This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-4052 Worksheet S Peri od: From 07/01/2019 Parts I-III AND SETTLEMENT SUMMARY 06/30/2020 Date/Time Prepared: 11/23/2020 4:00 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 11/23/2020 Ti me: 4:00 pm Manually prepared cost report use only ]If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. 6. Date Received: 7. Contractor No. Contractor 10. NPR Date: ]Cost Report Status (1) As Submitted

7. Contractor No.

(2) Settled without Audit 8. [ N ] Initial Report for this Provider CCN 12. [ 0 ] If line 5, column 1 is 4: Enter (3) Settled with Audit

9. [ N ] Final Report for this Provider CCN | number of times reopened = 0-9. 11. Contractor's Vendor Code: use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

## PART II - CERTIFICATION

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PORTER-STARKE SERVICES, INC (15-4052) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 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.

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

(Signed) MARY IDSTEIN
Officer or Administrator of Provider(s)

CFO

Title

(Dated when report is electronically signed.)
Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	792	2, 580	0	6, 656	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	792	2, 580	0	6, 656	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-STARKE SERVICES, INC In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-4052 Peri od: Worksheet S-2 From 07/01/2019 Part I Date/Time Prepared: 06/30/2020 11/23/2020 4:00 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 601 WALL ST 1.00 PO Box: 1.00 City: VALPARAISO State: IN 2.00 Zi p Code: 46385 County: PORTER 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, 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-STARKE SERVICES. 154052 23844 4 08/01/2007 3.00 Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospital -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital-Based Health Clinic - RHC 15 00 15 00 16.00 Hospital -Based Health Clinic - FQHC 16.00 Hospital -Based (CMHC) I 17.00 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2019 06/30/2020 20.00 21.00 Type of Control (see instructions) 21.00 1.00 2.00 3.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for N 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 Ν 22.03 Ν 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

if date of discharge. Is the method of identifying t reporting period different from the method used in t							
reporting period? In column 2, enter "Y" for yes or	"N" for no	).					
	In-State	In-State	Out-of	Out-of	Medi cai d	Other	
	Medicaid	Medi cai d	State	State	HMO days	Medi cai d	
	paid days	eligible	Medi cai d	Medi cai d	_	days	
		unpai d	paid days	eligible			
		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	0	0	0	0	C	0	24.00
in-state Medicaid paid days in column 1, in-state							
Medicaid eligible unpaid days in column 2,							
out-of-state Medicaid paid days in column 3,							
out-of-state Medicaid eligible unpaid days in column							
4, Medicaid HMO paid and eligible but unpaid days in							
column 5, and other Medicaid days in column 6.							
					•	•	

Ν

23.00

counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for

below? In column 1, enter 1 if date of admission, 2 if census days, or 3

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

ves or "N" for no

Health Financial Systems PORTER-STARKE SERVICES, INC In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-4052 Peri od: Worksheet S-2 From 07/01/2019 Part I Date/Time Prepared: 06/30/2020 11/23/2020 4:00 pm In-State In-State Out-of Out-of Medi cai d Medi cai d Medi cai d State State HMO days Medi cai d paid days eligible Medi cai d Medi cai d days unpai d pai d days el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6. 00 25.00 If this provider is an IRF, enter the in-state 25, 00  $\cap$ 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 N 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 Ν 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.

		ERVICES, INC	2011 45 4050		of Form CMS-2	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	IA	Provi der (	1	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Pre 11/23/2020 4:	pared:
	Y/N	IME	Direct GME	I ME	Direct GME	
	1. 00	2. 00	3. 00	4. 00	5. 00	
51.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0. 00	61.00
Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.0
Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. 02
on the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
51.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61. 04
current cost reporting period (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61. 0
b1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
1 10 05 11 575 1 11 11 11 15		1. 00	2. 00	3. 00	4. 00	(1.1.1
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				0.00	0. 00	61. 10
FTE unweighted count.  Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0. 00	61. 20
					1.00	
ACA Provisions Affecting the Health Resources and Ser 22.00 Enter the number of FTE residents that your hospital				riod for which	0. 00	62.00
your hospital received HRSA PCRE funding (see instruction).  2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC programmer.	ti ons) Teachi	ng Health Ce	nter (THC) int		0.00	62. 01
Teaching Hospitals that Claim Residents in Nonprovide	r Setti	i ngs				
33.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple					N	63.00
	-5 11116	o. tin ough	Unwei ghted FTEs Nonprovi der	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	

		Nonprovi der	Hospi tal	col. 2))	
		Si te			
		1. 00	2. 00	3. 00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings	This base year	is your cost	reporti ng	
	period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents	0.00	0. 00	0. 000000	64.00
	in the base year period, the number of unweighted non-primary care				1
	resident FTEs attributable to rotations occurring in all nonprovider				1
	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				1
	of (column 1 divided by (column 1 + column 2)). (see instructions)				1

From 07/01/2019 Part I Date/Time Prepared: 06/30/2020 11/23/2020 4:00 pm Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ (col. 3 + FTEs FTEs in col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if li is yes, or your facility 0.000000 65.00 0.00 0. 00 if line 63 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col . 1 + col . 2)) FTEs in FTFs Hospi tal Nonprovi der Si te 2. 00 3. 00 1 00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTEs FTEs in 3/(col. 3 +col. 4)) Nonprovi der Hospi tal Si te 1. 00 2.00 3. 00 4. 00 5. 00 67.00 Enter in column 1, the program 0. 00 0. 00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 70.00 Υ Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 Ν Ν 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF Ν 75.00 subprovider? Enter "Y" for yes and "N"

Health Financial Systems PORTER-STARKE SERVICES, HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provid		Peri od:	_i eu	of Form Workshe		
PLOVID	er con. 13-4032	From 07/01/20 To 06/30/20	20	Part I Date/Ti	me Pre	epared:
				11/23/2	020 4:	00 pm
76.00   If line 75 is yes: Column 1: Did the facility have an approved GME to	eaching program in		. 00	2. 00	3. 00	76.00
recent cost reporting period ending on or before November 15, 2004? In no. Column 2: Did this facility train residents in a new teaching process of the control of the control of the cost reporting period.	Enter "Y" for yes ogram in accordand 3: If column 2 is	or "N" for ce with 42 Y,				
Lang Tarry Cons. Hand tol. DDC				1. 0	0	
Long Term Care Hospital PPS  80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N"	for no.			N		80.00
B1.00 Is this a LTCH co-located within another hospital for part or all of "Y" for yes and "N" for no.  TEFRA Providers	the cost reportin	ng period? En	ter	N		81.00
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA?  B6.00 Did this facility establish a new Other subprovider (excluded unit) u §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			no.	N		85. 00 86. 00
87.00 Is this hospital an extended neoplastic disease care hospital classiful 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	fied under section	1		N		87. 00
		V 1.00		XI ) 2. 0		
Title V and XIX Services		Υ				00.00
90.00 Does this facility have title V and/or XIX inpatient hospital service yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the cost i		N N		N Y		90.00
full or in part? Enter "Y" for yes or "N" for no in the applicable of part.  Are title XIX NF patients occupying title XVIII SNF beds (dual certification).	olumn.	, IN		ı N		92.00
instructions) Enter "Y" for yes or "N" for no in the applicable colur 93.00 Does this facility operate an ICF/IID facility for purposes of title	mn.	N		N		93.00
"Y" for yes or "N" for no in the applicable column.  94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" 1		N N		N		94.00
applicable column. 95.00   fline 94 is "Y", enter the reduction percentage in the applicable of		0.00		0. 0	10	95. 00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" in applicable column.		N		N		96.00
97.00 If line 96 is "Y", enter the reduction percentage in the applicable of 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or column 1 for title V, and in column 2 for title XIX.	d residents post	0. 00 Y		0. 0 Y		97. 00 98. 00
98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and title XIX.				Υ		98. 01
P8.02 Does title V or XIX follow Medicare (title XVIII) for the calculation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for title V, and in column 2 for title XIX.		Y		Υ		98. 02
P8.03 Does title V or XIX follow Medicare (title XVIII) for a critical accereimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for title V, and in column 2 for title XIX.				N		98. 03
P8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimburse outpatient services cost? Enter "Y" for yes or "N" for no in column in column 2 for title XIX.	ed 101% of 1 for title V, and	i N		N		98. 04
98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RC Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 1 column 2 for title XIX.				Υ		98. 05
98.06 Does title V or XIXX follow Medicare (title XVIII) when cost reimburse Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for ticolumn 2 for title XIX.  Rural Providers		Y		Υ		98. 06
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive	e method of paymer	N nt				105. 00 106. 00
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbutraining programs? Enter "Y" for yes or "N" for no in column 1. (see Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train approved medical education program in the CAH's excluded IPF and/or	e instructions) n I&Rs in an	N				107. 00
Enter "Y" for yes or "N" for no in column 2. (see instructions)	1 M M H L (3):					

	Provi der C	CN: 15-4052	Peri od:	Worksheet S-	-2
			From 07/01/2019 To 06/30/2020	Part I Date/Time Pr 11/23/2020 4	
	Physi cal	Occupati ona		Respi ratory	
09.00  f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1. 00 N	2. 00 N	3. 00 N	4.00 N	109.0
				1. 00	
0.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	"N" for no.	If yes,	N N	110. (
			1.00	2. 00	
11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this construction for the construction for the second integration prong of the FCHIP demoin which this CAH is participated in the second for the second in the secon	ost reporting olumn 1 is Y, rticipating ir	period? Ente enter the n column 2.	r N		111. (
		1.00	2. 00	3. 00	-
2.00 Did this hospital participate in the Pennsylvania Rural Hea demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital centaricipation in the demonstration, if applicable.	period? s "Y", enter he	N			112. (
Miscellaneous Cost Reporting Information 5.00[s this an all-inclusive rate provider? Enter "Y" for yes o	r "N" for no	N			0115.
in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, §2208.1.	B, or E only) 93" percent (includes	N			0115.
6.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116.
7.00 Is this facility legally-required to carry malpractice insu	rance? Enter	Y			117.
"Y" for yes or "N" for no.					
8.00 Is the mal practice insurance a claims-made or occurrence po	licy? Enter 1		2		118.
8.00 s the malpractice insurance a claims-made or occurrence po if the policy is claim-made. Enter 2 if the policy is occur		Premiums	2 Losses	Insurance	118.
		Premi ums	2 Losses	Insurance	118.
if the policy is claim-made. Enter 2 if the policy is occur		1.00	2. 00	3. 00	
if the policy is claim-made. Enter 2 if the policy is occur			2. 00	3. 00	0118.
if the policy is claim-made. Enter 2 if the policy is occur  8.01 List amounts of malpractice premiums and paid losses:	rence.	1. 00 130, 0	2. 00 68 0	3. 00	0118.
if the policy is claim-made. Enter 2 if the policy is occur  8.01 List amounts of malpractice premiums and paid losses:  8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheland amounts contained therein.	center other	1.00 130,0	2.00	3.00	0118.
if the policy is claim-made. Enter 2 if the policy is occur  3.01 List amounts of malpractice premiums and paid losses:  3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheland amounts contained therein.  9.00 DO NOT USE THIS LINE	center other dule listing of d Harmless pro n column 1, "\ ualifies for 1	1.00 130,0  than the cost centers  ovision in AC. " for yes or the Outpatien	2. 00 68 0 1. 00 N	3.00	0118.
if the policy is claim-made. Enter 2 if the policy is occur  3.01 List amounts of malpractice premiums and paid losses:  3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schemand amounts contained therein.  3.00 DO NOT USE THIS LINE  3.00 Is this a SCH or EACH that qualifies for the Outpatient Holes  3.121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified the support of the Company of the Holes of the Holes of the Company of the Holes of the Hole	center other dule listing of d Harmless pro n column 1, "\ ualifies for 1 nts? (see inst	than the cost centers  ovision in AC/" for yes or the Outpatien tructions)	2.00 68 0 1.00 N	3.00	0118.
if the policy is claim-made. Enter 2 if the policy is occur  3.01 List amounts of malpractice premiums and paid losses:  3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schemand amounts contained therein.  3.00 DO NOT USE THIS LINE  3.00 Is this a SCH or EACH that qualifies for the Outpatient Holes (Sall and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies provision in ACA §3121 and applicable amendments. Enter in column 2, "Y" for yes or "N" for no.  3.00 Did this facility incur and report costs for high cost implipatients? Enter "Y" for yes or "N" for no.  3.00 Does the cost report contain healthcare related taxes as de Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included.	center other dule listing of the column 1, "Youalifies for the column 1s?" (see instantable device fined in §1903	than the cost centers  ovision in AC (" for yes or the Outpatien tructions)  es charged to  3(w)(3) of th	2.00 68 0 1.00 N A N t	3.00	0 118. 118. 119. 120.
if the policy is claim-made. Enter 2 if the policy is occur  3.01 List amounts of malpractice premiums and paid losses:  3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scherand amounts contained therein.  3.00 DO NOT USE THIS LINE  3.00 Is this a SCH or EACH that qualifies for the Outpatient Hole §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifier in column 2, "Y" for yes or "N" for no.  4.00 Did this facility incur and report costs for high cost implipatients? Enter "Y" for yes or "N" for no.  5.00 Does the cost report contain healthcare related taxes as de Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information  5.00 Does this facility operate a transplant center? Enter "Y" for	center other dule listing of d Harmless pro n column 1, "\ ualifies for to nts? (see instantable device fined in §1903	than the cost centers  ovision in AC. /" for yes or the Outpatien tructions) es charged to B(w)(3) of the r in column	2.00 68 0 1.00 N A N t	3.00	0118.
if the policy is claim-made. Enter 2 if the policy is occur  3.01 List amounts of malpractice premiums and paid losses:  3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schemand amounts contained therein.  3.00 DO NOT USE THIS LINE  3.00 Is this a SCH or EACH that qualifies for the Outpatient Hole §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole §3121 and applicable amendments? "The form one of the properties of the pr	center other dule listing of the column 1, "Yualifies for the column should be considered in \$1903 1 is "Y", enter the certi	than the cost centers  ovision in AC/" for yes or the Outpatien tructions)  es charged to B(w)(3) of the rin column	2.00 68 0 1.00 N A N t	3.00	0 118. 118. 119. 120.
if the policy is claim-made. Enter 2 if the policy is occur  3.01 List amounts of malpractice premiums and paid losses:  3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schemand amounts contained therein.  3.00 DO NOT USE THIS LINE  3.00 Is this a SCH or EACH that qualifies for the Outpatient Holes (Salland applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies provision in ACA (Salland applicable amendments).  4.00 Did this facility incur and report costs for high cost implipatients? Enter "Y" for yes or "N" for no.  5.00 Does the cost report contain heal thcare related taxes as de Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information  5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  6.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 7.00 If this is a Medicare certified heart transplant center, enter (manufacture).	center other dule listing of d Harmless pro n column 1, "\ ualifies for t nts? (see inst antable device fined in §1903 1 is "Y", ente  or yes and "N" nter the certi 2. ter the certif	than the cost centers  ovision in AC  "for yes or the Outpatien tructions)  es charged to  B(w)(3) of the in column  for no. If	2.00 68 0 1.00 N A N t N e N	3.00	0 118. 118. 119. 120. 121. 122.
if the policy is claim-made. Enter 2 if the policy is occur  3.01 List amounts of malpractice premiums and paid losses:  3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schemand amounts contained therein.  3.00 DO NOT USE THIS LINE  3.00 DIs this a SCH or EACH that qualifies for the Outpatient Hole §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole §3121 and applicable amendments.  4.00 Did this facility incur and report costs for high cost implipatients? Enter "Y" for yes or "N" for no.  5.00 Does the cost report contain healthcare related taxes as de Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information  5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  6.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 1.	center other dule listing of the dule list of the device of the dule list of th	1.00 130,0  than the cost centers  ovision in AC/" for yes or the Outpatien tructions)  es charged to B(w)(3) of the in column  for no. If fication date	2.00 68 0 1.00 N A N t N e N	3.00	118. 119. 120. 121. 122. 125. 126. 127.
if the policy is claim-made. Enter 2 if the policy is occur  3.01 List amounts of malpractice premiums and paid losses:  3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein.  3.00 DO NOT USE THIS LINE  3.00 Is this a SCH or EACH that qualifies for the Outpatient Hole §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifier in column 2, "Y" for yes or "N" for no.  1.00 Did this facility incur and report costs for high cost imple patients? Enter "Y" for yes or "N" for no.  2.00 Does the cost report contain healthcare related taxes as de Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information  5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  6.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 3.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 3.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 3.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 3.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 3.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 3.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 3.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 3.00 If this is a Medicare certified liver transplant center.	center other dule listing of the dule listing of the center of the center of the center of the center the certification.	than the cost centers  ovision in AC (" for yes or the Outpatien tructions)  es charged to ((3)) of the rin column  for no. If fication date (fication date)	2.00 68 0 1.00 N A N t N e N	3.00	0 118. 118. 119. 120. 121. 122. 125. 126. 127. 128.
8.01 List amounts of malpractice premiums and paid losses:  8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scherand amounts contained therein.  9.00 DO NOT USE THIS LINE  0.00 Is this a SCH or EACH that qualifies for the Outpatient Hole §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that quelid Hold Harmless provision in ACA §3121 and applicable amendments. Enter in column 2, "Y" for yes or "N" for no.  1.00 Did this facility incur and report costs for high cost imple patients? Enter "Y" for yes or "N" for no.  2.00 Does the cost report contain healthcare related taxes as de Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information  5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  6.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 7.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 8.00 If this is a Medicare certified liver transplant center, en	center other dule listing of d Harmless profunction of the center antable device fined in §1903 1 is "Y", enter or yes and "N" nter the certification of the	than the cost centers  ovision in AC  "for yes or the Outpatien tructions)  es charged to a company for no. If fication date cation date	2.00 68 0 1.00 N A N t N e N	3.00	0 118. 118. 119. 120. 121. 122. 125. 126.

Health Financial Systems	PORTER-STARKE S		N 45 4050	10		of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENIIFICATION DATA	Provi der CC	N: 15-4052		: 7/01/2019 6/30/2020	Worksheet S- Part I Date/Time Pr 11/23/2020 4	epared:
					1. 00	2. 00	+
32.00 If this is a Medicare certified in column 1 and termination date,			ication dat	е	1.00	2.00	132.00
33.00 Removed and reserved 34.00 If this is an organ procurement o and termination date, if applicab		he OPO number i	in column 1				133. 00 134. 00
All Providers  40.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 th	"N" for no in column 1. If	yes, and home	office cos		N		140. 00
1.00 If this facility is part of a cha	2.0		uab 142 +b		3.00	of the home	
office and enter the home office			ugn 143 the	e name ar	id addi ess	or the nome	
41. 00 Name:	Contractor's Name:		Contrac	ctor's Nu	ımber:		141.00
42.00 Street:	PO Box:						142.00
43. 00 Ci ty:	State:		Zi p Coo	le:			143. 0
						1. 00	-
44.00 Are provider based physicians' co	sts included in Worksheet	A?				Y	144.00
45 001.6			- 6		1. 00	2. 00	1.45 0
45.00  f costs for renal services are c inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N" 46.00  Has the cost allocation methodolo Enter "Y" for yes or "N" for no i	" for yes or "N" for no in clude Medicare utilization for no in column 2. gy changed from the previo n column 1. (See CMS Pub.	column 1. If of for this cost usly filed cos	column 1 is reporting t report?		N		145. 0
yes, enter the approval date (mm/	dd/yyyy) in column 2.						
47.00 Was there a change in the statist	ical basis? Enter "V" for	ves or "N" for	no			1. 00 N	147. 0
48.00 Was there a change in the order o						N	148. 0
49.00 Was there a change to the simplif				or no.		N	149. 0
		Part A	Part B	T	itle V	Title XIX	
Does this facility contain a prov	ider that qualifies for an	1.00	2.00 m the appli	cation o	3.00 of the low	4.00 er of costs	
or charges? Enter "Y" for yes or							
55. 00 Hospi tal		N	N		N	N	155. 0
56. 00 Subprovi der - IPF		N	N		N	N	156. 0
57. 00 Subprovi der – TRF 58. 00 SUBPROVI DER		N	N		N	N	157. 0 158. 0
59. 00 SNF		N	N		N	N	159. 0
60. 00 HOME HEALTH AGENCY		N	N		N	N	160. 0
61. 00 CMHC			N		N	N	161. 0
						1. 00	-
Multicampus						1.00	
65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has on	e or more camp	uses in dif	ferent C	BSAs?	N	165. 0
	Name	County		Zip Code	CBSA	FTE/Campus	
44 00 Lf Line 14E is yes for each	0	1. 00	2.00	3. 00	4. 00	5. 00	00144 0
66.00 ffline 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)						U. C	00166.0
Hool th Information Technology (III	T) incentive in the Arrest	an Dooryany	d Doi muss+	ont Ast		1.00	
Health Information Technology (HI 67.00 is this provider a meaningful use				ment Act		N	 167. 0
68.00 If this provider is a CAH (line 1) reasonable cost incurred for the	05 is "Y") and is a meanin	gful user (line		"), ente	r the	i v	168. 0
68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	not a meaningful user, doe ? Enter "Y" for yes or "N"	s this provided for no. (see i	instruction	ıs)	·		168. 0
69.00 If this provider is a meaningful transition factor. (see instruction		ıs not a CAH	(line 105 i	s "N"),	enter the	0.0	00169. 0

Health Financial Systems	PORTER-STARKE SERV	/ICES, INC	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIF					
			From 07/01/2019		
			To 06/30/2020	Date/Time Pre	
				11/23/2020 4:	00 pm
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					170. 00
			1. 00	2. 00	
171.00 If line 167 is "Y", does this provider have			N	0	171.00
section 1876 Medicare cost plans reported of					
"Y" for yes and "N" for no in column 1. If	column 1 is yes, er	nter the number of secti	on		
1876 Medicare days in column 2. (see instru					

Heal th	Financial Systems PORTER-STARKE S	SERVICES INC		In lie	u of Form CMS-	2552-10
	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der Co		Peri od: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II	epared:
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter Nmm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	l for all NO re	esponses. Ent	1.00 er all dates in	2.00 the	
	Provider Organization and Operation					
1. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a	e beginning of column 2. (see	the cost instructions	N )		1.00
			Y/N	Date	V/I	
2. 00	Has the provider terminated participation in the Medicare F	Program2 If	1.00 N	2. 00	3. 00	2.00
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for				
3. 00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3.00
	Teratronsings. (See Thetraetrons)		Y/N	Type	Date	
	Et		1. 00	2.00	3. 00	
4. 00	Financial Data and Reports  Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avaicolumn 3. (see instructions) If no, see instructions.	for Compiled,	Y	A		4.00
5. 00	Are the cost report total expenses and total revenues differentiates on the filed financial statements? If yes, submit reconstructions are total expenses and total revenues and total revenues.		N			5. 00
				Y/N 1.00	Legal Oper.	
	Approved Educational Activities			1.00	2. 00	
6. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is th	he provider i	s N		6.00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the	N N		7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	N		9. 00
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	or renewed in <sup>.</sup>	the current	N		10.00
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	\/ /N	11.00
					Y/N 1.00	
10.00	Bad Debts		ti ana		\ <u>'</u>	12.00
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	Y N	12.00
14. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? In	fyes, see in	structions.	N	14.00
15. 00	Did total beds available change from the prior cost reporti		yes, see ins t A	tructi ons. Par	t B	15.00
		Y/N	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? 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	Υ	09/10/2020	Y	09/10/2020	16.00
17. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N		N		17. 00
18. 00	in columns 2 and 4. (see instructions)  If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00
	, , , , , , , , , , , , , , , , , , , ,		•	'		•

	et S-2 me Prepared: 020 4:00 pm
Description Y/N Y/	
20.00   If line 16 or 17 is yes, were adjustments made to PS&R   N   N	20.00
Report data for Other? Describe the other adjustments:	20.00
Y/N Date Y/N Da	
1.00 2.00 3.00 4.0	
21.00 Was the cost report prepared only using the provider's N N records? If yes, see instructions.	21.00
1.0	)
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)	
Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions	22. 00
23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost	23. 00
reporting period? If yes, see instructions.	
24.00   Were new Leases and/or amendments to existing Leases entered into during this cost reporting period?   If yes, see instructions	24. 00
25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	25. 00
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	26. 00
27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	27. 00
Interest Expense 28.00 Were new Loans, mortgage agreements or letters of credit entered into during the cost reporting	28. 00
period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)	29. 00
treated as a funded depreciation account? If yes, see instructions 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see	30.00
instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see	31.00
instructions.  Purchased Services  32.00 Have changes or new agreements occurred in patient care services furnished through contractual	32.00
arrangements with suppliers of services? If yes, see instructions.	32.00
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	33.00
Provi der-Based Physi ci ans	24.00
34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians?  If yes, see instructions.	34.00
35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	35.00
Y/N Da	
1. 00 2. 0	)
Home Office Costs  36.00 Were home office costs claimed on the cost report?	36.00
37.00 If line 36 is yes, has a home office cost statement been prepared by the home office?  If yes, see instructions.	37. 00
38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	38.00
39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	39.00
40.00 If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	40.00
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.	41.00
42.00 Enter the employer/company name of the cost report BLUE & CO., LLC preparer.	42.00
43.00 Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.  TSEVERS@BLUEANDCOM. COM	43.00

Health Financial Systems PORTER-STARKE	SERVICES, INC	u of Form CMS-2	552-10	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCN: 15-4052	Peri od: From 07/01/2019 To 06/30/2020	Date/Time Prep	pared:
			11/23/2020 4:0	00 pm
	3. 00			
Cost Report Preparer Contact Information				
41.00 Enter the first name, last name and the title/position	MANAGER			41.00
held by the cost report preparer in columns 1, 2, and 3,				
respecti vel y.				
42.00 Enter the employer/company name of the cost report				42.00
preparer.				
43.00 Enter the telephone number and email address of the cost				43.00
report preparer in columns 1 and 2, respectively.				

 
 Heal th Fi nancial
 Systems
 PORTER-ST

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provi der CCN: 15-4052

						То	06/30/2020	Date/Time Pro		
								1/P Days /	1	J pili
								0/P Visits /		
								Trips		
	Component	Worksheet A	No.	of Beds	Bed Days		CAH Hours	Title V		
		Line Number			Avai I abl e					
		1. 00		2. 00	3. 00		4. 00	5. 00		
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		16	5, 84	0	0. 00	(	)	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 3. 00	HMO and other (see instructions) HMO IPF Subprovider									3.00
4. 00	HMO IRF Subprovider								ł	4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF							(	٠l	5.00
6. 00	Hospital Adults & Peds. Swing Bed NF							(		6.00
7. 00	Total Adults and Peds. (exclude observation			16	5, 84	0	0. 00	(		7. 00
7.00	beds) (see instructions)			10	3,04		0.00		1	7.00
8. 00	I NTENSI VE CARE UNIT								ı	8.00
9. 00	CORONARY CARE UNIT								ı	9. 00
10.00	BURN INTENSIVE CARE UNIT								İ	10.00
11.00	SURGICAL INTENSIVE CARE UNIT								İ	11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)								İ	12.00
13.00	NURSERY								1	13.00
14.00	Total (see instructions)			16	5, 84	0	0.00	(		14.00
15.00	CAH visits							(		15.00
16.00	SUBPROVI DER - I PF									16. 00
17.00	SUBPROVI DER - I RF									17. 00
18.00	SUBPROVI DER								- 1	18. 00
19. 00	SKILLED NURSING FACILITY									19. 00
20. 00	NURSING FACILITY								- 1	20. 00
21. 00	OTHER LONG TERM CARE								- 1	21. 00
22. 00	HOME HEALTH AGENCY								- 1	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)								- 1	23. 00
24.00	HOSPI CE									24. 00
24. 10	HOSPICE (non-distinct part)	30. 00								24. 10
25. 00	CMHC - CMHC								- 1	25. 00
26. 00	RURAL HEALTH CLINIC	89. 00							- 1	26. 00 26. 25
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00		16				(		26. 25 27. 00
27. 00 28. 00	Total (sum of lines 14-26) Observation Bed Days			10				C	- 1	27. 00 28. 00
29.00	Ambul ance Trips							(		26. 00 29. 00
30.00	Employee discount days (see instruction)								- 1	30. 00
31. 00	Employee discount days (see Histi detroit)									31. 00
32. 00	Labor & delivery days (see instructions)			0		0				32.00
32. 01	Total ancillary labor & delivery room			O			ŀ		- 1	32. 01
	outpatient days (see instructions)									
33.00	LTCH non-covered days								1	33. 00
33. 01	LTCH site neutral days and discharges									33. 01

Provider CCN: 15-4052

Peri od: Worksheet S-3
From 07/01/2019 Part I
To 06/30/2020 Date/Time Prepared:

						11/23/2020 4:	00 pm
		I/P Days	/ O/P Visits	/ Tri ps	Full Time	Equi val ents	
						1	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
			7.00	Pati ents	& Residents	Payrol I	
1 00	Tu	6. 00	7. 00	8.00	9. 00	10.00	1.00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	361	295	2, 547			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2. 00	for the portion of LDP room available beds) HMO and other (see instructions)	0	306				2.00
3. 00	HMO IPF Subprovider	0	0				3.00
4. 00	HMO IRF Subprovider	0	0				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0				5.00
6. 00	Hospital Adults & Peds. Swing Bed NF		0	1			6.00
7. 00	Total Adults and Peds. (exclude observation	361	295				7.00
7.00	beds) (see instructions)	301	275	2,547			7.00
8. 00	INTENSIVE CARE UNIT						8.00
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)	361	295	2, 547	0.00	222. 12	14.00
15.00	CAH vi si ts	o	0	C	1		15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVI DER - I RF						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	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			C			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C			
27. 00	Total (sum of lines 14-26)				0. 00	222. 12	
28. 00	Observation Bed Days	_	0	C			28. 00
29. 00	Ambul ance Tri ps	0		_			29. 00
30.00	Employee discount days (see instruction)			C			30.00
31.00	Employee discount days - IRF			C			31.00
32.00	Labor & delivery days (see instructions)	0	0	C			32.00
32. 01	Total ancillary labor & delivery room				1		32. 01
33. 00	outpatient days (see instructions)	0					33.00
	LTCH non-covered days LTCH site neutral days and discharges	0					33.00
33. UI	TETOR Site neutral days and discharges	ı Y		I	I	I	33.UI

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 07/01/2019 | Part I | To 06/30/2020 | Date/Time Prepared: Provi der CCN: 15-4052

Component   Figure					To	06/30/2020	Date/Time Pre 11/23/2020 4:	
Nonpail of   Workers   Title V   Title XIV   Total All   Patients					Di sch	arges		
Normal   N								
No.   Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)   No.		Component		litle V	litle XVIII	litle XIX		
1.00				40.00	10.00	44.00		
Sexclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)   Company of the portion of LDP room available beds)   Company of the portion of LDP room available beds)   Company of the portion of LDP room available beds)   Company of the portion of LDP room available beds)   Company of the portion of LDP room available beds)   Company of the portion of LDP room available beds)   Company of the portion of LDP room available beds)   Company of the portion of LDP room available beds)   Company of the portion of LDP room available beds)   Company of the portion of LDP room available beds)   Company of the portion of LDP room available beds)   Company of the portion of LDP room available beds)   Company of the portion of LDP room available beds)   Company of the portion of LDP room available beds)   Company of LDP room available beds)   Company of LDP room available beds)   Company of LDP room available beds)   Company of LDP room available beds)   Company of LDP room available beds)   Company of LDP room available beds)   Company of LDP room available beds)   Company of LDP room available beds)   Company of LDP room available beds)   Company of LDP room available beds)   Company of LDP room available beds)   Company of LDP room available beds)   Company of LDP room available beds)   Company of LDP room available beds)   Company of LDP room available beds)   Company of LDP room available beds)   Company of LDP room available beds)   Company of LDP room available beds   Company o	1 00	The state Allie A Bala Cal as 5 ( 7 and						1 00
Hospice days) (see instructions for col. 2	1.00			0	69	/5	512	1.00
For the portion of LDP room available beds)   0   80   2.00								
2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Hospital Adults & Peds. Swing Bed NF 8.00 Hospital Adults and Peds. (exclude observation beds) (see instructions) 8.00 Hospital Adults and Peds. (exclude observation beds) (see instructions) 8.00 Hospital Adults and Peds. (exclude observation beds) (see instructions) 8.00 Hospital Adults and Peds. (exclude observation beds) (see instructions) 8.00 Hospital Adults and Peds. (exclude observation beds) (see instructions) 8.00 GOROMARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 11.00 11.00 SUBRISIO CALL INTENSIVE CARE UNIT 11.00 11.00 OTHER SPECIAL CARE (SPECIFY) 11.00 OTHER SPECIAL CARE (SPECIFY) 11.00 OTHER SPECIAL CARE (SPECIFY) 11.00 Total (see instructions) 10.00 OTHER SPECIAL CARE (SPECIFY) 11.00 OTHER SPECIAL CARE (SPECIFY) 11.00 OTHER SPECIAL CARE (SPECIFY) 12.00 Total (see instructions) 15.00 CAH visits 16.00 Total (see instructions) 17.00 SUBPROVIDER - IPF 18.00 Hospital								
3.00	2 00				0	80		2 00
4.00   HMO IRF Subprovider					Ŭ			
5.00		•				0		
6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTERSIVE CARE UNIT 9.00 10.00 BURN INTERSIVE CARE UNIT 11.00 11.00 DURGICAL INTERSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 14.00 Total (see instructions) 15.00 CAH visits 16.00 17.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 HOSPICE 24.00 HOSPICE 24.00 HOSPICE 25.00 CAHC - CAMC 26.25 FEBERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 29.00 Ambulance Trips 29.00 20.00 Labor & delivery days (see instructions) 32.01 Total ancil lary labor & delivery room outpatient days (see instructions) 33.00 Lich Indian See Instructions) 33.00 Uct for non-covered days 33.00 33.00 Uct Ind non-covered days 33.00 34.00 Lich non-covered days 35.00 35.00 Lich non-covered days 36.00 37.00 Lich non-covered days 37.00 38.00		•				Ĭ		
7.00								
Beds) (see instructions)   8. 00								
8. 00   INTENSIVE CARE UNIT		·						
10.00 BURN INTENSIVE CARE UNIT	8.00							8.00
11. 00   SURGICAL INTENSIVE CARE (SPECIFY)   12. 00   12. 00   THER SPECIAL CARE (SPECIFY)   13. 00   NURSERY   13. 00   NURSERY   15. 00   CAH visits	9.00	CORONARY CARE UNIT						9.00
12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 CMHC - CMHC 27. 00 ODSPICE 28. 00 ODSPICATION BED Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTOH non-covered days 33. 00 LTOH non-covered days	10.00	BURN INTENSIVE CARE UNIT						10.00
13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH vi sits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 25 FEDERALLY OUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days	11.00	SURGICAL INTENSIVE CARE UNIT						11.00
14. 00 Total (see instructions)	12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SUBPROVIDER 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 00 HOSPICE 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTOH non-covered days  15. 00 16. 00 SUBPROVIDER - IPF 17. 00 18. 00 18. 00 19.		NURSERY						
16.00 SUBPROVIDER - IPF			0. 00	0	69	75	512	
17. 00 SUBPROVI DER - IRF 18. 00 SUBPROVI DER 19. 00 SKILLED NURSI NG FACILITY 20. 00 NURSI NG FACILITY 20. 00 OTHER LONG TERM CARE 21. 00 22. 00 AMBULATORY SURGI CAL CENTER (D. P.) 23. 00 AMBULATORY SURGI CAL CENTER (D. P.) 24. 00 HOSPI CE 24. 10 HOSPI CE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 33. 00 Labor & delivery days (see instructions) 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days								
18. 00   SUBPROVI DER   18. 00   19. 00   SKI LLED NURSI NG FACILITY   19. 00   20. 00   NURSI NG FACILITY   20. 00   OTHER LONG TERM CARE   21. 00   22. 00   23. 00   24. 00   HOSPI CE   24. 00   24. 10   HOSPI CE   24. 10   24. 10   25. 00   26. 00   26. 00   26. 00   27. 00   26. 00   27. 00   28. 00   29. 00   28. 00   29		1						
19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambul ance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days								1
20.00   NURSING FACILITY   20.00   21.00   21.00   22.00   HOME HEALTH AGENCY   22.00   AMBULATORY SURGICAL CENTER (D.P.)   23.00   24.00   HOSPICE   24.00   24.10   40.00   24.10   25.00   24.10   25.00   26.00   27.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00								
21.00 OTHER LONG TERM CARE  22.00 HOME HEALTH AGENCY  23.00 AMBULATORY SURGICAL CENTER (D.P.)  24.00 HOSPICE  41.10 HOSPICE (non-distinct part)  25.00 CMHC - CMHC  26.00 RURAL HEALTH CLINIC  26.00 RURAL HEALTH CLINIC  26.25 FEDERALLY OUALIFIED HEALTH CENTER  27.00 Total (sum of lines 14-26)  28.00 Observation Bed Days  29.00 Ambulance Trips  29.00  30.00 Employee discount days (see instruction)  31.00 Employee discount days - IRF  31.00  32.01 Total ancillary labor & delivery room outpatient days (see instructions)  33.00 LTCH non-covered days  0 STAND SURGILLARIA (SALE)  21.00								
22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 26.25 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 29.00 30.00 Employee discount days (see instruction) Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 31.00 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  22.00 22.00 23.00 24.10 24.10 25.00 25.00 26.25 27.00 26.25 27.00 27.00 28.00 29.00 29.00 29.00 29.00 29.00 20.0								
23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) Employee discount days (see instructions) 32.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  23.00 24.00 24.00 25.00 26.05 27.00 26.00 27.00 28.00 29.00 30.00 29.00 30.00 29.00 30.00 31.00 32.00 33.00								
24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 29. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days								
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 29. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 29. 00 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days		, ,						
25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 26. 25 27. 00 Total (sum of lines 14-26) 27. 00 Observation Bed Days 28. 00 29. 00 Ambul ance Trips 29. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days  25. 00 26. 05 27. 00 26. 25 27. 00 27. 00 28. 00 29. 00 29. 00 29. 00 29. 00 30. 00 31. 00 32. 01 32. 01 33. 00 32. 01 33. 00								
26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 26. 00 26. 25 Total (sum of lines 14-26) Total (sum of lines 14-26) 0. 00 28. 00 Observation Bed Days 29. 00 Ambul ance Trips Employee discount days (see instruction) Employee discount days - IRF 29. 00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) 31. 00 LTCH non-covered days  26. 00 26. 25 27. 00 28. 00 29. 00 29. 00 29. 00 30. 00 31. 00 31. 00 32. 01 32. 01 33. 00 33. 00								
26. 25 27. 00 Total (sum of lines 14-26)								
27.00			0 00					ı
28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  28.00 29.00 30.00 30.00 31.00 32.00 32.01		1						
29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  29.00 30.00 31.00 32.00 32.01		` ,						
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  30.00 31.00 32.01		,						
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  32.00 32.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30.00							30.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)  33.00 LTCH non-covered days  32.01	31.00	Employee discount days - IRF						31.00
outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.00	32.00	Labor & delivery days (see instructions)						32.00
33. 00 LTCH non-covered days 0 33. 00	32. 01	Total ancillary labor & delivery room						32. 01
		outpatient days (see instructions)						
33.01 LTCH site neutral days and discharges     0   33.01		3						
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	33. 01	LTCH site neutral days and discharges			0			33. 01

	5					6.5. 0110	0550 40
		PORTER-STARKE SE		ON 15 4050		u of Form CMS-:	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	JF EXPENSES	Provider Co		Period: From 07/01/2019	Worksheet A	
					To 06/30/2020		
						11/23/2020 4:	00 pm
	Cost Center Description	Sal ari es	0ther		Reclassificat		
				+ col . 2)	i ons (See	Trial Balance	
					A-6)	(col. 3 +-	
		1 00		2.22	4.00	col . 4)	
	OFFICE OFFICE COOK OFFICE	1. 00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS				_1		
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT		661, 627			661, 627	1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	187, 665	196, 275			383, 940	
5.00	00500 ADMI NI STRATI VE & GENERAL	2, 927, 579	1, 931, 936			4, 859, 515	1
7. 00	00700 OPERATION OF PLANT	233, 433	152, 637			386, 070	1
9. 00	00900 HOUSEKEEPI NG	121, 909	72, 985			194, 894	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	329, 892	110, 468	440, 36	0 0	440, 360	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				_		
30.00	03000 ADULTS & PEDIATRICS	1, 256, 535	707, 854	1, 964, 38	9 0	1, 964, 389	30.00
	ANCILLARY SERVICE COST CENTERS						
60.00	06000 LABORATORY	0	163, 683	163, 68	3 0	163, 683	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	120, 619	120, 61	9 0	120, 619	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	3, 403, 663	2, 427, 573	5, 831, 23	6 0	5, 831, 236	90.00
	SPECIAL PURPOSE COST CENTERS						
118.00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	8, 460, 676	6, 545, 657	15, 006, 33	3 0	15, 006, 333	118. 00
	NONREI MBURSABLE COST CENTERS						
194.00	07950 RESI DENTI AL	1, 656, 263	1, 255, 777	2, 912, 04	0	2, 912, 040	194. 00
	07951 OTHER NONREIMBURSABLE COST CENTERS	1, 809, 409	970, 845	2, 780, 25	4 0	2, 780, 254	
194. 02	07952 FQHC - MARRAM	2, 252, 984	1, 654, 147	3, 907, 13	1 0	3, 907, 131	194. 02
200.00	TOTAL (SUM OF LINES 118 through 199)	14, 179, 332	10, 426, 426	24, 605, 75	8 0	24, 605, 758	200.00

Health Financial Systems	PORTER-STARKE SERV	VICES, INC	In Lieu	ı of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL	L BALANCE OF EXPENSES	Provider CCN: 15-4052	Peri od:	Worksheet A

			From 07/01/2019 To 06/30/2020 Date/Ti	me Prepared: 2020 4:00 pm
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For		
		Allocation		
	6. 00	7. 00		
GENERAL SERVICE COST CENTERS				
1.00   00100   NEW CAP REL COSTS-BLDG & FLXT	-264, 093			1.00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT	0	383, 940		4. 00
5. 00   00500 ADMINI STRATI VE & GENERAL	-1, 378, 921	3, 480, 594		5.00
7.00  00700 OPERATION OF PLANT	-2, 547	383, 523		7.00
9. 00   00900   HOUSEKEEPI NG	0	194, 894		9. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	440, 360		16. 00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS	-321, 791	1, 642, 598		30.00
ANCILLARY SERVICE COST CENTERS				
60. 00   06000   LABORATORY	0	163, 683		60.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	120, 619		73.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	-2, 016, 961	3, 814, 275		90.00
SPECIAL PURPOSE COST CENTERS				
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-3, 984, 313	11, 022, 020		118. 00
NONREI MBURSABLE COST CENTERS				
194. 00 07950 RESI DENTI AL	0	2, 912, 040		194. 00
194.01 07951 OTHER NONREIMBURSABLE COST CENTERS	0	2, 780, 254		194. 01
194.02 07952 FQHC - MARRAM	0	3, 907, 131		194. 02
200.00   TOTAL (SUM OF LINES 118 through 199)	-3, 984, 313	20, 621, 445		200.00

Health Financial Systems RECLASSIFICATIONS PORTER-STARKE SERVICES, INC In Lieu of Form CMS-2552-10 Provider CCN: 15-4052 Peri od: From 07/01/2019 To 06/30/2020 Worksheet A-6 Date/Time Prepared: 11/23/2020 4:00 pm Increases Cost Center Li ne # Sal ary 0ther 2. 00 5. 00 3.00 4.00 A - DEFAULT 0.00 1.00 1.00 500.00 Grand Total: Increases 500.00

Health Financial Systems RECLASSIFICATIONS PORTER-STARKE SERVICES, INC In Lieu of Form CMS-2552-10 Provider CCN: 15-4052 Peri od: From 07/01/2019 To 06/30/2020 Worksheet A-6 Date/Time Prepared: 11/23/2020 4:00 pm Decreases Wkst. A-7 Ref. 10.00 Cost Center Li ne # Sal ary 0ther 9.00 6. 00 7.00 8. 00 A - DEFAULT 0.00 1.00 1.00 500.00 Grand Total: Decreases 500.00

Provi der CCN: 15-4052

				10	06/30/2020	11/23/2020 4:	
			•	Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4. 00	5. 00	
	<u> PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE</u>						
1. 00	Land	965, 693	0	0	0	0	1.00
2. 00	Land Improvements	614, 798	5, 176		5, 176	0	2.00
	Buildings and Fixtures	10, 430, 432	347, 983	0	347, 983	74, 183	
	Building Improvements	0	0	0	0	0	4. 00
	Fi xed Equi pment	4, 072, 859	444, 859	0	444, 859		5. 00
	Movable Equipment	0	0	0	0	0	6. 00
	HIT designated Assets	0	0	0	0	0	7. 00
	Subtotal (sum of lines 1-7)	16, 083, 782	798, 018	0	798, 018		8.00
	Reconciling Items	0	0	0	0	0	,,,,,
10.00	Total (line 8 minus line 9)	16, 083, 782	798, 018	0	798, 018	240, 817	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
			Assets				
	DADT I ANALYCIC OF CHANCEC IN CADITAL ACCE	6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		0				1 00
1.00	Land	965, 693	0				1.00
2.00	Land Improvements	619, 974	0				2.00
	Buildings and Fixtures	10, 704, 232	0				3.00
	Building Improvements	4 251 004	0				4.00
	Fixed Equipment	4, 351, 084	0				5. 00 6. 00
	Movable Equipment	0	0				7.00
	HIT designated Assets Subtotal (sum of lines 1-7)	14 440 003	0				8.00
	Reconciling Items	16, 640, 983	0				9.00
		16, 640, 983	0				10.00
10.00	Total (line 8 minus line 9)	10, 640, 983	U	l			10.00

Heal th	Financial Systems	PORTER-STARKE S	SERVICES, INC		In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS			Provider Co	CN: 15-4052	Peri od: From 07/01/2019 To 06/30/2020		pared:	
			SL	JMMARY OF CAP	PI TAL			
	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 WO	RKSHEET A, COLU	MN 2, LINES 1 a	and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	661, 627	0		0	0	1.00	
3.00	Total (sum of lines 1-2)	661, 627	0		0 0	0	3.00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	0ther	Total (1)					
		Capi tal -Rel at	(sum of cols.					
		ed Costs (see	9 through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WO	RKSHEET A, COLUM	MN 2, LINES 1 a	and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	661, 627		-		1.00	
3. 00	Total (sum of lines 1-2)	0	661, 627				3.00	

Health Financial Systems	PORTER-STARKE	SERVICES, INC		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7	
				From 07/01/2019 To 06/30/2020		narod:
			'	00/30/2020	11/23/2020 4:0	
	COMI	COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL				
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 -			
	1, 00	2.00	col . 2) 3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS		2.00	3.00	4.00	5.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	16, 640, 983	0	16, 640, 983	1. 000000	0	1. 00
3.00 Total (sum of lines 1-2)	16, 640, 983					3. 00
or compression (commercial)		TION OF OTHER (			F CAPITAL	0.00
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at				
		ed Costs	through 7)			
	6. 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS		1	1			
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	1	(	001,027	-264, 093	1.00
3.00 Total (sum of lines 1-2)	0	·	( ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) (	661, 627	-264, 093	3.00
		St	JMMARY OF CAPI	IAL		
Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
, , , , , , , , , , , , , , , , , , ,		(see		Capi tal -Rel at		
		instructions)		ed Costs (see	9 through 14)	
				instructions)		
	11. 00	12. 00	13. 00	14. 00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS						
1.00 NEW CAP REL COSTS-BLDG & FLXT	0					1.00
3.00  Total (sum of lines 1-2)	0	0	(	0	397, 534	3.00

ADJUST	MENTS TO EXPENSES				eri od:	Worksheet A-8	-
					rom 07/01/2019	D. I. (T' D	
					o 06/30/2020	Date/Time Pre 11/23/2020 4:	
				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)				Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
31. 00	Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68. 00		31.00
	pathology costs in excess of						
22 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32.00
32.00	Depreciation and Interest		0		0.00	U	32.00
33. 00	LEASE INCOME	В	-236 442	NEW CAP REL COSTS-BLDG &	1.00	10	33.00
00.00	LENGE THOUME	5	·	FIXT			00.00
33. 01	PHONE I NCOME	В	-823	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33. 02	OTHER INC MISC	В	-36, 402	ADMINISTRATIVE & GENERAL	5. 00	0	33. 02
33. 03	OTHER INC MISC	В		OPERATION OF PLANT	7. 00	0	00.00
33. 04	OTHER INC MISC	В		ADULTS & PEDIATRICS	30. 00	0	
33. 05	OTHER INC MISC	В	-84, 559	la contraction of the contractio	90.00	0	33.05
33.06	OTHER SALARY REIMBURSEMENT	В		OPERATION OF PLANT	7.00	0	1 00.00
33. 07 33. 08	OTHER INCOME PORTER HOSPITAL COMMUNITY RELATIONS	B A		ADULTS & PEDIATRICS ADMINISTRATIVE & GENERAL	30. 00 5. 00	0	
33. 09	COMMUNITY RELATIONS	A		OPERATION OF PLANT	7. 00	0	
33. 10	COMMUNITY RELATIONS	Ä		ADULTS & PEDIATRICS	30.00	0	
33. 11	HOSPITAL ASSESSMENT FEES	A	-634, 714	1	90.00	0	
33. 12	PROMOTI ONAL ADVERTI SI NG	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 12
33. 13	PROMOTIONAL ADVERTISING	Α	-1, 046	ADULTS & PEDIATRICS	30.00	0	33. 13
33. 14	ADMISSIONS REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 15	INTEREST OFFSET	Α		NEW CAP REL COSTS-BLDG &	1.00	10	33. 15
				FIXT		_	
33. 16	LOBBYING EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 17	ADMISSIONS/ER REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	0	1 00. 17
50. 00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,		-3, 984, 313				50.00
	column 6 Line 200 )						

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

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

B. Amount Received - if cost cannot be determined.

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provi der CCN: 15-4052

						To 06/30/2020	Date/Time Pre 11/23/2020 4:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00		ADULTS & PEDIATRICS	346, 400					1. 00
2.00		CLINIC	2, 261, 841	1, 297, 688				
3.00	0. 00		0	0	C	_		3. 00
4. 00	0. 00		0	0	C	0	0	4. 00
5.00	0.00		0	0	C	0	0	5. 00
6.00	0.00		0	0	C	0	0	6. 00
7. 00	0.00		0	0	C	0	0	7. 00
8.00	0. 00		0	0	C	0	0	8. 00
9. 00	0. 00		0	0	C	0	0	9. 00
10.00	0. 00		0	0	C	0	0	10.00
200.00			2, 608, 241					200.00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit		Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00		ADULTS & PEDIATRICS	149, 311	7, 466		_		
2. 00		CLINIC	1, 081, 263			,		2. 00
3. 00	0. 00		0	0	_	_		3. 00
4. 00	0.00		0	0	_	0	Ĭ	4. 00
5.00	0. 00		0	0	C	0	0	5. 00
6. 00	0.00		0	0	C	0	0	6. 00
7. 00	0.00		0	0	C	0	0	7. 00
8. 00	0. 00		0	0	C	0	0	8. 00
9. 00	0. 00		0	0	C	0	0	9. 00
10.00	0. 00		0	0	C	0	0	10.00
200.00			1, 230, 574			0	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00		
1. 00		ADULTS & PEDIATRICS	15.00					1. 00
2. 00		CLINIC		1, 081, 263		1, 297, 688		2.00
3. 00	0.00			1,081,263		1, 297, 688		3. 00
4. 00	0.00			0	_	0		4.00
	0.00							
5. 00						0		5.00
6. 00	0.00							6.00
7.00	0.00					0		7.00
8. 00	0.00					0		8.00
9. 00	0.00							9.00
10.00	0. 00			1 220 574	120 202	1 404 777		10.00
200.00	l		0	1, 230, 574	129, 383	1, 494, 777		200.00

Health Financial Systems	PORTER-STARKE SERVICES, INC			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider Co		Period: From 07/01/2019 To 06/30/2020	Worksheet B Part I Date/Time Prep 11/23/2020 4:0		
		CAPITAL RELATED COSTS	5MB1 0V55		45W W 075471V		

					o 06/30/2020		pared:
	Cost Center Description		CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIV E & GENERAL	у ри
		Allocation (from Wkst A col. 7)		DEI AKTWENT			
		0	1. 00	4. 00	4A	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	397, 534	397, 534				1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	383, 940	3, 668				4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	3, 480, 594	105, 049				
7. 00	00700 OPERATION OF PLANT	383, 523	3, 774				
9. 00	00900 HOUSEKEEPI NG	194, 894	3, 589				
16. 00	01600 MEDI CAL RECORDS & LI BRARY	440, 360	8, 367	9, 139	457, 866	99, 021	16. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	1 (42 500	(0. (01	24 010	1 720 000	275 001	20.00
30. 00	ANCILLARY SERVICE COST CENTERS	1, 642, 598	60, 681	34, 810	1, 738, 089	375, 891	30.00
60.00	06000 LABORATORY	163, 683	0		163, 683	35, 399	60.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	103,003	0		103, 003	35, 399	71.00
73.00	07300 DRUGS CHARGED TO PATTENTS	120, 619	0		120, 619	1	
73.00	OUTPATIENT SERVICE COST CENTERS	120, 017	<u> </u>		120,017	20,000	73.00
90.00		3, 814, 275	70, 456	94, 289	3, 979, 020	860, 531	90.00
	SPECIAL PURPOSE COST CENTERS	27 3		, ===	27 7		
118.00		11, 022, 020	255, 584	229, 185	10, 721, 647	1, 525, 742	118.00
	NONREI MBURSABLE COST CENTERS	'					
194.00	07950 RESI DENTI AL	2, 912, 040	66, 960	45, 883	3, 024, 883	654, 182	194. 00
194.01	1 07951 OTHER NONREIMBURSABLE COST CENTERS	2, 780, 254	26, 411	50, 126	2, 856, 791	617, 830	194. 01
	2 07952 FQHC - MARRAM	3, 907, 131	48, 579	62, 414	4, 018, 124	868, 992	194. 02
200.00					0	l .	200. 00
201.00	1 3		0	C	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	20, 621, 445	397, 534	387, 608	20, 621, 445	3, 666, 746	202. 00

Health Financial Systems	PORTER-STARKE SERVICI	CES, INC	In Lieu	of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Pr		From 07/01/2019	Worksheet B Part I Date/Time Prepared:

					rom 07/01/2019 o 06/30/2020		
						11/23/2020 4:	00 pm
	Cost Center Description	OPERATION OF	HOUSEKEEPI NG	MEDI CAL	Subtotal	Intern &	
		PLANT		RECORDS &		Resi dents	
				LI BRARY		Cost & Post	
						Stepdown	
						Adjustments	
	OFFICE AND SERVICE ASSTRAIN	7. 00	9. 00	16. 00	24. 00	25. 00	
	GENERAL SERVICE COST CENTERS	I					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT	478, 922					7. 00
9. 00	00900 HOUSEKEEPI NG	6, 030					9. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	14, 059	7, 478	578, 424			16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				1		
30. 00	03000 ADULTS & PEDI ATRI CS	101, 954	54, 233	218, 003	2, 488, 170	0	30.00
	ANCILLARY SERVICE COST CENTERS		. 1		1		
60.00	06000 LABORATORY	0	0	21, 239	220, 321	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	15, 651	162, 356	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	118, 379	62, 969	323, 531	5, 344, 430	0	90.00
	SPECIAL PURPOSE COST CENTERS						
118.00		240, 422	124, 680	578, 424	8, 215, 277	0	118. 00
	NONREI MBURSABLE COST CENTERS				1		
	07950 RESI DENTI AL	112, 504		0	3, 851, 413		194. 00
	07951 OTHER NONREI MBURSABLE COST CENTERS	44, 375	·	0	3, 542, 601		194. 01
	07952 FQHC - MARRAM	81, 621	43, 417	0	5, 012, 154		194. 02
200.00	1 1				0		200.00
201.00	1 3	0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	478, 922	251, 546	578, 424	20, 621, 445	0	202. 00

	2 10
From 07/01/2019   Part I   Date/Time Prepar   To 06/30/2020   Date/Time Prepar   11/23/2020 4:00	2-10
To 06/30/2020   Date/Time Prepar   11/23/2020 4: 00	
Cost Center Description	
26.00  GENERAL SERVICE COST CENTERS  1.00   O0100   NEW CAP REL COSTS-BLDG & FIXT	pm
GENERAL SERVICE COST CENTERS  1. 00   O0100   NEW CAP REL COSTS-BLDG & FIXT	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	
	1.00
	4. 00
	5. 00
	7. 00
	9. 00
	6. 00
INPATIENT ROUTINE SERVICE COST CENTERS	
	0.00
ANCILLARY SERVICE COST CENTERS	
	0.00
	1.00
	3. 00
OUTPATIENT SERVICE COST CENTERS	
	0.00
SPECIAL PURPOSE COST CENTERS	
	8. 00
NONREI MBURSABLE COST CENTERS	
	4.00
	4. 01
	4. 02
	0.00
	1.00
202.00   TOTAL (sum lines 118 through 201)   20,621,445   202	2. 00

Health Financial Systems	PORTER-STARKE SERVICES, INC	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-4052	Period: Worksheet B From 07/01/2019 Part II

				Fi To	rom 07/01/2019 o 06/30/2020	Part II Date/Time Pre 11/23/2020 4:	
			CAPI TAL			11/23/2020 4.	oo piii
			RELATED COSTS				
	Cost Center Description	Di rectly	NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI V	
	cost center beserretron	Assigned New	FLXT	Subtotal	BENEFITS	E & GENERAL	
		Capi tal	IIXI		DEPARTMENT	L & OLIVLIAL	
		Related Costs			DEI / III III EII I		
		0	1.00	2A	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	3, 668	3, 668	3, 668		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	0	105, 049	105, 049	767	105, 816	5.00
7.00	00700 OPERATION OF PLANT	0	3, 774	3, 774	61	2, 457	7.00
9.00	00900 HOUSEKEEPI NG	0	3, 589	3, 589	32	1, 260	9.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	8, 367	8, 367	86	2, 858	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	60, 681	60, 681	329	10, 847	30.00
	ANCILLARY SERVICE COST CENTERS						
60.00	06000 LABORATORY	0	0	0	0	1, 022	60.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	753	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	70, 456	70, 456	895	24, 833	90.00
	SPECIAL PURPOSE COST CENTERS						
118.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0	255, 584	255, 584	2, 170	44, 030	118. 00
	NONREI MBURSABLE COST CENTERS						
	07950 RESI DENTI AL	0	66, 960	· ·		18, 878	
	07951 OTHER NONREIMBURSABLE COST CENTERS	0	26, 411	26, 411	474	17, 829	
	07952 FQHC - MARRAM	0	48, 579	48, 579	590	25, 079	
200.00	, ,			0			200. 00
201.00	3		0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	0	397, 534	397, 534	3, 668	105, 816	202. 00

Health Financial Systems	PORTER-STARKE S	SERVICES, INC		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 07/01/2019 To 06/30/2020	Worksheet B Part II Date/Time Pre 11/23/2020 4:	
Cost Center Description	OPERATION OF PLANT	HOUSEKEEPI NG	MEDICAL RECORDS &	Subtotal	Intern & Residents	

				F	rom 07/01/2019 o 06/30/2020	Part II   Date/Time Pre	pared.
						11/23/2020 4:	
	Cost Center Description	OPERATION OF	HOUSEKEEPI NG	MEDI CAL	Subtotal	Intern &	
		PLANT		RECORDS &		Resi dents	
				LI BRARY		Cost & Post	
						Stepdown	
						Adjustments	
		7. 00	9. 00	16. 00	24. 00	25. 00	
	GENERAL SERVICE COST CENTERS	Г					
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7. 00	00700 OPERATION OF PLANT	6, 292					7. 00
9. 00	00900 HOUSEKEEPI NG	79	4, 960				9. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	185	147	11, 643			16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	1, 339	1, 069	4, 388	78, 653	0	30.00
	ANCILLARY SERVICE COST CENTERS						
	06000 LABORATORY	0	0	427	1, 449	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	315	1, 068	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	1, 556	1, 243	6, 513	105, 496	0	90.00
	SPECIAL PURPOSE COST CENTERS						
118.00		3, 159	2, 459	11, 643	186, 666	0	118. 00
	NONREI MBURSABLE COST CENTERS						
	07950 RESI DENTI AL	1, 478	1, 180		88, 930		194. 00
	07951 OTHER NONREI MBURSABLE COST CENTERS	583	465		45, 762		194. 01
	07952 FQHC - MARRAM	1, 072	856	0	76, 176		194. 02
200.00	J				0		200. 00
201.00	1 3	0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	6, 292	4, 960	11, 643	397, 534	0	202. 00

Heal th	Financial Systems	PORTER-STARKE SEE	RVICES, INC	In Lie	u of Form CMS-2	552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CCN: 15-4052	Peri od: From 07/01/2019 To 06/30/2020	Worksheet B Part II Date/Time Prep 11/23/2020 4:0	ared:
	Cost Center Description	Total 26. 00				
	GENERAL SERVICE COST CENTERS					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 00	00500 ADMINISTRATIVE & GENERAL					5.00
7. 00	00700 OPERATION OF PLANT					7.00
9. 00	00900 HOUSEKEEPI NG					9.00
16.00	01600 MEDICAL RECORDS & LIBRARY					16.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS	78, 653				30.00
	ANCILLARY SERVICE COST CENTERS	<u>,                                      </u>				
60.00	06000 LABORATORY	1, 449				60.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O				71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 068				73.00
	OUTPATIENT SERVICE COST CENTERS	<u> </u>				
90.00	09000 CLI NI C	105, 496				90.00
	SPECIAL PURPOSE COST CENTERS					
110 00	CUDTOTALS (CUM OF LINES 1 +brough 117)	104 444			1	110 00

186, 666

88, 930 45, 762 76, 176

397, 534

0

0

118. 00

194. 00 194. 01 194. 02

200.00

201.00

202.00

SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS

TOTAL (sum lines 118 through 201)

194. 00 07950 RESI DENTI AL 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 194. 02 07952 FQHC - MARRAM

Cross Foot Adjustments Negative Cost Centers

200.00

201.00

202.00

llool +b	Financial Customs	DODTED STADUE S	EDVICES INC		la li o	u of Form CMS-2	2552 10
	Financial Systems      LLOCATION - STATISTICAL BASIS	PORTER-STARKE S	Provider C	CN: 15 4052	Period:	Worksheet B-1	
C031 P	LECCATION - STATISTICAL BASIS		Frovider		From 07/01/2019	WOLKSHEET D-1	
					To 06/30/2020	Date/Time Pre 11/23/2020 4:	
		CAPI TAL					
	0	RELATED COSTS	EMBL OVEE	B	ADMINI CEDATIV	ODEDATION OF	
	Cost Center Description	NEW BLDG & FLXT	EMPLOYEE BENEFITS		ADMINISTRATIV	OPERATION OF PLANT	
		(SQUARE	DEPARTMENT	n	(ACCUM.	(SQUARE	
		FEET)	(GROSS		COST)	FEET)	
		1)	SALARI ES)		(031)	1 [[]	
		1. 00	4.00	5A	5. 00	7. 00	
	GENERAL SERVICE COST CENTERS				2.22		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	60, 147					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	555	13, 991, 667				4.00
5.00	00500 ADMINISTRATIVE & GENERAL	15, 894	2, 927, 579	-3, 666, 74	6 16, 954, 699		5.00
7.00	00700 OPERATION OF PLANT	571	233, 433		0 393, 764	43, 127	7.00
9.00	00900 HOUSEKEEPI NG	543	121, 909		0 201, 860	543	9. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 266	329, 892		0 457, 866	1, 266	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	9, 181	1, 256, 535		0 1, 738, 089	9, 181	30.00
	ANCILLARY SERVICE COST CENTERS	1		T	al		
	06000 LABORATORY	0	0	1	163, 683	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	1	0 0 120, 619	0	
73.00	OUTPATIENT SERVICE COST CENTERS	U U	0	1	0  120, 619	U	73.00
90 00	09000 CLINIC	10, 660	3, 403, 663		0 3, 979, 020	10, 660	90.00
70.00	SPECIAL PURPOSE COST CENTERS	10,000	3, 403, 003	1	0 3, 777, 020	10,000	70.00
118.00		38, 670	8, 273, 011	-3, 666, 74	6 7, 054, 901	21, 650	118.00
	NONREI MBURSABLE COST CENTERS	22, 2.3	2/2/2/2/		., ., ,	=1,7222	1
194.00	07950 RESI DENTI AL	10, 131	1, 656, 263		0 3, 024, 883	10, 131	194. 00
194. 01	07951 OTHER NONREIMBURSABLE COST CENTERS	3, 996	1, 809, 409		0 2, 856, 791	3, 996	194. 01
194.02	07952 FQHC - MARRAM	7, 350	2, 252, 984		0 4, 018, 124	7, 350	194. 02
200.00							200.00
201.00							201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	397, 534	387, 608		3, 666, 746	478, 922	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	6. 609374	0. 027703		0. 216267	11. 104923	203.00
204.00			3, 668		105, 816	6, 292	204.00
	Part II)						
205.00			0. 000262		0. 006241	0. 145895	205. 00
206.00							206. 00
207 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
207.00	Parts III and IV)						207.00
		1		I	1		1

Health Financial Systems	PORTER-STARKE SERVICES, INC	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-4052	Period: Worksheet B-1 From 07/01/2019
		To 06/30/2020 Date/Time Prepared:

C031 F	LECCATION - STATISTICAL BASIS		TI OVI GET C	CN. 13-4032	From 07/01/2019	WOLKSHEET B-1	
						Date/Time Prepar	
	01 01	HOUGEKEEDING	MEDIONI		L.	11/23/2020 4: 00	pm
	Cost Center Description	HOUSEKEEPI NG	MEDI CAL				
		(SQUARE	RECORDS &				
		FEET)	LI BRARY				
			(GROSS				
		9. 00	CHARGES) 16. 00	_			
	GENERAL SERVICE COST CENTERS	7.00	10.00				
1. 00	00100 NEW CAP REL COSTS-BLDG & FLXT					1	1. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
9. 00	00900 HOUSEKEEPI NG	42, 584					9. 00
	01600 MEDICAL RECORDS & LIBRARY	1, 266	7, 604, 059				6. 00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	1,200	7,001,007				3. 00
30.00	03000 ADULTS & PEDI ATRI CS	9, 181	2, 865, 899	1		30	0. 00
	ANCILLARY SERVICE COST CENTERS	, ,	, , .	'			
60.00	06000 LABORATORY	0	279, 211			60	0. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	0	1		71	1. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	205, 752			73	3.00
	OUTPATIENT SERVICE COST CENTERS	·					
90.00	09000 CLI NI C	10, 660	4, 253, 197			90	0. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	21, 107	7, 604, 059			118	8. 00
	NONREI MBURSABLE COST CENTERS						
	07950 RESI DENTI AL	10, 131	0	1			4. 00
	07951 OTHER NONREI MBURSABLE COST CENTERS	3, 996	0	)			4. 01
	07952 FQHC - MARRAM	7, 350	0				4. 02
200.00	1						0. 00
201.00							1. 00
202.00		251, 546	578, 424			202	2. 00
	Part I)						
203.00		5. 907054	0. 076068	1			3.00
204.00		4, 960	11, 643			204	4. 00
	Part II)						
205.00		0. 116476	0. 001531			205	5. 00
	[11]						
206.00						20€	6. 00
	(per Wkst. B-2)						
207.00						207	7. 00
	Parts III and IV)			I			

Health Fina	ncial Systems	PORTER-STARKE	SERVICES, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATI Of	N OF RATIO OF COSTS TO CHARGES		Provi der Co		Period: From 07/01/2019 To 06/30/2020		pared: 00 pm
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	(from Wkst.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		B, Part I,					
		col . 26) 1.00	2.00	3.00	4. 00	5. 00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS	•		•		•	
30. 00 0300	O ADULTS & PEDIATRICS	2, 488, 170		2, 488, 1	70 129, 383	2, 617, 553	30.00
ANCI	LLARY SERVICE COST CENTERS						
60.00 0600	O LABORATORY	220, 321		220, 3	21 0	220, 321	60.00
71. 00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	71.00
73.00 0730	O DRUGS CHARGED TO PATIENTS	162, 356		162, 3	56 0	162, 356	73.00
	ATIENT SERVICE COST CENTERS						
	O CLI NI C	5, 344, 430		5, 344, 4		5, 344, 430	90.00
200. 00	Subtotal (see instructions)	8, 215, 277	0	8, 215, 2	129, 383		1
201. 00	Less Observation Beds	0			0		201.00
202. 00	Total (see instructions)	8, 215, 277	0	8, 215, 2	129, 383	8, 344, 660	202. 00

Health Financial Systems	PORTER-STARKE SERVICES, INC			In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	Provi der CCN: 15-4052		Worksheet C Part I Date/Time Pre 11/23/2020 4:	
	Title XVIII		Hospi tal	PPS		
	Charges					
Cost Center Description	I npati ent	Outpati ent	Total (col. + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
	6. 00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS				<u> </u>		
30.00 03000 ADULTS & PEDIATRICS	2, 865, 899		2, 865, 89	9		30.00
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	279, 211	0	279, 21	1 0. 789084	0.000000	60.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0. 000000	0.000000	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	205, 752	0	205, 75	2 0. 789086	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	4, 253, 197	4, 253, 19	7 1. 256568	0.000000	90.00
200.00 Subtotal (see instructions)	3, 350, 862	4, 253, 197	7, 604, 05	9		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	3, 350, 862	4, 253, 197	7, 604, 05	9		202. 00

Health Financial Systems	PORTER-STARKE SERVICES, INC		In Lieu of Form CMS-2552-10		
OMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-4052	Peri od: From 07/01/2019 To 06/30/2020		
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
ANCILLARY SERVICE COST CENTERS					
60. 00 06000 LABORATORY	0. 789084				60.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 789086				73.00
OUTPATIENT SERVICE COST CENTERS					1
90. 00 09000 CLI NI C	1. 256568				90.00
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-STARKE S	SERVICES, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO	CHARGES		Provi der C	CN: 15-4052	Peri od: From 07/01/2019		
					To 06/30/2020	Date/Time Pre 11/23/2020 4:	
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
Cost Center Descript	i on	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		2, 488, 170		2, 488, 17	129, 383	2, 617, 553	30.00
ANCILLARY SERVICE COST CEN	NTERS						
60. 00   06000   LABORATORY		220, 321		220, 32	21 0	220, 321	60.00
71.00 07100 MEDICAL SUPPLIES CHA	RGED TO PATIENTS	0			0	0	71.00
73.00 07300 DRUGS CHARGED TO PAT	TENTS	162, 356		162, 35	66 0	162, 356	73.00
OUTPATIENT SERVICE COST CE	ENTERS						
90. 00   09000   CLI NI C		5, 344, 430		5, 344, 43	0	5, 344, 430	90.00
200.00 Subtotal (see instru	ıcti ons)	8, 215, 277	0	8, 215, 27	7 129, 383	8, 344, 660	200. 00
201.00 Less Observation Bed	ls	0			0	0	201.00
202.00 Total (see instructi	ons)	8, 215, 277	0	8, 215, 27	129, 383	8, 344, 660	202. 00

Health Financial Systems	PORTER-STARKE S	ERVICES, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		eri od:	Worksheet C	
				rom 07/01/2019 o 06/30/2020	Part I Date/Time Pre 11/23/2020 4:	pared: 00 pm_
		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 & PEDIATRICS	2, 865, 899		2, 865, 899			30.00
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	279, 211	0	279, 211	0. 789084	0.000000	60.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0. 000000	0.000000	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	205, 752	0	205, 752	0. 789086	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	4, 253, 197	4, 253, 197	1. 256568	0.000000	90.00
200.00 Subtotal (see instructions)	3, 350, 862	4, 253, 197	7, 604, 059			200. 00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	3, 350, 862	4, 253, 197	7, 604, 059			202. 00

Health Financ	cial Systems	PORTER-STARKE SE	RVICES, INC	In Lieu of Form CMS-2552-1		
COMPUTATI ON	OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-4052	Peri od: From 07/01/2019 To 06/30/2020		pared: 00 pm
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
INPATI	ENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS					30.00
ANCI LL	ARY SERVICE COST CENTERS					
60.00 06000	LABORATORY	0. 000000				60.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTPAT	TIENT SERVICE COST CENTERS					1
90.00 09000	CLINIC	0.000000				90.00
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-STARKE SERVICES, INC In				ieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	F		Period: From 07/01/2019 To 06/30/2020		pared:	
					11/23/2020 4:	00 pm	
			XVIII	Hospi tal PPS			
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem		
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /		
	(from Wkst.		Related Cost		col. 4)		
	B, Part II,		(col. 1 -				
	col . 26)		col . 2)				
	1. 00	2. 00	3.00	4. 00	5. 00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	78, 653	0	78, 65	2, 547	30. 88	30.00	
200.00 Total (lines 30 through 199)	78, 653		78, 65	2, 547		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	1				
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDIATRICS	361	11, 148				30.00	
200.00 Total (lines 30 through 199)	361	11, 148				200.00	

Health Financial Systems						
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider CO		Period: From 07/01/2019 To 06/30/2020		pared: 00 pm
		Title	XVIII	Hospi tal	PPS	
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						
60. 00   06000   LABORATORY	1, 449	279, 211	0. 00519	0 1	0	60.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.00000	0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 068	205, 752	0. 00519	24, 276	126	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	105, 496	4, 253, 197	0. 02480	04	0	90.00
200.00   Total (lines 50 through 199)	108, 013	4, 738, 160		24, 277	126	200. 00
						1

Health Financial Systems	PORTER-STARKE SERVICES, INC In Lieu of Form CN				u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provider Co		Period: From 07/01/2019 To 06/30/2020		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng School Post-Stepdown	Nursi ng School	Allied Healt Post-Stepdow Adjustments	Allied Health Cost	All Other Medical Education	
	Adjustments 1A	1 00	24	2.00	Cost 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	IA	1. 00	2A	2. 00	3.00	
30. 00 03000 ADULTS & PEDIATRICS		0		0	0	30.00
200.00 Total (lines 30 through 199)	0	0		0 0		200.00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patien Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0	0	2, 54 2, 54		l	30. 00 200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0					30. 00 200. 00

Health Financial Systems							
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS			Peri od: From 07/01/2019 To 06/30/2020	com 07/01/2019 Part IV			
					Date/Time Pre 11/23/2020 4:	pared: 00 pm_	
		Title XVIII			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							
60. 00 06000 LABORATORY	0	0		0 0	0	60.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00	
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLI NI C	0	0		0 0	0	90.00	
200.00 Total (Lines 50 through 199)	0	0			0	200.00	

Health Financial Systems PORTER-STARKE SERVICES, INC In Lieu of Form CMS-2552-10							
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provider C		Peri od:	Worksheet D		
THROUGH COSTS				From 07/01/2019 To 06/30/2020		narod:	
				10 00/30/2020	11/23/2020 4:	00 pm	
		Title	: XVIII	Hospi tal	PPS		
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost		
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges		
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷		
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)		
			and 4)		(see		
					instructions)		
	4. 00	5. 00	6. 00	7. 00	8. 00		
ANCILLARY SERVICE COST CENTERS							
60. 00  06000   LABORATORY	0	0		0 279, 211	0. 000000	60.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0.000000	71.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 205, 752	0. 000000	73.00	
OUTPATIENT SERVICE COST CENTERS							
90. 00   09000   CLI NI C	0	0		0 4, 253, 197	0.000000	90.00	
200.00   Total (lines 50 through 199)	0	0		0 4, 738, 160		200. 00	
, ,			'		'		

Health Financial Systems	cial Systems PORTER-STARKE SERVICES, INC In Lieu of Form CMS-255						
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEITHROUGH COSTS	RVICE OTHER PASS	Provi der Co		Period: From 07/01/2019 To 06/30/2020			
		Title	XVIII	Hospi tal	PPS		
Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent		
	Ratio of Cost	Program	Program	Program	Program		
	to Charges	Charges	Pass-Through	Charges	Pass-Through		
	(col. 6 ÷	•	Costs (col.	3	Costs (col. 9		
	col. 7)		x col. 10)		x col. 12)		
	9. 00	10. 00	11. 00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS							
60. 00 06000 LABORATORY	0. 000000	1		0 0	0	60.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	24, 276		0 0	0	73.00	
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLINIC	0. 000000	0		0 213, 819	0	90.00	
200.00 Total (lines 50 through 199)		24, 277		0 213, 819	0	200. 00	

Health Financial Systems PORTER-STARKE SERVICES, INC In Lieu of Form CMS-2552-10								
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Prov	ider C	CN: 15-4052	Peri od: From 07/01/2019 To 06/30/2020		
				Title	XVIII	Hospi tal	PPS	
					Charges		Costs	
	Cost Center Description	Cost to	PPS		Cost	Cost	PPS Services	
		Charge Ratio	Rei mbu	rsed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Servi ces	s (see	Servi ces	Services Not		
		Worksheet C,	inst	.)	Subject To	Subject To		
		Part I, col.			Ded. & Coins	. Ded. & Coins.		
		9			(see inst.)	(see inst.)		
		1. 00	2.0	0	3. 00	4. 00	5. 00	
ANCI L	LARY SERVICE COST CENTERS							
60.00 06000	LABORATORY	0. 789084		0		0 0	0	60.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000		0	1	0 0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0. 789086		0	1	0 0	0	73.00
OUTPA	ATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	1. 256568	2	13, 819		0 0	268, 678	90.00
200. 00	Subtotal (see instructions)		2	13, 819		0 0	268, 678	200.00
201.00	Less PBP Clinic Lab. Services-Program			,		0 0		201.00
	Only Charges		1			-		
202. 00	Net Charges (line 200 - line 201)		2	13, 819		0 0	268, 678	202. 00

Health Financial Systems PORTER-STARKE SERVICES, INC In Lieu of Form CMS-255						
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der C	CN: 15-4052	Peri od:	Worksheet D	
				From 07/01/2019 To 06/30/2020	Part V   Date/Time Pre	nared:
				10 00/00/2020	11/23/2020 4:	
			XVIII	Hospi tal	PPS	
	Cos					
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
60. 00  06000 LABORATORY	0	0				60.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0				73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000  CLI NI C	0	0				90.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00   Net Charges (line 200 - line 201)	0	0				202.00

	Financial Systems ATION OF INPATIENT OPERATING COST	PORTER-STARKE SER	Provider CCN: 15-4052		u of Form CMS-2	
COMPUT	ATTON OF INPATTENT OPERATING COST		Provider CCN: 15-4052	Peri od: From 07/01/2019	Worksheet D-1	
				To 06/30/2020	Date/Time Pre 11/23/2020 4:	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description					
					1. 00	
	PART I - ALL PROVIDER COMPONENTS					-
	I NPATI ENT DAYS			1	2 547	1 00
. 00	Inpatient days (including private room days Inpatient days (including private room days				2, 547 2, 547	
. 00	Private room days (excluding swing-bed and			rivata room days	2, 547	3.00
. 00	do not complete this line.	observation bed da	iys). If you have only p	irvate room days,	U	3.00
. 00	Semi-private room days (excluding swing-bed	d and observation b	ned days)		2, 547	4.00
. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost					
	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost of reporting period					
00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 0					
	reporting period (if calendar year, enter 0 on this line)					
00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost					
	reporting period					
. 00	Total swing-bed NF type inpatient days (inc		om days) after December	31 of the cost	0	8. 00
00	reporting period (if calendar year, enter (		. II. B		0.44	0.00
00	Total inpatient days including private roor newborn days) (see instructions)	n days applicable 1	to the Program (excludin	g swing-bed and	361	9. 00
0.00	Swing-bed SNF type inpatient days applicable	e to title XVIII o	only (including private	room days)	0	10.00
J. 00	through December 31 of the cost reporting p			1 doil days)	O	10.00
1. 00	Swing-bed SNF type inpatient days applicable			room days) after	0	11.00
	December 31 of the cost reporting period (i			, ,		
2. 00	Swing-bed NF type inpatient days applicable	e to titles V or XI	X only (including priva	te room days)	0	12.00
	through December 31 of the cost reporting ;					
3. 00	Swing-bed NF type inpatient days applicable				0	13. 00
	after December 31 of the cost reporting per				_	
	Medically necessary private room days appli	cable to the Progr	ram (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only)				0	1
5. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT				0	16.00
. 00	Medicare rate for swing-bed SNF services as	anlicable to service	cos through Docombor 21	of the cost	0.00	17. 00
. 00	reporting period	opincable to service	es through becember 31	or the cost	0.00	17.00
. 00	Medicare rate for swing-bed SNF services as	oplicable to servic	ces after December 31 of	the cost	0.00	18.00
	reporting period		22 23 20 200020. 01 01		3.00	10.00
9. 00	Medicaid rate for swing-bed NF services app	olicable to service	es through December 31 o	f the cost	0.00	19.00
	reporting period		Ü			
$\cap$	Medicald rate for swing-hed NE services and	alicable to service	s after December 31 of	the cost	0.00	20 00

	Cost Contor Description	PP5	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1. 00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2, 547	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	2, 547 0	2. 00 3. 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 December 31 of the cost	2, 547 0	4. 00 5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room 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 room days) through December 31 of the cost reporting period	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	361	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12. 00 13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period  Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00 13. 00
14. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00	Total nursery days (title V or XIX only)	0	15.00
16. 00	Nursery days (title V or XIX only)	0	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0. 00	18. 00
19. 00	Medical d rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0. 00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	
21. 00 22. 00	Total general inpatient routine service cost (see instructions)  Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	2, 617, 553 0	21. 00 22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line $7 \times 1$ line 19)	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	2, 617, 553	26. 00 27. 00
28. 00		0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	
	Semi -pri vate room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	•
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
	Average per diem private room cost differential (line 34 x line 31)	0. 00	
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 differential (line 27 minus line 36)	0 2, 617, 553	36. 00 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)	1, 027. 70	
	Program general inpatient routine service cost (line 9 x line 38)	371, 000	
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)	371, 000	1 4 1. ()()

	Financial Systems	PORTER-STARKE S				u of Form CMS-2	
COMPUT	TATION OF INPATIENT OPERATING COST		Provi der (		Period: From 07/01/2019	Worksheet D-1	
					To 06/30/2020	Date/Time Pre	
			Ti tl	e XVIII	Hospi tal	11/23/2020 4: PPS	oo piii
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient	Inpatient	Diem (col. 1		(col. 3 x	
		1.00	2. 00	÷ col. 2) 3.00	4.00	col . 4) 5.00	
42.00	NURSERY (title V & XIX only)		21 00	0.00	11 00	0.00	42.00
	Intensive Care Type Inpatient Hospital Unit	S			T	T	
43. 00 44. 00	INTENSIVE CARE UNIT						43. 00 44. 00
45.00	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT						46.00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (W	kst. D-3, col. 3	3, line 200)			19, 157	48. 00
49.00	Total Program inpatient costs (sum of lines			ons)		390, 157	1
F0 00	PASS THROUGH COST ADJUSTMENTS				C De la Lace	11 110	F0 00
50. 00	Pass through costs applicable to Program in	patient routine	services (Tro	DM WKST. D, SUI	m or Parts I and	11, 148	50.00
51.00	Pass through costs applicable to Program in	patient ancillar	ry services (1	from Wkst. D,	sum of Parts II	126	51.00
	and IV)	•					
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost excl		lated non a	weician anas+	notist and	11, 274 378, 883	1
53.00	medical education costs (line 49 minus line		erated, non-pr	iysi ci ani anesti	netrst, and	378,883	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	527					
	Program di scharges					0	
	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00
	Difference between adjusted inpatient opera	ting cost and ta	arget amount	(line 56 minus	line 53)	0	
58.00	Bonus payment (see instructions)	o de la companya de la companya de la companya de la companya de la companya de la companya de la companya de	· ·			0	
59. 00	Lesser of lines 53/54 or 55 from the cost r	eporting period	endi ng 1996,	updated and c	ompounded by the	0.00	59.00
60.00	market basket Lesser of lines 53/54 or 55 from prior year	cost report. ur	dated by the	market basket		0.00	60.00
	If line 53/54 is less than the lower of lin				the amount by	0	1
	which operating costs (line 53) are less th		s (lines 54 )	( 60), or 1% o	f the target		
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.00
	Allowable Inpatient cost plus incentive pay	ment (see instru	uctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	9 1	sts through Dece	ember 31 of th	ne cost report	ing period (See	0	64.00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co</pre>	sts after Decemb	er 31 of the	cost reporting	a period (See	0	65.00
	instructions)(title XVIII only)				9 1 (		
66. 00		ine costs (line	64 plus line	65)(title XVI	ll only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31	of the cost re	enorting period	0	67.00
07.00	(line 12 x line 19)	ne costs timougi	i becember or	or the cost is	sporting period		07.00
68. 00	Title V or XIX swing-bed NF inpatient routi	ne costs after [	December 31 of	f the cost rep	orting period	0	68. 00
69. 00	(line 13 x line 20)  Total title V or XIX swing-bed NF inpatient	routine costs (	′line 67 ± lir	ne 68)		0	69.00
07.00	PART III - SKILLED NURSING FACILITY, OTHER I						07.00
70.00	Skilled nursing facility/other nursing faci	lity/ICF/IID rου	ıtine service	cost (line 37)	)		70.00
71.00	Adjusted general inpatient routine service		ine 70 ÷ line	e 2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost appli		n (line 14 x l	ine 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine ser		•				74.00
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from	Worksheet B,	Part II, column		75. 00
76. 00	26, line 45)   Per diem capital-related costs (line 75 ÷ l	ine 2)					76. 00
77. 00	Program capital -related costs (line 9 x lin	,					77.00
78. 00	Inpatient routine service cost (line 74 min						78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exce Total Program routine service costs for com	, ,		,	nus lina 70)		79. 00 80. 00
80.00	Inpatient routine service costs for com	•	ost rimitati(	71 (1116 /0 IIII)	143 IIIE /7)		81.00
82.00	Inpatient routine service cost limitation (	line 9 x line 81	* .				82.00
83.00	Reasonable inpatient routine service costs		ns)				83.00
84. 00 85. 00	Program inpatient ancillary services (see i Utilization review - physician compensation		ons)				84. 00 85. 00
86.00	Total Program inpatient operating costs (su	•					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PA	SS THROUGH COST					
87. 00 88. 00	Total observation bed days (see instruction Adjusted general inpatient routine cost per	•	line 2)			0	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (s	•	,				89.00
	, , , , , , , , , , , , , , , , , , , ,					,	

Health Financial Systems	F	PORTER-STARKE S	SERVICES, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der CC		Peri od:	Worksheet D-1	
					From 07/01/2019 To 06/30/2020		pared: 00 pm_
			Title	XVIII	Hospi tal	PPS	
Cost Center Description		Cost	Routine Cost	column 1 ÷	Total	Observati on	
			(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 C	COST					
90.00 Capital-related cost		78, 653	2, 617, 553	0. 03004	8 0	0	90.00
91.00 Nursing School cost		o	2, 617, 553	0.00000	0	0	91.00
92.00 Allied health cost		o	2, 617, 553	0.00000	0	0	92.00
93.00 All other Medical Education		o	2, 617, 553	0.00000	0	0	93.00

Heal th	Financial Systems	PORTER-STARKE SER	VICES, INC	In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Provi der CCN: 15-4052	Peri od:	Worksheet D-1	
				From 07/01/2019 To 06/30/2020	Date/Time Pre	nared:
				10 007 007 2020	11/23/2020 4:	
			Title XIX	Hospi tal	Cost	
	Cost Center Description					
	DART I ALL PROVIDER COMPONENTS				1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS					1
1. 00	Inpatient days (including private room days	c and cui na had day	s ovel udi na nowborn)		2.547	1.00
2. 00	Inpatient days (including private room days				2, 547	2.00
3. 00	Private room days (excluding swing-bed and			rivato room daye	2, 547	3.00
3.00	do not complete this line.	observation bed da	ys). If you have only p	irvate room days,	U	3.00
4. 00	Semi-private room days (excluding swing-bed	d and observation b	ed days)		2, 547	4.00
5. 00	Total swing-bed SNF type inpatient days (in			er 31 of the cost		
0.00	reporting period	nerdaring private re	om days) im odgri beceme	or or or the cost	Ü	0.00
6.00	Total swing-bed SNF type inpatient days (in	ncludina private ro	om davs) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter (					
7.00	Total swing-bed NF type inpatient days (inc		m days) through Decembe	r 31 of the cost	0	7.00
	reporting period	5 1	3 / 3			
8.00	Total swing-bed NF type inpatient days (inc	cluding private roo	m days) after December	31 of the cost	0	8. 00
	reporting period (if calendar year, enter (	0 on this line)				
9.00	Total inpatient days including private room	m days applicable t	o the Program (excludin	g swing-bed and	295	9. 00
	newborn days) (see instructions)					
10.00	Swing-bed SNF type inpatient days applicable			room days)	0	10.00
	through December 31 of the cost reporting				_	
11. 00	Swing-bed SNF type inpatient days applicable			room days) after	0	11. 00
10.00	December 31 of the cost reporting period (i				0	10.00
12. 00	Swing-bed NF type inpatient days applicable		x only (including priva	te room days)	0	12.00
13. 00	through December 31 of the cost reporting particular Swing-bed NF type inpatient days applicable		V only (including priva	to room days)	0	13.00
13.00	after December 31 of the cost reporting per				U	13.00
14. 00	Medically necessary private room days appli				0	14.00
15. 00	Total nursery days (title V or XIX only)	readire to the rrogi	am (exertaining swring bed	days)	0	
16. 00	Nursery days (title V or XIX only)				0	
	SWING BED ADJUSTMENT					10.00
17.00	Medicare rate for swing-bed SNF services as	pplicable to servic	es through December 31	of the cost	0.00	17. 00
	reporting period	' '	3			
18.00	Medicare rate for swing-bed SNF services a	pplicable to servic	es after December 31 of	the cost	0.00	18.00
	reporting period					
19.00	Medicaid rate for swing-bed NF services app	plicable to service	s through December 31 c	f the cost	0.00	19. 00
	reporting period					
20.00	Medicaid rate for swing-bed NF services app	plicable to service	s after December 31 of	the cost	0. 00	20.00
	reporting period		`		0 400 470	
21.00	Total general inpatient routine service cos				2, 488, 170	
22. 00	Swing-bed cost applicable to SNF type servi	ices through Decemb	er 31 of the cost repor	ting period (line	. 0	22.00
23. 00	5 x line 17)	ions ofter December	21 of the cost resert:	ng poriod (line	0	23.00
∠ა. ∪∪	Swing-bed cost applicable to SNF type servi x line 18)	ices aitei December	or the cost reporti	ng perrou (Tine o	0	∠3.00
24. 00	Swing-bed cost applicable to NF type servio	res through Decembe	r 31 of the cost report	ing period (line	0	24.00
24.00	7 x line 19)	ccs through becellibe	i or or the cost report	ing period (ille	U	24.00
25. 00	Swing-bed cost applicable to NF type service	ces after December	31 of the cost reportin	a period (line 8	0	25. 00
	x line 20)			5 ,	ū	
2/ 02	Transfer the form to the design of the second second					1 04 00

	Cost Center Description	LOST	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS		
	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2, 547	1. 00 2. 00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	2, 547 0	3.00
3.00	do not complete this line.	o o	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2, 547	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5.00
4 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	4 00
6. 00	reporting period (if calendar year, enter 0 on this line)	U	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7.00
	reporting period		
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	295	9. 00
7. 00	newborn days) (see instructions)	273	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
11 00	through December 31 of the cost reporting period (see instructions)	0	11 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11. 00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
	reporting period		
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20. 00
	reporting period		
21.00	Total general inpatient routine service cost (see instructions)	2, 488, 170	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line $5 \times 1$ ) x line 17)	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8)	0	25. 00
20.00	x line 20)	o .	20.00
26. 00		0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2, 488, 170	27. 00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
	Pri vate room charges (excluding swing-bed charges)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3)  Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00 0. 00	32. 00 33. 00
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35. 00		0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	2, 488, 170	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)	976. 90	38.00
	Program general inpatient routine service cost (line 9 x line 38)	288, 186	39.00
40. 00 41. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)  Total Program general inpatient routine service cost (line 39 + line 40)	0 288, 186	40. 00 41. 00
11.00	1. State 1. Signature de la contrata del contrata de la contrata de la contrata del contrata de la contrata del contrata de la contrata de la contrata de la contrata de la contrata del contrata de la contrata de la contrata de la contrata de la contrata de la contrata de la contrata de la contrata de la contrata de la contrata de la contrata de la contrata de la contrata de la contrata de la contrata de la contrata de la contrata del contrata del contrata de la contrata del contrata del contrata de la contrata del contr	200, 100	11.00

Cost Center Description  Total  Cost Center Description  Total  T		Financial Systems	PORTER-STARKE S				eu of Form CMS-	
11/23/2001 4.50   Cost Center Description   Total   Total   Total   Description   Total   Total   Description   Total   Description   Total   Description	COMPUT	TATION OF INPATIENT OPERATING COST		Provi der (	CCN: 15-4052	Peri od: From 07/01/2019	Worksheet D-1	
Cost Center Description  Total Inpatt and Inpatt and Inpatt and Average Per Program Days Program Cost University Case (Col. 3 x Col. 1 a x Col. 1 a x Col. 1 a x Col. 1 a x Col. 1 a x Col. 1 a x Col. 1 a x Col. 1 a x Col. 1 a x Col. 1 a x Col. 1 a x Col. 2 a x Col.						To 06/30/2020		
Input init							Cost	
Cost   Days   Facil   Days   Facil   Days   Facil   Days   Facil   Days   Cost   Days   Day		Cost Center Description			9			
Authority   Auth				•	7			
Intensive Care Type Inpatient Hospital Units  44.00   Direct Style CARE UNIT   4.4  45.00   Direct Style CARE UNIT   4.6  46.00   Size Intensive Care UNIT   4.6  47.00   Other Style Care UNIT   4.6  48.00   Pregnam Inpatient Ancillary Service cost (Wist D. 3, cel. 3, line 200)   4.7  48.00   Pregnam Inpatient Ancillary Service cost (Wist D. 3, cel. 3, line 200)   4.7  48.00   Pregnam Inpatient Ancillary Service cost (Wist D. 3, cel. 3, line 200)   4.7  48.00   Pregnam Inpatient Ancillary Service cost (Wist D. 3, cel. 3, line 200)   4.7  48.00   Pregnam Inpatient Ancillary Service cost (Wist D. 3, cel. 3, line 200)   4.7  48.00   Pregnam Inpatient Ancillary Service cost (Wist D. 3, cel. 3, line 200)   4.7  48.00   Pregnam Inpatient Ancillary Service Cost (Wist D. 3, cel. 3, line 200)   4.7  48.00   Pregnam Inpatient Ancillary Service Cost (Wist D. 3, cel. 3, line 200)   4.7  48.00   Pregnam Inpatient Ancillary Service Cost (Wist D. 3, cel. 3, line 200)   4.7  48.00   Pregnam Inpatient Ancillary Service Cost (Wist D. 3, cel. 3, line 200)   4.7  48.00   Pregnam Inpatient Operating Cost (Wist D. 3, cel. 3, line 200)   4.7  48.00   Pregnam Inpatient Operating Cost (Service Cost Cost Cost Cost Cost Cost Cost Cost	42.00	MUDGEDY (+!+L- V 0 VIVL-)	1. 00	2. 00	3. 00	4. 00	5. 00	12.00
INTENSIVE CARE UNIT	42.00							42.00
45.00   SURRI INTENSIVE CARE UNIT   4   4   4   4   6   0   SURRICAL INTENSIVE CARE UNIT   4   SURRICAL INTENSIVE CARE UNIT   5   SURRICAL INTENSIVE CARE U		INTENSIVE CARE UNIT						43.00
4.6.00 SIRRGICAL INTERSIVE CARE UNIT Cost Center Description Cost Center Descr								44. 00 45. 00
47.00 O'THER SPECIAL CARE (SPECIFY)  48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)  49.00 Intail Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)  49.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)  49.00 Plass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts II and III)  50.00 Plass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts III and III)  51.00 Plass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts III and III)  52.00 Total Program excludable cost (sum of lines 50 and 51)  53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 0 s responsible for the program inpatient operating cost excluding capital related, non-physician anesthetist, and 0 s responsible for the program inpatient operating cost excluding capital related, non-physician anesthetist, and 0 s responsible for the program inpatient operating cost excluding capital related, non-physician anesthetist, and 0 s responsible for the program inpatient operating cost excluding capital related, non-physician anesthetist, and 0 s responsible for program inpatient operating cost and target amount (line 56 inclusion in program discharges 0 s responsible for program discharges 0 s responsible for program discharges 0 s responsible for program discharges 0 s responsible for program discharges 0 s responsible for program discharges 0 s responsible for program discharges 0 s responsible for program discharges 0 s responsible for program discharges 0 s responsible for program discharges 0 s responsible for program discharges 0 s responsible for program discharges 0 s responsible for program discharges 0 s responsible for program discharges 0 s responsible for program discharges 0 s responsible for program discharges 0 s responsible for program discharges 0 s responsible for program discharges 0 s responsibl								46. 00
1.00		OTHER SPECIAL CARE (SPECIFY)						47. 00
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III)   St. 100   Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II of and IV)   St. 00   Total Program excludable cost (sum of lines 50 and 51)   O   Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and   O   St. 100   Program inpatient operating cost excluding capital related, non-physician anesthetist, and   O   St. 100   Program inpatient operating cost excluding capital related, non-physician anesthetist, and   O   St. 100   Program inpatient operating cost excluding capital related, non-physician anesthetist, and   O   St. 100   Program inpatient operating cost and target amount (line 56 minus line 53)   O   St. 100   Program amount previous discharge   O   Co. 100   Program amount previous discharge   O   Co. 100   Program amount (line 54 x line 55)   O   St. 100   Program amount (line 54 x line 55)   O   St. 100   Program amount (line 54 x line 55)   O   St. 100   Program amount (line 54 x line 55)   O   St. 100   Program amount (line 54 x line 55)   O   St. 100   Program amount (line 54 x line 55)   O   St. 100   Program amount (see instructions)   O   St. 100   Program amou	50.00		natient routine	services (fro	nm Wkst D su	m of Parts I and	0	50.00
and IV)  1 Total Program excludable cost (sum of lines 50 and 51) 1 Total Program excludable cost (sum of lines 50 and 51) 1 Total Program excludable cost (sum of lines 50 and 51) 1 Total Program excludable cost (sum of lines 50 and 51) 2 Total Program exchange and substitute costs (line 52) 2 TARSET AMOUNT AMD LIMIT COMPUTATION  5 TOTAL COMPUTATION COMPUTATION CONTROL COST (line 50 and 10 septiments) 3 Total Cost (line 50 and 10 septiments) 4 Total Cost (line 50 and 10 septiments) 5	00.00		patront routino	33. 1. 333 (1.1	J	0 a	1	
Total Program excludable cost (sum of lines 50 and 51)   St. 00 Total Program excludable cost (sum of lines 50 and 51)   St. 00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and need call education costs (line 49 minus line 52)   TARSET AMOUNT AMO LIMIT COMPUTATION	51. 00		patient ancillar	ry services (1	from Wkst. D,	sum of Parts II	0	51.00
Sal Dotal Program Inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)   TARKET AMOUNT AND LIMIT COMPUTATION	52. 00	1	50 and 51)				0	52.00
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60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 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 amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Relief payment (see instructions) 64.00 Allowable inpatient cost plus incentive payment (see instructions) 65.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.71 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.72 Total title V or XIX swing-bed NF inpatient routine scosts (line 67 + line 68) 71.00 Adjusted general inpatient routine service cost (line 7 + line 68) 72.00 Part III - SetLED NURSINO FACILITY, OTHER NURSIN FACILITY, AND ICETION ONLY 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 75.00 Capital-related costs (line 9 x line 71) 77.00 Per diem capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 9 x line 77) 79.00 Aggrapate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program inpatient operating costs (see	59. 00		eporting period	endi ng 1996,	updated and c	ompounded by the	0.00	59. 00
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77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 70.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation (line 9 x line 81) 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Total observation bed days (see instructions) 0 8		26, line 45)						
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 70.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions) 0 8		'	,					76. 00 77. 00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 0 8			· .					78.00
81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service cost limitation (line 9 x line 81)  83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  0 8		99 9	, ,		,	I : 70)		79.00
82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions) 0 8				JUST LIMITATIO	on (iine 78 Mi	ilus IIIIe /9)		80.00
84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  8 8 8 8 8 8 9 9 9 9 9 9 9 9 9 9 9 9 9	82.00	Inpatient routine service cost limitation (	line 9 x line 81	* .				82.00
85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)				ns)				83. 00 84. 00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  8 0 8		1		ons)				85.00
87.00 Total observation bed days (see instructions) 0 8		Total Program inpatient operating costs (su	m of lines 83 th					86. 00
	87 ∩∩						<u> </u>	87.00
	88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	,			0.00	88. 00
89.00   Observation bed cost (line 87 x line 88) (see instructions)   0   8	89. 00	Observation bed cost (line 87 x line 88) (se	ee instructions)				0	89.00

Health Financial Sy	ystems	PORTER-STARKE S	SERVICES, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INP	ATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
					From 07/01/2019 To 06/30/2020		pared: 00 pm_
			Ti tl	e XIX	Hospi tal	Cost	
Cost C	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 -rela	ated cost	78, 653	2, 488, 170	0. 03161	1 0	0	90.00
91.00 Nursing Scho	ool cost	0	2, 488, 170	0.00000	0 0	0	91.00
92.00 Allied heal	th cost	o	2, 488, 170	0. 00000	0 0	0	92.00
93.00 All other Me	edical Education	o	2, 488, 170	0.00000	0	0	93.00

Health Finan	cial Systems PORTER-STA	RKE SERVICES, INC		In Lie	u of Form CMS-2	2552-10
INPATIENT AN	NCILLARY SERVICE COST APPORTIONMENT	Provi der (	CCN: 15-4052	Period: From 07/01/2019	Worksheet D-3	
				To 06/30/2020		
		Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	•	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
			1.00	2. 00	3. 00	
	ENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS			512, 416		30.00
ANCI L	LARY SERVICE COST CENTERS					
60.00 06000	LABORATORY		0. 78908	4 1	1	60.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000	0 0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS		0. 78908	6 24, 276	19, 156	73.00
OUTPA	TIENT SERVICE COST CENTERS					
90.00 09000	CLINIC		1. 25656	8 0	0	90.00
200.00	Total (sum of lines 50 through 94 and 96 through	98)		24, 277	19, 157	200.00
201.00	Less PBP Clinic Laboratory Services-Program only	charges (line 61)		0		201.00
202. 00	Net charges (line 200 minus line 201)			24, 277		202.00

Health Financial Systems	PORTER-STARKE SERVICES, INC		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		eriod: rom 07/01/2019	Worksheet D-3	
			o 06/30/2020		
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cost To Charges	100000000000000000000000000000000000000	Inpatient Program Costs (col. 1 x col. 2)	
		1. 00	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			446, 591		30.00
ANCILLARY SERVICE COST CENTERS					
60. 00 06000 LABORATORY		0. 789084	. 0	0	60.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 000000	0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 789086	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		1. 256568	0	0	90.00
200.00 Total (sum of lines 50 through 94 and	96 through 98)		0	0	200.00
201.00 Less PBP Clinic Laboratory Services-Pr	rogram only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)	-		0		202. 00

Health Financial Systems	PORTER-STARKE SERVICES, INC	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-4052	Peri od: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/23/2020 4:00 pm

		Title XVIII	Hospi tal	11/23/2020 4: PPS	00 pm
			110061 (41		
	DADT D. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES  Medical and other services (see instructions)			0	1.00
2. 00	Medical and other services (see Fistractions)	ns)		268, 678	
3.00	OPPS payments			630, 905	3.00
4.00	Outlier payment (see instructions)			0	4.00
4. 01	Outlier reconciliation amount (see instructions)			0	
5.00	Enter the hospital specific payment to cost ratio (see instructi	ons)		0.000	1
6.00	Line 2 times line 5			0	
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	1
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13. Line 200		0	
10.00	Organ acqui si ti ons			0	ı
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
10.00	Reasonable charges			0	10.00
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	(0)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13)	: 07)		0	
00	Customary charges				1 00
15.00	Aggregate amount actually collected from patients liable for pay	ment for services on	a charge basis	0	15.00
16. 00	Amounts that would have been realized from patients liable for p	ayment for services o	n a chargebasis	0	16.00
47.00	had such payment been made in accordance with 42 CFR §413.13(e)			0 000000	47.00
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0.000000	
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	0	1
17.00	instructions)	TT TTHE TO EXCECUS TT	110 11) (300		17.00
20.00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20.00
	instructions)			_	
21. 00	Lesser of cost or charges (see instructions)			0	
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instruc	tions)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	iti ons)		630, 905	1
2 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			000,700	200
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			158, 959	25. 00
26.00	Deductibles and Coinsurance amounts relating to amount on line 2			0	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu	s the sum of lines 22	! and 23] (see	471, 946	27. 00
28. 00	<pre>instructions) Direct graduate medical education payments (from Wkst. E-4, line</pre>	50)		0	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36)	30)		0	
	Subtotal (sum of lines 27 through 29)			471, 946	1
31.00	Primary payer payments			0	31.00
32. 00	Subtotal (line 30 minus line 31)			471, 946	32.00
22 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	)		0	22.00
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0 4, 163	
	Adjusted reimbursable bad debts (see instructions)			2, 706	
	Allowable bad debts for dual eligible beneficiaries (see instruc	tions)		4, 163	1
37.00	Subtotal (see instructions)			474, 652	
	MSP-LCC reconciliation amount from PS&R			0	1
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50 39. 97	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration			0	39. 50 39. 97
	Partial or full credits received from manufacturers for replaced	devices (see instruc	ti ons)	0	ı
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	(222 1122 22	,,	0	1
40.00	Subtotal (see instructions)			474, 652	40.00
40. 01	Sequestration adjustment (see instructions)			7, 927	1
40. 02	Demonstration payment adjustment amount after sequestration			0	
	Sequestration adjustment-PARHM pass-throughs Interim payments			464, 145	40. 03 41. 00
	Interim payments  Interim payments-PARHM			404, 143	41.00
42. 00	Tentative settlement (for contractors use only)			0	1
	Tentative settlement-PARHM (for contractor use only)				42. 01
43.00	Balance due provider/program (see instructions)			2, 580	1
43. 01	Balance due provider/program-PARHM (see instructions)			_	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	cnapter 1,	0	44.00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				1
90.00	Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	1
	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0	
94.00	Total (sum of lines 91 and 93)			0	94.00

Health Financial Systems PORTER ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1 From 07/01/2019 Part I To 06/30/2020 Date/Time Prepared: Provider CCN: 15-4052

					11/23/2020 4:0	00 pm
		Title	: XVIII	Hospi tal	PPS	
		I npati er	it 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		249, 00	00	464, 145	1. 00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for			0	0	2. 00
	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	0	3.02
3.03				0	0	3.03
3.04				0	ol	3.04
3.05				0	ol	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	l ol	3.51
3.52				0	o	3.52
3.53				0	ol	3.53
3.54				0	ol	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	ol	3.99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		249, 00	00	464, 145	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider		1	-1		
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	0	5. 02
5. 03				0	0	5. 03
F F0	Provi der to Program					F 50
5. 50	TENTATI VE TO PROGRAM			0	0	5.50
5. 51				0	0	5. 51
5. 52	C. I. I. I. I. C C. I			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
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		79		2, 580	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)		249, 79		466, 725	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00			)	1. 00	2. 00	0.05
8. 00	Name of Contractor					8.00

Health Financial Systems	PORTER-STARKE SERVICES, I	In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi de	er CCN: 15-4052	Peri od: From 07/01/2019	Worksheet E-3 Part II Date/Time Prepared:
			10 00, 00, 2020	11/23/2020 4:00 pm
	Т	i +1	Hocni tal	DDC

		Title XVIII	Hospi tal	PPS	оо рііі
		THE ATTE	nospi tui	113	
				1. 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS			11 00	
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and med	lical education payments)		308, 730	1. 00
2.00	Net IPF PPS Outlier Payments	, , , , , , , , , , , , , , , , , , , ,		2, 467	2.00
3. 00	Net IPF PPS ECT Payments			0	3. 00
4.00	Unweighted intern and resident FTE count in the most recent of	ost report filed on or b	efore November	0.00	4.00
	15, 2004. (see instructions)				
4. 01	Cap increases for the unweighted intern and resident FTE coun	t for residents that wer	e displaced by	0.00	4. 01
	program or hospital closure, that would not be counted withou	it a temporary cap adjust	ment under 42		
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)				
5.00	New Teaching program adjustment. (see instructions)			0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	period of a "new	0.00	6.00
	teaching program" (see instuctions)				
7.00	Current year's unweighted I&R FTE count for residents within	the new program growth p	period of a "new	0. 00	7. 00
	teaching program" (see instuctions)				
8. 00	Intern and resident count for IPF PPS medical education adjus	tment (see instructions)		0. 00	8. 00
9. 00	Average Daily Census (see instructions)			6. 959016	9. 00
10. 00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to	the power of .5150 -1}.		0.000000	10.00
11. 00	Teaching Adjustment (line 1 multiplied by line 10).			0	11. 00
12. 00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			311, 197	12.00
13. 00	Nursing and Allied Health Managed Care payment (see instructi	on)		0	13.00
14. 00	Organ acquisition (DO NOT USE THIS LINE)				14. 00
15. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	15.00
16. 00	Subtotal (see instructions)			311, 197	16. 00
17. 00	Primary payer payments			0	17. 00
18. 00	Subtotal (line 16 less line 17).			311, 197	18. 00
19. 00	Deducti bl es			55, 220	
20.00	Subtotal (line 18 minus line 19)			255, 977	20.00
21. 00	Coinsurance			2, 464	21.00
22. 00	,			253, 513	
23. 00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		801	23. 00
24. 00	Adjusted reimbursable bad debts (see instructions)			521	24.00
	Allowable bad debts for dual eligible beneficiaries (see inst	ructi ons)		801	25. 00
26. 00	Subtotal (sum of lines 22 and 24)			254, 034	26. 00
27. 00	Direct graduate medical education payments (see instructions)			0	27. 00
	Other pass through costs (see instructions)			0	28. 00
29.00	Outlier payments reconciliation			0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	30.00
30. 50	Pioneer ACO demonstration payment adjustment (see instruction	IS)		0	30. 50
30. 99	Demonstration payment adjustment amount before sequestration			0	30. 99
31.00	Total amount payable to the provider (see instructions)			254, 034	
31. 01	Sequestration adjustment (see instructions)			4, 242	
31. 02	Demonstration payment adjustment amount after sequestration			0	31. 02
32. 00 33. 00	1 3			249, 000	32. 00 33. 00
	Tentative settlement (for contractor use only)	12 22 and 22)		0	
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.0		obonton 1	792	34.00
35. 00	Protested amounts (nonallowable cost report items) in accorda	nice with two Pub. 15-2,	спартег т,	0	35. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
50 00	Original outlier amount from Worksheet E-3, Part II, line 2			2, 467	50.00
	Outlier reconciliation adjustment amount (see instructions)			2, 467	50.00
	The rate used to calculate the Time Value of Money			-	52.00
	Time Value of Money (see instructions)				53.00
55.00	Time value of money (see first detroits)			U	55.00

Health Financial Systems	PORTER-STARKE SERVICES, INC	In Lieu of Form CMS-2552-1		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-4052	Peri od: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 11/23/2020 4:00 pm	
•				

			06/30/2020	Date/Time Pre 11/23/2020 4:	
		Title XIX	Hospi tal	Cost	оо рііі
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	/ICES FOR TITLES V OR XI		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	71023 1 010 11 1223 1 010 71	X OLIVI OLO		
1. 00	Inpati ent hospital/SNF/NF services		288, 186		1.00
2. 00	Medical and other services		200, 100	0	
3. 00	Organ acquisition (certified transplant centers only)		0	J	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		288, 186	0	
5. 00	Inpatient primary payer payments		200, 100	o ,	5.00
6. 00	Outpatient primary payer payments			0	
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		288, 186	0	
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		200, 100	J	7.00
	Reasonable Charges				
8. 00	Routine service charges		446, 591		8.00
9. 00	Ancillary service charges		0	0	
10.00	Organ acquisition charges, net of revenue		o	o ,	10.00
	Incentive from target amount computation				11.00
	Total reasonable charges (sum of lines 8 through 11)		446, 591	0	
12.00	CUSTOMARY CHARGES		110,071	Ü	12.00
13.00	Amount actually collected from patients liable for payment for	services on a charge	O	0	13.00
.0.00	basis	ser vi ses en a enarge		· ·	10.00
14.00	Amounts that would have been realized from patients liable for	payment for services on	0	0	14.00
	a charge basis had such payment been made in accordance with 42				
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15.00
16.00	Total customary charges (see instructions)		446, 591	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only	y if line 16 exceeds	158, 405	0	17. 00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only	y if line 4 exceeds line	0	0	18.00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19. 00
	Cost of physicians' services in a teaching hospital (see instru		0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16		288, 186	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be c	completed for PPS provid			
	Other than outlier payments		0	0	
	Outlier payments		0	0	
	Program capital payments		0		24.00
	Capital exception payments (see instructions)		0	_	25.00
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29.00	Titles V or XIX (sum of lines 21 and 27)		288, 186	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	00.00
	Excess of reasonable cost (from line 18)		0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		288, 186	0	31.00
32.00	Deducti bl es		0	0	
33.00	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	34.00
35. 00 36. 00	Utilization review	22)	200 104	0	35. 00 36. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	33)	288, 186	0	
	Subtotal (line 36 ± line 37)		288, 186	0	
	Direct graduate medical education payments (from Wkst. E-4)		200, 180	U	39.00
	Total amount payable to the provider (sum of lines 38 and 39)		288, 186	0	
40.00	Interim payments		281, 530	0	1
41.00	Balance due provider/program (line 40 minus line 41)		6, 656	0	1
42.00	Protested amounts (nonallowable cost report items) in accordance	ca with CMS Pub 15 2	0, 030	0	
45.00	chapter 1, §115.2	50 W1 til GW5 FUD 15-2,		U	45.00
	10.1ap co, 3110.2		1	l	ı

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

Provider CCN: 15-4052

oni y)				007 007 2020	11/23/2020 4:	00 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	9, 430, 460	O	0	0	1.00
2. 00	Temporary investments	6, 130, 199		0	0	
3. 00	Notes recei vabl e	999, 951	0	0	ő	
4. 00	Accounts recei vabl e	1, 202, 487	O	0	0	
5.00	Other recei vable	1, 737, 417	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	
8. 00	Prepai d expenses	392, 318	0	0	0	
9. 00	Other current assets	0	0	0	0	
10.00	Due from other funds	0	0	0	0	
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	19, 892, 832	0	0	0	11.00
12. 00	Land	0	O	0	0	12.00
13. 00	Land improvements	0	0	0	0	
14. 00	Accumul ated depreciation	0	0	0	_	
15. 00	Bui I di ngs	7, 100, 019		0	Ō	
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	
20.00	Accumulated depreciation	0	0	0	0	
21.00	Automobiles and trucks	0	0	0	0	
22. 00	Accumulated depreciation	0	0	0	0	
23. 00	Major movable equipment	0	0	0	0	1
24.00	Accumulated depreciation	0	0	0	0	
25. 00 26. 00	Minor equipment depreciable Accumulated depreciation	0	0	0	0	
27. 00	HIT designated Assets	0	0	0	0	
28. 00	Accumulated depreciation	0	0	0	0	
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	ő	
30.00	Total fixed assets (sum of lines 12-29)	7, 100, 019	Ö	0		
	OTHER ASSETS	, , , , , ,		-		
31.00	Investments	35, 293	0	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	
33.00	Due from owners/officers	0	0	0	0	
34.00	Other assets	1, 609, 321	0	0	0	
35.00	Total other assets (sum of lines 31-34)	1, 644, 614		0	0	
36. 00	Total assets (sum of lines 11, 30, and 35)	28, 637, 465	0	0	0	36.00
37. 00	CURRENT LIABILITIES Accounts payable	449, 147	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2, 131, 452		0	0	
39.00	Payroll taxes payable	2, 131, 432	0	0	0	
40. 00	Notes and Loans payable (short term)	1, 254, 599		0	Ö	
41.00	Deferred income	0	o o	0	0	
42.00	Accel erated payments	0		-	·	42.00
43.00	Due to other funds	1, 049, 812	0	0	0	43.00
44.00	Other current liabilities	21, 037	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4, 906, 047	0	0	0	45.00
	LONG TERM LIABILITIES					1
46. 00	Mortgage payable	2, 224, 679		0	0	
47.00	Notes payable	999, 951		0		
48.00	Unsecured Loans	35, 293		0	0	
49.00	Other long term liabilities	1, 609, 321		0	0	•
50.00	Total long term liabilities (sum of lines 46 thru 49)	4, 869, 244		0	_	•
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	9, 775, 291	l 0	0	0	51.00
52.00	General fund balance	18, 862, 174				52.00
53.00	Speci fi c purpose fund	10,002,174	0			53.00
		1	ı	0		54.00
54.00						
54. 00 55. 00	Donor created - endowment fund balance - restricted			0		55.00
54. 00 55. 00 56. 00				0		
55.00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0	0	56.00
55. 00 56. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance			0	0	56.00 57.00
55. 00 56. 00 57. 00 58. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, replacement, and expansion			0	0	56. 00 57. 00 58. 00
55. 00 56. 00 57. 00 58. 00 59. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, replacement, and expansion Total fund balances (sum of lines 52 thru 58)	18, 862, 174		0	0	58. 00 59. 00
55. 00 56. 00 57. 00 58. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, replacement, and expansion	18, 862, 174 28, 637, 465		0	0	56. 00 57. 00 58. 00 59. 00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-4052

Peri od: From 07/01/2019 06/30/2020 Date/Time Prepared:

11/23/2020 4:00 pm General Fund Special Purpose Fund Endowment Fund 1. 00 2.00 3. 00 4.00 5.00 1.00 Fund balances at beginning of period 17, 634, 281 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 1, 227, 893 2.00 2.00 3 00 Total (sum of line 1 and line 2) 18, 862, 174 ol 3.00 4.00 Additions (credit adjustments) (specify) 4.00 0 5.00 0000 0 5.00 0 6.00 0 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 18, 862, 174 Subtotal (line 3 plus line 10) 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 00000 13.00 13.00 14.00 0 0 14.00 15.00 0 15.00 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 18, 862, 174 19.00 19.00 sheet (line 11 minus line 18) Endowment Plant Fund Fund 6.00 8.00 7.00 1.00 Fund balances at beginning of period 0 0 2.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 0 3.00 3.00 Total (sum of line 1 and line 2) 0 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 6.00 0 6.00 0 7.00 7.00 8.00 0 8.00 9.00 0 9.00 Total additions (sum of line 4-9) 0 10.00 10.00 11.00 Subtotal (line 3 plus line 10) 0 11.00 Deductions (debit adjustments) (specify) 12.00 12.00 13.00 0 13.00 14.00 0 14.00 15.00 15.00 16.00 0 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 0 18.00 Fund balance at end of period per balance 0 0 19.00 sheet (line 11 minus line 18)

 
 Heal th Financial Systems
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 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES
 Provider CCN: 15-4052

			10 06/30/2020	11/23/2020 4:	
	Cost Center Description	I npati ent	Outpati ent	Total	
	······································	1, 00	2.00	3. 00	
	PART I - PATIENT REVENUES	<u>.</u>		•	
	General Inpatient Routine Services				1
1.00	Hospi tal	3, 350, 8	62	3, 350, 862	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF		0	0	5.00
6.00	Swing bed - NF		0	0	
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)	3, 350, 8	62	3, 350, 862	
	Intensive Care Type Inpatient Hospital Services	, , , , , , , ,	-		
11. 00	INTENSIVE CARE UNIT				11.00
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 li	nes	0	0	
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3, 350, 8	62	3, 350, 862	17. 00
18. 00	Ancillary services		0	0	18. 00
19. 00	Outpati ent servi ces		0 8, 198, 452		
20.00	RURAL HEALTH CLINIC		0 0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	
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/NONREI MBURSABLE	1	60 11, 168, 024	11, 168, 184	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to				
	G-3, line 1)	,,,,,,		,,	
	PART II - OPERATING EXPENSES		<u> </u>	<u>'</u>	
29.00	Operating expenses (per Wkst. A, column 3, line 200)		24, 605, 758		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			0		35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)		0		37.00
38.00			0		38.00
39.00			0		39.00
40.00			0		40.00
41.00			0		41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(	transfer	24, 605, 758		43.00
	to Wkst. G-3, line 4)				
		*			

Heal th	Financial Systems PORTER-STARK	E SERVICES, INC	In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES	Provi der CCN: 15-4052	Peri od:	Worksheet G-3	
			From 07/01/2019 To 06/30/2020		
				1.00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3	lino 29)		1. 00 22, 717, 498	1.00
2. 00	Less contractual allowances and discounts on patients' a			8, 334, 655	
3. 00	Net patient revenues (line 1 minus line 2)	ccounts		14, 382, 843	
4. 00	Less total operating expenses (from Wkst. G-2, Part II,	line 43)		24, 605, 758	
5. 00	Net income from service to patients (line 3 minus line 4			-10, 222, 915	
0.00	OTHER I NCOME	/		10, 222, 710	0.00
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	3.00 Revenues from telephone and other miscellaneous communication services			0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical supplies to ot	her than patients		0	16.00
	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21. 00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	PUBLI C SUPPORT			9, 282, 707	
	OTHER REVENUE			2, 104, 643	1
	COVI D-19 PHE Fundi ng			63, 457	
	Total other income (sum of lines 6-24)			11, 450, 807	
26 00	00 Total (line E plus line 2E)				24 00

1, 227, 892

26.00 -1 27.00 -1 28.00 1, 227, 893 29. 00

24.50 COVID-19 PHE Funding
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 RECONCILING OTHER
28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)