 | 0 0 | | | | 76. 0° |
| 90. 00 | CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART Subtotal (see instructions) Less PBP Clinic Lab. Services-Program Only Charges Net Charges (line 200 - line 201) | 0 0 0 0 0 0 0 | 0 0 0 512 | | | | 90. 00 91. 00 92. 00 200. 00 201. 00 |

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-0035 Worksheet D From 01/01/2020 Part V 12/31/2020 Date/Time Prepared: 7/28/2021 4:36 pm Title XIX Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Part I, col. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 3.00 5.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0.076184 23, 263, 115 05100 RECOVERY ROOM 0 0.000000 51.00 51.00 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0. 315665 6, 570 0 52.00 53.00 05300 ANESTHESI OLOGY 0.008382 0 1, 433, 601 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.073633 0 21, 299, 924 0 54.00 05401 ULTRASOUND 0 54.01 0.000000 0 0 54.01 0 0 56.00 05600 RADI OI SOTOPE 0.000000 0 0 0 56.00 57.00 05700 CT SCAN 0.000000 0 0 57.00 0 58.00 05800 MRI 0.000000 0 0 58.00 0 0 06000 LABORATORY 15, 078, 658 0.076661 0 60.00 0 60.00 65.00 06500 RESPIRATORY THERAPY 0.082187 345, 778 0 65.00 06600 PHYSI CAL THERAPY 0. 215077 783, 139 66.00 0 66.00 06700 OCCUPATIONAL THERAPY 0.095757 199, 717 67 00 0 67 00 280, 513 68.00 06800 SPEECH PATHOLOGY 0.209310 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.060546 7, 999, 138 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.032929 1, 727, 202 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72 00 0. 164512 0 72.00 3, 663, 348 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0.155225 0 16, 138, 463 0 73.00 74.00 07400 RENAL DIALYSIS 0. 223613 8,685 0 74.00 03950 ANCI LLARY 0 76.00 0.000000 0 0 0 76.00 0 03610 SLEEP LAB 0.000000 0 76.01 76.01 0 03951 WOUND CARE 76.03 0. 245552 0 869, 463 0 76.03 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 90.00 0.001251 332, 328 0 90.00 0. 091420 0 32, 043, 722 91.00 91. 00 09100 EMERGENCY 0 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 260755 0 1, 341, 394 0 92.00 200.00 Subtotal (see instructions) 0 0 126, 814, 758 0 200.00 0 Less PBP Clinic Lab. Services-Program 201.00 201.00

0

0 202.00

126, 814, 758

Only Charges

202.00

Net Charges (line 200 - line 201)

| Health Financial Systems | PORTER MEMORIAL HOSPIT | AL In Lie | u of Form CMS-2552-10 |
|---------------------------|---|---|-----------------------|
| APPORTIONMENT OF MEDICAL, | THER HEALTH SERVICES AND VACCINE COST Provi | der CCN: 15-0035 Period: From 01/01/2020 | |
| | | | Date/Time Prepared |

| | | | | From 01/01/2020 To 12/31/2020 | Date/Time Pre | |
|---|-------------------------|----------------------------|-------|----------------------------------|----------------|---------|
| | | T' 11 | | | 7/28/2021 4: 3 | 36 pm |
| | | | e XIX | Hospi tal | Cost | |
| 01.01 | | sts | | | | |
| Cost Center Description | Cost Reimbursed | Cost | | | | |
| | | Reimbursed | | | | |
| | Servi ces Subject To | Services Not Subject To | | | | |
| | Ded. & Coins. | | | | | |
| | (see inst.) | (see inst.) | | | | |
| | 6.00 | 7.00 | - | | | |
| ANCILLARY SERVICE COST CENTERS | 0.00 | 7.00 | l | | | |
| 50. 00 05000 OPERATI NG ROOM | 0 | 1, 772, 277 | | | | 50.00 |
| 51. 00 05100 RECOVERY ROOM | 0 | 0 | | | | 51.00 |
| 52. 00 05200 DELIVERY ROOM & LABOR ROOM | 0 | 2, 074 | 1 | | | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0 | 12, 016 | 1 | | | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 1, 568, 377 | | | | 54.00 |
| 54. 01 05401 ULTRASOUND | 0 | 0 | | | | 54. 01 |
| 56. 00 05600 RADI 0I 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, 155, 945 | | | | 60.00 |
| 65. 00 06500 RESPIRATORY THERAPY | 0 | 28, 418 | | | | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 168, 435 | | | | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0 | 19, 124 | | | | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 0 | 58, 714 | | | | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 484, 316 | | | | 69.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0 | 56, 875 | | | | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 602, 665 | | | | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 2, 505, 093 | | | | 73.00 |
| 74. 00 07400 RENAL DI ALYSI S | 0 | 1, 942 | | | | 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 | 213, 498 | | | | 76. 03 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90. 00 09000 CLI NI C | 0 | 1 | | | | 90.00 |
| 91. 00 09100 EMERGENCY | 0 | | | | | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0 | 349, 775 | | | | 92.00 |
| 200.00 Subtotal (see instructions) | 0 | 11, 929, 397 | | | | 200.00 |
| 201.00 Less PBP Clinic Lab. Services-Program | 0 |) | | | | 201.00 |
| Only Charges | | | | | | |
| 202.00 Net Charges (line 200 - line 201) | 0 | 11, 929, 397 | | | | 202. 00 |

| Health Financial Systems | PORTER MEMORIAL | HOSPI TAL | In Lie | u of Form CMS-2 | 2552-10 |
|---|-----------------|-----------------------|-----------------------------|-----------------------------|----------------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provider CCN: 15-0035 | Peri od: From 01/01/2020 | Worksheet D-1 | |
| | | | To 12/31/2020 | Date/Time Pre 7/28/2021 4:3 | pared: 6 pm |
| | | Title XVIII | Hospi tal | PPS | |
| Cost Center Description | | | | | |
| | | | | 1. 00 | |
| PART I - ALL PROVIDER COMPONENTS | | | | | |

| | | Title XVIII | Hospi tal | PPS | |
|------------------|--|--------------------------------|------------------|-------------------------|------------------|
| | Cost Center Description | | - | 1 00 | |
| | PART I - ALL PROVIDER COMPONENTS | | | 1. 00 | |
| | I NPATI ENT DAYS | | | | |
| 1.00 | Inpatient days (including private room days and swing-bed day | rs, excluding newborn) | | 47, 212 | 1.00 |
| 2.00 | Inpatient days (including private room days, excluding swing- | | | 47, 212 | 2.00 |
| 3. 00 | Private room days (excluding swing-bed and observation bed da | 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 b | (ave) | | 43, 228 | 4.00 |
| 5. 00 | Total swing-bed SNF type inpatient days (including private ro | | r 31 of the cost | 43, 220 | 5.00 |
| | reporting period | 3 , | | | |
| 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) Total swing-bed NF type inpatient days (including private roo | m days) through Docombor | 21 of the cost | 0 | 7. 00 |
| 7.00 | reporting period | iii days) tiii dugii beceiibei | 31 Of the cost | U | 7.00 |
| 8.00 | Total swing-bed NF type inpatient days (including private roo | 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 t | o the Program (excluding | swing-bed and | 16, 536 | 9. 00 |
| 10.00 | newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o | nlv (including private r | noom days) | 0 | 10.00 |
| | through December 31 of the cost reporting period (see instruc | | | _ | |
| 11. 00 | Swing-bed SNF type inpatient days applicable to title XVIII o | | oom days) after | 0 | 11.00 |
| 12. 00 | December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI | | o room days) | 0 | 12.00 |
| 12.00 | through December 31 of the cost reporting period | x only (including privat | e room days) | U | 12.00 |
| 13.00 | Swing-bed NF type inpatient days applicable to titles V or XI | X only (including privat | e room days) | 0 | 13.00 |
| | after December 31 of the cost reporting period (if calendar y | ear, enter 0 on this lin | e) | | |
| 14.00 | Medically necessary private room days applicable to the Progr | am (excluding swing-bed | days) | 0 | 14.00 |
| 15.00 | 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 | | | | 10.00 |
| 17. 00 | Medicare rate for swing-bed SNF services applicable to service | es through December 31 c | f the cost | 0.00 | 17. 00 |
| 40.00 | reporting period | | | | 40.00 |
| 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 | Medicaid rate for swing-bed NF services applicable to service | 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 service reporting period | s after December 31 of t | he cost | 0. 00 | 20.00 |
| 21. 00 | | s) | | 44, 795, 558 | 21.00 |
| 22. 00 | Swing-bed cost applicable to SNF type services through Decemb | | ing period (line | | 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 reportin | g period (line 6 | 0 | 23. 00 |
| 24. 00 | | r 31 of the cost reporti | ng period (line | 0 | 24.00 |
| | 7 x line 19) | • | | | |
| 25. 00 |] 3 | 31 of the cost reporting | period (line 8 | 0 | 25. 00 |
| 26. 00 | x line 20) Total swing-bed cost (see instructions) | | | 0 | 26.00 |
| 27. 00 | | (line 21 minus line 26) | | 44, 795, 558 | |
| | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | | | | |
| 28. 00 | General inpatient routine service charges (excluding swing-be | d and observation bed ch | arges) | 0 | |
| 29. 00 30. 00 | Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) | | | 0 | 29. 00 30. 00 |
| 31.00 | General inpatient routine service cost/charge ratio (line 27 | ÷ line 28) | | 0. 000000 | |
| 32. 00 | Average private room per diem charge (line 29 ÷ line 3) | 20, | | 0.00 | ı |
| 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 mi | | tions) | 0.00 | |
| 35.00 | Average per diem private room cost differential (line 34 x li | ne 31) | | 0.00 | ł |
| 36. 00 37. 00 | Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost | and private room cost di | fferential (line | 0 44, 795, 558 | 36. 00 37. 00 |
| 37.00 | 27 minus line 36) | and private room cost dr | | 77, 773, 330 | 37.00 |
| | PART II - HOSPITAL AND SUBPROVIDERS ONLY | | <u>'</u> | | |
| 00.05 | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ | | 1 | 212 == | 00.05 |
| 38. 00 39. 00 | Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line | | | 948. 82 15, 689, 688 | |
| 40.00 | Medically necessary private room cost applicable to the Progr | | | 15, 689, 688 | 40.00 |
| | Total Program general inpatient routine service cost (line 39 | | | 15, 689, 688 | |
| | | | · | | |

| | PART II - HUSPITAL AND SUBPROVIDERS UNLY | | |
|-----|--|--------------|-------|
| | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS | | |
| 38. | 00 Adjusted general inpatient routine service cost per diem (see instructions) | 948. 82 | 38.0 |
| 39. | 00 Program general inpatient routine service cost (line 9 x line 38) | 15, 689, 688 | 39.0 |
| 40. | 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) | 0 | 40.0 |
| 41. | 00 Total Program general inpatient routine service cost (line 39 + line 40) | 15, 689, 688 | 41. (|
| | | | |
| | | | |
| | | | |

| | Financial Systems | PORTER MEMORIA | | ON 15 0025 | | u of Form CMS-2 | |
|--|---|-----------------------------|----------------------------|--|---|---|------------------|
| COMPUT | ATION OF INPATIENT OPERATING COST | | Provi der C | F | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 Date/Time Pre 7/28/2021 4:3 | pared: |
| | | | Ti tl e | · XVIII | Hospi tal | PPS | о рііі |
| | Cost Center Description | Total Inpatient Cost | Total Inpatient Days | Average Per Diem (col. 1 ÷ col. 2) | Program Days | Program Cost (col. 3 x col. 4) | |
| 10.00 | Interpretation of the state of | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | 10.00 |
| | NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units | 0 | 0 | | | | 42.00 |
| 43. 00 43. 01 44. 00 45. 00 46. 00 47. 00 | INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) Cost Center Description | 12, 560, 292 4, 215, 781 | 5, 535 2, 996 | | | 4, 533, 962 0 | 1 |
| | cost center bescription | | | | | 1. 00 | |
| 48. 00 49. 00 | Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines | | | ons) | | 26, 422, 475 46, 646, 125 | |
| 50. 00 | PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp | atient routine | servi ces (fro | m Wkst. D, sum | of Parts I and | 1, 477, 859 | 50.00 |
| 51. 00 | Pass through costs applicable to Program inp | atient ancillar | ry services (f | rom Wkst. D, s | um of Parts II | 1, 146, 727 | 51.00 |
| 52. 00 53. 00 | and IV) Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu medical education costs (line 49 minus line | ding capital re | elated, non-ph | ysician anesth | etist, and | 2, 624, 586 44, 021, 539 | |
| | TARGET AMOUNT AND LIMIT COMPUTATION | 52) | | | | | |
| | Program di scharges | | | | | 0 | ı |
| | Target amount per discharge Target amount (line 54 x line 55) | | | | | 0.00 | ı |
| 57. 00 | Difference between adjusted inpatient operat | ing cost and ta | rget amount (| line 56 minus | line 53) | 0 | |
| 58. 00 59. 00 | Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re | porting period | endi ng 1996, | updated and co | mpounded by the | 0.00 | 58. 00 59. 00 |
| 60. 00 | market basket Lesser of lines 53/54 or 55 from prior year | cost report. up | dated by the | market basket | | 0. 00 | 60.00 |
| | 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target | | | | | 0 | 61.00 |
| 62. 00 | amount (line 56), otherwise enter zero (see instructions) 2.00 Relief payment (see instructions) | | | | | | 62.00 |
| 63. 00 | 63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST | | | | | | 63.00 |
| 64. 00 | 64.00 Medicare swing bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only) | | | | | | 64.00 |
| 65. 00 | Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only) | ts after Decemb | er 31 of the | cost reporting | period (See | 0 | 65.00 |
| 66. 00 | Total Medicare swing-bed SNF inpatient routi CAH (see instructions) | ne costs (line | 64 plus line | 65)(title XVII | l only). For | 0 | 66. 00 |
| 67. 00 | Title V or XIX swing-bed NF inpatient routin (line 12 x line 19) | e costs through | December 31 | of the cost re | porting period | 0 | 67.00 |
| 68. 00 | Title V or XIX swing-bed NF inpatient routin (line 13 x line 20) | e costs after [| ecember 31 of | the cost repo | rting period | 0 | 68. 00 |
| 69. 00 | Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N | | | | | 0 | 69.00 |
| 70. 00 | Skilled nursing facility/other nursing facil | | | | | | 70.00 |
| 71.00 | Adjusted general inpatient routine service c | , | ine 70 ÷ line | 2) | | | 71.00 |
| 72. 00 73. 00 | Program routine service cost (line 9 x line Medically necessary private room cost applic | | ı (line 14 x l | ine 35) | | | 72. 00 73. 00 |
| 74.00 | Total Program general inpatient routine serv | ice costs (line | 2 72 + line 73 |) | | | 74.00 |
| 75. 00 | Capital-related cost allocated to inpatient 26, line 45) | | e costs (from | Worksheet B, P | art II, column | | 75.00 |
| 76. 00 77. 00 | Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line | . * | | | | | 76. 00 77. 00 |
| 78. 00 | Inpatient routine service cost (line 74 minu | s line 77) | | | | | 78. 00 |
| 79.00 | Aggregate charges to beneficiaries for exces | | | | us lino 70) | | 79.00 |
| 80. 00 81. 00 | | | | | | | 80. 00 81. 00 |
| 82.00 | Inpatient routine service cost limitation (| ine 9 x line 81 | * . | | | | 82.00 |
| 83.00 | Reasonable inpatient routine service costs (| | ns) | | | | 83. 00 84. 00 |
| 84. 00 85. 00 | Program inpatient ancillary services (see in Utilization review - physician compensation | | ons) | | | | 85.00 |
| | 36.00 Total Program inpatient operating costs (sum of lines 83 through 85) | | | | | | |
| 87. 00 | PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions | | | | | 3, 984 | 87.00 |
| 88. 00 | Adjusted general inpatient routine cost per | diem (line 27 ÷ | , | | | 948. 82 | 88. 00 |
| 89.00 | Observation bed cost (line 87 x line 88) (se | e instructions) | | | | 3, 780, 099 | 89.00 |

| Health Financial Systems | PORTER MEMORI | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---|---------------|--------------|------------|----------------------------------|-----------------|----------------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provi der CO | | Peri od: | Worksheet D-1 | |
| | | | | From 01/01/2020 To 12/31/2020 | | pared: 6 pm |
| | | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | Cost | Routine Cost | column 1 ÷ | Total | Observation | |
| | | (from line | column 2 | Observati on | Bed Pass | |
| | | 21) | | Bed Cost | Through Cost | |
| | | | | (from line | (col. 3 x | |
| | | | | 89) | col. 4) (see | |
| | | | | | instructions) | |
| | 1. 00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST | | | | | |
| 90.00 Capital -related cost | 3, 547, 294 | 44, 795, 558 | 0. 07918 | 9 3, 780, 099 | 299, 342 | 90.00 |
| 91.00 Nursing School cost | 0 | 44, 795, 558 | 0.00000 | 0 3, 780, 099 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 44, 795, 558 | 0.00000 | 0 3, 780, 099 | 0 | 92.00 |
| 93.00 All other Medical Education | o | 44, 795, 558 | 0. 00000 | 0 3, 780, 099 | 0 | 93. 00 |

| Health Financial Systems | PORTER MEMORIAL HOSPITAL | In Lie | u of Form CMS-2552-10 |
|---|--------------------------|-----------------|-----------------------|
| COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0035 | Peri od: | Worksheet D-1 |
| | 0 | From 01/01/2020 | |
| | Component CCN: 15-T035 | 10 12/31/2020 | |
| | | | 7/28/2021 4:36 pm |
| | Title XVIII | Subprovi der - | PPS |
| | | LRF | |

| | | I RF | | |
|------------------|--|----------------------|---------------------------|------------------|
| | Cost Center Description | | 1 00 | |
| | PART I - ALL PROVIDER COMPONENTS | | 1. 00 | |
| | I NPATI ENT DAYS | | | |
| 1.00 | Inpatient days (including private room days and swing-bed days, excluding newborn) | | 3, 182 | 1.00 |
| 2.00 | Inpatient days (including private room days, excluding swing-bed and newborn days | | 3, 182 | 2.00 |
| 3.00 | Private room days (excluding swing-bed and observation bed days). If you have only | private room days, | 0 | 3. 00 |
| 4 00 | do not complete this line. | | 2 102 | 4 00 |
| 4. 00 5. 00 | Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through Dece | mhar 31 of the cost | 3, 182 0 | 4. 00 5. 00 |
| 3.00 | reporting period | liber 31 of the cost | O | 3.00 |
| 6.00 | Total swing-bed SNF type inpatient days (including private room days) after Decemb | er 31 of the cost | 0 | 6.00 |
| | reporting period (if calendar year, enter 0 on this line) | | | |
| 7. 00 | Total swing-bed NF type inpatient days (including private room days) through Decem | ber 31 of the cost | 0 | 7. 00 |
| 8. 00 | reporting period Total swing-bed NF type inpatient days (including private room days) after Decembe | r 31 of the cost | 0 | 8. 00 |
| 0.00 | reporting period (if calendar year, enter 0 on this line) | i 31 or the cost | O | 0.00 |
| 9.00 | Total inpatient days including private room days applicable to the Program (exclud | ing swing-bed and | 1, 946 | 9. 00 |
| | newborn days) (see instructions) | | | |
| 10. 00 | Swing-bed SNF type inpatient days applicable to title XVIII only (including privat | e room days) | 0 | 10. 00 |
| 11. 00 | through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including privat | a room days) after | 0 | 11. 00 |
| 11.00 | December 31 of the cost reporting period (if calendar year, enter 0 on this line) | e room days) arter | O | 11.00 |
| 12.00 | Swing-bed NF type inpatient days applicable to titles V or XIX only (including pri | vate room days) | 0 | 12.00 |
| | through December 31 of the cost reporting period | | | |
| 13. 00 | | | 0 | 13. 00 |
| 14. 00 | after December 31 of the cost reporting period (if calendar year, enter 0 on this Medically necessary private room days applicable to the Program (excluding swing-b | | 0 | 14. 00 |
| 15. 00 | | eu uays) | 0 | 15.00 |
| | Nursery days (title V or XIX only) | | 0 | 16.00 |
| | SWING BED ADJUSTMENT | | | |
| 17. 00 | 11 9 | 1 of the cost | 0. 00 | 17. 00 |
| 18. 00 | reporting period Medicara rate for swing had SNE services applicable to services after December 21 | of the cost | 0.00 | 10 00 |
| 16.00 | Medicare rate for swing-bed SNF services applicable to services after December 31 reporting period | or the cost | 0.00 | 18. 00 |
| 19. 00 | Medicaid rate for swing-bed NF services applicable to services through December 31 | of the cost | 0. 00 | 19. 00 |
| | reporting period | | | |
| 20. 00 | | f the cost | 0. 00 | 20. 00 |
| 21. 00 | reporting period Total general inpatient routine service cost (see instructions) | | 3, 685, 423 | 21. 00 |
| 22. 00 | Swing-bed cost applicable to SNF type services through December 31 of the cost rep | orting period (line | | 22.00 |
| | 5 x line 17) | | | |
| 23. 00 | | ting period (line 6 | 0 | 23. 00 |
| 24.00 | X line 18) | | 0 | 24.00 |
| 24. 00 | Swing-bed cost applicable to NF type services through December 31 of the cost repo $ 7 \times $ line 19) | rting period (line | 0 | 24. 00 |
| 25. 00 | Swing-bed cost applicable to NF type services after December 31 of the cost report | ing period (line 8 | 0 | 25. 00 |
| | x line 20) | | | |
| 26. 00 | | | 0 | 26. 00 |
| 27. 00 | General inpatient routine service cost net of swing-bed cost (line 21 minus line 2 | 6) | 3, 685, 423 | 27. 00 |
| 28 00 | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed | charges) | 0 | 28. 00 |
| | Private room charges (excluding swing-bed charges) | charges) | 0 | |
| 30.00 | Semi - pri vate room charges (excluding swing-bed charges) | | 0 | |
| 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) | ruoti ana) | 0.00 | |
| 34. 00 35. 00 | Average per diem private room charge differential (line 32 minus line 33)(see inst Average per diem private room cost differential (line 34 x line 31) | ructions) | 0. 00 0. 00 | 34. 00 35. 00 |
| 36.00 | | | 0.00 | 36.00 |
| 37. 00 | General inpatient routine service cost net of swing-bed cost and private room cost | differential (line | | |
| | 27 minus line 36) | · | | |
| | PART II - HOSPITAL AND SUBPROVIDERS ONLY | | | |
| 20 00 | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS | T | 1 150 01 | 20 00 |
| 38. 00 39. 00 | Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) | | 1, 158. 21 2, 253, 877 | 38.00 39.00 |
| | Medically necessary private room cost applicable to the Program (line 14 x line 35) |) | 2, 255, 677 | 40.00 |
| | Total Program general inpatient routine service cost (line 39 + line 40) | | 2, 253, 877 | |
| | | · | | |

| COMPUT | Financial Systems ATION OF INPATIENT OPERATING COST | PORTER MEMORIA | | CCN: 15-0035 | Peri od: From 01/01/2020 | eu of Form CMS- Worksheet D-1 | |
|------------------|---|-------------------|-------------------|--------------------------|-----------------------------|----------------------------------|--------|
| | | | Component | CCN: 15-T035 | To 12/31/2020 | | |
| | | | Ti tl | e XVIII | Subprovi der - | PPS | о рііі |
| | Cost Center Description | Total | Total | Average Pe | IRF r Program Days | Program Cost | |
| | · | Inpatient Cost | Inpatient Days | Di em (col. + col. 2) | 1 | (col. 3 x col. 4) | |
| 42. 00 | NURSERY (title V & XIX only) | 1. 00 | 2.00 | 3.00 | 4.00 | 5. 00 | 42.00 |
| 42.00 | Intensive Care Type Inpatient Hospital Units | | | <u>J</u> 0. | 00 | 5 0 | 42.00 |
| 43.00 | INTENSIVE CARE UNIT | 0 | | 1 | | 0 | |
| 43. 01 | NEONATAL INTENSIVE CARE UNIT | 0 | (| 0. | 00 | 0 | |
| 44. 00 45. 00 | CORONARY CARE UNIT BURN INTENSIVE CARE UNIT | | | | | • | 44.00 |
| 46. 00 | SURGICAL INTENSIVE CARE UNIT | | | | | | 46.00 |
| | OTHER SPECIAL CARE (SPECIFY) | | | | | | 47.00 |
| | Cost Center Description | | | | | 1.00 | |
| 48. 00 | Program inpatient ancillary service cost (Wk | st D-3 col 3 | line 200) | | | 1. 00 916, 395 | 48.00 |
| 49. 00 | Total Program inpatient costs (sum of lines | | | ons) | | 3, 170, 272 | |
| | PASS THROUGH COST ADJUSTMENTS | • | | | | | |
| 50. 00 | Pass through costs applicable to Program inp | atient routine | servi ces (fro | om Wkst. D, s | um of Parts I ar | d 261, 445 | 50.00 |
| 51. 00 | | atient ancillar | v services (f | rom Wkst. D. | sum of Parts II | 50, 029 | 51.00 |
| | and IV) | | , (. | | | | |
| 52.00 | Total Program excludable cost (sum of lines | | | | | 311, 474 | |
| 53. 00 | Total Program inpatient operating cost exclumedical education costs (line 49 minus line | | lated, non-pr | iysi ci an anes | thetist, and | 2, 858, 798 | 53.00 |
| | TARGET AMOUNT AND LIMIT COMPUTATION | 52) | | | | | 1 |
| 54.00 | Program di scharges | | | | | 0 | 54.00 |
| | Target amount per discharge | | | | | 1 | 55.00 |
| 56. 00 57. 00 | Target amount (line 54 x line 55) Difference between adjusted inpatient operat | ing cost and to | ract amount (| lino E4 minu | c line E2) | 0 0 | |
| 58. 00 | Bonus payment (see instructions) | ing cost and ta | rget amount (| iiiie 50 iiiiiiu | 5 TITIE 55) | | 1 |
| 59. 00 | Lesser of lines 53/54 or 55 from the cost re | porting period | endi ng 1996, | updated and | compounded by th | | 59.00 |
| | market basket | | 1.1.1. | | | 0.00 | |
| 60. 00 61. 00 | Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line | | | | | 0.00 | 1 |
| 01.00 | which operating costs (line 53) are less than | | | | | | 01.00 |
| | amount (line 56), otherwise enter zero (see | | • | | 3 | | |
| 62.00 | Relief payment (see instructions) | | | | | 0 | |
| 63. 00 | Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST | ent (see instru | CTI ONS) | | |] 0 | 63.00 |
| 64.00 | Medicare swing-bed SNF inpatient routine cos | ts through Dece | mber 31 of th | ne cost repor | ting period (See | . 0 | 64.00 |
| | instructions)(title XVIII only) | | | | | | |
| 65. 00 | Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only) | ts after Decemb | er 31 of the | cost reporti | ng period (See | 0 | 65.00 |
| 66. 00 | Total Medicare swing-bed SNF inpatient routi | ne costs (line | 64 plus line | 65)(title XV | III only). For | 0 | 66.00 |
| | CAH (see instructions) | | | | | | |
| 67. 00 | Title V or XIX swing-bed NF inpatient routin | e costs through | December 31 | of the cost | reporting period | 0 | 67.00 |
| 68. 00 | <pre>(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin</pre> | e costs after D | ecember 31 of | the cost re | porting period | 0 | 68.00 |
| 00.00 | (line 13 x line 20) | c costs arter b | ccciniber or or | 1110 0031 10 | por tring period | | 00.00 |
| 69. 00 | Total title V or XIX swing-bed NF inpatient | | | | | 0 | 69.00 |
| 70. 00 | PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil | | | | 7) | | 70.00 |
| 71. 00 | Adjusted general inpatient routine service c | • | | • | • • | | 71.00 |
| 72.00 | Program routine service cost (line 9 x line | 71) | | | | | 72.00 |
| 73. 00 74. 00 | Medically necessary private room cost applic | • | • | , | | | 73.00 |
| 75.00 | Total Program general inpatient routine serv Capital-related cost allocated to inpatient | | | | Part II column | | 74.00 |
| | 26, line 45) | | (110111 | 2300 | , | | |
| 76.00 | Per diem capital-related costs (line 75 ÷ li | | | | | | 76.00 |
| 77. 00 78. 00 | Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu | | | | | | 77.00 |
| 79. 00 | Aggregate charges to beneficiaries for exces | | rovi der recor | ds) | | | 79.00 |
| 80.00 | Total Program routine service costs for comp | arison to the c | ost limitatio | on (line 78 m | inus line 79) | | 80.00 |
| 81.00 | Inpatient routine service cost per diem limi | | ` | | | | 81.0 |
| 82. 00 83. 00 | Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (| | | | | | 82.00 |
| 84. 00 | Program inpatient ancillary services (see in | | ٠, | | | | 84.00 |
| 85. 00 | Utilization review - physician compensation | | ns) | | | | 85.00 |
| 86. 00 | Total Program inpatient operating costs (sum | | rough 85) | | | | 86.00 |
| 87. 00 | PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions | | | | | Ιο | 87.00 |
| | Adjusted general inpatient routine cost per | | line 2) | | | 1 | 88.00 |
| 88. 00 | That as tea general impatricit routine cost ber | | | | | | |

| Health Financial Systems | PORTER MEMORI | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---|---------------|--------------|--------------|----------------------------------|--------------------------------|----------------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provi der Co | | Peri od: | Worksheet D-1 | |
| | | Component | CCN: 15-T035 | From 01/01/2020 To 12/31/2020 | Date/Time Pre 7/28/2021 4:3 | pared: 6 pm |
| | | Title | XVIII | Subprovi der - | PPS | |
| | | | | I RF | | |
| Cost Center Description | Cost | Routine Cost | column 1 ÷ | Total | Observation | |
| | | (from line | column 2 | Observati on | Bed Pass | |
| | | 21) | | Bed Cost | Through Cost | |
| | | | | (from line | (col. 3 x | |
| | | | | 89) | col. 4) (see | |
| | | | | | instructions) | |
| | 1. 00 | 2.00 | 3.00 | 4. 00 | 5. 00 | |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST | | | | | |
| 90.00 Capital-related cost | 427, 506 | 3, 685, 423 | 0. 11599 | 9 0 | 0 | 90.00 |
| 91.00 Nursing School cost | 0 | 3, 685, 423 | 0. 00000 | 0 0 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 3, 685, 423 | 0. 00000 | 0 0 | 0 | 92.00 |
| 93.00 All other Medical Education | 0 | 3, 685, 423 | 0. 00000 | 00 0 | 0 | 93.00 |

| Health Financial Systems | PORTER MEMORIAL | HOSPI TAL | In Lie | u of Form CMS-2 | 2552-10 |
|---|-----------------|-----------------------|-----------------------------|-----------------------------|----------------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provider CCN: 15-0035 | Peri od: From 01/01/2020 | Worksheet D-1 | |
| | | | To 12/31/2020 | Date/Time Pre 7/28/2021 4:3 | pared: 6 pm |
| | | Title XIX | Hospi tal | Cost | |
| Cost Center Description | | | | | |
| | | | | 1. 00 | |
| PART I - ALL PROVIDER COMPONENTS | | | | | |

| Dest 1. All PROVIDER COMPONENTS 1.00 Post 1. All PROVIDER COMPONENTS 1.00 Impatient days (including private room days and seing-bed days, excluding newborn) 47, 212 1.00 | | | Title XIX | Hospi tal | 7/28/2021 4: 3 Cost | 6 pm_ |
|--|--------|---|----------------------------|---|------------------------|--------|
| NAME | | Cost Center Description | THE WAY | nospi tui | 0031 | |
| MPATIENT IMANS | | | | | 1. 00 | |
| Inpati ent days (including private room days and swing-bed days, excluding neeborn) | | | | | | |
| Injection Dispatch | 1 00 | | s evaluding newborn) | | 47 212 | 1 00 |
| Private room days (excluding swing-bed and observation bed days), If you have only private room days, do not complete this line. 43,228 4,00 | | | | | | |
| | | | | ivate room days, | | |
| Total xwing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | do not complete this line. | 3 . | | | |
| reporting period (| | | | | | |
| Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | 5. 00 | | om days) through Decembe | er 31 of the cost | 0 | 5.00 |
| reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 7.00 Total swing-bed NF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 Swing-bed SWF type inpatient days applicable to title XWIII only (including private room days) after 11.00 through December 31 of the cost reporting period (isee instructions) 11.00 Swing-bed SWF type inpatient days applicable to title XWIII only (including private room days) after 11.00 December 31 of the cost reporting period (isee instructions) 12.00 Swing-bed MF type inpatient days applicable to title XWIII only (including private room days) 13.00 Swing-bed MF type inpatient days applicable to titles V or XX xonly (including private room days) 14.00 Medically necessary private room days applicable to titles V or XX xonly (including private room days) 15.00 Total nursery days (title V or XX xonly) 16.00 Miscard (including private room days) 17.00 Medicare rate for swing-bed SWF services applicable to services through December 31 of the cost 10.00 Total nursery days (title V or XX xonly) 18.00 Medicare rate for swing-bed SWF services applicable to services after December 31 of the cost 10.00 Total nursery days (title V or XX xonly) 18.00 Medicare rate for swing-bed SWF services applicable to services after December 31 of the cost 10.00 Total nursery days (title V or XX xonly) 19.00 Medical drate for swing-bed SWF services applicable to services after December 31 of the cost 10.00 Total nursery days (title V or XX xonly) 19.00 Medical drate for swing-bed SWF services applicable to services after December 31 of the cost 10.00 Total nursery days (title V or XX xonly) 19.00 Medical drate for swing-bed SWF services ap | 6 00 | 1 1 3 1 4 4 | om days) after December | 31 of the cost | 0 | 6.00 |
| 7.00 Total swing-bed NF type inpatient days (including private room days) after becember 31 of the cost reporting period (17 calendar year, enter 0 on this line) 7.00 Total inpatient days including private room days apricable to the Program (excluding swing-bed and private room days applicable to the Program (excluding swing-bed and private room days applicable to the Program (excluding swing-bed and private room days applicable to the Program (excluding swing-bed and private room days) 7.00 Swing-bed SNF type inpatient days applicable to title xVIII enty (including private room days) after becember 31 of the cost reporting period (see instructions) 7.00 Swing-bed SNF type inpatient days applicable to title xVIII enty (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Swing-bed NF type inpatient days applicable to title xVIII enty (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Swing-bed NF type inpatient days applicable to title xVIII enty XVIII enty (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Swing-bed NF type inpatient days applicable to title xVIII enty XVIII enty (including private room days) 7.01 Swing-bed NF type inpatient days applicable to title xVIII enty XVIII enty (including private room days) 7.02 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 7.03 Swing-bed William (including private room days) 7.04 Swing-bed William (including private room days) 7.05 Swing-bed William (including private room days) 7.06 Swing-bed William (including private room days) 7.07 Swing-bed William (including private room days) 7.08 Swing-bed William (including private room days) 7.09 Swing-bed William (including private room days) 7.09 Swing-bed William (including Swing-bed William (including Swing-bed William (including Swing-bed William (includ | 0.00 | | om days) arter becember | 31 01 1110 0031 | 0 | 0.00 |
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| 12.00 Swing-bed NF type inpatient days applicable to titles \(\tilde{V} \) or XIX only \(\tilde{V} \) including private room days \(\tilde{V} \) or 3.00 12.00 | 11. 00 | 1 3 11 | 3 \ 3 \ | oom days) after | 0 | 11. 00 |
| through December 31 of the cost reporting period 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 18.00 Norticare rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period 20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of x line 18) 21.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of x line 18) 22.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 19) 23.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 20) 24.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 29) 26.00 First Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 29) 27.00 General inpat | 12 00 | | | o room days) | 0 | 12.00 |
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| SWING BED ADJUSTMENT | | | | | | |
| 17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 0.00 17. 00 18. 00 18. 00 19. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00 19. 00 | 10.00 | | | | 1, 100 | 10.00 |
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| 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line of x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 19) 26.00 Total swing-bed cost (see instructions) 27.00 Private room charges (excluding swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service cost net of swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 29.00 General inpatient routine service cost reporting period (line of x line 21) 28.00 General inpatient routine service cost reporting period (line of x line 21) 29.00 Private room charges (excluding swing-bed cost (line 21 minus line 26) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room per diem charges (line 29 + line 3) 30.00 Average per vate room per diem charge (line 30 + line 4) 30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 35) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 44, 795, 558) 30.00 Average per diem private room cost differential (line 34 x line 35) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 44, 795, 558) 30.00 Average per diem private room cost differential (line 34 x line 35) 30.00 Average per diem private room cost differential (line 34 x line 35) 30.00 Average per diem private room cost differential (line 34 x line 35) 30.00 Average per diem private room cost differential (line 34 x line 35) 30.00 Average per diem private room cost different | 22.00 | | ci 31 di the cost report | ing period (ind | | 22.00 |
| 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 30.00 Average per diem private room per diem charge (line 30 + line 3) 30.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 31.00 Average per diem private room cost differential (line 3 x line 31) 32.00 Average per diem private room cost differential (line 3 x line 35) 33.00 Average per diem private room cost differential (line 3 x line 35) 34.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 44, 795, 558) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 44.795, 558 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 49.8.82 38.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) | 23. 00 | | 31 of the cost reportir | g period (line 6 | 0 | 23. 00 |
| 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 vine 20) 26.00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 Private room charges (excluding swing-bed charges) 29.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 Average private room per diem charge (line 29 + line 3) 32.00 Average semi-private room per diem charge (line 29 + line 3) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 44, 795, 558) 37.00 Average per diem private room cost differential (line 3 x line 35) 38.00 Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) 38.00 Average per diem private room cost differential (line 3 x line 35) 44.795,558 37.00 Average per diem private room cost differential (line 44,795,558) 37.00 Average per diem private room cost differential (line 3 x line 35) 38.00 Average per diem private room cost differential (line 3 x line 35) 44.795,558 45.00 Average per diem private room cost differential (line 44,795,558) 44.795,558 45.00 Average per diem private room cost differential (line 3 x line 31) 44.795,558 45.00 Average per diem private room cost differential (line 3 x line 31) 44.795,558 45.00 46.00 47.70 48.82 48.80 498.82 40.00 40.00 40.00 | | | | | _ | |
| 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 44, 795, 558) 37.00 Agusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Medically necessary private room cost diplicable to the Program (line 14 x line 35) 1,068,371 0,00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 | 24.00 | | r 31 of the cost reporti | ng period (line | 0 | 24.00 |
| x line 20) 26.00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) OPIC vate room charges (excluding swing-bed charges) OPIC vate room charges (excluding swing-bed charges) OPIC vate room charges (excluding swing-bed charges) OPIC vate room charges (excluding swing-bed charges) OPIC vate room charges (excluding swing-bed charges) OPIC vate room charges (excluding swing-bed charges) OPIC vate room charges (excluding swing-bed charges) OPIC vate room per diem charge (line 27 + line 28) OPIC vate room per diem charge (line 29 + line 3) OPIC vate room per diem charge (line 29 + line 3) OPIC vate room per diem charge (line 30 + line 4) OPIC vate room cost differential (line 34 x line 31) OPIC vate room cost differential (line 34 x line 31) OPIC vate room cost differential adjustment (line 3 x line 35) OPIC vate room cost differential adjustment (line 3 x line 35) OPIC vate room cost differential adjustment (line 3 x line 35) OPIC vate room cost differential adjustment (line 3 x line 35) OPIC vate room cost differential adjustment (line 3 x line 35) OPIC vate room cost differential (line 3 x line 35) OPIC vate room cost differential (line 3 x line 35) OPIC vate room cost differential (line 3 x line 35) OPIC vate room cost differential (line 3 x line 35) OPIC vate room cost differential (line 3 x line 35) OPIC vate room cost differential (line 3 x line 35) OPIC vate room cost differential (line 3 x line 35) OPIC vate room cost differential (line 3 x line 35) OPIC vate room cost differential (line 3 x line 35) OPIC vate room cost differential (line 3 x line 35) OPIC vate room cost differential (line 3 x line 35) OPIC vate room cost differential (line 3 x line 35) OPIC vate room cost differential (line 3 x line 35) OPIC vate room cost differential (line 3 x line 35) OPIC va | 25 00 | | 31 of the cost reporting | period (line 8 | 0 | 25 00 |
| 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) 30. 00 General inpatient routine service cost/charge ratio (line 27 ± line 28) Average private room per diem charge (line 29 ± line 3) Average per diem private room per diem charge (line 30 ± line 4) Average per diem private room charge differential (line 32 minus line 33) (see instructions) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 44, 795, 558) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Medically necessary private room cost applicable to the Program (line 14 x line 35) Q 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) Q 50. 00 Aucrage per diem private room cost applicable to the Program (line 14 x line 35) Q 50. 00 | | | | , | _ | |
| PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 3 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 44, 795, 558) 37.00 FART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28.00 28.00 29.00 20.00 20.00 31.00 20.00 32.00 | | , , | | | | |
| 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 ÷ line 3) 31.00 Average semi-private room per diem charge (line 30 ÷ line 4) 32.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 44, 795, 558) 37.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28.00 29.00 29.00 30.00 30.00 0.000000 31.00 0.000000 32.00 32.00 34.00 40.00 | 27. 00 | | (line 21 minus line 26) | | 44, 795, 558 | 27. 00 |
| 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 44, 795, 558) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 29.00 29.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 31.00 32.00 3 | 28 00 | | d and observation had ch | arges) | 0 | 28 00 |
| 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 44, 795, 558) 37.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 10.00 30.00 30.00 30.00 30.00 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 20.00 30.00 30.00 30.00 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 30.00 30.00 30.00 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) | | | d and observation bed cr | iai ges) | | |
| Average private room per diem charge (line 29 ÷ line 3) 32.00 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 44, 795, 558) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.00 3 | | | | | 0 | |
| 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 44, 795, 558) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | , | ÷ line 28) | | | |
| Average per diem private room charge differential (line 32 minus line 33) (see instructions) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 44, 795, 558 37.00) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 948.82 940.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | | | | |
| 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 44, 795, 558 37.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 948.82 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 1,068,371 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 | | | nus line 22)(see instru | etions) | | |
| 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 948.82 38.00 Program general inpatient routine service cost (line 9 x line 38) 1,068,371 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 | | , | | . (1 0113) | | |
| 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 948. 82 38. 00 Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00 | | , , , | / | | | |
| PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 948.82 38.00 Program general inpatient routine service cost (line 9 x line 38) 1,068,371 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 | | , | and private room cost di | fferential (line | 44, 795, 558 | |
| PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 948.82 38.00 Program general inpatient routine service cost (line 9 x line 38) 1,068,371 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 | | | | | | |
| 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 948.82 38.00 Program general inpatient routine service cost (line 9 x line 38) 1,068,371 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 | | | LICTMENTS | | | |
| 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,068,371 39.00 40.00 | 38 00 | | | | 948 82 | 38 00 |
| 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 | | | • | | | |
| 41.00 Total Program general inpatient routine service cost (line 39 + line 40) 1,068,371 41.00 | 40.00 | Medically necessary private room cost applicable to the Progr | am (line 14 x line 35) | | 0 | 40. 00 |
| | 41. 00 | Total Program general inpatient routine service cost (line 39 | + line 40) | | 1, 068, 371 | 41.00 |

| 34.00 | Average per drein private room charge differential (fine 32 minus fine 33) (see firstructions) | 0.00 | 34.00 |
|-------|---|--------------|-------|
| 35.00 | Average per diem private room cost differential (line 34 x line 31) | 0.00 | 35.00 |
| 36.00 | Private room cost differential adjustment (line 3 x line 35) | 0 | 36.00 |
| 37.00 | General inpatient routine service cost net of swing-bed cost and private room cost differential (line | 44, 795, 558 | 37.00 |
| | 27 minus line 36) | | |
| | PART II - HOSPITAL AND SUBPROVIDERS ONLY | | |
| | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS | | |
| 38.00 | Adjusted general inpatient routine service cost per diem (see instructions) | 948. 82 | 38.00 |
| 39.00 | Program general inpatient routine service cost (line 9 x line 38) | 1, 068, 371 | 39.00 |
| 40.00 | Medically necessary private room cost applicable to the Program (line 14 x line 35) | 0 | 40.00 |
| 41.00 | Total Program general inpatient routine service cost (line 39 + line 40) | 1, 068, 371 | 41.00 |
| | | | |
| | | | |

| | Financial Systems | PORTER MEMORIA | | ON 45 0005 5 | | u of Form CMS-2 | |
|------------------|---|----------------------------|----------------------------|--|--|--------------------------------------|------------------|
| COMPUT | ATION OF INPATIENT OPERATING COST | | Provi der Co | F | eriod: rom 01/01/2020 o 12/31/2020 | | pared: |
| | | | Ti tl | e XIX | Hospi tal | 7/28/2021 4: 30 Cost | о рііі |
| | Cost Center Description | Total Inpatient Cost | Total Inpatient Days | Average Per Diem (col. 1 ÷ col. 2) | Program Days | Program Cost (col. 3 x col. 4) | |
| 42.00 | MUDCEDY (+; +Lo, V, 0, VLV, cpl,v) | 1.00 | 2.00 | 3.00 | 4.00 | 5. 00 | 42.00 |
| 42.00 | NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units | 1, 372, 218 | 2, 400 | 571. 76 | 1, 106 | 632, 367 | 42.00 |
| 43.00 | INTENSIVE CARE UNIT | 12, 560, 292 | 5, 535 | 2, 269. 25 | 60 | 136, 155 | 43.00 |
| 43. 01 | NEONATAL INTENSIVE CARE UNIT | 4, 215, 781 | 2, 996 | 1, 407. 14 | 207 | 291, 278 | 43. 01 |
| 44.00 | CORONARY CARE UNIT | | | | | | 44.00 |
| 45. 00 46. 00 | BURN INTENSIVE CARE UNIT | | | | | | 45. 00 46. 00 |
| | OTHER SPECIAL CARE (SPECIFY) | | | | | | 47.00 |
| | Cost Center Description | l l | | | 1 | | |
| | T- · · · · · · · · · · · · · · · · · · · | | | | | 1. 00 | |
| | Program inpatient ancillary service cost (Wk | | | 222) | | 9, 622, 380 | |
| 49. 00 | Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS | 41 through 48) | see mstructio | JIIS) | | 11, 750, 551 | 49. 00 |
| 50.00 | Pass through costs applicable to Program inp | atient routine | services (from | m Wkst. D, sum | of Parts I and | 0 | 50.00 |
| 51. 00 | <pre> </pre> | atient ancillar | v services (fi | rom Wkst D s | um of Parts II | 0 | 51.00 |
| | and IV) | | y 301 V 003 (11 | om with b, s | um or rures rr | | |
| 52.00 | Total Program excludable cost (sum of lines | | | | | 0 | |
| 53. 00 | Total Program inpatient operating cost exclumedical education costs (line 49 minus line | | erated, non-pny | ysician anestn | etist, and | 0 | 53.00 |
| | TARGET AMOUNT AND LIMIT COMPUTATION | 32) | | | | | |
| 54.00 | Program di scharges | | | | | 0 | 54.00 |
| | Target amount per discharge | | | | | 0. 00 | |
| 56. 00 57. 00 | Target amount (line 54 x line 55) | ing cost and to | ract amount (| lino E4 minus | lino E2) | 0 | 56. 00 57. 00 |
| 58. 00 | Difference between adjusted inpatient operat Bonus payment (see instructions) | ing cost and ta | inger amount (i | Title 50 IIII lius | 111le 53) | 0 | 58.00 |
| 59. 00 | Lesser of lines 53/54 or 55 from the cost re | porting period | endi ng 1996, u | updated and co | mpounded by the | | |
| | market basket | | | | | | |
| 60.00 | Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line | | | | the amount by | 0. 00 0 | 60. 00 61. 00 |
| 01.00 | which operating costs (line 53) are less than | | | | | U | 61.00 |
| | amount (line 56), otherwise enter zero (see | | (| | g | | |
| 62.00 | | | | | | 0 | |
| 63.00 | Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST | ent (see instru | ictions) | | | 0 | 63.00 |
| 64. 00 | | ts through Dece | ember 31 of the | e cost reporti | ng period (See | 0 | 64. 00 |
| 65. 00 | <pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre> | ts after Decemb | or 21 of the | cost roporting | pariod (Saa | 0 | 65. 00 |
| 03.00 | instructions)(title XVIII only) | ts after beceilik | ber 31 of the t | cost reporting | perrou (see | | 05.00 |
| 66. 00 | Total Medicare swing-bed SNF inpatient routi CAH (see instructions) | ne costs (line | 64 plus line 6 | 65)(title XVII | l only). For | 0 | 66. 00 |
| 67. 00 | Title V or XIX swing-bed NF inpatient routin | e costs through | December 31 o | of the cost re | porting period | 0 | 67. 00 |
| 68. 00 | <pre>(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin</pre> | e costs after [| ecember 31 of | the cost reno | rting period | 0 | 68. 00 |
| | (line 13 x line 20) | | | • | iting period | | |
| 69. 00 | Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N | | | | | 0 | 69. 00 |
| 70. 00 | Skilled nursing facility/other nursing facil | | • | | | | 70.00 |
| 71. 00 | Adjusted general inpatient routine service c | , | | , | | | 71.00 |
| 72.00 | Program routine service cost (line 9 x line | | | 25) | | | 72.00 |
| 73. 00 74. 00 | Medically necessary private room cost applic Total Program general inpatient routine serv | | | | | | 73. 00 74. 00 |
| 75. 00 | Capital -related cost allocated to inpatient | • | | • | art II, column | | 75.00 |
| | 26, line 45) | > | | | | | |
| 76. 00 77. 00 | Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line | . * | | | | | 76. 00 77. 00 |
| 78. 00 | Inpatient routine service cost (line 74 minu | | | | | | 78.00 |
| 79. 00 | Aggregate charges to beneficiaries for exces | | provi der record | ds) | | | 79.00 |
| 80.00 | Total Program routine service costs for comp | | cost limitation | n (line 78 min | us line 79) | | 80.00 |
| 81. 00 82. 00 | Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I | | | | | | 81. 00 82. 00 |
| 82.00 | Reasonable inpatient routine service cost it ill tation (i | | * . | | | | 82.00 |
| 84. 00 | Program inpatient ancillary services (see in | | , | | | | 84.00 |
| | Utilization review - physician compensation | (see instruction | | | | | 85.00 |
| 86. 00 | Total Program inpatient operating costs (sum | | rough 85) | | | | 86. 00 |
| 87. 00 | PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions | | | | | 3, 984 | 87. 00 |
| 88. 00 | Adjusted general inpatient routine cost per | • | line 2) | | | 948. 82 | 88. 00 |
| 89. 00 | Observation bed cost (line 87 x line 88) (se | e instructions) | 1 | | | 3, 780, 099 | 89. 00 |
| | | | | | | | |

| Health Financial Systems | PORTER MEMORI | 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 01/01/2020 To 12/31/2020 | | pared: 6 pm |
| | | Ti tl | e XIX | Hospi tal | Cost | |
| Cost Center Description | Cost | Routine Cost | column 1 ÷ | Total | Observation | |
| | | (from line | column 2 | Observati on | Bed Pass | |
| | | 21) | | Bed Cost | Through Cost | |
| | | | | (from line | (col. 3 x | |
| | | | | 89) | col. 4) (see | |
| | | | | | instructions) | |
| | 1. 00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST | | | | | |
| 90.00 Capital -related cost | 3, 547, 294 | 44, 795, 558 | 0. 07918 | 9 3, 780, 099 | 299, 342 | 90.00 |
| 91.00 Nursing School cost | 0 | 44, 795, 558 | 0.00000 | 0 3, 780, 099 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 44, 795, 558 | 0.00000 | 0 3, 780, 099 | 0 | 92.00 |
| 93.00 All other Medical Education | 0 | 44, 795, 558 | 0. 00000 | 0 3, 780, 099 | 0 | 93. 00 |

| I NPATI | ENT ANCILLARY SERVICE COST APPORTIONMENT | Provi der C | CN: 15-0035 | Peri od: From 01/01/2020 To 12/31/2020 | | pared |
|---------|---|-------------|----------------------------|--|---|-------|
| | | Ti +Lo | e XVIII | Hospi tal | 7/28/2021 4: 3 PPS | 6 pm |
| | Cost Center Description | 11116 | Ratio of Cos To Charges | st Inpatient | Inpatient Program Costs (col. 1 x col. 2) | |
| | | | 1.00 | 2. 00 | 3. 00 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | |
| 30.00 | 03000 ADULTS & PEDIATRICS | | | 54, 509, 895 | | 30.0 |
| 31. 00 | 03100 I NTENSI VE CARE UNI T | | | 11, 325, 108 | | 31.0 |
| 31. 01 | 03101 NEONATAL INTENSIVE CARE UNIT | | | 0 | | 31.0 |
| 41. 00 | 04100 SUBPROVI DER - I RF | | | 0 | | 41.0 |
| 13. 00 | 04300 NURSERY | | | | | 43.0 |
| | ANCILLARY SERVICE COST CENTERS | | | | | |
| 0.00 | 05000 OPERATING ROOM | | 0. 0761 | | | |
| 1. 00 | 05100 RECOVERY ROOM | | 0.0000 | | 0 | |
| 2.00 | 05200 DELIVERY ROOM & LABOR ROOM | | 0. 3156 | | 5, 040 | |
| 3.00 | 05300 ANESTHESI OLOGY | | 0.0083 | | 20, 366 | |
| 4. 00 | 05400 RADI OLOGY-DI AGNOSTI C | | 0. 0736 | | 1, 743, 663 | |
| 4. 01 | 05401 ULTRASOUND | | 0.0000 | | 0 | 54. |
| 6. 00 | 05600 RADI OI SOTOPE | | 0.0000 | | 0 | 56. |
| 7. 00 | 05700 CT SCAN | | 0.0000 | | 0 | 57. |
| 8. 00 | 05800 MRI | | 0.0000 | | 0 | 58. |
| 0.00 | 06000 LABORATORY | | 0. 0766 | | 2, 919, 321 | 60.0 |
| 5. 00 | 06500 RESPI RATORY THERAPY | | 0. 0821 | | | |
| 6. 00 | 06600 PHYSI CAL THERAPY | | 0. 2150 | | | |
| 7. 00 | 06700 OCCUPATI ONAL THERAPY | | 0. 0957 | | 319, 711 | |
| 8. 00 | 06800 SPEECH PATHOLOGY | | 0. 2093 | | 261, 726 | |
| 9. 00 | 06900 ELECTROCARDI OLOGY | | 0. 0605 | | | |
| 1. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | | 0. 0329 | | | |
| 2.00 | 07200 IMPL. DEV. CHARGED TO PATIENTS | | 0. 1645 | | | |
| 3. 00 | 07300 DRUGS CHARGED TO PATIENTS | | 0. 1552 | | | |
| 4. 00 | 07400 RENAL DI ALYSI S | | 0. 2236 | | 442, 669 | |
| 6. 00 | 03950 ANCI LLARY | | 0.0000 | | 0 | 76. |
| 6. 01 | 03610 SLEEP LAB | | 0.0000 | | 0 | 76. |
| 6. 03 | 03951 WOUND CARE | | 0. 2455 | 52 94, 681 | 23, 249 | 76. |
| | OUTPATIENT SERVICE COST CENTERS | | | eal - | _ | |
| 90.00 | | | 0.0012 | | 0 | 90. |
| | 09100 EMERGENCY | | 0.0914 | | | |
| | | | | | | |

26, 422, 475 200. 00 201. 00 202. 00

92.00

574, 611

2, 203, 644

263, 699, 054

263, 699, 054

0. 260755

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Net charges (line 200 minus line 201)

200.00

201.00 202.00 Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges (line 61)

| <i></i> | EMORIAL HOSPITAL | ON 15 0005 | | u of Form CMS-2 | |
|--|-------------------|----------------------------|-----------------------------|---|------|
| NPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider C | CN: 15-0035 | Peri od: From 01/01/2020 | Worksheet D-3 | 5 |
| | Component | CCN: 15-T035 | To 12/31/2020 | Date/Time Pre 7/28/2021 4:3 | |
| | Ti tl e | e XVIII | Subprovi der - I RF | PPS | |
| Cost Center Description | | Ratio of Cos To Charges | Program Charges | Inpatient Program Costs (col. 1 x col. 2) | |
| INDATI ENT. DOUTINE CERVI OF COCT OFNITERS | | 1.00 | 2. 00 | 3. 00 | |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS | | | | | 1 |
| 0. 00 03000 ADULTS & PEDI ATRI CS | | | 0 | | 30. |
| 1. 00 03100 INTENSIVE CARE UNIT | | | 0 | | 31. |
| 1. 01 03101 NEONATAL INTENSIVE CARE UNIT | | | | | 31. |
| 1. 00 04100 SUBPROVI DER - I RF | | | 5, 744, 972 | | 41. |
| 3. 00 04300 NURSERY | | | | | 43. |
| ANCILLARY SERVICE COST CENTERS 0.00 05000 OPERATING ROOM | | 0. 07618 | 19, 439 | 1, 481 | 50. |
| 0.00 05000 OPERATING ROOM 1.00 05100 RECOVERY ROOM | | 0.07618 | · · | 1, 481 | 1 |
| 2.00 05200 DELIVERY ROOM & LABOR ROOM | | 0. 31566 | | 0 | |
| 2. 00 05200 DELIVERY ROOM & LABOR ROOM 3. 00 05300 ANESTHESI OLOGY | | • | | 9 | 53. |
| | | 0. 00838 0. 07363 | | , | |
| 1 1 | | 0.07363 | | 14, 084 | |
| 4. 01 05401 ULTRASOUND 6. 00 05600 RADI OI SOTOPE | | 0.00000 | | 0 | |
| 7. 00 05700 CT SCAN | | 0.00000 | | 0 | |
| 3. 00 05800 MRI | | 0.00000 | | 0 | |
| 0. 00 06000 LABORATORY | | 0.07666 | | | |
| 5. 00 06500 RESPI RATORY THERAPY | | • | | 94, 256 191 | |
| 6. 00 06600 PHYSI CAL THERAPY | | 0. 08218 | | | |
| | | 0. 21507 | | 380, 994 | |
| | | 0.09575 | | 179, 704 | |
| 8. 00 06800 SPEECH PATHOLOGY | | 0. 20931 | · · | 88, 995 | |
| 9. 00 06900 ELECTROCARDI OLOGY 1. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT | | 0. 06054 0. 03292 | | 3, 325 | |
| | | | | 24 | 1 |
| | | 0. 16451 | · · | 250 | 1 |
| 3. 00 07300 DRUGS CHARGED TO PATIENTS | | 0. 15522 | · · | 133, 412 | |
| 4. 00 07400 RENAL DI ALYSI S | | 0. 2236 | | 18, 439 | |
| 6. 00 03950 ANCI LLARY | | 0.00000 | | 0 | |
| 6. 01 03610 SLEEP LAB | | 0.00000 | | _ | 1 |
| 6. 03 03951 WOUND CARE | | 0. 24555 | 52 1, 950 | 479 | 76. |
| OUTPATIENT SERVICE COST CENTERS | | 0.00405 | -1 | ^ | - |
| 0. 00 09000 CLI NI C | | 0.00125 | | 0 | |
| 1. 00 09100 EMERGENCY | | 0. 09142 | | 752 | |
| 2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 00) | 0. 26075 | | 017.305 | |
| Total (sum of lines 50 through 94 and 96 through | | | 6, 526, 200 | 916, 395 | 1 |
| O1.00 Less PBP Clinic Laboratory Services-Program only | cnarges (line 61) | | 0 | | 201. |
| 02.00 Net charges (line 200 minus line 201) | | 1 | 6, 526, 200 | | 202. |

| Health Financial Systems | PORTER MEMORIAL HOSPI | ΓAL | In Lie | u of Form CMS-2 | 2552-10 |
|--|-----------------------|----------------------|----------------------------------|--------------------------------|------------------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | | der CCN: 15-0035 | Peri od: | Worksheet D-3 | |
| | | | From 01/01/2020 To 12/31/2020 | Date/Time Pre 7/28/2021 4:3 | |
| | | Title XIX | Hospi tal | Cost | |
| Cost Center Description | | Ratio of Cos | | I npati ent | |
| | | To Charges | Program | Program Costs | |
| | | | Charges | (col. 1 x | |
| | | 1.00 | 2.00 | col. 2) 3.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | 1.00 | 2.00 | 3.00 | |
| 30. 00 03000 ADULTS & PEDIATRICS | | | 18, 039, 206 | | 30.00 |
| 31. 00 03100 NTENSI VE CARE UNI T | | | 4, 463, 077 | | 31.00 |
| 31. 01 03101 NEONATAL INTENSIVE CARE UNIT | | | 8, 771, 803 | | 31. 01 |
| 41. 00 04100 SUBPROVI DER - RF | | | 0 | | 41.00 |
| 43. 00 04300 NURSERY | | | 1, 366, 393 | | 43.00 |
| ANCILLARY SERVICE COST CENTERS | | <u>'</u> | | | |
| 50.00 05000 OPERATING ROOM | | 0. 07618 | 16, 015, 107 | 1, 220, 095 | 50.00 |
| 51.00 05100 RECOVERY ROOM | | 0. 00000 | 00 | 0 | 51.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | | 0. 31566 | | 1, 603, 285 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | | 0. 00838 | | 11, 549 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | | 0. 07363 | | 606, 338 | 54.00 |
| 54. 01 05401 ULTRASOUND | | 0.00000 | | 0 | 54.01 |
| 56. 00 05600 RADI 01 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 | | 0.07666 | | 1, 124, 881 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY | | 0. 08218 0. 21503 | | 437, 102 250, 914 | 65. 00 66. 00 |
| 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY | | 0. 2150 | | 250, 914 55, 554 | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | | 0. 09373 | | 128, 208 | |
| 69. 00 06900 ELECTROCARDI OLOGY | | 0. 2093 | | 385, 153 | 69.00 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | | 0. 03292 | | 78, 795 | 71.00 |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS | | 0. 1645 | | 868, 418 | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | | 0. 15522 | | 1, 618, 917 | 73.00 |
| 74. 00 07400 RENAL DIALYSIS | | 0. 2236 | | 125, 702 | 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. 24555 | | 22, 216 | 76. 03 |
| OUTDATIENT SERVICE COST CENTERS | | - | | | ĺ |

0. 001251 0. 091420

0. 260755

9, 699, 702 761, 274

88, 633, 719

88, 633, 719

886, 747

198, 506

0 90.00

9, 622, 380 200. 00

91.00

92.00

201.00

202.00

OUTPATIENT SERVICE COST CENTERS

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)

90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY

200.00

201.00

202.00

| Health Financial Systems | PORTER MEMORIAL HOSPITAL | | In Lie | u of Form CMS- | 2552-10 |
|--|-----------------------------|--------------|----------------------------------|--------------------------------|---------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provi der C | CN: 15-0035 | Peri od: | Worksheet D-3 | 3 |
| | Component | CCN: 15-T035 | From 01/01/2020 To 12/31/2020 | Date/Time Pre 7/28/2021 4:3 | |
| | Ti tl | e XIX | Subprovi der - I RF | Cost | |
| Cost Center Description | | Ratio of Cos | st Inpatient | I npati ent | |
| | | To Charges | Program | Program Costs | |
| | | | Charges | (col. 1 x | |
| | | | | col. 2) | |
| | | 1.00 | 2. 00 | 3. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS | | | 0 | | 30.00 |
| 31. 00 03100 INTENSIVE CARE UNIT | | | 0 | | 31.00 |
| 31. 01 03101 NEONATAL INTENSIVE CARE UNIT | | | 0 | | 31.01 |
| 41. 00 04100 SUBPROVI DER - I RF | | | 1, 275, 696 | | 41.00 |
| 43. 00 04300 NURSERY | | | 0 | | 43.00 |
| ANCILLARY SERVICE COST CENTERS | | | | | |
| 50. 00 05000 OPERATI NG ROOM | | 0. 0761 | · | 522 | |
| 51.00 05100 RECOVERY ROOM | | 0.0000 | | 0 | |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | | 0. 3156 | | 0 | |
| 53. 00 05300 ANESTHESI OLOGY | | 0. 0083 | | 0 | |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | | 0. 0736 | · · | 3, 175 | |
| 54. 01 05401 ULTRASOUND | | 0.0000 | | 0 | |
| 56. 00 05600 RADI 01 SOTOPE | | 0.0000 | | 0 | |
| 57. 00 05700 CT SCAN | | 0.0000 | | 0 | 57.00 |
| 58. 00 05800 MRI | | 0.0000 | | 0 | |
| 60. 00 06000 LABORATORY | | 0. 0766 | | 20, 610 | |
| 65. 00 06500 RESPI RATORY THERAPY | | 0. 0821 | | 0 | |
| 66. 00 06600 PHYSI CAL THERAPY | | 0. 2150 | · · | 89, 056 | |
| 67. 00 06700 OCCUPATI ONAL THERAPY | | 0. 0957 | · | 40, 298 | 1 |
| 68. 00 06800 SPEECH PATHOLOGY | | 0. 2093 | · | 18, 134 | 1 |
| 69. 00 06900 ELECTROCARDI OLOGY | | 0.0605 | · | 571 | 69.00 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | | 0. 0329 | | 0 | 1 |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS | | 0. 1645 | | 0 | 1 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | | 0. 1552 | | 28, 360 | |
| 74. 00 07400 RENAL DI ALYSI S | | 0. 2236 | | 659 | |
| 76. 00 03950 ANCI LLARY | | 0.0000 | | 0 | 76.00 |
| 76. 01 03610 SLEEP LAB | | 0.0000 | | 0 | |
| 76. 03 03951 WOUND CARE | | 0. 2455 | 52 1, 170 | 287 | 76. 03 |
| OUTPATIENT SERVICE COST CENTERS | | 0.0040 | F1 0 | _ | 00.00 |
| 90. 00 09000 CLI NI C | | 0.0012 | | 0 | |
| 91. 00 09100 EMERGENCY | | 0.0914 | | 17 | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | (+bsquab 00) | 0. 2607 | | 0 | |
| Total (sum of lines 50 through 94 and 9 | | | 1, 436, 792 | 201, 689 | |
| 201.00 Less PBP Clinic Laboratory Services-Pro | gram only charges (line 61) | | 1 424 700 | | 201. 00 |
| 202.00 Net charges (line 200 minus line 201) | | | 1, 436, 792 | | 202.00 |

| Heal th | Financial Systems | PORTER MEMORIAL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---------|--|--------------------------|--------------|-----------------------------|-----------------------------|----------------|
| INPATI | ENT ANCILLARY SERVICE COST APPORTIONMENT | Provi der Co | | Peri od: From 01/01/2020 | | |
| | | Component | CCN: 15-U035 | To 12/31/2020 | Date/Time Pre 7/28/2021 4:3 | pared: 6 pm |
| | | Ti tl | | Swing Beds - SNF | Cost | |
| | Cost Center Description | | Ratio of Cos | | I npati ent | |
| | | | To Charges | | Program Costs | |
| | | | | Charges | (col. 1 x | |
| | | | 1 00 | 0.00 | col . 2) | |
| | LUBATI ENT. DOUTLING OFFICE OFFICE | | 1.00 | 2. 00 | 3. 00 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | |
| | 03000 ADULTS & PEDIATRICS | | | 0 | | 30.00 |
| | 03100 I NTENSI VE CARE UNI T | | | 0 | | 31.00 |
| | 03101 NEONATAL INTENSIVE CARE UNIT | | | 0 | | 31.01 |
| | 04100 SUBPROVI DER – I RF | | | 0 | | 41.00 |
| 43.00 | 04300 NURSERY | | | 0 | | 43.00 |
| | ANCILLARY SERVICE COST CENTERS | | | | _ | |
| | 05000 OPERATI NG ROOM | | 0. 07618 | | 0 | 50.00 |
| | 05100 RECOVERY ROOM | | 0.00000 | | 0 | 51.00 |
| | 05200 DELIVERY ROOM & LABOR ROOM | | 0. 31566 | | 0 | 52.00 |
| 53. 00 | 05300 ANESTHESI OLOGY | | 0. 00838 | 32 0 | 0 | 53.00 |

54.00

0 54.01

58.00

66.00

67.00

69.00

71.00

73.00

0 76.01

0 200.00

201.00

202.00

0 56.00

0 57.00

0

0 60.00

0 65.00

0

0 68.00

0

0

0 72.00

0

0 74.00

0 76.00

0 76.03

0 90.00

0 91.00

0 92.00

0.073633

0.000000

0.000000

0.000000

0.000000

0.076661

0.082187

0. 215077

0.095757

0. 209310

0.060546

0.032929

0.164512

0.155225

0. 223613

0.000000

0.000000

0.245552

0.001251

0.091420

0. 260755

54.00

54.01

56.00

57.00

58.00

60.00

65.00

66.00

67.00

68.00

69.00

71.00

72.00

73.00

76.00

76.01

76.03

90.00

200. 00 201. 00

202.00

05400 RADI OLOGY-DI AGNOSTI C

06500 RESPIRATORY THERAPY

06700 OCCUPATI ONAL THERAPY

07100 MEDICAL SUPPLIES CHARGED TO PATIENT

07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

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)

06600 PHYSI CAL THERAPY

06800 SPEECH PATHOLOGY

06900 ELECTROCARDI OLOGY

05401 ULTRASOUND

06000 LABORATORY

74.00 07400 RENAL DIALYSIS

03950 ANCI LLARY

03610 SLEEP LAB

03951 WOUND CARE

09000 CLI NI C

91.00 09100 EMERGENCY

05700 CT SCAN

05800 MRI

05600 RADI OI SOTOPE

| Health Financial Systems | PORTER MEMORIAL HOSPITAL | | In Lie | u of Form CMS-2552-10 |
|---|--------------------------|--------------|--|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der | CCN: 15-0035 | Peri od: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Date/Time Prepared: 7/28/2021 4:36 pm |

| | | | 10 12/31/2020 | 7/28/2021 4:3 | |
|--------|--|-------------------------|-------------------|---------------|--------|
| | | Title XVIII | Hospi tal | PPS | |
| | | | | | |
| | | | | 1. 00 | |
| 4 00 | PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS | | | 0 | 4 00 |
| 1.00 | DRG Amounts Other than Outlier Payments | | | 0 240 740 | 1.00 |
| 1. 01 | DRG amounts other than outlier payments for discharges occurring instructions) | prior to Uctober i (| see | 26, 812, 748 | 1. 01 |
| 1. 02 | DRG amounts other than outlier payments for discharges occurring | on or after October | 1 (500 | 9, 861, 050 | 1. 02 |
| 1.02 | instructions) | on or arter october | 1 (366 | 7, 001, 030 | 1.02 |
| 1. 03 | DRG for federal specific operating payment for Model 4 BPCI for | di scharges occurri ng | prior to October | 0 | 1.03 |
| | 1 (see instructions) | | | _ | |
| 1.04 | DRG for federal specific operating payment for Model 4 BPCI for | di scharges occurri ng | on or after | 0 | 1.04 |
| | October 1 (see instructions) | | | | |
| 2.00 | Outlier payments for discharges. (see instructions) | | | | 2.00 |
| 2. 01 | Outlier reconciliation amount | | | 0 | 2. 01 |
| 2. 02 | Outlier payment for discharges for Model 4 BPCI (see instruction | • | | 0 | 2. 02 |
| 2. 03 | Outlier payments for discharges occurring prior to October 1 (se | | | 436, 804 | 2.03 |
| 2. 04 | Outlier payments for discharges occurring on or after October 1 | (see instructions) | | 127, 027 | 2.04 |
| 3.00 | Managed Care Simulated Payments | | -4:> | 18, 769, 148 | 3.00 |
| 4. 00 | Bed days available divided by number of days in the cost reporti | ng period (see instru | ctrons) | 227. 11 | 4. 00 |
| 5. 00 | Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most r | cocont cost roporting | port od onding or | 0. 00 | 5.00 |
| 3.00 | or before 12/31/1996. (see instructions) | ecent cost reporting | period ending on | 0.00 | 3.00 |
| 6. 00 | FTE count for allopathic and osteopathic programs that meet the | criteria for an add-o | n to the cap for | 0.00 | 6. 00 |
| 0.00 | new programs in accordance with 42 CFR 413.79(e) | 00 | to the dap | 0.00 | 0.00 |
| 7.00 | MMA Section 422 reduction amount to the IME cap as specified und | ler 42 CFR §412.105(f) | (1) (i v) (B) (1) | 0.00 | 7. 00 |
| 7. 01 | ACA § 5503 reduction amount to the IME cap as specified under 42 | 2 CFR §412. 105(f)(1)(i | v)(B)(2) If the | 0.00 | 7. 01 |
| | cost report straddles July 1, 2011 then see instructions. | | | | |
| 8.00 | Adjustment (increase or decrease) to the FTE count for allopathi | | | 0.00 | 8. 00 |
| | affiliated programs in accordance with 42 CFR 413.75(b), 413.79(| (c)(2)(iv), 64 FR 2634 | 0 (May 12, | | |
| | 1998), and 67 FR 50069 (August 1, 2002). | | | | |
| 8. 01 | The amount of increase if the hospital was awarded FTE cap slots | s under § 5503 of the | ACA. If the cost | 0. 00 | 8. 01 |
| 0.00 | report straddles July 1, 2011, see instructions. | from a algood toochi | na hooni tol | 0.00 | 0 00 |
| 8. 02 | The amount of increase if the hospital was awarded FTE cap slots under § 5506 of ACA. (see instructions) | s from a crosed teachi | ng nospi tai | 0. 00 | 8. 02 |
| 9. 00 | Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines | (8 8 01 and 8 02) (| 992 | 0. 00 | 9. 00 |
| 7. 00 | instructions) | (0, 0, 01 and 0, 02) | 300 | 0.00 | 7.00 |
| 10.00 | FTE count for allopathic and osteopathic programs in the current | vear from your recor | ds | 0.00 | 10.00 |
| | FTE count for residents in dental and podiatric programs. | , y y | | 0. 00 | |
| | Current year allowable FTE (see instructions) | | | | 12.00 |
| 13.00 | Total allowable FTE count for the prior year. | | | 0. 00 | 13.00 |
| 14.00 | Total allowable FTE count for the penultimate year if that year | ended on or after Sep | tember 30, 1997, | 0.00 | • |
| | otherwise enter zero. | | | | |
| | Sum of lines 12 through 14 divided by 3. | | | 0.00 | 15.00 |
| 16.00 | Adjustment for residents in initial years of the program | | | 0.00 | 16. 00 |
| 17.00 | Adjustment for residents displaced by program or hospital closur | re e | | 0. 00 | 17. 00 |
| | Adjusted rolling average FTE count | | | | 18. 00 |
| | Current year resident to bed ratio (line 18 divided by line 4). | | | 0. 000000 | |
| | Prior year resident to bed ratio (see instructions) | | | 0. 000000 | |
| 21. 00 | Enter the lesser of lines 19 or 20 (see instructions) | | | 0. 000000 | |
| 22. 00 | IME payment adjustment (see instructions) | | | 0 | 22.00 |
| 22. 01 | IME payment adjustment - Managed Care (see instructions) | | | 0 | 22. 01 |
| | Indirect Medical Education Adjustment for the Add-on for § 422 o | | | | |
| 23. 00 | Number of additional allopathic and osteopathic IME FTE resident | cap slots under 42 (| FR 412. 105 | 0. 00 | 23. 00 |
| 24.00 | (f)(1)(iv)(C). | | | 0.00 | 24 00 |
| 24. 00 | IME FTE Resident Count Over Cap (see instructions) | on of line 22 on line | 24 (000 | 0.00 | |
| 25.00 | If the amount on line 24 is greater than -O-, then enter the low | ver of tine 23 of tine | 24 (See | 0. 00 | 25. 00 |
| 26. 00 | instructions) Resident to bed ratio (divide line 25 by line 4) | | | 0. 000000 | 26. 00 |
| | IME payments adjustment factor. (see instructions) | | | 0. 000000 | |
| | IME add-on adjustment amount (see instructions) | | | 0.000000 | 28. 00 |
| | IME add-on adjustment amount (see Firstructions) | | | 0 | 28. 01 |
| 29. 00 | 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 | | | 0 | |
| 30.00 | Percentage of SSI recipient patient days to Medicare Part A pati | ent days (see instruc | tions) | 2. 19 | 30.00 |
| | Percentage of Medicaid patient days (see instructions) | (222 | - / | 18. 43 | |
| | Sum of lines 30 and 31 | | | 20. 62 | |
| 33.00 | Allowable disproportionate share percentage (see instructions) | | | 6. 23 | |
| 34.00 | Disproportionate share adjustment (see instructions) | | | 571, 195 | |
| | | | ' | | |

| CALCUL | ATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0035 | Peri od: From 01/01/2020 To 12/31/2020 | Date/Time Pre 7/28/2021 4:3 | pared: 6 pm |
|--|---|--------------------------|--|----------------------------------|--------------------------------------|
| | | Title XVIII | Hospi tal | PPS On/After 10/1 | |
| | | | 1.00 | 2. 00 | |
| | Uncompensated Care Adjustment | | | | |
| 35. 00 35. 01 | Total uncompensated care amount (see instructions) Factor 3 (see instructions) | | 8, 350, 599, 096 0. 000183986 | 8, 290, 014, 521 0. 000131341 | 35. 00 35. 01 |
| 35. 02 | , | er zero on this line) (s | | | |
| 35. 03 36. 00 | Pro rata share of the hospital uncompensated care payment am Total uncompensated care (sum of columns 1 and 2 on line 35.0 | , | 1, 150, 196 1, 424, 638 | | 35. 03 36. 00 |
| | Additional payment for high percentage of ESRD beneficiary di | | | | |
| 40. 00 | Total Medicare discharges, excluding MS-DRGs 652, 682, 683, (instructions) | 684 and 685. (See | 0 | | 40.00 |
| 41. 00 | Total ESRD Medicare discharges excluding MS-DRGs 652, 682, (instructions) | • | 0 | | 41.00 |
| 41. 01 | Total ESRD Medicare covered and paid discharges excluding MS an 685. (see instructions) | | 4 O | | 41.01 |
| 42. 00 43. 00 | Divide line 41 by line 40 (if less than 10%, you do not qualitated Medicare ESRD inpatient days excluding MS-DRGs 652, 66 instructions) | | e 0.00 0 | | 42. 00 43. 00 |
| 44. 00 | Ratio of average length of stay to one week (line 43 divided days) | by line 41 divided by 7 | 0. 000000 | | 44.00 |
| 45.00 | Average weekly cost for dialysis treatments (see instructions | | 0.00 | | 45.00 |
| 46. 00 47. 00 | Total additional payment (line 45 times line 44 times line 4 Subtotal (see instructions) | 1.01) | 39, 233, 462 | | 46. 00 47. 00 |
| 48. 00 | Hospital specific payments (to be completed by SCH and MDH, sonly, (see instructions) | small rural hospitals | 0 | | 48. 00 |
| | | | | Amount | |
| 49. 00 | Total payment for inpatient operating costs (see instructions | e) | | 1. 00 39, 233, 462 | 49.00 |
| 50.00 | Payment for inpatient program capital (from Wkst. L, Pt. I a | nd Pt. II, as applicable |) | 3, 014, 016 | • |
| 51. 00 | Exception payment for inpatient program capital (Wkst. L, Pt. | | | 0 | 51.00 |
| 52. 00 53. 00 | Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment | ine 49 see instructions) | • | 0 | 52.00 53.00 |
| 54. 00 | Special add-on payments for new technologies | | | 197, 065 | |
| 54. 01 | Islet isolation add-on payment | | | 0 | 54.01 |
| 55. 00 56. 00 | Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cost of physicians' services in a teaching hospital (see into | | | 0 | 55. 00 56. 00 |
| 57. 00 | Routine service other pass through costs (from Wkst. D, Pt. | | through 35). | 0 | 57.00 |
| 58. 00 | Ancillary service other pass through costs from Wkst. D, Pt. | | 3 / | 0 | 58.00 |
| 59.00 | Total (sum of amounts on lines 49 through 58) | | | 42, 444, 543 | l |
| 50.00 | Primary payer payments Total amount payable for program beneficiaries (line 59 minus | s line 60) | | 27, 975 42, 416, 568 | |
| 52. 00 | Deductibles billed to program beneficiaries | 3 1116 00) | | 3, 439, 612 | |
| 53. 00 | 1 9 | | | 138, 336 | |
| 64.00 | | | | 319, 416 | |
| 65. 00 66. 00 | Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins | tructions) | | 207, 620 62, 672 | 65. 00 66. 00 |
| 57. 00 | Subtotal (line 61 plus line 65 minus lines 62 and 63) | tructrons) | | 39, 046, 240 | |
| | Credits received from manufacturers for replaced devices for | | | 0 | 68.00 |
| | Outlier payments reconciliation (sum of lines 93, 95 and 96). | .(For SCH see instructio | ns) | 0 | 69.00 |
| 68. 00 69. 00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | tration) adjustment (see | instructions) | 0 | 70.00 70.50 |
| 68. 00 69. 00 70. 00 | | | instructions) | - | 70.87 |
| 68. 00 69. 00 70. 00 70. 50 | Rural Community Hospital Demonstration Project (§410A Demons: Demonstration payment adjustment amount before sequestration | | | 0 | |
| 68. 00 69. 00 70. 00 70. 50 70. 87 70. 88 | Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) | , , | | 0 | 70. 88 |
| 68. 00 69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 | Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instance) | , , | | 0 | 70. 88 70. 89 |
| 68. 00 69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 | Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) | , , | | 0 | 70. 88 70. 89 70. 90 |
| 68. 00 69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90 | Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions) | , , | | 0 | 70. 88 70. 89 70. 90 70. 9 |
| 68. 00 69. 00 70. 00 70. 50 70. 87 70. 88 70. 90 70. 91 70. 92 70. 93 | Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions) | , , | | 0 | 70. 88 70. 89 70. 90 70. 92 |

| Health Financial Systems | PORTER MEMORIAL | HOSPI TAL | | In Lie | u of Form CMS-: | 2552-10 |
|---|---------------------------|-------------|---------------|---|-----------------|---------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | | Provi der C | | Period: From 01/01/2020 To 12/31/2020 | | |
| | | Title | xVIII | Hospi tal | PPS | о рііі |
| | | | | (уууу) | Amount | |
| | | | | 0 | 1. 00 | |
| 70.96 Low volume adjustment for federal f the corresponding federal year for | | n column 0 | | 0 | 0 | 70. 96 |
| 70.97 Low volume adjustment for federal f the corresponding federal year for | | | | 0 | 0 | 70. 97 |
| 70.98 Low Volume Payment-3 | | | | | 0 | 1 |
| 70.99 HAC adjustment amount (see instruct | | | | | 0 | 1 |
| 71.00 Amount due provider (line 67 minus | | 69 & 70) | | | 38, 801, 190 | |
| 71.01 Sequestration adjustment (see instr | | | | | 256, 088 | |
| 71.02 Demonstration payment adjustment an | | | | | 0 | 1 |
| 71.03 Sequestration adjustment-PARHM pass 72.00 Interim payments | s- thi oughs | | | | 37, 982, 296 | 71.03 |
| 72.00 Interim payments 72.01 Interim payments PARHM | | | | | 31, 902, 290 | 72.00 |
| 73.00 Tentative settlement (for contracto | or use only) | | | | 0 | |
| 73. 01 Tentative settlement-PARHM (for cor | | | | | Ü | 73. 01 |
| 74.00 Balance due provider/program (line 73) | | 2, 72, and | | | 562, 806 | |
| 74.01 Balance due provider/program-PARHM | (see instructions) | | | | | 74. 01 |
| 75.00 Protested amounts (nonal lowable cos CMS Pub. 15-2, chapter 1, §115.2 | · | nce with | | | 4, 288, 854 | 75. 00 |
| TO BE COMPLETED BY CONTRACTOR (line | | | 1 | | | |
| 90.00 Operating outlier amount from Wkst. | E, Pt. A, line 2, or sum | of 2.03 | | | 0 | 90.00 |
| plus 2.04 (see instructions) 91.00 Capital outlier from Wkst. L, Pt. I | line 2 | | | | 0 | 91.00 |
| 92.00 Operating outlier reconciliation as | | uctions) | | | 0 | 1 |
| 93.00 Capital outlier reconciliation adju | | | | | 0 | |
| 94.00 The rate used to calculate the time | • | , | | | 0.00 | |
| 95.00 Time value of money for operating e | y (| | | | 0 | |
| 96.00 Time value of money for capital rel | , | tions) | | | 0 | |
| | • | | • | 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 Payme | | | | 0.000000000 | 0.000000000 | 101 00 |
| 101.00 HVBP adjustment factor (see instruction) | | 5) | | 0. 0000000000 | 0. 0000000000 | |
| 102.00 HVBP adjustment amount for HSP bonu HRR Adjustment for HSP Bonus Paymen | | S) | | 0 | 0 | 102. 00 |
| 103.00 HRR adjustment factor (see instruct | | | | 0.0000 | 0.0000 | 103.00 |
| 104. 00 HRR adjustment amount for HSP bonus | , |) | | 0.0000 | | 104.00 |
| Rural Community Hospital Demonstrat | | | ustment | | 0 | 1104.00 |
| 200.00 Is this the first year of the curre | | | | | | 200.00 |
| Century Cures Act? Enter "Y" for ye | | | | | | |
| Cost Reimbursement | | | | | | |
| 201.00 Medicare inpatient service costs (f | | e 49) | | | | 201.00 |
| 202.00 Medicare discharges (see instruction | • | | | | | 202.00 |
| 203.00 Case-mix adjustment factor (see ins | | | | | | 203. 00 |
| Computation of Demonstration Target | Amount Limitation (N/A in | first year | of the currer | nt 5-year demons | strati on | |
| peri od) 204.00 Medi care target amount | | | | | | 204.00 |
| 204. 00 Wedicale larget allouit | 000 11 11 001 | | | | | 204.00 |

| 204.00 Medicare target amount | 204. 0 |
|--|--------|
| 205.00 Case-mix adjusted target amount (line 203 times line 204) | 205.0 |
| 206.00 Medicare inpatient routine cost cap (line 202 times line 205) | 206. 0 |
| Adjustment to Medicare Part A Inpatient Reimbursement | |
| 207.00 Program reimbursement under the §410A Demonstration (see instructions) | 207. 0 |
| 208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) | 208.0 |
| 209.00 Adjustment to Medicare IPPS payments (see instructions) | 209. 0 |
| 210.00 Reserved for future use | 210.0 |
| 211.00 Total adjustment to Medicare IPPS payments (see instructions) | 211. 0 |
| Comparision of PPS versus Cost Reimbursement | |
| 212.00 Total adjustment to Medicare Part A IPPS payments (from line 211) | 212.0 |
| 213.00 Low-volume adjustment (see instructions) | 213.0 |
| 218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) | 218.0 |
| (line 212 minus line 213) (see instructions) | |
| | |
| | |
| | |

| Health Financial Systems | PORTER MEMORIAL HOSPITAL | In Lie | u of Form CMS-2552-10 |
|---|--------------------------|-----------------|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 1 | From 01/01/2020 | Worksheet E Part B Date/Time Prepared: 7/28/2021 4:36 pm |
| | | | |

| | Title | e XVIII | Hospi tal | 7/28/2021 4: 3 PPS | 6 pm |
|------------------|--|---------------|----------------|------------------------|------------------|
| | | 7,,,,, | nespi tai | | |
| | PART B - MEDICAL AND OTHER HEALTH SERVICES | | | 1. 00 | |
| 1. 00 | Medical and other services (see instructions) | | | 26, 814 | 1.00 |
| 2.00 | Medical and other services reimbursed under OPPS (see instructions) | | | 33, 318, 049 | |
| 3.00 | OPPS payments | | | 32, 911, 529 | |
| 4.00 | Outlier payment (see instructions) | | | 56, 891 | 4.00 |
| 4. 01 | Outlier reconciliation amount (see instructions) | | | 0 | |
| 5.00 | Enter the hospital specific payment to cost ratio (see instructions) | | | 0. 000 | |
| 6.00 | Line 2 times line 5 | | | 0 00 | |
| 7. 00 8. 00 | Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions) | | | 0. 00 0 | 1 |
| 9. 00 | Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13 | Line 200 | | 0 | 9.00 |
| 10.00 | Organ acquisitions | , 11110 200 | | 0 | |
| 11.00 | Total cost (sum of lines 1 and 10) (see instructions) | | | 26, 814 | 11.00 |
| | COMPUTATION OF LESSER OF COST OR CHARGES | | | | |
| | Reasonable charges | | | | |
| 12.00 | Ancillary service charges | | | 207, 752 | |
| | Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) Total reasonable charges (sum of lines 12 and 13) | | | 0 207, 752 | |
| 14.00 | Customary charges | | | 201, 132 | 14.00 |
| 15. 00 | Aggregate amount actually collected from patients liable for payment for | servi ces on | a charge basis | 0 | 15.00 |
| 16.00 | Amounts that would have been realized from patients liable for payment f | | | 0 | |
| | had such payment been made in accordance with 42 CFR §413.13(e) | | · · | | |
| 17.00 | Ratio of line 15 to line 16 (not to exceed 1.000000) | | | 0. 000000 | |
| | Total customary charges (see instructions) | | | 207, 752 | |
| 19. 00 | Excess of customary charges over reasonable cost (complete only if line | 18 exceeds Li | ne 11) (see | 180, 938 | 19.00 |
| 20. 00 | <pre>instructions) Excess of reasonable cost over customary charges (complete only if line</pre> | 11 exceeds Li | ne 18) (see | 0 | 20.00 |
| 20.00 | instructions) | TT CACCCUS TI | 110 10) (300 | 0 | 20.00 |
| 21.00 | Lesser of cost or charges (see instructions) | | | 26, 814 | 21.00 |
| 22.00 | Interns and residents (see instructions) | | | 0 | 22.00 |
| 23.00 | Cost of physicians' services in a teaching hospital (see instructions) | | | 0 | 23.00 |
| 24.00 | Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) | | | 32, 968, 420 | 24.00 |
| 25 00 | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | /7.017 | 25 00 |
| 25. 00 26. 00 | Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH) | 'AU coo inct | suctions) | 67, 917 5, 640, 133 | 25. 00 26. 00 |
| 27. 00 | Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the su | | | 27, 287, 184 | |
| 27.00 | instructions) | 01 111103 22 | 20] (300 | 27,207,101 | 27.00 |
| 28.00 | Direct graduate medical education payments (from Wkst. E-4, line 50) | | | 0 | 28. 00 |
| | ESRD direct medical education costs (from Wkst. E-4, line 36) | | | 0 | 29. 00 |
| | Subtotal (sum of lines 27 through 29) | | | 27, 287, 184 | 1 |
| 31.00 | Primary payer payments | | | 11, 513 | |
| 32.00 | Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) | | | 27, 275, 671 | 32.00 |
| 33 00 | Composite rate ESRD (from Wkst. I-5, line 11) | | | 0 | 33.00 |
| | Allowable bad debts (see instructions) | | | 489, 259 | |
| | Adjusted reimbursable bad debts (see instructions) | | | 318, 018 | |
| 36.00 | Allowable bad debts for dual eligible beneficiaries (see instructions) | | | 275, 645 | 36.00 |
| 37.00 | Subtotal (see instructions) | | | 27, 593, 689 | |
| | MSP-LCC reconciliation amount from PS&R | | | -413 | |
| | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | | 0 | |
| | Prioneer ACO demonstration payment adjustment (see instructions) | | | 0 | 39.50 |
| 39. 97 | Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices | (coo instru | etions) | 0 | ı |
| 39. 90 | RECOVERY OF ACCELERATED DEPRECIATION | (See Histiud | LTI UIIS) | 0 | 1 |
| | Subtotal (see instructions) | | | 27, 594, 102 | 1 |
| 40. 01 | Sequestration adjustment (see instructions) | | | 182, 121 | 1 |
| 40. 02 | Demonstration payment adjustment amount after sequestration | | | 0 | 1 |
| 40. 03 | Sequestration adjustment-PARHM pass-throughs | | | | 40. 03 |
| | Interim payments | | | 27, 470, 398 | 41.00 |
| | Interim payments-PARHM | | | _ | 41.01 |
| 42.00 | Tentative settlement (for contractors use only) | | | 0 | |
| 42.01 | Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions) | | | -58, 417 | 42. 01 43. 00 |
| 43.00 | Balance due provider/program (see instructions) | | | -38, 417 | 43.00 |
| 44. 00 | Protested amounts (nonallowable cost report items) in accordance with CN | IS Pub. 15-2 | chapter 1. | 0 | 1 |
| 00 | §115. 2 | | | | |
| | TO BE COMPLETED BY CONTRACTOR | | | | |
| | 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 | |
| | Time Value of Money (see instructions) Total (sum of lines 91 and 93) | | | 0 | 93. 00 94. 00 |
| , 1. 50 | 1.22. (2am 3. 1.1.03 /1 and /0/ | | | · | , , , , , , , , |

| Health Financial Systems | PORTER MEMORIAL HOSPITAL | In Lieu | u of Form CMS-2552-10 |
|---|--------------------------|----------------------------------|-----------------------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0035 | | Worksheet E |
| | Component CCN: 15-T035 | From 01/01/2020 To 12/31/2020 | Date/Time Prepared: |
| | | | 7/28/2021 4:36 pm |
| | Title XVIII | Subprovi der - | PPS |
| | | | |

| | Title XVIII Subprovider - | PPS | |
|------------------|---|-----------|------------------|
| | I IM | | |
| | PART B - MEDICAL AND OTHER HEALTH SERVICES | 1.00 | |
| 1.00 | Medical and other services (see instructions) | 512 | 1.00 |
| 2.00 | Medical and other services reimbursed under OPPS (see instructions) | 60 | 2.00 |
| 3. 00 4. 00 | OPPS payments Outlier payment (see instructions) | 256 | 3. 00 4. 00 |
| 4. 01 | Outlier reconciliation amount (see instructions) | Ö | 4. 01 |
| 5. 00 | Enter the hospital specific payment to cost ratio (see instructions) | 0.000 | |
| 6. 00 7. 00 | Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6 | 0.00 | 6. 00 7. 00 |
| 8. 00 | Transitional corridor payment (see instructions) | 0.00 | 8. 00 |
| 9. 00 | Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 | 0 | 9. 00 |
| 10.00 | Organ acquisitions | 0 | 10.00 |
| 11. 00 | Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES | 512 | 11. 00 |
| | Reasonabl e charges | | |
| 12.00 | Ancillary service charges | | 12.00 |
| 13. 00 14. 00 | Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) Total reasonable charges (sum of lines 12 and 13) | 3, 297 | 13. 00 14. 00 |
| 14.00 | Customary charges | 3,277 | 14.00 |
| 15. 00 | Aggregate amount actually collected from patients liable for payment for services on a charge basis | | 15.00 |
| 16. 00 | Amounts that would have been realized from patients liable for payment for services on a chargebasi had such payment been made in accordance with 42 CFR §413.13(e) | s 0 | 16. 00 |
| 17. 00 | Ratio of line 15 to line 16 (not to exceed 1.000000) | 0. 000000 | 17. 00 |
| 18. 00 | Total customary charges (see instructions) | 3, 297 | 18. 00 |
| 19. 00 | Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see | 2, 785 | 19. 00 |
| 20. 00 | instructions) Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see | 0 | 20. 00 |
| 21. 00 | instructions) Lesser of cost or charges (see instructions) | 512 | 21. 00 |
| 22. 00 | | 0 | 22.00 |
| 23.00 | Cost of physicians' services in a teaching hospital (see instructions) | 0 | 23.00 |
| 24. 00 | Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT | 256 | 24. 00 |
| 25. 00 | Deductibles and coinsurance amounts (for CAH, see instructions) | 0 | 25. 00 |
| 26. 00 | Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) | 0 | 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 instructions) | 768 | 27. 00 |
| 28. 00 | | 0 | 28. 00 |
| 29. 00 | | 0 | 29. 00 |
| 30. 00 31. 00 | Subtotal (sum of lines 27 through 29) | 768 | 30. 00 31. 00 |
| 32. 00 | | 768 | |
| | ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) | | |
| 33. 00 34. 00 | | 0 | 33. 00 34. 00 |
| 35. 00 | · · · · · · · · · · · · · · · · · · · | 0 | 35. 00 |
| 36. 00 | | 0 | 36. 00 |
| | | 768 | |
| 38. 00 39. 00 | MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | 0 | 38. 00 39. 00 |
| 39. 50 | Pioneer ACO demonstration payment adjustment (see instructions) | | 39. 50 |
| 39. 97 | Demonstration payment adjustment amount before sequestration | 0 | 39. 97 |
| 39. 98 | Partial or full credits received from manufacturers for replaced devices (see instructions) | 0 | 39. 98 |
| 39. 99 40. 00 | RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) | 0 768 | 39. 99 40. 00 |
| 40. 01 | Sequestration adjustment (see instructions) | 5 | 40.00 |
| 40. 02 | Demonstration payment adjustment amount after sequestration | 0 | 40. 02 |
| 40. 03 | Sequestration adjustment-PARHM pass-throughs | 000 | 40. 03 |
| 41. 00 41. 01 | Interim payments Interim payments-PARHM | 909 | 41. 00 41. 01 |
| 42. 00 | Tentative settlement (for contractors use only) | 0 | |
| 42. 01 | Tentative settlement-PARHM (for contractor use only) | | 42.01 |
| 43. 00 43. 01 | Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions) | -146 | 43. 00 43. 01 |
| 44. 00 | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, | О | |
| | §115. 2 TO BE COMPLETED BY CONTRACTOR | | |
| 90.00 | Original outlier amount (see instructions) | 0 | 90. 00 |
| | Outlier reconciliation adjustment amount (see instructions) | 0 | |
| | The rate used to calculate the Time Value of Money Time Value of Money (see instructions) | 0.00 | 92. 00 93. 00 |
| | Time Value of Money (see instructions) Total (sum of lines 91 and 93) | 0 | |
| | | 1 | |

Health Financial Systems PORT ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2020 | Part | | To 12/31/2020 | Date/Time Prepared: Provi der CCN: 15-0035

| | | | | 10 12/31/2020 | 7/28/2021 4: 30 | |
|-------|--|------------|-------------|---------------|-----------------|-------|
| | | Ti tl e | e XVIII | Hospi tal | PPS | |
| | | Inpatier | nt Part A | Par | t 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 | | 37, 982, 29 | | 27, 470, 398 | 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) | | | | | |
| | Program to Provider | | | | | |
| 3. 01 | ADJUSTMENTS TO PROVIDER | | | 0 | 0 | 3. 01 |
| 3.02 | | | | 0 | l ol | 3. 02 |
| 3.03 | | | | 0 | l ol | 3. 03 |
| 3.04 | | | | 0 | l ol | 3. 04 |
| 3.05 | | | | 0 | l ol | 3. 05 |
| | Provider to Program | | | | | |
| 3.50 | ADJUSTMENTS TO PROGRAM | | | 0 | 0 | 3.50 |
| 3. 51 | | | | 0 | 0 | 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) | | 37, 982, 29 | 6 | 27, 470, 398 | 4.00 |
| | (transfer to Wkst. E or Wkst. E-3, line and column as | | | | | |
| | appropri ate) | | | | | |
| | TO BE COMPLETED BY CONTRACTOR | | | <u></u> | | |
| 5.00 | List separately each tentative settlement payment after | | | | | 5.00 |
| | desk review. Also show date of each payment. If none, | | | | | |
| | write "NONE" or enter a zero. (1) | | | | | |
| | Program to Provider | | | | | |
| 5. 01 | TENTATI VE TO PROVI DER | | II. | 0 | 0 | 5. 01 |
| 5.02 | | | l | 0 | 0 | 5. 02 |
| 5. 03 | | | | 0 | 0 | 5. 03 |
| | Provi der to Program | | | | | |
| 5. 50 | TENTATI VE TO PROGRAM | | | 0 | 0 | 5. 50 |
| 5. 51 | | | | 0 | 0 | 5. 51 |
| 5. 52 | 6 1 1 1 1 1 7 2 2 6 1 2 2 2 5 04 5 40 2 2 2 2 2 2 2 2 2 2 | | | 0 | 0 | 5. 52 |
| 5. 99 | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) | | | 0 | 0 | 5. 99 |
| 4 00 | Determined net settlement amount (balance due) based on | | | | | 4 00 |
| 6. 00 | the cost report. (1) | | | | | 6. 00 |
| 6. 01 | SETTLEMENT TO PROVIDER | | 562, 80 | 6 | o | 6. 01 |
| 6. 02 | SETTLEMENT TO PROGRAM | | | o | 58, 417 | 6. 02 |
| 7. 00 | Total Medicare program liability (see instructions) | | 38, 545, 10 | 2 | 27, 411, 981 | 7. 00 |
| | | | | Contractor | NPR Date | |
| | | | | Number | (Mo/Day/Yr) | |
| | | | 0 | 1.00 | 2. 00 | |
| 8.00 | Name of Contractor | | | | | 8.00 |

| Health Financial Systems | PORTER MEMORIAL | HOSPI TAL | | In Lieu | u of Form CMS-2552-10 |
|---|-----------------|-----------|---------|----------------------------------|-----------------------|
| ANALYSIS OF PAYMENTS TO PROVIDERS FOR SER | VICES RENDERED | | | From 01/01/2020 To 12/31/2020 | Date/Time Prepared: |
| | | T' 11 | o V/III | Cubagovi dog | 7/28/2021 4: 36 pm |

| Inpatient Part A | | | Title | · XVIII | Subprovi der - I RF | PPS | <u>5 piii </u> |
|--|-------|---|------------|-------------|------------------------|--------|--|
| 1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 | | | I npati en | it Part A | | t B | |
| 1.00 | | | mm/dd/yyyy | Amount | mm/dd/yyyy | Amount | |
| 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 tist 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) | | | 1. 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 | | | | | | | |
| Services rendered in the cost reporting period. If none, write "NoNE" or enter a zero that it 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 | 2. 00 | | | |) | 0 | 2.00 |
| write "NONE" or enter a zero 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 3.01 3.02 3.03 3.04 3.05 ADJUSTMENTS TO PROVIDER 0 0 0 3.03 3.04 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 0 3.05 3.50 Provider to Program 3.51 3.52 0 0 0 3.55 3.53 3.54 0 0 0 0 3.55 3.53 3.54 0 0 0 3.55 3.53 3.54 0 0 0 0 3.55 3.50.3.98) Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 0 0.3.56 3.50.3.99 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NoNE" or enter a zero. (1) Program to Provider TENTATIVE TO PROGRAM 0 0 0 5.00 Entry Program TENTATIVE TO PROGRAM 0 0 0 5.50 Provider to Program TENTATIVE TO PROGRAM 0 0 0 5.50 Provider to Program 1 0 0 0 5.50 Provider to Program 1 0 0 0 5.50 5.50 Provider to Program 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) Program to Provider 1 ENTATIVE TO PROGRAM 0 0 0 5.50 5.50 Provider to Program 5.50 ENTON Program 5.50 ENTON Program 5.50-5.98 5.50-5.98 5.50-5.98 5.50-5.98 5.50-5.98 5.50-5.98 5.50-5.98 5.50-5.98 5.70 5. | | | | | | | |
| 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 | | | | | | | |
| 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) | 3.00 | | | | | | 3.00 |
| payment, If none, write "NONE" or enter a zero. (1) Proyam to Provider | | | | | | | |
| Program to Provider | | | | | | | |
| 3. 01 3. 02 3. 03 3. 04 3. 05 0 0 0 3. 01 3. 03 3. 04 3. 05 0 0 0 3. 03 3. 04 3. 05 0 0 0 3. 05 | | | | | | | |
| 3. 02 0 | | | | 1 | | | |
| 3.03 3.04 3.05 9 9 9 9 9 9 9 9 9 | | ADJUSTMENTS TO PROVIDER | | | | | |
| 3. 04 | | | | | | - 1 | |
| 3.05 | | | | | | | |
| 3. 50 ADJUSTMENTS TO PROGRAM | | | | | | - 1 | |
| 3.51 3.52 3.53 0 0 0 3.51 3.52 3.53 0 0 0 3.53 3.53 3.54 0 0 0 3.53 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 0 3.54 3.99 3.50-3.98) 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 appropriate) To BE COMPLETED BY CONTRACTOR | | Provi der to Program | | | • | - | |
| 3.52 3.53 3.54 3.99 3.50 3.62 3.53 3.54 3.99 3.50 3.99 3.50 3.99 3.50 3.99 3.50 | 3.50 | ADJUSTMENTS TO PROGRAM | | (|) | 0 | 3.50 |
| 3.53 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.55 3.59 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.99 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.99 3.50-3.99 3.50-3.11 909 4.00 | | | | | | | |
| 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 3,502,411 909 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR | | | | | | | |
| 3. 99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.09) 3. 99 3. 50-3.98) 4. 00 Total interim payments (sum of lines 1, 2, and 3.99) 3, 502, 411 909 4. 00 | | | | - | | - 1 | |
| 3. 50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total Medicare program liability (see instructions) Total Medicare program liability (see instructions) Total Medicare program liability (see instructions) Total Medicare program liability (see instructions) Total Medicare program liability (see instructions) Total Medicare program liability (see instructions) Total Medicare program liability (see instructions) Total Medicare program liability (see instructions) Total Medicare program liability (see instructions) Total Medicare program liability (see instructions) Total Medicare program liability (see instructions) Total Medicare program liability (see instructions) Total Medicare program liability (see instructions) Total Medicare program liability (see instructions) Total Medicare program liability (see instructions) Total Medicare program liability (see liable liab | | Subtotal (sum of lines 3 M1-3 40 minus sum of lines | | | | | |
| 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 appropriate) TO BE COMPLETED BY CONTRACTOR | 3. 77 | | | | | | 5. 77 |
| appropriate 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) Program to Provider 0 | 4.00 | | | 3, 502, 411 | | 909 | 4.00 |
| TO BE COMPLÉTED BY CONTRACTOR | | (transfer to Wkst. E or Wkst. E-3, line and column as | | | | | |
| 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) Program to Provider | | | | | | | |
| desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider | г оо | | | I | | | F 00 |
| Write "NONE" or enter a zero. (1) Program to Provider | 5.00 | | | | | | 5.00 |
| Program to Provider TENTATIVE TO PROVIDER 0 | | | | | | | |
| TENTATI VE TO PROVIDER | | | | | | | |
| Solution Settlement Settl | 5. 01 | | | (|) | 0 | 5. 01 |
| Provider to Program | | | | | | | |
| TENTATI VE TO PROGRAM | 5. 03 | | | (|) | 0 | 5. 03 |
| 5.51 5.52 5.52 5.59 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 81,105 0 6.01 6.02 SETTLEMENT TO PROGRAM 0 146 6.02 7.00 Total Medicare program liability (see instructions) 3,583,516 Contractor NPR Date (Mo/Day/Yr) NPR Date (Mo/Day/Yr) 0 1.00 2.00 Contractor NPR Date (Mo/Day/Yr) NPR Date (Mo/Day/Yr) Contractor NPR Date (Mo | F F0 | | | 1 / | | | F F0 |
| 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 81,105 0 6.01 6.02 SETTLEMENT TO PROGRAM 0 146 6.02 7.00 Total Medicare program liability (see instructions) 3,583,516 Contractor Number (Mo/Day/Yr) Contractor Number (Mo/Day/Yr) 0 1.00 2.00 Contractor Number (Mo/Day/Yr) Contractor Number (Mo/Da | | TENTATIVE TO PROGRAM | | | | | |
| 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 81,105 0 6.01 6.02 SETTLEMENT TO PROGRAM 0 146 6.02 7.00 Total Medicare program liability (see instructions) 3,583,516 Contractor NPR Date (Mo/Day/Yr) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00 | | | | | | 1 | |
| 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 81,105 0 6.01 146 6.02 7,00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00 | | Subtotal (sum of lines 5.01-5.49 minus sum of lines | | | | | |
| the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 81,105 0 6.01 146 6.02 7,00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00 | | 5. 50-5. 98) | | | | | |
| 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00 | 6.00 | | | | | | 6.00 |
| 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00 | . 01 | | | 04.405 | .[| | . 01 |
| 7.00 Total Medicare program liability (see instructions) 3,583,516 Contractor Number (Mo/Day/Yr) 0 1.00 2.00 | | | | | | | |
| Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00 | | | | 1 | 1 | I I | |
| Number (Mo/Day/Yr) 0 1.00 2.00 | 7.00 | Total modical or program frability (see first detroits) | | 3, 303, 310 | | | 7.00 |
| | | | | | | | |
| 8.00 Name of Contractor 8.00 | | | (|) | 1. 00 | 2. 00 | |
| | 8. 00 | Name of Contractor | | | | | 8. 00 |

| Heal th | Financial Systems PORTER MEMORIA | L HOSPI TAL | In Lie | u of Form CMS- | 2552-10 |
|---------|---|--------------------------|-----------------------------|----------------|---------|
| CALCUL | ATION OF REIMBURSEMENT SETTLEMENT FOR HIT | Provi der CCN: 15-0035 | Peri od: From 01/01/2020 | Worksheet E- | 1 |
| | | | To 12/31/2020 | | |
| | | Title XVIII | Hospi tal | PPS | |
| | | | | | |
| | | | | 1. 00 | |
| | TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS | | | | _ |
| | HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION | | | | _ |
| 1. 00 | Total hospital discharges as defined in AARA §4102 from Wkst | | e 14 | | 1.00 |
| 2.00 | Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, | 8-12 | | | 2.00 |
| 3.00 | Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 | | | | 3. 00 |
| 4.00 | Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, | 8-12 | | | 4. 00 |
| 5.00 | Total hospital charges from Wkst C, Pt. I, col. 8 line 200 | | | | 5.00 |
| 6.00 | Total hospital charity care charges from Wkst. S-10, col. 3 | line 20 | | | 6. 00 |
| 7.00 | CAH only - The reasonable cost incurred for the purchase of | 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 | | | | |
| 30.00 | Initial/interim HIT payment adjustment (see instructions) | | | | 30.00 |
| 31.00 | Other Adjustment (specify) | | | | 31.00 |
| 32. 00 | Balance due provider (line 8 (or line 10) minus line 30 and | line 31) (see instructio | ns) | | 32.00 |

| Health Financial Systems | PORTER MEMORIAL | HOSPI TAL | In Lieu | ı of Form CMS-2552-10 |
|---|-----------------|------------------------|-----------------------------|-----------------------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT - | SWING BEDS | Provi der CCN: 15-0035 | Peri od: From 01/01/2020 | Worksheet E-2 |
| | | Component CCN: 15-U035 | | Date/Time Prepared: |

| | | Component CCN: 15-U035 | To 12/31/2020 | Date/Time Pr 7/28/2021 4: | |
|---------|--|-----------------------------|---------------------------------------|------------------------------|---------|
| | | Title XIX | Swing Beds - SNF | | о рііі |
| | | | Part A | Part B | |
| | | | 1. 00 | 2. 00 | |
| | COMPUTATION OF NET COST OF COVERED SERVICES | | | | |
| 1.00 | Inpatient routine services - swing bed-SNF (see instructions) | | 0 | | 1.00 |
| 2.00 | Inpatient routine services - swing bed-NF (see instructions) | | 0 | | 2.00 |
| 3. 00 | Ancillary services (from Wkst. D-3, col. 3, line 200, for Par | | 0 | | 3.00 |
| | Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swill instructions) | ng-bed pass-through, see | | | |
| 3. 01 | Nursing and allied health payment-PARHM (see instructions) | | | | 3. 01 |
| 4. 00 | Per diem cost for interns and residents not in approved teach | ing program (see | 0.00 | | 4.00 |
| 1. 00 | instructions) | riig program (see | 0.00 | | 1.00 |
| 5.00 | Program days | | o | | 5.00 |
| 6. 00 | Interns and residents not in approved teaching program (see i | nstructions) | ol | | 6.00 |
| 7.00 | Utilization review - physician compensation - SNF optional me | | o | | 7.00 |
| 8.00 | Subtotal (sum of lines 1 through 3 plus lines 6 and 7) | , | o | | 8.00 |
| 9.00 | Primary payer payments (see instructions) | | o | | 9.00 |
| 10.00 | Subtotal (line 8 minus line 9) | | o | | 10.00 |
| 11.00 | Deductibles billed to program patients (exclude amounts appli- | cable to physician | 0 | | 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 |) (exclude coinsurance | 0 | | 13. 00 |
| | for physician professional services) | | | | |
| 14.00 | 80% of Part B costs (line 12 x 80%) | | 0 | | 14.00 |
| | Subtotal (see instructions) | | 0 | | 15.00 |
| | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | 0 | | 16.00 |
| 16. 50 | Pioneer ACO demonstration payment adjustment (see instruction | | | | 16. 50 |
| 16. 55 | Rural community hospital demonstration project (§410A Demonst | ration) payment | | | 16. 55 |
| 16. 99 | adjustment (see instructions) Demonstration payment adjustment amount before sequestration | | 0 | | 16. 99 |
| | Allowable bad debts (see instructions) | | | | 17. 00 |
| | Adjusted reimbursable bad debts (see instructions) | | 0 | | 17. 01 |
| | Allowable bad debts for dual eligible beneficiaries (see inst | ructions) | Ö | | 18.00 |
| | Total (see instructions) | ructions) | o o | | 19.00 |
| 19. 01 | Sequestration adjustment (see instructions) | | Ö | | 19. 01 |
| | Demonstration payment adjustment amount after sequestration) | | Ö | | 19. 02 |
| | Sequestration adjustment-PARHM pass-throughs | | | | 19. 03 |
| | Interim payments | | o | | 20.00 |
| | Interim payments-PARHM | | | | 20. 01 |
| | Tentative settlement (for contractor use only) | | o | | 21.00 |
| 21.01 | Tentative settlement-PARHM (for contractor use only) | | | | 21. 01 |
| 22.00 | Balance due provider/program (line 19 minus lines 19.01, 20, | and 21) | 0 | | 22.00 |
| 22.01 | Balance due provider/program-PARHM (see instructions) | | | | 22. 01 |
| 23.00 | Protested amounts (nonallowable cost report items) in accorda | nce with CMS Pub. 15-2, | 0 | | 23. 00 |
| | chapter 1, §115.2 | | | | |
| | Rural Community Hospital Demonstration Project (§410A Demonstr | | | | 4 |
| 200.00 | Is this the first year of the current 5-year demonstration pe | riod under the 21st | | | 200. 00 |
| | Century Cures Act? Enter "Y" for yes or "N" for no. | | | | |
| 201 00 | Cost Reimbursement | Wko+ D 1 D+ II line | | | 201 00 |
| 201.00 | Medicare swing-bed SNF inpatient routine service costs (from 66 (title XVIII hospital)) | wkst. D-1, Pt. 11, Tille | | | 201. 00 |
| 202 00 | Medicare swing-bed SNF inpatient ancillary service costs (fro | m Wkst D_3 col 3 lin | | | 202.00 |
| 202.00 | 200 (title XVIII swing-bed SNF)) | III WK31. D-3, COI. 3, IIII | | | 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-vear demons | trati on | |
| | peri od) | | , , , , , , , , , , , , , , , , , , , | | |
| 205.00 | Medicare swing-bed SNF target amount | | | | 205. 00 |
| 206.00 | Medicare swing-bed SNF inpatient routine cost cap (line 205 t | imes line 204) | | | 206.00 |
| | Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs | sement | | | |
| 207.00 | Program reimbursement under the §410A Demonstration (see inst | ructions) | | | 207. 00 |
| 208.00 | Medicare swing-bed SNF inpatient service costs (from Wkst. E-: | 2, col. 1, sum of lines | 1 | | 208.00 |
| | and 3) | | | | 1 |
| | Adjustment to Medicare swing-bed SNF PPS payments (see instru | ctions) | | | 209. 00 |
| 210.00 | Reserved for future use | | | | 210. 00 |
| 045 - | Comparision of PPS versus Cost Reimbursement | | | | J |
| 215. 00 | Total adjustment to Medicare swing-bed SNF PPS payment (line | 209 plus line 210) (see | | | 215. 00 |
| | instructions) | | 1 | | 1 |

| Health Financial Systems | PORTER MEMORIAL HOSPITAL | In Lie | u of Form CMS-2 | 2552-10 |
|---|--------------------------|----------------------------|-----------------------------|---------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-0035 | Period: From 01/01/2020 | Worksheet E-3 Part III | 1 |
| | Component CCN: 15-T035 | To 12/31/2020 | Date/Time Pre 7/28/2021 4:3 | |
| | Title XVIII | Subprovi der - I RF | PPS | |
| | | 110 | 1. 00 | |

| | , IRF | | |
|------------------|--|------------------|------------------|
| | | 1. 00 | |
| | PART III - MEDICARE PART A SERVICES - IRF PPS | 1.00 | |
| 1. 00 | Net Federal PPS Payment (see instructions) | 3, 441, 721 | 1.00 |
| 2. 00 | Medicare SSI ratio (IRF PPS only) (see instructions) | 0. 0243 | |
| 3. 00 | Inpatient Rehabilitation LIP Payments (see instructions) | 165, 547 | 3.00 |
| 4.00 | Outlier Payments | 26, 104 | 4.00 |
| 5. 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. 00 |
| 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. 01 |
| 6.00 | New Teaching program adjustment. (see instructions) | 0. 00 | 6. 00 |
| 7. 00 | Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new | 0. 00 | 7. 00 |
| | teaching program" (see instructions) | | |
| 8. 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. 00 |
| 9. 00 | Intern and resident count for IRF PPS medical education adjustment (see instructions) | 0. 00 | 9. 00 |
| 10.00 | Average Daily Census (see instructions) | 8. 693989 | |
| 11. 00 | Teaching Adjustment Factor (see instructions) | 0. 000000 | |
| 12.00 | Teaching Adjustment (see instructions) | 0 | 12.00 |
| 13.00 | Total PPS Payment (see instructions) | 3, 633, 372 | |
| 14.00 | Nursing and Allied Health Managed Care payments (see instruction) | 0 | 14.00 |
| 15.00 | Organ acquisition (DO NOT USE THIS LINE) | 0 | 15.00 |
| 16. 00 17. 00 | Cost of physicians' services in a teaching hospital (see instructions) Subtotal (see instructions) | 0 3, 633, 372 | |
| 18.00 | · | 3, 033, 372 | 18.00 |
| 19.00 | | 3, 633, 372 | |
| 20.00 | | 7, 040 | |
| 21. 00 | | 3, 626, 332 | |
| 22. 00 | | 19, 008 | |
| 23. 00 | | 3, 607, 324 | |
| 24. 00 | Allowable bad debts (exclude bad debts for professional services) (see instructions) | 0 | 24.00 |
| 25.00 | Adjusted reimbursable bad debts (see instructions) | 0 | 25. 00 |
| 26.00 | | 0 | 26.00 |
| 27.00 | Subtotal (sum of lines 23 and 25) | 3, 607, 324 | 27.00 |
| 28.00 | Direct graduate medical education payments (from Wkst. E-4, line 49) | 0 | 28. 00 |
| 29. 00 | Other pass through costs (see instructions) | 0 | 29. 00 |
| 30.00 | Outlier payments reconciliation | 0 | 30.00 |
| 31. 00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | 0 | 31.00 |
| 31. 50 | | 0 | 31. 50 |
| 31. 99 | Demonstration payment adjustment amount before sequestration | 0 | 31. 99 |
| 32.00 | Total amount payable to the provider (see instructions) | 3, 607, 324 | |
| 32. 01 | Sequestration adjustment (see instructions) | 23, 808 | |
| 32. 02 33. 00 | Demonstration payment adjustment amount after sequestration | 0 | 32. 02 33. 00 |
| 34.00 | 1.3 | 3, 502, 411 0 | 34.00 |
| 35.00 | Tentative settlement (for contractor use only) Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) | 81, 105 | |
| 36.00 | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, | 17, 897 | 36.00 |
| 00.00 | §115. 2 | 17,077 | 00.00 |
| | TO BE COMPLETED BY CONTRACTOR | | |
| | Original outlier amount from Wkst. E-3, Pt. III, line 4 | 26, 104 | 50.00 |
| | Outlier reconciliation adjustment amount (see instructions) | 0 | 51.00 |
| | The rate used to calculate the Time Value of Money | | 52.00 |
| 53.00 | Time Value of Money (see instructions) | 0 | 53.00 |

Health Financial Systems

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

Provider CCN: 15-0035

Peri od: Worksheet G From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 7/28/2021 4:36 pm

| Cultiform Asserts 1.00 | 37 | · | General Fund | Specific Purpose Fund | Endowment Fund | 7/28/2021 4:3 Plant Fund | 6 pm |
|---|--------|--|----------------|--------------------------|-------------------|-----------------------------|--------|
| 1.00 Cash on hand In hanks | | | 1.00 | | | 4. 00 | |
| Temporary Investments | | | | | | | |
| 3.00 Notices receivable 0 | | | -75, 381 | | 0 | | |
| Accounts receivable 70 367, 564 0 0 0 4.00 | | ' | 0 | | - 1 | | |
| O | | | 70 367 564 | | 0 | | |
| 10,000 Propelar di expenses 1,130, 385 0 0 0 1,000 | | | 0 | | Ö | | |
| Prepaid Expenses 1,130,355 0 0 0 0,00 | 6.00 | Allowances for uncollectible notes and accounts receivable | -20, 880, 700 | 0 | 0 | 0 | 6.00 |
| 0.00 Other current assets -13,774 0 0 0 0 0 0 0 0 0 | | | | | 0 | | |
| 10.00 Due From other Funds 0 0 0 0 10.00 | | | 1 | | 0 | | |
| 11.00 | | | -13, 774 | | 0 | | |
| FIXED_ASSETS | | | 60 815 043 | | 0 | | |
| 12.00 Land Improvements | 11.00 | | 00,013,743 | 0 | <u> </u> | | 11.00 |
| 14.00 Accumulated depreciation -2,992.702 0 0 14.00 | 12.00 | | 11, 615, 241 | 0 | 0 | 0 | 12.00 |
| 15.00 Bull dings | 13.00 | | 4, 932, 134 | 0 | 0 | 0 | 13.00 |
| 16.00 Accumul atted depreciation -39, 685, 428 0 0 0 10.00 | | | | | 0 | | |
| 17.00 Leasehold Improvements | | | 1 | 1 | 0 | | |
| 18. 00 Accumul ated depreciation | | | | 1 | O O | | |
| 19.00 Executual ated depreciation -5,669,885 0 0 0 20.00 | | • | | 1 | 0 | | |
| 20. 00 Accumulated depreciation -5, 659, 885 0 0 0 20. 00 | | | | 1 | 0 | | 1 |
| 21.00 Automobiles and trucks | | | | 1 | o | | |
| 23.00 Major movable equipment 55, 408, 204 0 0 23.00 | 21.00 | | 247, 016 | 0 | 0 | 0 | 21.00 |
| Accumulated depreciation | | • | 1 | | 0 | | |
| 25.00 Minor equipment depreciable 17,574,660 0 0 25.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 27.00 27.00 28.00 27.00 28.00 29.00 2 | | | | _ | 0 | | |
| 26. 00 Accumulated depreciation | | | | | 0 | | |
| 27. 00 | | | | 1 | 0 | | 1 |
| 28. 00 Accumula fed depreciation 0 0 0 0 28. 00 0 0 0 29. 00 0 0 0 0 0 29. 00 0 0 0 0 0 0 0 0 0 | | | -14, 730, 173 | | 0 | | 1 |
| 29.00 Minor equipment-nondepreciable 0 0 0 0 0 0 0 0 0 | | | 0 | Ö | Ö | | |
| OTHER ASSETS | 29.00 | • | 0 | 0 | 0 | 0 | 29. 00 |
| 31.00 | 30.00 | | 181, 575, 664 | 0 | 0 | 0 | 30.00 |
| 32.00 Deposits on leases 0 0 0 0 32.00 33.00 Due from owners/officers 0 0 0 0 33.00 34.00 Other assets 17,132,978 0 0 0 34.00 35.00 Total other assets (sum of lines 31-34) 17,132,978 0 0 0 35.00 35.00 Total assets (sum of lines 11, 30, and 35) 259,524,585 0 0 0 36.00 CURRENT LIABILITIES | | | 1 | | _r | | |
| 33.00 Due from owners/officers 0 0 0 0 0 0 33.00 | | | 0 | 1 | - 1 | | |
| 34.00 Other assets 17, 132, 978 0 0 0 34.00 | | | 0 | 1 | Ol | | |
| 35.00 Total other assets (sum of lines 31-34) 17, 132, 978 0 0 0 35.00 | | | 17 132 978 | _ | 0 | | 1 |
| 36. 00 Total assets (sum of lines 11, 30, and 35) 259, 524, 585 0 0 0 36. 00 | | | | | Ö | | |
| 37.00 Accounts payable 10,754,716 0 0 0 37.00 38.00 Salaries, wages, and fees payable 10,006,812 0 0 0 38.00 39.00 Payroll taxes payable 2,548 0 0 0 39.00 40.00 Notes and loans payable (short term) 2,618,886 0 0 0 0 41.00 41.00 Deferred income 0 0 0 0 0 41.00 42.00 Accelerated payments 0 0 0 0 42.00 42.00 Accelerated payments 0 0 0 0 43.00 43.00 Due to other funds -332,973,145 0 0 0 0 43.00 44.00 Other current liabilities 38,827,302 0 0 0 0 0 43.00 45.00 Total current liabilities (sum of lines 37 thru 44) -270,762,881 0 0 0 0 45.00 LONG TERM LIABILITIES | 36.00 | Total assets (sum of lines 11, 30, and 35) | 259, 524, 585 | 0 | 0 | 0 | 36.00 |
| 38.00 Salaries, wages, and fees payable 10,006,812 0 0 38.00 39.00 Payroll taxes payable 2,548 0 0 0 39.00 40.00 Notes and loans payable (short term) 2,618,886 0 0 0 0 41.00 41.00 Deferred income 0 0 0 0 41.00 42.00 Accelerated payments 0 0 0 42.00 42.00 Accelerated payments 0 0 0 0 43.00 44.00 Other current liabilities 38,827,302 0 0 0 0 44.00 45.00 Total current liabilities 38,827,302 0 0 0 0 0 0 0 0 0 | | | | | | | |
| 39.00 | | | | | - 1 | | |
| 40. 00 Notes and Loans payable (short term) 41. 00 Deferred income 42. 00 Accelerated payments 6 | | | | | O O | | |
| 41.00 Deferred income | | | | | 0 | | |
| 42. 00 | | | 2,010,000 | l ö | Ö | | 1 |
| 44.00 Other current liabilities | | | 0 | | | _ | 1 |
| 45. 00 Total current liabilities (sum of lines 37 thru 44) | 43.00 | Due to other funds | -332, 973, 145 | 0 | 0 | 0 | 43.00 |
| LONG TERM LIABILITIES | | Other current liabilities | | | 0 | | |
| 46.00 Mortgage payable 0 0 0 0 0 0 0 46.00 47.00 Notes payable 0 0 0 0 0 0 0 47.00 48.00 Unsecured Loans 0 0 0 0 0 0 0 48.00 49.00 Other Long term Liabilities (sum of Lines 46 thru 49) 22, 463, 874 0 0 0 0 50.00 50.00 Total Liabilities (sum of Lines 45 and 50) -248, 299, 007 0 0 0 51.00 Total Liabilities (sum of Lines 45 and 50) -248, 299, 007 0 0 0 51.00 CAPITAL ACCOUNTS 52.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 0 54.00 55.00 Governing body created - endowment fund balance 55.00 Found that balance - invested in plant 0 57.00 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total Liabilities and fund balances (sum of Lines 51 and 259, 524, 585 0 0 0 60.00 | 45. 00 | | -270, 762, 881 | 0 | 0 | 0 | 45.00 |
| 47. 00 Notes payable | 44 00 | | 1 0 | | ٥ | 0 | 44 00 |
| 48.00 Unsecured loans 0 0 0 0 0 48.00 49.00 Other long term liabilities 22, 463, 874 0 0 0 0 49.00 50.00 Total long term liabilities (sum of lines 46 thru 49) 22, 463, 874 0 0 0 0 50.00 Total liabilities (sum of lines 45 and 50) -248, 299, 007 0 0 0 51.00 CAPITAL ACCOUNTS 52.00 General fund balance 52.00 Specific purpose fund 53.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 77.00 Plant fund balance - invested in plant 88.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total liabilities and fund balances (sum of lines 51 and 259, 524, 585 0 0 0 0 0 60.00 | | | 0 | | - 1 | | |
| 49.00 Other long term liabilities 22,463,874 0 0 0 49.00 50.00 Total long term liabilities (sum of lines 46 thru 49) 22,463,874 0 0 0 50.00 51.00 Total liabilities (sum of lines 45 and 50) -248,299,007 0 0 0 51.00 CAPITAL ACCOUNTS 52.00 53.00 Specific purpose fund 0 53.00 54.00 Donor created - endowment fund balance - restricted 0 54.00 55.00 Donor created - endowment fund balance - unrestricted 0 55.00 56.00 Governing body created - endowment fund balance 0 55.00 57.00 Plant fund balance - invested in plant 0 57.00 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 0 57.00 59.00 Total fund balances (sum of lines 52 thru 58) 507,823,592 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 259,524,585 0 0 0 60.00 | | | | | - 1 | | |
| Total long term liabilities (sum of lines 46 thru 49) 22, 463, 874 0 0 0 50.00 | | | 22, 463, 874 | | - 1 | | 1 |
| CAPITAL ACCOUNTS 52.00 General fund balance 507,823,592 52.00 53.00 Specific purpose fund 0 53.00 54.00 Donor created - endowment fund balance - restricted 0 54.00 Donor created - endowment fund balance - unrestricted 0 55.00 Governing body created - endowment fund balance 0 56.00 Flant fund balance - invested in plant 0 57.00 Flant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 507,823,592 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 259,524,585 0 0 0 60.00 | | | | 1 | 0 | 0 | |
| 52.00 General fund balance 507,823,592 52.00 53.00 Specific purpose fund 0 53.00 54.00 Donor created - endowment fund balance - unrestricted 0 54.00 55.00 Governing body created - endowment fund balance 0 55.00 56.00 Flant fund balance - invested in plant 0 57.00 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 0 58.00 59.00 Total fund balances (sum of lines 52 thru 58) 507,823,592 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 259,524,585 0 0 0 60.00 | 51. 00 | | -248, 299, 007 | 0 | 0 | 0 | 51.00 |
| 53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 259, 524, 585) 53.00 0 53.00 0 55.00 0 55.00 0 55.00 0 55.00 0 0 57.00 0 0 59.00 0 0 60.00 | F0 00 | | 507.000.500 | | | | |
| 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 259,524,585) 55.00 Countries | | | 507, 823, 592 | 1 | | | |
| 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 259,524,585) 55.00 56.00 57.00 58.00 59.00 60.00 | | | • | ١ | | | |
| 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 259, 524, 585) 56.00 56.00 0 57.00 0 0 59.00 0 0 60.00 | | | | | 0 | | 1 |
| 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 259,524,585) 0 0 0 60.00 | | | | | Ö | | 1 |
| replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 259,524,585) 0 0 0 60.00 | | | | | | 0 | |
| 59.00 Total fund balances (sum of lines 52 thru 58) 507,823,592 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 259,524,585) 259,524,585 0 0 0 60.00 | | Plant fund balance - reserve for plant improvement, | | | | | |
| 60.00 Total liabilities and fund balances (sum of lines 51 and 259,524,585 0 0 0 60.00 | | 1 . | | | | | |
| | | | | 1 | - 1 | | |
| | 60.00 | | 259, 524, 585 | 0 | 0 | 0 | 60.00 |
| | | 15.7 | 1 | ı | ı | | ı |

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES PORTER MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

Peri od: From 01/01/2020 Provi der CCN: 15-0035 Worksheet G-1

| | | | | | To 12/31/2020 | Date/Time Pro 7/28/2021 4:3 | |
|---|--|--------------------------------------|---|-----------|--|--------------------------------|--|
| | | General | Fund | Special P | Purpose Fund | Endowment Fund | |
| | | 1. 00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | |
| 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 | Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance | 0 0 0 0 0 0 0 0 | 2. 00 454, 153, 122 53, 670, 470 507, 823, 592 0 507, 823, 592 | | 4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 0 0 0 0 0 | 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 |
| | sheet (line 11 minus line 18) | Endowment | PI ant | Fund | | | |
| | | Fund | | 1 | | | |
| | | 6. 00 | 7. 00 | 8.00 | | | |
| 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 | Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) | 0 | 0 0 0 0 0 | | 0 | | 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 |
| 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 | Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) | 0 0 | 0 0 0 0 0 | | 0 | | 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 |
| 19. 00 | Fund balance at end of period per balance sheet (line 11 minus line 18) | 0 | | 1 | 0 | | 19. 00 |

| In Lieu of Form CMS-2552-10 | Period: | Worksheet G-2 | From 01/01/2020 | Parts | & | | | To | 12/31/2020 | Date/Time Prepared: Health Financial Systems PATIENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-0035

| | | | To 12/31/2020 | Date/Time Pre 7/28/2021 4:3 | |
|------------------|---|----------------|--------------------|-----------------------------|------------------|
| | Cost Center Description | Inpatient | Outpati ent | Total | O pili |
| | oost center bescription | 1.00 | 2.00 | 3. 00 | |
| | PART I - PATIENT REVENUES | 1.00 | 2.00 | 3.00 | |
| | General Inpatient Routine Services | | | | |
| 1.00 | Hospi tal | 145, 469, 75 | 9 | 145, 469, 759 | 1.00 |
| 2. 00 | SUBPROVIDER - IPF | 110, 107, 70 | | 110, 107, 707 | 2.00 |
| 3. 00 | SUBPROVI DER - I RF | 9, 396, 44 | 6 | 9, 396, 446 | |
| 4. 00 | SUBPROVI DER | ,,0,0,11 | | 7, 676, 116 | 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) | 154, 866, 20 | 5 | 154, 866, 205 | |
| | Intensive Care Type Inpatient Hospital Services | 1,, | | 10.1/000/-00 | |
| 11.00 | INTENSIVE CARE UNIT | 31, 388, 98 | 5 | 31, 388, 985 | 11.00 |
| 11. 01 | NEONATAL INTENSIVE CARE UNIT | 17, 173, 90 | 9 | 17, 173, 909 | 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 lines | 48, 562, 89 | 4 | 48, 562, 894 | 16.00 |
| | 11-15) | | | | |
| 17.00 | Total inpatient routine care services (sum of lines 10 and 16) | 203, 429, 09 | 9 | 203, 429, 099 | 17. 00 |
| 18.00 | Ancillary services | 661, 628, 81 | 2 981, 551, 464 | 1, 643, 180, 276 | 18.00 |
| 19.00 | Outpatient services | 73, 678, 21 | 5 125, 368, 356 | 199, 046, 571 | 19.00 |
| 20.00 | RURAL HEALTH CLINIC | | 0 0 | 0 | 20.00 |
| 21.00 | FEDERALLY QUALIFIED HEALTH CENTER | | 0 0 | 0 | 21.00 |
| 22.00 | HOME HEALTH AGENCY | | | | 22.00 |
| 23.00 | AMBULANCE SERVICES | | | | 23.00 |
| 24.00 | CMHC | | | | 24.00 |
| 25.00 | AMBULATORY SURGICAL CENTER (D. P.) | | | | 25. 00 |
| 26.00 | HOSPI CE | | | | 26. 00 |
| 27. 00 | OTHER (SPECIFY) | | 0 | 0 | 27. 00 |
| 28. 00 | Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. | 938, 736, 12 | 6 1, 106, 919, 820 | 2, 045, 655, 946 | 28. 00 |
| | G-3, line 1) | | | | |
| | PART II - OPERATING EXPENSES | | | 1 | |
| 29. 00 | Operating expenses (per Wkst. A, column 3, line 200) | | 259, 960, 384 | | 29. 00 |
| 30.00 | ADD (SPECIFY) | | 0 | | 30.00 |
| 31. 00 | | | 0 | | 31.00 |
| 32. 00 | | | 0 | | 32.00 |
| 33. 00 | | | 0 | | 33.00 |
| 34.00 | | | 0 | | 34.00 |
| 35. 00 | T-1-1 | | 0 | | 35.00 |
| 36.00 | Total additions (sum of lines 30-35) | | 0 | | 36.00 |
| 37. 00 | DEDUCT (SPECIFY) | | 0 | | 37.00 |
| 38. 00 39. 00 | | | 0 | | 38. 00 39. 00 |
| | | | | | |
| 40.00 | | | 0 | | 40. 00 41. 00 |
| 41. 00 42. 00 | Total deductions (sum of lines 37-41) | | ۸ ا | | 41.00 |
| 42.00 | Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe | ₂ r | 259, 960, 384 | | 42.00 |
| 43.00 | to Wkst. G-3, line 4) | 7 | 207, 900, 384 | | 43.00 |
| | 10 mor. 5 5, 1110 7) | 1 | T | ı | ı |

| Heal th | Financial Systems | PORTER MEMORIAL HOS | PITAL | In Lieu | u of Form CMS-2 | <u> 2552-10</u> |
|---------|--|-------------------------|---------------------|----------------------------------|------------------|-----------------|
| STATEM | MENT OF REVENUES AND EXPENSES | Pro | ovider CCN: 15-0035 | Peri od: | Worksheet G-3 | |
| | | | | From 01/01/2020 To 12/31/2020 | Date/Time Pre | nared· |
| | | | | 12/01/2020 | 7/28/2021 4: 3 | |
| | | | | | | |
| | | | | | 1. 00 | |
| 1. 00 | Total patient revenues (from Wkst. G-2, Par | | 8) | | 2, 045, 655, 946 | 1.00 |
| 2.00 | Less contractual allowances and discounts of | on patients' accounts | | | 1, 743, 634, 336 | 2. 00 |
| 3.00 | Net patient revenues (line 1 minus line 2) | | | | 302, 021, 610 | 3.00 |
| 4.00 | Less total operating expenses (from Wkst. (| | | | 259, 960, 384 | 4. 00 |
| 5.00 | Net income from service to patients (line 3 | 3 minus line 4) | | | 42, 061, 226 | 5. 00 |
| | OTHER I NCOME | | | 1 | | , |
| 6. 00 | Contributions, donations, bequests, etc | | | | 0 | 6.00 |
| 7.00 | Income from investments | | | | 0 | 7.00 |
| 8. 00 | Revenues from telephone and other miscellar | neous communication sei | rvi ces | | 0 | 8. 00 |
| 9. 00 | Revenue from television and radio service | | | | 0 | 9. 00 |
| 10.00 | Purchase di scounts | | | | 0 | 10.00 |
| 11.00 | Rebates and refunds of expenses | | | | 0 | 11.00 |
| | Parking lot receipts | | | | 0 | 12.00 |
| | Revenue from laundry and linen service | | | | 0 | 13.00 |
| | Revenue from meals sold to employees and gu | uests | | | 0 | 14.00 |
| | Revenue from rental of living quarters | | | | 0 | 15.00 |
| | Revenue from sale of medical and surgical s | | pati ents | | 0 | 16.00 |
| | Revenue from sale of drugs to other than pa | | | | 0 | 17. 00 |
| | Revenue from sale of medical records and al | | | | 0 | 18. 00 |
| | Tuition (fees, sale of textbooks, uniforms, | | | | 0 | 19. 00 |
| | Revenue from gifts, flowers, coffee shops, | and canteen | | | 0 | 20.00 |
| | 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 | | | | 11, 609, 244 | 24.00 |
| | COVI D-19 PHE Fundi ng | | | | 0 | 24. 50 |
| | Total other income (sum of lines 6-24) | | | | 11, 609, 244 | 25.00 |
| | Total (line 5 plus line 25) | | | | 53, 670, 470 | 26.00 |
| | OTHER EXPENSES (SPECIFY) | | | | 0 | 27. 00 |
| 28.00 | Total other expenses (sum of line 27 and su | ubscri pts) | | | 0 | 28.00 |
| 29.00 | Net income (or loss) for the period (line 2 | 26 minus line 28) | | | 53, 670, 470 | 29.00 |

| Hoal th | Financial Systems PORTER MEMORIAL | LIOSDI TAI | In Lio | u of Form CMS-2 | 2552 10 |
|--------------------------------|---|--------------------------|--|----------------------------|----------------|
| CALCULATION OF CAPITAL PAYMENT | | Provi der CCN: 15-0035 | Peri od: From 01/01/2020 To 12/31/2020 | Worksheet L Parts I-III | |
| Title XVIII Hospital | | | | PPS | |
| | | | | | |
| | DART I FILLY PROCRECTIVE METHOD | | | 1. 00 | |
| | PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT | | | | |
| 1. 00 | Capital DRG other than outlier | | | 2, 864, 313 | 1.00 |
| 1. 00 | Model 4 BPCI Capital DRG other than outlier | | | 2,004,313 | 1.00 |
| 2. 00 | Capital DRG outlier payments | | | 27, 397 | 2.00 |
| 2. 01 | Model 4 BPCI Capital DRG outlier payments | | | 0 | 2. 01 |
| 3.00 | Total inpatient days divided by number of days in the cost reporting period (see instructions) | | | 143. 04 | 3.00 |
| 4.00 | Number of interns & residents (see instructions) | | | 0.00 | 4.00 |
| 5.00 | Indirect medical education percentage (see instructions) | | | 0. 00 0 | 1 |
| 6. 00 | Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions) | | | | 6. 00 |
| 7. 00 | Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions) | | | 2. 19 | 7. 00 |
| 8.00 | | | | 18. 43 | 8. 00 |
| 9.00 | | | | 20. 62 | 1 |
| 10.00 | | | | 4. 27 | |
| 11.00 | | | | 122, 306 | |
| 12. 00 | Total prospective capital payments (see instructions) | | | 3, 014, 016 | 12.00 |
| | | | | 1. 00 | |
| | PART II - PAYMENT UNDER REASONABLE COST | | | 1.00 | |
| 1.00 | Program inpatient routine capital cost (see instructions) | | | 0 | 1.00 |
| 2.00 | Program inpatient ancillary capital cost (see instructions) | | | 0 | 2.00 |
| 3.00 | Total inpatient program capital cost (line 1 plus line 2) | | | 0 | 3.00 |
| 4. 00 | | | | 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 | Program inpatient capital costs (see instructions) | ann (ann i natuurti) | | 0 | 1.00 |
| 2. 00 3. 00 | Program inpatient capital costs for extraordinary circumstan Net program inpatient capital costs (line 1 minus line 2) | ces (see instructions) | | 0 | 2. 00 3. 00 |
| 4. 00 | Applicable exception percentage (see instructions) | | | 0. 00 | 4.00 |
| 5. 00 | Capital cost for comparison to payments (line 3 x line 4) | | 0.00 | 5.00 | |
| 6. 00 | Percentage adjustment for extraordinary circumstances (see in | nstructions) | | 0. 00 | 6.00 |
| 7.00 | Adjustment to capital minimum payment level for extraordinar | | x line 6) | 0 | 7. 00 |
| 8.00 | Capital minimum payment level (line 5 plus line 7) | | | 0 | 8.00 |
| 9. 00 | Current year capital payments (from Part I, line 12, as appl | | | 0 | 9. 00 |
| 10.00 | Current year comparison of capital minimum payment level to | | , | 0 | 10.00 |
| 11. 00 | Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) | capital payment (from pr | ior year | 0 | 11. 00 |
| 12.00 | Net comparison of capital minimum payment level to capital p | | | 0 | 12.00 |
| 13.00 | Current year exception payment (if line 12 is positive, ente | | | 0 | 13.00 |
| 14. 00 | Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line) | | following period | 0 | 14.00 |
| 15. 00 | Current year allowable operating and capital payment (see in | structions) | | 0 | 15.00 |
| 16.00 | | | | 0 | 16.00 |
| 17.00 | Current year exception offset amount (see instructions) | | | 0 | 17. 00 |