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: 15-0035 Worksheet S Peri od: From 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/30/2022 6: 28 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/30/2022 6: 28 pm ] Manually prepared cost report use only Ilf 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. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[12] [9] If line 5, column 1 is 4: Enter
[13] NPR Date:
[14] 12. Contractor's Vendor Code:
[15] 13. NPR Date:
[16] 13. NPR Date:
[17] 14. Contractor's Vendor Code:
[18] 15. Contractor's Vendor Code:
[18] 16. NPR Date:
[19] 17. Contractor's Vendor Code:
[19] 18. Contractor's Vendor Code:
[19] 19. Contractor's Vendor Code:
[19] Contractor use only

number of times reopened = 0-9.

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

(3) Settled with Audit

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PORTER REGIONAL HOSPITAL (15-0035) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

|   | SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR | CHECKBOX | ELECTRONI C   |   |
|---|---|----------|---|---|
|   | 1   |          | SI GNATURE STATEMENT  |   |
| 1 |   |          | I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature. | 1 |
| 2 | Signatory Printed Name                                |          |   | 2 |
| 3 | Signatory Title                                       |          |   | 3 |
| 4 | Date  |          |   | 4 |

|                               |         | Title    | XVIII     |       |           |         |
|-------------------------------|---------|----------|-----------|-------|-----------|---------|
| 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       | 688, 004 | -182, 160 | 0     | 0         | 1. 00   |
| 2.00 Subprovider - IPF        | 0       | 0        | 0         |       | 0         | 2. 00   |
| 3.00 Subprovider - IRF        | 0       | 84, 095  | -229      |       | 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       | 772, 099 | -182, 389 | 0     | 0         | 200. 00 |

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

Health Financial Systems PORTER REGIONAL HOSPITAL In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0035 Peri od: Worksheet S-2 From 01/01/2021 Part I 12/31/2021 Date/Time Prepared: 5/30/2022 6:28 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 85 EAST US HIGHWAY 6 1.00 PO Box: 1.00 State: IN 2.00 City: VALPARAISO Zip Code: 46383 County: PORTER 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) 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 REGIONAL 150035 23844 07/01/1966 N 0 3.00 1 HOSPI TAI Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF PORTER REHAB UNIT 15T035 23844 01/01/2009 Ν Ρ 0 5.00 5 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF PORTER SWING BEDS 15U035 23844 Р 0 7.00 01/01/2020 N 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2021 12/31/2021 20.00 21.00 Type of Control (see instructions) 21.00 4 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 Ν Ν 22.01 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)

Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) 22.02 22.02 N N Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 N Ν 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 counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 Ν Ν Ν rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, yes or "N" for no. 23 00 Which method is used to determine Medicaid days on lines 24 and/or 25 23 00 3 N below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

of (column 1 divided by (column 1 + column 2)). (see instructions)

| HUSPI I          | AL AND HOSPITAL HEALTH CARE COMPL  | LEX IDENTIFICATION DA  | IA Provider CC  | F   | eriod:<br>rom 01/01/2021<br>o 12/31/2021 | Worksheet S-2 Part I Date/Time Pre                         |        |
|------------------|--|--|---|---|--|--|--------|
|                  |  | Program Name   | Program Code  | Unwei ghted<br>FTEs<br>Nonprovi der<br>Si te                            | Unwei ghted<br>FTEs in<br>Hospital       | 5/30/2022 6: 20<br>Ratio (col. 3/<br>(col. 3 + col.<br>4)) |        |
|                  |  | 1. 00  | 2.00  | 3. 00   | 4.00                                     | 5. 00  |        |
| 65. 00           | Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column |  |   | 0.00  | 0.00                                     | 0. 000000  | 65.00  |
|                  | 4)). (see instructions)  |  |   | Unwei ghted<br>FTEs<br>Nonprovi der<br>Si te                            | Unwei ghted<br>FTEs in<br>Hospi tal      | Ratio (col. 1/<br>(col. 1 + col.<br>2))                    |        |
|                  | Section 5504 of the ACA Current  | Vear FTF Posidonts in  | Nonnrovider Sotting   | 1.00  | 2.00                                     | 3.00   |        |
| 66. 00           | beginning on or after July 1, 20<br>Enter in column 1 the number of of<br>FTEs attributable to rotations of<br>Enter in column 2 the number of of<br>FTEs that trained in your hospits   | 10<br>unweighted non-primar<br>ccurring in all nonpr<br>unweighted non-primar  | y care resident<br>ovider settings.<br>y care resident  | 0.00  |  |  | 66. 00 |
|                  | (column 1 divided by (column 1 +   | column 2)). (see ins<br>Program Name   | tructions)<br>Program Code  | Unwei ghted<br>FTEs<br>Nonprovi der                                     | Unweighted<br>FTEsin<br>Hospital         | Ratio (col. 3/<br>(col. 3 + col.<br>4))                    |        |
|                  |  |  |   | Si te   | 1103pi tai                               | 4//  |        |
| 67. 00           | Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)   | 1.00   | 2.00  | 3.00  | 4.00                                     | 5.00   | 67. 00 |
|                  |  |  |   |   | 1. 0                                     | 0 2.00 3.00  |        |
| 70.5-            | Inpatient Psychiatric Facility P   |  | DE)   |   |  |  | 70     |
| 70. 00<br>71. 00 | Is this facility an Inpatient Ps<br>Enter "Y" for yes or "N" for no<br>If line 70 is yes: Column 1: Did<br>recent cost report filed on or b<br>42 CFR 412.424(d)(1)(iii)(c)) Co<br>program in accordance with 42 CFI<br>Column 3: If column 2 is Y, india<br>(see instructions)  | the facility have an<br>efore November 15, 20<br>lumn 2: Did this faci<br>R 412.424 (d)(1)(iii)<br>cate which program ye | approved GME teachin<br>04? Enter "Y" for yo<br>lity train residents<br>(D)? Enter "Y" for yo | ng program in f<br>es or "N" for r<br>in a new teach<br>es or "N" for r | the most<br>no. (see<br>ni ng<br>no.     | 0  | 70.00  |
| 75. 00           | Inpatient Rehabilitation Facilit<br>Is this facility an Inpatient Re   |  | (IRF), or does it co  | ontain an IRF   | Y  |  | 75. 00 |
| 76. 00           | subprovider? Enter "Y" for yes a lf line 75 is yes: Column 1: Did recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year began  | and "N" for no.<br>the facility have an<br>ing on or before Nove<br>train residents in a<br>r "Y" for yes or "N"         | approved GME teachir<br>mber 15, 2004? Enter<br>new teaching program<br>for no. Column 3: If  | ng program in t<br>"Y" for yes on<br>in accordance<br>column 2 is Y,    | the most N<br>"N" for<br>with 42         | N O  | 76. 00 |

|   | IDENTIFICATION DATA  | Provi der CC                                       | N: 15-0035          | Peri od:                         | Worksheet S-2                            | 2          |
|---|--|--|---------------------|----------------------------------|--|------------|
|   |  |  |                     | From 01/01/2021<br>To 12/31/2021 | Part I<br>Date/Time Pro<br>5/30/2022 6:2 |            |
|   |  |  |                     |                                  | 1. 00                                    |            |
| Long Term Care Hospital PPS  On Is this a long term care hospital (Long term care hospital (Long term)  Is this a LTCH co-located within and "Y" for yes and "N" for no.  |  |  |                     | ng period? Enter                 | N<br>N                                   | 80.<br>81. |
| TEFRA Providers  .00 Is this a new hospital under 42 CFR  .00 Did this facility establish a new 01  | her subprovider (exclude   |  |                     |                                  | N  | 85.<br>86. |
| \$413.40(f)(1)(ii)? Enter "Y" for ye 1886(d)(1)(B)(vi)? Enter "Y" for yes   | stic disease care hospita  | l classified u                                     | nder section        | ١                                | N  | 87         |
| 11000(a) (1) (b) (v1): Enter 1 101 yes  | 5 OF IN 101 HO.  |  |                     | V                                | XIX                                      |            |
| Title V and XIX Services  |  |  |                     | 1. 00                            | 2. 00                                    | _          |
| OD Does this facility have title V and yes or "N" for no in the applicable  |  | I services? En                                     | ter "Y" for         | N                                | Y  | 90         |
| 00 Is this hospital reimbursed for titl<br>full or in part? Enter "Y" for yes o   | e V and/or XIX through t   |  | either in           | N                                | N  | 91         |
| OO Are title XIX NF patients occupying instructions) Enter "Y" for yes or '   | title XVIII SNF beds (du   | al certificati                                     | on)? (see           |                                  | N  | 92         |
| 00 Does this facility operate an ICF/II "Y" for yes or "N" for no in the app  | D facility for purposes  |  | XIX? Enter          | N                                | N  | 93         |
| Does title V or XIX reduce capital of applicable column.  |  | and "N" for no                                     | in the              | N                                | N  | 94         |
| 00   If line 94 is "Y", enter the reducti 00   Does title V or XIX reduce operating   |  |  |                     | 0. 00<br>N                       | 0. 00<br>N                               | 95         |
| applicable column. 00 If line 96 is "Y", enter the reducti  | ,  |  |                     | 0. 00                            | 0. 00                                    | 97         |
| 00 Does title V or XIX follow Medicare stepdown adjustments on Wkst. B, Pt. column 1 for title V, and in column   | (title XVIII) for the in I, col. 25? Enter "Y" f   | iterns and resi                                    | dents post          | Y                                | Y  | 98         |
| O1 Does title V or XIX follow Medicare C, Pt. I? Enter "Y" for yes or "N" 1 title XIX.  | (title XVIII) for the re   |  |                     |                                  | Y  | 98         |
| 02 Does title V or XIX follow Medicare<br>bed costs on Wkst. D-1, Pt. IV, line<br>for title V, and in column 2 for tit  | e 89? Enter "Y" for yes o  |  |                     | Y                                | Y  | 98         |
| 03 Does title V or XIX follow Medicare reimbursed 101% of inpatient service for title V, and in column 2 for tit  | (title XVIII) for a crit<br>es cost? Enter "Y" for ye  |  |                     |                                  | N  | 98         |
| Does title V or XIX follow Medicare outpatient services cost? Enter "Y"   | (title XVIII) for a CAH  |  |                     | N                                | N  | 98         |
| in column 2 for title XIX.  Does title V or XIX follow Medicare  Wkst. C, Pt. I, col. 4? Enter "Y" fo   |  |  |                     |                                  | Y  | 98         |
| O6 Does title V or XIX follow Medicare<br>Pts. I through IV? Enter "Y" for yes<br>column 2 for title XIX.   |  |  |                     | Y                                | Y  | 98         |
| Rural Providers  .00 Does this hospital qualify as a CAH? .00 If this facility qualifies as a CAH,  | has it elected the all-  | inclusive meth                                     | od of paymer        | N<br>nt N                        |  | 105<br>106 |
| for outpatient services? (see instru. OO Column 1: If line 105 is Y, is this training programs? Enter "Y" for yes Column 2: If column 1 is Y and line approved medical education program i                                  | facility eligible for co<br>s or "N" for no in column<br>2 70 or line 75 is Y, do<br>n the CAH's excluded IP | ı 1. (see inst<br>you train I&Rs<br>F and/or IRF u | ructions)<br>in an  | N                                |  | 107        |
| Enter "Y" for yes or "N" for no in c<br>.00 Is this a rural hospital qualifying<br>CFR Section §412.113(c). Enter "Y" 1   | for an exception to the  |  | ule? See 42         | 2 N                              |  | 108        |
| , | ,  | Physi cal<br>1.00                                  | Occupationa<br>2.00 | Speech<br>3.00                   | Respiratory<br>4.00                      |            |
| therapy services provided by outside<br>for yes or "N" for no for each thera  | e supplier? Enter "Y"  | 1.00   | 2.00                | 3.00                             | 1. 00                                    | 109        |
|   |  |  | ·                   | ·                                |  |            |

| 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A | N | 110. 00 |
|---|---|---------|
| Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes,     |   |         |
| complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as |   |         |
| appl i cabl e.  |   |         |
|   |   |         |
|   |   |         |
|   |   |         |
|   |   |         |

| Health Financial Systems PORTER REGIONAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CC   |   | eri od:    | of Form CMS<br>Worksheet S-<br>Part I |                    |
|---|---|------------|---------------------------------------|--------------------|
|   | To                                      | 12/31/2021 | Date/Time Pr<br>5/30/2022 6:          |                    |
|   |   | 1. 00      | 2.00                                  | +                  |
| 111.00 If this facility qualifies as a CAH, did it participate in the Frontier Co<br>Health Integration Project (FCHIP) demonstration for this cost reporting p<br>"Y" for yes or "N" for no in column 1. If the response to column 1 is Y, e<br>integration prong of the FCHIP demo in which this CAH is participating in<br>Enter all that apply: "A" for Ambulance services; "B" for additional beds;<br>for tele-health services.             | period? Enter<br>enter the<br>column 2. | N          |                                       | 111. 00            |
|   | 1. 00                                   | 2. 00      | 3.00                                  | +                  |
| 112.00 Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period?  Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information | N                                       |            |                                       | 112. 00            |
| 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1.                 | N                                       |            |                                       | 0115.00            |
| 116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.   | N                                       |            |                                       | 116. 00            |
| 117.00 s this facility legally-required to carry malpractice insurance? Enter   | N                                       |            |                                       | 117. 00            |
| "Y" for yes or "N" for no.  118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.   | 1                                       |            |                                       | 118. 00            |
| 1   | Premi ums                               | Losses     | Insurance                             |                    |
|   | 1. 00                                   | 2.00       | 3.00                                  | 4                  |
| 118.01 List amounts of malpractice premiums and paid losses:  | 668, 128                                | 668, 359   |                                       | 0 118. 01          |
|   |   | 1. 00      | 2.00                                  | -                  |
| 118.02 Are malpractice premiums and paid losses reported in a cost center other t<br>Administrative and General? If yes, submit supporting schedule listing co<br>and amounts contained therein.  |   | N          |                                       | 118. 02            |
| 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for th Hold Harmless provision in ACA §3121 and applicable amendments? (see instr Enter in column 2, "Y" for yes or "N" for no.  | for yes or<br>ne Outpatient             | N          | N                                     | 119. 00<br>120. 00 |
| 121.00 Did this facility incur and report costs for high cost implantable devices   | s charged to                            | Y          |                                       | 121. 00            |
| patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain healthcare related taxes as defined in §1903(   |   | N          |                                       | 122. 00            |
| Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N"   | for no. If                              | N          |                                       | 125. 00            |
| yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 f this is a Medicare certified kidney transplant center, enter the certified kidney transplant center, enter the certified kidney transplant center.   |   |            |                                       | 126. 00            |
| in column 1 and termination date, if applicable, in column 2. 127.00 f this is a Medicare certified heart transplant center, enter the certifi  |   |            |                                       | 127. 00            |
| in column 1 and termination date, if applicable, in column 2.  128.00  f this is a Medicare certified liver transplant center, enter the certifi  |   |            |                                       | 128. 00            |
| in column 1 and termination date, if applicable, in column 2.   |   |            |                                       |                    |
| 129.00  f this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2.  130.00  f this is a Medicare certified pancreas transplant center, enter the cert   |   |            |                                       | 129. 00<br>130. 00 |
| date in column 1 and termination date, if applicable, in column 2.  |   |            |                                       |                    |
| 131.00  f this is a Medicare certified intestinal transplant center, enter the ce date in column 1 and termination date, if applicable, in column 2.  |   |            |                                       | 131. 00            |
| 132.00   f this is a Medicare certified islet transplant center, enter the certifiin column 1 and termination date, if applicable, in column 2.   | cation date                             |            |                                       | 132. 00            |
| 133.00 Removed and reserved 134.00 If this is an organ procurement organization (0PO), enter the OPO number i and termination date, if applicable, in column 2.   | n column 1                              |            |                                       | 133. 00<br>134. 00 |
| All Providers  140.00 Are there any related organization or home office costs as defined in CMS chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home are claimed, enter in column 2 the home office chain number. (see instruct  | office costs                            | Y          | HB1848                                | 140. 00            |

Health Financial Systems PORTER REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0035 Peri od: Worksheet S-2 From 01/01/2021 Part I То 12/31/2021 Date/Time Prepared: 5/30/2022 6:28 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: CHS/COMMUNITY HEALTH SYSTEMS Contractor's Name: WISCONSIN PHYSICIAN Contractor's Number: 52280 141 00 SERVI CES LNC 142.00 Street: 4000 MERIDIAN BLVD PO Box: 142.00 143.00 Ci ty: FRANKLIN State: Zip Code: 37067 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 2.00 1.00 145.00|| f costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is 145.00 no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? Ν 146, 00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147. 00 N 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1 00 2 00 3.00 4 00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν Ν Ν N 155. 00 156.00 Subprovi der - IPF Ν 156. 00 Ν Ν Ν 157.00 Subprovi der - IRF 157 00 Ν Ν Ν N 158. 00 SUBPROVI DER 158.00 159.00 SNF N Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν Ν 161.00 1.00 Mul ti campus 165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no. Ν 165.00 FTE/Campus Zip Code Name County **CBSA** State | 3.00 5.00 0 1.00 2.00 4.00 166.00 If line 165 is yes, for each 0. 00 166. 00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4. FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

| near the fination reclinology (ner) incentive in the American Recovery and Reinvestment         | ACI            |         |           |  |  |  |
|---|----------------|---------|-----------|--|--|--|
| 167.00[Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.      |                |         |           |  |  |  |
| 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"),  | enter the      |         | 168. 00   |  |  |  |
| reasonable cost incurred for the HIT assets (see instructions)                                  |                |         |           |  |  |  |
| 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a | a hardshi p    |         | 168. 01   |  |  |  |
| exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)          |                |         |           |  |  |  |
| 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "I | N"), enter the | 9.      | 99169.00  |  |  |  |
| transition factor. (see instructions)   |                |         |           |  |  |  |
|   | 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        |                |         | 170. 00   |  |  |  |
| period respectively (mm/dd/yyyy)  |                |         |           |  |  |  |
|   |                |         |           |  |  |  |
|   | 1.00           | 2.00    |           |  |  |  |
| 171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in         | N              |         | 0 171. 00 |  |  |  |
| section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter            |                |         |           |  |  |  |
| "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section         |                |         |           |  |  |  |
| 1876 Medicare days in column 2. (see instructions)  |                |         |           |  |  |  |
|   |                |         |           |  |  |  |
|   |                |         |           |  |  |  |

| DP1 17 | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE  | Provi der C                           | CN: 15-0035    | Peri od:<br>From 01/01/2021<br>To 12/31/2021<br>Y/N |             | epared: |
|--------|--|---------------------------------------|----------------|---|-------------|---------|
|        |  |                                       |                | 1.00  | 2. 00       |         |
| ļ      | General Instruction: Enter Y for all YES responses. Enter N<br>mm/dd/yyyy format.<br>COMPLETED BY ALL HOSPITALS  | for all NO re                         | esponses. Ente |   |             |         |
|        | Provider Organization and Operation  |                                       |                |   | T           |         |
| 00     | Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in co   |                                       |                | N   |             | 1.00    |
|        | reporting perrous in yes, enter the date of the change in co   | 7 dilii 2. (3ee                       | Y/N            | Date  | V/I         |         |
|        |  |                                       | 1.00           | 2. 00   | 3.00        |         |
| 00     | Has the provider terminated participation in the Medicare Pryes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.   |                                       | N              |   |             | 2.00    |
|        | Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions) | fices, drug<br>er or its<br>the board | Y              |   |             | 3.00    |
|        |  |                                       | Y/N            | Туре  | Date        |         |
|        | Financial Data and Dangett   |                                       | 1.00           | 2. 00   | 3. 00       |         |
| 00     | Financial Data and Reports  Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" fo or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions.   | or Compiled,<br>lable in              | N              |   |             | 4.00    |
| 00     | Are the cost report total expenses and total revenues differ   |                                       | N              |   |             | 5.00    |
|        | those on the filed financial statements? If yes, submit reco   | onciliation.                          |                | Y/N   | Legal Oper. |         |
|        |  |                                       |                | 1. 00   | 2. 00       |         |
|        | Approved Educational Activities  |                                       |                |   |             |         |
| 00     | Column 1: Are costs claimed for a nursing program? Column 2  | 2: If yes, is                         | s the provider | - Y   | Y           | 6. 00   |
| 00     | is the legal operator of the program?  Are costs claimed for Allied Health Programs? If "Y" see ins  | structions                            |                | Υ   | •           | 7.00    |
| 00     | Were nursing programs and/or allied health programs approved cost reporting period? If yes, see instructions.  | d and/or renew                        | · ·            | e N   |             | 8. 00   |
|        | Are costs claimed for Interns and Residents in an approved g   |                                       | cal education  | N   |             | 9.00    |
| 00     | program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated or cost reporting period? If yes, see instructions.   |                                       | the current    | N   |             | 10.00   |
| 00     | Are GME cost directly assigned to cost centers other than I<br>Teaching Program on Worksheet A? If yes, see instructions.  | & R in an App                         | oroved         | N   | Y/N         | 11.00   |
|        |  |                                       |                |   | 1. 00       |         |
| - t    | Bad Debts  |                                       |                |   |             |         |
| 00     | Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.  |                                       |                | ost reporting                                       | Y<br>N      | 12.00   |
| 00     | If line 12 is yes, were patient deductibles and/or co-paymer   | nts waived? If                        | fyes, see ins  | structi ons.  | N           | ] 14. 0 |
|        | Bed Complement Did total beds available change from the prior cost reportir  | na neriod2 lf                         | ves see inst   | ructions.   | Y           | 15. 0   |
| 00     | bru total bous available change from the prior cost reportin   |                                       | -t A           |   | -t B        | 13.00   |
|        |  | Y/N                                   | Date           | Y/N   | Date        |         |
|        |  | 1.00                                  | 2.00           | 3. 00   | 4. 00       |         |
| 00     | PS&R Data 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  | Y                                     | 04/12/2022     | Y   | 04/12/2022  | 16. 0   |
|        | 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  |
|        | 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   |
| 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   |

| Heal th | Financial Systems PORTER REGION  | NAL HOSPITAL     |                | In Lie                                       | eu of Form CMS-  | -2552-10 |  |  |
|---------|--|------------------|----------------|--|--|----------|--|--|
| HOSPI T | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE  | Provider CC      | CN: 15-0035    | Peri od:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet S-<br>Part II<br>Date/Time Pro<br>5/30/2022 6: | epared:  |  |  |
|         |  | Descri           | •              | Y/N  | Y/N  |          |  |  |
|         | In a second control of the second control of | C                | )              | 1.00   | 3. 00  |          |  |  |
| 20. 00  | If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:  |                  |                | N  | N  | 20. 00   |  |  |
|         | report data for other: bescribe the other adjustments.   | Y/N              | Date           | Y/N  | Date   |          |  |  |
|         |  | 1.00             | 2.00           | 3. 00  | 4. 00  |          |  |  |
| 21. 00  | Was the cost report prepared only using the provider's records? If yes, see instructions.  | N                |                | N  |  | 21. 00   |  |  |
|         |  |                  |                |  | 1. 00  |          |  |  |
|         | COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE  | EPT CHILDRENS HO | OSPI TALS)     |  | 1.00   |          |  |  |
|         | Capital Related Cost   |                  | Í              |  |  |          |  |  |
| 22. 00  | Have assets been relifed for Medicare purposes? If yes, see  |                  |                |  | N  | 22. 00   |  |  |
| 23. 00  | Have changes occurred in the Medicare depreciation expense   | due to apprais   | als made dur   | ing the cost                                 | N  | 23. 00   |  |  |
| 24. 00  | reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entere  | od into during   | this cost ro   | norting poriod?                              | N  | 24. 00   |  |  |
| 24.00   | If yes, see instructions   | ed filto duffing | till's cost re | portring perrou?                             | IN IN  | 24.00    |  |  |
| 25. 00  | Have there been new capitalized leases entered into during instructions.   | the cost repor   | ting period?   | If yes, see                                  | N  | 25. 00   |  |  |
| 26. 00  | Were assets subject to Sec. 2314 of DEFRA acquired during the  | he cost reporti  | ng period? I   | f yes, see                                   | N  | 26. 00   |  |  |
| 27 00   | instructions.  | o cost rorest!   | a norioda le   | Voe cubmi +                                  | N  | 27. 00   |  |  |
| 27. 00  | Has the provider's capitalization policy changed during the copy.  | e cost reporting | y period? II   | yes, subili t                                | IN .   | 27.00    |  |  |
| 28. 00  | Interest Expense Were new loans, mortgage agreements or letters of credit en   | ntered into dur  | ing the cost   | reporti ng                                   | N  | 28. 00   |  |  |
| 29. 00  | period? If yes, see instructions.<br>Did the provider have a funded depreciation account and/or  |                  | bt Service R   | eserve Fund)                                 | N  | 29. 00   |  |  |
| 30. 00  | treated as a funded depreciation account? If yes, see insti-<br>Has existing debt been replaced prior to its scheduled mate  |                  | debt? If yes   | , see  | N  | 30. 00   |  |  |
| 31. 00  | instructions. Has debt been recalled before scheduled maturity without is  | ssuance of new u | deht? If ves   | See  | N  | 31. 00   |  |  |
| 01.00   | instructions. Purchased Services   |                  |                |  |  |          |  |  |
| 32. 00  | Have changes or new agreements occurred in patient care set<br>arrangements with suppliers of services? If yes, see instri   |                  | d through co   | ntractual                                    | Y  | 32. 00   |  |  |
| 33. 00  | If line 32 is yes, were the requirements of Sec. 2135. 2 applies, see instructions.  |                  | g to competi   | tive bidding? If                             | Y  | 33. 00   |  |  |
|         | Provi der-Based Physi ci ans   |                  |                |  | l  |          |  |  |
| 34.00   | Are services furnished at the provider facility under an a   | rrangement with  | provi der-ba   | sed physicians?                              | Υ  | 34. 00   |  |  |
|         | If yes, see instructions.  | •                |                |  |  |          |  |  |
| 35. 00  | If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in   |                  | ts with the    | provi der-based                              | Y  | 35. 00   |  |  |
|         |  |                  |                | Y/N  | Date   |          |  |  |
|         | Homo Offi on Costs   |                  |                | 1.00   | 2. 00  |          |  |  |
| 36. 00  | Home Office Costs Were home office costs claimed on the cost report?   |                  |                | Y  |  | 36.00    |  |  |
| 37. 00  | If line 36 is yes, has a home office cost statement been pullf yes, see instructions.  | repared by the I | home office?   |  |  | 37. 00   |  |  |
| 38. 00  | If line 36 is yes , was the fiscal year end of the home of<br>the provider? If yes, enter in column 2 the fiscal year en   |                  |                | N  | 12/31/2020   | 38. 00   |  |  |
| 39. 00  | If line 36 is yes, did the provider render services to other see instructions.   |                  |                | , N  |  | 39. 00   |  |  |
| 40. 00  | If line 36 is yes, did the provider render services to the instructions.   | home office?     | If yes, see    | N  |  | 40. 00   |  |  |
|         | 1.00 2.00  |                  |                |  |  |          |  |  |
|         | Cost Report Preparer Contact Information   |                  |                |  |  |          |  |  |
| 41. 00  | Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,  | VI CTORI A       |                | ROMANKO                                      |  | 41.00    |  |  |
| 42. 00  | respectively. Enter the employer/company name of the cost report   | COMMUNITY HEAL   | TH SYSTEMS     |  |  | 42. 00   |  |  |
| 43. 00  | preparer. Enter the telephone number and email address of the cost   | 615-925-4333     |                | VICTORIA ROMAN                               | KN@CHS NFT   | 43.00    |  |  |
| 10.00   | report preparer in columns 1 and 2, respectively.  | 0.0 /20 4000     |                | 71 STORT A_ROWAR                             | NO PONO. INC.  | 15.00    |  |  |
|         |  |                  |                |  |  |          |  |  |

| Heal th | Financial Systems PORTER REGIO                           | NAL HOSPITAL          | In Lie                     | u of Form CMS-2                | 2552-10        |
|---------|--|-----------------------|----------------------------|--------------------------------|----------------|
| HOSPI T | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE  | Provider CCN: 15-0035 | Period:<br>From 01/01/2021 | Worksheet S-2<br>Part II       |                |
|         |  |                       | To 12/31/2021              | Date/Time Pre<br>5/30/2022 6:2 | pared:<br>8 pm |
|         |  |                       |                            |                                |                |
|         |  | 3. 00                 |                            |                                |                |
|         | Cost Report Preparer Contact Information                 | _                     |                            |                                |                |
| 41.00   | Enter the first name, last name and the title/position   | REVENUE MANAGER       |                            |                                | 41.00          |
|         | held by the cost report preparer in columns 1, 2, and 3, |                       |                            |                                |                |
|         | respectively.  |                       |                            |                                |                |
| 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.        |                       |                            |                                |                |

 
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 PORTER

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 | Peri od: | Worksheet S-3 | From 01/01/2021 | Part I | Date/Time Prepared: | Provider CCN: 15-0035

|                  |  |             |             |              | 0 12/31/2021 | 5/30/2022 6:28 |                  |
|------------------|--|-------------|-------------|--------------|--------------|----------------|------------------|
|                  |  |             |             |              |              | I/P Days / 0/P | o piii           |
|                  |  |             |             |              |              | 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      | 192         | 70, 080      | 0.00         | 0              | 1. 00            |
|                  | 8 exclude Swing Bed, Observation Bed and     |             |             |              |              |                |                  |
|                  | Hospice days)(see instructions for col. 2    |             |             |              |              |                |                  |
|                  | for the portion of LDP room available beds)  |             |             |              |              |                |                  |
| 2.00             | HMO and other (see instructions)             |             |             |              |              |                | 2. 00            |
| 3.00             | HMO IPF Subprovider                          |             |             |              |              |                | 3. 00            |
| 4.00             | HMO IRF Subprovider                          |             |             |              |              |                | 4. 00            |
| 5.00             | Hospital Adults & Peds. Swing Bed SNF        |             |             |              |              | 0              | 5. 00            |
| 6. 00            | Hospital Adults & Peds. Swing Bed NF         |             |             |              |              | 0              | 6. 00            |
| 7. 00            | Total Adults and Peds. (exclude observation  |             | 192         | 70, 080      | 0.00         | 0              | 7. 00            |
|                  | beds) (see instructions)                     |             |             |              |              | _              |                  |
| 8. 00            | INTENSIVE CARE UNIT                          | 31. 00      |             | · ·          |              |                | 8. 00            |
| 8. 01            | NEONATAL INTENSIVE CARE UNIT                 | 31. 01      | 14          | 5, 110       | 0. 00        | 0              | 8. 01            |
| 9.00             | CORONARY CARE UNIT                           |             |             |              |              |                | 9. 00            |
| 10.00            | BURN INTENSIVE CARE UNIT                     |             |             |              |              |                | 10.00            |
| 11. 00           | SURGICAL INTENSIVE CARE UNIT                 |             |             |              |              |                | 11. 00           |
| 12.00            | OTHER SPECIAL CARE (SPECIFY)                 | 40.00       |             |              |              |                | 12.00            |
| 13.00            | NURSERY                                      | 43. 00      |             | 0, 070       | 0.00         | 0              | 13.00            |
| 14. 00           | Total (see instructions)                     |             | 238         | 86, 870      | 0.00         |                | 14.00            |
| 15.00            | CAH visits                                   |             |             |              |              | 0              | 15. 00           |
| 16. 00<br>17. 00 | SUBPROVI DER - I PF<br>  SUBPROVI DER - I RF | 41. 00      | 1.4         | 5, 110       |              | 0              | 16. 00<br>17. 00 |
| 17.00            | SUBPROVIDER - TRE                            | 41.00       | 14          | 5, 110       |              | U              | 18.00            |
| 19. 00           | SKILLED NURSING FACILITY                     |             |             |              |              |                | 19. 00           |
| 20. 00           | NURSING FACILITY                             |             |             |              |              |                | 20.00            |
| 21. 00           | OTHER LONG TERM CARE                         |             |             |              |              |                | 21. 00           |
| 22. 00           | HOME HEALTH AGENCY                           |             |             |              |              |                | 22. 00           |
| 23. 00           | AMBULATORY SURGICAL CENTER (D. P. )          |             |             |              |              |                | 23. 00           |
| 24. 00           | HOSPI CE                                     |             |             |              |              |                | 24. 00           |
| 24. 10           | HOSPICE (non-distinct part)                  | 30. 00      |             |              |              |                | 24. 10           |
| 25. 00           | CMHC - CMHC                                  | 00.00       |             |              |              |                | 25. 00           |
| 26. 00           | RURAL HEALTH CLINIC                          |             |             |              |              |                | 26. 00           |
| 26. 25           | FEDERALLY QUALIFIED HEALTH CENTER            | 89. 00      |             |              |              | o              | 26. 25           |
| 27. 00           | Total (sum of lines 14-26)                   |             | 252         |              |              |                | 27. 00           |
| 28.00            | Observation Bed Days                         |             |             |              |              | 0              | 28. 00           |
| 29.00            | Ambul ance Trips                             |             |             |              |              |                | 29. 00           |
| 30.00            | Employee discount days (see instruction)     |             |             |              |              |                | 30. 00           |
| 31.00            | Employee discount days - IRF                 |             |             |              |              |                | 31. 00           |
| 32.00            | Labor & delivery days (see instructions)     |             | 0           | C            |              |                | 32. 00           |
| 32. 01           | Total ancillary labor & delivery room        |             |             |              |              |                | 32. 01           |
|                  | outpatient days (see instructions)           |             |             |              |              |                |                  |
|                  | LTCH non-covered days                        |             |             |              |              |                | 33. 00           |
| 33. 01           | LTCH site neutral days and discharges        |             |             |              |              |                | 33. 01           |

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

outpatient days (see instructions)

33.01 LTCH site neutral days and discharges

LTCH non-covered days

Provider CCN: 15-0035

Peri od: Worksheet S-3 From 01/01/2021 Part I To 12/31/2021 Date/Time Prepared:

33.00

33.01

5/30/2022 6:28 pm I/P Days / O/P Visits / Trips Full Time Equivalents Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 10.00 6.00 7.00 8.00 9.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 16, 347 1, 164 47, 398 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 13, 946 9, 276 2 00 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 449 406 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 57 C 57 Hospital Adults & Peds. Swing Bed NF 6.00 C6.00 7.00 Total Adults and Peds. (exclude observation 16, 404 1, 164 47, 455 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 1,924 124 5,900 8.00 8.01 NEONATAL INTENSIVE CARE UNIT 472 3, 305 8.01 9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 1,071 2, 402 13.00 Total (see instructions) 1, 305. 29 14.00 18, 328 2,831 59,062 0.00 14.00 15.00 CAH visits 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 2, 235 105 3,707 0.00 16.09 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 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23 00 24.00 HOSPI CE 24.00 24. 10 HOSPICE (non-distinct part) 24. 10 0 25.00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.00 0.00 26. 25 27.00 Total (sum of lines 14-26) 0.00 1, 321. 38 27.00 Observation Bed Days 5, 030 28.00 0 28.00 29 00 Ambul ance Trips 29 00 30.00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 31.00 0 Labor & delivery days (see instructions) 0 32.00 32.00 241 558 Total ancillary labor & delivery room 32.01

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: 
 Heal th Financial
 Systems
 PORTER

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provider CCN: 15-0035

|        |   |                  |         | To               | 12/31/2021       | Date/Time Pre<br>5/30/2022 6:28 |        |
|--------|---|------------------|---------|------------------|------------------|---------------------------------|--------|
|        |   | Full Time        |         | Di sch           | arges            | 07 007 2022 0. 2                | рш     |
|        |   | Equi val ents    |         |                  |                  |                                 |        |
|        | Component   | Nonpai d         | Title V | Title XVIII      | Title XIX        | Total All                       |        |
|        |   | Workers<br>11.00 | 12.00   | 12.00            | 14.00            | Pati ents                       |        |
| 1.00   | Hospital Adults & Peds. (columns 5, 6, 7 and  | 11.00            | 12. 00  | 13. 00<br>3, 489 | 14. 00<br>1, 789 | 15. 00<br>11, 521               | 1. 00  |
| 1.00   | B exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) |                  | O       | 3, 409           | 1, 709           | 11, 521                         | 1.00   |
| 2.00   | HMO and other (see instructions)  |                  |         | 2, 123           | 0                |                                 | 2. 00  |
| 3.00   | HMO IPF Subprovider   |                  |         |                  | 0                |                                 | 3. 00  |
| 4.00   | HMO IRF Subprovider   |                  |         |                  | 0                |                                 | 4. 00  |
| 5.00   | Hospital Adults & Peds. Swing Bed SNF   |                  |         |                  |                  |                                 | 5. 00  |
| 6.00   | Hospital Adults & Peds. Swing Bed NF  |                  |         |                  |                  |                                 | 6. 00  |
| 7. 00  | Total Adults and Peds. (exclude observation beds) (see instructions)  |                  |         |                  |                  |                                 | 7. 00  |
| 8. 00  | INTENSIVE CARE UNIT   |                  |         |                  |                  |                                 | 8. 00  |
| 8. 01  | NEONATAL INTENSIVE CARE UNIT  |                  |         |                  |                  |                                 | 8. 01  |
| 9.00   | CORONARY CARE UNIT  |                  |         |                  |                  |                                 | 9. 00  |
| 10.00  | BURN INTENSIVE CARE UNIT  |                  |         |                  |                  |                                 | 10.00  |
| 11. 00 | SURGICAL INTENSIVE CARE UNIT  |                  |         |                  |                  |                                 | 11. 00 |
| 12.00  | OTHER SPECIAL CARE (SPECIFY)  |                  |         |                  |                  |                                 | 12. 00 |
| 13.00  | NURSERY   |                  |         |                  |                  |                                 | 13. 00 |
| 14.00  | Total (see instructions)  | 0.00             | 0       | 3, 489           | 1, 789           | 11, 521                         | 14. 00 |
| 15. 00 | CAH visits  |                  |         |                  |                  |                                 | 15. 00 |
| 16.00  | SUBPROVI DER - I PF   |                  |         |                  |                  |                                 | 16. 00 |
| 17. 00 | SUBPROVI DER - I RF   | 0.00             | 0       | 211              | 38               | 342                             | 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)   |                  |         |                  |                  |                                 | 24. 10 |
| 25.00  | CMHC - CMHC   |                  |         |                  |                  |                                 | 25. 00 |
| 26.00  | RURAL HEALTH CLINIC   |                  |         |                  |                  |                                 | 26. 00 |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER   | 0.00             |         |                  |                  |                                 | 26. 25 |
| 27. 00 | Total (sum of lines 14-26)  | 0.00             |         |                  |                  |                                 | 27. 00 |
| 28. 00 | Observation Bed Days  |                  |         |                  |                  |                                 | 28. 00 |
| 29. 00 | Ambul ance Tri ps   |                  |         |                  |                  |                                 | 29. 00 |
| 30.00  | Employee discount days (see instruction)  |                  |         |                  |                  |                                 | 30. 00 |
| 31.00  | Employee discount days - IRF  |                  |         |                  |                  |                                 | 31.00  |
| 32.00  | Labor & delivery days (see instructions)  |                  |         |                  |                  |                                 | 32.00  |
| 32. 01 | Total ancillary labor & delivery room   |                  |         |                  |                  |                                 | 32. 01 |
|        | outpatient days (see instructions)  |                  |         |                  |                  |                                 |        |
| 33.00  | LTCH non-covered days   |                  |         | 0                |                  |                                 | 33. 00 |
| 33. 01 | LTCH site neutral days and discharges   |                  |         | 0                |                  |                                 | 33. 01 |

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0035

|                            |  |                        |                    |   |                  | 12/31/2021                              | 5/30/2022 6: 28                             | pared:<br>8 pm             |
|----------------------------|--|------------------------|--------------------|---|------------------|---|---|----------------------------|
|                            |  | Wkst. A Line<br>Number | Amount<br>Reported | Reclassificati<br>on of Salaries<br>(from Wkst. |                  | Paid Hours<br>Related to<br>Salaries in | Average Hourly<br>Wage (col. 4 ÷<br>col. 5) |                            |
|                            |  | 1.00                   |                    | A-6)  | 3)               | col. 4                                  | ŕ   |                            |
|                            | PART II - WAGE DATA  | 1.00                   | 2. 00              | 3. 00   | 4. 00            | 5. 00                                   | 6. 00                                       |                            |
|                            | SALARI ES  |                        |                    | 1   |                  |   |   |                            |
| 1. 00                      | Total salaries (see instructions)  | 200. 00                | 91, 151, 222       | 0   | 91, 151, 222     | 2, 748, 472. 00                         | 33. 16                                      | 1. 00                      |
| 2.00                       | Non-physician anesthetist Part   |                        | 0                  | 0   | 0                | 0.00                                    | 0.00  | 2. 00                      |
| 3. 00                      | Non-physician anesthetist Part   |                        | 0                  | 0   | 0                | 0.00                                    | 0.00  | 3. 00                      |
| 4. 00                      | Physician-Part A -<br>Administrative   |                        | 475, 293           | 0   | 475, 293         | 2, 235. 00                              | 212. 66                                     | 4. 00                      |
| 4. 01<br>5. 00             | Physicians - Part A - Teaching<br>Physician and Non                                      |                        | 0                  | 0   | 0                | 0. 00<br>0. 00                          | 1   |                            |
| 6. 00                      | Physician-Part B Non-physician-Part B for hospital-based RHC and FOHC services           |                        | 0                  | 0   | 0                | 0. 00                                   | 0. 00                                       | 6. 00                      |
| 7. 00                      | Interns & residents (in an approved program)   | 21. 00                 | 0                  | 0   | 0                | 0. 00                                   | 0.00  | 7. 00                      |
| 7. 01                      | Contracted interns and residents (in an approved programs)                               |                        | 0                  | 0   | 0                | 0.00                                    | 0. 00                                       | 7. 01                      |
| 8. 00                      | Home office and/or related organization personnel  |                        | 0                  | 0   | 0                | 0. 00                                   | 0. 00                                       | 8. 00                      |
| 9. 00<br>10. 00            | SNF<br>Excluded area salaries (see   | 44. 00                 | 0<br>1, 325, 030   | 0   | 0<br>1, 325, 030 | 0. 00<br>37, 537. 00                    | 1   |                            |
| 10.00                      | instructions) OTHER WAGES & RELATED COSTS  |                        | 1, 323, 030        |   | 1, 325, 030      | 37, 337. 00                             | 35. 30                                      | 10.00                      |
| 11. 00                     | Contract Labor: Direct Patient   |                        | 13, 415, 939       | 0   | 13, 415, 939     | 109, 030. 00                            | 123. 05                                     | 11. 00                     |
| 12. 00                     | Care Contract labor: Top level management and other management and administrative        |                        | 202, 805           | 0   | 202, 805         | 3, 225. 00                              | 62. 89                                      | 12. 00                     |
| 13. 00                     | services<br>Contract Labor: Physician-Part<br>A - Administrative                         |                        | 2, 917, 682        | 0   | 2, 917, 682      | 13, 649. 00                             | 213. 77                                     | 13. 00                     |
| 14. 00                     | Home office and/or related organization salaries and                                     |                        | 0                  | 0   | 0                | 0.00                                    | 0. 00                                       | 14. 00                     |
| 14. 01                     | wage-related costs<br>Home office salaries   |                        | 8, 677, 984        | 0   | 8, 677, 984      | 304, 364. 00                            | 28. 51                                      | 14. 01                     |
| 14. 02<br>15. 00           | Related organization salaries<br>Home office: Physician Part A                           |                        | 0                  | 0   | 0                | 0. 00<br>0. 00                          | 1   | 14. 02<br>15. 00           |
|                            | - Administrative   |                        | O                  |   |                  |   |   |                            |
| 16. 00                     | Home office and Contract Physicians Part A - Teaching                                    |                        | 0                  | 0   | 0                | 0.00                                    | 0.00  | 16. 00                     |
| 16. 01                     | Home office Physicians Part A - Teaching   |                        | 0                  | 0   | 0                | 0. 00                                   | 0.00  | 16. 01                     |
| 16. 02                     | Home office contract<br>Physicians Part A - Teaching                                     |                        | 0                  | 0   | 0                | 0. 00                                   | 0. 00                                       | 16. 02                     |
| 17. 00                     | WAGE-RELATED COSTS Wage-related costs (core) (see instructions)                          |                        | 23, 481, 134       | 0   | 23, 481, 134     |   |   | 17. 00                     |
| 18. 00                     | Wage-related costs (other) (see instructions)  |                        |                    |   |                  |   |   | 18. 00                     |
| 19. 00<br>20. 00           | Èxcluded areas<br>Non-physician anesthetist Part   |                        | 339, 135<br>0      | 0   | 339, 135<br>0    |   |   | 19. 00<br>20. 00           |
| 21. 00                     | A<br>Non-physician anesthetist Part  |                        | 0                  | 0   | О                |   |   | 21. 00                     |
| 22. 00                     | Physician Part A -<br>Administrative   |                        | 38, 435            | 0   | 38, 435          |   |   | 22. 00                     |
| 22. 01                     | Physician Part A - Teaching  |                        | 0                  | 0   | 0                |   |   | 22. 01                     |
| 23. 00<br>24. 00<br>25. 00 | Physician Part B<br>Wage-related costs (RHC/FQHC)<br>Interns & residents (in an          |                        | 0                  | 0   | 0 0              |   |   | 23. 00<br>24. 00<br>25. 00 |
| 25. 50                     | approved program)<br>Home office wage-related  |                        | 2, 299, 250        | 0   | 2, 299, 250      |   |   | 25. 50                     |
| 25. 51                     | (core) Related organization  |                        | 0                  | 0   | 0                |   |   | 25. 51                     |
| 25. 52                     | wage-related (core) Home office: Physician Part A - Administrative - wage-related (core) |                        | 0                  | 0   | 0                |   |   | 25. 52                     |

Provider CCN: 15-0035

Period: Worksheet S-3
From 01/01/2021 Part II
To 1/21/21/2021 Part/II me Propagad:

|        |                                 |              |              |                  | Т             | o 12/31/2021 | Date/Time Prep<br>5/30/2022 6:28 |        |
|--------|---------------------------------|--------------|--------------|------------------|---------------|--------------|----------------------------------|--------|
|        |                                 | Wkst. A Line | Amount       | Reclassi fi cati | Adj usted     | Pai d Hours  | Average Hourly                   |        |
|        |                                 | Number       | Reported     | on of Salaries   | Sal ari es    | Related to   | Wage (col. 4 ÷                   |        |
|        |                                 |              |              | (from Wkst.      | (col.2 ± col. | Salaries in  | col . 5)                         |        |
|        |                                 |              |              | A-6)             | 3)            | col. 4       |                                  |        |
|        |                                 | 1.00         | 2. 00        | 3. 00            | 4. 00         | 5. 00        | 6. 00                            |        |
| 25. 53 | Home office: Physicians Part A  |              | 0            | 0                | 0             |              |                                  | 25. 53 |
|        | - Teaching - wage-related       |              |              |                  |               |              |                                  |        |
|        | (core)                          |              |              |                  |               |              |                                  |        |
|        | OVERHEAD COSTS - DIRECT SALARIE |              |              | _                |               |              |                                  |        |
| 26. 00 | Employee Benefits Department    | 4. 00        | 411, 332     |                  | 411, 332      |              |                                  |        |
| 27. 00 | Administrative & General        | 5. 00        | 10, 514, 604 |                  |               |              |                                  |        |
| 28. 00 | Administrative & General under  |              | 212, 140     | 0                | 212, 140      | 9, 833. 00   | 21. 57                           | 28. 00 |
|        | contract (see inst.)            | , , ,        |              |                  |               |              |                                  |        |
| 29. 00 | Maintenance & Repairs           | 6. 00        |              | 0                | 0             | 0.00         |                                  | 29. 00 |
| 30. 00 | Operation of Plant              | 7. 00        | 1, 921, 011  | 0                | 1, 921, 011   |              |                                  | 30. 00 |
| 31. 00 | Laundry & Linen Service         | 8. 00        | 103, 687     |                  | 103, 687      |              |                                  |        |
| 32. 00 | Housekeepi ng                   | 9. 00        | 1, 500, 828  |                  | 1, 500, 828   |              |                                  |        |
| 33. 00 | Housekeeping under contract     |              | 494, 859     | 0                | 494, 859      | 15, 667. 00  | 31. 59                           | 33. 00 |
|        | (see instructions)              |              |              |                  |               |              |                                  |        |
| 34.00  | Dietary                         | 10. 00       | 1, 723, 053  |                  |               |              |                                  | 34. 00 |
| 35. 00 | Di etary under contract (see    |              | 326, 414     | 0                | 326, 414      | 6, 072. 00   | 53. 76                           | 35. 00 |
| 04.00  | instructions)                   | 44.00        |              | 0,000            | 0/0 007       | F7 4F0 00    | 44 70                            | 07.00  |
| 36.00  | Cafeteri a                      | 11. 00       | 0            | 960, 887         | 960, 887      |              |                                  | 36. 00 |
| 37. 00 | Maintenance of Personnel        | 12.00        | 0 (00 0(4    | 0 0 0 7 0        | 0 000 440     | 0.00         |                                  | 37. 00 |
| 38. 00 | Nursing Administration          | 13. 00       | 3, 622, 864  |                  |               |              |                                  |        |
| 39. 00 | Central Services and Supply     | 14. 00       | 895, 675     |                  | 895, 675      |              |                                  |        |
| 40. 00 | Pharmacy                        | 15. 00       | 2, 901, 144  |                  | 2, 901, 144   |              |                                  |        |
| 41. 00 | Medical Records & Medical       | 16. 00       | 660, 125     | 0                | 660, 125      | 28, 008. 00  | 23. 57                           | 41. 00 |
| 40.00  | Records Li brary                | 47.00        | 4 000 001    |                  | 4 000 007     | 04.054.00    | 05 15                            | 40.00  |
| 42.00  | Soci al Servi ce                | 17. 00       | 1, 238, 886  | 0                | 1, 238, 886   |              |                                  | 42.00  |
| 43.00  | Other General Service           | 18. 00       | 0            | 1 0              | 0             | 0.00         | 0.00                             | 43.00  |

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0035

|                                |   |   |                        |  |  | 5/30/2022 6: 28   | 5 PIII   |
|--------------------------------|---|---|------------------------|--|--|---|--|
|                                | Worksheet A   | Amount  | Reclassi fi cati       | Adj usted  | Pai d Hours  | Average Hourly  |  |
|                                | Line Number   | Reported  | on of Salaries         | Sal ari es   | Related to   | Wage (col. 4 ÷  |  |
|                                |   |   | (from                  | (col.2 ± col.  | Salaries in  | col. 5)   |  |
|                                |   |   | Worksheet A-6)         | 3)   | col. 4   |   |  |
|                                | 1.00  | 2.00  | 3.00                   | 4. 00  | 5. 00  | 6. 00   |  |
| PART III - HOSPITAL WAGE INDEX | SUMMARY   |   |                        |  |  |   |  |
| Net salaries (see              |   | 92, 184, 635  | 0                      | 92, 184, 635   | 2, 780, 044. 00  | 33. 16  | 1.00   |
| instructions)                  |   |   |                        |  |  |   |  |
| Excluded area salaries (see    |   | 1, 325, 030   | 0                      | 1, 325, 030  | 37, 537. 00  | 35. 30  | 2.00   |
| instructions)                  |   |   |                        |  |  |   |  |
| Subtotal salaries (line 1      |   | 90, 859, 605  | 0                      | 90, 859, 605   | 2, 742, 507. 00  | 33. 13  | 3.00   |
| minus line 2)                  |   |   |                        |  |  |   |  |
| Subtotal other wages & related |   | 25, 214, 410  | 0                      | 25, 214, 410   | 430, 268. 00   | 58. 60  | 4.00   |
| costs (see inst.)              |   |   |                        |  |  |   |  |
| Subtotal wage-related costs    |   | 25, 818, 819  | 0                      | 25, 818, 819   | 0.00   | 28. 42  | 5.00   |
| (see inst.)                    |   |   |                        |  |  |   |  |
| Total (sum of lines 3 thru 5)  |   | 141, 892, 834   | 0                      | 141, 892, 834  | 3, 172, 775. 00  | 44. 72  | 6.00   |
| Total overhead cost (see       |   | 26, 526, 622  | 0                      | 26, 526, 622   | 969, 728. 00   | 27. 35  | 7.00   |
| instructions)                  |   |   |                        |  |  |   |  |
|                                | Net salaries (see instructions) Excluded area salaries (see instructions) Subtotal salaries (line 1 minus line 2) Subtotal other wages & related costs (see inst.) Subtotal wage-related costs (see inst.) Total (sum of lines 3 thru 5) Total overhead cost (see | DART III - HOSPITAL WAGE INDEX SUMMARY  Net salaries (see instructions) Excluded area salaries (see instructions) Subtotal salaries (line 1 minus line 2) Subtotal other wages & related costs (see inst.) Subtotal wage-related costs (see inst.) Total (sum of lines 3 thru 5) Total overhead cost (see | Line Number   Reported | Line Number   Reported   on of Salaries (from Worksheet A-6) | Line Number Reported on of Salaries (col.2 ± col. 3)  1.00 2.00 3.00 4.00  PART III - HOSPITAL WAGE INDEX SUMMARY  Net salaries (see instructions) Excluded area salaries (see 1, 325, 030 0 1, 325, 030 instructions) Subtotal salaries (line 1 90, 859, 605 0 90, 859, 605 minus line 2) Subtotal other wages & related costs (see inst.) Subtotal wage-related costs (see inst.) Total (sum of lines 3 thru 5) Total overhead cost (see | Line Number   Reported   on of Salaries   (col.2 ± col. 3)   Salaries   (col.2 ± col. 3)   Col. 4 | Worksheet A   Line Number   Reported   Reported   Reported   Reported   Salaries   Salaries   Salaries   Col. 2 ± col.   Salaries   Col. 4 ± col.   Salaries   Col. 5 ± col.   Salaries   Col. 5 ± col.   Salaries   Col. 4 ± col.   Salaries   Col. 5 ± col.   Salaries   Col. 4 ± col.   Salaries   Col. 4 ± col.   Salaries   Col. 5 ± col.   Salaries   Col. 5 ± col.   Salaries   Col. 4 ± col.   Salaries   Col. 5 ± col.   Salaries   Col. 4 ± col.   Col. 4 ± col. |

| Health Financial Systems    | PORTER REGIONAL HOSPITAL | In Lieu of Form CMS-2552-10                      |
|-----------------------------|--------------------------|--|
| HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0035    | Period: Worksheet S-3<br>From 01/01/2021 Part IV |
|                             |                          | From 01/01/2021 Part TV                          |

|        | To 12/31/2021  | Date/Time Prep<br>5/30/2022 6: 28 |        |
|--------|--|-----------------------------------|--------|
|        |  | Amount                            |        |
|        |  | Reported                          |        |
|        |  | 1. 00                             |        |
|        | PART IV - WAGE RELATED COSTS   |                                   |        |
|        | Part A - Core List   |                                   |        |
|        | RETI REMENT COST   |                                   |        |
| 1.00   | 401K Employer Contributions  | 1, 810, 168                       | 1. 00  |
| 2.00   | Tax Sheltered Annuity (TSA) Employer Contribution  | 0                                 | 2.00   |
| 3.00   | Nonqualified Defined Benefit Plan Cost (see instructions)  | 0                                 | 3.00   |
| 4.00   | Qualified Defined Benefit Plan Cost (see instructions)   | 0                                 | 4.00   |
|        | PLAN ADMINISTRATIVE COSTS (Paid to External Organization)  |                                   |        |
| 5.00   | 401K/TSA Plan Administration fees  | 0                                 | 5. 00  |
| 6.00   | Legal/Accounting/Management Fees-Pension Plan  | 0                                 | 6.00   |
| 7.00   | Employee Managed Care Program Administration Fees  | 0                                 | 7. 00  |
|        | HEALTH AND INSURANCE COST  |                                   |        |
| 8.00   | Health Insurance (Purchased or Self Funded)  | 0                                 | 8. 00  |
| 8. 01  | Health Insurance (Self Funded without a Third Party Administrator)   | 0                                 | 8. 01  |
| 8. 02  | Health Insurance (Self Funded with a Third Party Administrator)  | 13, 643, 343                      | 8. 02  |
| 8. 03  | Health Insurance (Purchased)   | 0                                 | 8. 03  |
| 9.00   | Prescription Drug Plan   | 0                                 | 9. 00  |
| 10.00  | Dental, Hearing and Vision Plan  | 187, 380                          | 10.00  |
| 11. 00 | Life Insurance (If employee is owner or beneficiary)   | 66, 431                           | 11. 00 |
| 12.00  | Accident Insurance (If employee is owner or beneficiary)   | 0                                 | 12.00  |
| 13.00  | Disability Insurance (If employee is owner or beneficiary)   | 200, 596                          | 13.00  |
| 14.00  | Long-Term Care Insurance (If employee is owner or beneficiary)   | 0                                 | 14.00  |
| 15. 00 | 'Workers' Compensation Insurance   | 1, 186, 485                       | 15.00  |
| 16.00  | Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.                  | 0                                 | 16.00  |
|        | Non cumulative portion)  |                                   |        |
|        | TAXES  |                                   |        |
| 17.00  | FICA-Employers Portion Only  | 5, 327, 841                       | 17. 00 |
| 18.00  | Medicare Taxes - Employers Portion Only  | 1, 246, 027                       | 18.00  |
| 19.00  | Unemployment Insurance   | 0                                 | 19. 00 |
| 20.00  | State or Federal Unemployment Taxes  | 198, 662                          | 20.00  |
|        | OTHER  |                                   |        |
| 21. 00 | Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions)) | 0                                 | 21. 00 |
| 22. 00 | Day Care Cost and Allowances   | 0                                 | 22. 00 |
| 23.00  | Tuition Reimbursement  | 0                                 | 23. 00 |
| 24.00  | Total Wage Related cost (Sum of lines 1 -23)   | 23, 866, 933                      | 24. 00 |
|        | Part B - Other than Core Related Cost  |                                   |        |
| 25. 00 | OTHER WAGE RELATED COSTS (SPECIFY)   |                                   | 25. 00 |

| Heal th Financ | ial Systems                              | PORTER REGIONAL | HOSPI TAL |      |         | In Lie                                       | u of Form CMS-2   | 2552-10 |
|----------------|--|-----------------|-----------|------|---------|--|---|---------|
| HOSPI TAL CONT | FRACT LABOR AND BENEFIT COST             |                 | Provi der | CCN: | 15-0035 | Peri od:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet S-3<br>Part V<br>Date/Time Prep<br>5/30/2022 6:28 | pared:  |
| (              | Cost Center Description                  |                 |           |      |         | Contract Labor                               | Benefit Cost  |         |
|                |  |                 |           |      |         | 1. 00  | 2. 00   |         |
| PART V         | - Contract Labor and Benefit Cost        |                 |           |      |         |  |   |         |
| Hospi ta       | al and Hospital-Based Component Identif  | i cati on:      |           |      |         |  |   |         |
| 1.00 Total     | facility's contract labor and benefit of | cost            |           |      |         | 13, 415, 939                                 | 23, 866, 933  | 1. 00   |
| 2.00 Hospit    | al                                       |                 |           |      |         | 13, 415, 939                                 | 23, 866, 933  | 2. 00   |
|                |  |                 |           |      |         |  |   |         |

|       |   | 1. 00        | 2. 00        |        |
|-------|---|--------------|--------------|--------|
|       | PART V - Contract Labor and Benefit Cost              |              |              |        |
|       | Hospital and Hospital-Based Component Identification: |              |              |        |
| 1.00  | Total facility's contract labor and benefit cost      | 13, 415, 939 | 23, 866, 933 | 1. 00  |
| 2.00  | Hospi tal   | 13, 415, 939 | 23, 866, 933 | 2. 00  |
| 3.00  | Subprovi der - I PF                                   |              |              | 3. 00  |
| 4.00  | Subprovi der - I RF                                   | 0            | 0            | 4. 00  |
| 5.00  | Subprovi der - (Other)                                | 0            | 0            | 5. 00  |
| 6.00  | Swing Beds - SNF                                      | 0            | 0            | 6. 00  |
| 7.00  | Swing Beds - NF                                       | 0            | 0            | 7. 00  |
| 8.00  | Hospi tal -Based SNF                                  |              |              | 8. 00  |
| 9.00  | Hospi tal -Based NF                                   |              |              | 9. 00  |
| 10.00 | Hospi tal -Based OLTC                                 |              |              | 10.00  |
| 11.00 | Hospi tal -Based HHA                                  |              |              | 11. 00 |
| 12.00 | Separately Certified ASC                              |              |              | 12.00  |
| 13.00 | Hospi tal -Based Hospi ce                             |              |              | 13.00  |
| 14.00 | Hospital-Based Health Clinic RHC                      |              |              | 14.00  |
| 15.00 | Hospital-Based Health Clinic FQHC                     |              |              | 15. 00 |
| 16.00 | Hospi tal -Based-CMHC                                 |              |              | 16. 00 |
| 17.00 | Renal Dialysis  | 0            | 0            | 17. 00 |
| 18.00 | Other   | 0            | 0            | 18. 00 |
|       |   |              |              |        |

| HOSEL  | Financial Systems PORTER REGIONAL HOSPIT  |  |  | u of Form CMS-2  |  |  |
|--|---|--|--|--|--|--|
|  | TAL UNCOMPENSATED AND INDIGENT CARE DATA Provi  | der CCN: 15-0035   | Peri od:<br>From 01/01/2021  | Worksheet S-10   | )  |  |
|  |   |  | To 12/31/2021  | Date/Time Pre<br>5/30/2022 6:2   | pared:<br>8 pm   |  |
|  |   |  |  | 1. 00  |  |  |
|  | Uncompensated and indigent care cost computation  |  |  |  |  |  |
| 1. 00  | Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided Medicaid (see instructions for each line)   | by line 202 colum  | nn 8)  | 0. 116752  | 1. 00  |  |
| 2.00   | Net revenue from Medicaid   |  |  | 49, 980, 327   | 2. 00  |  |
| 3.00   | Did you receive DSH or supplemental payments from Medicaid?   |  | Υ  | 3. 00  |  |  |
| 4.00   | If line 3 is yes, does line 2 include all DSH and/or supplemental pa  | cai d?   | Υ  | 4. 00  |  |  |
| 5.00   | If line 4 is no, then enter DSH and/or supplemental payments from Me  | edi cai d  |  | 0  | 5. 00  |  |
| 6. 00<br>7. 00   | Medicaid charges Medicaid cost (line 1 times line 6)  |  |  | 322, 374, 829<br>37, 637, 906  |  |  |
| 8.00   | Difference between net revenue and costs for Medicaid program (line   | 7 minus sum of li  | nes 2 and 5 if   | 37,037,400   | 8. 00  |  |
| 0.00   | < zero then enter zero)   | ,  |  |  | 0.00   |  |
|  | Children's Health Insurance Program (CHIP) (see instructions for eac  | h line)  |  |  |  |  |
| 9.00   | Net revenue from stand-alone CHIP   |  |  | 0  | 9. 00  |  |
| 10.00  | Stand-alone CHIP charges  |  |  | 0  | 10.00  |  |
| 11. 00<br>12. 00   | Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (line  | 11 minus lina 0:   | if / zero then   | 0  | 11. 00<br>12. 00   |  |
| 12.00  | enter zero)   | TI IIII IIIGS TITIE 7,   | TI V Zero then   |  | 12.00  |  |
|  | Other state or local government indigent care program (see instructi  | ons for each line  | e)   |  |  |  |
| 13.00  | Net revenue from state or local indigent care program (Not included   |  |  | 0  | 13. 00<br>14. 00   |  |
| 14. 00   | OD Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  |  |  |  |  |  |
| 15. 00   | State or local indigent care program cost (line 1 times line 14)  | 0  | 15. 00   |  |  |  |
| 16. 00   |   |  |  |  |  |  |
|  | 13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and   | state/Lecal indi   | gont care program  | ms (soo  |  |  |
|  | instructions for each line)   |  | gent care progran  |  |  |  |
|  | Private grants, donations, or endowment income restricted to funding  |  |  | 0  |  |  |
| 18. 00<br>19. 00   | Government grants, appropriations or transfers for support of hospit  |  | oc (cum of lines   | 0  | 18. 00   |  |
| 19.00  | 8, 12 and 16)   |  |  |  |  |  |
|  |   |  |  |  | 19. 00   |  |
|  |   | Uni nsured   | Insured  | Total (col. 1  | 19. 00   |  |
|  | 0, 12 dilu 10)  | pati ents  | pati ents  | Total (col. 1<br>+ col. 2)   | 19. 00   |  |
|  |   |  |  | Total (col. 1  | 19. 00   |  |
| 20.00  | Uncompensated Care (see instructions for each line)   | patients<br>1.00   | pati ents<br>2.00  | Total (col. 1<br>+ col. 2)<br>3.00   |  |  |
| 20. 00   |   | patients<br>1.00   | pati ents<br>2.00  | Total (col. 1<br>+ col. 2)<br>3.00   |  |  |
|  | Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility  | pati ents 1.00 13,778,   | pati ents<br>2. 00<br>160 56, 647  | Total (col. 1<br>+ col. 2)<br>3.00   | 20. 00   |  |
| 20. 00<br>21. 00<br>22. 00   | Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions)   | pati ents 1.00 13,778, (see 1,608,6)   | pati ents 2.00  160 56,647 528 56,647  | Total (col. 1<br>+ col. 2)<br>3.00<br>13,834,807<br>1,665,275  | 20. 00   |  |
| 21. 00<br>22. 00   | Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care   | pati ents 1.00  13,778,  (see 1,608,6)  35,4   | pati ents 2.00  160 56,647  528 56,647  481 315                                  | Total (col. 1<br>+ col. 2)<br>3.00<br>13,834,807<br>1,665,275<br>35,796  | 20. 00<br>21. 00<br>22. 00   |  |
| 21. 00<br>22. 00   | Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a  | pati ents 1.00 13,778, (see 1,608,6)   | pati ents 2.00  160 56,647  528 56,647  481 315                                  | Total (col. 1<br>+ col. 2)<br>3.00<br>13,834,807<br>1,665,275<br>35,796  | 20. 00<br>21. 00<br>22. 00   |  |
| 21. 00<br>22. 00   | Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (line 21 minus line 22)  | pati ents 1.00  13,778,  (see 1,608,6 1,573,   | pati ents 2.00  160 56,647  528 56,647  481 315  147 56,332                      | Total (col. 1<br>+ col. 2)<br>3.00<br>13,834,807<br>1,665,275<br>35,796  | 20. 00<br>21. 00<br>22. 00   |  |
| 21. 00<br>22. 00<br>23. 00   | Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (instructions)  Payments received from patients for amounts previously written off a charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient day  | pati ents 1.00  13,778,  (see 1,608,6)  1,573,  (s beyond a Length   | pati ents 2.00  160 56,647  528 56,647  481 315  147 56,332                      | Total (col. 1<br>+ col. 2)<br>3.00<br>13,834,807<br>1,665,275<br>35,796<br>1,629,479   | 20. 00<br>21. 00<br>22. 00   |  |
| 21. 00<br>22. 00<br>23. 00   | Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (line 21 minus line 22)  | pati ents 1.00  13,778,7  (see 1,608,6) 1,573,7  (s beyond a length am?  | pati ents 2.00  160 56,647  528 56,647  181 315  147 56,332                      | Total (col. 1<br>+ col. 2)<br>3.00<br>13,834,807<br>1,665,275<br>35,796<br>1,629,479   | 20. 00<br>21. 00<br>22. 00<br>23. 00   |  |
| 21. 00<br>22. 00<br>23. 00<br>24. 00<br>25. 00   | Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (instructions)  Payments received from patients for amounts previously written off a charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care progrif line 24 is yes, enter the charges for patient days beyond the indistay limit  | pati ents 1.00  13,778,  see 1,608,6  1,573,  see 1,57 | pati ents 2.00  160 56,647  528 56,647  181 315  147 56,332                      | Total (col. 1<br>+ col. 2)<br>3.00<br>13,834,807<br>1,665,275<br>35,796<br>1,629,479   | 20. 00<br>21. 00<br>22. 00<br>23. 00<br>24. 00<br>25. 00   |  |
| 21. 00<br>22. 00<br>23. 00<br>24. 00<br>25. 00<br>26. 00                               | Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (instructions)  Payments received from patients for amounts previously written off a charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care progriffine 24 is yes, enter the charges for patient days beyond the incomplex limit Total bad debt expense for the entire hospital complex (see instructions)  | patients 1.00  13,778,  see 1,608,6  1,573,  1,573,  rs beyond a length ram?  li gent care progrations)  | pati ents 2.00  160 56,647  528 56,647  181 315  147 56,332                      | Total (col. 1<br>+ col. 2)<br>3.00<br>13,834,807<br>1,665,275<br>35,796<br>1,629,479<br>1.00<br>N  | 20. 00<br>21. 00<br>22. 00<br>23. 00<br>24. 00<br>25. 00<br>26. 00                               |  |
| 21. 00<br>22. 00<br>23. 00<br>24. 00<br>25. 00<br>26. 00<br>27. 00                     | Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (instructions)  Payments received from patients for amounts previously written off a charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care progr If line 24 is yes, enter the charges for patient days beyond the incompany limit  Total bad debt expense for the entire hospital complex (see instruct Medicare reimbursable bad debts for the entire hospital complex (see   | patients 1.00  13,778,  see 1,608,6  1,573,  1,573,  ss beyond a length am? ligent care progrations)   | pati ents 2.00  160 56,647  528 56,647  181 315  147 56,332                      | Total (col. 1<br>+ col. 2)<br>3.00<br>13,834,807<br>1,665,275<br>35,796<br>1,629,479<br>1.00<br>N<br>0<br>15,606,266<br>361,143                          | 20. 00<br>21. 00<br>22. 00<br>23. 00<br>24. 00<br>25. 00<br>26. 00<br>27. 00                     |  |
| 21. 00<br>22. 00<br>23. 00<br>24. 00<br>25. 00<br>26. 00<br>27. 00<br>27. 01           | Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (instructions)  Payments received from patients for amounts previously written off a charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care progrif line 24 is yes, enter the charges for patient days beyond the inc stay limit  Total bad debt expense for the entire hospital complex (see instruct Medicare reimbursable bad debts for the entire hospital complex (see   | patients 1.00  13,778,  see 1,608,6  1,573,  1,573,  ss beyond a length am? ligent care progrations)   | pati ents 2.00  160 56,647  528 56,647  181 315  147 56,332                      | Total (col. 1<br>+ col. 2)<br>3.00<br>13,834,807<br>1,665,275<br>35,796<br>1,629,479<br>1.00<br>N<br>0<br>15,606,266<br>361,143<br>555,604               | 20. 00<br>21. 00<br>22. 00<br>23. 00<br>24. 00<br>25. 00<br>26. 00<br>27. 00<br>27. 01           |  |
| 21. 00<br>22. 00<br>23. 00<br>24. 00<br>25. 00<br>26. 00<br>27. 00<br>27. 01<br>28. 00 | Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (instructions)  Payments received from patients for amounts previously written off a charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care progr If line 24 is yes, enter the charges for patient days beyond the incompany limit  Total bad debt expense for the entire hospital complex (see instruct Medicare reimbursable bad debts for the entire hospital complex (see   | patients 1.00  13,778,7  See 1,608,6  1,573,7  s beyond a length ram? ligent care progrations) s instructions)   | patients 2.00  160 56,647  181 315  147 56,332  The of stay limit am's length of | Total (col. 1<br>+ col. 2)<br>3.00<br>13,834,807<br>1,665,275<br>35,796<br>1,629,479<br>1.00<br>N<br>0<br>15,606,266<br>361,143                          | 20. 00<br>21. 00<br>22. 00<br>23. 00<br>24. 00<br>25. 00<br>26. 00<br>27. 00<br>28. 00           |  |
| 21. 00<br>22. 00<br>23. 00<br>24. 00   | Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (instructions)  Payments received from patients for amounts previously written off a charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care progrif line 24 is yes, enter the charges for patient days beyond the indistal limit  Total bad debt expense for the entire hospital complex (see instruct Medicare reimbursable bad debts for the entire hospital complex (see in Non-Medicare bad debt expense (see instructions) | patients 1.00  13,778,7  See 1,608,6  1,573,7  s beyond a length ram? ligent care progrations) s instructions)   | patients 2.00  160 56,647  181 315  147 56,332  The of stay limit am's length of | Total (col. 1<br>+ col. 2)<br>3.00<br>13,834,807<br>1,665,275<br>35,796<br>1,629,479<br>1.00<br>N<br>0<br>15,606,266<br>361,143<br>555,604<br>15,050,662 | 20. 00<br>21. 00<br>22. 00<br>23. 00<br>24. 00<br>25. 00<br>26. 00<br>27. 01<br>28. 00<br>29. 00 |  |

| Health Financial Systems   | PORTER REGIONA | L HOSPITAL          |                         | In Lie                         | u of Form CMS-2 | 2552-10            |
|--|----------------|---------------------|-------------------------|--------------------------------|-----------------|--------------------|
| RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O                                    | F EXPENSES     | Provider CO         |                         | eri od:                        | Worksheet A     |                    |
|  |                |                     |                         | rom 01/01/2021<br>o 12/31/2021 | Date/Time Pre   | narod:             |
|  |                |                     | '                       | o 12/31/2021                   | 5/30/2022 6: 2  |                    |
| Cost Center Description  | Sal ari es     | Other               | Total (col. 1           | Recl assi fi cati              | Recl assi fi ed |                    |
| · ·  |                |                     | + col . 2)              | ons (See A-6)                  | Trial Balance   |                    |
|  |                |                     |                         |                                | (col. 3 +-      |                    |
|  |                |                     |                         |                                | col . 4)        |                    |
|  | 1.00           | 2. 00               | 3. 00                   | 4. 00                          | 5. 00           |                    |
| GENERAL SERVICE COST CENTERS   |                |                     |                         |                                |                 |                    |
| 1.00 O0100 CAP REL COSTS-BLDG & FIXT   |                | 169, 747            | 169, 747                |                                | 5, 727, 013     | 1. 00              |
| 2.00 O0200 CAP REL COSTS-MVBLE EQUIP   |                | 9, 848, 810         | 9, 848, 810             |                                | 11, 135, 089    | 2. 00              |
| 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT  | 411, 332       | 296, 431            | 707, 763                |                                | 17, 895, 517    | 4. 00              |
| 5.00 00500 ADMINISTRATIVE & GENERAL  | 10, 514, 604   | 40, 140, 494        | 50, 655, 098            |                                | 28, 910, 598    | 5. 00              |
| 7.00 O0700 OPERATION OF PLANT  | 1, 921, 011    | 5, 533, 150         |                         |                                | 12, 324, 874    | 7. 00              |
| 8.00   00800   LAUNDRY & LINEN SERVICE   | 103, 687       | 1, 625, 132         |                         |                                | 1, 728, 819     | 8. 00              |
| 9. 00   00900   HOUSEKEEPI NG  | 1, 500, 828    | 1, 651, 637         | 3, 152, 465             |                                | 3, 141, 760     | 9. 00              |
| 10. 00   01000   DI ETARY  | 1, 723, 053    | 1, 426, 400         | 3, 149, 453             |                                | 1, 354, 076     | 10. 00             |
| 11. 00   01100   CAFETERI A  | 0              | 0                   | 0                       |                                | 1, 707, 127     | 11. 00             |
| 13. 00 01300 NURSING ADMINISTRATION  | 3, 622, 864    | 385, 434            |                         |                                | 4, 373, 708     | 13. 00             |
| 14. 00   01400   CENTRAL SERVI CES & SUPPLY  | 895, 675       | 23, 418, 825        | 24, 314, 500            |                                | 1, 930, 838     | 14. 00             |
| 15. 00   01500   PHARMACY  | 2, 901, 144    | 34, 752, 153        |                         |                                | 3, 232, 113     | 15. 00             |
| 16. 00 01600 MEDI CAL RECORDS & LI BRARY   | 660, 125       | 1, 289, 414         |                         |                                | 1, 949, 539     | 16. 00             |
| 17. 00 01700 SOCIAL SERVICE  | 1, 238, 886    | 545, 707            | 1, 784, 593             | 0                              | 1, 784, 593     | 17. 00             |
| INPATIENT ROUTINE SERVICE COST CENTERS   | 4, 004 045     | 0 007 744           | 0, 010 05,              | 1 045 050                      | 04.070.407      |                    |
| 30. 00   03000   ADULTS & PEDI ATRI CS   | 16, 381, 215   | 9, 837, 741         | 26, 218, 956            |                                | 24, 973, 106    | 30.00              |
| 31. 00   03100   INTENSIVE CARE UNIT   | 5, 375, 190    | 5, 537, 317         |                         |                                | 10, 836, 220    | 31.00              |
| 31. 01  03101  NEONATAL INTENSIVE CARE UNIT  | 2, 060, 756    | 1, 176, 078         |                         |                                | 3, 225, 361     | 31. 01             |
| 41. 00   04100   SUBPROVI DER - I RF   | 1, 269, 328    | 357, 306            |                         |                                | 1, 602, 014     | 41. 00             |
| 43. 00   04300   NURSERY   | 1, 873         | 87, 912             | 89, 785                 | 644, 703                       | 734, 488        | 43. 00             |
| ANCI LLARY SERVI CE COST CENTERS   |                |                     |                         |                                |                 |                    |
| 50. 00   05000   OPERATI NG ROOM   | 5, 925, 232    | 7, 728, 243         |                         |                                | 14, 876, 640    | 50.00              |
| 51. 00   05100   RECOVERY ROOM   | 2, 367, 909    | 502, 322            | 2, 870, 231             |                                | 0               | 51. 00             |
| 52.00   05200   DELIVERY ROOM & LABOR ROOM   | 1, 936, 060    | 693, 401            | 2, 629, 461             |                                | 3, 055, 538     | 52. 00             |
| 53. 00   05300   ANESTHESI OLOGY   | 0              | 2, 996, 936         | 2, 996, 936             |                                | 2, 996, 936     | 53.00              |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C   | 6, 313, 605    | 3, 083, 318         |                         |                                | 10, 461, 298    | 54.00              |
| 54. 01   05401   ULTRASOUND  | 451, 090       | 95, 295             | 546, 385                |                                | 0               | 54. 01             |
| 56. 00 05600 RADI 0I SOTOPE  | 374, 650       | 730, 906            |                         |                                | 0               | 56. 00             |
| 57. 00   05700   CT   SCAN   | 660, 090       | 275, 618            |                         |                                | 0               | 57. 00             |
| 58. 00   05800   MRI   | 233, 390       | 175, 455            | 408, 845                |                                | 0               | 58. 00             |
| 60. 00   06000   LABORATORY  | 5, 388, 026    | 6, 962, 562         |                         |                                | 11, 990, 465    | 60.00              |
| 65. 00 06500 RESPIRATORY THERAPY   | 1, 984, 522    | 1, 366, 942         | 3, 351, 464             |                                | 3, 168, 094     | 65. 00             |
| 66. 00   06600   PHYSI CAL THERAPY   | 2, 088, 383    | 304, 121            | 2, 392, 504             |                                | 2, 329, 221     | 66. 00             |
| 67. 00 06700 OCCUPATI ONAL THERAPY   | 759, 476       | 56, 160             | 815, 636                |                                | 815, 636        | 67. 00             |
| 68. 00   06800   SPEECH PATHOLOGY  | 661, 128       | 142, 022            | 803, 150                |                                | 803, 150        | 68. 00             |
| 69. 00 06900 ELECTROCARDI OLOGY  | 3, 641, 599    | 2, 020, 059         |                         |                                | 5, 391, 538     | 69. 00             |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                                       | 0              | 0                   | C                       | ., ,                           | 1, 959, 834     | 71.00              |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS  | 121 011        | 42.220              | 1/4 220                 | ,                              | 19, 192, 026    | 72.00              |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS   | 121, 011       | 43, 328             |                         |                                | 33, 504, 419    | 73.00              |
| 74. 00   07400   RENAL DI ALYSI S<br>76. 00   03950   ANCI LLARY                       | 0              | 763, 832            | 763, 832                |                                | 763, 832        | 74.00              |
|  | 207 700        | 70 4/4              | 2/7 173                 |                                | 0               | 76. 00             |
| 76. 01 03610 SLEEP LAB   | 287, 708       | 79, 464<br>761, 387 | 367, 172<br>1, 650, 058 |                                | 1 (40 000       |                    |
| 76. 03 03951 WOUND CARE OUTPATIENT SERVICE COST CENTERS                                | 888, 671       | /01, 38/            | 1, 650, 058             | -69                            | 1, 649, 989     | 76.03              |
| 90. 00   09000   CLINIC  |                | 0                   |                         | ol                             | 0               | 90. 00             |
| 91. 00   09100  EMERGENCY  | 6, 431, 399    | 7, 173, 750         | 13, 605, 149            |                                | 13, 604, 860    |                    |
|  | 0, 431, 399    | 7, 173, 730         | 13, 003, 149            | -209                           | 13, 004, 000    |                    |
| `  |                |                     |                         |                                |                 | 92. 00             |
| SPECIAL PURPOSE COST CENTERS   | 91, 095, 520   | 174, 034, 809       | 265, 130, 329           |                                | 2/5 120 220     | 110 00             |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS            | 91,095,520     | 174, 034, 809       | 205, 130, 329           | 0                              | 265, 130, 329   | 118.00             |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                                       | EE 702         | 3, 967              | E0 440                  | ا                              | 59, 669         | 100 00             |
|  | 55, 702        | 3, 907              | 59, 669                 |                                |                 |                    |
| 192. 00 19200  PHYSI CLANS' PRI VATE OFFI CES<br>192. 01 19201  OTHER NONREI MBURSABLE |                | 0                   |                         |                                |                 | 192. 00<br>192. 01 |
| 192.01 19201 01HER NONRETMBURSABLE<br>194.00 07950 NONRETMBURSABLE                     |                | 0                   |                         |                                |                 | 192. 01<br>194. 00 |
| 194. 01 07951 MARKETI NG   |                | 0                   |                         |                                |                 | 194. 00<br>194. 01 |
| 194. 02 07952 SENI OR CIRCLE   |                | 0                   |                         |                                |                 | 194. 01            |
| 194.03 07953 NONREIMB - REGENCY LTC  |                | 0                   |                         |                                |                 | 194. 02<br>194. 03 |
| 194.04 07954 VACANT UNFINISHED AREA  |                | 0                   |                         |                                |                 | 194. 03<br>194. 04 |
| 200.00 TOTAL (SUM OF LINES 118 through 199)  | 91, 151, 222   | 174, 038, 776       | 265, 189, 998           |                                | 265, 189, 998   |                    |
| 200.00   TOTAL (SOM OF LINES THE UNIOUGH 177)  | /1, /51, 222   | 174,030,770         | 200, 107, 770           | ı 9                            | 200, 107, 770   | 200.00             |
|  |                |                     |                         |                                |                 |                    |

Provider CCN: 15-0035

Peri od: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/30/2022 6:28 pm

|                  |  |   |                   | 5/30/2022 6: 2   |                  |
|------------------|--|---|-------------------|--|------------------|
|                  | Cost Center Description                                  | Adjustments                             | Net Expenses      |  |                  |
|                  |  |   | For Allocation    | 1  |                  |
|                  |  | 6. 00                                   | 7. 00             |  |                  |
|                  | GENERAL SERVICE COST CENTERS                             |   |                   | T  | 4                |
| 1. 00            | 00100 CAP REL COSTS-BLDG & FIXT                          | 840, 235                                | 6, 567, 248       |  | 1. 00            |
| 2. 00            | 00200 CAP REL COSTS-MVBLE EQUIP                          | 323, 702                                | 11, 458, 791      |  | 2. 00            |
| 4.00             | 00400 EMPLOYEE BENEFITS DEPARTMENT                       | -5, 114                                 | 17, 890, 403      |  | 4. 00            |
| 5.00             | 00500 ADMINISTRATIVE & GENERAL                           | 34, 957, 221                            | 63, 867, 819      |  | 5. 00            |
| 7. 00            | 00700 OPERATION OF PLANT                                 | -324, 763                               | 12, 000, 111      | l e e e e e e e e e e e e e e e e e e e  | 7. 00            |
| 8. 00            | 00800 LAUNDRY & LINEN SERVICE                            | 0                                       | 1, 728, 819       |  | 8. 00            |
| 9. 00            | 00900 HOUSEKEEPI NG                                      | 0                                       | 3, 141, 760       |  | 9. 00            |
| 10. 00           | 01000 DI ETARY   | 0                                       | 1, 354, 076       |  | 10. 00           |
| 11. 00           | 01100 CAFETERI A   | 0                                       | 1, 707, 127       |  | 11. 00           |
| 13. 00           | 01300 NURSING ADMINISTRATION                             | -15, 902                                | 4, 357, 806       |  | 13. 00           |
| 14. 00           | 01400 CENTRAL SERVICES & SUPPLY                          | 0                                       | 1, 930, 838       |  | 14. 00           |
| 15. 00           | 01500 PHARMACY   | 0                                       | 3, 232, 113       |  | 15. 00           |
| 16. 00           | 01600 MEDICAL RECORDS & LIBRARY                          | -229                                    | 1, 949, 310       |  | 16. 00           |
| 17. 00           | 01700 SOCI AL SERVI CE                                   | 0                                       | 1, 784, 593       | 3  | 17. 00           |
|                  | I NPATI ENT ROUTI NE SERVI CE COST CENTERS               |   |                   | ı  | 4                |
| 30.00            | 03000 ADULTS & PEDI ATRI CS                              | -1, 781, 091                            | 23, 192, 015      |  | 30.00            |
| 31.00            | 03100 I NTENSI VE CARE UNI T                             | -763, 789                               | 10, 072, 431      |  | 31.00            |
| 31. 01           | 03101 NEONATAL INTENSIVE CARE UNIT                       | -755, 400                               | 2, 469, 961       | i de la companya del companya de la companya de la companya del companya de la co | 31. 01           |
| 41. 00           | 04100 SUBPROVI DER - I RF                                | 0                                       | 1, 602, 014       |  | 41.00            |
| 43. 00           | 04300 NURSERY  | 0                                       | 734, 488          | 3  | 43. 00           |
| EO 00            | ANCILLARY SERVICE COST CENTERS                           | 204 052                                 | 14 400 F00        | , i  | F0 00            |
| 50.00            | 05000 OPERATI NG ROOM                                    | -396, 052                               | 14, 480, 588      | l e e e e e e e e e e e e e e e e e e e  | 50.00            |
| 51.00            | 05100 RECOVERY ROOM                                      | 200.750                                 | 0 054 700         |  | 51.00            |
| 52. 00<br>53. 00 | 05200 DELIVERY ROOM & LABOR ROOM<br>05300 ANESTHESIOLOGY | -200, 750                               | 2, 854, 788       |  | 52.00            |
|                  |  | -2, 925, 354                            | 71, 582           |  | 53.00            |
| 54.00            | 05400 RADI OLOGY-DI AGNOSTI C<br>05401 ULTRASOUND        | -403, 905                               | 10, 057, 393<br>0 | 1  | 54.00            |
| 54. 01<br>56. 00 | 05600 RADI OI SOTOPE                                     | 0                                       | 0                 |  | 54. 01<br>56. 00 |
| 57. 00           | 05700 CT SCAN  | 0                                       | 0                 |  | 57. 00           |
| 58. 00           | 05800 MRI  | 0                                       | 0                 |  | 58.00            |
| 60.00            | 06000 LABORATORY   | 0                                       | 11, 990, 465      |  | 60.00            |
| 65. 00           | 06500 RESPI RATORY THERAPY                               | 0                                       | 3, 168, 094       |  | 65. 00           |
| 66. 00           | 06600 PHYSI CAL THERAPY                                  | 0                                       | 2, 329, 221       |  | 66. 00           |
| 67. 00           | 06700 OCCUPATI ONAL THERAPY                              | 0                                       | 815, 636          |  | 67. 00           |
| 68. 00           | 06800 SPEECH PATHOLOGY                                   | 0                                       | 803, 150          |  | 68. 00           |
| 69. 00           | 06900 ELECTROCARDI OLOGY                                 | -                                       | 5, 154, 288       |  | 69. 00           |
| 71. 00           | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                | -237, 250<br>0                          | 1, 959, 834       |  | 71. 00           |
| 71.00            | 07200 IMPL. DEV. CHARGED TO PATIENTS                     | 0                                       | 19, 192, 026      |  | 72.00            |
| 73. 00           | 07300 DRUGS CHARGED TO PATIENTS                          | 0                                       | 33, 504, 419      |  | 73. 00           |
| 74. 00           | 07400 RENAL DIALYSIS                                     | 0                                       | 763, 832          |  | 74.00            |
| 76. 00           | 03950 ANCI LLARY   | 0                                       | 703, 832          |  | 76.00            |
| 76. 00           | 03610 SLEEP LAB  | 0                                       | 0                 | 1  | 76. 00           |
| 76. 01           | 03951 WOUND CARE   | 0                                       | 1, 649, 989       |  | 76. 03           |
| 70.03            | OUTPATIENT SERVICE COST CENTERS                          | <u> </u>                                | 1,047,707         | 1  | 70.03            |
| 90. 00           | 09000 CLINIC   | 0                                       | 0                 |  | 90.00            |
|                  | 09100 EMERGENCY  | -1, 741, 509                            | 11, 863, 351      |  | 91.00            |
|                  | 09200 OBSERVATION BEDS (NON-DISTINCT PART                | .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | , 000, 00 .       |  | 92.00            |
| 72.00            | SPECIAL PURPOSE COST CENTERS                             |   |                   |  | 72.00            |
| 118.00           |  | 26, 570, 050                            | 291, 700, 379     |  | 118. 00          |
|                  | NONREI MBURSABLE COST CENTERS                            | 20,0,0,000                              | 27177007077       |  | 1                |
| 190 00           | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                | 0                                       | 59, 669           |  | 190. 00          |
|                  | 19200 PHYSI CI ANS' PRI VATE OFFI CES                    | Ö                                       | 07,007            | 1  | 192. 00          |
|                  | 19201 OTHER NONREI MBURSABLE                             | 0                                       | 0                 |  | 192. 01          |
|                  | 07950 NONREI MBURSABLE                                   | Ö                                       | 0                 |  | 194. 00          |
|                  | 07951 MARKETI NG   | n                                       | n                 |  | 194. 01          |
|                  | 07952 SENI OR CI RCLE                                    | 0                                       | 0                 |  | 194. 02          |
|                  | 07953 NONREIMB - REGENCY LTC                             | 0                                       | 0                 |  | 194. 03          |
|                  | 07954 VACANT UNFINISHED AREA                             | 0                                       | 0                 |  | 194. 04          |
| 200.00           |  | 26, 570, 050                            | 291, 760, 048     | 3  | 200. 00          |
|                  |  |   | ,                 | 1  |                  |
|                  |  |   |                   |  |                  |

Health Financial Systems RECLASSIFICATIONS

Peri od: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/30/2022 6:28 pm

|                  |  |  |                  |                                       | 5/30/2022 6 |                  |
|------------------|--|--|------------------|---------------------------------------|-------------|------------------|
|                  |  | Increases                                      |                  |                                       |             | ,                |
|                  | Cost Center  | Li ne #  | Salary           | 0ther                                 |             |                  |
|                  | 2. 00  | 3.00   | 4. 00            | 5. 00                                 |             |                  |
| 1. 00            | A - EMPLOYEE BENEFITS EMPLOYEE BENEFITS DEPARTMENT | 4.00   | 0                | 17, 189, 339                          |             | 1.00             |
| 1.00             | 0  | <del>- 1.00</del>                              | — — <del>ŏ</del> | 17, 189, 339                          |             | 1.00             |
|                  | C - RENTAL AND LEASE EXPENSES                      | 5  | -,               | ,,                                    |             |                  |
| 1.00             | CAP REL COSTS-BLDG & FIXT                          | 1.00   | 0                | 2, 447, 773                           |             | 1. 00            |
| 2.00             | CAP REL COSTS-MVBLE EQUIP                          | 2.00   | 0                | 1, 131, 925                           |             | 2. 00            |
| 3.00             | EMERGENCY  | 91.00  | 0                | 27, 527                               |             | 3. 00            |
| 4. 00<br>5. 00   | +  | 0. 00<br>0. 00                                 | 0                | 0                                     |             | 4. 00<br>5. 00   |
| 6. 00            |  | 0.00   | 0                | 0                                     |             | 6. 00            |
| 7. 00            |  | 0.00   | o                | O                                     |             | 7. 00            |
| 8.00             |  | 0.00   | 0                | 0                                     |             | 8. 00            |
| 9.00             |  | 0.00   | 0                | 0                                     |             | 9. 00            |
| 10.00            |  | 0.00   | 0                | 0                                     |             | 10.00            |
| 11. 00<br>12. 00 |  | 0. 00<br>0. 00                                 | 0                | 0                                     |             | 11. 00<br>12. 00 |
| 13. 00           |  | 0.00   | 0                | 0                                     |             | 13. 00           |
| 14. 00           |  | 0.00   | 0                | 0                                     |             | 14. 00           |
| 15.00            |  | 0.00   | 0                | 0                                     |             | 15. 00           |
| 16. 00           |  | 0.00   | •                | 0                                     |             | 16. 00           |
|                  | D OTHER CARLTAL COSTS                              |  | 0                | 3, 607, 225                           |             |                  |
| 1. 00            | D - OTHER CAPITAL COSTS CAP REL COSTS-BLDG & FIXT  | 1.00   | 0                | 479, 001                              |             | 1.00             |
| 2. 00            | CAP REL COSTS-BLDG & FIXT                          | 1.00   | o                | 2, 630, 492                           |             | 2. 00            |
| 3.00             | CAP REL COSTS-MVBLE EQUIP                          | 2. 00  | 0                | 154, 354                              |             | 3. 00            |
|                  | 0  |  |                  | 3, 263, 847                           |             |                  |
| 4 00             | E - REPAIRS AND MAINTENANCE (                      |  | اه               | 4 000 07                              |             | 4.00             |
| 1. 00<br>2. 00   | OPERATION OF PLANT                                 | 7. 00<br>0. 00                                 | 0                | 4, 902, 067<br>0                      |             | 1. 00<br>2. 00   |
| 3.00             |  | 0.00   | 0                | 0                                     |             | 3. 00            |
| 4. 00            |  | 0.00   | o                | 0                                     |             | 4. 00            |
| 5.00             |  | 0.00   | 0                | 0                                     |             | 5. 00            |
| 6.00             |  | 0.00   | 0                | 0                                     |             | 6. 00            |
| 7.00             |  | 0.00   | 0                | 0                                     |             | 7. 00            |
| 8. 00<br>9. 00   | 1  | 0. 00<br>0. 00                                 | 0                | 0                                     |             | 8. 00<br>9. 00   |
| 10. 00           |  | 0.00   | o                | 0                                     |             | 10.00            |
| 11. 00           |  | 0.00   | 0                | 0                                     |             | 11. 00           |
| 12.00            |  | 0.00   | 0                | 0                                     |             | 12. 00           |
| 13.00            |  | 0.00   | 0                | 0                                     |             | 13.00            |
| 14. 00<br>15. 00 |  | 0. 00<br>0. 00                                 | 0                | 0                                     |             | 14. 00<br>15. 00 |
| 16. 00           |  | 0.00   | 0                | 0                                     |             | 16. 00           |
| 17. 00           |  | 0.00   | Ö                | 0                                     |             | 17. 00           |
| 18.00            |  | 0.00   | 0                | 0                                     |             | 18. 00           |
| 19. 00           |  | 0.00   | 0                | 0                                     |             | 19. 00           |
| 20.00            |  | 0.00   | 0                | 0                                     |             | 20.00            |
| 21. 00<br>22. 00 | +  | 0. 00<br>0. 00                                 | 0                | 0                                     |             | 21. 00<br>22. 00 |
| 23. 00           |  | 0.00   | o                | ő                                     |             | 23. 00           |
| 24. 00           |  | 0.00   | 0                | 0                                     |             | 24. 00           |
| 25. 00           |  | 0.00   | 0                | 0                                     |             | 25. 00           |
| 26. 00           |  | 0.00   | 0                | 0                                     |             | 26. 00           |
|                  | F - CHIEF NURSING OFFICER COS                      | <u>                                       </u> | 0                | 4, 902, 067                           |             |                  |
| 1.00             | NURSING ADMINISTRATION                             | 13. 00   | 369, 279         | 0                                     |             | 1.00             |
|                  | 0  |  | 369, 279         |                                       |             |                  |
|                  | G - MEDICAL SUPPLIES                               |  |                  |                                       |             |                  |
| 1.00             | MEDICAL SUPPLIES CHARGED TO                        | 71. 00   | 0                | 1, 959, 834                           |             | 1. 00            |
| 2. 00            | PATIENT<br>IMPL. DEV. CHARGED TO                   | 72. 00   | 0                | 19, 192, 026                          |             | 2. 00            |
| 2.00             | PATIENTS   | 72.00  |                  | 19, 192, 020                          |             | 2.00             |
| 3.00             | OPERATI NG_ROOM                                    | 50.00  | 0                | 1, 063, 460                           |             | 3. 00            |
|                  | 0 — — — — —  |  |                  | 22, 215, 320                          |             |                  |
| 1 00             | H - COST OF DRUGS/IV SOLUTION                      |  | <u>.</u> 1       | 22 275 224                            |             | 1.00             |
| 1. 00            | DRUGS CHARGED TO PATIENTS                          | 73.00  | 0                | 33, 37 <u>5, 9</u> 84<br>33, 375, 984 |             | 1. 00            |
|                  | I - LABOR AND DELIVERY COSTS                       |  | <u> </u>         | JJ, J/J, 784                          |             |                  |
| 1.00             | ADULTS & PEDIATRICS                                | 30.00  | 0                | 33, 727                               |             | 1.00             |
| 2.00             | NURSERY  | 43.00  | 604, 858         | 58, 195                               |             | 2. 00            |
| 3.00             | DELIVERY ROOM & LABOR ROOM                         | 52.00  | 561, 677         | 0                                     |             | 3. 00            |
|                  | 0  |  | 1, 166, 535      | 91, 922                               |             |                  |
|                  |  |  |                  |                                       |             |                  |

| Health Financial Systems | PORTER REGIONAL HOSPITAL | In Lie          | u of Form CMS-2552-10 |
|--------------------------|--------------------------|-----------------|-----------------------|
| RECLASSI FI CATI ONS     | Provi der CCN: 15-0035   | Peri od:        | Worksheet A-6         |
|                          |                          | From 01/01/2021 | Dato/Timo Propared:   |

|        |                               |           |             |              | 5/30/2022 6: |        |
|--------|-------------------------------|-----------|-------------|--------------|--------------|--------|
|        |                               | Increases |             |              |              |        |
|        | Cost Center                   | Li ne #   | Sal ary     | 0ther        |              |        |
|        | 2. 00                         | 3.00      | 4.00        | 5. 00        |              |        |
|        | K - RECOVERY ROOM             |           |             |              |              |        |
| 1.00   | OPERATING ROOM                | 50.00     | 2, 367, 909 | 502, 322     |              | 1. 00  |
|        | 0                             |           | 2, 367, 909 | 502, 322     |              |        |
|        | L - OTHER RADIOLOGY COST      |           |             |              |              |        |
| 1.00   | RADI OLOGY-DI AGNOSTI C       | 54.00     | 1, 719, 220 | 894, 928     |              | 1. 00  |
| 2.00   |                               | 0.00      | 0           | 0            |              | 2. 00  |
| 3.00   |                               | 0.00      | 0           | 0            |              | 3. 00  |
| 4.00   |                               | 0.00      | 0           | 0            |              | 4. 00  |
|        | 0                             |           | 1, 719, 220 | 894, 928     |              |        |
|        | M - DIETARY COSTS TO CAFETERI | A         |             |              |              |        |
| 1.00   | CAFETERI A                    | 11. 00    | 960, 887    | 746, 240     |              | 1. 00  |
|        | 0                             |           | 960, 887    | 746, 240     |              |        |
|        | O - SLEEP LAB COSTS TO EKG    |           |             |              |              |        |
| 1.00   | ELECTROCARDI OLOGY            | 69. 00    | 287, 708    | 74, 554      |              | 1. 00  |
|        | 0                             |           | 287, 708    | 74, 554      |              |        |
| 500.00 | Grand Total: Increases        |           | 6, 871, 538 | 86, 863, 748 |              | 500.00 |

Provider CCN: 15-0035

Peri od: From 01/01/2021 To 12/31/2021 Date/Ti me Prepared: 5/30/2022 6: 28 pm

|        |                               |                  |                |                     |                  | 5/30/2022 6: | 28 pm  |
|--------|-------------------------------|------------------|----------------|---------------------|------------------|--------------|--------|
|        |                               | Decreases        |                |                     |                  |              |        |
|        | Cost Center                   | Li ne #          | Sal ary        | 0ther               | Wkst. A-7 Ref.   |              |        |
|        | 6. 00                         | 7. 00            | 8.00           | 9. 00               | 10. 00           |              |        |
|        | A - EMPLOYEE BENEFITS         |                  |                |                     |                  |              |        |
| 1.00   | ADMINISTRATIVE & GENERAL      | 5. 00            | 0              | 17, 189, 339        | 0                |              | 1.00   |
|        |                               | - $  -$          |                | 17, 189, 339        | 1                |              | ĺ      |
|        | C - RENTAL AND LEASE EXPENSES | 5                |                |                     | '                |              | 1      |
| 1.00   | ADMI NI STRATI VE & GENERAL   | 5. 00            | 0              | 176, 785            | 10               |              | 1.00   |
| 2.00   | OPERATION OF PLANT            | 7.00             | o              | 31, 354             | 10               |              | 2. 00  |
| 3.00   | DI ETARY                      | 10.00            | O              | 10, 303             | 0                |              | 3. 00  |
| 4. 00  | SLEEP LAB                     | 76. 01           | o              | 4, 910              | o                |              | 4. 00  |
| 5. 00  | CENTRAL SERVICES & SUPPLY     | 14. 00           | o              | 13, 023             | o                |              | 5. 00  |
| 6. 00  | PHARMACY                      | 15. 00           | o              | 875, 625            | o                |              | 6. 00  |
| 7. 00  | ADULTS & PEDIATRICS           | 30.00            | ő              | 105, 842            | 0                |              | 7. 00  |
| 8. 00  | INTENSIVE CARE UNIT           | 31.00            | Ö              | •                   | o                |              | 8. 00  |
| 9.00   | PHYSICAL THERAPY              | 1                | o              | 66, 247             | 0                |              | 9. 00  |
|        | OPERATING ROOM                | 66. 00<br>50. 00 |                | 63, 208             | 0                |              | 1      |
| 10.00  |                               | l I              | 0              | 1, 209, 151         | 0                |              | 10.00  |
| 11.00  | LABORATORY                    | 60.00            | 0              | 132, 265            | -                |              | 11. 00 |
| 12.00  | RESPIRATORY THERAPY           | 65.00            | 0              | 154, 330            | 0                |              | 12.00  |
| 13. 00 | ELECTROCARDI OLOGY            | 69. 00           | 0              | 90, 304             | 0                |              | 13. 00 |
| 14. 00 | CT SCAN                       | 57. 00           | 0              | 18, 882             | 0                |              | 14. 00 |
| 15. 00 | RADI OLOGY-DI AGNOSTI C       | 54.00            | 0              | 631, 290            | 0                |              | 15. 00 |
| 16. 00 | SUBPROVI DER - I RF           | 41.00            |                | 23, 706             | 0                |              | 16. 00 |
|        | 0                             |                  | 0              | 3, 607, 225         |                  |              |        |
|        | D - OTHER CAPITAL COSTS       |                  |                |                     |                  |              | 4      |
| 1.00   | ADMINISTRATIVE & GENERAL      | 5.00             | 0              | 3, 263, 847         | 12               |              | 1. 00  |
| 2.00   |                               | 0.00             | 0              | 0                   | 13               |              | 2. 00  |
| 3.00   |                               | 0.00             | 0_             | 0                   | 12               |              | 3. 00  |
|        | 0 — — — — — —                 |                  |                | 3, 263, 847         |                  |              |        |
|        | E - REPAIRS AND MAINTENANCE ( | COSTS            |                |                     |                  |              |        |
| 1.00   | EMPLOYEE BENEFITS DEPARTMENT  | 4.00             | 0              | 1, 585              | 0                |              | 1.00   |
| 2.00   | ADMINISTRATIVE & GENERAL      | 5.00             | o              | 745, 250            | 0                |              | 2. 00  |
| 3.00   | HOUSEKEEPI NG                 | 9.00             | O              | 10, 705             | 0                |              | 3. 00  |
| 4.00   | DI ETARY                      | 10.00            | o              | 77, 947             | 0                |              | 4. 00  |
| 5.00   | CENTRAL SERVICES & SUPPLY     | 14. 00           | Ö              | 223, 919            | 0                |              | 5. 00  |
| 6. 00  | PHARMACY                      | 15. 00           | 0              | 169, 575            | 0                |              | 6. 00  |
| 7. 00  | ADULTS & PEDIATRICS           | 30.00            | 0              | 7, 200              | 0                |              | 7. 00  |
| 8. 00  | INTENSIVE CARE UNIT           | 31.00            | ő              | 10, 040             | 0                |              | 8. 00  |
| 9. 00  | NEONATAL INTENSIVE CARE UNIT  | 31.00            | Ö              | 11, 473             | o                |              | 9. 00  |
| 10. 00 | NURSERY                       | 1                | o              |                     | 0                |              | 10.00  |
|        |                               | 43.00            | o              | 18, 350             | 0                |              | 1      |
| 11.00  | OPERATING ROOM                | 50.00            |                | 1, 501, 375         | - 1              |              | 11.00  |
| 12.00  | EMERGENCY                     | 91.00            | 0              | 27, 816             | 0                |              | 12. 00 |
| 13.00  | DELIVERY ROOM & LABOR ROOM    | 52.00            | 0              | 43, 678             | 0                |              | 13. 00 |
| 14. 00 | RADI OLOGY-DI AGNOSTI C       | 54.00            | 0              | 849, 883            | 0                |              | 14. 00 |
| 15. 00 | ULTRASOUND                    | 54. 01           | 0              | 40, 758             | 0                |              | 15. 00 |
| 16. 00 | RADI OI SOTOPE                | 56.00            | 0              | 38, 644             | 0                |              | 16. 00 |
| 17. 00 | CT SCAN                       | 57.00            | 0              | 133, 037            | 0                |              | 17. 00 |
| 18. 00 | MRI                           | 58. 00           | 0              | 151, 025            | 0                |              | 18. 00 |
| 19. 00 | LABORATORY                    | 60.00            | 0              | 227, 858            | 0                |              | 19. 00 |
| 20. 00 | RESPI RATORY THERAPY          | 65.00            | 0              | 29, 040             | 0                |              | 20.00  |
| 21. 00 | WOUND CARE                    | 76. 03           | 0              | 69                  | 0                |              | 21. 00 |
| 22.00  | DRUGS CHARGED TO PATIENTS     | 73.00            | 0              | 35, 904             | 0                |              | 22. 00 |
| 23.00  | ELECTROCARDI OLOGY            | 69.00            | 0              | 542, 078            | 0                |              | 23. 00 |
| 24.00  | NURSING ADMINISTRATION        | 13.00            | 0              | 3, 869              | 0                |              | 24. 00 |
| 25.00  | SUBPROVI DER - I RF           | 41.00            | o              | 914                 | 0                |              | 25. 00 |
| 26.00  | PHYSI CAL THERAPY             | 66.00            | O              | 75                  | 0                |              | 26. 00 |
|        |                               | $+$              | <sub>o</sub> _ | 4, 902, 067         | 1                |              | i      |
|        | F - CHIEF NURSING OFFICER COS | ST               | -              | ., ., .,            |                  |              |        |
| 1.00   | ADMINISTRATIVE & GENERAL      | 5.00             | 369, 279       | 0                   | 0                |              | 1.00   |
|        | 0                             | — — <del></del>  | 369, 279       |                     | — — <del>"</del> |              | 1.00   |
|        | G - MEDICAL SUPPLIES          | 1                | 307, 217       | <u> </u>            |                  |              | 1      |
| 1. 00  | CENTRAL SERVICES & SUPPLY     | 14, 00           | n              | 22, 146, 720        | 0                |              | 1.00   |
| 2. 00  | RADI OLOGY-DI AGNOSTI C       | 54.00            | ő              | 68, 600             | 0                |              | 2. 00  |
| 3. 00  | INADI OLOGI-DI AGNOSTI C      | 0.00             |                | 00, 000             | 0                |              | 3. 00  |
| 3.00   |                               |                  |                | 22, 215, 320        | — — — 4          |              | 3.00   |
|        | H - COST OF DRUGS/IV SOLUTION | IC               | · υ            | 22, 213, 320        |                  |              | -      |
| 1 00   |                               |                  | ما             | 22 275 004          | ٥                |              | 1 00   |
| 1. 00  | PHARMACY                      | 1500             | •              | <u>33, 375, 984</u> |                  |              | 1. 00  |
|        | U LABOR AND DELLYSBY COSTS    |                  | 0              | 33, 375, 984        |                  |              | -      |
| 4 0-   | I - LABOR AND DELIVERY COSTS  |                  | 4 4 1          |                     | 1                |              | 4      |
| 1.00   | ADULTS & PEDIATRICS           | 30.00            | 1, 166, 535    | 0                   | 0                |              | 1.00   |
| 2. 00  | DELIVERY ROOM & LABOR ROOM    | 52.00            | 0              | 91, 922             | 0                |              | 2. 00  |
| 3. 00  | L                             |                  | •              | 0                   | 0                |              | 3. 00  |
|        | 0                             |                  | 1, 166, 535    | 91, 922             |                  |              | ╛      |
|        | K - RECOVERY ROOM             |                  |                |                     |                  |              |        |
| 1.00   | RECOVERY ROOM                 | 51.00            | 2, 367, 909    | 502, 322            | 0                |              | 1. 00  |
|        | 0                             | Τ                | 2, 367, 909    | 502, 322            | 7                |              |        |
|        |                               |                  |                |                     |                  |              |        |
|        |                               |                  |                |                     |                  |              |        |

Heal th Financial Systems PORTER REGIONAL HOSPITAL In Lieu of Form CMS-2552-10

RECLASSIFICATIONS Provider CCN: 15-0035 Period: From 01/01/2021 To 12/31/2021 Date/Time Prepared:

|        |                               |           |             |                   |                | 5/30/2022 6: |        |
|--------|-------------------------------|-----------|-------------|-------------------|----------------|--------------|--------|
|        |                               | Decreases |             |                   |                |              |        |
|        | Cost Center                   | Li ne #   | Sal ary     | 0ther             | Wkst. A-7 Ref. |              |        |
|        | 6. 00                         | 7.00      | 8. 00       | 9. 00             | 10. 00         |              |        |
|        | L - OTHER RADIOLOGY COST      |           |             |                   |                |              |        |
| 1.00   | ULTRASOUND                    | 54. 01    | 451, 090    | 54, 537           | 0              |              | 1. 00  |
| 2.00   | RADI OI SOTOPE                | 56.00     | 374, 650    | 692, 262          | 0              |              | 2. 00  |
| 3.00   | CT SCAN                       | 57. 00    | 660, 090    | 123, 699          | 0              |              | 3. 00  |
| 4.00   | MRI                           | 58. 00    | 233, 390    | 24, 430           | 0              |              | 4. 00  |
|        | 0                             |           | 1, 719, 220 | 894, 928          |                |              |        |
|        | M - DIETARY COSTS TO CAFETERI | A         |             |                   |                |              |        |
| 1.00   | DI ETARY                      | 1000      | 960, 887    | 74 <u>6, 2</u> 40 | 0              |              | 1. 00  |
|        | 0                             |           | 960, 887    | 746, 240          |                |              |        |
|        | O - SLEEP LAB COSTS TO EKG    |           |             |                   |                |              |        |
| 1.00   | SLEEP LAB                     | 76. 01    | 287, 708    | 74, 554           | 0              |              | 1. 00  |
|        | 0                             |           | 287, 708    | 74, 554           |                | <u> </u>     |        |
| 500.00 | Grand Total: Decreases        |           | 6, 871, 538 | 86, 863, 748      |                |              | 500.00 |

Provider CCN: 15-0035

|       |   |                  |              | Т               | o 12/31/2021 | Date/Time Pre 5/30/2022 6: 2 |        |
|-------|---|------------------|--------------|-----------------|--------------|------------------------------|--------|
|       |   |                  |              | Acqui si ti ons |              | 0,00,2022 0.2                | O PIII |
|       |   | Begi nni ng      | Purchases    | Donati on       | Total        | Di sposal s and              |        |
|       |   | Bal ances        |              |                 |              | Retirements                  |        |
|       |   | 1.00             | 2. 00        | 3. 00           | 4. 00        | 5. 00                        |        |
|       | PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET | Γ BALANCES       |              |                 |              |                              |        |
| 1.00  | Land  | 2, 949, 373      | 0            | 0               | 0            | 0                            | 1. 00  |
| 2.00  | Land Improvements                             | 3, 517, 751      | 196, 971     | 0               | 196, 971     | 0                            | 2. 00  |
| 3.00  | Buildings and Fixtures                        | 166, 659, 364    | 2, 918       | 0               | 2, 918       | 0                            | 3. 00  |
| 4.00  | Building Improvements                         | 8, 377, 615      | 661, 654     | 0               | 661, 654     | 0                            | 4. 00  |
| 5.00  | Fixed Equipment                               | 6, 942, 820      | 292, 745     | 0               | 292, 745     | 3, 701                       | 5. 00  |
| 6.00  | Movable Equipment                             | 70, 712, 621     | 2, 048, 272  | 0               | 2, 048, 272  | 4, 611, 922                  | 6. 00  |
| 7.00  | HIT designated Assets                         | 17, 287, 906     | 21, 867      | 0               | 21, 867      | 226, 521                     | 7. 00  |
| 8.00  | Subtotal (sum of lines 1-7)                   | 276, 447, 450    | 3, 224, 427  | 0               | 3, 224, 427  | 4, 842, 144                  | 8. 00  |
| 9.00  | Reconciling Items                             | 0                | 0            | 0               | 0            | 0                            | 9. 00  |
| 10.00 | Total (line 8 minus line 9)                   | 276, 447, 450    | 3, 224, 427  | 0               | 3, 224, 427  | 4, 842, 144                  | 10.00  |
|       |   | Endi ng Bal ance | Fully        |                 |              |                              |        |
|       |   |                  | Depreci ated |                 |              |                              |        |
|       |   |                  | Assets       |                 |              |                              |        |
|       |   | 6.00             | 7. 00        |                 |              |                              |        |
|       | PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET |                  |              |                 |              |                              |        |
| 1.00  | Land  | 2, 949, 373      | 0            |                 |              |                              | 1. 00  |
| 2.00  | Land Improvements                             | 3, 714, 722      | 0            |                 |              |                              | 2. 00  |
| 3.00  | Buildings and Fixtures                        | 166, 662, 282    | 0            |                 |              |                              | 3. 00  |
| 4.00  | Building Improvements                         | 9, 039, 269      | 0            |                 |              |                              | 4. 00  |
| 5.00  | Fixed Equipment                               | 7, 231, 864      | 0            |                 |              |                              | 5. 00  |
| 6.00  | Movable Equipment                             | 68, 148, 971     | 0            |                 |              |                              | 6. 00  |
| 7.00  | HIT designated Assets                         | 17, 083, 252     | 0            |                 |              |                              | 7. 00  |
| 8.00  | Subtotal (sum of lines 1-7)                   | 274, 829, 733    | 0            |                 |              |                              | 8. 00  |
| 9.00  | Reconciling Items                             | 0                | 0            |                 |              |                              | 9. 00  |
| 10.00 | Total (line 8 minus line 9)                   | 274, 829, 733    | 0            |                 |              |                              | 10.00  |
|       |   |                  |              |                 |              |                              |        |

| 111-41- | Figure in Contains                            | DODTED DECLON      | IAL HOCDLEAL    |                | 1 - 11 -        | £ F CNC         | 0550 10 |
|---------|---|--------------------|-----------------|----------------|-----------------|-----------------|---------|
|         | Financial Systems                             | PORTER REGION      |                 |                |                 | u of Form CMS-2 |         |
| RECON   | CILIATION OF CAPITAL COSTS CENTERS            |                    | Provi der Co    |                | Peri od:        | Worksheet A-7   |         |
|         |   |                    |                 |                | From 01/01/2021 | Part II         |         |
|         |   |                    |                 |                | To 12/31/2021   | Date/Time Pre   | pared:  |
|         |   |                    |                 | ####B\/ OF OAB | . =             | 5/30/2022 6: 2  | 8 pm    |
|         |   | SUMMARY OF CAPITAL |                 |                |                 |                 |         |
|         |   |                    |                 |                |                 |                 |         |
|         | Cost Center Description                       | Depreciation       | Lease           | Interest       | Insurance (see  |                 |         |
|         |   |                    |                 |                | instructions)   | instructions)   |         |
|         |   | 9. 00              | 10.00           | 11. 00         | 12.00           | 13.00           |         |
| '       | PART II - RECONCILIATION OF AMOUNTS FROM WORK | KSHEET A, COLUM    | IN 2, LINES 1 a | ind 2          |                 |                 |         |
| 1.00    | CAP REL COSTS-BLDG & FLXT                     | 169, 747           | 0               |                | 0 0             | 0               | 1.00    |
| 2.00    | CAP REL COSTS-MVBLE EQUIP                     | 9, 848, 810        | 0               | ,              | 0 0             | 0               | 2. 00   |
| 3.00    | Total (sum of lines 1-2)                      | 10, 018, 557       | 0               | 1              | 0 0             | 0               | 3. 00   |
|         |   | SUMMARY 0          | F CAPITAL       |                |                 |                 |         |
|         |   |                    |                 |                |                 |                 |         |
|         | Cost Center Description                       | Other              | Total (1) (sum  |                |                 |                 |         |
|         |   | Capi tal -Relate   | of cols. 9      |                |                 |                 |         |
|         |   | d Costs (see       | through 14)     |                |                 |                 |         |
|         |   | instructions)      |                 |                |                 |                 |         |
|         |   | 14. 00             | 15. 00          |                |                 |                 |         |
|         | PART II - RECONCILIATION OF AMOUNTS FROM WORK |                    |                 | nd 2           |                 |                 |         |
| 1.00    | CAP REL COSTS-BLDG & FIXT                     | 0                  | 169, 747        |                |                 |                 | 1. 00   |
| 2. 00   | CAP REL COSTS-MVBLE EQUIP                     | 0                  | 9, 848, 810     | 1              |                 |                 | 2.00    |
| 2.00    | T. I. C. C.I. 4.0)                            |                    | 7,040,010       |                |                 |                 | 2.00    |

169, 747 9, 848, 810 10, 018, 557

1. 00 2. 00 3. 00

3.00 Total (sum of lines 1-2)

| Heal th | n Financial Systems                           | PORTER REGION                                  | IAL HOSPITAL      |                      | In Lieu of Form CMS-2552-10                 |  |        |
|---------|---|--|-------------------|----------------------|---|--|--------|
| RECON   | CILIATION OF CAPITAL COSTS CENTERS            |  | Provider C        |                      | Period:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet A-7<br>Part III<br>Date/Time Pre<br>5/30/2022 6:28 | pared: |
|         |   | COMI   | PUTATION OF RA    | TIOS                 | ALLOCATION OF                               | OTHER CAPITAL  |        |
|         | Cost Center Description                       | Gross Assets                                   | Capi tal i zed    | Gross Assets         |   | Insurance  |        |
|         |   |  | Leases            | for Ratio            | instructions)                               |  |        |
|         |   |  |                   | (col . 1 - col<br>2) |   |  |        |
|         |   | 1. 00  | 2.00              | 3.00                 | 4. 00                                       | 5. 00  |        |
|         | PART III - RECONCILIATION OF CAPITAL COSTS CI |  | 2.00              | 0.00                 | 1. 00                                       | 0.00   |        |
| 1.00    | CAP REL COSTS-BLDG & FLXT                     | 182, 365, 647                                  | C                 | 182, 365, 64         | 7 0. 663559                                 | 0  | 1. 00  |
| 2.00    | CAP REL COSTS-MVBLE EQUIP                     | 92, 464, 086                                   | 0                 | 92, 464, 08          | 6 0. 336441                                 | 0  | 2. 00  |
| 3.00    | Total (sum of lines 1-2)                      | 274, 829, 733                                  |                   | 274, 829, 73         |   |  | 3. 00  |
|         |   | ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL |                   |                      |   |  |        |
|         | Cost Center Description                       | Taxes  | Other             | Total (sum of        | Depreciation                                | Lease  |        |
|         |   |  | Capi tal -Rel ate |                      |   |  |        |
|         |   |  | d Costs           | through 7)           | 0.00  | 10.00  |        |
|         | DART III DECONOLILIATION OF CARLTAL COSTS OF  | 6. 00  | 7. 00             | 8. 00                | 9. 00                                       | 10. 00   |        |
| 1. 00   | PART III - RECONCILIATION OF CAPITAL COSTS CI | ENTERS   |                   | 1                    | 0 280, 884                                  | 2, 447, 773  | 1. 00  |
| 2.00    | CAP REL COSTS-BLDG & FIXT                     |  |                   |                      | 0 10, 172, 512                              |  | 2.00   |
| 3.00    | Total (sum of lines 1-2)                      | 0  |                   |                      | 0 10, 172, 312                              |  | 3. 00  |
| 0.00    | Total (Sam of Triles 1 2)                     | J  | SI                | JMMARY OF CAPI       |   | 0, 0, 7, 0,0   | 0.00   |
|         |   |  |                   |                      |   |  |        |
|         | Cost Center Description                       | Interest                                       | Insurance (see    |                      |   | Total (2) (sum   |        |
|         |   |  | instructions)     | instructions)        | Capi tal -Rel ate                           |  |        |
|         |   |  |                   |                      | d Costs (see                                | through 14)  |        |
|         |   | 11.00  | 12.00             | 13.00                | instructions)                               | 15. 00   |        |
|         | PART III - RECONCILIATION OF CAPITAL COSTS CI |  | 12.00             | 13.00                | 14. 00                                      | 15.00  |        |
| 1. 00   | CAP REL COSTS-BLDG & FLXT                     | 729, 098                                       | 479, 001          | 2, 630, 49           | 2 0   | 6, 567, 248  | 1. 00  |
| 2.00    | CAP REL COSTS-MVBLE EQUIP                     | 727,070  |                   |                      | 0 0   |  | 2.00   |
| 3.00    | Total (sum of lines 1-2)                      | 729, 098                                       |                   | •                    | -   | ,,   |        |
|         |   |  |                   |                      | •   |  |        |

In Lieu of Form CMS-2552-10
Worksheet A-8 Provider CCN: 15-0035 | Peri od: | From 01/01/2021 | To 12/31/2021 | Date/Ti me Prepared:

|                  |   |                         |                | To                          | 12/31/2021       | Date/Time Prep<br>5/30/2022 6:28 |                  |
|------------------|---|-------------------------|----------------|-----------------------------|------------------|----------------------------------|------------------|
|                  |   |                         |                | Expense Classification on   |                  |                                  |                  |
|                  |   |                         |                | To/From Which the Amount is | to be Adjusted   |                                  |                  |
|                  |   |                         |                |                             |                  |                                  |                  |
|                  |   |                         |                |                             |                  |                                  |                  |
|                  | Cost Center Description                                     | Basi s/Code (2)<br>1.00 | Amount<br>2.00 | Cost Center<br>3.00         | Li ne #<br>4. 00 | Wkst. A-7 Ref.<br>5.00           |                  |
| 1.00             | Investment income - CAP REL                                 |                         |                | CAP REL COSTS-BLDG & FIXT   | 1. 00            | 0                                | 1. 00            |
| 2.00             | COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL   |                         | 0              | CAP REL COSTS-MVBLE EQUIP   | 2. 00            | 0                                | 2. 00            |
| 3. 00            | COSTS-MVBLE EQUIP (chapter 2) Investment income - other     |                         | 0              |                             | 0. 00            | 0                                | 3. 00            |
|                  | (chapter 2)   |                         | 0              |                             |                  |                                  |                  |
| 4. 00            | Trade, quantity, and time discounts (chapter 8)             |                         | 0              |                             | 0.00             | 0                                | 4. 00            |
| 5. 00            | Refunds and rebates of expenses (chapter 8)                 |                         | 0              |                             | 0. 00            | 0                                | 5. 00            |
| 6.00             | Rental of provider space by                                 |                         | 0              |                             | 0. 00            | 0                                | 6. 00            |
| 7. 00            | suppliers (chapter 8) Telephone services (pay               | А                       | -80, 565       | ADMINISTRATIVE & GENERAL    | 5. 00            | 0                                | 7. 00            |
|                  | stations excluded) (chapter                                 |                         |                |                             |                  |                                  |                  |
| 8. 00            | 21) Television and radio service                            | А                       | -324, 763      | OPERATION OF PLANT          | 7. 00            | 0                                | 8. 00            |
| 9. 00            | (chapter 21) Parking Lot (chapter 21)                       |                         | 0              |                             | 0. 00            | 0                                | 9. 00            |
| 10. 00           | Provi der-based physician                                   | A-8-2                   | -9, 205, 100   |                             | 0.00             | Ö                                | 10. 00           |
| 11. 00           | adjustment<br>Sale of scrap, waste, etc.                    | В                       | 0              | RADI OLOGY-DI AGNOSTI C     | 54. 00           | 0                                | 11. 00           |
| 12. 00           | (chapter 23)<br>Related organization                        | A-8-1                   | 42, 697, 416   |                             |                  | 0                                | 12. 00           |
|                  | transactions (chapter 10)                                   | A-0-1                   | 42,077,410     |                             |                  |                                  |                  |
| 13. 00<br>14. 00 | Laundry and linen service<br>Cafeteria-employees and guests |                         | 0              |                             | 0. 00<br>0. 00   | 0                                | 13. 00<br>14. 00 |
| 15. 00           | Rental of quarters to employee                              |                         | 0              |                             | 0. 00            | 0                                | 15. 00           |
| 16. 00           | and others Sale of medical and surgical                     |                         | 0              |                             | 0.00             | 0                                | 16. 00           |
|                  | supplies to other than patients                             |                         |                |                             |                  |                                  |                  |
| 17. 00           | Sale of drugs to other than                                 |                         | 0              |                             | 0. 00            | 0                                | 17. 00           |
| 18. 00           | patients Sale of medical records and                        | В                       | -229           | MEDICAL RECORDS & LIBRARY   | 16. 00           | 0                                | 18. 00           |
| 19. 00           | abstracts Nursing and allied health                         |                         | 0              |                             | 0. 00            | 0                                | 19. 00           |
| 19.00            | education (tuition, fees,                                   |                         | 0              |                             | 0.00             | J                                | 19.00            |
| 20. 00           | books, etc.)<br>Vending machines                            |                         | 0              |                             | 0. 00            | 0                                | 20. 00           |
| 21. 00           | Income from imposition of                                   |                         | 0              |                             | 0. 00            | 0                                | 21. 00           |
|                  | interest, finance or penalty charges (chapter 21)           |                         |                |                             |                  |                                  |                  |
| 22. 00           | Interest expense on Medicare overpayments and borrowings to |                         | 0              |                             | 0. 00            | 0                                | 22. 00           |
|                  | repay Medicare overpayments                                 |                         | _              |                             |                  |                                  |                  |
| 23. 00           | Adjustment for respiratory therapy costs in excess of       | A-8-3                   | 0              | RESPIRATORY THERAPY         | 65. 00           |                                  | 23. 00           |
| 24. 00           | limitation (chapter 14)<br>Adjustment for physical          | A-8-3                   | ^              | PHYSI CAL THERAPY           | 66. 00           |                                  | 24. 00           |
| ∠4. UU           | therapy costs in excess of                                  | A-0-3                   | U              | INTOINAL THERAFT            | 66. 00           |                                  | 24. UU           |
| 25. 00           | limitation (chapter 14)<br>Utilization review -             |                         | 0              | *** Cost Center Deleted *** | 114. 00          |                                  | 25. 00           |
|                  | physicians' compensation                                    |                         | ·              |                             |                  |                                  |                  |
| 26. 00           | (chapter 21)<br>Depreciation - CAP REL                      | А                       | -286, 505      | CAP REL COSTS-BLDG & FIXT   | 1. 00            | 9                                | 26. 00           |
| 27. 00           | COSTS-BLDG & FIXT Depreciation - CAP REL                    | А                       | -560 090       | CAP REL COSTS-MVBLE EQUIP   | 2. 00            | g                                | 27. 00           |
|                  | COSTS-MVBLE EQUIP   |                         |                |                             |                  | ĺ                                |                  |
| 28. 00<br>29. 00 | Non-physician Anesthetist<br>Physicians' assistant          |                         | 0              | *** Cost Center Deleted *** | 19. 00<br>0. 00  | 0                                | 28. 00<br>29. 00 |
| 30. 00           | Adjustment for occupational therapy costs in excess of      | A-8-3                   | 0              | OCCUPATI ONAL THERAPY       | 67. 00           |                                  | 30. 00           |
|                  | limitation (chapter 14)                                     |                         |                |                             |                  |                                  |                  |
| 30. 99           | Hospice (non-distinct) (see instructions)                   |                         | 0              | ADULTS & PEDIATRICS         | 30. 00           |                                  | 30. 99           |
| 31. 00           | Adjustment for speech                                       | A-8-3                   | 0              | SPEECH PATHOLOGY            | 68. 00           |                                  | 31. 00           |
|                  | pathology costs in excess of limitation (chapter 14)        |                         |                |                             |                  |                                  |                  |
| 32. 00           | CAH HIT Adjustment for Depreciation and Interest            |                         | 0              |                             | 0. 00            | 0                                | 32. 00           |
| 33. 00           | TRAINING REVENUE  | В                       | -15, 902       | NURSING ADMINISTRATION      | 13. 00           | 0                                | 33. 00           |
|                  |   |                         |                |                             |                  |                                  |                  |

|        |                                |       |              |                             | To 12/31/2021  | Date/Time Pre 5/30/2022 6:2 |        |
|--------|--------------------------------|-------|--------------|-----------------------------|----------------|-----------------------------|--------|
|        |                                |       |              | Expense Classification o    | n Worksheet A  |                             |        |
|        |                                |       |              | To/From Which the Amount is | to be Adjusted |                             |        |
|        |                                |       |              |                             |                |                             |        |
|        |                                |       |              |                             |                |                             |        |
|        |                                |       |              |                             |                |                             |        |
|        |                                |       |              |                             | T              |                             |        |
|        | Cost Center Description        |       | Amount       | Cost Center                 | Li ne #        | Wkst. A-7 Ref.              |        |
|        | T                              | 1. 00 | 2. 00        | 3. 00                       | 4. 00          | 5. 00                       |        |
| 33. 01 | MISC. NON PATIENT REVENUE      | В     | ·            | ADMINISTRATIVE & GENERAL    | 5. 00          |                             |        |
| 33. 02 | NON-ALLOWABLE LEGAL FEES       | A     | ·            | ADMINISTRATIVE & GENERAL    | 5. 00          | l .                         | 33. 02 |
| 33. 03 | PATIENT PHONES WAGE COSTS      | A     | ·            | ADMINISTRATIVE & GENERAL    | 5. 00          |                             | 33. 03 |
| 33. 04 | PATIENT PHONES BENEFITS COSTS  | A     | ·            | EMPLOYEE BENEFITS DEPARTMEN |                |                             | 33. 04 |
| 33. 05 | PATIENT PHONE DEPRECIATION     | A     | -184         | CAP REL COSTS-MVBLE EQUIP   | 2.00           | 9                           | 33. 05 |
| 33. 06 | MARKETI NG                     | A     | -790, 200    | ADMINISTRATIVE & GENERAL    | 5. 00          | 0                           | 33. 06 |
| 33. 07 | PHYSICIAN RECRUITING           | A     | -157, 911    | ADMINISTRATIVE & GENERAL    | 5. 00          | 0                           | 33. 07 |
| 33. 08 | LOBBYING EXPENSE IN            | A     | -14, 861     | ADMINISTRATIVE & GENERAL    | 5. 00          | 0                           | 33. 08 |
|        | ASSOCIATION DUES               |       |              |                             |                |                             |        |
| 33. 09 | PENALTI ES                     | A     | -15          | ADMINISTRATIVE & GENERAL    | 5. 00          | 0                           | 33. 09 |
| 33. 10 | DUES & SPECIAL EVENTS          | A     | -151, 364    | ADMINISTRATIVE & GENERAL    | 5.00           | 0                           | 33. 10 |
| 33. 11 | MI NORI TY I NTEREST           | A     | -4, 379, 978 | ADMINISTRATIVE & GENERAL    | 5. 00          | 0                           | 33. 11 |
| 33. 12 | CHARI TY                       | A     | -250         | CAP REL COSTS-MVBLE EQUIP   | 2.00           | 9                           | 33. 12 |
| 33. 16 | SENI OR CIRCLE                 | A     | -1, 120      | ADMINISTRATIVE & GENERAL    | 5. 00          | 0                           | 33. 16 |
| 50.00  | TOTAL (sum of lines 1 thru 49) |       | 26, 570, 050 |                             |                |                             | 50.00  |
|        | (Transfer to Worksheet A,      |       |              |                             |                |                             |        |
|        | column 6, line 200.)           |       |              |                             |                |                             |        |

<sup>(1)</sup> 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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME
OFFICE COSTS

OFFIC

|       |   |                               |                              | 10 12/01/2021   | 5/30/2022 6: 2 |       |
|-------|---|-------------------------------|------------------------------|-----------------|----------------|-------|
|       | Li ne No.   | Cost Center                   | Expense I tems               | Amount of       | Amount         |       |
|       |   |                               |                              | Allowable Cost  |                |       |
|       |   |                               |                              |                 | Wks. A, column |       |
|       |   |                               |                              |                 | 5              |       |
|       | 1. 00   | 2. 00                         | 3. 00                        | 4. 00           | 5. 00          |       |
|       | A. COSTS INCURRED AND ADJUSTM<br>HOME OFFICE COSTS: | MENTS REQUIRED AS A RESULT OF | TRANSACTIONS WITH RELATED OF | RGANIZATIONS OR | CLAI MED       |       |
| 1.00  | 1.00  | CAP REL COSTS-BLDG & FIXT     | NEW CAPITAL - BUILDING & FIX | 379, 148        | 0              | 1.00  |
| 2.00  | 2. 00   | CAP REL COSTS-MVBLE EQUIP     | NEW CAPITAL - MOVABLE EQUIPM | 881, 938        | 0              | 2.00  |
| 3.00  | 5. 00   | ADMINISTRATIVE & GENERAL      | NON-CAPITAL HOME OFFICE COST | 9, 497, 323     | 0              | 3.00  |
| 4.00  | 1.00  | CAP REL COSTS-BLDG & FIXT     | Capital-Related Interest     | 729, 098        | 0              | 4.00  |
| 4.01  | •   | CAP REL COSTS-BLDG & FIXT     | PASI Capital Costs - Bldg &  | 18, 494         |                | 4. 01 |
| 4.02  |   | CAP REL COSTS-MVBLE EQUIP     | PASI Capital Costs - Moveabl | 2, 288          | 0              | 4. 02 |
| 4.03  |   | ADMINISTRATIVE & GENERAL      | PASI Operating Costs         | 1, 567, 749     | 1, 630, 303    | 4. 03 |
| 4.04  | 5. 00   | ADMINISTRATIVE & GENERAL      | Shared Service Center Alloca | 6, 101, 733     | 3, 000, 000    | 4.04  |
| 4.08  | 5. 00   | ADMINISTRATIVE & GENERAL      | Malpractice Costs            | 1, 336, 487     | 1, 532, 446    | 4. 08 |
| 4.09  | 5. 00   | ADMINISTRATIVE & GENERAL      | Interest Expense             | 0               | -39, 717, 223  | 4. 09 |
| 4. 10 |   | ADMINISTRATIVE & GENERAL      | Management Fees              | 0               | 7, 149, 877    | 4. 10 |
| 4. 11 | 5. 00   | ADMINISTRATIVE & GENERAL      | 401K Fees                    | 0               | 4, 400         | 4. 11 |
| 4. 12 | 5. 00   | ADMINISTRATIVE & GENERAL      | Audit Fees                   | 0               | 128, 797       | 4. 12 |
| 4. 13 | 5. 00   | ADMINISTRATIVE & GENERAL      | Corporate Overhead Allocatio | 0               | 2, 723, 225    | 4. 13 |
| 4.14  | 5. 00   | ADMINISTRATIVE & GENERAL      | HIIM Allocation              | 0               | 1, 099, 216    | 4. 14 |
| 4. 15 |   | ADMINISTRATIVE & GENERAL      | Contract Management          | 0               | 109, 205       | 4. 15 |
| 4. 16 | 5. 00   | ADMINISTRATIVE & GENERAL      | PASI Lien Unit Collection Fe | 0               | 156, 596       | 4. 16 |
| 5.00  | TOTALS (sum of lines 1-4).                          |                               |                              | 20, 514, 258    | -22, 183, 158  | 5.00  |
|       | Transfer column 6, line 5 to                        |                               |                              |                 |                |       |
|       | Worksheet A-8, column 2,                            |                               |                              |                 |                |       |
|       | line 12.  |                               |                              |                 |                |       |

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

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

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

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

| 6. 00  | В                       | 0.00 CHS 100.00 | 6.00   |
|--------|-------------------------|-----------------|--------|
| 7.00   |                         | 0.00            | 7.00   |
| 8.00   |                         | 0.00            | 8.00   |
| 9.00   |                         | 0.00            | 9.00   |
| 10.00  |                         | 0.00            | 10.00  |
| 100.00 | G. Other (financial or  |                 | 100.00 |
|        | non-financial) specify: |                 |        |

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

|       |                |                 | 10 12/31/2021  | 5/30/2022 6: 28 pm |
|-------|----------------|-----------------|--|--------------------|
|       | Net            | Wkst. A-7 Ref.  |  |                    |
|       | Adjustments    |                 |  |                    |
|       | (col. 4 minus  |                 |  |                    |
|       | col. 5)*       |                 |  |                    |
|       | 6. 00          | 7. 00           |  |                    |
|       | A. COSTS INCUR | RED AND ADJUSTN | IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR ( | CLAIMED            |
|       | HOME OFFICE CO |                 |  |                    |
| 1.00  | 379, 148       |                 |  | 1. 0               |
| 2.00  | 881, 938       |                 |  | 2. 0               |
| 3.00  | 9, 497, 323    | 0               |  | 3. 0               |
| 4.00  | 729, 098       | 11              |  | 4. 0               |
| 4.01  | 18, 494        | 9               |  | 4. 0               |
| 4.02  | 2, 288         | 9               |  | 4. 0               |
| 4.03  | -62, 554       | 0               |  | 4. 0               |
| 4.04  | 3, 101, 733    | 0               |  | 4. 0               |
| 4.08  | -195, 959      | 0               |  | 4. 0               |
| 4.09  | 39, 717, 223   | 11              |  | 4. 0               |
| 4. 10 | -7, 149, 877   | 0               |  | 4. 1               |
| 4. 11 | -4, 400        | 0               |  | 4. 1               |
| 4. 12 | -128, 797      | 0               |  | 4. 1.              |
| 4. 13 | -2, 723, 225   | 0               |  | 4. 1               |
| 4.14  | -1, 099, 216   | 0               |  | 4. 1               |
| 4. 15 | -109, 205      | 0               |  | 4. 1               |
| 4. 16 | -156, 596      | 0               |  | 4. 1               |
| 5.00  | 42, 697, 416   |                 |  | 5. 0               |
|       |                |                 |  |                    |

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

| Related Organization(s)   |  |  |  |  |  |
|---|--|--|--|--|--|
| and/or Home Office  |  |  |  |  |  |
|   |  |  |  |  |  |
|   |  |  |  |  |  |
| Type of Business  |  |  |  |  |  |
|   |  |  |  |  |  |
| 6. 00   |  |  |  |  |  |
| B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE: |  |  |  |  |  |

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

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

| Termbursement under title AVIII. |             |    |        |  |  |  |  |  |
|----------------------------------|-------------|----|--------|--|--|--|--|--|
| 6.00                             | HOME OFFICE |    | 6. 00  |  |  |  |  |  |
| 7.00                             |             |    | 7.00   |  |  |  |  |  |
| 8.00                             |             |    | 8.00   |  |  |  |  |  |
| 9.00                             |             |    | 9.00   |  |  |  |  |  |
| 10.00                            |             | 1  | 10. 00 |  |  |  |  |  |
| 100.00                           |             | 10 | 00.00  |  |  |  |  |  |

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

| Period: | Worksheet A-8-2 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0035

|                |                                    |                              |                |               | -               | Γο 12/31/2021 | Date/Time Pre 5/30/2022 6:2 |         |
|----------------|------------------------------------|------------------------------|----------------|---------------|-----------------|---------------|-----------------------------|---------|
|                | Wkst. A Line #                     | Cost Center/Physician        | Total          | Professi onal | Provi der       | RCE Amount    | Physi ci an/Prov            | . С р   |
|                |                                    | l denti fi er                | Remuneration   | Component     | Component       |               | ider Component              |         |
|                |                                    |                              |                | · ·           | '               |               | Hours                       |         |
|                | 1. 00                              | 2.00                         | 3. 00          | 4. 00         | 5. 00           | 6. 00         | 7. 00                       |         |
| 1.00           | 30. 00                             | ADULTS & PEDIATRICS          | 1, 781, 091    | 1, 781, 091   | 0               | 0             | 0                           | 1. 00   |
| 2.00           | 31. 00                             | INTENSIVE CARE UNIT          | 763, 789       | 763, 789      | 0               | 0             | 0                           | 2.00    |
| 3.00           | 31. 01                             | NEONATAL INTENSIVE CARE UNIT | 755, 400       |               |                 | 0             | 0                           | 3.00    |
| 4.00           |                                    | OPERATING ROOM               | 396, 052       |               | 0               | 0             | 0                           | 4.00    |
| 5.00           | 52. 00                             | DELIVERY ROOM & LABOR ROOM   | 200, 750       | 200, 750      | 0               | 0             | 0                           | 5.00    |
| 6.00           | 53. 00                             | ANESTHESI OLOGY              | 2, 925, 354    | 2, 925, 354   | 0               | 0             | 0                           | 6.00    |
| 7.00           | 54. 00                             | RADI OLOGY-DI AGNOSTI C      | 403, 905       |               | 0               | 0             | 0                           | 7. 00   |
| 8.00           | 69. 00                             | ELECTROCARDI OLOGY           | 237, 250       | 237, 250      | 0               | 0             | 0                           | 8. 00   |
| 9. 00          | 91. 00                             | EMERGENCY                    | 1, 741, 509    | 1, 741, 509   | 0               | 0             | 0                           | 9. 00   |
| 10.00          | 0. 00                              |                              | 0              | 0             | -               | 0             | 0                           | 10.00   |
| 200.00         |                                    |                              | 9, 205, 100    |               |                 |               | 0                           | 200.00  |
|                | Wkst. A Line #                     | Cost Center/Physician        | Unadjusted RCE |               | Cost of         | Provi der     | Physician Cost              |         |
|                |                                    | l denti fi er                | Li mi t        | ,             | Memberships &   | Component     | of Malpractice              |         |
|                |                                    |                              |                | Limit         | Conti nui ng    | Share of col. | Insurance                   |         |
|                | 1 00                               | 2.00                         | 0.00           | 0.00          | Educati on      | 12            | 44.00                       |         |
| 1 00           | 1.00                               | 2.00<br>ADULTS & PEDIATRICS  | 8.00           | 9.00          | 12.00           | 13.00         | 14.00                       | 1. 00   |
| 1. 00<br>2. 00 |                                    | INTENSIVE CARE UNIT          | 0              | 1             |                 |               | 0                           | 2. 00   |
| 3.00           |                                    | NEONATAL INTENSIVE CARE UNIT | 0              | 0             |                 |               |                             | 3. 00   |
| 4.00           |                                    | OPERATING ROOM               | 0              | 0             | 0               |               |                             | 4. 00   |
| 5.00           |                                    | DELIVERY ROOM & LABOR ROOM   | 0              | 0             | 0               | -             |                             | 5. 00   |
| 6.00           |                                    | ANESTHESI OLOGY              | 0              |               | 0               | -             |                             | 6. 00   |
| 7. 00          |                                    | RADI OLOGY-DI AGNOSTI C      | 0              |               | 0               |               |                             | 7. 00   |
| 8. 00          |                                    | ELECTROCARDI OLOGY           | 0              | 0             | 0               |               | Ö                           | 8. 00   |
| 9. 00          |                                    | EMERGENCY                    | 0              | 0             | 0               |               | Ö                           | 9. 00   |
| 10. 00         | 0.00                               |                              | 0              | 0             | 0               |               | Ö                           | 10. 00  |
| 200.00         | 0.00                               |                              | 0              | 0             | 0               | 0             | Ö                           |         |
|                | Wkst. A Line #                     | Cost Center/Physician        | Provi der      | Adjusted RCE  | RCE             | Adjustment    |                             | 200.00  |
|                |                                    | I denti fi er                | Component      | Limit         | Di sal I owance | .,            |                             |         |
|                |                                    |                              | Share of col.  |               |                 |               |                             |         |
|                |                                    |                              | 14             |               |                 |               |                             |         |
|                | 1. 00                              | 2. 00                        | 15. 00         | 16. 00        | 17. 00          | 18. 00        |                             |         |
| 1.00           |                                    | ADULTS & PEDIATRICS          | 0              | 0             |                 |               |                             | 1.00    |
| 2.00           |                                    | INTENSIVE CARE UNIT          | 0              | 0             |                 |               |                             | 2.00    |
| 3.00           | 31.01 NEONATAL INTENSIVE CARE UNIT |                              | 0              | 0             |                 |               |                             | 3. 00   |
| 4.00           | 50. 00 OPERATI NG ROOM             |                              | 0              | 0             | _               |               |                             | 4. 00   |
| 5. 00          | 52.00 DELIVERY ROOM & LABOR ROOM   |                              | 0              | 0             | _               | ,             |                             | 5. 00   |
| 6. 00          | 53. 00 ANESTHESI OLOGY             |                              | 0              | 0             | _               | _,,           |                             | 6. 00   |
| 7.00           | 54. 00 RADI OLOGY-DI AGNOSTI C     |                              | 0              | 0             |                 | ,             |                             | 7. 00   |
| 8. 00          | 69. 00 ELECTROCARDI OLOGY          |                              | 0              | 0             | _               |               |                             | 8. 00   |
| 9.00           | 91. 00 EMERGENCY                   |                              | 0              | 0             |                 |               |                             | 9. 00   |
| 10.00          | 0. 00                              |                              | 0              | 0             | 0               | 1             |                             | 10.00   |
| 200. 00        |                                    |                              | 0              | 0             | 0               | 9, 205, 100   |                             | 200. 00 |

| Heal th          | Finan   | cial Systems   | PORTER REGIONA               | AL HOSPITAL       |              | In Lie                   | u of Form CMS-2              | <u> 2552-10</u>     |
|------------------|---------|--|------------------------------|-------------------|--------------|--------------------------|------------------------------|---------------------|
| COST A           | ALLOCAT | TION - GENERAL SERVICE COSTS                             |                              | Provi der CO      |              | eriod:<br>rom 01/01/2021 | Worksheet B<br>Part I        |                     |
|                  |         |  |                              |                   |              | o 12/31/2021             | Date/Time Pre                | pared:              |
|                  |         |  |                              | OADLTAL DEL       | ATER COSTS   |                          | 5/30/2022 6: 2               | 8 pm                |
|                  |         |  |                              | CAPI TAL REL      | LATED COSTS  |                          |                              |                     |
|                  |         | Cost Center Description                                  | Net Expenses                 | BLDG & FIXT       | MVBLE EQUIP  | EMPLOYEE                 | Subtotal                     |                     |
|                  |         |  | for Cost                     |                   |              | BENEFITS                 |                              |                     |
|                  |         |  | Allocation                   |                   |              | DEPARTMENT               |                              |                     |
|                  |         |  | (from Wkst A                 |                   |              |                          |                              |                     |
|                  |         |  | col. 7)<br>0                 | 1. 00             | 2.00         | 4. 00                    | 4A                           |                     |
|                  | GENERA  | AL SERVICE COST CENTERS                                  | 0                            | 1.00              | 2.00         | 4.00                     | 4A                           |                     |
| 1.00             |         | CAP REL COSTS-BLDG & FIXT                                | 6, 567, 248                  | 6, 567, 248       |              |                          |                              | 1.00                |
| 2.00             |         | CAP REL COSTS-MVBLE EQUIP                                | 11, 458, 791                 |                   | 11, 458, 791 |                          |                              | 2. 00               |
| 4.00             | 1 .     | EMPLOYEE BENEFITS DEPARTMENT                             | 17, 890, 403                 | 21, 654           | 37, 783      |                          |                              | 4. 00               |
| 5.00             |         | ADMINISTRATIVE & GENERAL                                 | 63, 867, 819                 | 267, 471          | 466, 694     |                          | 66, 608, 892                 | 5. 00               |
| 7.00             |         | OPERATION OF PLANT                                       | 12, 000, 111                 | 1, 462, 728       |              |                          | 16, 395, 068                 |                     |
| 8. 00<br>9. 00   |         | LAUNDRY & LINEN SERVICE<br>HOUSEKEEPING                  | 1, 728, 819<br>3, 141, 760   | 7, 759<br>50, 134 |              |                          | 1, 770, 627<br>3, 576, 258   |                     |
| 10.00            |         | DIETARY  | 1, 354, 076                  | 158, 267          | 276, 150     |                          | 1, 939, 262                  |                     |
| 11. 00           |         | CAFETERI A   | 1, 707, 127                  | 0                 | 270, 100     | I                        | 1, 897, 206                  |                     |
| 13.00            | 1 1     | NURSING ADMINISTRATION                                   | 4, 357, 806                  | 31, 296           | 54, 607      |                          | 5, 233, 419                  |                     |
| 14.00            | 01400   | CENTRAL SERVICES & SUPPLY                                | 1, 930, 838                  | 106, 656          | 186, 097     | 177, 179                 | 2, 400, 770                  |                     |
| 15. 00           |         | PHARMACY   | 3, 232, 113                  | 60, 068           |              |                          | 3, 970, 884                  |                     |
| 16.00            |         | MEDICAL RECORDS & LIBRARY                                | 1, 949, 310                  | 20, 778           |              |                          | 2, 136, 925                  |                     |
| 17. 00           |         | SOCIAL SERVICE ENT ROUTINE SERVICE COST CENTERS          | 1, 784, 593                  | 2, 386            | 4, 163       | 245, 071                 | 2, 036, 213                  | 17. 00              |
| 30. 00           |         | ADULTS & PEDIATRICS                                      | 23, 192, 015                 | 836, 104          | 1, 458, 866  | 3, 009, 742              | 28, 496, 727                 | 30.00               |
| 31. 00           |         | INTENSIVE CARE UNIT                                      | 10, 072, 431                 | 158, 178          |              |                          | 11, 569, 902                 | 1                   |
| 31. 01           |         | NEONATAL INTENSIVE CARE UNIT                             | 2, 469, 961                  | 61, 148           |              |                          | 3, 045, 453                  | 1                   |
| 41.00            | 04100   | SUBPROVIDER - IRF  | 1, 602, 014                  | 107, 605          | 187, 754     | 251, 093                 | 2, 148, 466                  | 41. 00              |
| 43.00            |         | NURSERY  | 734, 488                     | 19, 390           | 33, 832      | 120, 021                 | 907, 731                     | 43. 00              |
| F0 00            |         | LARY SERVICE COST CENTERS                                | 44 400 500                   | F04 744           | 007.000      | 4 (40 54)                | 47.500.757                   | F0 00               |
| 50.00            |         | OPERATING ROOM<br>RECOVERY ROOM                          | 14, 480, 588                 | 531, 744          | 927, 808     | I                        | 17, 580, 656                 |                     |
| 51. 00<br>52. 00 |         | DELIVERY ROOM & LABOR ROOM                               | 2, 854, 788                  | 105, 836          | 184, 667     | - 1                      | 0<br>3, 639, 383             |                     |
| 53. 00           |         | ANESTHESI OLOGY  | 71, 582                      | 9, 179            |              |                          | 96, 778                      |                     |
| 54. 00           |         | RADI OLOGY-DI AGNOSTI C                                  | 10, 057, 393                 | 351, 206          |              | l l                      | 12, 610, 419                 |                     |
| 54. 01           | 05401   | ULTRASOUND   | 0                            | 0                 | C            | o                        | 0                            | 1                   |
| 56. 00           | 1 .     | RADI OI SOTOPE   | 0                            | 0                 | C            | 0                        | 0                            |                     |
| 57. 00           |         | CT SCAN  | 0                            | 0                 | C            | 0                        | 0                            |                     |
| 58. 00<br>60. 00 | 05800   | MRI<br>LABORATORY  | 11, 990, 465                 | 112, 832          | 196, 874     | 1, 065, 838              | 0<br>13, 366, 009            |                     |
| 65. 00           |         | RESPI RATORY THERAPY                                     | 3, 168, 094                  | 25, 858           |              |                          | 3, 631, 641                  |                     |
| 66. 00           |         | PHYSI CAL THERAPY  | 2, 329, 221                  | 145, 492          |              |                          | 3, 141, 689                  |                     |
| 67. 00           |         | OCCUPATI ONAL THERAPY                                    | 815, 636                     | 0                 | · c          | I                        | 965, 873                     |                     |
| 68. 00           |         | SPEECH PATHOLOGY   | 803, 150                     | 0                 | C            | ,                        | 933, 932                     |                     |
| 69. 00           |         | ELECTROCARDI OLOGY                                       | 5, 154, 288                  | 244, 397          | 426, 433     | I                        | 6, 602, 398                  |                     |
| 71. 00<br>72. 00 |         | MEDICAL SUPPLIES CHARGED TO PATIENT                      | 1, 959, 834                  | 0                 |              | 1                        | 1, 959, 834                  |                     |
|                  |         | IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS | 19, 192, 026<br>33, 504, 419 | 0                 |              | l l                      | 19, 192, 026<br>33, 528, 357 |                     |
|                  |         | RENAL DIALYSIS   | 763, 832                     | 5, 340            |              |                          | 778, 490                     |                     |
| 76. 00           |         | ANCI LLARY   | 0                            | 0                 | c            |                          | 0                            | 1                   |
| 76. 01           | 03610   | SLEEP LAB  | O                            | 0                 | C            | o                        | 0                            | 76. 01              |
| 76. 03           |         | WOUND CARE   | 1, 649, 989                  | 55, 661           | 97, 120      | 175, 793                 | 1, 978, 563                  | 76. 03              |
| 00.00            |         | TIENT SERVICE COST CENTERS                               |                              |                   |              |                          |                              | 00.00               |
| 90. 00<br>91. 00 |         | CLI NI C<br>EMERGENCY                                    | 0<br>11, 863, 351            | 0<br>371, 026     | 647, 381     | - 1                      | 0<br>14, 153, 992            |                     |
| 91.00            |         | OBSERVATION BEDS (NON-DISTINCT PART                      | 11,003,331                   | 371,020           | 047, 301     | 1, 272, 234              | 14, 153, 992                 |                     |
| 72.00            |         | AL PURPOSE COST CENTERS                                  |                              |                   |              | 1                        |                              | 72.00               |
| 118.00           |         | SUBTOTALS (SUM OF LINES 1 through 117)                   | 291, 700, 379                | 5, 330, 193       | 9, 300, 329  | 17, 938, 821             | 288, 293, 843                | 118. 00             |
|                  | NONRE   | MBURSABLE COST CENTERS                                   |                              |                   |              |                          |                              |                     |
|                  |         | GIFT, FLOWER, COFFEE SHOP & CANTEEN                      | 59, 669                      | 7, 816            |              |                          | 92, 142                      |                     |
|                  |         | PHYSI CLANS' PRI VATE OFFI CES                           | 0                            | 1, 106, 773       |              | l I                      | 3, 037, 913                  | 1                   |
|                  |         | OTHER NONREIMBURSABLE<br>NONREIMBURSABLE                 | 0                            | 0                 |              | 0                        |                              | 192. 01<br>194. 00  |
|                  | 1 .     | MARKETI NG   | 0                            | 0                 |              |                          |                              | 194. 00             |
|                  |         | SENI OR CI RCLE  |                              | 0                 |              |                          |                              | 194. 02             |
|                  |         | NONREIMB - REGENCY LTC                                   | o                            | 122, 466          | 213, 684     | o                        | 336, 150                     |                     |
|                  |         | VACANT UNFINISHED AREA                                   | 0                            | 0                 | [ c          | 0                        |                              | 194. 04             |
| 200.00           | 1 .     | Cross Foot Adjustments                                   |                              |                   |              |                          |                              | 200.00              |
| 201.00           | 1 1     | Negative Cost Centers                                    | 201 740 040                  | 6 547 340         | 11 4E0 701   | 17 040 040               |                              | 201. 00             |
| 202.00           | ا اد    | TOTAL (sum lines 118 through 201)                        | 291, 760, 048                | 6, 567, 248       | 11, 458, 791 | 17, 949, 840             | 291, 760, 048                | <sub>1</sub> 202.00 |
|                  |         |  |                              |                   |              |                          |                              |                     |

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0035

Peri od: Worksheet B From 01/01/2021 Part I To 12/31/2021 Date/Time Prepared:

5/30/2022 6:28 pm Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 66, 608, 892 5 00 5 00 7.00 00700 OPERATION OF PLANT 4, 850, 333 21, 245, 401 7.00 00800 LAUNDRY & LINEN SERVICE 2, 328, 707 8.00 523.824 34, 256 8.00 9.00 00900 HOUSEKEEPI NG 1,058,004 221, 336 4, 855, 598 9.00 0 01000 DI ETARY 3, 373, 344 10.00 10.00 573, 713 698, 731 0 161, 638 01100 CAFETERI A 561, 271 0 11.00 11.00 0 13 00 01300 NURSING ADMINISTRATION 1,548,260 138, 170 C 31, 963 0 13.00 01400 CENTRAL SERVICES & SUPPLY 108, 928 710, 246 470, 873 9.505 14 00 14 00 0 15.00 01500 PHARMACY 1, 174, 750 265, 195 61, 348 0 15.00 C 16.00 01600 MEDICAL RECORDS & LIBRARY 632, 190 91, 731 0 21, 220 0 16.00 01700 SOCIAL SERVICE 602, 395 10, 535 17.00 17.00 2, 437 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 8, 430, 500 3, 691, 307 814, 488 853, 914 1, 954, 338 30.00 03100 INTENSIVE CARE UNIT 135, 364 31.00 3, 422, 851 698, 337 170, 573 161, 547 31.00 03101 NEONATAL INTENSIVE CARE UNIT 24, 292 23, 256 900, 970 269, 961 62.450 31.01 31.01 04100 SUBPROVIDER - IRF 41.00 635, 604 475, 065 52, 607 109 897 174, 589 41 00 04300 NURSERY 13, 906 43.00 268, 544 85, 604 19,803 43.00 ANCILLARY SERVICE COST CENTERS 4, 310 05000 OPERATING ROOM 5, 201, 079 2, 347, 593 50.00 283, 658 543, 072 50.00 51.00 05100 RECOVERY ROOM 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 1.076.679 467, 254 60, 378 108.090 50, 263 52.00 05300 ANESTHESI OLOGY 9, 375 53.00 28.631 40, 526 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 3, 730, 679 1, 543, 085 238, 785 356, 964 2, 109 54.00 54.01 05401 ULTRASOUND 54.01 C 0 05600 RADI OI SOTOPE 56.00 0 0 0 0 56.00 05700 CT SCAN 0 0 ol 57.00 57.00 C 0 05800 MRI 58.00 0 0 0 58.00 60.00 06000 LABORATORY 3, 954, 213 491, 548 176 113, 710 0 60.00 06500 RESPIRATORY THERAPY 1, 074, 388 65.00 114, 162 26, 409 0 65.00 C 66 00 06600 PHYSI CAL THERAPY 929, 440 642 331 10 474 148 591 66 00 0 06700 OCCUPATIONAL THERAPY 67.00 285, 745 0 67.00 06800 SPEECH PATHOLOGY 276, 295 0 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 1, 953, 260 1, 078, 984 145, 741 249, 603 29, 690 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 579, 799 71.00 C C Λ 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 5, 677, 788 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 9, 919, 016 0 0 73.00 74 00 07400 RENAL DIALYSIS 230, 309 0 74 00 23.578 5 454 0 76.00 03950 ANCI LLARY 0 0 76.00 03610 SLEEP LAB 76.01 76.01 0 76.03 03951 WOUND CARE 79, 563 56, 847 0 76.03 585.340 245.738 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 0 91.00 09100 EMERGENCY 4, 187, 331 1, 638, 041 424, 561 378, 930 120, 775 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 65, 583, 447 15, 783, 941 2, 328, 707 3, 592, 190 2, 494, 694 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 27, 259 34, 507 7. 982 0 190, 00 613, 255 192. 00 898.739 4, 886, 279 0 1, 130, 351 192. 01 19201 OTHER NONREI MBURSABLE 0 192.01 194. 00 07950 NONREI MBURSABLE 0 C 0 0 0 194.00 194. 01 07951 MARKETI NG 0 0 194, 01 0 C 0 0 0 194. 02 194. 02 07952 SENI OR CIRCLE 194. 03 07953 NONREIMB - REGENCY LTC 0 265, 395 194. 03 99, 447 540, 674 125, 075 194. 04 07954 VACANT UNFINISHED AREA 0 0 194. 04 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 66, 608, 892 21, 245, 401 2, 328, 707 4, 855, 598 3, 373, 344 202. 00

Provider CCN: 15-0035

|   |   |                   | 10          | 12/31/2021     | 5/30/2022 6: 2     |                    |
|---|---|-------------------|-------------|----------------|--------------------|--------------------|
| Cost Center Description   | CAFETERI A                              | NURSI NG          | CENTRAL     | PHARMACY       | MEDI CAL           | , p                |
| ·   |   | ADMI NI STRATI ON | SERVICES &  |                | RECORDS &          |                    |
|   |   |                   | SUPPLY      |                | LI BRARY           |                    |
| OFFICE A SERVICE ASSET OFFICE   | 11. 00                                  | 13. 00            | 14.00       | 15. 00         | 16. 00             |                    |
| GENERAL SERVICE COST CENTERS  1.00 O0100 CAP REL COSTS-BLDG & FLXT                        |   |                   |             |                |                    | 1 00               |
| 1.00   00100   CAP REL COSTS-BLDG & FIXT 2.00   00200   CAP REL COSTS-MVBLE EQUIP         |   |                   |             |                |                    | 1. 00<br>2. 00     |
| 4.00   00400   EMPLOYEE BENEFITS DEPARTMENT   |   |                   |             |                |                    | 4. 00              |
| 5. 00   00500 ADMI NI STRATI VE & GENERAL   |   |                   |             |                |                    | 5. 00              |
| 7. 00   00700   OPERATION OF PLANT  |   |                   |             |                |                    | 7. 00              |
| 8. 00 00800 LAUNDRY & LINEN SERVICE   |   |                   |             |                |                    | 8. 00              |
| 9. 00 00900 HOUSEKEEPI NG   |   |                   |             |                |                    | 9. 00              |
| 10. 00 01000 DI ETARY   |   |                   |             |                |                    | 10. 00             |
| 11. 00   01100   CAFETERI A   | 2, 458, 477                             |                   |             |                |                    | 11. 00             |
| 13.00 O1300 NURSING ADMINISTRATION  | 105, 517                                |                   |             |                |                    | 13. 00             |
| 14.00  01400   CENTRAL SERVICES & SUPPLY  | 59, 065                                 |                   | 3, 759, 387 |                |                    | 14. 00             |
| 15. 00   01500   PHARMACY   | 70, 962                                 |                   | 0           | 5, 543, 139    |                    | 15. 00             |
| 16. 00 01600 MEDICAL RECORDS & LIBRARY  | 33, 247                                 |                   | 432         | 0              | 2, 915, 745        | 16.00              |
| 17. 00 01700 SOCIAL SERVICE   | 41, 466                                 | 0                 | 282         | U              | 0                  | 17. 00             |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00 03000 ADULTS & PEDI ATRI CS            | 509, 788                                | 2, 614, 305       | 179, 937    | ol             | 217, 102           | 30.00              |
| 31. 00   03100   NTENSI VE CARE UNIT  | 158, 115                                |                   | · ·         | 0              | 41, 531            | 31.00              |
| 31. 01 03101 NEONATAL INTENSIVE CARE UNIT   | 54, 424                                 |                   |             | 0              | 23, 051            | 31. 01             |
| 41. 00   04100   SUBPROVI DER -   I RF  | 39, 714                                 |                   |             | o              | 13, 588            | 41. 00             |
| 43. 00   04300 NURSERY  | 19, 104                                 |                   |             | o              | 5, 219             | 43.00              |
| ANCILLARY SERVICE COST CENTERS  |   |                   |             |                |                    |                    |
| 50. 00   05000 OPERATING ROOM   | 277, 305                                | 936, 506          | 372, 801    | 0              | 507, 752           | 50. 00             |
| 51. 00   05100   RECOVERY ROOM  | 0                                       | 0                 | 0           | 0              | 0                  | 51. 00             |
| 52. 00   05200   DELI VERY ROOM & LABOR ROOM  | 78, 662                                 | 298, 454          | 29, 633     | 0              | 21, 484            | 52. 00             |
| 53. 00 05300 ANESTHESI OLOGY  | 0 | 0                 | 7, 434      | 0              | 33, 608            | 53.00              |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C<br>54. 01   05401   ULTRASOUND                   | 262, 027                                | 270, 065          | 130, 782    | 0              | 359, 960<br>0      | 54. 00<br>54. 01   |
| 56. 00   05600   RADI 0I SOTOPE   |   |                   | 0           | 0              | 0                  | 56. 00             |
| 57. 00   05700 CT SCAN  |   |                   | 0           | 0              | 0                  | 57. 00             |
| 58. 00   05800 MRI  |   | 0                 | 0           | 0              | 0                  | 58. 00             |
| 60. 00   06000   LABORATORY   | 238, 924                                | 18                | 475, 875    | o              | 336, 058           | 60. 00             |
| 65. 00 06500 RESPIRATORY THERAPY  | 57, 880                                 |                   | · ·         | O              | 71, 363            | 65. 00             |
| 66. 00   06600 PHYSI CAL THERAPY  | 67, 506                                 | 0                 | 2, 770      | 0              | 31, 924            | 66. 00             |
| 67.00 06700 OCCUPATIONAL THERAPY  | 24, 312                                 | 0                 | 30          | 0              | 17, 282            | 67. 00             |
| 68.00 06800 SPEECH PATHOLOGY  | 18, 462                                 |                   | 0           | 0              | 7, 540             | 68. 00             |
| 69. 00 06900 ELECTROCARDI OLOGY   | 125, 262                                |                   |             | 0              | 242, 279           | 69. 00             |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  | 0                                       | -                 | 203, 535    | 0              | 56, 284            | 71.00              |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS   | 0                                       |                   | 1, 993, 162 | U<br>5 542 120 | 225, 638           | 72.00              |
| 73. 00   07300   DRUGS CHARGED TO PATIENTS<br>74. 00   07400   RENAL DIALYSIS             | 2, 295                                  |                   | 0           | 5, 543, 139    | 404, 112<br>5, 922 | 73. 00<br>74. 00   |
| 74. 00   07400   RENAL BLASTS<br>76. 00   03950   ANCI LLARY                              |   |                   | 0           | 0              | 5, 922             | 76.00              |
| 76. 01   03610   SLEEP LAB  |   | 0                 | 0           | 0              | 0                  | 76. 01             |
| 76. 03   03951   WOUND CARE   | 28, 681                                 | 145, 673          | 18, 082     | o              | 15, 906            | 76. 03             |
| OUTPATIENT SERVICE COST CENTERS   |   |                   |             | - 1            |                    |                    |
| 90. 00 09000 CLI NI C   | 0                                       |                   |             | 0              | 0                  | 90. 00             |
| 91. 00 09100 EMERGENCY  | 180, 921                                | 1, 068, 900       | 104, 952    | 0              | 278, 142           | 91. 00             |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART   |   |                   |             |                |                    | 92. 00             |
| SPECIAL PURPOSE COST CENTERS  |   |                   |             |                |                    |                    |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)   | 2, 453, 639                             | 7, 057, 329       | 3, 759, 387 | 5, 543, 139    | 2, 915, 745        | 118. 00            |
| NONREI MBURSABLE COST CENTERS   | 4 020                                   |                   |             | ما             | 0                  | 100.00             |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES | 4, 838                                  |                   | _           | 0              |                    | 190. 00<br>192. 00 |
| 192. 00 19200 PHTSICIANS PRIVATE OFFICES  192. 01 19201 OTHER NONREI MBURSABLE            |   |                   |             | 0              |                    | 192. 00            |
| 194. 00 07950 NONREI MBURSABLE  |   |                   |             | 0              |                    | 194. 00            |
| 194. 01 07951 MARKETI NG  |   | 0                 | 0           | 0              |                    | 194. 01            |
| 194. 02 07952 SENI OR CI RCLE   |   | l ő               | l           | o              |                    | 194. 02            |
| 194. 03 07953 NONREIMB - REGENCY LTC  |   | O                 | o           | ō              |                    | 194. 03            |
| 194. 04 07954 VACANT UNFINISHED AREA  | 0                                       | 0                 | 0           | О              | 0                  | 194. 04            |
| 200.00 Cross Foot Adjustments   |   |                   |             |                |                    | 200. 00            |
| 201.00 Negative Cost Centers  | 0                                       | _ 0               | 0           | 0              |                    | 201. 00            |
| 202.00   TOTAL (sum lines 118 through 201)  | 2, 458, 477                             | 7, 057, 329       | 3, 759, 387 | 5, 543, 139    | 2, 915, 745        | 202. 00            |
|   |   |                   |             |                |                    |                    |

| COST ALLOCATION - GENERAL SERVICE COSTS   |                      | Provi der CC                |                      | eri od:                        | Worksheet B             |                    |
|---|----------------------|-----------------------------|----------------------|--------------------------------|-------------------------|--------------------|
|   |                      |                             | Fi                   | rom 01/01/2021<br>o 12/31/2021 | Part I<br>Date/Time Pre | nared:             |
|   |                      |                             |                      | J 12/31/2021                   | 5/30/2022 6: 2          | 8 pm               |
| Cost Center Description   | SOCI AL SERVI CE     | Subtotal                    | Intern &             | Total                          |                         |                    |
|   |                      |                             | Residents Cost       |                                |                         |                    |
|   |                      |                             | & Post               |                                |                         |                    |
|   |                      |                             | Stepdown             |                                |                         |                    |
|   | 17. 00               | 24. 00                      | Adjustments<br>25.00 | 26. 00                         |                         |                    |
| GENERAL SERVICE COST CENTERS  | 17.00                | 24.00                       | 25.00                | 20.00                          |                         |                    |
| 1.00 00100 CAP REL COSTS-BLDG & FIXT  |                      |                             |                      |                                |                         | 1.00               |
| 2.00 00200 CAP REL COSTS-MVBLE EQUIP  |                      |                             |                      |                                |                         | 2. 00              |
| 4.00   00400 EMPLOYEE BENEFITS DEPARTMENT   |                      |                             |                      |                                |                         | 4. 00              |
| 5.00 00500 ADMINISTRATIVE & GENERAL   |                      |                             |                      |                                |                         | 5. 00              |
| 7. 00 00700 OPERATION OF PLANT  |                      |                             |                      |                                |                         | 7. 00              |
| 8. 00   00800   LAUNDRY & LINEN SERVICE   |                      |                             |                      |                                |                         | 8.00               |
| 9. 00   00900  HOUSEKEEPI NG<br>10. 00   01000  DI ETARY                                    |                      |                             |                      |                                |                         | 9. 00<br>10. 00    |
| 11. 00   01100   CAFETERI A   |                      |                             |                      |                                |                         | 11.00              |
| 13. 00 01300 NURSI NG ADMI NI STRATI ON   |                      |                             |                      |                                |                         | 13. 00             |
| 14.00 01400 CENTRAL SERVICES & SUPPLY   |                      |                             |                      |                                |                         | 14. 00             |
| 15. 00 01500 PHARMACY   |                      |                             |                      |                                |                         | 15. 00             |
| 16.00 01600 MEDICAL RECORDS & LIBRARY   |                      |                             |                      |                                |                         | 16. 00             |
| 17. 00 01700 SOCI AL SERVI CE   | 2, 693, 328          |                             |                      |                                |                         | 17. 00             |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS  |                      |                             |                      |                                |                         |                    |
| 30. 00   03000   ADULTS & PEDI ATRI CS  | 2, 035, 628          | 49, 798, 034                | 0                    | 49, 798, 034                   |                         | 30.00              |
| 31. 00   03100   INTENSI VE CARE UNIT 31. 01   03101   NEONATAL   INTENSI VE CARE UNIT      | 253, 391             | 17, 528, 822                | 0                    | 17, 528, 822                   |                         | 31. 00<br>31. 01   |
| 41. 00   04100   SUBPROVI DER - I RF  | 141, 942<br>159, 207 | 4, 950, 001<br>3, 987, 154  |                      | 4, 950, 001<br>3, 987, 154     |                         | 41.00              |
| 43. 00   04300   NURSERY  | 103, 160             | 1, 430, 281                 | 0                    |                                |                         | 43.00              |
| ANCI LLARY SERVI CE COST CENTERS  | 100, 100             | 1, 100, 201                 | <u> </u>             | 1, 100, 201                    |                         | 10.00              |
| 50. 00 05000 OPERATI NG ROOM  | 0                    | 28, 054, 732                | 0                    | 28, 054, 732                   |                         | 50.00              |
| 51.00   05100   RECOVERY ROOM   | 0                    | 0                           | 0                    | 0                              |                         | 51.00              |
| 52.00   05200   DELIVERY ROOM & LABOR ROOM  | 0                    | 5, 830, 280                 |                      | 5, 830, 280                    |                         | 52.00              |
| 53. 00   05300   ANESTHESI OLOGY  | 0                    | 216, 352                    | 0                    | 216, 352                       |                         | 53. 00             |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C  | 0                    | 19, 504, 875                | 0                    | 19, 504, 875                   |                         | 54.00              |
| 54. 01   05401   ULTRASOUND<br>56. 00   05600   RADI 0I SOTOPE                              | 0                    | 0                           | 0                    | 0                              |                         | 54. 01<br>56. 00   |
| 57. 00   05700 CT SCAN  |                      | 0                           | 0                    | 0                              |                         | 57.00              |
| 58. 00   05800   MRI  |                      | 0                           | 0                    | 0                              |                         | 58.00              |
| 60. 00   06000   LABORATORY   | o                    | 18, 976, 531                | 0                    | 18, 976, 531                   |                         | 60.00              |
| 65. 00 06500 RESPIRATORY THERAPY  | 0                    | 5, 029, 424                 | 0                    | 5, 029, 424                    |                         | 65. 00             |
| 66. 00 06600 PHYSI CAL THERAPY  | 0                    | 4, 974, 725                 |                      | 4, 974, 725                    |                         | 66. 00             |
| 67. 00 06700 OCCUPATI ONAL THERAPY  | 0                    | 1, 293, 242                 |                      | 1, 293, 242                    |                         | 67. 00             |
| 68. 00 06800 SPEECH PATHOLOGY   | 0                    | 1, 236, 229                 |                      | 1, 236, 229                    |                         | 68. 00             |
| 69. 00   06900   ELECTROCARDI OLOGY 71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT | 0                    | 10, 829, 684<br>2, 799, 452 | 0                    | 10, 829, 684<br>2, 799, 452    |                         | 69. 00<br>71. 00   |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS   |                      | 27, 088, 614                | 0                    | 27, 088, 614                   |                         | 72.00              |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS  | o                    | 49, 396, 919                | o o                  | 49, 396, 919                   |                         | 73. 00             |
| 74.00 07400 RENAL DIALYSIS  | o                    | 1, 043, 753                 |                      | 1, 043, 753                    |                         | 74. 00             |
| 76. 00   03950   ANCI LLARY   | 0                    | 0                           | 0                    | 0                              |                         | 76. 00             |
| 76. 01   03610   SLEEP LAB  | 0                    | 0                           | 0                    | 0                              |                         | 76. 01             |
| 76. 03   03951   WOUND CARE   | 0                    | 3, 154, 393                 | 0                    | 3, 154, 393                    |                         | 76. 03             |
| OUTPATIENT SERVICE COST CENTERS   |                      | ٥                           |                      | ٥                              |                         | 00.00              |
| 90. 00   09000   CLI NI C<br>91. 00   09100   EMERGENCY                                     | 0                    | 22, 536, 545                | 0                    |                                |                         | 90. 00<br>91. 00   |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART  |                      | 22, 330, 343                | 0                    | 22, 330, 343                   |                         | 92.00              |
| SPECIAL PURPOSE COST CENTERS  |                      |                             |                      |                                |                         | 72.00              |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)   | 2, 693, 328          | 279, 660, 042               | 0                    | 279, 660, 042                  |                         | 118. 00            |
| NONREI MBURSABLE COST CENTERS   |                      |                             |                      | ,                              |                         |                    |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN  | 0                    | 166, 728                    | 0                    | 166, 728                       |                         | 190. 00            |
| 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES  | 0                    | 10, 566, 537                | 0                    | 10, 566, 537                   |                         | 192. 00            |
| 192. 01 19201 OTHER NONREI MBURSABLE  | 0                    | 0                           | 0                    | 0                              |                         | 192. 01            |
| 194. 00 07950 NONREI MBURSABLE  | 0                    | 0                           | 0                    | 0                              |                         | 194. 00            |
| 194. 01 07951 MARKETI NG<br>194. 02 07952 SENI OR CI RCLE                                   |                      | 0                           |                      | 0                              |                         | 194. 01<br>194. 02 |
| 194. 03 07953  NONREIMB - REGENCY LTC   |                      | 1, 366, 741                 |                      | 1, 366, 741                    |                         | 194. 02            |
| 194. 04 07954 VACANT UNFINISHED AREA  |                      | 0                           | 0                    | ., 555, , 41                   |                         | 194. 04            |
| 200.00 Cross Foot Adjustments   |                      | o                           | o                    | o                              |                         | 200. 00            |
| 201.00 Negative Cost Centers  | 0                    | 0                           | 0                    | o                              |                         | 201. 00            |
| 202.00 TOTAL (sum lines 118 through 201)  | 2, 693, 328          | 291, 760, 048               | 0                    | 291, 760, 048                  |                         | 202. 00            |
|   |                      |                             |                      |                                |                         |                    |

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | From 12/31/2021 | Date/Time Prepared: | From 12/31/2021 | Prepa Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0035

|                  |   |                    |                     | l C          | 12/31/2021          | 5/30/2022 6:2    |                    |
|------------------|---|--------------------|---------------------|--------------|---------------------|------------------|--------------------|
|                  |   |                    | CAPI TAL REI        | LATED COSTS  |                     | 37 307 2022 0. 2 | Dill Dill          |
|                  |   |                    |                     |              |                     |                  |                    |
|                  | Cost Center Description   | Di rectl y         | BLDG & FIXT         | MVBLE EQUIP  | Subtotal            | EMPLOYEE         |                    |
|                  |   | Assi gned New      |                     |              |                     | BENEFI TS        |                    |
|                  |   | Capi tal           |                     |              |                     | DEPARTMENT       |                    |
|                  |   | Related Costs<br>0 | 1. 00               | 2.00         | 2A                  | 4. 00            |                    |
|                  | GENERAL SERVICE COST CENTERS  | 0                  | 1.00                | 2.00         | ZA                  | 4.00             |                    |
|                  | 00100 CAP REL COSTS-BLDG & FLXT   |                    |                     |              |                     |                  | 1.00               |
|                  | 00200 CAP REL COSTS-MVBLE EQUIP   |                    |                     |              |                     |                  | 2. 00              |
| 4.00             | 00400 EMPLOYEE BENEFITS DEPARTMENT  | 0                  | 21, 654             | 37, 783      | 59, 437             | 59, 437          | 4. 00              |
| 5.00             | 00500 ADMINISTRATIVE & GENERAL  | 0                  | 267, 471            | 466, 694     | 734, 165            | 6, 645           | 5. 00              |
| 7.00             | 00700 OPERATION OF PLANT  | 0                  | 1, 462, 728         |              | 4, 014, 950         |                  | 1                  |
| 8.00             | 00800 LAUNDRY & LINEN SERVICE   | 0                  | 7, 759              |              | 21, 297             |                  | 1                  |
| 9.00             | 00900 HOUSEKEEPI NG   | 0                  | 50, 134             |              | 137, 610            |                  | 9. 00              |
| 10.00            | 01000 DI ETARY  | 0                  | 158, 267            |              | 434, 417            | 499              | 1                  |
| 11.00            | 01100 CAFETERI A  | 0                  | 0                   | 1 1          | 0                   | 629              | 11.00              |
| 13. 00<br>14. 00 | 01300   NURSI NG   ADMI NI STRATI ON   01400   CENTRAL   SERVI CES & SUPPLY | 0                  | 31, 296<br>106, 656 |              | 85, 903<br>292, 753 | 2, 615<br>587    | 13. 00<br>14. 00   |
|                  | 01500 PHARMACY  | 0                  | 60, 068             |              | 164, 878            |                  | 1                  |
| 16. 00           | 01600 MEDICAL RECORDS & LIBRARY   | 0                  | 20, 778             |              | 57, 032             |                  | 16.00              |
|                  | 01700 SOCIAL SERVICE  | 0                  | 2, 386              |              | 6, 549              |                  | 1                  |
|                  | I NPATI ENT ROUTI NE SERVI CE COST CENTERS                                  |                    | ,                   |              | -,                  |                  |                    |
| 30.00            | 03000 ADULTS & PEDIATRICS   | 0                  | 836, 104            | 1, 458, 866  | 2, 294, 970         | 9, 970           | 30. 00             |
| 31.00            | 03100 INTENSIVE CARE UNIT   | 0                  | 158, 178            | 275, 994     | 434, 172            | 3, 521           | 31. 00             |
| 31. 01           | 03101 NEONATAL INTENSIVE CARE UNIT  | 0                  | 61, 148             |              | 167, 841            | 1, 350           | 1                  |
|                  | 04100 SUBPROVI DER - I RF   | 0                  | 107, 605            |              | 295, 359            |                  | 41. 00             |
| 43. 00           | 04300 NURSERY   | 0                  | 19, 390             | 33, 832      | 53, 222             | 397              | 43. 00             |
| EO 00            | ANCI LLARY SERVI CE COST CENTERS  05000 OPERATI NG ROOM                     | 0                  | E21 744             | 027 000      | 1, 459, 552         | F 422            | FO 00              |
| 50. 00<br>51. 00 | 05100 RECOVERY ROOM   | 0                  | 531, 744<br>0       |              | 1, 459, 552         | 5, 432<br>0      | 50. 00<br>51. 00   |
|                  | 05200 DELIVERY ROOM & LABOR ROOM  | 0                  | 105, 836            | _            | 290, 503            |                  | 1                  |
| 53. 00           | 05300 ANESTHESI OLOGY   | 0                  | 9, 179              |              | 25, 196             |                  | 53. 00             |
|                  | 05400 RADI OLOGY-DI AGNOSTI C   | 0                  | 351, 206            |              | 964, 005            |                  | 54. 00             |
| 54. 01           | 05401 ULTRASOUND  | 0                  | 0                   | 0            | 0                   | 0                | 54. 01             |
| 56.00            | 05600 RADI OI SOTOPE  | 0                  | 0                   | 0            | 0                   | 0                | 56. 00             |
| 57.00            | 05700 CT SCAN   | 0                  | 0                   | 0            | 0                   | 0                | 57. 00             |
| 58.00            | 05800 MRI   | 0                  | 0                   | 0            | 0                   | 0                | 58. 00             |
| 60.00            | 06000 LABORATORY  | 0                  | 112, 832            |              | 309, 706            |                  | 1                  |
| 65. 00           | 06500 RESPI RATORY THERAPY  | 0                  | 25, 858             |              | 70, 977             | 1, 300           | 1                  |
| 66.00            | 06600 PHYSI CAL THERAPY   | 0                  | 145, 492            |              | 399, 352            |                  | 1                  |
| 67. 00<br>68. 00 | 06700 OCCUPATI ONAL THERAPY   | 0                  | 0                   | 0            | 0                   |                  | 67.00              |
| 69. 00           | 06800   SPEECH PATHOLOGY   06900   ELECTROCARDI OLOGY                       | 0                  | 244, 397            | _            | 670, 830            | 433<br>2, 574    | 68. 00<br>69. 00   |
|                  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                                   | 0                  | 244, 397<br>0       | 420, 433     | 070, 630<br>N       | 2, 3/4           | 71.00              |
| 72.00            | 07200 I MPL. DEV. CHARGED TO PATIENTS                                       | 0                  | 0                   | 0            | 0                   | Ö                | 1                  |
|                  | 07300 DRUGS CHARGED TO PATIENTS   | 0                  | Ö                   | O            | 0                   | 79               |                    |
| 74.00            | 07400 RENAL DIALYSIS  | 0                  | 5, 340              | 9, 318       | 14, 658             | 0                | 74. 00             |
| 76.00            | 03950 ANCI LLARY  | 0                  | 0                   | 0            | 0                   | 0                | 76. 00             |
|                  | 03610 SLEEP LAB   | 0                  | 0                   | 0            | 0                   | -                |                    |
|                  | 03951 WOUND CARE  | 0                  | 55, 661             | 97, 120      | 152, 781            | 582              | 76. 03             |
|                  | OUTPATIENT SERVICE COST CENTERS   |                    |                     | 1 0          |                     |                  | 00.00              |
|                  | 09000 CLI NI C  | 0                  |                     | (47.201      | 1 010 407           | 0                | 1                  |
|                  | O9100  EMERGENCY<br>  O9200  OBSERVATION BEDS (NON-DISTINCT PART            | 0                  | 371, 026            | 647, 381     | 1, 018, 407         | 4, 213           | 91. 00<br>92. 00   |
| 92.00            | SPECIAL PURPOSE COST CENTERS  |                    |                     |              | 0                   |                  | 72.00              |
| 118. 00          |   | 0                  | 5, 330, 193         | 9, 300, 329  | 14, 630, 522        | 59, 401          | 118 00             |
|                  | NONREI MBURSABLE COST CENTERS   |                    | 0,000,170           | 7,000,027    | 11/000/022          | 37, 101          |                    |
| 190.00           | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                                   | 0                  | 7, 816              | 13, 638      | 21, 454             | 36               | 190. 00            |
| 192.00           | 19200 PHYSICIANS' PRIVATE OFFICES   | 0                  | 1, 106, 773         | 1, 931, 140  | 3, 037, 913         | 0                | 192. 00            |
|                  | 19201 OTHER NONREI MBURSABLE  | 0                  | 0                   | 0            | 0                   | 0                | 192. 01            |
|                  | 07950 NONREI MBURSABLE  | 0                  | 0                   | 0            | 0                   |                  | 194. 00            |
|                  | 07951 MARKETI NG  | 0                  | 0                   | 0            | 0                   |                  | 194. 01            |
|                  | 07952 SENI OR CI RCLE   | 0                  | 0                   | 0            | 0                   |                  | 194. 02            |
|                  | 07953 NONREIMB - REGENCY LTC  | 0                  | 122, 466            | 213, 684     | 336, 150            |                  | 194. 03            |
| 194.04           | 07954 VACANT UNFINISHED AREA<br>Cross Foot Adjustments                      | 0                  | 0                   | 0            | 0                   |                  | 194. 04<br>200. 00 |
| 200.00           |   |                    | _                   |              | 0                   |                  | 200.00             |
| 201.00           |   | 0                  | 6, 567, 248         | 11, 458, 791 | 18, 026, 039        |                  | 202. 00            |
| 202.00           | 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -                                     | 1                  | 3,007,240           | , 100, 771   | .5, 525, 557        | 0,, 10,          | ,_02.00            |

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0035

Peri od: Worksheet B From 01/01/2021 Part II To 12/31/2021 Date/Time Prepared:

5/30/2022 6:28 pm Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 740, 810 5 00 5 00 7.00 00700 OPERATION OF PLANT 53, 940 4, 070, 148 7.00 00800 LAUNDRY & LINEN SERVICE 5,825 8.00 6, 563 33, 753 8.00 9.00 00900 HOUSEKEEPI NG 11, 766 42, 403 0 192, 762 9.00 01000 DI ETARY 0 581, 574 10.00 10.00 6.380 133, 861 6, 417 01100 CAFETERI A 6, 242 0 0 11.00 11.00 13 00 01300 NURSING ADMINISTRATION 17, 218 26, 470 0 1, 269 0 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 7.899 90, 209 138 14 00 4.324 0 15.00 01500 PHARMACY 13,064 50, 806 0 2, 435 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 7,030 17, 574 0 842 0 16.00 01700 SOCIAL SERVICE <u>6, 6</u>99 17.00 2,018 97 17.00 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 93, 754 707, 172 11, 806 33, 899 336, 932 30.00 03100 INTENSIVE CARE UNIT 31.00 38,065 133, 786 2, 472 6, 413 23, 337 31.00 03101 NEONATAL INTENSIVE CARE UNIT 2, 479 4, 009 10,020 51, 719 352 31.01 31.01 04100 SUBPROVIDER - IRF 41.00 7.068 91,012 762 4, 363 30, 100 41 00 04300 NURSERY 43.00 43.00 2,986 16, 400 202 786 0 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 743 50.00 57,840 449, 747 4, 111 21, 559 50.00 05100 RECOVERY ROOM 51.00 C 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 89, 516 4, 291 52.00 11, 974 875 8,666 52.00 05300 ANESTHESI OLOGY 318 7, 764 372 53.00 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 41, 488 295, 621 3, 461 14, 171 364 54.00 54.01 05401 ULTRASOUND 0 0 54.01 0 05600 RADI OI SOTOPE 56.00 0 0 0 0 56.00 57.00 05700 CT SCAN 0 0 ol 57.00 0 0 05800 MRI 58.00 0 0 0 0 58.00 60.00 06000 LABORATORY 43, 974 94, 170 3 4, 514 0 60.00 06500 RESPIRATORY THERAPY 65.00 11, 948 21,871 C 1, 048 0 65.00 66 00 06600 PHYSI CAL THERAPY 10 336 123, 056 152 5 899 66 00 0 06700 OCCUPATIONAL THERAPY 67.00 3, 178 0 0 67.00 06800 SPEECH PATHOLOGY 3,073 0 68.00 68.00 C 69.00 06900 ELECTROCARDI OLOGY 21.722 206, 709 2.112 9.909 5.119 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 6, 448 C 0 0 71.00 63, 142 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS C 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 110, 372 0 0 0 73.00 74 00 07400 RENAL DIALYSIS 4 517 0 217 74 00 2 561 0 03950 ANCI LLARY 76.00 0 0 0 76.00 C 03610 SLEEP LAB 0 0 76.01 76.01 C 76.03 03951 WOUND CARE 6,509 47,078 0 76.03 1, 153 257 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00  $\cap$ 91.00 09100 EMERGENCY 46, 567 313, 812 6, 154 15, 043 20, 822 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 729, 406 3, 023, 854 33, 753 142, 604 430, 092 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 190. 00 303 317 6.611 9 995 936, 102 0 44.876 105, 727 192. 00 192. 01 19201 OTHER NONREI MBURSABLE 0 0 192.01 194. 00 07950 NONREI MBURSABLE 0 Ω 0 0 0 194.00 194. 01 07951 MARKETI NG 0 0 194, 01 0 C 0 0 0 194. 02 194. 02 07952 SENI OR CIRCLE 194. 03 07953 NONREIMB - REGENCY LTC 0 45, 755 194. 03 1, 106 103, 581 4, 965 194. 04 07954 VACANT UNFINISHED AREA 0 0 194. 04 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 201.00 202.00 TOTAL (sum lines 118 through 201) 740, 810 4, 070, 148 33, 753 192, 762 581, 574 202. 00 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

| Period: | Worksheet B | From 01/01/2021 | Part II | To | 12/31/2021 | Date/Time Prepared:

|   |                          |                   | To                | 12/31/2021    | Date/Time Pre               |                    |
|---|--------------------------|-------------------|-------------------|---------------|-----------------------------|--------------------|
| Cost Center Description   | CAFETERI A               | NURSI NG          | CENTRAL           | PHARMACY      | 5/30/2022 6: 2:<br>MEDI CAL | 8 piii             |
| oost denter bescriptron   | SALE LEIGH               | ADMI NI STRATI ON | SERVICES &        | 11000001      | RECORDS &                   |                    |
|   |                          |                   | SUPPLY            |               | LI BRARY                    |                    |
| OSUSPAL OSPILLOS COOT OSUSPA  | 11. 00                   | 13. 00            | 14. 00            | 15. 00        | 16. 00                      |                    |
| GENERAL SERVICE COST CENTERS  1.00 O0100 CAP REL COSTS-BLDG & FLX                   | <del>-</del>             |                   |                   |               |                             | 1 00               |
| 1.00   00100   CAP REL COSTS-BLDG & FIX<br>2.00   00200   CAP REL COSTS-MVBLE EQUIT |                          |                   |                   |               |                             | 1. 00<br>2. 00     |
| 4.00 00400 EMPLOYEE BENEFITS DEPARTI  |                          |                   |                   |               |                             | 4.00               |
| 5. 00 00500 ADMINISTRATIVE & GENERAL  | WIEIVI                   |                   |                   |               |                             | 5. 00              |
| 7. 00 00700 OPERATION OF PLANT  |                          |                   |                   |               |                             | 7. 00              |
| 8.00 00800 LAUNDRY & LINEN SERVICE  |                          |                   |                   |               | l                           | 8. 00              |
| 9. 00 00900 HOUSEKEEPI NG   |                          |                   |                   |               |                             | 9. 00              |
| 10. 00   01000 DI ETARY   |                          |                   |                   |               | ļ                           | 10.00              |
| 11. 00   01100   CAFETERI A   | 6, 87                    | 1                 |                   |               |                             | 11. 00             |
| 13. 00 01300 NURSI NG ADMINI STRATI ON  | 29                       |                   | 224 275           |               |                             | 13.00              |
| 14. 00 01400 CENTRAL SERVICES & SUPPL'  | 1                        | 1                 | 396, 075          | 222 201       |                             | 14.00              |
| 15. 00   01500  PHARMACY<br>16. 00   01600  MEDI CAL RECORDS & LI BRAR'             | 19<br>v                  | 3 0               | 0                 | 233, 281<br>0 | 83, 049                     | 15. 00<br>16. 00   |
| 17. 00   01700   MEDICAL RECORDS & LIBRAR   17. 00   01700   SOCIAL SERVICE         | 11                       |                   | 46<br>30          | 0             | 03, 049                     | 17. 00             |
| I NPATI ENT ROUTI NE SERVI CE COST  |                          | <u> </u>          | 30                | ·             | 0                           | 17.00              |
| 30. 00 03000 ADULTS & PEDIATRICS  | 1, 42                    | 49, 556           | 18, 958           | 0             | 6, 244                      | 30.00              |
| 31.00 03100 INTENSIVE CARE UNIT   | 44                       |                   | 7, 968            | 0             | 1, 194                      | 31.00              |
| 31.01 03101 NEONATAL INTENSIVE CARE   |                          |                   | 1, 882            | 0             | 663                         | 31. 01             |
| 41. 00   04100   SUBPROVI DER - I RF  | 11                       | 1 3, 223          | 882               | O             | 391                         | 41.00              |
| 43. 00 04300 NURSERY  |                          | 3 0               | 760               | 0             | 150                         | 43. 00             |
| ANCILLARY SERVICE COST CENTERS  |                          |                   |                   |               |                             |                    |
| 50. 00   05000   0PERATI NG ROOM  | 77                       |                   | 39, 278           | 0             | 13, 797                     | 50.00              |
| 51. 00   05100   RECOVERY ROOM  | OM 25                    | 0 0               | 0                 | 0             | 0                           | 51.00              |
| 52. 00   05200   DELI VERY ROOM & LABOR ROO<br>53. 00   05300   ANESTHESI OLOGY     | OM 22                    | 0 5, 657<br>0 0   | 3, 122<br>783     | 0             | 618<br>967                  | 52. 00<br>53. 00   |
| 54. 00   05400 RADI OLOGY-DI AGNOSTI C  | 73                       | - 1               | 13, 779           | 0             | 10, 352                     | 54. 00             |
| 54. 01   05401   ULTRASOUND   | /5                       | 0 3, 117          | 13, 777           | 0             | 10, 332                     | 54. 01             |
| 56. 00   05600 RADI OI SOTOPE   |                          | ol ol             | 0                 | Ö             | 0                           | 56. 00             |
| 57. 00 05700 CT SCAN  |                          | ol ol             | 0                 | O             | 0                           | 57. 00             |
| 58. 00   05800 MRI  |                          | ol ol             | 0                 | 0             | 0                           | 58. 00             |
| 60. 00   06000   LABORATORY   | 66                       | 8 0               | 50, 138           | 0             | 9, 665                      | 60.00              |
| 65. 00 06500 RESPIRATORY THERAPY  | 16                       | 1                 | 5, 417            | 0             | 2, 052                      | 65. 00             |
| 66. 00   06600   PHYSI CAL THERAPY  | 18                       | 1                 | 292               | 0             | 918                         | 66. 00             |
| 67. 00 06700 OCCUPATI ONAL THERAPY  |                          | 8 0               | 3                 | 0             | 497                         | 67.00              |
| 68. 00 06800 SPEECH PATHOLOGY   | 1                        | 2 0               | 0 244             | 0             | 217                         | 68. 00             |
| 69. 00   06900   ELECTROCARDI OLOGY<br>71. 00   07100   MEDI CAL SUPPLI ES CHARGED  | TO DATI ENT              | 0 6, 127<br>0 0   | 8, 344<br>21, 445 | 0             | 6, 968<br>1, 619            | 69. 00<br>71. 00   |
| 72. 00 07100 MEDICAL SUPPLIES CHARGED TO PA   | 1                        |                   | 209, 985          | 0             | 6, 489                      | 72.00              |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS  | 1                        | 6 0               | 0                 | 233, 281      | 11, 622                     | 73. 00             |
| 74. 00 07400 RENAL DIALYSIS   |                          | ol ol             | 0                 | 0             | 170                         | 74. 00             |
| 76. 00 03950 ANCI LLARY   |                          | ol ol             | 0                 | 0             | 0                           | 76. 00             |
| 76. 01   03610   SLEEP LAB  |                          | 0 0               | 0                 | 0             | 0                           | 76. 01             |
| 76. 03 03951 WOUND CARE   |                          | 0 2, 761          | 1, 905            | 0             | 457                         | 76. 03             |
| OUTPATIENT SERVICE COST CENTER  | S                        | ما ما             | 2                 | al            |                             |                    |
| 90. 00   09000   CLI NI C   |                          | 0 0               | 11 050            | 0             |                             | 90.00              |
| 91. 00   09100   EMERGENCY  | STINCT DART              | 6 20, 260         | 11, 058           | U             | 7, 999                      | 91. 00<br>92. 00   |
| 92. 00   09200   OBSERVATI ON BEDS (NON-DI:<br>SPECIAL PURPOSE COST CENTERS         | STINCT PART              |                   |                   |               |                             | 92.00              |
| 118.00 SUBTOTALS (SUM OF LINES  | 1 through 117) 6,85      | 7 133, 770        | 396, 075          | 233, 281      | 83, 049                     | 118 00             |
| NONREI MBURSABLE COST CENTERS   | 7 till odgil 117)   0,00 | 7 133, 770        | 370, 073          | 255, 261      | 03, 047                     | 1110.00            |
| 190. 00 19000 GIFT, FLOWER, COFFEE SHOP   | P & CANTEEN 1            | 4 0               | 0                 | 0             | 0                           | 190. 00            |
| 192.00 19200 PHYSICIANS' PRIVATE OFFI   |                          | ol ol             | 0                 | 0             | 0                           | 192. 00            |
| 192.01 19201 OTHER NONREIMBURSABLE  |                          | 이                 | 0                 | 0             | 0                           | 192. 01            |
| 194. 00 07950 NONREI MBURSABLE  |                          | 이                 | 0                 | О             |                             | 194. 00            |
| 194. 01 07951 MARKETI NG  |                          | 0 0               | 0                 | 0             |                             | 194. 01            |
| 194. 02 07952 SENI OR CI RCLE   |                          | 이                 | 0                 | 0             |                             | 194. 02            |
| 194. 03 07953 NONREIMB - REGENCY LTC  |                          | 0 0               | 0                 | 0             |                             | 194. 03            |
| 194. 04 07954 VACANT UNFI NI SHED AREA  |                          | 이                 | 0                 | 0             | 01                          | 194. 04            |
| 200.00 Cross Foot Adjustments<br>201.00 Negative Cost Centers                       |                          | ا ا               | 0                 |               | 0                           | 200. 00<br>201. 00 |
| 202.00 TOTAL (sum lines 118 three   | ough 201) 6,87           | 1 133, 770        | 396, 075          | 233, 281      | 83, 049                     |                    |
|   |                          | ., 100, 770       | 370, 070          | 200, 201      | 00, 047                     | 1-02.00            |

| ALLOCA             | ITON OF CAPITAL RELATED COSTS   |                  | Frovider C          |  | Period:<br>From 01/01/2021<br>Fo 12/31/2021 | Part II Date/Time Prepared: |
|--------------------|---|------------------|---------------------|--|---|-----------------------------|
|                    | Cost Center Description   | SOCI AL SERVI CE | Subtotal            | Intern &<br>Residents Cos<br>& Post<br>Stepdown<br>Adjustments | Total<br>t                                  | 5/30/2022 6: 28 pm          |
|                    | OFNEDAL CERVICE COST OFNEDO   | 17. 00           | 24. 00              | 25. 00   | 26. 00                                      |                             |
| 1 00               | GENERAL SERVICE COST CENTERS  |                  |                     |  |   | 1 00                        |
| 1. 00<br>2. 00     | 00100 CAP REL COSTS-BLDG & FIXT<br>00200 CAP REL COSTS-MVBLE EQUIP                |                  |                     |  |   | 1. 00<br>2. 00              |
| 4. 00<br>5. 00     | 00400 EMPLOYEE BENEFITS DEPARTMENT  |                  |                     |  |   | 4.00                        |
| 5. 00<br>7. 00     | OO5OO   ADMINISTRATIVE & GENERAL   OO7OO   OPERATION OF PLANT                     | 1                |                     |  |   | 5. 00<br>7. 00              |
| 8. 00              | 00800 LAUNDRY & LINEN SERVICE   |                  |                     |  |   | 8. 00                       |
| 9. 00              | 00900 HOUSEKEEPI NG   |                  |                     |  |   | 9. 00                       |
| 10.00              | 01000 DI ETARY  |                  |                     |  |   | 10. 00                      |
| 11.00              | 01100 CAFETERI A  |                  |                     |  |   | 11. 00                      |
| 13. 00             | 01300 NURSING ADMINISTRATION  |                  |                     |  |   | 13.00                       |
|                    | 01400 CENTRAL SERVICES & SUPPLY   |                  |                     |  |   | 14. 00                      |
|                    | 01500 PHARMACY  |                  |                     |  |   | 15. 00                      |
|                    | 01600 MEDI CAL RECORDS & LI BRARY   | 1, 200           |                     |  |   | 16.00                       |
| 17. 00             | 01700 SOCI AL SERVI CE  | 16, 320          |                     |  |   | 17. 00                      |
| 30. 00             | INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS                  | 12, 335          | 3, 577, 020         | 1  | 3, 577, 020                                 | 30.00                       |
|                    | 03100 INTENSIVE CARE UNIT   | 1, 535           | 668, 857            | 1  | 668, 857                                    | 31.00                       |
|                    | 03101 NEONATAL INTENSIVE CARE UNIT  | 860              | 248, 650            | 1  | 248, 650                                    | 31. 01                      |
| 41. 00             | 04100 SUBPROVI DER - I RF   | 965              | 435, 067            |  | 435, 067                                    | 41. 00                      |
| 43.00              | 04300 NURSERY   | 625              | 75, 581             | •  | 75, 581                                     | 43.00                       |
|                    | ANCILLARY SERVICE COST CENTERS  |                  |                     |  |   |                             |
| 50.00              | 05000 OPERATING ROOM  | 0                | 2, 070, 585         | 1  | 2, 070, 585                                 | 50.00                       |
|                    | 05100 RECOVERY ROOM   | 0                | 0                   | 1  | 0   | 51.00                       |
|                    | 05200 DELIVERY ROOM & LABOR ROOM  | 0                | 417, 078            | 1  | 417, 078                                    | 52.00                       |
| 53. 00             | 05300 ANESTHESI OLOGY   | 0                | 35, 400             | 1  | 35, 400                                     | 53.00                       |
| 54. 00<br>54. 01   | 05400  RADI OLOGY-DI AGNOSTI C<br>  05401  ULTRASOUND                             |                  | 1, 354, 354         | 1  | 1, 354, 354                                 | 54. 00<br>54. 01            |
| 56. 00             | 05600 RADI OI SOTOPE  |                  | 0                   |  |   | 56. 00                      |
| 57. 00             | 05700 CT SCAN   |                  | 0                   |  |   | 57. 00                      |
| 58. 00             | 05800 MRI   | o                | 0                   |  | 0   | 58.00                       |
| 60.00              | 06000 LABORATORY  | 0                | 516, 367            | ,  | 516, 367                                    | 60.00                       |
| 65.00              | 06500 RESPIRATORY THERAPY   | 0                | 114, 816            |  | 114, 816                                    | 65. 00                      |
| 66.00              | 06600 PHYSI CAL THERAPY   | 0                | 541, 562            | 2  | 0,002                                       | 66. 00                      |
| 67. 00             | 06700 OCCUPATI ONAL THERAPY   | 0                | 4, 243              |  | 4, 243                                      | 67. 00                      |
| 68. 00             | 06800 SPEECH PATHOLOGY  | 0                | 3, 775              |  |   | 68.00                       |
| 69. 00             | 06900 ELECTROCARDI OLOGY  | 0                | 940, 764            |  | 940, 764                                    | 69.00                       |
|                    | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT<br>07200 IMPL. DEV. CHARGED TO PATIENTS | 0                | 29, 512<br>279, 616 |  | 29, 512<br>279, 616                         | 71. 00<br>72. 00            |
|                    | 07300 DRUGS CHARGED TO PATIENTS   |                  | 355, 360            |  |   | 73.00                       |
| 74. 00             | 07400 RENAL DIALYSIS  |                  | 22, 123             |  | 22, 123                                     | 74.00                       |
| 76. 00             | 03950 ANCI LLARY  | 0                | 0                   |  | 0 0   | 76. 00                      |
| 76. 01             | 03610 SLEEP LAB   | O                | 0                   | )  | 0   | 76. 01                      |
| 76. 03             | 03951 WOUND CARE  | 0                | 215, 563            | (  | 215, 563                                    | 76. 03                      |
|                    | OUTPATIENT SERVICE COST CENTERS   |                  |                     |  |   |                             |
|                    | 09000 CLI NI C  | 0                | 0                   | 1  | 0   | 90.00                       |
|                    | 09100 EMERGENCY   | 0                | 1, 464, 841         |  | 1, 464, 841                                 | 91.00                       |
| 92. 00             | 09200 OBSERVATION BEDS (NON-DISTINCT PART   |                  |                     |  |   | 92.00                       |
| 118. 00            | SPECIAL PURPOSE COST CENTERS  SUPPORTALS (SUM OF LINES 1 through 117)             | 16, 320          | 12 271 124          | 1  | 13, 371, 134                                | 118. 00                     |
| 116.00             | SUBTOTALS (SUM OF LINES 1 through 117)   NONREI MBURSABLE COST CENTERS            | 10, 320          | 13, 371, 134        | •  | 13, 3/1, 134                                | 110.00                      |
| 190 00             | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN   | 0                | 28, 735             | ;[   | 28, 735                                     | 190.00                      |
|                    | 19200 PHYSI CI ANS' PRI VATE OFFI CES   | o                | 4, 134, 613         | 1  | 4, 134, 613                                 | 192. 00                     |
|                    | 19201 OTHER NONREI MBURSABLE  | O                | 0                   | )  | 0   | 192. 01                     |
| 194.00             | 07950 NONREI MBURSABLE  | 0                | 0                   | )  | 0   | 194. 00                     |
| 194. 01            | 07951 MARKETI NG  | 0                | 0                   | )  | 0   | 194. 01                     |
|                    | 07952 SENI OR CIRCLE  | 0                | 0                   |  | 0   | 194. 02                     |
|                    | 07953 NONREIMB - REGENCY LTC  | 0                | 491, 557            | []   | 491, 557                                    | 194. 03                     |
|                    | 07954 VACANT UNFI NI SHED AREA  | 0                | 0                   |  |   | 194. 04                     |
| 200. 00<br>201. 00 | 1 1   |                  | 0                   |  |   | 200. 00<br>201. 00          |
| 201.00             | 3   | 16, 320          | 18, 026, 039        | 1  | 0<br>18, 026, 039                           | 202. 00                     |
| 202.00             | 1.01/12 (3diii 111103 110 tili 0dgii 201)   | 10, 520          | 10, 020, 007        | '  | 10, 020, 007                                | 1202.00                     |

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0035 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/30/2022 6:28 pm CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE (SQUARE FEET) (SQUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5A 5. 00 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 809 148 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 809, 148 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 90, 739, 890 4.00 2,668 2,668 00500 ADMINISTRATIVE & GENERAL 10, 145, 325 5 00 32, 955 32, 955 -66, 608, 892 225, 151, 156 5 00 7.00 00700 OPERATION OF PLANT 180, 222 180, 222 1, 921, 011 16, 395, 068 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 956 956 103, 687 1, 770, 627 8.00 00900 HOUSEKEEPI NG 6, 177 6, 177 1,500,828 0 3, 576, 258 9.00 9.00 01000 DI ETARY 10.00 1, 939, 262 762, 166 10 00 19,500 19, 500 11.00 01100 CAFETERI A 960, 887 1, 897, 206 11.00 01300 NURSING ADMINISTRATION 3, 856 3, 992, 143 5, 233, 419 13.00 3,856 0 13.00 01400 CENTRAL SERVICES & SUPPLY 13, 141 895, 675 2, 400, 770 14.00 13.141 14.00 7.401 7, 401 2, 901, 144 3, 970, 884 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 2,560 2, 560 660, 125 0 2, 136, 925 16.00 01700 SOCIAL SERVICE 17.00 294 294 1, 238, 886 2, 036, 213 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 103, 016 103, 016 15, 214, 680 0 28, 496, 727 30.00 19, 489 03100 INTENSIVE CARE UNIT 19, 489 5, 375, 190 0 11, 569, 902 31.00 31.00 31.01 03101 NEONATAL INTENSIVE CARE UNIT 7,534 7, 534 2, 060, 756 0 3, 045, 453 31.01 04100 SUBPROVI DER - I RF 0 2, 148, 466 13, 258 13, 258 1, 269, 328 41.00 41.00 04300 NURSERY 907, 731 43.00 2, 389 2, 389 606, 731 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 65, 516 65, 516 8, 293, 141 17, 580, 656 50.00 51.00 05100 RECOVERY ROOM 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 13,040 13,040 2, 497, 737 3, 639, 383 52.00 05300 ANESTHESI OLOGY 0 53.00 1, 131 1, 131 96, 778 53.00 0 12, 610, 419 54.00 05400 RADI OLOGY-DI AGNOSTI C 43.272 43, 272 8, 032, 825 54.00 54.01 05401 ULTRASOUND 0 C 0 54.01 05600 RADI OI SOTOPE 56.00 0 0 0 0 0 0 0 0 0 0 0 0 56.00 57.00 05700 CT SCAN 0 0 57.00 05800 MRI 58.00  $\cap$ 58 00 60.00 06000 LABORATORY 13, 902 13, 902 5, 388, 026 13, 366, 009 60.00 06500 RESPIRATORY THERAPY 1, 984, 522 3, 631, 641 65.00 3, 186 3, 186 65.00 06600 PHYSI CAL THERAPY 17, 926 2, 088, 383 3, 141, 689 66.00 17, 926 66.00 06700 OCCUPATIONAL THERAPY 759, 476 965, 873 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 661, 128 933, 932 68.00 69.00 06900 ELECTROCARDI OLOGY 30, 112 30, 112 3, 929, 307 6, 602, 398 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1, 959, 834 71 00 C 71 00 0 C 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 C  $\cap$ 19, 192, 026 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 121, 011 33, 528, 357 73.00 07400 RENAL DIALYSIS 0 74.00 658 778, 490 74.00 658 0 03950 ANCI LLARY 76 00 0 76 00 0 0 76.01 03610 SLEEP LAB  $\cap$ 0 76.01 03951 WOUND CARE 6,858 6,858 1, 978, 563 76.03 76.03 888, 671 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0 90 00 91.00 09100 EMERGENCY 45, 714 45, 714 6, 431, 399 14, 153, 992 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 656, 731 656, 731 90, 684, 188 -66, 608, 892 221, 684, 951 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 963 963 55, 702 92, 142 190. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 3, 037, 913 192. 00 0 136, 365 136, 365 0 192. 01 19201 OTHER NONREI MBURSABLE 0 0 0 192. 01 194. 00 07950 NONREI MBURSABLE 0 0 0 194.00 0 C 0 194. 01 07951 MARKETI NG 0 194. 01 0 C 0 0 194. 02 07952 SENI OR CIRCLE 0 194, 02 194. 03 07953 NONREIMB - REGENCY LTC 15,089 15, 089 0 336, 150 194. 03 194. 04 07954 VACANT UNFINISHED AREA 0 194.04 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201. 00 11, 458, 791 202.00 Cost to be allocated (per Wkst. B, 17, 949, 840 66, 608, 892 202. 00 6, 567, 248 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 8. 116251 0.197816 0. 295841 203. 00 14. 161551 740, 810 204. 00 Cost to be allocated (per Wkst. B, 204.00 59, 437 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000655 0.003290 205.00 II)

| Heal th Finar | ncial Systems  | PORTER REGION                | AL HOSPITAL                  |   | In Lie                           | u of Form CMS-2                                 | 2552-10 |
|---------------|--|------------------------------|------------------------------|---|----------------------------------|---|---------|
| COST ALLOCA   | TION - STATISTICAL BASIS                               |                              | Provi der Co                 |   | Peri od:                         | Worksheet B-1                                   |         |
|               |  |                              |                              |   | From 01/01/2021<br>To 12/31/2021 | Date/Time Pre<br>5/30/2022 6:2                  |         |
|               |  | CAPITAL REL                  | LATED COSTS                  |   |                                  |   |         |
|               | Cost Center Description                                | BLDG & FLXT<br>(SQUARE FEET) | MVBLE EQUIP<br>(SQUARE FEET) | EMPLOYEE<br>BENEFITS<br>DEPARTMENT<br>(GROSS<br>SALARIES) | Reconciliation                   | ADMI NI STRATI VE<br>& GENERAL<br>(ACCUM. COST) |         |
|               |  | 1. 00                        | 2. 00                        | 4.00  | 5A                               | 5. 00   |         |
| 206. 00       | NAHE adjustment amount to be allocated (per Wkst. B-2) |                              |                              |   |                                  |   | 206. 00 |
| 207. 00       | NAHE unit cost multiplier (Wkst. D, Parts III and IV)  |                              |                              |   |                                  |   | 207. 00 |

|                                      |                         | cial Systems  | PORTER REGION                          |                                      |                               | In Lie                                   | u of Form CMS-2                          |                                   |
|--------------------------------------|-------------------------|---|--|--------------------------------------|-------------------------------|--|--|-----------------------------------|
| COST A                               | ILLOCAT                 | TION - STATISTICAL BASIS  |  | Provi der Co                         | F                             | eriod:<br>rom 01/01/2021<br>o 12/31/2021 | Worksheet B-1 Date/Time Pre              | pared:                            |
|                                      |                         | Cost Center Description   | OPERATION OF<br>PLANT<br>(SQUARE FEET) | LAUNDRY & LI NEN SERVI CE (POUNDS OF | HOUSEKEEPING<br>(SQUARE FEET) | DI ETARY<br>(MEALS SERVED)               | 5/30/2022 6: 2<br>CAFETERI A<br>(FTE' S) | 28 pm                             |
|                                      |                         |   | 7.00                                   | LAUNDR)<br>8. 00                     | 9.00                          | 10.00                                    | 11. 00                                   |                                   |
|                                      | GENER                   | AL SERVICE COST CENTERS   | 7.00                                   | 0.00                                 | 7.00                          | 10.00                                    | 11.00                                    |                                   |
| 1. 00<br>2. 00<br>4. 00<br>5. 00     | 00100<br>00200<br>00400 | CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL |  |                                      |                               |  |  | 1. 00<br>2. 00<br>4. 00<br>5. 00  |
| 7. 00<br>8. 00<br>9. 00<br>10. 00    | 00800<br>00900<br>01000 | OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY   | 592, 911<br>956<br>6, 177<br>19, 500   | 1, 532, 947<br>0                     | 585, 778<br>19, 500           |  |  | 7. 00<br>8. 00<br>9. 00<br>10. 00 |
| 11. 00<br>13. 00<br>14. 00<br>15. 00 | 01300<br>01400<br>01500 | CAFETERIA NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY                                       | 0<br>3, 856<br>13, 141<br>7, 401       | 6, 257<br>0                          | 3, 856<br>13, 141<br>7, 401   | 0  | 99, 605<br>4, 275<br>2, 393<br>2, 875    | 13. 00<br>14. 00<br>15. 00        |
| 16. 00<br>17. 00                     |                         | MEDICAL RECORDS & LIBRARY<br>SOCIAL SERVICE   | 2, 560<br>294                          | 0                                    | 2, 560<br>294                 |  | 1, 347<br>1, 680                         |                                   |
|                                      | I NPAT                  | IENT ROUTINE SERVICE COST CENTERS   |  |                                      |                               | -  | ,  |                                   |
| 30.00                                | 1                       | ADULTS & PEDIATRICS   | 103, 016                               |                                      |                               |  | 20, 654                                  |                                   |
| 31. 00<br>31. 01                     |                         | INTENSIVE CARE UNIT<br>NEONATAL INTENSIVE CARE UNIT   | 19, 489<br>7, 534                      |                                      | 19, 489<br>7, 534             |  | 6, 406<br>2, 205                         | 1                                 |
| 41. 00                               |                         | SUBPROVI DER - I RF   | 13, 258                                |                                      |                               |  | 1, 609                                   |                                   |
| 43. 00                               |                         | NURSERY   | 2, 389                                 | 9, 154                               | 2, 389                        | 0  | 774                                      | 43.00                             |
| 50. 00                               |                         | LARY SERVICE COST CENTERS OPERATING ROOM  | 65, 516                                | 186, 727                             | 65, 516                       | 278                                      | 11, 235                                  | 50.00                             |
| 51. 00                               |                         | RECOVERY ROOM   | 03,310                                 | 0                                    | 03, 310                       |  | 0  |                                   |
| 52. 00                               |                         | DELIVERY ROOM & LABOR ROOM  | 13, 040                                | 39, 746                              |                               |  | 3, 187                                   |                                   |
| 53. 00<br>54. 00                     |                         | ANESTHESI OLOGY<br>RADI OLOGY-DI AGNOSTI C  | 1, 131<br>43, 064                      | 0<br>157, 188                        | 1, 131<br>43, 064             |  | 0<br>10, 616                             |                                   |
| 54. 00                               |                         | ULTRASOUND  | 43,004                                 | 157, 188                             | 43,004                        | 0  | 10, 010                                  |                                   |
| 56.00                                | 1                       | RADI OI SOTOPE  | 0                                      | 0                                    | C                             | 0  | 0  |                                   |
| 57.00                                |                         | CT SCAN   | 0                                      | 0                                    | C                             | 0  | 0  |                                   |
| 58. 00<br>60. 00                     | 05800                   | MRI<br>LABORATORY   | 13, 718                                | 116                                  | [ 0<br>13, 718                | 0  | 9, 680                                   |                                   |
| 65. 00                               | 1                       | RESPI RATORY THERAPY  | 3, 186                                 | l .                                  | 3, 186                        |  | 2, 345                                   |                                   |
| 66. 00                               |                         | PHYSI CAL THERAPY   | 17, 926                                | 6, 895                               | 17, 926                       |  | 2, 735                                   | 66.00                             |
| 67. 00                               |                         | OCCUPATIONAL THERAPY  | 0                                      | 0                                    | 0                             | 0  | 985                                      |                                   |
| 68. 00<br>69. 00                     |                         | SPEECH PATHOLOGY<br>ELECTROCARDI OLOGY  | 30, 112                                | 95, 939                              | 30, 112                       | 1, 915                                   | 748<br>5. 075                            |                                   |
| 71. 00                               | 1                       | MEDICAL SUPPLIES CHARGED TO PATIENT   | 0                                      | · ·                                  | 00,112                        |  | 0  |                                   |
| 72. 00                               | 1                       | IMPL. DEV. CHARGED TO PATIENTS  | 0                                      | 0                                    | C                             |  | 0  |                                   |
| 73. 00<br>74. 00                     |                         | DRUGS CHARGED TO PATIENTS RENAL DIALYSIS  | 0<br>658                               | 0                                    | C<br>658                      |  | 93<br>0                                  |                                   |
| 76. 00                               |                         | ANCILLARY   | 030                                    |                                      | 030                           |  | 0  |                                   |
|                                      |                         | SLEEP LAB   | 0                                      |                                      |                               |  | 0  |                                   |
| 76. 03                               |                         | WOUND CARE<br>TIENT SERVICE COST CENTERS  | 6, 858                                 | 52, 375                              | 6, 858                        | 0  | 1, 162                                   | 76. 03                            |
| 90. 00                               |                         | CLINIC  | 1 0                                    | 0                                    |                               | ol                                       | 0  | 90.00                             |
| 91.00                                | 09100                   | EMERGENCY   | 45, 714                                | 279, 481                             | 45, 714                       | 7, 790                                   | 7, 330                                   |                                   |
| 92. 00                               |                         | OBSERVATION BEDS (NON-DISTINCT PART   |  |                                      |                               |  |  | 92.00                             |
| 118.00                               |                         | AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)  | 440, 494                               | 1, 532, 947                          | 433, 361                      | 160, 908                                 | 99, 409                                  | 118.00                            |
|                                      |                         | MBURSABLE COST CENTERS  |  | 1 1/11=/                             | ,                             |  | ,  |                                   |
|                                      |                         | GIFT, FLOWER, COFFEE SHOP & CANTEEN   | 963                                    |                                      | 963                           |  |  | 190.00                            |
|                                      |                         | PHYSICIANS' PRIVATE OFFICES OTHER NONREIMBURSABLE   | 136, 365                               | 0                                    | 136, 365                      | 39, 555<br>0                             |  | 192. 00<br>192. 01                |
| 194.00                               | 07950                   | NONREI MBURSABLE  | 0                                      | Ö                                    | Ö                             | o  |  | 194. 00                           |
|                                      |                         | MARKETI NG  | 0                                      | 0                                    | C                             | 0  |  | 194. 01                           |
|                                      | 1                       | SENIOR CIRCLE<br>NONREIMB - REGENCY LTC   | 15, 089                                | 0                                    | 0<br>15, 089                  | 0<br>17, 118                             |  | 194. 02<br>194. 03                |
|                                      |                         | VACANT UNFINISHED AREA  | 13,089                                 | 0                                    | 15,009                        | 0  |  | 194. 04                           |
| 200.00                               |                         | Cross Foot Adjustments  |  |                                      |                               |  |  | 200. 00                           |
| 201. 00<br>202. 00                   |                         | Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)  | 21, 245, 401                           | 2, 328, 707                          | 4, 855, 598                   | 3, 373, 344                              | 2, 458, 477                              |                                   |
| 203. 00<br>204. 00                   | 1                       | Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)                        | 35. 832361<br>4, 070, 148              | l .                                  |                               |  | 24. 682265<br>6, 871                     | 203. 00<br>204. 00                |
| 205.00                               | )                       | Unit cost multiplier (Wkst. B, Part   | 6. 864686                              | 0. 022018                            | 0. 329070                     | 2. 672908                                | 0. 068982                                | 205. 00                           |
| 206. 00                              |                         | NAHE adjustment amount to be allocated (per Wkst. B-2)  |  |                                      |                               |  |  | 206. 00                           |
| 207. 00                              |                         | NAHE unit cost multiplier (Wkst. D,<br>Parts III and IV)  |  |                                      |                               |  |  | 207. 00                           |

| COST A  | LLOCATION - STATISTICAL BASIS  |   | Provider CC                                   |                                 | eriod:<br>rom 01/01/2021<br>o 12/31/2021                | Worksheet B-1 Date/Time Pre                     | pared:  |
|---|--|---|---|---------------------------------|---|---|---|
|   | Cost Center Description  | NURSI NG<br>ADMI NI STRATI ON<br>(NURSI NG WA<br>GES) | CENTRAL SERVI CES & SUPPLY (COSTED REQUI S. ) | PHARMACY<br>(COSTED<br>REQUIS.) | MEDI CAL<br>RECORDS &<br>LI BRARY<br>(GROSS<br>CHARGES) | 5/30/2022 6:2<br>SOCIAL SERVICE<br>(TIME SPENT) |   |
|   |  | 13.00   | 14. 00  | 15. 00                          | 16. 00  | 17. 00  |   |
| 4 00  | GENERAL SERVICE COST CENTERS   |   |   |                                 |   |   | 1   |
| 1. 00<br>2. 00<br>4. 00<br>5. 00<br>7. 00<br>8. 00<br>9. 00<br>11. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00 | 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE | 37, 522, 263<br>0<br>0<br>0<br>0                      | 36, 198, 992<br>0<br>4, 159<br>2, 715         | 33, 414, 725<br>0<br>0          | 2, 395, 331, 076<br>0                                   | 62, 712   | 1. 00<br>2. 00<br>4. 00<br>5. 00<br>7. 00<br>8. 00<br>9. 00<br>11. 00<br>13. 00<br>14. 00<br>15. 00<br>17. 00 |
| 30.00   | 03000 ADULTS & PEDIATRICS  | 13, 899, 712  | 1, 732, 615                                   | 0                               | 178, 390, 957   | 47, 398   | 30.00   |
| 31.00   | 03100 INTENSIVE CARE UNIT  | 4, 474, 533   | 728, 169                                      | 0                               | 34, 125, 600  | 5, 900  |   |
| 31. 01  | 03101 NEONATAL INTENSIVE CARE UNIT   | 2, 054, 077   | 171, 998                                      | 0                               | 18, 941, 053  | 3, 305  |   |
| 41. 00<br>43. 00  | 04100 SUBPROVI DER - I RF<br>04300 NURSERY   | 904, 091  | 80, 614<br>69, 426                            | 0                               | 11, 165, 484<br>4, 288, 096                             | 3, 707<br>2, 402                                |   |
| 10.00   | ANCILLARY SERVICE COST CENTERS   | 9   | 077 120                                       |                                 | 1, 200, 0, 0  | 2/ 102  | ]   |
| 50.00   | 05000 OPERATING ROOM   | 4, 979, 189   | 3, 589, 696                                   | 0                               | 416, 701, 547   | 0   |   |
| 51. 00<br>52. 00  | 05100 RECOVERY ROOM<br>05200 DELIVERY ROOM & LABOR ROOM  | 0<br>1, 586, 813                                      | 0<br>285, 339                                 | 0                               | 0<br>17, 652, 850                                       | 0   |   |
| 53. 00  | 05300 ANESTHESI OLOGY  | 1, 300, 613   | 71, 582                                       | 0                               | 27, 615, 312  | 0   |   |
| 54.00   | 05400 RADI OLOGY-DI AGNOSTI C  | 1, 435, 877   | 1, 259, 295                                   | 0                               | 295, 776, 464   | 0   | 1   |
| 54. 01  | 05401 ULTRASOUND   | 0   | 0   | 0                               | 0   | 0   |   |
| 56. 00<br>57. 00  | 05600 RADI 0I SOTOPE<br>05700 CT SCAN  | 0   | 0   | 0                               | 0   | 0   |   |
| 58. 00  | 05800 MRI  | o   | Ö   | 0                               | Ö   | 0   |   |
| 60.00   | 06000 LABORATORY   | 94  | 4, 582, 196                                   | 0                               | 276, 136, 377   | 0   |   |
| 65. 00<br>66. 00  | 06500 RESPI RATORY THERAPY<br>06600 PHYSI CAL THERAPY  | 11, 493   | 495, 110<br>26, 675                           | 0                               | 58, 638, 402<br>26, 231, 559                            | 0   |   |
| 67. 00  | 06700 OCCUPATI ONAL THERAPY  | 0   | 20, 073                                       | 0                               | 14, 200, 606  | 0   |   |
| 68. 00  | 06800 SPEECH PATHOLOGY   | 0   | 0   | 0                               | 6, 195, 446   | 0   |   |
| 69. 00<br>71. 00  | 06900 ELECTROCARDIOLOGY<br>07100 MEDICAL SUPPLIES CHARGED TO PATIENT   | 1, 718, 773   | 762, 551                                      | 0                               | 199, 078, 951   | 0   |   |
| 71.00   | 07200 IMPL. DEV. CHARGED TO PATIENTS   | 0   | 1, 959, 834<br>19, 192, 026                   | 0                               | 46, 247, 861<br>185, 405, 071                           | 0   |   |
|   | 07300 DRUGS CHARGED TO PATIENTS  | o   | 0   | 33, 414, 725                    |   | 0   |   |
| 74. 00  | 07400 RENAL DI ALYSI S   | 0   | 0   | 0                               | 4, 866, 399   | 0   |   |
| 76. 00<br>76. 01  | 03950 ANCI LLARY<br>03610 SLEEP LAB  | 0   | 0   | 0                               | 0   | 0   |   |
|   | 03951 WOUND CARE   | 774, 511  | 174, 114                                      |                                 | _   |   |   |
|   | OUTPATIENT SERVICE COST CENTERS  | ·   |   |                                 |   |   |   |
| 90.00   | 09000 CLI NI C   | 0   | 1 010 507                                     | 0                               |   | 0   |   |
|   | 09100 EMERGENCY<br>09200 OBSERVATION BEDS (NON-DISTINCT PART   | 5, 683, 100   | 1, 010, 587                                   | 0                               | 228, 547, 369   | 0   | 92.00   |
|   | SPECIAL PURPOSE COST CENTERS   |   |   |                                 |   |   |   |
| 118. 00   |  | 37, 522, 263  | 36, 198, 992                                  | 33, 414, 725                    | 2, 395, 331, 076  | 62, 712   | 118. 00   |
| 190 00  | NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN   | 0   | O   | 0                               | 0   | 0   | 190. 00   |
|   | 19200 PHYSI CI ANS' PRI VATE OFFI CES  | o   | o   | 0                               | 0   | 0   | 192.00  |
|   | 19201 OTHER NONREI MBURSABLE   | 0   | 0   | 0                               | 0   |   | 192. 0  |
|   | 07950 NONREI MBURSABLE<br>07951 MARKETI NG   | 0   | 0   | 0                               | 0   |   | 194. 00<br>194. 0   |
|   | 07952 SENI OR CI RCLE  |   | o   | 0                               | 0   |   | 194. 02   |
|   | 07953 NONREIMB - REGENCY LTC   | O   | o   | 0                               | 0   |   | 194. 03   |
|   | 07954 VACANT UNFINISHED AREA   | 0   | 0   | 0                               | 0   | 0   | 194. 04<br>200. 00  |
| 200.00<br>201.00  |  |   |   |                                 |   |   | 200.00  |
| 202. 00   | Cost to be allocated (per Wkst. B,   | 7, 057, 329   | 3, 759, 387                                   | 5, 543, 139                     | 2, 915, 745   | 2, 693, 328                                     |   |
| 202 00  | Part I)  | 0.100004  | 0 100050                                      | 0 1/5000                        | 0 001047  | 40 047570                                       | 202 00  |
| 203. 00<br>204. 00  |  | 0. 188084<br>133, 770                                 | 0. 103853<br>396, 075                         | 0. 165889<br>233, 281           |   | 42. 947570<br>16, 320                           | 204. 00   |
| 205. 00   |  | 0. 003565   | 0. 010942                                     | 0. 006981                       | 0. 000035   | 0. 260237                                       | 205. 00   |
| 206. 00   | 1 /  |   |   |                                 |   |   | 206. 00   |

| Heal th Financ | cial Systems   | PORTER REGIONA    | AL HOSPITAL  |             | In Lie                      | eu of Form CMS-2               | 2552-10 |
|----------------|--|-------------------|--------------|-------------|-----------------------------|--------------------------------|---------|
| COST ALLOCATI  | ION - STATISTICAL BASIS                                  |                   | Provi der Co | CN: 15-0035 | Peri od:<br>From 01/01/2021 |                                |         |
|                |  |                   |              |             | To 12/31/2021               | Date/Time Pre<br>5/30/2022 6:2 |         |
| (              | Cost Center Description                                  | NURSI NG          | CENTRAL      | PHARMACY    | MEDI CAL                    | SOCIAL SERVICE                 |         |
|                |  | ADMI NI STRATI ON | SERVICES &   | (COSTED     | RECORDS &                   |                                |         |
|                |  |                   | SUPPLY       | REQUIS.)    | LI BRARY                    | (TIME SPENT)                   |         |
|                |  | (NURSING WA       | (COSTED      |             | (GROSS                      |                                |         |
|                |  | GES)              | REQUIS.)     |             | CHARGES)                    |                                |         |
|                |  | 13.00             | 14.00        | 15. 00      | 16.00                       | 17. 00                         |         |
|                | NAHE unit cost multiplier (Wkst. D,<br>Parts III and IV) |                   |              |             |                             |                                | 207. 00 |

Date/Time Prepared: 12/31/2021 5/30/2022 6:28 pm Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 49, 798, 034 30 00 03000 ADULTS & PEDIATRICS 49, 798, 034 49, 798, 034 03100 INTENSIVE CARE UNIT 17, 528, 822 17, 528, 822 0 17, 528, 822 31.00 31.00 03101 NEONATAL INTENSIVE CARE UNIT 0 31.01 4, 950, 001 4, 950, 001 4, 950, 001 31.01 04100 SUBPROVI DER - I RF 3, 987, 154 3, 987, 154 3, 987, 154 0 41.00 41.00 04300 NURSERY 43.00 1, 430, 281 1, 430, 281 1, 430, 281 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 28, 054, 732 28, 054, 732 28, 054, 732 50.00 05100 RECOVERY ROOM 0 51.00 Λ 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 5, 830, 280 5, 830, 280 0 5, 830, 280 52.00 53.00 05300 ANESTHESI OLOGY 216, 352 216, 352 0 216, 352 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 19, 504, 875 19, 504, 875 0 19, 504, 875 54.00 05401 ULTRASOUND 54.01 54.01 0 0 0 56.00 05600 RADI OI SOTOPE 0 0 0 56.00 05700 CT SCAN 0 57.00 0 0 0 0 0 0 0 0 57.00 05800 MRI 58 00 0 0 0 58 00 18, 976, 531 60.00 06000 LABORATORY 18, 976, 531 18, 976, 531 60.00 65.00 06500 RESPIRATORY THERAPY 5, 029, 424 5, 029, 424 5, 029, 424 65.00 06600 PHYSI CAL THERAPY 4, 974, 725 4, 974, 725 66.00 4, 974, 725 66.00 1, 293, 242 06700 OCCUPATIONAL THERAPY 1, 293, 242 1, 293, 242 0 67 00 67 00 68.00 06800 SPEECH PATHOLOGY 1, 236, 229 1, 236, 229 1, 236, 229 68.00 06900 ELECTROCARDI OLOGY 10, 829, 684 69.00 10, 829, 684 0 0 0 10, 829, 684 69.00 2, 799, 452 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 2, 799, 452 2, 799, 452 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 27, 088, 614 27, 088, 614 27, 088, 614 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 49, 396, 919 49, 396, 919 49, 396, 919 73.00 0 07400 RENAL DIALYSIS 74.00 1,043,753 1,043,753 1, 043, 753 74.00 76 00 03950 ANCLLLARY 76.00 0 0 0 76.01 03610 SLEEP LAB 0 0 76.01 03951 WOUND CARE 3, 154, 393 3, 154, 393 3, 154, 393 76.03 76.03 OUTPATIENT SERVICE COST CENTERS 90 00 90 00 09000 CLINIC 0 0 91.00 09100 EMERGENCY 22, 536, 545 22, 536, 545 0 22, 536, 545 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 4, 777, 695 4, 777, 695 4, 777, 695 92.00 284, 437, 737 200. 00 200.00 Subtotal (see instructions) 284, 437, 737 0 284, 437, 737 0 4, 777, 695 201. 00 Less Observation Beds 4, 777, 695 4, 777, 695 201.00

279, 660, 042

279, 660, 042

279, 660, 042 202. 00

202.00

Total (see instructions)

|   |                  |                                  |                               | rom 01/01/2021<br>o 12/31/2021 | Part I<br>Date/Time Pre<br>5/30/2022 6:2 | pared:<br>8 pm |
|---|------------------|----------------------------------|-------------------------------|--------------------------------|--|----------------|
|   |                  | Title                            | XVIII                         | Hospi tal                      | PPS                                      |                |
|   |                  | Charges                          |                               |                                |  |                |
| Cost Center Description   | I npati ent      | Outpati ent                      | Total (col. 6                 | Cost or Other                  | TEFRA                                    |                |
|   |                  |                                  | + col. 7)                     | Ratio                          | Inpati ent                               |                |
|   |                  |                                  |                               |                                | Rati o                                   |                |
|   | 6.00             | 7. 00                            | 8. 00                         | 9. 00                          | 10. 00                                   |                |
| INPATIENT ROUTINE SERVICE COST CENTERS  | 150 440 050      |                                  | 1 450 440 054                 |                                |  |                |
| 30. 00 03000 ADULTS & PEDI ATRI CS  | 159, 168, 252    |                                  | 159, 168, 252                 |                                |  | 30.00          |
| 31. 00   03100   INTENSIVE CARE UNIT  | 34, 125, 600     |                                  | 34, 125, 600                  |                                |  | 31.00          |
| 31. 01   03101   NEONATAL   INTENSIVE CARE UNIT                               | 18, 941, 053     |                                  | 18, 941, 053                  |                                |  | 31. 01         |
| 41. 00   04100   SUBPROVI DER -   RF  | 11, 165, 484     |                                  | 11, 165, 484                  |                                |  | 41.00          |
| 43. 00   04300   NURSERY  | 4, 288, 096      |                                  | 4, 288, 096                   |                                |  | 43. 00         |
| ANCILLARY SERVICE COST CENTERS  | 450 400 007      | 0/0 0/0 7/0                      | 144 704 54                    | 0.047004                       | 0.00000                                  |                |
| 50. 00   05000   OPERATING ROOM   | 153, 432, 807    | 263, 268, 740                    |                               |                                | 0.000000                                 |                |
| 51. 00 05100 RECOVERY ROOM  | 0                | 0                                | 1                             | 0.00000                        | 0. 000000                                |                |
| 52. 00 05200 DELIVERY ROOM & LABOR ROOM                                       | 17, 623, 123     | 29, 727                          |                               |                                | 0. 000000                                |                |
| 53. 00 05300 ANESTHESI OLOGY  | 10, 328, 734     | 17, 286, 578                     |                               |                                | 0. 000000                                |                |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C  | 71, 565, 964     | 224, 210, 500                    | 295, 776, 464                 |                                | 0. 000000                                |                |
| 54. 01   05401   ULTRASOUND   | 0                | 0                                |                               | 0.000000                       | 0. 000000                                |                |
| 56. 00   05600   RADI OI SOTOPE   | 0                | 0                                |                               | 0.000000                       | 0. 000000                                |                |
| 57. 00 05700 CT SCAN  | 0                | 0                                |                               | 0.000000                       | 0. 000000                                |                |
| 58. 00   05800   MRI  | 122 500 070      | 150 545 200                      | 07/ 10/ 07                    | 0.000000                       | 0.000000                                 |                |
| 60. 00 06000 LABORATORY   | 123, 590, 978    | 152, 545, 399                    |                               |                                | 0. 000000                                |                |
| 65. 00 06500 RESPI RATORY THERAPY   | 55, 825, 174     | 2, 813, 228                      |                               |                                | 0.000000                                 |                |
| 66. 00 06600 PHYSI CAL THERAPY  | 16, 356, 184     | 9, 875, 375                      |                               |                                | 0. 000000                                |                |
| 67. 00 06700 OCCUPATI ONAL THERAPY  | 12, 376, 900     | 1, 823, 706                      |                               |                                | 0. 000000                                |                |
| 68. 00 06800 SPEECH PATHOLOGY   | 4, 327, 407      | 1, 868, 039                      |                               |                                | 0. 000000                                |                |
| 69. 00 06900 ELECTROCARDI OLOGY   | 74, 780, 637     | 124, 298, 314                    |                               |                                | 0.000000                                 |                |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                              | 25, 077, 894     | 21, 169, 967                     |                               |                                | 0. 000000                                |                |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS                                   | 100, 865, 109    | 84, 539, 962                     |                               |                                | 0.000000                                 |                |
| 73. 00   07300   DRUGS CHARGED TO PATIENTS<br>74. 00   07400   RENAL DIALYSIS | 88, 049, 907     | 244, 006, 122                    |                               |                                | 0.000000                                 |                |
|   | 4, 762, 906      | 103, 493                         | 4, 866, 399                   |                                | 0.000000                                 |                |
| 76. 00   03950   ANCI LLARY   | 0                | 0                                |                               | 0.00000                        | 0. 000000                                |                |
| 76. 01   03610   SLEEP LAB  | (02.704          | 10 07/ 050                       | 12.0(0.44)                    | 0.000000                       | 0.000000                                 |                |
| 76. 03 03951 WOUND CARE   | 692, 784         | 12, 376, 859                     | 13, 069, 643                  | 0. 241353                      | 0. 000000                                | 76. 03         |
| OUTPATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC                          | 0                | 0                                |                               | 0.000000                       | 0.000000                                 | 90.00          |
| 90. 00   09000   CLI NI C<br>91. 00   09100   EMERGENCY                       | 82, 025, 080     | 0<br>146, 522, 289               | 1                             | 0.00000                        | 0. 000000<br>0. 000000                   |                |
| 92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART                          |                  |                                  |                               |                                | 0. 000000                                |                |
| 200.00 Subtotal (see instructions)  | 6, 977, 842      | 12, 244, 863<br>1, 318, 983, 161 |                               |                                | 0.000000                                 | 200.00         |
| 201.00   Subtotal (see Instructions)<br>201.00   Less Observation Beds        | 1,076,347,915    | 1, 318, 983, 161                 | 2, 393, 331, 0/6              | ]                              |  | 200.00         |
| 202.00 Total (see instructions)   | 1, 076, 347, 915 | 1 210 002 141                    | 2 205 221 074                 |                                |  | 201.00         |
| 202.00   TOTAL (SEE THISTI UCTIONS)   | 1,070,347,915    | 1, 310, 703, 101                 | ∠, 3 <del>9</del> 3, 331, 0/6 | ۱ ا                            |  | 1202.00        |

| Health Financial Systems                 | PORTER REGIONAL HOSPITAL | In Lie          | u of Form CMS-2552-10                  |
|--|--------------------------|-----------------|--|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15         | From 01/01/2021 | Worksheet C Part I Date/Time Prepared: |

|   |               |             | 10 12/31/2021 | Date/lime Prepared:<br>5/30/2022 6:28 pm |
|---|---------------|-------------|---------------|--|
|   |               | Title XVIII | Hospi tal     | PPS                                      |
| Cost Center Description                         | PPS Inpatient |             |               |  |
|   | Ratio         |             |               |  |
|   | 11. 00        |             |               |  |
| INPATIENT ROUTINE SERVICE COST CENTERS          |               |             |               |  |
| 30. 00   03000   ADULTS & PEDI ATRI CS          |               |             |               | 30.00                                    |
| 31.00  03100   INTENSIVE CARE UNIT              |               |             |               | 31.00                                    |
| 31.01  03101 NEONATAL INTENSIVE CARE UNIT       |               |             |               | 31. 01                                   |
| 41. 00   04100   SUBPROVI DER - I RF            |               |             |               | 41.00                                    |
| 43. 00 04300 NURSERY                            |               |             |               | 43. 00                                   |
| ANCI LLARY SERVI CE COST CENTERS                |               |             |               |  |
| 50.00   05000   OPERATING ROOM                  | 0. 067326     |             |               | 50. 00                                   |
| 51.00 05100 RECOVERY ROOM                       | 0. 000000     |             |               | 51. 00                                   |
| 52.00   05200   DELIVERY ROOM & LABOR ROOM      | 0. 330274     |             |               | 52. 00                                   |
| 53. 00   05300   ANESTHESI OLOGY                | 0. 007834     |             |               | 53. 00                                   |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C        | 0. 065945     |             |               | 54. 00                                   |
| 54. 01   05401   ULTRASOUND                     | 0. 000000     |             |               | 54. 01                                   |
| 56. 00   05600   RADI 0I SOTOPE                 | 0. 000000     |             |               | 56. 00                                   |
| 57. 00  05700 CT SCAN                           | 0. 000000     |             |               | 57. 00                                   |
| 58. 00   05800   MRI                            | 0. 000000     |             |               | 58. 00                                   |
| 60. 00   06000   LABORATORY                     | 0. 068722     |             |               | 60.00                                    |
| 65. 00   06500   RESPI RATORY THERAPY           | 0. 085770     |             |               | 65. 00                                   |
| 66. 00  06600 PHYSI CAL THERAPY                 | 0. 189647     |             |               | 66. 00                                   |
| 67. 00 06700 OCCUPATI ONAL THERAPY              | 0. 091069     |             |               | 67. 00                                   |
| 68. 00   06800   SPEECH PATHOLOGY               | 0. 199538     |             |               | 68. 00                                   |
| 69. 00   06900   ELECTROCARDI OLOGY             | 0. 054399     |             |               | 69. 00                                   |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0. 060531     |             |               | 71. 00                                   |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS      | 0. 146105     |             |               | 72. 00                                   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS           | 0. 148761     |             |               | 73. 00                                   |
| 74.00   07400   RENAL DIALYSIS                  | 0. 214482     |             |               | 74. 00                                   |
| 76. 00   03950   ANCI LLARY                     | 0. 000000     |             |               | 76. 00                                   |
| 76. 01   03610   SLEEP LAB                      | 0. 000000     |             |               | 76. 01                                   |
| 76. 03 03951 WOUND CARE                         | 0. 241353     |             |               | 76. 03                                   |
| OUTPATIENT SERVICE COST CENTERS                 |               |             |               |  |
| 90. 00 09000 CLINIC                             | 0. 000000     |             |               | 90. 00                                   |
| 91. 00   09100   EMERGENCY                      | 0. 098608     |             |               | 91. 00                                   |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0. 248544     |             |               | 92. 00                                   |
| 200.00 Subtotal (see instructions)              |               |             |               | 200. 00                                  |
| 201.00 Less Observation Beds                    |               |             |               | 201. 00                                  |
| 202.00   Total (see instructions)               |               |             |               | 202. 00                                  |

|                  |   |                             | Trovider ex   |                           |                 | Part I<br>Date/Time Prepared:<br>5/30/2022 6:28 pm |         |
|------------------|---|-----------------------------|---------------|---------------------------|-----------------|--|---------|
|                  |   |                             | Ti tl         | e XIX                     | Hospi tal       | Cost   |         |
|                  |   |                             |               |                           | Costs           | I  |         |
|                  | Cost Center Description                       | Total Cost                  | Therapy Limit | Total Costs               | RCE             | Total Costs  |         |
|                  |   | (from Wkst. B,              | Adj .         |                           | Di sal I owance |  |         |
|                  |   | Part I, col.                |               |                           |                 |  |         |
|                  |   | 26)<br>1. 00                | 2.00          | 3. 00                     | 4. 00           | 5. 00  |         |
|                  | INPATIENT ROUTINE SERVICE COST CENTERS        | 1.00                        | 2.00          | 3.00                      | 4.00            | 5.00   |         |
| 30. 00           | 03000 ADULTS & PEDI ATRI CS                   | 49, 798, 034                |               | 49, 798, 03               | 4 0             | 49, 798, 034                                       | 30.00   |
| 31. 00           | 03100   NTENSI VE CARE UNI T                  | 17, 528, 822                |               | 17, 528, 82               |                 |  |         |
| 31. 01           | 03101 NEONATAL INTENSIVE CARE UNIT            | 4, 950, 001                 |               | 4, 950, 00                |                 |  | 31. 01  |
| 41. 00           | 04100 SUBPROVI DER - I RF                     | 3, 987, 154                 |               | 3, 987, 15                |                 |  |         |
| 43. 00           | 04300 NURSERY                                 | 1, 430, 281                 |               | 1, 430, 28                |                 |  | 43. 00  |
|                  | ANCILLARY SERVICE COST CENTERS                | ,                           |               | ,                         |                 | , , , , , ,  |         |
| 50.00            | 05000 OPERATI NG ROOM                         | 28, 054, 732                |               | 28, 054, 73               | 2 0             | 28, 054, 732                                       | 50.00   |
| 51.00            | 05100 RECOVERY ROOM                           | o                           |               |                           | 0               | 0  | 51.00   |
| 52.00            | 05200 DELIVERY ROOM & LABOR ROOM              | 5, 830, 280                 |               | 5, 830, 28                | 0 0             | 5, 830, 280  | 52.00   |
| 53.00            | 05300 ANESTHESI OLOGY                         | 216, 352                    |               | 216, 35                   | 2 0             | 216, 352   | 53.00   |
| 54.00            | 05400 RADI OLOGY-DI AGNOSTI C                 | 19, 504, 875                |               | 19, 504, 87               | 5 0             | 19, 504, 875                                       | 54.00   |
| 54. 01           | 05401 ULTRASOUND                              | 0                           |               |                           | 0               | 0  | 54. 01  |
| 56.00            | 05600 RADI OI SOTOPE                          | 0                           |               |                           | 0               | 0  | 56. 00  |
| 57.00            | 05700 CT SCAN                                 | 0                           |               |                           | 0               | 0  | 57. 00  |
| 58. 00           | 05800  MRI                                    | 0                           |               |                           | 0               | 0  | 58. 00  |
| 60.00            | 06000 LABORATORY                              | 18, 976, 531                |               | 18, 976, 53               | 1 0             | 18, 976, 531                                       | 60.00   |
| 65. 00           | 06500 RESPI RATORY THERAPY                    | 5, 029, 424                 | 0             | 5, 029, 42                |                 |  |         |
| 66. 00           | 06600 PHYSI CAL THERAPY                       | 4, 974, 725                 | 0             | 4, 974, 72                |                 | 4, 974, 725  |         |
| 67. 00           | 06700 OCCUPATI ONAL THERAPY                   | 1, 293, 242                 | 0             | 1, 293, 24                |                 | .,,  |         |
| 68. 00           | 06800 SPEECH PATHOLOGY                        | 1, 236, 229                 | 0             | 1, 236, 22                |                 | .,,  |         |
| 69. 00           | 06900 ELECTROCARDI OLOGY                      | 10, 829, 684                |               | 10, 829, 68               |                 |  |         |
| 71. 00           | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT     | 2, 799, 452                 |               | 2, 799, 45                |                 | _, ,   |         |
| 72.00            | 07200 I MPL. DEV. CHARGED TO PATIENTS         | 27, 088, 614                |               | 27, 088, 61               |                 |  |         |
| 73. 00           | 07300 DRUGS CHARGED TO PATIENTS               | 49, 396, 919                |               | 49, 396, 91               |                 | 1,,0,0,,,,   |         |
| 74. 00           | 07400 RENAL DIALYSIS                          | 1, 043, 753                 |               | 1, 043, 75                |                 | ., ,   |         |
| 76. 00           | 03950 ANCI LLARY                              | 0                           |               |                           | 0               | _  | 76. 00  |
| 76. 01           | 03610 SLEEP LAB                               | 0                           |               |                           | 0               | _  | 76. 01  |
| 76. 03           | 03951 WOUND CARE                              | 3, 154, 393                 |               | 3, 154, 39                | 3 0             | 3, 154, 393  | 76. 03  |
| 00.00            | OUTPATIENT SERVICE COST CENTERS  O9000 CLINIC |                             |               |                           | 0 0             |  | 00.00   |
| 90.00            | 09100 EMERGENCY                               | 0                           |               |                           | -               | _  |         |
| 91. 00<br>92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART     | 22, 536, 545<br>4, 777, 695 |               | 22, 536, 54<br>4, 777, 69 |                 | 22, 536, 545<br>4, 777, 695                        |         |
| 200.00           |   | 284, 437, 737               | 0             |                           |                 |  |         |
| 200.00           | ,   | 4, 777, 695                 | U             | 4, 777, 69                |                 | 4, 777, 695  |         |
| 201.00           | 1 1   | 279, 660, 042               | 0             | 279, 660, 04              |                 |  |         |
| 202.00           | Total (See Histructions)                      | 217,000,042                 | U             | 217,000,04                | ۷ د             | 217,000,042  | 1202.00 |

|   |                  |                  |                 | From 01/01/2021<br>To 12/31/2021 | Part I<br>Date/Time Pre<br>5/30/2022 6:2 | pared:<br>8 pm |
|---|------------------|------------------|-----------------|----------------------------------|--|----------------|
|   |                  | Titl             | e XIX           | Hospi tal                        | Cost                                     |                |
|   |                  | Charges          |                 | ·                                |  |                |
| Cost Center Description                         | I npati ent      | Outpati ent      | Total (col. 6   | Cost or Other                    | TEFRA                                    |                |
|   |                  | ·                | + col. 7)       | Ratio                            | Inpati ent                               |                |
|   |                  |                  |                 |                                  | Ratio                                    |                |
|   | 6. 00            | 7. 00            | 8. 00           | 9. 00                            | 10.00                                    |                |
| INPATIENT ROUTINE SERVICE COST CENTERS          |                  |                  |                 |                                  |  |                |
| 30. 00   03000   ADULTS & PEDIATRICS            | 159, 168, 252    |                  | 159, 168, 25    | 2                                |  | 30. 00         |
| 31.00   03100   INTENSIVE CARE UNIT             | 34, 125, 600     |                  | 34, 125, 60     | 0                                |  | 31. 00         |
| 31.01 03101 NEONATAL INTENSIVE CARE UNIT        | 18, 941, 053     |                  | 18, 941, 05     | 3                                |  | 31. 01         |
| 41. 00   04100   SUBPROVI DER - I RF            | 11, 165, 484     |                  | 11, 165, 48     | 4                                |  | 41. 00         |
| 43. 00 04300 NURSERY                            | 4, 288, 096      |                  | 4, 288, 09      | 6                                |  | 43. 00         |
| ANCILLARY SERVICE COST CENTERS                  |                  |                  |                 |                                  |  |                |
| 50. 00   05000   OPERATI NG ROOM                | 153, 432, 807    | 263, 268, 740    | 416, 701, 54    |                                  | 0.000000                                 | 50.00          |
| 51.00   05100   RECOVERY ROOM                   | 0                | 0                |                 | 0. 000000                        | 0.000000                                 | 51.00          |
| 52.00   05200   DELIVERY ROOM & LABOR ROOM      | 17, 623, 123     | 29, 727          | 17, 652, 85     | 0. 330274                        | 0.000000                                 | 52.00          |
| 53. 00   05300   ANESTHESI OLOGY                | 10, 328, 734     | 17, 286, 578     |                 |                                  | 0.000000                                 | 53. 00         |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C        | 71, 565, 964     | 224, 210, 500    | 295, 776, 46    | 4 0. 065945                      | 0.000000                                 | 54.00          |
| 54. 01   05401   ULTRASOUND                     | 0                | 0                |                 | 0. 000000                        | 0.000000                                 | 54. 01         |
| 56. 00   05600   RADI 0I SOTOPE                 | 0                | 0                |                 | 0. 000000                        | 0.000000                                 | 56. 00         |
| 57. 00  05700 CT SCAN                           | 0                | 0                |                 | 0. 000000                        | 0.000000                                 | 57. 00         |
| 58. 00   05800   MRI                            | 0                | 0                |                 | 0. 000000                        | 0.000000                                 | 58. 00         |
| 60. 00   06000   LABORATORY                     | 123, 590, 978    | 152, 545, 399    | 276, 136, 37    | 7 0. 068722                      | 0.000000                                 | 60.00          |
| 65. 00 06500 RESPIRATORY THERAPY                | 55, 825, 174     | 2, 813, 228      | 58, 638, 40     | 2 0. 085770                      | 0.000000                                 | 65. 00         |
| 66. 00 06600 PHYSI CAL THERAPY                  | 16, 356, 184     | 9, 875, 375      | 26, 231, 55     | 9 0. 189647                      | 0.000000                                 | 66. 00         |
| 67. 00 06700 OCCUPATI ONAL THERAPY              | 12, 376, 900     | 1, 823, 706      | 14, 200, 60     | 6 0. 091069                      | 0.000000                                 | 67. 00         |
| 68. 00 06800 SPEECH PATHOLOGY                   | 4, 327, 407      | 1, 868, 039      | 6, 195, 44      | 6 0. 199538                      | 0.000000                                 | 68. 00         |
| 69. 00 06900 ELECTROCARDI OLOGY                 | 74, 780, 637     | 124, 298, 314    | 199, 078, 95    | 0. 054399                        | 0.000000                                 | 69. 00         |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 25, 077, 894     | 21, 169, 967     | 46, 247, 86     | 1 0. 060531                      | 0.000000                                 | 71. 00         |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS      | 100, 865, 109    | 84, 539, 962     | 185, 405, 07    | 0. 146105                        | 0.000000                                 | 72. 00         |
| 73.00 07300 DRUGS CHARGED TO PATIENTS           | 88, 049, 907     | 244, 006, 122    | 332, 056, 02    | 9 0. 148761                      | 0.000000                                 | 73. 00         |
| 74.00 07400 RENAL DIALYSIS                      | 4, 762, 906      | 103, 493         | 4, 866, 39      | 9 0. 214482                      | 0.000000                                 | 74.00          |
| 76. 00   03950   ANCI LLARY                     | 0                | 0                |                 | 0. 000000                        | 0.000000                                 | 76. 00         |
| 76. 01 03610 SLEEP LAB                          | O                | 0                |                 | 0. 000000                        | 0.000000                                 | 76. 01         |
| 76. 03   03951   WOUND CARE                     | 692, 784         | 12, 376, 859     | 13, 069, 64     | 3 0. 241353                      | 0.000000                                 | 76. 03         |
| OUTPATIENT SERVICE COST CENTERS                 |                  |                  |                 |                                  |  |                |
| 90. 00 09000 CLI NI C                           | 0                | 0                |                 | 0.000000                         | 0.000000                                 | 90.00          |
| 91. 00 09100 EMERGENCY                          | 82, 025, 080     | 146, 522, 289    | 228, 547, 36    | 9 0. 098608                      | 0.000000                                 | 91.00          |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 6, 977, 842      | 12, 244, 863     | 19, 222, 70     | 5 0. 248544                      | 0.000000                                 | 92.00          |
| 200.00 Subtotal (see instructions)              | 1, 076, 347, 915 | 1, 318, 983, 161 | 2, 395, 331, 07 | 6                                |  | 200. 00        |
| 201.00 Less Observation Beds                    |                  |                  |                 |                                  |  | 201. 00        |
| 202.00 Total (see instructions)                 | 1, 076, 347, 915 | 1, 318, 983, 161 | 2, 395, 331, 07 | 6                                |  | 202. 00        |

| Health Financial Systems                 | PORTER REGIONAL HOSPITAL | In Lieu of Form CMS-2552-10   |
|--|--------------------------|---|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 15-0035   | Peri od: Worksheet C<br>From 01/01/2021 Part I<br>To 12/31/2021 Date/Time Prepared: 5/30/2022 6:28 pm |

|   |               |           | 10 12/31/2021 | 5/30/2022 6: 28 |         |
|---|---------------|-----------|---------------|-----------------|---------|
|   |               | Title XIX | Hospi tal     | Cost            |         |
| Cost Center Description                         | PPS Inpatient |           | <u> </u>      |                 |         |
|   | Ratio         |           |               |                 |         |
|   | 11. 00        |           |               |                 |         |
| INPATIENT ROUTINE SERVICE COST CENTERS          |               |           |               |                 |         |
| 30. 00   03000   ADULTS & PEDI ATRI CS          |               |           |               |                 | 30.00   |
| 31.00   03100   INTENSIVE CARE UNIT             |               |           |               |                 | 31.00   |
| 31.01 03101 NEONATAL INTENSIVE CARE UNIT        |               |           |               |                 | 31. 01  |
| 41. 00  04100  SUBPROVI DER - I RF              |               |           |               |                 | 41.00   |
| 43. 00 04300 NURSERY                            |               |           |               |                 | 43.00   |
| ANCILLARY SERVICE COST CENTERS                  |               |           |               |                 |         |
| 50.00   05000   OPERATING ROOM                  | 0. 000000     |           |               |                 | 50.00   |
| 51.00   05100   RECOVERY ROOM                   | 0. 000000     |           |               |                 | 51.00   |
| 52.00   05200   DELIVERY ROOM & LABOR ROOM      | 0. 000000     |           |               |                 | 52.00   |
| 53. 00   05300   ANESTHESI OLOGY                | 0. 000000     |           |               |                 | 53.00   |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C        | 0. 000000     |           |               |                 | 54.00   |
| 54. 01   05401   ULTRASOUND                     | 0. 000000     |           |               |                 | 54. 01  |
| 56. 00   05600   RADI 01 SOTOPE                 | 0. 000000     |           |               |                 | 56.00   |
| 57.00  05700 CT SCAN                            | 0. 000000     |           |               |                 | 57.00   |
| 58. 00   05800   MRI                            | 0. 000000     |           |               |                 | 58. 00  |
| 60. 00   06000   LABORATORY                     | 0. 000000     |           |               |                 | 60.00   |
| 65. 00 06500 RESPI RATORY THERAPY               | 0. 000000     |           |               |                 | 65.00   |
| 66. 00 06600 PHYSI CAL THERAPY                  | 0. 000000     |           |               |                 | 66.00   |
| 67. 00 06700 OCCUPATI ONAL THERAPY              | 0. 000000     |           |               |                 | 67.00   |
| 68.00 06800 SPEECH PATHOLOGY                    | 0. 000000     |           |               |                 | 68. 00  |
| 69. 00  06900 ELECTROCARDI OLOGY                | 0. 000000     |           |               |                 | 69. 00  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0. 000000     |           |               |                 | 71.00   |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS      | 0. 000000     |           |               |                 | 72.00   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS           | 0. 000000     |           |               |                 | 73.00   |
| 74.00  07400   RENAL DIALYSIS                   | 0. 000000     |           |               |                 | 74.00   |
| 76. 00   03950   ANCI LLARY                     | 0. 000000     |           |               |                 | 76. 00  |
| 76. 01  03610  SLEEP LAB                        | 0. 000000     |           |               |                 | 76. 01  |
| 76. 03 03951 WOUND CARE                         | 0. 000000     |           |               |                 | 76. 03  |
| OUTPATIENT SERVICE COST CENTERS                 |               |           |               |                 |         |
| 90. 00 09000 CLI NI C                           | 0. 000000     |           |               |                 | 90.00   |
| 91. 00   09100   EMERGENCY                      | 0. 000000     |           |               |                 | 91.00   |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0. 000000     |           |               |                 | 92.00   |
| 200.00 Subtotal (see instructions)              |               |           |               |                 | 200. 00 |
| 201.00 Less Observation Beds                    |               |           |               |                 | 201. 00 |
| 202.00 Total (see instructions)                 |               |           |               |                 | 202. 00 |

|         | Financial Systems                                  | PORTER REGION  | IAL_HOSPITAL   |                | In Lie                                      | eu of Form CMS-2 | 2552-10        |
|---------|--|----------------|----------------|----------------|---|------------------|----------------|
| APPORTI | APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL |                | Provi der C    | F              | Period:<br>From 01/01/2021<br>To 12/31/2021 |                  | pared:<br>8 pm |
|         |  |                | Ti tl e        | 2 XVIII        | Hospi tal                                   | PPS              |                |
|         | Cost Center Description                            | Capi tal       | Swing Bed      | Reduced        | Total Patient                               | Per Diem (col.   |                |
|         |  | Related Cost   | Adjustment     | Capi tal       | Days  | 3 / col . 4)     |                |
|         |  | (from Wkst. B, |                | Related Cost   |   |                  |                |
|         |  | Part II, col.  |                | (col. 1 - col. |   |                  |                |
|         |  | 26)            |                | 2)             |   |                  |                |
|         |  | 1.00           | 2.00           | 3. 00          | 4. 00                                       | 5. 00            |                |
|         | INPATIENT ROUTINE SERVICE COST CENTERS             |                |                |                |   |                  |                |
| 30. 00  | ADULTS & PEDI ATRI CS                              | 3, 577, 020    | 0              | 3, 577, 020    |   |                  |                |
| 31. 00  | INTENSIVE CARE UNIT                                | 668, 857       |                | 668, 857       | 5, 900                                      |                  |                |
| 31. 01  | NEONATAL INTENSIVE CARE UNIT                       | 248, 650       |                | 248, 650       | 3, 305                                      | 75. 23           | 31. 01         |
| 41. 00  | SUBPROVI DER - I RF                                | 435, 067       | 0              | 435, 067       | 3, 707                                      |                  |                |
| 43. 00  | NURSERY  | 75, 581        |                | 75, 581        | 2, 402                                      | 31. 47           | 43. 00         |
| 200.00  | Total (lines 30 through 199)                       | 5, 005, 175    |                | 5, 005, 175    | 67, 742                                     |                  | 200. 00        |
|         | Cost Center Description                            | I npati ent    | I npati ent    |                |   |                  |                |
|         |  | Program days   | Program        |                |   |                  |                |
|         |  |                | Capital Cost   |                |   |                  |                |
|         |  |                | (col. 5 x col. |                |   |                  |                |
|         |  |                | 6)             |                |   |                  |                |
|         |  | 6. 00          | 7. 00          |                |   |                  |                |
|         | INPATIENT ROUTINE SERVICE COST CENTERS             |                |                |                |   |                  |                |
|         | ADULTS & PEDIATRICS                                | 16, 347        |                |                |   |                  | 30. 00         |
|         | INTENSIVE CARE UNIT                                | 1, 924         |                |                |   |                  | 31. 00         |
|         | NEONATAL INTENSIVE CARE UNIT                       | 0              | 0              |                |   |                  | 31. 01         |
|         | SUBPROVI DER - I RF                                | 2, 235         |                | 1              |   |                  | 41. 00         |
|         | NURSERY  | 0              | 1              |                |   |                  | 43. 00         |
| 200.00  | Total (lines 30 through 199)                       | 20, 506        | 1, 595, 780    | 1              |   |                  | 200. 00        |

| Health Financial Systems                            | PORTER REGIONA            | AL HOS | SPI TAL   |              | In Lie                                       | u of Form CMS-2  | 2552-10 |
|---|---------------------------|--------|-----------|--------------|--|--|---------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA | L COSTS                   | Pr     | ovider Co |              | Peri od:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet D<br>Part II<br>Date/Time Prep<br>5/30/2022 6:28 |         |
|   |                           |        | Title     | XVIII        | Hospi tal                                    | PPS  |         |
| Cost Center Description                             | Capi tal<br>Rel ated Cost |        |           | Ratio of Cos |  | Capital Costs<br>(column 3 x                               |         |

|        |   |                |                  | T              | 12/31/2021    | Date/Time Pre 5/30/2022 6:2 |         |
|--------|---|----------------|------------------|----------------|---------------|-----------------------------|---------|
|        |   |                | Ti tl e          | xVIII          | Hospi tal     | PPS                         |         |
|        | Cost Center Description                   | Capi tal       | Total Charges    | Ratio of Cost  | I npati ent   | Capital Costs               |         |
|        | ·   | Related Cost   | (from Wkst. C,   | to Charges     | Program       | (column 3 x                 |         |
|        |   | (from Wkst. B, | Part I, col.     | (col. 1 + col. | Charges       | column 4)                   |         |
|        |   | Part II, col.  | 8)               | 2)             |               |                             |         |
|        |   | 26)            |                  |                |               |                             |         |
|        |   | 1.00           | 2.00             | 3. 00          | 4. 00         | 5. 00                       |         |
|        | ANCILLARY SERVICE COST CENTERS            |                |                  |                |               |                             |         |
| 50.00  | 05000 OPERATING ROOM                      | 2, 070, 585    | 416, 701, 547    |                | 51, 553, 530  | 256, 169                    |         |
| 51. 00 | 05100 RECOVERY ROOM                       | 0              | 0                | 0. 000000      | 0             | 0                           | 51.00   |
| 52.00  | 05200 DELIVERY ROOM & LABOR ROOM          | 417, 078       |                  |                | 15, 795       | •                           |         |
| 53.00  | 05300 ANESTHESI OLOGY                     | 35, 400        |                  |                | 2, 964, 064   |                             | 1       |
| 54.00  | 05400 RADI OLOGY-DI AGNOSTI C             | 1, 354, 354    | 295, 776, 464    | 0.004579       | 26, 268, 746  | 120, 285                    | 54.00   |
| 54. 01 | 05401 ULTRASOUND                          | 0              | 0                | 0.000000       | 0             | 0                           | 54. 01  |
| 56.00  | 05600 RADI OI SOTOPE                      | 0              | 0                | 0.000000       | 0             | 0                           | 56. 00  |
| 57.00  | 05700 CT SCAN                             | 0              | 0                | 0.000000       | 0             | 0                           | 57. 00  |
| 58. 00 | 05800 MRI                                 | 0              | 0                | 0.000000       | 0             | 0                           | 58. 00  |
| 60.00  | 06000 LABORATORY                          | 516, 367       | 276, 136, 377    | 0. 001870      | 40, 946, 534  | 76, 570                     | 60.00   |
| 65.00  | 06500 RESPI RATORY THERAPY                | 114, 816       | 58, 638, 402     | 0. 001958      | 20, 272, 212  | 39, 693                     | 65. 00  |
| 66.00  | 06600 PHYSI CAL THERAPY                   | 541, 562       | 26, 231, 559     | 0. 020645      | 5, 036, 468   | 103, 978                    | 66. 00  |
| 67.00  | 06700 OCCUPATI ONAL THERAPY               | 4, 243         | 14, 200, 606     | 0.000299       | 3, 649, 470   | 1, 091                      | 67. 00  |
| 68.00  | 06800 SPEECH PATHOLOGY                    | 3, 775         | 6, 195, 446      | 0.000609       | 1, 221, 475   | 744                         | 68. 00  |
| 69.00  | 06900 ELECTROCARDI OLOGY                  | 940, 764       | 199, 078, 951    | 0.004726       | 26, 260, 340  | 124, 106                    | 69.00   |
| 71.00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 29, 512        | 46, 247, 861     | 0.000638       | 8, 648, 141   | 5, 518                      | 71.00   |
| 72.00  | 07200 IMPL. DEV. CHARGED TO PATIENTS      | 279, 616       | 185, 405, 071    | 0. 001508      | 40, 324, 901  | 60, 810                     | 72. 00  |
| 73.00  | 07300 DRUGS CHARGED TO PATIENTS           | 355, 360       | 332, 056, 029    | 0. 001070      | 26, 898, 422  | 28, 781                     | 73. 00  |
| 74.00  | 07400 RENAL DIALYSIS                      | 22, 123        | 4, 866, 399      | 0. 004546      | 1, 751, 770   | 7, 964                      | 74.00   |
| 76.00  | 03950 ANCI LLARY                          | 0              | 0                | 0.000000       | 0             | 0                           | 76. 00  |
| 76. 01 | 03610 SLEEP LAB                           | 0              | 0                | 0.000000       | 0             | 0                           | 76. 01  |
| 76. 03 | 03951 WOUND CARE                          | 215, 563       | 13, 069, 643     | 0. 016493      | 329, 258      | 5, 430                      | 76. 03  |
|        | OUTPATIENT SERVICE COST CENTERS           | •              |                  | •              |               |                             |         |
| 90.00  | 09000 CLI NI C                            | 0              | 0                | 0.000000       | 0             | 0                           | 90.00   |
| 91.00  | 09100 EMERGENCY                           | 1, 464, 841    | 228, 547, 369    | 0.006409       | 29, 102, 350  | 186, 517                    | 91.00   |
| 92.00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART | 343, 187       | 19, 222, 705     | 0. 017853      | 2, 286, 840   | 40, 827                     | 92.00   |
| 200.00 |   | 8, 709, 146    | 2, 167, 642, 591 |                | 287, 530, 316 | 1, 062, 656                 | 200. 00 |

| APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER I  | PASS THROUGH COST  | rs Provider C   |                                  | Peri od:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet D<br>Part III<br>Date/Time Pre<br>5/30/2022 6:2 |   |
|---|--|---|----------------------------------|--|---|---|
|   |  | Title   | : XVIII                          | Hospi tal                                    | PPS   | •   |
| Cost Center Description   | Nursi ng<br>Program<br>Post-Stepdown<br>Adjustments        | Nursi ng<br>Program   |                                  |  | All Other<br>Medical<br>Education Cost                    |   |
|   | 1A   | 1. 00   | 2A                               | 2. 00  | 3. 00   |   |
| INPATIENT ROUTINE SERVICE COST CENTERS  |  |   | •                                |  |   |   |
| 30. 00   03000   ADULTS & PEDIATRICS   31. 00   03100   INTENSIVE CARE UNIT   31. 01   03101   NEONATAL INTENSIVE CARE UNIT   41. 00   04100   SUBPROVI DER - IRF   43. 00   04300   NURSERY   200. 00   Total (lines 30 through 199) | 0<br>0<br>0<br>0   | 0<br>0<br>0<br>0  | 1                                | 0 0 0<br>0 0 0<br>0 0 0<br>0 0 0             | 0<br>0<br>0<br>0  | 31. 00<br>31. 01<br>41. 00                                |
| Cost Center Description   |  | Total Costs<br>(sum of cols.<br>1 through 3,<br>minus col. 4) | Days                             | Per Diem (col.<br>5 ÷ col. 6)                | Inpatient<br>Program Days                                 |   |
| UNDATIONE DOUTING CERVICE COCT CENTERS  | 4. 00  | 5. 00   | 6. 00                            | 7. 00  | 8. 00   |   |
| 30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 31. 01 03101 NEONATAL INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 43. 00 04300 NURSERY 200. 00 Total (lines 30 through 199)                                  | 0  | 0<br>0<br>0<br>0  | 5, 90<br>3, 30<br>3, 70<br>2, 40 | 00 0.00<br>05 0.00<br>07 0.00<br>02 0.00     | 1, 924<br>0<br>2, 235<br>0                                | 31. 00<br>31. 01<br>41. 00                                |
| Cost Center Description   | Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 | 0   | , 07, 74                         |  | 1 20, 300   | 250.00  |
| INPATIENT ROUTINE SERVICE COST CENTERS  | 0 0 0 0 0 0 0 0  |   |                                  |  |   | 30. 00<br>31. 00<br>31. 01<br>41. 00<br>43. 00<br>200. 00 |

| Peri od: | Worksheet D | From 01/01/2021 | Part IV | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Provider CCN: 15-0035 THROUGH COSTS

|        |                                  |               |               |          | 5/30/2022 6: 28 |               |         |
|--------|----------------------------------|---------------|---------------|----------|-----------------|---------------|---------|
|        |                                  |               | Title         | XVIII    | Hospi tal       | PPS           |         |
|        | Cost Center Description          | Non Physician | Nursi ng      | Nursi ng | Allied Health   | Allied Health |         |
|        |                                  | Anesthetist   | Program       | Program  | Post-Stepdown   |               |         |
|        |                                  | Cost          | Post-Stepdown |          | Adjustments     |               |         |
|        |                                  |               | Adjustments   |          |                 |               |         |
|        |                                  | 1.00          | 2A            | 2.00     | 3A              | 3. 00         |         |
|        | ANCILLARY SERVICE COST CENTERS   | 1             |               | 1        |                 |               |         |
| 50.00  |                                  | 0             | 0             |          | 0               | 0             |         |
| 51. 00 | 05100 RECOVERY ROOM              | 0             | 0             |          | 0               | 0             |         |
| 52. 00 | 05200 DELIVERY ROOM & LABOR ROOM | 0             | 0             |          | 0               | 0             |         |
| 53.00  | 05300 ANESTHESI OLOGY            | 0             | 0             |          | 0               | 0             | 53.00   |
| 54.00  | 05400 RADI OLOGY-DI AGNOSTI C    | 0             | 0             |          | 0               | 0             | 54. 00  |
| 54. 01 | 05401 ULTRASOUND                 | 0             | 0             |          | 0               | 0             | 54. 01  |
| 56. 00 | 05600 RADI OI SOTOPE             | 0             | 0             |          | 0               | 0             | 56. 00  |
| 57. 00 | 05700 CT SCAN                    | 0             | 0             |          | 0               | 0             | 57. 00  |
| 58. 00 | 05800 MRI                        | 0             | 0             |          | 0               | 0             | 58. 00  |
| 60.00  | 06000 LABORATORY                 | 0             | 0             |          | 0               | 0             | 60.00   |
| 65. 00 | 06500 RESPI RATORY THERAPY       | 0             | 0             |          | 0               | 0             | 65. 00  |
| 66. 00 | 06600 PHYSI CAL THERAPY          | 0             | 0             |          | 0               | 0             | 66. 00  |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY      | 0             | 0             |          | 0               | 0             | 67. 00  |
| 68. 00 | 06800 SPEECH PATHOLOGY           | 0             | 0             |          | 0               | 0             | 68. 00  |
| 69. 00 | 06900 ELECTROCARDI OLOGY         | 0             | 0             |          | 0               | 0             | 69. 00  |
| 71. 00 |                                  | 0             | 0             |          | 0               | 0             | 71. 00  |
| 72. 00 |                                  | 0             | 0             |          | 0               | 0             | 72. 00  |
| 73. 00 | 07300 DRUGS CHARGED TO PATIENTS  | 0             | 0             |          | 0               | 0             | 73. 00  |
| 74. 00 | 07400 RENAL DI ALYSI S           | 0             | 0             |          | 0               | 0             | 74. 00  |
| 76. 00 | 03950 ANCI LLARY                 | 0             | 0             |          | 0               | 0             | 76. 00  |
| 76. 01 | 03610 SLEEP LAB                  | 0             | 0             |          | 0               | 0             |         |
| 76. 03 | 03951 WOUND CARE                 | 0             | 0             |          | 0 (             | 0             | 76. 03  |
|        | OUTPATIENT SERVICE COST CENTERS  | 1             |               | 1        |                 | 1             |         |
| 90.00  | 09000 CLI NI C                   | 0             | 0             |          | 0 (             | 1             | 90. 00  |
| 91. 00 |                                  | 0             | 0             |          | 0               | 0             | 91. 00  |
| 92.00  |                                  | 0             | _             |          | 0               | 0             | , 2. 00 |
| 200. 0 | Total (lines 50 through 199)     | 0             | 0             | 1        | 0 0             | )  0          | 200. 00 |

| Heal th | Financial Systems  | PORTER REGION  | IAI HOSPITAI  |              | In lie                                      | eu of Form CMS-2       | 2552_10 |
|---------|--|----------------|---------------|--------------|---|------------------------|---------|
| APPORT  | IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER<br>H COSTS |                |               |              | Period:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet D<br>Part IV | pared:  |
|         |  |                |               | XVIII        | Hospi tal                                   | PPS                    |         |
|         | Cost Center Description                                  | All Other      | Total Cost    | Total        |   | Ratio of Cost          |         |
|         |  | Medi cal       | (sum of cols. | Outpati ent  | (from Wkst. C,                              |                        |         |
|         |  | Education Cost |               | Cost (sum of |   | (col. 5 ÷ col.         |         |
|         |  |                | 4)            | col s. 2, 3, | 8)  | 7)                     |         |
|         |  |                |               | and 4)       |   | (see                   |         |
|         |  |                |               | , ,,         | 7.00  | instructions)          |         |
|         |  | 4.00           | 5. 00         | 6. 00        | 7. 00                                       | 8. 00                  |         |
|         | ANCILLARY SERVICE COST CENTERS                           | _              |               | T            | 0 444 704 547                               |                        |         |
|         | 05000 OPERATI NG ROOM                                    | 0              | 1             |              | 0 416, 701, 547                             |                        |         |
|         | 05100 RECOVERY ROOM                                      | 0              | 0             |              | 0 0   | 1                      |         |
| 52. 00  | 05200 DELIVERY ROOM & LABOR ROOM                         | 0              | 0             |              | 0 17, 652, 850                              |                        |         |
| 53. 00  | 05300 ANESTHESI OLOGY                                    | 0              | 0             |              | 0 27, 615, 312                              |                        |         |
| 54.00   | 05400 RADI OLOGY-DI AGNOSTI C                            | 0              | 0             |              | 0 295, 776, 464                             | 1                      |         |
| 54. 01  | 05401 ULTRASOUND   | 0              | 0             |              | 0   | 0.000000               |         |
| 56. 00  | 05600 RADI OI SOTOPE                                     | 0              | 0             |              | 0   | 0.000000               |         |
| 57. 00  | 05700 CT SCAN  | 0              | 0             |              | 0   | 0. 000000              |         |
| 58. 00  | 05800 MRI  | 0              | 0             |              | 0   | 0.000000               |         |
| 60.00   | 06000 LABORATORY   | 0              | 0             |              | 0 276, 136, 377                             |                        |         |
| 65. 00  | 06500 RESPI RATORY THERAPY                               | 0              | 0             |              | 0 58, 638, 402                              | 1                      |         |
| 66.00   | 06600 PHYSI CAL THERAPY                                  | 0              | 0             |              | 0 26, 231, 559                              |                        |         |
|         | 06700 OCCUPATI ONAL THERAPY                              | 0              | 0             |              | 0 14, 200, 606                              |                        |         |
|         | 06800 SPEECH PATHOLOGY                                   | 0              | 0             |              | 0 6, 195, 446                               |                        |         |
|         | 06900 ELECTROCARDI OLOGY                                 | 0              | 0             |              | 0 199, 078, 951                             | l .                    |         |
|         | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                | 0              | 0             |              | 0 46, 247, 861                              |                        |         |
|         | 07200 IMPL. DEV. CHARGED TO PATIENTS                     | 0              | 0             |              | 0 185, 405, 071                             | l .                    |         |
|         | 07300 DRUGS CHARGED TO PATIENTS                          | 0              | 0             |              | 0 332, 056, 029                             |                        |         |
|         | 07400 RENAL DIALYSIS                                     | 0              | 0             |              | 0 4, 866, 399                               | 0.000000               | 74. 00  |
|         | 03950 ANCI LLARY   | 0              | 0             |              | 0   | 0.000000               | 76. 00  |
|         | 03610 SLEEP LAB  | 0              | 0             | l .          | 0   | 0.000000               |         |
| 76. 03  | 03951 WOUND CARE   | 0              | 0             |              | 0 13, 069, 643                              | 0.000000               | 76. 03  |
|         | OUTPATIENT SERVICE COST CENTERS                          |                |               |              | _   |                        |         |
| 90.00   | 09000 CLI NI C   | 0              | 0             |              | 0   | 0.000000               | 90.00   |

0 0 0

0 0 0

91.00

92.00 200.00

0. 000000 0. 000000 0. 000000

0 0 228, 547, 369 0 19, 222, 705 0 2, 167, 642, 591

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

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

|                          | ancial Systems                                   | PORTER REGIONAL  |              |               |   | u of Form CMS-2  | 2552-10 |
|--------------------------|--|------------------|--------------|---------------|---|--|---------|
| APPORTIONM<br>THROUGH CO | ENT OF INPATIENT/OUTPATIENT ANCILLARY SEI<br>STS | RVICE OTHER PASS | Provi der Co |               | Period:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet D<br>Part IV<br>Date/Time Pre<br>5/30/2022 6:2 |         |
|                          |  |                  | Title        | XVIII         | Hospi tal                                   | PPS  |         |
|                          | Cost Center Description                          | Outpati ent      | I npati ent  | I npati ent   | Outpati ent                                 | Outpati ent  |         |
|                          |  | Ratio of Cost    | Program      | Program       | Program                                     | Program  |         |
|                          |  | to Charges       | Charges      | Pass-Through  |   | Pass-Through   |         |
|                          |  | (col. 6 ÷ col.   |              | Costs (col. 8 | 3   | Costs (col. 9  |         |
|                          |  | 7)               |              | x col. 10)    |   | x col. 12)   |         |
|                          |  | 9. 00            | 10. 00       | 11. 00        | 12.00                                       | 13. 00   |         |
|                          | LLARY SERVICE COST CENTERS                       |                  |              |               |   |  |         |
|                          | OO OPERATING ROOM                                | 0. 000000        | 51, 553, 530 |               | 0 76, 130, 316                              | 0  | 50.00   |
| 51.00 0510               | 00 RECOVERY ROOM                                 | 0. 000000        | 0            |               | 0   | 0  | 51.00   |
|                          | DO DELIVERY ROOM & LABOR ROOM                    | 0. 000000        | 15, 795      |               | 0   | 0  | 52.00   |
| 53.00 0530               | DO ANESTHESI OLOGY                               | 0. 000000        | 2, 964, 064  |               | 0 4, 814, 009                               | 0  | 53.00   |
| 54.00 0540               | DO RADI OLOGY-DI AGNOSTI C                       | 0. 000000        | 26, 268, 746 |               | 0 57, 879, 635                              | 0  | 54.00   |
| 54. 01 0540              | D1 ULTRASOUND                                    | 0. 000000        | 0            |               | 0   | 0  | 54. 01  |
| 56. 00 0560              | 00 RADI OI SOTOPE                                | 0. 000000        | 0            |               | 0   | 0  | 56. 00  |
| 57. 00 0570              | DO CT SCAN                                       | 0. 000000        | 0            |               | 0   | 0  | 57. 00  |
| 58. 00 0580              | DO MRI   | 0. 000000        | 0            |               | 0 0   | 0  | 58. 00  |
| 60.00 0600               | DO LABORATORY                                    | 0. 000000        | 40, 946, 534 |               | 0 16, 853, 493                              | 0  | 60.00   |
| 65. 00 0650              | OO RESPI RATORY THERAPY                          | 0. 000000        | 20, 272, 212 |               | 0 756, 335                                  | 0  | 65. 00  |
| 66. 00 0660              | 00 PHYSI CAL THERAPY                             | 0. 000000        | 5, 036, 468  |               | 0 228, 860                                  | 0  | 66. 00  |
| 67. 00 0670              | OO OCCUPATIONAL THERAPY                          | 0. 000000        | 3, 649, 470  |               | 0 79, 886                                   | 0  | 67. 00  |
| 68. 00 0680              | OO SPEECH PATHOLOGY                              | 0. 000000        | 1, 221, 475  |               | 0 17, 750                                   | 0  | 68. 00  |
| 69. 00 0690              | DO ELECTROCARDI OLOGY                            | 0. 000000        | 26, 260, 340 |               | 0 45, 444, 356                              | 0  | 69. 00  |
| 71. 00 0710              | OO MEDICAL SUPPLIES CHARGED TO PATIENT           | 0. 000000        | 8, 648, 141  |               | 0 5, 885, 100                               | 0  | 71. 00  |
| 72. 00 0720              | DO IMPL. DEV. CHARGED TO PATIENTS                | 0. 000000        | 40, 324, 901 |               | 0 32, 166, 045                              |  | 72. 00  |
|                          | DO DRUGS CHARGED TO PATIENTS                     | 0. 000000        | 26, 898, 422 |               | 0 91, 596, 843                              |  | 73. 00  |
| 74. 00 0740              | DO RENAL DIALYSIS                                | 0. 000000        | 1, 751, 770  |               | 0 58, 358                                   |  | 74.00   |
| 76. 00 039               | 50 ANCI LLARY                                    | 0. 000000        | 0            |               | 0 0   | 0  | 76. 00  |
| 76. 01 036°              | IO SLEEP LAB                                     | 0. 000000        | 0            |               | 0 0   | 0  | 76. 01  |
|                          | MOUND CARE                                       | 0. 000000        | 329, 258     |               | 0 2, 951, 149                               | 0  | 76. 03  |

0. 000000

0.000000

0. 000000

29, 102, 350 2, 286, 840 287, 530, 316

21, 878, 970 2, 794, 480 359, 535, 585

0 0 0

0

90.00

0 91.00 0 92.00 0 200.00

03951 WOUND CARE
OUTPATIENT SERVICE COST CENTERS

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

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

| APPORT | APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND |                | Provi der Co    | 1             | Period:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet D<br>Part V<br>Date/Time Prepared: |                |
|--------|---|----------------|-----------------|---------------|---|--|----------------|
|        |   |                |                 |               | 10 12/31/2021                               | 5/30/2022 6: 2                               | pareu.<br>8 pm |
|        |   |                | Title           | : XVIII       | Hospi tal                                   | PPS  |                |
|        | ·   |                |                 | Charges       |   | Costs  |                |
|        | Cost Center Description                             | Cost to Charge | PPS Reimbursed  | Cost          | Cost  | PPS Services                                 |                |
|        |   | Ratio From     | Services (see   | Rei mbursed   | Rei mbursed                                 | (see inst.)                                  |                |
|        |   | Worksheet C,   | inst.)          | Servi ces     | Services Not                                |  |                |
|        |   | Part I, col. 9 |                 | Subject To    | Subject To                                  |  |                |
|        |   |                |                 | Ded. & Coins. |   |  |                |
|        |   |                |                 | (see inst.)   | (see inst.)                                 |  |                |
|        | T   | 1. 00          | 2. 00           | 3. 00         | 4. 00                                       | 5. 00  |                |
|        | ANCILLARY SERVICE COST CENTERS                      |                |                 | 1             |   |  |                |
|        | 05000 OPERATING ROOM                                | 0. 067326      |                 |               | ٥   | 5, 125, 550                                  |                |
| 51. 00 | 05100 RECOVERY ROOM                                 | 0. 000000      |                 | (             | ٥   | 0  | 51. 00         |
| 52.00  | 05200 DELIVERY ROOM & LABOR ROOM                    | 0. 330274      |                 | (             | 0   | -  |                |
| 53. 00 | 05300 ANESTHESI OLOGY                               | 0. 007834      |                 |               | 0   | 37, 713                                      |                |
| 54.00  | 05400 RADI OLOGY-DI AGNOSTI C                       | 0. 065945      |                 |               | 0   | 3, 816, 873                                  | 1              |
| 54. 01 | 05401 ULTRASOUND                                    | 0. 000000      |                 |               | 0   | 0  |                |
| 56.00  | 05600 RADI OI SOTOPE                                | 0. 000000      |                 | (             | 0   | 0  | 00.00          |
| 57.00  | 05700 CT SCAN                                       | 0. 000000      |                 | (             | 0   | 0  | 57. 00         |
| 58. 00 | 05800  MRI  | 0. 000000      |                 | (             | 0   | 0  | 58. 00         |
| 60.00  | 06000 LABORATORY                                    | 0. 068722      | 16, 853, 493    |               | 0   | 1, 158, 206                                  | 60.00          |
| 65.00  | 06500 RESPI RATORY THERAPY                          | 0. 085770      |                 |               | 0   | 64, 871                                      | 65. 00         |
| 66.00  | 06600 PHYSI CAL THERAPY                             | 0. 189647      | 228, 860        | (             | 0   | 43, 403                                      | 66. 00         |
| 67.00  | 06700 OCCUPATI ONAL THERAPY                         | 0. 091069      | 79, 886         | (             | 0   | 7, 275                                       | 67. 00         |
| 68.00  | 06800 SPEECH PATHOLOGY                              | 0. 199538      |                 | (             | 0   | 3, 542                                       | 68. 00         |
| 69. 00 | 06900 ELECTROCARDI OLOGY                            | 0. 054399      | 45, 444, 356    | (             | 0   | 2, 472, 128                                  | 69. 00         |
| 71.00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT           | 0. 060531      | 5, 885, 100     | (             | 0   | 356, 231                                     | 71. 00         |
|        | 07200 I MPL. DEV. CHARGED TO PATIENTS               | 0. 146105      | 32, 166, 045    |               | ٥ -   | 4, 699, 620                                  | 72. 00         |
| 73.00  | 07300 DRUGS CHARGED TO PATIENTS                     | 0. 148761      | 91, 596, 843    | 82            | 7 735, 516                                  | 13, 626, 038                                 | 73. 00         |
| 74.00  | 07400 RENAL DIALYSIS                                | 0. 214482      | 58, 358         | (             | 0   | 12, 517                                      | 74. 00         |
| 76.00  | 03950 ANCI LLARY                                    | 0. 000000      | 0               | (             | 0   | 0  | 76. 00         |
| 76. 01 | 03610 SLEEP LAB                                     | 0. 000000      | 0               | (             | 0   | 0  | 76. 01         |
| 76. 03 | 03951 WOUND CARE                                    | 0. 241353      | 2, 951, 149     | (             | 0   | 712, 269                                     | 76. 03         |
|        | OUTPATIENT SERVICE COST CENTERS                     |                |                 |               |   |  |                |
| 90.00  | 09000 CLI NI C                                      | 0. 000000      | 0               | (             | 0   | 0  | 90.00          |
| 91.00  | 09100 EMERGENCY                                     | 0. 098608      | 21, 878, 970    | (             | 0   | 2, 157, 441                                  | 91.00          |
| 92.00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART           | 0. 248544      | 2, 794, 480     | (             | 0   | 694, 551                                     | 92. 00         |
| 200.00 | Subtotal (see instructions)                         |                | 359, 535, 585   | 82            | 7 735, 516                                  | 34, 988, 228                                 | 200. 00        |
| 201.00 |   |                |                 |               | 0   |  | 201. 00        |
| 202.00 | Only Charges<br>Net Charges (line 200 - line 201)   |                | 359, 535, 585   | 82            | 7 735, 516                                  | 34, 988, 228                                 | 202 00         |
| 202.00 | p   | T              | 1 337, 333, 363 | 1 02          | 133,310                                     | J4, 700, 220                                 | 1202.00        |

| Health Financial Systems                            | PORTER REGIONAL | HOSPI TAL   |              | In Lie                                | u of Form CMS-2   | 2552-10 |
|---|-----------------|-------------|--------------|---------------------------------------|---|---------|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | VACCINE COST    | Provi der ( | CCN: 15-0035 | From 01/01/2021                       | Worksheet D<br>Part V<br>Date/Time Pre<br>5/30/2022 6:2 |         |
|   |                 | Ti tl       | e XVIII      | Hospi tal                             | PPS   |         |
|   | Costs           |             |              | · · · · · · · · · · · · · · · · · · · |   |         |

|          |   |               |               |       | To 12/31/2021 | Date/Time Pro<br>5/30/2022 6: |         |
|----------|---|---------------|---------------|-------|---------------|-------------------------------|---------|
|          |   |               | Title         | XVIII | Hospi tal     | PPS                           |         |
|          |   | Cos           | its           |       |               |                               |         |
|          | Cost Center Description                   | Cost          | Cost          |       |               |                               |         |
|          |   | Rei mbursed   | Rei mbursed   |       |               |                               |         |
|          |   | Servi ces     | Services Not  |       |               |                               |         |
|          |   | Subject To    | Subject To    |       |               |                               |         |
|          |   | Ded. & Coins. | Ded. & Coins. |       |               |                               |         |
|          |   | (see inst.)   | (see inst.)   |       |               |                               |         |
|          |   | 6. 00         | 7. 00         |       |               |                               |         |
|          | ANCILLARY SERVICE COST CENTERS            |               |               | T     |               |                               |         |
|          | 05000 OPERATING ROOM                      | 0             | 0             |       |               |                               | 50.00   |
|          | D5100 RECOVERY ROOM                       | 0             | 0             |       |               |                               | 51. 00  |
|          | D5200 DELIVERY ROOM & LABOR ROOM          | 0             | 0             |       |               |                               | 52.00   |
|          | D5300 ANESTHESI OLOGY                     | 0             | 0             |       |               |                               | 53. 00  |
|          | D5400 RADI OLOGY-DI AGNOSTI C             | 0             | 0             |       |               |                               | 54. 00  |
|          | D5401 ULTRASOUND                          | 0             | 0             |       |               |                               | 54. 01  |
|          | D5600 RADI OI SOTOPE                      | 0             | 0             |       |               |                               | 56. 00  |
|          | D5700 CT SCAN                             | 0             | 0             |       |               |                               | 57. 00  |
|          | 05800 MRI                                 | 0             | 0             |       |               |                               | 58. 00  |
|          | 06000 LABORATORY                          | 0             | 0             |       |               |                               | 60. 00  |
|          | 06500 RESPI RATORY THERAPY                | 0             | 0             |       |               |                               | 65. 00  |
| 1        | D6600 PHYSI CAL THERAPY                   | 0             | 0             |       |               |                               | 66. 00  |
|          | 06700 OCCUPATI ONAL THERAPY               | 0             | 0             |       |               |                               | 67. 00  |
|          | D6800 SPEECH PATHOLOGY                    | 0             | 0             |       |               |                               | 68. 00  |
|          | D6900 ELECTROCARDI OLOGY                  | 0             | 0             |       |               |                               | 69. 00  |
| 71.00    | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0             | 0             |       |               |                               | 71. 00  |
|          | 07200 IMPL. DEV. CHARGED TO PATIENTS      | 0             | 0             |       |               |                               | 72. 00  |
| 73.00    | D7300 DRUGS CHARGED TO PATIENTS           | 123           | 109, 416      |       |               |                               | 73. 00  |
|          | 07400 RENAL DIALYSIS                      | 0             | 0             |       |               |                               | 74. 00  |
|          | 03950 ANCI LLARY                          | 0             | 0             |       |               |                               | 76. 00  |
|          | 03610 SLEEP LAB                           | 0             | 0             |       |               |                               | 76. 01  |
| 76. 03 C | D3951 WOUND CARE                          | 0             | 0             |       |               |                               | 76. 03  |
|          | OUTPATIENT SERVICE COST CENTERS           |               |               |       |               |                               |         |
|          | 09000 CLI NI C                            | 0             | 0             |       |               |                               | 90. 00  |
|          | 09100 EMERGENCY                           | 0             | 0             |       |               |                               | 91.00   |
|          | 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0             | 0             |       |               |                               | 92. 00  |
| 200.00   | Subtotal (see instructions)               | 123           | 109, 416      |       |               |                               | 200. 00 |
| 201.00   | Less PBP Clinic Lab. Services-Program     | 0             |               |       |               |                               | 201. 00 |
|          | Only Charges                              |               |               |       |               |                               |         |
| 202. 00  | Net Charges (line 200 - line 201)         | 123           | 109, 416      |       |               |                               | 202. 00 |

| Health Financial Systems                            | PORTER REGION  |                  |               |                                  | u of Form CMS-2          | 2552-10 |
|---|----------------|------------------|---------------|----------------------------------|--------------------------|---------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA | L COSTS        | Provi der C      | CN: 15-0035   | Peri od:                         | Worksheet D              |         |
|   |                | Component        | CCN: 15-T035  | From 01/01/2021<br>To 12/31/2021 | Part II<br>Date/Time Pre | narod:  |
|   |                | Component        | CCN. 13-1033  | 10 12/31/2021                    | 5/30/2022 6: 2           | 8 pm    |
|   |                | Ti tl e          | XVIII         | Subprovi der -                   | PPS                      |         |
|   |                |                  |               | İRF                              |                          |         |
| Cost Center Description                             | Capi tal       | Total Charges    |               | t Inpatient                      | Capital Costs            |         |
|   |                | (from Wkst. C,   |               | Program                          | (column 3 x              |         |
|   | (from Wkst. B, | Part I, col.     | (col. 1 ÷ col | . Charges                        | column 4)                |         |
|   | Part II, col.  | 8)               | 2)            |                                  |                          |         |
|   | 26)            |                  |               |                                  |                          |         |
|   | 1.00           | 2.00             | 3. 00         | 4. 00                            | 5. 00                    |         |
| ANCILLARY SERVICE COST CENTERS                      |                |                  |               |                                  |                          |         |
| 50.00   05000   OPERATING ROOM                      | 2, 070, 585    |                  | 1             | ·                                | 1                        |         |
| 51.00   05100   RECOVERY ROOM                       | 0              | _                |               |                                  | 0                        | 51.00   |
| 52.00   05200   DELIVERY ROOM & LABOR ROOM          | 417, 078       |                  |               |                                  | 0                        | 52.00   |
| 53. 00   05300   ANESTHESI OLOGY                    | 35, 400        |                  |               |                                  |                          | 53.00   |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C            | 1, 354, 354    | 295, 776, 464    |               |                                  | 1, 005                   | 54.00   |
| 54. 01   05401   ULTRASOUND                         | 0              | 0                | 0.00000       |                                  | 0                        | 54. 01  |
| 56. 00   05600   RADI 0I SOTOPE                     | 0              | 0                | 0.00000       |                                  | 0                        | 56. 00  |
| 57. 00   05700   CT   SCAN                          | 0              | 0                | 0. 00000      | 00                               | 0                        | 57. 00  |
| 58. 00   05800 MRI                                  | 0              | 0                | 0. 00000      | 00                               | 0                        | 58. 00  |
| 60. 00   06000   LABORATORY                         | 516, 367       | 276, 136, 377    | 0. 00187      | 70 1, 467, 226                   | 2, 744                   | 60.00   |
| 65. 00 06500 RESPI RATORY THERAPY                   | 114, 816       | 58, 638, 402     | 0.00195       | 58 2, 933                        | 6                        | 65. 00  |
| 66. 00 06600 PHYSI CAL THERAPY                      | 541, 562       | 26, 231, 559     |               |                                  | 45, 622                  | 66. 00  |
| 67. 00 06700 OCCUPATI ONAL THERAPY                  | 4, 243         | 14, 200, 606     | 0.00029       | 2, 368, 311                      | 708                      | 67. 00  |
| 68. 00 06800 SPEECH PATHOLOGY                       | 3, 775         | 6, 195, 446      | 0. 00060      | 519, 533                         | 316                      | 68. 00  |
| 69. 00 06900 ELECTROCARDI OLOGY                     | 940, 764       | 199, 078, 951    | 0.00472       | 26 65, 941                       | 312                      | 69. 00  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT     | 29, 512        | 46, 247, 861     | 0.00063       | 32                               | 0                        | 71. 00  |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS          | 279, 616       | 185, 405, 071    | 0. 00150      | 12, 427                          | 19                       | 72.00   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS               | 355, 360       | 332, 056, 029    | 0.00107       | 70 1, 060, 134                   | 1, 134                   | 73. 00  |
| 74. 00   07400   RENAL DI ALYSI S                   | 22, 123        | 4, 866, 399      | 0. 00454      | 49, 031                          | 223                      | 74.00   |
| 76. 00 03950 ANCI LLARY                             | 0              | 0                | 0. 00000      | 00                               | 0                        | 76. 00  |
| 76. 01   03610   SLEEP LAB                          | 0              | 0                | 0. 00000      | 00                               | 0                        | 76. 01  |
| 76. 03   03951   WOUND CARE                         | 215, 563       | 13, 069, 643     | 0. 01649      | 3, 280                           | 54                       | 76. 03  |
| OUTPATIENT SERVICE COST CENTERS                     |                |                  |               |                                  |                          |         |
| 90. 00 09000 CLI NI C                               | 0              | C                | 0.00000       | 00                               | 0                        | 90. 00  |
| 91. 00   09100   EMERGENCY                          | 1, 464, 841    | 228, 547, 369    | 0. 00640      | 9 84, 425                        | 541                      | 91. 00  |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART     | 0              | 19, 222, 705     | 0.00000       | 00                               | 0                        | 92.00   |
| 200.00   Total (lines 50 through 199)               | 8, 365, 959    | 2, 167, 642, 591 |               | 8, 120, 431                      | 52, 961                  | 200. 00 |

| Health Financial Systems  | PORTER REGION                        |                                   |                             |                            |                                | u of Form CMS-2   | 2552-10  |
|---|--------------------------------------|-----------------------------------|-----------------------------|----------------------------|--------------------------------|---|--|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS   | RVICE OTHER PAS                      |                                   | CN: 15-0035<br>CCN: 15-T035 |                            | l:<br>01/01/2021<br>02/31/2021 | Worksheet D<br>Part IV<br>Date/Time Pre<br>5/30/2022 6:20 | pared:<br>8 pm                                 |
|   |                                      | Title                             | : XVIII                     | Subprovi der - PPS<br>I RF |                                | PPS   |  |
| Cost Center Description   | Non Physician<br>Anesthetist<br>Cost | Program Post-Stepdown Adjustments |                             | Post                       | -Stepdown<br>ustments          | Allied Health   |  |
| ANOLUL ADV. CEDVI OF COCT. OFNITEDO   | 1.00                                 | 2A                                | 2.00                        |                            | 3A                             | 3. 00   |  |
| ANCILLARY SERVICE COST CENTERS  |                                      |                                   | ı                           |                            |                                |   | F0 00  |
| 50. 00  | 0 0 0 0 0                            | 0 0 0                             |                             | 0<br>0<br>0<br>0           | 0<br>0<br>0<br>0               | 0<br>0<br>0<br>0  | 50. 00<br>51. 00<br>52. 00<br>53. 00<br>54. 00 |
| 54. 01 05401 ULTRASOUND<br>56. 00 05600 RADI OI SOTOPE  | 0                                    | 0                                 |                             | 0                          | 0                              | 0   | 54. 01<br>56. 00                               |
| 57. 00  | 0 0 0                                | 0 0                               |                             | 0 0                        | 0 0                            | 0 0   | 57. 00<br>58. 00<br>60. 00<br>65. 00           |
| 66. 00 06600 PHYSI CAL THERAPY<br>67. 00 06700 OCCUPATI ONAL THERAPY  | 0                                    | 0                                 |                             | 0<br>0<br>0                | 0                              | 0<br>0<br>0   | 66. 00<br>67. 00                               |
| 68. 00   06800   SPEECH PATHOLOGY<br>69. 00   06900   ELECTROCARDI OLOGY<br>71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT | 0 0                                  | 0 0                               |                             | 0<br>0<br>0                | 0<br>0<br>0                    | 0<br>0<br>0   | 68. 00<br>69. 00<br>71. 00                     |
| 72.00   07200   IMPL. DEV. CHARGED TO PATIENTS<br>73.00   07300   DRUGS CHARGED TO PATIENTS<br>74.00   07400   RENAL DIALYSIS       | 0                                    | 0                                 |                             | 0                          | 0                              | 0<br>0<br>0   | 72. 00<br>73. 00<br>74. 00                     |
| 76. 00 03950 ANCI LLARY<br>76. 01 03610 SLEEP LAB<br>76. 03 03951 WOUND CARE  | 0                                    | 0 0                               |                             | 0                          | 0                              | 0 0   | 76. 00<br>76. 01<br>76. 03                     |
| OUTPATIENT SERVICE COST CENTERS   | •                                    |                                   | •                           |                            |                                |   | 1  |
| 90. 00  | 0 0 0 0 0                            | 0 0                               |                             | 0<br>0<br>0                | 0<br>0                         | 0   |  |

| =:           |   | DODTED DEGL 011 |               |                          |                    | 6.5 0110 /                       |                |
|--------------|---|-----------------|---------------|--------------------------|--------------------|----------------------------------|----------------|
|              | ncial Systems<br>NT OF INPATIENT/OUTPATIENT ANCILLARY SEF | PORTER REGION   |               | CN. 1E 002E              | Period:            | eu of Form CMS-2<br>Worksheet D  | 2552-10        |
| THROUGH COS  |   | WICE UTHER PASS | S Provider C  |                          | From 01/01/2021    | Part IV                          |                |
|              | 13  |                 | ·             | CCN: 15-T035             | To 12/31/2021      | Date/Time Prep<br>5/30/2022 6:28 | pared:<br>8 pm |
|              |   |                 | Title         | e XVIII                  | Subprovi der -     | PPS                              |                |
|              |   |                 |               |                          | IRF                |                                  |                |
|              | Cost Center Description                                   | All Other       | Total Cost    | Total                    |                    | Ratio of Cost                    |                |
|              |   | Medical         | (sum of cols. | Outpatient               | (from Wkst. C,     | to Charges                       |                |
|              |   | Education Cost  |               | Cost (sum of cols. 2, 3, | 8)                 | (col. 5 ÷ col. 7)                |                |
|              |   |                 | 4)            | and 4)                   | 0)                 | (see                             |                |
|              |   |                 |               | and 4)                   |                    | instructions)                    |                |
|              |   | 4.00            | 5. 00         | 6, 00                    | 7. 00              | 8. 00                            |                |
| ANCLL        | LARY SERVICE COST CENTERS                                 | 4.00            | 3.00          | 0.00                     | 7.00               | 0.00                             |                |
|              | OPERATING ROOM  | 0               | 0             |                          | 0 416, 701, 547    | 0.000000                         | 50.00          |
|              | RECOVERY ROOM   | 0               | 0             |                          | 0 0                | 0. 000000                        | 1              |
|              | DELIVERY ROOM & LABOR ROOM                                | 0               | 0             | ,                        | 0 17, 652, 850     |                                  |                |
|              | ANESTHESI OLOGY   | 0               | 0             | )                        | 0 27, 615, 312     | 0. 000000                        | 1              |
|              | RADI OLOGY-DI AGNOSTI C                                   | 0               | 0             | )                        | 0 295, 776, 464    |                                  | 1              |
|              | ULTRASOUND  | 0               | 0             | ,                        | 0 0                | 0. 000000                        |                |
| 56.00 05600  | RADI OI SOTOPE  | 0               | 0             | ,                        | 0 0                | 0. 000000                        | 56. 00         |
| 57.00 05700  | CT SCAN   | 0               | 0             | ,                        | 0 0                | 0. 000000                        | 57. 00         |
| 58.00 05800  | MRI   | 0               | 0             | 1                        | 0 0                | 0.000000                         | 58. 00         |
| 60.00 06000  | LABORATORY  | 0               | 0             | )                        | 0 276, 136, 377    | 0.000000                         | 60.00          |
| 65. 00 06500 | RESPI RATORY THERAPY                                      | 0               | 0             | )                        | 0 58, 638, 402     | 0.000000                         | 65. 00         |
| 66. 00 06600 | PHYSI CAL THERAPY   | 0               | 0             | )                        | 0 26, 231, 559     | 0.000000                         | 66. 00         |
| 67. 00 06700 | OCCUPATIONAL THERAPY                                      | 0               | 0             | )                        | 0 14, 200, 606     | 0.000000                         | 67.00          |
| 68. 00 06800 | SPEECH PATHOLOGY  | 0               | 0             | )                        | 0 6, 195, 446      | 0.000000                         | 68. 00         |
| 69. 00 06900 | ELECTROCARDI OLOGY  | 0               | 0             | )                        | 0 199, 078, 951    | 0.000000                         |                |
|              | MEDICAL SUPPLIES CHARGED TO PATIENT                       | 0               | 0             | )                        | 0 46, 247, 861     | 0.000000                         | 71. 00         |
|              | IMPL. DEV. CHARGED TO PATIENTS                            | 0               | 0             | )                        | 0 185, 405, 071    | 0.000000                         |                |
|              | DRUGS CHARGED TO PATIENTS                                 | 0               | 0             | 1                        | 0 332, 056, 029    |                                  | 73. 00         |
|              | RENAL DIALYSIS  | 0               | 0             | )                        | 0 4, 866, 399      | 0.000000                         | 74. 00         |
|              | ANCI LLARY  | 0               | 0             | )                        | 0                  | 0.000000                         |                |
|              | SLEEP LAB   | 0               | 0             | 1                        | 0                  | 0.000000                         | 76. 01         |
|              | WOUND CARE  | 0               | 0             |                          | 0 13, 069, 643     | 0.000000                         | 76. 03         |
|              | TIENT SERVICE COST CENTERS                                |                 |               |                          |                    |                                  |                |
|              | CLINIC  | 0               | 0             | 1                        | 0 0                |                                  | 1              |
|              | EMERGENCY   | 0               | 0             |                          | 0 228, 547, 369    |                                  |                |
|              | OBSERVATION BEDS (NON-DISTINCT PART                       | 0               | 0             | 1                        | 0 19, 222, 705     |                                  |                |
| 200. 00      | Total (lines 50 through 199)                              | 0               | 0             | 1                        | 0 2, 167, 642, 591 |                                  | 200. 00        |

|        | Financial Systems                             | PORTER REGIONAL  |              |              |                                  | eu of Form CMS-2         | 2552-10 |  |
|--------|---|------------------|--------------|--------------|----------------------------------|--------------------------|---------|--|
|        | TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER | RVICE OTHER PASS | Provi der Co | CN: 15-0035  | Peri od:                         | Worksheet D              |         |  |
| THROUG | SH COSTS                                      |                  | Component (  | CCN: 15-T035 | From 01/01/2021<br>To 12/31/2021 | Part IV<br>Date/Time Pre | narad:  |  |
|        |   |                  | Component    | JCN. 13-1033 | 10 12/31/2021                    | 5/30/2022 6: 2           |         |  |
|        |   |                  | Title        | XVIII        | Subprovi der -                   | PPS                      | Орш     |  |
|        |   |                  |              |              | IRF                              |                          |         |  |
|        | Cost Center Description                       | Outpati ent      | I npati ent  | Inpati ent   | Outpati ent                      | Outpati ent              |         |  |
|        |   | Ratio of Cost    | Program      | Program      | Program                          | Program                  |         |  |
|        |   | to Charges       | Charges      | Pass-Throug  |                                  | Pass-Through             |         |  |
|        |   | (col. 6 ÷ col.   | -            | Costs (col.  | 8                                | Costs (col. 9            |         |  |
|        |   | 7)               |              | x col. 10)   |                                  | x col. 12)               |         |  |
|        |   | 9. 00            | 10.00        | 11. 00       | 12.00                            | 13.00                    |         |  |
|        | ANCILLARY SERVICE COST CENTERS                |                  |              |              |                                  |                          |         |  |
| 50.00  | 05000 OPERATI NG ROOM                         | 0. 000000        | 54, 899      |              | 0                                | 0                        | 50.00   |  |
| 51.00  | 05100 RECOVERY ROOM                           | 0. 000000        | 0            |              | 0 0                              | 0                        | 51.00   |  |
| 52.00  | 05200 DELIVERY ROOM & LABOR ROOM              | 0. 000000        | 0            |              | 0 0                              | 0                        | 52. 00  |  |
| 53.00  | 05300 ANESTHESI OLOGY                         | 0. 000000        | 2, 904       |              | 0 0                              | 0                        | 53. 00  |  |
| 54.00  | 05400 RADI OLOGY-DI AGNOSTI C                 | 0. 000000        | 219, 529     |              | 0 0                              | 0                        | 54.00   |  |
| 54.01  | 05401 ULTRASOUND                              | 0. 000000        | 0            |              | 0 0                              | 0                        | 54. 01  |  |
| 56.00  | 05600 RADI OI SOTOPE                          | 0. 000000        | 0            |              | 0 0                              | 0                        | 56. 00  |  |
| 57.00  | 05700 CT SCAN                                 | 0. 000000        | 0            |              | 0                                | 0                        | 57. 00  |  |
| 58.00  | 05800 MRI                                     | 0. 000000        | 0            |              | 0                                | 0                        | 58. 00  |  |
| 60.00  | 06000 LABORATORY                              | 0. 000000        | 1, 467, 226  |              | 0                                | 0                        | 60.00   |  |
| 65.00  | 06500 RESPIRATORY THERAPY                     | 0. 000000        | 2, 933       |              | 0                                | 0                        | 65. 00  |  |
| 66.00  | 06600 PHYSI CAL THERAPY                       | 0. 000000        | 2, 209, 826  |              | 0                                | 0                        | 66. 00  |  |
| 67.00  | 06700 OCCUPATI ONAL THERAPY                   | 0. 000000        | 2, 368, 311  |              | 0                                | 0                        | 67. 00  |  |
| 68.00  | 06800 SPEECH PATHOLOGY                        | 0. 000000        | 519, 533     |              | 0 0                              | 0                        | 68. 00  |  |
| 69.00  | 06900 ELECTROCARDI OLOGY                      | 0. 000000        | 65, 941      |              | 0                                | 0                        | 69. 00  |  |
| 71.00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT     | 0. 000000        | 32           |              | 0                                | 0                        | 71.00   |  |
| 72.00  | 07200 I MPL. DEV. CHARGED TO PATIENTS         | 0. 000000        | 12, 427      |              | 0 0                              | 0                        | 72.00   |  |
| 73.00  | 07300 DRUGS CHARGED TO PATIENTS               | 0. 000000        | 1, 060, 134  |              | 0 0                              | 0                        | 73. 00  |  |
| 74.00  | 07400 RENAL DIALYSIS                          | 0. 000000        | 49, 031      |              | 0 0                              | 0                        | 74.00   |  |
| 76.00  | 03950 ANCI LLARY                              | 0. 000000        | 0            |              | 0 0                              | 0                        | 76. 00  |  |
| 76. 01 | 03610 SLEEP LAB                               | 0. 000000        | 0            |              | 0 0                              | 0                        | 76. 01  |  |
| 76. 03 | 03951 WOUND CARE                              | 0. 000000        | 3, 280       |              | 0 0                              | 0                        | 76. 03  |  |
|        | OUTPATIENT SERVICE COST CENTERS               |                  |              |              |                                  |                          | 1       |  |
| 90.00  | 09000 CLI NI C                                | 0. 000000        | 0            |              | 0 0                              | 0                        | 90. 00  |  |
| 91. 00 | 09100 EMERGENCY                               | 0. 000000        | 84, 425      |              | 0 784                            | Ō                        |         |  |
| 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART     | 0. 000000        | 0            |              | 0 0                              |                          |         |  |
| 200.00 |   |                  | 8, 120, 431  |              | 0 784                            | 0                        | 200. 00 |  |
|        | ,       | 1                |              | '            | ,                                |                          |         |  |

|        | Financial Systems                             | PORTER REGION                |                                 |                    |  | u of Form CMS-2   | 2552-10          |
|--------|---|------------------------------|---------------------------------|--------------------|--|---|------------------|
| APPORT | IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | VACCINE COST                 | Provider CO                     |                    | Peri od:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet D<br>Part V<br>Date/Time Pre<br>5/30/2022 6:2 | pared:<br>8 pm   |
|        |   |                              | Title                           | XVIII              | Subprovider -<br>IRF                         | PPS   |                  |
|        |   |                              |                                 | Charges            |  | Costs   |                  |
|        | Cost Center Description                       | Cost to Charge<br>Ratio From | PPS Reimbursed<br>Services (see | Cost<br>Reimbursed | Cost<br>Rei mbursed                          | PPS Services (see inst.)                                |                  |
|        |   | Worksheet C,                 | inst.)                          | Servi ces          | Services Not                                 | ` ,   |                  |
|        |   | Part I, col. 9               | ,                               | Subject To         | Subject To                                   |   |                  |
|        |   |                              |                                 | Ded. & Coins.      |  |   |                  |
|        |   |                              |                                 | (see inst.)        | (see inst.)                                  |   |                  |
|        |   | 1.00                         | 2. 00                           | 3.00               | 4. 00  | 5. 00   |                  |
|        | ANCILLARY SERVICE COST CENTERS                |                              |                                 |                    |  |   | 1                |
|        | 05000 OPERATING ROOM                          | 0. 067326                    | 0                               |                    | 0  | 0   |                  |
|        | 05100 RECOVERY ROOM                           | 0. 000000                    | 0                               |                    | 0  | 0   | 51.00            |
|        | 05200 DELIVERY ROOM & LABOR ROOM              | 0. 330274                    | 0                               |                    | 0  | 0   |                  |
|        | 05300 ANESTHESI OLOGY                         | 0. 007834                    | 0                               |                    | 0  | 0   | 53. 00           |
|        | 05400 RADI OLOGY-DI AGNOSTI C                 | 0. 065945                    | 0                               |                    | 0  | 0   | 54.00            |
|        | 05401 ULTRASOUND                              | 0. 000000                    | 0                               |                    | 0  | 0   | 54. 01           |
|        | 05600 RADI OI SOTOPE                          | 0. 000000                    | 0                               |                    | 0  | 0   | 56.00            |
|        | 05700 CT SCAN                                 | 0.000000                     | 0                               |                    | 0  | 0   | 57. 00<br>58. 00 |
|        | 05800 MRI<br>06000 LABORATORY                 | 0.000000                     | 0                               |                    | 0 0  | 0   | 1                |
|        | 06500 RESPIRATORY THERAPY                     | 0. 068722<br>0. 085770       | 0                               |                    | 0 0  | 0   | 60.00            |
|        | 06600 PHYSI CAL THERAPY                       | 0. 083770                    | 0                               |                    | 0 0  | 0   | 66.00            |
|        | 06700 OCCUPATIONAL THERAPY                    | 0. 189647                    | 0                               |                    | 0 0  | 0   | 67.00            |
|        | 06800 SPEECH PATHOLOGY                        | 0. 199538                    |                                 |                    | 0 0  | 0   | 68.00            |
|        | 06900 ELECTROCARDI OLOGY                      | 0. 177338                    | 0                               |                    | 0 0  | 0   | 69.00            |
|        | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT     | 0. 060531                    | 0                               |                    |  | 0   | 71.00            |
|        | 07200 I MPL. DEV. CHARGED TO PATIENTS         | 0. 146105                    | 0                               |                    | 0 0  | 0   | 72.00            |
|        | 07300 DRUGS CHARGED TO PATIENTS               | 0. 148761                    | 0                               |                    | 0 4, 470                                     | 0   | 1                |
|        | 07400 RENAL DI ALYSI S                        | 0. 214482                    | 0                               |                    | 0 .,   | 0   | 74.00            |
|        | 03950 ANCI LLARY                              | 0. 000000                    | 0                               |                    | 0 0  | 0   | 76.00            |
|        | 03610 SLEEP LAB                               | 0. 000000                    | 0                               |                    | 0 0  | 0   | 76. 01           |
|        | 03951 WOUND CARE                              | 0. 241353                    | l o                             |                    | 0 0  | 0   | 1                |
|        | OUTPATIENT SERVICE COST CENTERS               |                              |                                 |                    |  |   | 1                |
| 90.00  | 09000 CLI NI C                                | 0. 000000                    | 0                               |                    | 0 0  | 0   | 90.00            |
|        | 09100 EMERGENCY                               | 0. 098608                    | 784                             |                    | 0 0  | 77  | 91.00            |
| 92.00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART     | 0. 248544                    | 0                               |                    | 0  | 0   | 92. 00           |
| 200.00 | Subtotal (see instructions)                   |                              | 784                             |                    | 0 4, 470                                     | 77  | 200.00           |
| 201.00 | Less PBP Clinic Lab. Services-Program         |                              |                                 |                    | 0  |   | 201.00           |
|        | Only Charges                                  |                              | I                               |                    | 1  |   | 1                |

784

201. 00 77 202. 00

202.00

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges
Net Charges (line 200 - line 201)

| Health Financial Systems                                   | PORTER REGIONAL     | _             |             |                             | u of Form CMS-        | 2552-10       |
|--|---------------------|---------------|-------------|-----------------------------|-----------------------|---------------|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICE             | ES AND VACCINE COST | Provi der CCN | N: 15-0035  | Peri od:<br>From 01/01/2021 | Worksheet D<br>Part V |               |
|  |                     | Component CO  | CN: 15-T035 | To 12/31/2021               |                       |               |
|  |                     | Title         | XVIII       | Subprovi der -<br>I RF      | PPS                   |               |
|  | Costs               | s             |             | 1                           |                       |               |
| Cost Center Description                                    | Cost                | Cost          |             |                             |                       |               |
|  | Rei mbursed         | Rei mbursed   |             |                             |                       |               |
|  |                     | Services Not  |             |                             |                       |               |
|  |                     | Subject To    |             |                             |                       |               |
|  |                     | ed. & Coins.  |             |                             |                       |               |
|  |                     | (see inst.)   |             |                             |                       |               |
| ANGLEL ADV. CEDVI CE COCT. CENTEDO                         | 6. 00               | 7. 00         |             |                             |                       |               |
| ANCI LLARY SERVI CE COST CENTERS  50. 00   OPERATI NG ROOM | 0                   | 0             |             |                             |                       | 50.00         |
| 51. 00   05100   RECOVERY   ROOM                           | 0                   | 0             |             |                             |                       | 51.00         |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM                     | 0                   | 0             |             |                             |                       | 52.00         |
| 53. 00 05300 ANESTHESI OLOGY                               |                     | 0             |             |                             |                       | 53.00         |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C                   | 0                   | 0             |             |                             |                       | 54.00         |
| 54. 01   05401 ULTRASOUND                                  | o o                 | 0             |             |                             |                       | 54. 0         |
| 56. 00 05600 RADI OI SOTOPE                                |                     | o             |             |                             |                       | 56.00         |
| 57. 00 05700 CT SCAN                                       |                     | 0             |             |                             |                       | 57. 00        |
| 58. 00   05800 MRI   | ol                  | o             |             |                             |                       | 58. 00        |
| 60. 00 06000 LABORATORY                                    | o                   | o             |             |                             |                       | 60.0          |
| 65. 00 06500 RESPIRATORY THERAPY                           | o                   | o             |             |                             |                       | 65.00         |
| 66. 00 06600 PHYSI CAL THERAPY                             | o                   | o             |             |                             |                       | 66.00         |
| 67. 00 06700 OCCUPATI ONAL THERAPY                         | o                   | О             |             |                             |                       | 67.00         |
| 68.00 06800 SPEECH PATHOLOGY                               | o                   | О             |             |                             |                       | 68.00         |
| 69. 00 06900 ELECTROCARDI OLOGY                            | o                   | О             |             |                             |                       | 69.00         |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE              | NT O                | 0             |             |                             |                       | 71.00         |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS                 | 0                   | 0             |             |                             |                       | 72.00         |
| 73.00 07300 DRUGS CHARGED TO PATIENTS                      | 0                   | 665           |             |                             |                       | 73. 0         |
| 74.00 07400 RENAL DIALYSIS                                 | 0                   | 0             |             |                             |                       | 74.00         |
| 76. 00   03950   ANCI LLARY                                | 0                   | 0             |             |                             |                       | 76. 00        |
| 76. 01   03610   SLEEP LAB                                 | 0                   | 0             |             |                             |                       | 76. 0°        |
| 76. 03 03951 WOUND CARE                                    | 0                   | 0             |             |                             |                       | 76. 03        |
| OUTPATIENT SERVICE COST CENTERS                            |                     |               |             |                             |                       |               |
| 90. 00   09000   CLI NI C                                  | 0                   | 0             |             |                             |                       | 90.00         |
| 91. 00   09100   EMERGENCY                                 | 0                   | 0             |             |                             |                       | 91.00         |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PA              | RT 0                | 0             |             |                             |                       | 92.00         |
| ZUU UUI ISUNTATAI (SEE INSTRUCTIONS)                       | 1 ()                | 665           |             |                             |                       | 1 20 10 1 ( ) |

665

200. 00

202. 00

200. 00 201. 00

202.00

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges
Net Charges (line 200 - line 201)

| Health Financial Systems                           | PORTER REGION  | IAL HOSPITAL   |              | In Lie                      | u of Form CMS-2              | 2552-10 |
|--|----------------|----------------|--------------|-----------------------------|------------------------------|---------|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN | D VACCINE COST | Provi der C    |              | Peri od:<br>From 01/01/2021 | Worksheet D<br>Part V        |         |
|  |                | Component      | CCN: 15-U035 | To 12/31/2021               | Date/Time Pre 5/30/2022 6: 2 |         |
|  | _              | Title          | : XVIII      | Swing Beds - SNF            | PPS                          |         |
|  |                |                | Charges      |                             | Costs                        |         |
| Cost Center Description                            | Cost to Charge | PPS Reimbursed | Cost         | Cost                        | PPS Services                 |         |
|  | Ratio From     | Services (see  | Rei mbursed  | Rei mbursed                 | (see inst.)                  |         |
|  | Worksheet C,   | inst.)         | Servi ces    | Services Not                |                              |         |
|  | Part I, col. 9 |                | Subject To   | Subject To                  |                              |         |
|  |                |                | Ded. & Coins | . Ded. & Coins.             |                              |         |

|        |   |                |                | Charges       |               | 60313        |         |
|--------|---|----------------|----------------|---------------|---------------|--------------|---------|
|        | Cost Center Description                   | Cost to Charge | PPS Reimbursed | Cost          | Cost          | PPS Services |         |
|        |   | Ratio From     | Services (see  | Reimbursed    | Rei mbursed   | (see inst.)  |         |
|        |   | Worksheet C,   | inst.)         | Servi ces     | Services Not  |              |         |
|        |   | Part I, col. 9 |                | Subject To    | Subject To    |              |         |
|        |   |                |                | Ded. & Coins. | Ded. & Coins. |              |         |
|        |   |                |                | (see inst.)   | (see inst.)   |              |         |
|        |   | 1.00           | 2.00           | 3. 00         | 4. 00         | 5. 00        |         |
|        | ANCILLARY SERVICE COST CENTERS            |                |                |               |               |              |         |
| 50.00  |   | 0. 067326      |                | 0             | 0             | 0            | 50.00   |
| 51.00  |   | 0. 000000      |                | 0             | 0             | 0            | 51. 00  |
| 52.00  |   | 0. 330274      |                | 0             | 0             | 0            | 52.00   |
| 53.00  |   | 0. 007834      |                | 0             | 0             | 0            | 53.00   |
| 54.00  |   | 0. 065945      | l .            | 0             | 0             | 0            | 54.00   |
| 54. 01 |   | 0. 000000      |                | 0             | 0             | 0            | 54. 01  |
| 56.00  |   | 0. 000000      | 0              | 0             | 0             | 0            | 56.00   |
| 57. 00 | 05700 CT SCAN                             | 0. 000000      | 0              | 0             | 0             | 0            | 57.00   |
| 58. 00 | 05800 MRI                                 | 0. 000000      | 0              | 0             | 0             | 0            | 58. 00  |
| 60.00  | 06000 LABORATORY                          | 0. 068722      | 0              | 0             | 0             | 0            | 60.00   |
| 65.00  | 06500 RESPI RATORY THERAPY                | 0. 085770      | 0              | 0             | 0             | 0            | 65.00   |
| 66.00  | 06600 PHYSI CAL THERAPY                   | 0. 189647      | 0              | 0             | 0             | 0            | 66.00   |
| 67.00  | 06700 OCCUPATIONAL THERAPY                | 0. 091069      | 0              | 0             | 0             | 0            | 67. 00  |
| 68. 00 | 06800 SPEECH PATHOLOGY                    | 0. 199538      | 0              | 0             | 0             | 0            | 68. 00  |
| 69.00  | 06900 ELECTROCARDI OLOGY                  | 0. 054399      | 0              | 0             | 0             | 0            | 69. 00  |
| 71.00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0. 060531      | 0              | 0             | 0             | 0            | 71. 00  |
| 72.00  | 07200 IMPL. DEV. CHARGED TO PATIENTS      | 0. 146105      | 0              | 0             | 0             | 0            | 72.00   |
| 73.00  | 07300 DRUGS CHARGED TO PATIENTS           | 0. 148761      | 0              | 0             | 0             | 0            | 73. 00  |
| 74.00  | 07400 RENAL DIALYSIS                      | 0. 214482      | 0              | 0             | 0             | 0            | 74. 00  |
| 76.00  | 03950 ANCI LLARY                          | 0. 000000      | 0              | 0             | 0             | 0            | 76. 00  |
| 76. 01 | 03610 SLEEP LAB                           | 0. 000000      | 0              | 0             | 0             | 0            | 76. 01  |
| 76. 03 | 03951 WOUND CARE                          | 0. 241353      | 0              | 0             | 0             | 0            | 76. 03  |
|        | OUTPATIENT SERVICE COST CENTERS           |                |                | •             |               | •            |         |
| 90.00  | 09000 CLI NI C                            | 0. 000000      | 0              | 0             | 0             | 0            | 90. 00  |
| 91.00  | 09100 EMERGENCY                           | 0. 098608      | 0              | 0             | 0             | 0            | 91. 00  |
| 92.00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0. 248544      | 0              | 0             | 0             | 0            | 92. 00  |
| 200.0  |   |                | 0              | 0             | 0             | 0            | 200. 00 |
| 201.0  |   |                |                | 0             | 0             |              | 201. 00 |
|        | Only Charges                              |                |                | ]             |               |              |         |
| 202.0  |   |                | 0              | 0             | 0             | 0            | 202. 00 |
|        |   |                |                | •             | •             |              | •       |

| Heal th | Financial Systems                                   | PORTER REGION | AL HOSPITAL   |              | In Lie           | u of Form CMS-2             | 2552-10        |
|---------|---|---------------|---------------|--------------|------------------|-----------------------------|----------------|
| APPORT  | TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND       | VACCINE COST  | Provi der Co  | CN: 15-0035  | Peri od:         | Worksheet D                 |                |
|         |   |               |               | 00N 4E 1100E | From 01/01/2021  | Part V                      |                |
|         |   |               | Component     | CCN: 15-U035 | To 12/31/2021    | Date/Time Pre 5/30/2022 6:2 | parea:<br>8 nm |
|         |   |               | Title         | e XVIII      | Swing Beds - SNF |                             | о ріп          |
|         |   | Cos           |               |              |                  |                             |                |
|         | Cost Center Description                             | Cost          | Cost          | 1            |                  |                             |                |
|         | ·   | Rei mbursed   | Reimbursed    |              |                  |                             |                |
|         |   | Servi ces     | Services Not  |              |                  |                             |                |
|         |   | Subject To    | Subject To    |              |                  |                             |                |
|         |   | Ded. & Coins. | Ded. & Coins. |              |                  |                             |                |
|         |   | (see inst.)   | (see inst.)   | -            |                  |                             |                |
|         | ANOLLI ADV CEDVI CE COCT CENTEDO                    | 6. 00         | 7. 00         |              |                  |                             |                |
| 50. 00  | ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM | 0             | 0             | ,            |                  |                             | 50.00          |
|         | 05100 RECOVERY ROOM                                 | 0             |               | 1            |                  |                             | 51.00          |
|         | 05200 DELIVERY ROOM & LABOR ROOM                    | 0             | 0             |              |                  |                             | 52.00          |
|         | 05300 ANESTHESI OLOGY                               | 0             | 0             | 1            |                  |                             | 53.00          |
|         | 05400 RADI OLOGY-DI AGNOSTI C                       | 0             | 0             | 1            |                  |                             | 54.00          |
|         | 05401 ULTRASOUND                                    | 0             | 0             |              |                  |                             | 54. 01         |
|         | 05600 RADI OI SOTOPE                                | 0             | 0             |              |                  |                             | 56.00          |
|         | 05700 CT SCAN                                       | 0             | 0             |              |                  |                             | 57.00          |
|         | 05800 MRI   | 0             | 0             |              |                  |                             | 58.00          |
|         | 06000 LABORATORY                                    | 0             | 0             |              |                  |                             | 60.00          |
|         | 06500 RESPI RATORY THERAPY                          | 0             | 0             |              |                  |                             | 65. 00         |
|         | 06600 PHYSI CAL THERAPY                             | 0             | 0             |              |                  |                             | 66.00          |
| 67. 00  | 06700 OCCUPATI ONAL THERAPY                         | 0             | 0             |              |                  |                             | 67. 00         |
| 68. 00  | 06800 SPEECH PATHOLOGY                              | 0             | 0             |              |                  |                             | 68. 00         |
| 69. 00  | 06900 ELECTROCARDI OLOGY                            | 0             | 0             |              |                  |                             | 69. 00         |
| 71. 00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT           | 0             | 0             |              |                  |                             | 71. 00         |
|         | 07200 IMPL. DEV. CHARGED TO PATIENTS                | 0             | 0             |              |                  |                             | 72. 00         |
|         | 07300 DRUGS CHARGED TO PATIENTS                     | 0             | 0             | )            |                  |                             | 73. 00         |
|         | 07400 RENAL DI ALYSI S                              | 0             | 0             | )            |                  |                             | 74. 00         |
|         | 03950 ANCI LLARY                                    | 0             | 0             | 1            |                  |                             | 76. 00         |
|         | 03610 SLEEP LAB                                     | 0             | 0             | 1            |                  |                             | 76. 01         |
| 76. 03  | 03951 WOUND CARE                                    | 0             | 0             | )            |                  |                             | 76. 03         |

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OUTPATIENT SERVICE COST CENTERS 09000 CLINIC

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Subtotal (see instructions) Less PBP Clinic Lab. Services-Program

Only Charges Net Charges (line 200 - line 201)

91. 00 09100 EMERGENCY

200.00

201.00

202.00

From 01/01/2021 Part V 12/31/2021 Date/Time Prepared: 5/30/2022 6:28 pm Title XIX Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) 3.00 (see inst.) 1. 00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.067326 29, 247, 260 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0. 330274 0 0 9 506 52 00 0 05300 ANESTHESI OLOGY 0 53.00 0.007834 0 1, 987, 175 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.065945 30, 974, 283 0 54.00 54. 01 05401 ULTRASOUND 0.000000 0 0 0 54.01 O 0 05600 RADI OI SOTOPE 0.000000 0 56.00 0 0 56.00 57.00 05700 CT SCAN 0.000000 0 0 57.00 05800 MRI 0.000000 0 58.00 0 0 0 58.00 0 21, 222, 566 06000 LABORATORY 0.068722 0 60 00 60 00 0 65.00 06500 RESPIRATORY THERAPY 0.085770 513, 313 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.189647 700, 243 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.091069 135, 637 67.00 0 06800 SPEECH PATHOLOGY 68.00 0. 199538 0 0 283, 275 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.054399 0 11, 611, 589 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.060531 2, 383, 503 71.00 71.00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 146105 0 0 5, 817, 393 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 18, 571, 623 73.00 73.00 0.148761 0 74.00 07400 RENAL DIALYSIS 0. 214482 15, 226 0 74.00 03950 ANCI LLARY 0.000000 0 0 76.00 76.00 0 0 0 03610 SLEEP LAB 76.01 0.000000 0 0 76.01 03951 WOUND CARE 1, 105, 148 76.03 76.03 0. 241353 0 Ω OUTPATIENT SERVICE COST CENTERS 0. 000000 90.00 90.00 09000 CLI NI C 0 0 91.00 91.00 09100 EMERGENCY 0.098608 0 46, 105, 012 0

0.248544

0

92.00

201. 00

0 200. 00

0 202. 00

0

2, 088, 947

172, 771, 699

172, 771, 699

0

0

09200 OBSERVATION BEDS (NON-DISTINCT PART

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Subtotal (see instructions)

Only Charges

92.00

200.00

201.00

202.00

| Health Financial Systems PORT                             | ER REGIONAL HOSPITAL |                | In Lieu of Form CMS-2552-10  |
|---|----------------------|----------------|--|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCO | INE COST Provi der   |                | /2021 Worksheet D /2021 Part V /2021 Date/Time Prepared: 5/30/2022 6:28 pm |
|   | Ti t                 | tle XIX Hospit | al Cost  |

|          |   |               |               |       | To 12/31/2021 | Date/Time Pr<br>5/30/2022 6: |         |
|----------|---|---------------|---------------|-------|---------------|------------------------------|---------|
|          |   |               | Ti tl         | e XIX | Hospi tal     | Cost                         |         |
|          |   | Cos           | sts           |       |               |                              |         |
|          | Cost Center Description                   | Cost          | Cost          |       |               |                              |         |
|          |   | Rei mbursed   | Rei mbursed   |       |               |                              |         |
|          |   | Servi ces     | Services Not  |       |               |                              |         |
|          |   | Subject To    | Subject To    |       |               |                              |         |
|          |   | Ded. & Coins. | Ded. & Coins. |       |               |                              |         |
|          |   | (see inst.)   | (see inst.)   |       |               |                              |         |
|          |   | 6.00          | 7. 00         |       |               |                              |         |
|          | ANCILLARY SERVICE COST CENTERS            |               |               |       |               |                              |         |
|          | 05000 OPERATING ROOM                      | 0             | 1, 969, 101   |       |               |                              | 50. 00  |
| 51.00    | 05100 RECOVERY ROOM                       | 0             | 0             |       |               |                              | 51.00   |
| 52.00    | 05200 DELIVERY ROOM & LABOR ROOM          | 0             | 3, 140        |       |               |                              | 52.00   |
| 53.00    | 05300 ANESTHESI OLOGY                     | 0             | 15, 568       |       |               |                              | 53. 00  |
| 54.00    | 05400 RADI OLOGY-DI AGNOSTI C             | 0             | 2, 042, 599   |       |               |                              | 54. 00  |
| 54. 01   | 05401 ULTRASOUND                          | 0             | 0             |       |               |                              | 54. 01  |
| 56.00    | 05600 RADI 0I S0T0PE                      | 0             | 0             |       |               |                              | 56. 00  |
| 57.00    | 05700 CT SCAN                             | 0             | 0             |       |               |                              | 57. 00  |
| 58. 00   | 05800 MRI                                 | 0             | 0             |       |               |                              | 58. 00  |
| 60.00    | 06000 LABORATORY                          | 0             | 1, 458, 457   |       |               |                              | 60.00   |
|          | 06500 RESPI RATORY THERAPY                | 0             | 44, 027       |       |               |                              | 65. 00  |
|          | 06600 PHYSI CAL THERAPY                   | 0             | 132, 799      | •     |               |                              | 66, 00  |
|          | 06700 OCCUPATIONAL THERAPY                | 0             | 12, 352       | •     |               |                              | 67. 00  |
|          | 06800 SPEECH PATHOLOGY                    | 0             | 56, 524       |       |               |                              | 68. 00  |
|          | 06900 ELECTROCARDI OLOGY                  | 0             | 631, 659      |       |               |                              | 69.00   |
|          | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0             | 144, 276      | •     |               |                              | 71.00   |
| 1        | 07200 I MPL. DEV. CHARGED TO PATIENTS     | 0             | 849, 950      |       |               |                              | 72. 00  |
|          | 07300 DRUGS CHARGED TO PATIENTS           | 0             | 2, 762, 733   | •     |               |                              | 73. 00  |
|          | 07400 RENAL DIALYSIS                      | 0             | 3, 266        | •     |               |                              | 74. 00  |
|          | 03950 ANCI LLARY                          | 0             | 0, 200        |       |               |                              | 76. 00  |
|          | 03610 SLEEP LAB                           | 0             | 1             |       |               |                              | 76. 01  |
|          | 03951 WOUND CARE                          | 0             |               |       |               |                              | 76. 03  |
| <u> </u> | OUTPATIENT SERVICE COST CENTERS           |               | 200, 701      |       |               |                              | 70.00   |
|          | 09000 CLINIC                              | 0             | 0             |       |               |                              | 90.00   |
|          | 09100 EMERGENCY                           | 0             | 4, 546, 323   |       |               |                              | 91.00   |
|          | 09200 OBSERVATION BEDS (NON-DISTINCT PART |               | 519, 195      |       |               |                              | 92. 00  |
| 200.00   | Subtotal (see instructions)               |               | 15, 458, 700  |       |               |                              | 200. 00 |
| 201.00   | Less PBP Clinic Lab. Services-Program     |               | 13, 430, 700  |       |               |                              | 201. 00 |
| 201.00   | Only Charges                              |               |               |       |               |                              | 1201.00 |
| 202. 00  | Net Charges (line 200 - line 201)         | 0             | 15, 458, 700  |       |               |                              | 202. 00 |

| Health Financial Systems                | PORTER REGIONAL HOSPITAL | eu of Form CMS-2552-10      |                             |  |
|---|--------------------------|-----------------------------|-----------------------------|--|
| COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0035    | Peri od:<br>From 01/01/2021 | Worksheet D-1               |  |
|   |                          | To 12/31/2021               | Date/Time Pre 5/30/2022 6:2 |  |
|   | Title XVIII              | Hospi tal                   | PPS                         |  |
| Cost Center Description                 |                          |                             |                             |  |

|                         |  | Title XVIII              | Hospi tal        | 5/30/2022 6: 2<br>PPS | 8 pm                    |  |
|-------------------------|--|--------------------------|------------------|-----------------------|-------------------------|--|
|                         | Cost Center Description  | I tie will               | 1103pi tai       | 113                   |                         |  |
|                         |  |                          |                  |                       |                         |  |
|                         | PART I - ALL PROVIDER COMPONENTS   |                          |                  |                       |                         |  |
| 1. 00<br>2. 00<br>3. 00 | INPATIENT DAYS Inpatient days (including private room days and swing-bed days, excluding newborn) 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, |                          |                  |                       | 1. 00<br>2. 00<br>3. 00 |  |
| 4. 00<br>5. 00          | do not complete this line.<br>Semi-private room days (excluding swing-bed and observation bed days)<br>Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost   |                          |                  |                       | 4. 00<br>5. 00          |  |
| 6. 00                   | reporting period<br>Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost<br>reporting period (if calendar year, enter 0 on this line)   |                          |                  | 0                     | 6. 00                   |  |
| 7. 00                   | 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 reporting period (if calendar year, enter 0 on this line)   | n days) after December 3 | 1 of the cost    | 0                     | 8. 00                   |  |
| 9. 00                   | Total inpatient days including private room days applicable to newborn days) (see instructions)  | the Program (excluding   | swi ng-bed and   | 16, 347               | 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)   |                          |                  |                       | 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)   |                          |                  |                       | 11. 00                  |  |
| 12. 00                  | Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period  |                          |                  | 0                     | 12.00                   |  |
| 13. 00                  | Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar year).  | ear, enter O on this lin | e)               | 0                     | 13. 00                  |  |
| 14. 00<br>15. 00        | Medically necessary private room days applicable to the Progra<br>Total nursery days (title V or XIX only)   | am (excluding swing-bed  | days)            | 0                     | 14. 00<br>15. 00        |  |
| 16. 00                  | Nursery days (title V or XLX only) SWING BED ADJUSTMENT  |                          |                  | 0                     | 16. 00                  |  |
| 17. 00                  | Medicare rate for swing-bed SNF services applicable to service reporting period  | es through December 31 o | f the cost       | 0.00                  | 17. 00                  |  |
| 18. 00                  | Medicare rate for swing-bed SNF services applicable to service reporting period  | es after December 31 of  | the cost         | 0. 00                 | 18. 00                  |  |
| 19. 00                  | Medicaid rate for swing-bed NF services applicable to services reporting period  | s through December 31 of | the cost         | 0. 00                 | 19. 00                  |  |
| 20. 00                  | Medical drate for swing-bed NF services applicable to services reporting period  | s after December 31 of t | he cost          | 0.00                  |                         |  |
| 21. 00<br>22. 00        | Total general inpatient routine service cost (see instructions $Swing$ -bed cost applicable to $SNF$ type services through $December 5 \times Iine 17$ )   |                          | ing period (line | 49, 798, 034<br>0     | 21. 00<br>22. 00        |  |
| 23. 00                  | Swing-bed cost applicable to SNF type services after December x line 18)   | 31 of the cost reporting | g period (line 6 | 0                     | 23. 00                  |  |
| 24. 00                  | Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)  | 31 of the cost reporti   | ng period (line  | 0                     | 24. 00                  |  |
| 25. 00                  | Swing-bed cost applicable to NF type services after December $(x,y)$ line $(x,y)$  | 31 of the cost reporting | period (line 8   | 0                     | 25. 00                  |  |
| 26. 00<br>27. 00        | Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (   | (line 21 minus line 26)  |                  | 0<br>49, 798, 034     | 26. 00<br>27. 00        |  |
| 28. 00                  | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed  | d and observation bed ch | arges)           | 0                     | 28. 00                  |  |
| 29. 00                  | Pri vate room charges (excluding swing-bed charges)  |                          | 9/               | 0                     | 29. 00                  |  |
| 30. 00                  | Semi-private room charges (excluding swing-bed charges)  |                          |                  | 0                     | 30. 00                  |  |
| 31. 00                  | General inpatient routine service cost/charge ratio (line 27   | line 28)                 |                  | 0. 000000             | •                       |  |
| 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 mir   | nus line 33)(see instruc | tions)           | 0.00                  | 34.00                   |  |
| 35.00                   | Average per diem private room cost differential (line 34 x lin   | ne 31)                   |                  | 0.00                  | 35. 00                  |  |
| 36. 00<br>37. 00        | Private room cost differential adjustment (line 3 x line 35)<br>General inpatient routine service cost net of swing-bed cost a   |                          | fferential (line | 0<br>49, 798, 034     | 36. 00<br>37. 00        |  |
|                         | 27 mi nus 1 i ne 36) PART II - HOSPITAL AND SUBPROVI DERS ONLY   |                          |                  |                       |                         |  |
|                         | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  |                          |                  |                       |                         |  |
| 38. 00                  | Adjusted general inpatient routine service cost per diem (see  |                          |                  | 949. 84               | 38. 00                  |  |
| 39. 00                  | Program general inpatient routine service cost (line 9 x line  | *                        |                  | 15, 527, 034          |                         |  |
| 40.00                   | Medically necessary private room cost applicable to the Progra   | •                        |                  | 0                     | 40. 00                  |  |
| 41.00                   | Total Program general inpatient routine service cost (line 39  | + line 40)               |                  | 15, 527, 034          | 41.00                   |  |
|                         |  |                          | ·                |                       |                         |  |

| Heal th          | Financial Systems   | PORTER REGIONA          | AL HOSPITAL        |                             | In Lie                           | eu of Form CMS-2    | 2552-10          |
|------------------|---|-------------------------|--------------------|-----------------------------|----------------------------------|---------------------|------------------|
|                  | ATION OF INPATIENT OPERATING COST   |                         |                    | CN: 15-0035                 | Peri od:                         | Worksheet D-1       |                  |
|                  |   |                         |                    |                             | From 01/01/2021<br>To 12/31/2021 | Date/Time Pre       | pared:           |
|                  |   |                         |                    |                             |                                  | 5/30/2022 6: 2      |                  |
|                  | Coot Conton Decemintion   | Total                   | Ti tl e            | XVIII                       | Hospi tal                        | PPS<br>Program Cost |                  |
|                  | Cost Center Description   | Total<br>Inpatient Cost |                    | Average Per<br>Diem (col. 1 |                                  | (col. 3 x col.      |                  |
|                  |   | inpatront oost          | patront baye       | col . 2)                    |                                  | 4)                  |                  |
|                  | I   | 1.00                    | 2. 00              | 3. 00                       | 4. 00                            | 5. 00               |                  |
| 42. 00           | NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units                   | 0                       | C                  | 0. (                        | 00 0                             | 0                   | 42. 00           |
| 43. 00           | INTENSIVE CARE UNIT   | 17, 528, 822            | 5, 900             | 2, 970.                     | 99 1, 924                        | 5, 716, 185         | 43 00            |
| 43. 01           | NEONATAL INTENSIVE CARE UNIT  | 4, 950, 001             | 3, 305             |                             |                                  | 0, 710, 100         | 1                |
| 44.00            | CORONARY CARE UNIT  |                         |                    |                             |                                  |                     | 44. 00           |
| 45.00            | BURN INTENSIVE CARE UNIT  |                         |                    |                             |                                  |                     | 45. 00           |
| 46.00            | SURGICAL INTENSIVE CARE UNIT<br>OTHER SPECIAL CARE (SPECIFY)                                |                         |                    |                             |                                  |                     | 46. 00<br>47. 00 |
| 47.00            | Cost Center Description   |                         |                    |                             |                                  |                     | 47.00            |
|                  |   |                         |                    |                             |                                  | 1. 00               |                  |
| 48. 00           | Program inpatient ancillary service cost (Wk  |                         | •                  |                             |                                  | 27, 053, 952        |                  |
| 49. 00           | Total Program inpatient costs (sum of lines   | 41 through 48)(         | see instructio     | ons)                        |                                  | 48, 297, 171        | 49. 00           |
| 50. 00           | PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inp                 | atient routine          | services (from     | n Wkst D sum                | n of Parts I and                 | 1, 333, 480         | 50 00            |
| 30.00            |   | attent routine          | aci vi cea (ii oli | i wkst. b, sui              | ii Oi Tai ta Taila               | 1, 333, 400         | 30.00            |
| 51. 00           | Pass through costs applicable to Program inp and IV)  | atient ancillar         | y services (fr     | om Wkst. D, s               | sum of Parts II                  | 1, 062, 656         | 51.00            |
| 52. 00           | Total Program excludable cost (sum of lines   |                         |                    |                             |                                  | 2, 396, 136         |                  |
| 53. 00           | Total Program inpatient operating cost exclu  |                         | lated, non-phy     | sician anesth               | netist, and                      | 45, 901, 035        | 53. 00           |
|                  | medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION             | 52)                     |                    |                             |                                  |                     |                  |
| 54.00            | Program di scharges   |                         |                    |                             |                                  | 0                   | 54. 00           |
|                  | Target amount per discharge   |                         |                    |                             |                                  |                     | 55. 00           |
| 56.00            | Target amount (line 54 x line 55)   |                         |                    | ! F/!                       | 1: 52)                           | 0                   |                  |
| 57. 00<br>58. 00 | Difference between adjusted inpatient operat<br>Bonus payment (see instructions)            | ing cost and ta         | rget amount (i     | ine 56 minus                | Tine 53)                         | 0                   |                  |
| 59. 00           | Lesser of lines 53/54 or 55 from the cost re  | porting period          | endi ng 1996, ເ    | updated and co              | ompounded by the                 |                     | 59.00            |
|                  | market basket   |                         | -                  |                             | ,                                |                     |                  |
| 60.00            | Lesser of lines 53/54 or 55 from prior year   |                         |                    |                             | *b b                             |                     | 60.00            |
| 61. 00           | If line 53/54 is less than the lower of line which operating costs (line 53) are less that  |                         |                    |                             |                                  | 0                   | 61.00            |
|                  | amount (line 56), otherwise enter zero (see   |                         | o (TTTICS OT X     | 00), 01 1% 01               | the target                       |                     |                  |
|                  | Relief payment (see instructions)   |                         |                    |                             |                                  | 0                   |                  |
| 63.00            | Allowable Inpatient cost plus incentive paym<br>PROGRAM INPATIENT ROUTINE SWING BED COST    | ent (see instru         | ctions)            |                             |                                  | 0                   | 63.00            |
| 64. 00           | Medicare swing-bed SNF inpatient routine cos  | ts through Dece         | mber 31 of the     | cost reporti                | na period (See                   | 0                   | 64. 00           |
|                  | instructions)(title XVIII only)   |                         |                    |                             |                                  |                     |                  |
| 65.00            | Medicare swing-bed SNF inpatient routine cos  | ts after Decemb         | er 31 of the d     | ost reportino               | g period (See                    | 0                   | 65. 00           |
| 66. 00           | instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi                | ne costs (line          | 64 nlus line A     | 5)(title XVII               | Lonly) For                       | 0                   | 66. 00           |
| 00.00            | CAH (see instructions)  | ne costs (Trie          | by prus rine c     | 55) (ti ti e xvi i          | 1 Om y). 101                     |                     | 00.00            |
| 67. 00           | Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)                            | e costs through         | December 31 c      | of the cost re              | eporting period                  | 0                   | 67. 00           |
| 68. 00           | Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)                            | e costs after D         | ecember 31 of      | the cost repo               | orting period                    | 0                   | 68. 00           |
| 69. 00           | Total title V or XIX swing-bed NF inpatient   | routine costs (         | line 67 + line     | e 68)                       |                                  | 0                   | 69. 00           |
|                  | PART III - SKILLED NURSING FACILITY, OTHER N  | URSING FACILITY,        | AND ICF/IID        | ONLY                        |                                  |                     |                  |
| 70.00            | Skilled nursing facility/other nursing facil  | ,                       |                    |                             | 1                                |                     | 70.00            |
| 71. 00<br>72. 00 | Adjusted general inpatient routine service c<br>Program routine service cost (line 9 x line |                         | ine /U ÷ IINE      | ۷)                          |                                  |                     | 71. 00<br>72. 00 |
| 73. 00           | Medically necessary private room cost applic  |                         | (line 14 x li      | ne 35)                      |                                  |                     | 73. 00           |
| 74. 00           | Total Program general inpatient routine serv  | ice costs (line         | 72 + line 73)      |                             |                                  |                     | 74. 00           |
| 75. 00           | Capital-related cost allocated to inpatient 26, line 45)                                    |                         | costs (from V      | Vorksheet B, F              | Part II, column                  |                     | 75. 00           |
| 76. 00           | Per diem capital-related costs (line 75 ÷ li  |                         |                    |                             |                                  |                     | 76. 00           |
| 77. 00<br>78. 00 | Program capital-related costs (line 9 x line   Inpatient routine service cost (line 74 minu |                         |                    |                             |                                  |                     | 77. 00<br>78. 00 |
| 79. 00           | Aggregate charges to beneficiaries for exces  |                         | rovi der record    | ls)                         |                                  |                     | 79.00            |
|                  | Total Program routine service costs for comp  |                         |                    |                             | nus line 79)                     |                     | 80. 00           |
| 81.00            | Inpatient routine service cost per diem limi  |                         |                    |                             |                                  |                     | 81.00            |
| 82. 00<br>83. 00 | Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (   |                         |                    |                             |                                  |                     | 82. 00<br>83. 00 |
| 84. 00           | Program inpatient ancillary services (see in  |                         | رد                 |                             |                                  |                     | 84. 00           |
| 85. 00           | Utilization review - physician compensation   |                         | ns)                |                             |                                  |                     | 85. 00           |
|                  | Total Program inpatient operating costs (sum  | of lines 83 th          |                    |                             |                                  |                     | 86. 00           |
| 07.00            | PART IV - COMPUTATION OF OBSERVATION BED PAS  |                         |                    |                             |                                  | F 000               | 07.00            |
| 87. 00<br>88. 00 | Total observation bed days (see instructions Adjusted general inpatient routine cost per    | •                       | line 2)            |                             |                                  |                     | 87. 00<br>88. 00 |
|                  | Observation bed cost (line 87 x line 88) (se  | •                       | - /                |                             |                                  | 4, 777, 695         | 1                |
|                  | , ,   |                         |                    |                             |                                  |                     |                  |

| Health Financial Systems                      | PORTER REGION | AL HOSPITAL    |            | In Lie                           | u of Form CMS-2               | 2552-10 |
|---|---------------|----------------|------------|----------------------------------|-------------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST       |               | Provi der CC   |            | Peri od:                         | Worksheet D-1                 |         |
|   |               |                |            | From 01/01/2021<br>To 12/31/2021 | Date/Time Prep 5/30/2022 6:28 |         |
|   |               | Title          | XVIII      | Hospi tal                        | PPS                           |         |
| Cost Center Description                       | Cost          | Routine Cost   | column 1 ÷ | Total                            | Observation                   |         |
|   |               | (from line 21) | column 2   | Observati on                     | Bed Pass                      |         |
|   |               |                |            | Bed Cost (from                   | Through Cost                  |         |
|   |               |                |            | line 89)                         | (col. 3 x col.                |         |
|   |               |                |            |                                  | 4) (see                       |         |
|   |               |                |            |                                  | instructions)                 |         |
|   | 1.00          | 2. 00          | 3. 00      | 4. 00                            | 5. 00                         |         |
| COMPUTATION OF OBSERVATION BED PASS THROUGH ( | COST          |                |            |                                  |                               |         |
| 90.00 Capital-related cost                    | 3, 577, 020   | 49, 798, 034   | 0. 07183   | 1 4, 777, 695                    | 343, 187                      | 90.00   |
| 91.00 Nursing Program cost                    | 0             | 49, 798, 034   | 0.00000    | 0 4, 777, 695                    | 0                             | 91.00   |
| 92.00 Allied health cost                      | 0             | 49, 798, 034   | 0.00000    | 0 4, 777, 695                    | 0                             | 92.00   |
| 93.00 All other Medical Education             | 0             | 49, 798, 034   | 0. 00000   | 0 4, 777, 695                    | 0                             | 93. 00  |

| Health Financial Systems                | PORTER REGIONAL HOSPITAL | In Lie                        | eu of Form CMS-2552-10                |
|---|--------------------------|-------------------------------|---------------------------------------|
| COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-003     | 5 Peri od:<br>From 01/01/2021 | Worksheet D-1                         |
|   | Component CCN: 15-T0     |                               | Date/Time Prepared: 5/30/2022 6:28 pm |
|   | Title XVIII              | Subprovi der -                | PPS                                   |
|   |                          | IDE                           |                                       |

|                  |   | II the Aviii                          | I RF            | FF3              |                  |
|------------------|---|---------------------------------------|-----------------|------------------|------------------|
|                  | Cost Center Description   |                                       |                 |                  |                  |
|                  | PART I - ALL PROVIDER COMPONENTS  |                                       |                 | 1. 00            |                  |
|                  | I NPATI ENT DAYS  |                                       |                 |                  |                  |
| 1.00             | Inpatient days (including private room days and swing-bed days  |                                       |                 | 3, 707           | 1.00             |
| 2.00             | Inpatient days (including private room days, excluding swing-b  |                                       |                 | 3, 707           | 2.00             |
| 3. 00            | Private room days (excluding swing-bed and observation bed day do not complete this line.   | /s). If you have only pri             | vate room days, | 0                | 3. 00            |
| 4.00             | Semi-private room days (excluding swing-bed and observation be  | ed days)                              |                 | 3, 707           | 4. 00            |
| 5.00             | Total swing-bed SNF type inpatient days (including private roo  |                                       | 31 of the cost  | 0                | 5. 00            |
|                  | reporting period  | om dava) aftar Dagambar 3             | 11 of the cost  | 0                | 4 00             |
| 6. 00            | Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)         | om days) after becember 3             | or the cost     | 0                | 6. 00            |
| 7.00             | Total swing-bed NF type inpatient days (including private room  | n days) through December              | 31 of the cost  | 0                | 7. 00            |
|                  | reporting period  |                                       |                 | _                |                  |
| 8. 00            | Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)          | n days) after December 31             | of the cost     | 0                | 8. 00            |
| 9. 00            | Total inpatient days including private room days applicable to  | the Program (excluding                | swing-bed and   | 2, 235           | 9. 00            |
|                  | newborn days) (see instructions)  |                                       |                 |                  |                  |
| 10. 00           | Swing-bed SNF type inpatient days applicable to title XVIII or  |                                       | oom days)       | 0                | 10. 00           |
| 11. 00           | through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or     |                                       | nom davs) after | 0                | 11. 00           |
|                  | December 31 of the cost reporting period (if calendar year, er  | nter 0 on this line)                  | Join days) ares | Ü                |                  |
| 12. 00           | Swing-bed NF type inpatient days applicable to titles V or XI)  | ( only (including private             | e room days)    | 0                | 12. 00           |
| 13. 00           | through December 31 of the cost reporting period<br>Swing-bed NF type inpatient days applicable to titles V or XI)                | ( only (including private             | room days)      | 0                | 13. 00           |
| 13.00            | after December 31 of the cost reporting period (if calendar ve  |                                       |                 | O                | 13.00            |
| 14. 00           | Medically necessary private room days applicable to the Progra  | · · · · · · · · · · · · · · · · · · · | , I             | 0                | 14. 00           |
| 15.00            | Total nursery days (title V or XIX only)  |                                       |                 | 0                | 15.00            |
| 16. 00           | Nursery days (title V or XLX only) SWING BED ADJUSTMENT   |                                       |                 | 0                | 16. 00           |
| 17. 00           | Medicare rate for swing-bed SNF services applicable to service  | es through December 31 of             | the cost        | 0.00             | 17. 00           |
|                  | reporting period  | Ü                                     |                 |                  |                  |
| 18. 00           | Medicare rate for swing-bed SNF services applicable to service  | es after December 31 of t             | the cost        | 0. 00            | 18. 00           |
| 19. 00           | reporting period Medicaid rate for swing-bed NF services applicable to services   | s through December 31 of              | the cost        | 0. 00            | 19. 00           |
|                  | reporting period  | g                                     |                 | 2.22             |                  |
| 20. 00           | Medicaid rate for swing-bed NF services applicable to services  | s after December 31 of th             | ne cost         | 0. 00            | 20. 00           |
| 21. 00           | reporting period Total general inpatient routine service cost (see instructions   | :)                                    |                 | 3, 987, 154      | 21. 00           |
| 22. 00           | Swing-bed cost applicable to SNF type services through December   |                                       | ng period (line | 0, 707, 101      | 22. 00           |
|                  | 5 x line 17)  |                                       |                 |                  |                  |
| 23. 00           | Swing-bed cost applicable to SNF type services after December x line 18)  | 31 of the cost reporting              | period (line 6  | 0                | 23. 00           |
| 24. 00           | Swing-bed cost applicable to NF type services through December  | 31 of the cost reportin               | ng period (line | 0                | 24. 00           |
|                  | 7 x line 19)  | •                                     |                 |                  |                  |
| 25. 00           | Swing-bed cost applicable to NF type services after December 3  | 31 of the cost reporting              | period (line 8  | 0                | 25. 00           |
| 26. 00           | x line 20) Total swing-bed cost (see instructions)  |                                       |                 | 0                | 26. 00           |
| 27. 00           | General inpatient routine service cost net of swing-bed cost (  | (line 21 minus line 26)               |                 | 3, 987, 154      |                  |
|                  | PRI VATE ROOM DI FFERENTI AL ADJUSTMENT   |                                       | ,               |                  |                  |
| 28. 00<br>29. 00 | General inpatient routine service charges (excluding swing-bed<br>Private room charges (excluding swing-bed charges)              | d and observation bed cha             | irges)          | 0                | 28. 00<br>29. 00 |
| 30.00            | Semi - pri vate room charges (excluding swing-bed charges)  |                                       |                 | 0                | 30.00            |
| 31. 00           | General inpatient routine service cost/charge ratio (line 27 -  | - line 28)                            |                 | 0. 000000        |                  |
| 32. 00           | Average private room per diem charge (line 29 ÷ line 3)   |                                       |                 | 0. 00            |                  |
| 33.00            | Average semi-private room per diem charge (line 30 ÷ line 4)  | nus lina 22) (saa instrust            | i one)          | 0.00             |                  |
| 34. 00<br>35. 00 | Average per diem private room charge differential (line 32 mir<br>Average per diem private room cost differential (line 34 x line |                                       | .i ons)         | 0. 00<br>0. 00   |                  |
| 36. 00           | Private room cost differential adjustment (line 3 x line 35)  | - **/                                 |                 | 0.00             | 36. 00           |
| 37. 00           | General inpatient routine service cost net of swing-bed cost a  | and private room cost dif             | ferential (line | 3, 987, 154      | 37. 00           |
|                  | 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY  |                                       |                 |                  |                  |
|                  | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU  | ISTMENTS                              |                 |                  |                  |
| 38. 00           | Adjusted general inpatient routine service cost per diem (see   |                                       |                 | 1, 075. 57       | 38. 00           |
| 39. 00           | Program general inpatient routine service cost (line 9 x line   | •                                     |                 | 2, 403, 899      |                  |
| 40.00            | Medically necessary private room cost applicable to the Program general inpatient routine service cost (Line 30)                  |                                       |                 | 0<br>2, 403, 899 | 40.00            |
| 41. 00           | Total Program general inpatient routine service cost (line 39   | + IIIIC 4U)                           | I               | 2, 403, 899      | 41.00            |

| Heal th          | Financial Systems   | PORTER REGIONAL   | L HOSPITAL      |               | In Li€                      | eu of Form CMS-2      | 2552-10          |
|------------------|---|-------------------|-----------------|---------------|-----------------------------|-----------------------|------------------|
| COMPUT           | ATION OF INPATIENT OPERATING COST   |                   | Provi der CC    | :N: 15-0035   | Peri od:<br>From 01/01/2021 | Worksheet D-1         |                  |
|                  |   |                   | Component C     | CN: 15-T035   | To 12/31/2021               | Date/Time Pre         |                  |
|                  |   |                   | Title           | XVIII         | Subprovi der -              | 5/30/2022 6: 2<br>PPS | ο μιι            |
|                  | Cost Center Description   | Total             | Total           | Average Per   | IRF<br>Program Days         | Program Cost          |                  |
|                  | cost center bescription   | Inpatient Cost    |                 |               |                             | (col. 3 x col.        |                  |
|                  |   | 1.00              | 2.00            | 3. 00         | 4. 00                       | 5. 00                 |                  |
| 42. 00           | NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units                     | 0                 | 0               | 0.0           | 00 0                        | 0                     | 42.00            |
| 43.00            | INTENSIVE CARE UNIT   | 0                 | 0               | 0.0           | 00 0                        | 0                     | 43. 00           |
| 43. 01           | NEONATAL INTENSIVE CARE UNIT  | 0                 | 0               | 0.0           | 00 0                        | 0                     | 43. 01           |
| 44. 00<br>45. 00 | CORONARY CARE UNIT BURN INTENSIVE CARE UNIT   |                   |                 |               |                             |                       | 44. 00<br>45. 00 |
| 46. 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 (Wk  | st. D-3, col. 3,  | line 200)       |               |                             | 1, 040, 458           | 48. 00           |
| 49. 00           | Total Program inpatient costs (sum of lines   |                   |                 | ns)           |                             | 3, 444, 357           | 49. 00           |
| 50. 00           | PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program input                 | atient routine s  | ervices (from   | Wkst D sum    | of Parts I and              | 262, 300              | 50.00            |
| 30.00            |   | attent routine s  | ervices (ITOIII | WKSt. D, Suii | i or raits i and            | 202, 300              | 30.00            |
| 51. 00           | Pass through costs applicable to Program inpand IV)   | atient ancillary  | services (fro   | om Wkst. D, s | um of Parts II              | 52, 961               | 51. 00           |
| 52. 00           | Total Program excludable cost (sum of lines   |                   |                 |               |                             | 315, 261              | 1                |
| 53. 00           | Total Program inpatient operating cost exclumedical education costs (line 49 minus line !     |                   | ated, non-phys  | sician anesth | etist, and                  | 3, 129, 096           | 53. 00           |
|                  | TARGET AMOUNT AND LIMIT COMPUTATION   | 32)               |                 |               |                             |                       |                  |
| 54. 00           | Program di scharges   |                   |                 |               |                             | 0                     |                  |
| 55. 00<br>56. 00 | Target amount per discharge Target amount (line 54 x line 55)                                 |                   |                 |               |                             | 0.00                  | 1                |
| 57. 00           | Difference between adjusted inpatient operation   | ing cost and tar  | get amount (Li  | ne 56 minus   | line 53)                    | 0                     | 57. 00           |
| 58. 00           | Bonus payment (see instructions)  |                   |                 |               |                             | 0                     |                  |
| 59. 00           | Lesser of lines 53/54 or 55 from the cost remarket basket                                     | porting period e  | ndi ng 1996, uj | odated and co | mpounded by the             | 0.00                  | 59. 00           |
| 60.00            | Lesser of lines 53/54 or 55 from prior year   | cost report, upd  | ated by the ma  | arket basket  |                             | 0.00                  | 60.00            |
| 61. 00           | If line 53/54 is less than the lower of line  |                   |                 |               |                             | 0                     | 61. 00           |
|                  | which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see     |                   | (Tines 54 x c   | 50), OF 1% OF | the target                  |                       |                  |
| 62. 00           | Relief payment (see instructions)   | ,                 |                 |               |                             | 0                     | 62. 00           |
| 63. 00           | Allowable Inpatient cost plus incentive paym  | ent (see instruc  | tions)          |               |                             | 0                     | 63.00            |
| 64. 00           | PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine cos        | ts through Decem  | ber 31 of the   | cost reporti  | na period (See              | 0                     | 64. 00           |
|                  | instructions) (title XVIII only)  | 3                 |                 | •             | 3 1 (                       |                       |                  |
| 65. 00           | Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)                   | ts after Decembe  | r 31 of the co  | ost reporting | period (See                 | 0                     | 65. 00           |
| 66. 00           | Total Medicare swing-bed SNF inpatient routing  | ne costs (line 6  | 4 plus line 6   | 5)(title XVII | I only). For                | 0                     | 66. 00           |
| 67. 00           | CAH (see instructions)  | a costs through   | Docombor 21 o   | f the cost re | norting ported              |                       | 67. 00           |
| 67.00            | Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)                             | e costs till ough | beceiliber 31 0 | i the cost re | portring perrou             |                       | 67.00            |
| 68. 00           | Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)                             | e costs after De  | cember 31 of    | the cost repo | rting period                | 0                     | 68. 00           |
| 69. 00           | Total title V or XIX swing-bed NF inpatient   |                   |                 |               |                             | 0                     | 69. 00           |
| 70. 00           | PART III - SKILLED NURSING FACILITY, OTHER NU<br>Skilled nursing facility/other nursing facil |                   |                 |               |                             |                       | 70. 00           |
| 71.00            | Adjusted general inpatient routine service of   |                   |                 |               |                             |                       | 71.00            |
| 72. 00           | Program routine service cost (line 9 x line   | 71)               |                 |               |                             |                       | 72. 00           |
| 73. 00<br>74. 00 | Medically necessary private room cost applicated Program general inputions routing corre      | •                 | •               | ne 35)        |                             |                       | 73. 00<br>74. 00 |
| 75. 00           | Total Program general inpatient routine servicapital-related cost allocated to inpatient      | •                 | ,               | orksheet B, F | art II, column              |                       | 75. 00           |
|                  | 26, line 45)  |                   | •               |               |                             |                       |                  |
| 76. 00<br>77. 00 | Per diem capital-related costs (line 75 ÷ li<br>Program capital-related costs (line 9 x line  |                   |                 |               |                             |                       | 76. 00<br>77. 00 |
| 78. 00           | Inpatient routine service cost (line 74 minus   |                   |                 |               |                             |                       | 78.00            |
| 79. 00           | Aggregate charges to beneficiaries for excess   | s costs (from pr  |                 | *             |                             |                       | 79. 00           |
| 80.00            | Total Program routine service costs for compa   |                   | st limitation   | (line 78 min  | us line 79)                 |                       | 80.00            |
| 81. 00<br>82. 00 | Inpatient routine service cost per diem limi<br>Inpatient routine service cost limitation (I  |                   |                 |               |                             |                       | 81. 00<br>82. 00 |
| 83. 00           | Reasonable inpatient routine service costs (  |                   | )               |               |                             |                       | 83. 00           |
| 84.00            | Program inpatient ancillary services (see in  |                   | ->              |               |                             |                       | 84. 00           |
| 85. 00<br>86. 00 | Utilization review - physician compensation<br>Total Program inpatient operating costs (sum   | •                 | *               |               |                             |                       | 85. 00<br>86. 00 |
| 55. 55           | PART IV - COMPUTATION OF OBSERVATION BED PASS   |                   |                 |               |                             |                       | 33.30            |
| 87.00            | Total observation bed days (see instructions  |                   | 1: 0            |               |                             | 0                     |                  |
| 88. 00<br>89. 00 | Adjusted general inpatient routine cost per observation bed cost (line 87 x line 88) (see     |                   | iine 2)         |               |                             | 1                     | 88. 00<br>89. 00 |
| 37.00            | (30)  |                   |                 |               |                             | 1                     | , 57. 00         |

| Health Financial Systems                      | PORTER REGION | AL HOSPITAL    |            | In Lie                           | eu of Form CMS-2               | 2552-10 |
|---|---------------|----------------|------------|----------------------------------|--------------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST       |               | Provider CO    |            | Peri od:                         | Worksheet D-1                  |         |
|   |               | Component (    |            | From 01/01/2021<br>To 12/31/2021 | Date/Time Pre<br>5/30/2022 6:2 |         |
|   |               | Title          | XVIII      | Subprovi der -                   | PPS                            |         |
|   |               | B 11 0 1       |            | I RF                             |                                |         |
| Cost Center Description                       | Cost          | Routine Cost   | column 1 ÷ | Total                            | Observati on                   |         |
|   |               | (from line 21) | column 2   | Observati on                     | Bed Pass                       |         |
|   |               |                |            | Bed Cost (from                   | Through Cost                   |         |
|   |               |                |            | line 89)                         | (col. 3 x col.                 |         |
|   |               |                |            |                                  | 4) (see                        |         |
|   |               |                |            |                                  | instructions)                  |         |
|   | 1.00          | 2.00           | 3.00       | 4. 00                            | 5. 00                          |         |
| COMPUTATION OF OBSERVATION BED PASS THROUGH ( | COST          |                |            |                                  |                                |         |
| 90.00 Capital -related cost                   | 435, 067      | 3, 987, 154    | 0. 10911   | 7 0                              | 0                              | 90. 00  |
| 91.00 Nursing Program cost                    | 0             | 3, 987, 154    | 0.00000    | 0 0                              | 0                              | 91. 00  |
| 92.00 Allied health cost                      | 0             | 3, 987, 154    | 0.00000    | 0 0                              | 0                              | 92.00   |
| 93.00 All other Medical Education             | 0             | 3, 987, 154    | 0. 00000   | 0 0                              | 0                              | 93. 00  |

| Health Financial Systems                | PORTER REGIONAL HOSPITAL | In Lie          | u of Form CMS-2552-10                               |
|---|--------------------------|-----------------|---|
| COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15         | From 01/01/2021 | Worksheet D-1 Date/Time Prepared: 5/30/2022 6:28 pm |
|   | Title XIX                | K Hospi tal     | Cost  |
| C+ C+                                   |                          |                 |   |

|                  |   | Till VIV                     |                  | 5/30/2022 6: 28 | 8 pm    |
|------------------|---|------------------------------|------------------|-----------------|---------|
|                  | Cost Center Description   | Title XIX                    | Hospi tal        | Cost            |         |
|                  | cost center bescription   |                              |                  | 1. 00           |         |
|                  | PART I - ALL PROVIDER COMPONENTS  |                              |                  |                 |         |
|                  | I NPATI ENT DAYS  |                              |                  |                 |         |
| 1. 00            | Inpatient days (including private room days and swing-bed days  |                              |                  | 52, 485         |         |
| 2.00             | Inpatient days (including private room days, excluding swing-   | <i>3</i> ,                   |                  | 52, 428         | •       |
| 3. 00            | Private room days (excluding swing-bed and observation bed day do not complete this line.                                       | ys). IT you nave only pri    | vate room days,  | 0               | 3. 00   |
| 4.00             | Semi-private room days (excluding swing-bed and observation be  | ed days)                     |                  | 47, 398         | 4. 00   |
| 5. 00            | Total swing-bed SNF type inpatient days (including private room   |                              | r 31 of the cost | 57              | 5.00    |
| 0.00             | reporting period  | om days) trii odgir becember | or or the cost   | ,               | 0.00    |
| 6.00             | Total swing-bed SNF type inpatient days (including private roo  | om days) after December :    | 31 of the cost   | 0               | 6.00    |
|                  | reporting period (if calendar year, enter 0 on this line)   | <i>3</i> ,                   |                  |                 |         |
| 7.00             | Total swing-bed NF type inpatient days (including private room  | m days) through December     | 31 of the cost   | 0               | 7. 00   |
|                  | reporting period  |                              |                  | _               |         |
| 8. 00            | Total swing-bed NF type inpatient days (including private room  | m days) after December 3     | 1 of the cost    | 0               | 8. 00   |
| 9. 00            | reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to        | the Drogram (eveluding       | cwing had and    | 1, 164          | 9. 00   |
| 9.00             | newborn days) (see instructions)  | The Program (excruding       | Swifig-bed and   | 1, 104          | 9.00    |
| 10. 00           | Swing-bed SNF type inpatient days applicable to title XVIII or  | nly (including private r     | oom days)        | 0               | 10.00   |
|                  | through December 31 of the cost reporting period (see instruc-  |                              |                  |                 |         |
| 11.00            | Swing-bed SNF type inpatient days applicable to title XVIII or  |                              | oom days) after  | 0               | 11. 00  |
|                  | December 31 of the cost reporting period (if calendar year, en  |                              |                  |                 |         |
| 12. 00           | Swing-bed NF type inpatient days applicable to titles V or XIX  | Conly (including private     | e room days)     | 0               | 12. 00  |
| 12.00            | through December 31 of the cost reporting period  | /! /!!!!+                    |                  | 0               | 12 00   |
| 13. 00           | Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar year) |                              |                  | ١               | 13. 00  |
| 14. 00           | Medically necessary private room days applicable to the Progra  |                              |                  | 0               | 14. 00  |
| 15. 00           | Total nursery days (title V or XIX only)  | am (exertaining aming bea    | adys)            | 2, 402          | ı       |
| 16. 00           | Nursery days (title V or XIX only)  |                              |                  | 1, 071          |         |
|                  | SWING BED ADJUSTMENT  |                              |                  |                 | ĺ       |
| 17. 00           | Medicare rate for swing-bed SNF services applicable to service  | es through December 31 o     | f the cost       | 0.00            | 17. 00  |
|                  | reporting period  |                              |                  |                 |         |
| 18. 00           | Medicare rate for swing-bed SNF services applicable to service  | es after December 31 of      | the cost         | 0. 00           | 18. 00  |
| 19. 00           | reporting period Medicaid rate for swing-bed NF services applicable to services   | through Docombon 21 of       | the cost         | 0.00            | 19. 00  |
| 19.00            | reporting period  | s through becember 31 of     | the cost         | 0.00            | 19.00   |
| 20. 00           | Medicaid rate for swing-bed NF services applicable to services  | s after December 31 of th    | ne cost          | 0.00            | 20. 00  |
|                  | reporting period  |                              |                  |                 |         |
| 21. 00           | Total general inpatient routine service cost (see instructions  |                              |                  | 49, 798, 034    | 21. 00  |
| 22. 00           | Swing-bed cost applicable to SNF type services through December   | er 31 of the cost reporti    | ing period (line | 0               | 22. 00  |
| 22.00            | 5 x line 17)  | 21 -6                        |                  |                 | 22.00   |
| 23. 00           | Swing-bed cost applicable to SNF type services after December   x line 18)  | 31 of the cost reporting     | g period (iine 6 | 0               | 23. 00  |
| 24. 00           | ,   | - 31 of the cost reportion   | na neriod (line  | 0               | 24. 00  |
| 21.00            | 7 x line 19)  | or or the cost reportin      | ig period (iiiie | Ĭ               | 21.00   |
| 25. 00           | Swing-bed cost applicable to NF type services after December :  | 31 of the cost reporting     | period (line 8   | 0               | 25. 00  |
|                  | x line 20)  |                              |                  |                 |         |
| 26. 00           | Total swing-bed cost (see instructions)   |                              |                  | 0               | 26. 00  |
| 27. 00           | General inpatient routine service cost net of swing-bed cost  | (line 21 minus line 26)      |                  | 49, 798, 034    | 27. 00  |
| 20.00            | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  | d and shaarustion had also   | 25500)           |                 | 1 20 00 |
| 28. 00<br>29. 00 | Private room charges (excluding swing-bed charges)  | a and observation bed cha    | ar ges)          | 0               | ł       |
| 30. 00           | Semi -pri vate room charges (excluding swing-bed charges)   |                              |                  | 0               | 30.00   |
| 31. 00           | General inpatient routine service cost/charge ratio (line 27  | : line 28)                   |                  | 0. 000000       |         |
| 32.00            | Average private room per diem charge (line 29 ÷ line 3)   |                              |                  | 0.00            | 1       |
| 33.00            | Average semi-private room per diem charge (line 30 ÷ line 4)  |                              |                  | 0.00            | 33. 00  |
| 34.00            | Average per diem private room charge differential (line 32 mi)  |                              | tions)           | 0.00            |         |
| 35. 00           | Average per diem private room cost differential (line 34 x li   | ne 31)                       |                  | 0.00            |         |
| 36. 00           | Private room cost differential adjustment (line 3 x line 35)  |                              |                  | 0               | 36. 00  |
| 37. 00           | General inpatient routine service cost net of swing-bed cost  | and private room cost di     | rterential (line | 49, 798, 034    | 37. 00  |
|                  | 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY  |                              |                  |                 | -       |
|                  | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU  | ISTMENTS                     |                  |                 |         |
| 38. 00           | Adjusted general inpatient routine service cost per diem (see   |                              |                  | 949. 84         | 38. 00  |
| 39. 00           | Program general inpatient routine service cost per dreim (see   |                              |                  | 1, 105, 614     | 1       |
| 40. 00           | Medically necessary private room cost applicable to the Progra  | -                            |                  | 0               | 40.00   |
| 41.00            | Total Program general inpatient routine service cost (line 39   | + line 40)                   |                  | 1, 105, 614     | 41.00   |
|                  |   |                              |                  | ·               |         |

| Head In Friends al. Systems   Product City 15-0036   Product City           | Heal th | Financial Systems                            | PORTER REGION     | IAI HOSPITAI      |                    | In lie          | w.of Form CMS_1 | 2552_10 |
|---|---------|--|-------------------|-------------------|--------------------|-----------------|-----------------|---------|
| Cost Center Description   |         |  | TORTER REGION     |                   |                    | Peri od:        |                 | 2002 10 |
| Cost Centure Description  |         |  |                   |                   |                    |                 | Date/Time Pre   | nared:  |
| Total   |         |  |                   |                   |                    | 10 12/31/2021   |                 |         |
| Inpatient Cost Inpatient Dispublies (Eds.) 1 -   1.00   2.00   4.00   5.0   5.0   5.0   1.00   1.00   2.00   5.0   5.0   5.0   1.00   1.00   5.0   5.0   1.00   1          |         |  |                   |                   |                    |                 |                 |         |
| UNSERT (1110 V B XIX orly)  |         | Cost Center Description                      |                   |                   |                    | 9               |                 |         |
| 1.00   2.00   3.00   4.00   5.00   5.00   4.00   5.00   6.37.727   42.00   42.00   4          |         |  | l'ilpati ent cost | linpati ent bays  |                    | -               |                 |         |
| Intensive Care Type Input ent Hospital Units  4.0 (INTENSIVE CARE UNIT 17.528, 822 5,000 2.970.99 124 868.03 43.01 149.01 INTENSIVE CARE UNIT 4.990.00 3.305 1.497.72 477 706.999 43.01 49.00 19        |         |  | 1.00              | 2. 00             |                    | 4. 00           |                 |         |
| 1.00   INTERSIVE CARE (INIT   1.75           | 42. 00  |  | 1, 430, 281       | 2, 402            | 595. 4             | 5 1, 071        | 637, 727        | 42. 00  |
| MINISTRANSPECTATE   MINI          | 42.00   |  | 17 500 000        | E 000             | 2 070 0            | 0 124           | 240 402         | 12.00   |
| 44.00   |         |  |                   |                   |                    |                 |                 | •       |
| 3.00   Continue   1.00   1.0          |         |  | 4, 730, 001       | 3, 303            | 1,477.7            | 3               | 700, 727        | •       |
| 47.00   OTHER SPECIAL CARE (SPECIFY)   47.00  |         | · ·  |                   |                   |                    |                 |                 | •       |
| 1.00  |         | 1  |                   |                   |                    |                 |                 |         |
| 1.00  | 47.00   |  |                   |                   |                    |                 |                 | 47.00   |
| Program Inpati ent and Illary service cost (West. D-3, coll. 3. line 200)   11,115,816   49.00   Total Program Inpatient costs (cum of Illanes 4.1 through 48) (see Instructions)   13,934,489   49.00   Total Program Inpatient costs (cum of Illanes 4.1 through costs applicable to Program Inpatient routine services (from Wast. D. sum of Parts II and Discount of Illanes 4.1 through costs applicable to Program Inpatient ancillary services (from Wast. D. sum of Parts II and Discount of Illanes 1.1 through costs applicable to Program Inpatient ancillary services (from Wast. D. sum of Parts II and Discount of Illanes 1.1 through costs applicable to Program Inpatient ancillary services (from Wast. D. sum of Parts II and Discount of Illanes 1.1 through costs applicable to Program Inpatient ancillary services (from Wast. D. sum of Parts II and Discount of Illanes 1.1 through Costs (Illanes 5.1 through costs applicable to Program Inpatient operating cost excluding applicable to Illanes 5.2 through costs applicable to Program Inpatient operating cost and target amount (Illane 5.2 through Costs and Inpatient operating cost and target amount (Illane 5.2 through Costs applicable to Illanes 5.2 through Costs and Inpatient operating cost and target amount (Illane 5.2 through Costs applicable to Illanes 5.2 through Costs and Inpatient operating cost and target amount (Illane 5.2 through Costs applicable to Illanes 5.2 through Costs and Inpatient operating costs (Illanes 5.2 through Costs applicable of Illanes 5.2 through Costs (Illanes 5.2 through Costs and Illanes 5.2 through Costs and Illanes 5.2 through Costs (Illanes 5.2 throu          |         | cost center bescription                      |                   |                   |                    |                 | 1 00            |         |
| PASS THROUGH COST ADJUSTNERN'S   Do. 00   PASS through costs applicable to Program Inpatient routine services (from Wist. 0, sun of Parts I and 0   0   50.00   Pass through costs applicable to Program Inpatient and Illary services (from Wist. 0, sun of Parts I and 0   51.00   Pass through costs applicable to Program Inpatient and Illary services (from Wist. 0, sun of Parts II 0   51.00   Pass through costs applicable to Program Inpatient porating cost sext during applicable (parts II)   Do. 00   Do.           | 48. 00  | Program inpatient ancillary service cost (Wk | st. D-3, col. 3   | 3, line 200)      |                    |                 |                 | 48. 00  |
| 50.00   Pass through costs applicable to Program inpatient routine services (from West. D. sum of Parts I and III)  | 49. 00  |  | 41 through 48)(   | see instructio    | ns)                |                 | 13, 934, 489    | 49. 00  |
| III)   Sess through costs applicable to Program Inpatient ancillary services (from Wkst. D., sum of Parts II and IV)   Sess through costs applicable cost (sum of IInes 50 and 51)   Sess through costs applicable cost (sum of IInes 50 and 51)   Sess through costs applicable cost (sum of IInes 50 and 51)   Sess through costs applicable cost (sum of IInes 50 and 51)   Sess through costs applicable cost (sum of IInes 50 and 51)   Sess through costs applicable costs (sum of IInes 50 and 51)   Sess through costs applicable costs (sum of IInes 50 and 51)   Sess through costs applicable costs (sum of IInes 50 and 51)   Sess through costs and target amount per discharge   Sess through costs and target amount (sum of IInes 54 x sine 55)   Sess through costs and target amount (sum of IInes 54 x sine 55)   Sess through costs and target amount (sum of IInes 54 x sine 55)   Sess through costs and target amount (sum of IInes 54 x sine 55)   Sess through costs and target amount (sum of IInes 54 x sine 55)   Sess through costs (sine 54 x sine 54           |         |  |                   |                   |                    |                 |                 |         |
| 51.00   Pass through costs applicable to Program Inpatient ancillary services (from Whst. D., sum of Parts II and Information and ITO)   Total Program excludable cost (sum of lines 50 and 51)   Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and   Discoverage   D          | 50.00   |  | atient routine    | services (Trom    | I WKST. D, SUM     | or Parts I and  | 0               | 50.00   |
| and IV)  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 53.00 medical education costs (tine 40 minus line 52)  54.00 Program discharges  55.00 Target amount (line 54 x line 55)  56.00 Target amount (line 54 x line 55)  57.00 Total program discharges  58.00 Target amount (line 54 x line 55)  58.00 Target amount (line 54 x line 55)  58.00 Target amount (line 54 x line 55)  58.00 Total program of scharges  5        | 51. 00  |  | atient ancillar   | y services (fr    | om Wkst. D, s      | um of Parts II  | 0               | 51. 00  |
|   |         |  |                   | `                 |                    |                 |                 |         |
| medical education costs (line 49 in nus line 52)  |         |  |                   |                   |                    |                 | _               | 1       |
| TARGET MOUNT AND LIMIT COMPUTATION   54,00   754,00   755,00   767ger discharge   0.0   54,00   755,00   767ger discharge   0.0   55,00   767ger discharge   0.0   55,00   750,00   7          | 53.00   |  |                   | elated, non-phy   | sician anesth      | etist, and      | 0               | 53.00   |
| 54.00   Program discharges   0.56.00   Target amount per discharge   0.00   55.00   Target amount per discharge   0.00   55.00   Target amount per discharge   0.00   55.00   Target amount (line 54 x line 55)   0.56.00   0.56          |         | ,  | 32)               |                   |                    |                 |                 |         |
| 56.00 Target amount (line 54 x line 55) 57.00 Brous payment (see instructions) 58.00 Bonus payment (see instructions) 58.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 59.00 Lesser of lines 53/54 is 1ess 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) 60.00 Lesser of lines 50, otherwise enter zero (see instructions) 61.00 All loweble lippatient cost plus incentive payment (see instructions) 62.00 Reliderare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (lite Ix XVIII only). For CAM (See In        | 54.00   |  |                   |                   |                    |                 | 0               | 54. 00  |
| 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57.00 58.00 Box payment (see instructions) 0 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 60.00 minus (line 56), otherwise enter zero (see instructions) 0 63.00 All observation (line 56), otherwise enter zero (see instructions) 0 0 63.00 All observation (see instructions) 0 0 63.00 All observation (line 56), otherwise enter zero (see instructions) 0 0 63.00 All observation (line 56), otherwise enter zero (see instructions) 0 0 63.00 All observations (line 54 x 60). The see instructions (line 54 x 60        |         |  |                   |                   |                    |                 |                 | •       |
| 88.00 Bonus payment (see instructions) 99.00 Lesser of lines \$5.754 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 Lesser of lines \$5.754 or 55 from prior year cost report, updated by the market basket 0.00 Cesser of lines \$5.754 is less than the lower of lines \$5.59 or 60 enter the lesser of 50% of the amount by which operating costs (line \$53) are less than expected costs (lines \$4 x 60), or 1% of the target amount (line \$6), otherwise enter zero (see instructions) 0.0 63.00 Reign payment (see instructions) 0.0 63.00 All owable Inpatient cost plus incentive payment (see instructions) 0.0 All owable Inpatient cost plus incentive payment (see instructions) 0.0 All owable Inpatient cost plus incentive payment (see instructions) 0.0 All owable Inpatient cost plus incentive payment (see instructions) 0.0 All owable Inpatient cost plus incentive payment (see instructions) 0.0 All owable Inpatient cost plus incentive payment (see instructions) 0.0 All owable Inpatient cost plus incentive payment (see instructions) 0.0 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (till the XVIII only) 0.0 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For Company (see instructions) 0.0 Total Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (see instructions) 0.0 Total Medicare swing-bed NF inpatient routine costs after December 31 of the cost reporting period (see instructions) 0.0 Total Medicare swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only). For Company (see instructions) 0.0 Total Medicare swing-bed NF inpatient routine costs (line 67 + line 68) 0.0 Total Itile V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0.0 Total Itile V or XIX swing-bed NF inpatient routine service cost (line 67 + line 68) 0.0 Total Itile V or XIX swing-bed NF inpatient routine service cost (line 70 |         |  |                   |                   | ! F/!              | 1: 52)          |                 | •       |
| Section   Lesser of lines \$3/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket   0.00   59.00   |         | 1  | ing cost and ta   | irget alliount (i | The 56 III hus     | i i ne 53)      | _               | 1       |
| market basket  0.00   0.00   1   1   1   1   1   1   1   1   1  |         |  | porting period    | endi ng 1996, u   | pdated and co      | mpounded by the |                 | 1       |
| 1.0   |         | market basket                                |                   | •                 |                    |                 |                 |         |
| 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)  82.00 Relief payment (see instructions)  9.063.00 Allowable Inpatient costs plus incentive payment (see instructions)  9.063.00 Allowable Inpatient costs plus incentive payment (see instructions)  9.063.00 Allowable Inpatient costs partient proutine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) for instructions) (title XVIII only) instructions) (title XVIII only) for XVIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (title 12 X IIIne 13) (title XVIII only) for instructions (title 31 X IIIne 20) for ititle V or XIX swing-bed NF inpatient routine costs (tine 67 + title 68) for instructions (title 31 X IIIne 20) for ititle V or XIX swing-bed NF inpatient routine costs (tine 67 + title 68) for instructions (title 31 X IIIne 31 X         |         |  |                   |                   |                    | *I=             |                 | •       |
| amount (line 56), otherwise enter zero (see instructions)   0 62.00   | 61.00   |  |                   |                   |                    |                 | U               | 61.00   |
| Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 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 12 x line 19)  69.00 Total 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)  69.00 PART III - SKILLED NURSING FACILITY. OTHER NURSING FACILITY, AND ICETIED ONLY  70.00 Skilled nursing facility/other nursing facility/ICETIED routine service cost (line 37)  70.00 Program routine service cost (line 9 x line 71)  70.00 Program routine service cost (line 9 x line 71)  71.00 Program general inpatient routine service costs (line 72 + line 73)  72.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  73.00 Capital-related costs (line 9 x line 76)  74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 48)  75.00 Per diem capital-related costs (line 72 + line 20)  76.00 Program capital-related costs (line 74 minus line 77)  79.00 Aggregate charges to beneficial rels for excess costs (from provider records)  80.00 Total Program routine service cost imitation (line 78 minus line 79)  81.00 Reasonable inpatient routine service costs (see instructions)  82.00 Unjatient routine service cost imitation (line 81)  83.00 Reasonable inpatient routine servic        |         |  |                   | .5 (111165 61 X   | 00), 01 1% 01      | the target      |                 |         |
| ROGGRAM INPATLENT ROUTINE SWING BED COST  |         |  |                   |                   |                    |                 | _               |         |
| 64.00   Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)   Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)   Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (See instructions)          | 63. 00  |  | ent (see instru   | ıctions)          |                    |                 | 0               | 63. 00  |
| instructions)(title XVIII only)  66.00 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 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)  69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID DNLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  71.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  72.00 Total Program general inpatient routine service costs (line 72 + line 73)  73.00 Total Program capital-related costs (line 9 x line 76)  75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 9 x line 76)  77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79)  80.00 Total Program inpatient ancillary service costs (see instructions)  81.00 Inpatient routine service cost (see instructions)  82.00 Utilization review - physiclan compensation (see instructions)  82.00 Utilization review - physiclan compensation (see instructions)  84.00 Program inpatient ancillary service (see instructions)  85.00 Wedically the dependal inpatient routine cost yet diem (line 27 + line 2)  87.00 Total Program inpatient oper        | 64 00   |  | ts through Dece   | ember 31 of the   | cost reporti       | na period (See  | 0               | 64 00   |
| instructions) (title XVIII only) 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)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 37 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 37 + line 68)  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  70.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  71.00 Program routine service cost (line 9 x line 71)  72.00 Program routine service cost (line 9 x line 71)  73.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  74.00 Program capital -related costs (line 75 + line 2)  75.00 Capital -related costs (line 75 + line 2)  76.00 Program capital -related costs (line 75 + line 2)  77.00 Program capital -related costs (line 75 + line 2)  78.00 Total Program routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service cost (see instructions)  80.00 Inpatient routine service cost (see instructions)  81.00 Inpatient routine service cost (see instructions)  82.00 Villization review - physician compensation (see instructions)  82.00 Villization review - physician compensation (see instructions)  83.00 Adjusted general inpatient routine cost        | 0 11 00 |  | to timough book   |                   |                    | ng por rou (occ |                 | 0 11 00 |
| 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)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 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 26, line 45) 76.00 Program capital-related cost (line 75 + line 2) 77.00 Program capital-related costs (line 75 + line 2) 77.00 Aggregate charges to beneficiaries for excess costs (from provider records) 78.00 Total Program coutine service cost (line 74 ninus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 78.00 Inpatient routine service cost per diem limitation 78.00 Inpatient routine service cost per diem limitation 78.00 Program inpatient ancillary service (see instructions) 78.00 Inpatient routine service cost (see instructions) 78.00 Utilization review - physician compensation (see instructions) 78.00 Utilization review - physician compensation (see instructions) 78.00 Inpatient routine service cost (see instructions) 78.00 Total Program inpatient operating costs (sum of lines 83 through 85) 78.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST   | 65. 00  |  | ts after Decemb   | er 31 of the c    | ost reporting      | period (See     | 0               | 65. 00  |
| 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) 0 69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  70.00 Program routine service cost (line 9 x line 71)  70.00 Program routine service cost (line 9 x line 71)  70.00 Total Program general inpatient routine service costs (line 72 + line 73)  70.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  70.00 Per diem capital -related costs (line 75 + line 2)  70.00 Program capital -related costs (line 74 minus line 77)  70.00 Program capital -related costs (line 9 x line 76)  10.01 Inpatient routine service cost (line 74 minus line 77)  70.02 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79)  83.00 Reasonable inpatient routine service cost (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)  88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)  949.84 88.00   | 66 00   |  | no costs (lino    | 64 plus lino 6    | .5) (+i +l o V\/II | Lonly) For      | 0               | 66 00   |
| 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)  69.00 DART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost period (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Total Program general inpatient routine service costs (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 9 x line 76) 77.00 Program capital -related costs (line 9 x line 76) 78.00 Total Program service cost (line 9 x line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service cost fine 11 mitation 81.00 Inpatient routine service cost finitation (line 9 x line 81) 82.00 Reasonable inpatient routine service (see instructions) 83.00 Reasonable inpatient routine service (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 Ilines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 77.00 Reasonable inpatient routine cost per diem (line 27 + line 2) 949.84 88.00 Reasonable inpatient routine cost per diem (line 27 + line 2) 949.84 88.00   | 00.00   |  | ne costs (Title   | 04 prus rine d    | is)(title xvii     | i only). For    |                 | 00.00   |
| 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)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 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 26, line 45) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 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) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service cost limitation (line 9 x line 81) 80.00 Reasonable inpatient routine service costs (see instructions) 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 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) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 949.84 88.00   | 67. 00  | ,  | e costs through   | December 31 c     | of the cost re     | porting period  | 0               | 67. 00  |
| Cline 13 x line 20)   Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)   OPART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  |         |  |                   |                   |                    |                 |                 | ,,,,,,  |
| Total title V or XiX swing-bed NF inpatient routine costs (line 67 + line 68)   | 68. 00  |  | e costs after L   | December 31 of    | the cost repo      | rting period    | 0               | 68.00   |
| PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70. 00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71. 00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  72. 00 Program routine service cost (line 9 x line 71)  73. 00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74. 00 Total Program general inpatient routine service costs (line 72 + line 73)  75. 00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76. 00 Per diem capital-related costs (line 75 ÷ line 2)  77. 00 Program capital-related costs (line 9 x line 76)  78. 00 Inpatient routine service cost (line 74 minus line 77)  78. 00  79. 00 Aggregate charges to beneficiaries for excess costs (from provider records)  79. 00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79)  80. 00 Inpatient routine service cost per diem limitation  81. 00  82. 00 Reasonable inpatient routine service costs (see instructions)  83. 00 Willization review - physician compensation (see instructions)  84. 00 Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  84. 00  85. 00 Adjusted general inpatient routine cost per diem (line 27 + line 2)  86. 00  87. 00  88. 00 Adjusted general inpatient routine cost per diem (line 27 + line 2)   | 69. 00  | 1 '  | routine costs (   | line 67 + line    | : 68)              |                 | 0               | 69. 00  |
| 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 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) 80.00 Total Program routine service cost per diem limitation 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 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)  949.84   |         | PART III - SKILLED NURSING FACILITY, OTHER N | JRSING FACILITY   | , AND ICF/IID     | ONLY               |                 |                 |         |
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| Total Program general inpatient routine service costs (line 72 + line 73)  74.00  75.00  Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00  Per diem capital-related costs (line 75 ÷ line 2)  Program capital-related costs (line 9 x line 76)  1 Inpatient routine service cost (line 74 minus line 77)  78.00  79.00  Aggregate charges to beneficiaries for excess costs (from provider records)  Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  1 Inpatient routine service cost per diem limitation  1 Inpatient routine service cost limitation (line 9 x line 81)  82.00  1 Reasonable inpatient routine services (see instructions)  Program inpatient ancillary services (see instructions)  84.00  85.00  Willization review - physician compensation (see instructions)  86.00  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  74.00  75.00  76.00  77.00  76.00  77.00  78.00  79.00  80.00  79.00  80        |         |  |                   | n (line 14 x li   | ne 35)             |                 |                 | 1       |
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| 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient 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) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  949.84  98.00  | 75. 00  |  | routine service   | costs (from W     | orksheet B, P      | art II, column  |                 | 75. 00  |
| 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 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 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 949.84 88.00   | 76 00   |  | ne 2)             |                   |                    |                 |                 | 76.00   |
| 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 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 per diem limitation 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  Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 949.84 88.00  |         |  | . *               |                   |                    |                 |                 |         |
| 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) 85.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 PAPS IV - QUARTION OF OBSERVATION PAPS STANDUCH COST  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  89.00 PAPS IV - QUARTION OF OBSERVATION PAPS THROUGH COST  Total observation bed days (see instructions) 89.00 PAPS STANDUCH COST   | 78. 00  |  |                   |                   |                    |                 |                 | 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) 85.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00  |         | 00 0   |                   |                   |                    | 1. 70)          |                 | 1       |
| 82.00 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  85.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 PAGE INDICATION OF OBSERVATION BED PASS THROUGH COST  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  89.00 PAGE INDICATION OF OBSERVATION BED PASS THROUGH COST  89.00 PAGE INDICATION OF OBSERVATION BED PASS THROUGH COST  89.00 PAGE INDICATION OF OBSERVATION BED PASS THROUGH COST   |         |  |                   | cost ilmitation   | ı (iine 78 min     | us iine 79)     |                 | 1       |
| 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 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Reasonable inpatient routine service costs (see instructions)  85.00 85.00 85.00 85.00 86.00 87.00 87.00 88.00  |         | 1  |                   | )                 |                    |                 |                 | 1       |
| 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)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)   |         | Reasonable inpatient routine service costs ( | see instruction   | * .               |                    |                 |                 | 1       |
| 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)   |         |  |                   | `                 |                    |                 |                 |         |
| PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  949. 84 98. 00   |         |  |                   |                   |                    |                 |                 |         |
| 87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  5,030 87.00  949.84 88.00   | 00.00   |  |                   | ıı ouyıı 85)      |                    |                 |                 | 00.00   |
| 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 949.84 88.00  | 87. 00  |  |                   |                   |                    |                 | 5, 030          | 87. 00  |
| 89.00   Observation bed cost (line 87 x line 88) (see instructions)   4,777,695   89.00   |         | ,  |                   |                   |                    |                 |                 |         |
|   | 89. 00  | ubservation bed cost (line 87 x line 88) (se | e instructions)   |                   |                    |                 | 4, 777, 695     | 89. 00  |

| Health Financial Systems                    | PORTER REGION | AL HOSPITAL    |            | In Lie                           | eu of Form CMS-2               | 2552-10 |
|---|---------------|----------------|------------|----------------------------------|--------------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST     |               | Provi der CC   |            | Peri od:                         | Worksheet D-1                  |         |
|   |               |                |            | From 01/01/2021<br>To 12/31/2021 | Date/Time Pre<br>5/30/2022 6:2 |         |
|   |               | Ti tl          | e XIX      | Hospi tal                        | Cost                           |         |
| Cost Center Description                     | Cost          | Routine Cost   | column 1 ÷ | Total                            | Observation                    |         |
|   |               | (from line 21) | column 2   | Observati on                     | Bed Pass                       |         |
|   |               |                |            | Bed Cost (from                   | Through Cost                   |         |
|   |               |                |            | line 89)                         | (col. 3 x col.                 |         |
|   |               |                |            |                                  | 4) (see                        |         |
|   |               |                |            |                                  | instructions)                  |         |
|   | 1.00          | 2.00           | 3. 00      | 4. 00                            | 5. 00                          |         |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST          |                |            |                                  |                                |         |
| 90.00 Capital -related cost                 | 3, 577, 020   | 49, 798, 034   | 0. 07183   | 1 4, 777, 695                    | 343, 187                       | 90.00   |
| 91.00 Nursing Program cost                  | 0             | 49, 798, 034   | 0.00000    | 0 4, 777, 695                    | 0                              | 91.00   |
| 92.00 Allied health cost                    | 0             | 49, 798, 034   | 0.00000    | 0 4, 777, 695                    | 0                              | 92.00   |
| 93 00 All other Medical Education           | 0             | 49 798 034     | 0 00000    | 0 4 777 695                      | 0                              | 93 00   |

| Health Financial Systems                | PORTER REGIONAL HOSPITAL | In Lie                      | u of Form CMS-2552-10                 |
|---|--------------------------|-----------------------------|---------------------------------------|
| COMPUTATION OF INPATIENT OPERATING COST | Provi der CCN: 15-0035   | Peri od:<br>From 01/01/2021 | Worksheet D-1                         |
|   | Component CCN: 15-T035   | To 12/31/2021               | Date/Time Prepared: 5/30/2022 6:28 pm |
|   | Title XIX                | Subprovi der -              | Cost                                  |

|                  |  | litle XIX                   | I RF             | Cost             |                  |
|------------------|--|-----------------------------|------------------|------------------|------------------|
|                  | Cost Center Description  |                             | 110              |                  |                  |
|                  | PART I - ALL PROVIDER COMPONENTS   |                             |                  | 1. 00            |                  |
|                  | I NPATI ENT DAYS   |                             |                  |                  |                  |
| 1.00             | Inpatient days (including private room days and swing-bed days   |                             |                  | 3, 707           | 1. 00            |
| 2.00             | Inpatient days (including private room days, excluding swing-  |                             |                  | 3, 707           | 2. 00            |
| 3. 00            | Private room days (excluding swing-bed and observation bed day   | ys). If you have only pr    | ivate room days, | 0                | 3. 00            |
| 4. 00            | do not complete this line.<br>Semi-private room days (excluding swing-bed and observation be                                       | ed days)                    |                  | 3, 707           | 4. 00            |
| 5.00             | Total swing-bed SNF type inpatient days (including private room  |                             | r 31 of the cost | 3, 707           | 5. 00            |
|                  | reporting period   | <i>y-,</i> g                |                  | _                |                  |
| 6.00             | Total swing-bed SNF type inpatient days (including private roo   | om days) after December     | 31 of the cost   | 0                | 6. 00            |
| 7.00             | reporting period (if calendar year, enter 0 on this line)  |                             | 04 6 11          |                  | 7.00             |
| 7. 00            | Total swing-bed NF type inpatient days (including private room reporting period  | m days) through December    | 31 of the cost   | 0                | 7. 00            |
| 8. 00            | Total swing-bed NF type inpatient days (including private room   | m days) after December 3    | 1 of the cost    | 0                | 8. 00            |
|                  | reporting period (if calendar year, enter 0 on this line)  |                             |                  |                  |                  |
| 9.00             | Total inpatient days including private room days applicable to   | o the Program (excluding    | swing-bed and    | 105              | 9. 00            |
| 10.00            | newborn days) (see instructions)   | -1 (:1                      |                  | 0                | 10.00            |
| 10. 00           | Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instructions) |                             | oom days)        | 0                | 10. 00           |
| 11. 00           | Swing-bed SNF type inpatient days applicable to title XVIII or   |                             | oom days) after  | 0                | 11. 00           |
|                  | December 31 of the cost reporting period (if calendar year, en   |                             | ,                |                  |                  |
| 12. 00           | Swing-bed NF type inpatient days applicable to titles V or XIX   | X only (including privat    | e room days)     | 0                | 12. 00           |
| 13. 00           | through December 31 of the cost reporting period<br>Swing-bed NF type inpatient days applicable to titles V or XIX                 | V only (including privat    | o room days)     | 0                | 13. 00           |
| 13.00            | after December 31 of the cost reporting period (if calendar ye   |                             |                  | U                | 13.00            |
| 14. 00           | Medically necessary private room days applicable to the Progra   |                             |                  | 0                | 14. 00           |
| 15. 00           | Total nursery days (title V or XIX only)   |                             |                  | 2, 402           | 15. 00           |
| 16. 00           | Nursery days (title V or XIX only)   |                             |                  | 1, 071           | 16. 00           |
| 47.00            | SWING BED ADJUSTMENT   |                             | C 11 1           | 0.00             | 47.00            |
| 17. 00           | Medicare rate for swing-bed SNF services applicable to service reporting period  | es through December 31 o    | f the cost       | 0.00             | 17. 00           |
| 18. 00           | Medicare rate for swing-bed SNF services applicable to service   | es after December 31 of     | the cost         | 0.00             | 18. 00           |
|                  | reporting period   |                             |                  |                  |                  |
| 19. 00           | Medicaid rate for swing-bed NF services applicable to services   | s through December 31 of    | the cost         | 0.00             | 19. 00           |
| 20.00            | reporting period   | £t Db 21 -£ t               |                  | 0.00             | 20.00            |
| 20. 00           | Medicaid rate for swing-bed NF services applicable to services reporting period  | s after December 31 of t    | ne cost          | 0.00             | 20. 00           |
| 21. 00           | Total general inpatient routine service cost (see instructions   | 5)                          |                  | 3, 987, 154      | 21. 00           |
| 22. 00           | Swing-bed cost applicable to SNF type services through December  | er 31 of the cost report    | ing period (line | 0                | 22. 00           |
|                  | 5 x line 17)   |                             |                  | _                |                  |
| 23. 00           | Swing-bed cost applicable to SNF type services after December x line 18)   | 31 of the cost reporting    | g period (line 6 | 0                | 23. 00           |
| 24. 00           | Swing-bed cost applicable to NF type services through December   | r 31 of the cost reporti    | na period (line  | 0                | 24. 00           |
|                  | 7 x line 19)   |                             | g p (            | _                |                  |
| 25. 00           | Swing-bed cost applicable to NF type services after December 3   | 31 of the cost reporting    | period (line 8   | 0                | 25. 00           |
| 27, 00           | x line 20)   |                             |                  | 0                | 27.00            |
| 26.00            | Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost                               | (line 21 minus line 26)     |                  | 0<br>3, 987, 154 | 26.00            |
| 27.00            | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT   | (TITIC 21 IIITIGS TITIC 20) |                  | 3, 707, 134      | 27.00            |
| 28. 00           | General inpatient routine service charges (excluding swing-bed   | d and observation bed ch    | arges)           | 0                | 28. 00           |
| 29. 00           |  |                             |                  | 0                | 29. 00           |
| 30. 00           | Semi -pri vate room charges (excluding swing-bed charges)  |                             |                  | 0                | 30. 00           |
| 31. 00           | General inpatient routine service cost/charge ratio (line 27   | ÷ line 28)                  |                  | 0.000000         | 1                |
| 32. 00<br>33. 00 | Average private room per diem charge (line 29 ÷ line 3)<br>Average semi-private room per diem charge (line 30 ÷ line 4)            |                             |                  | 0. 00<br>0. 00   | 32. 00<br>33. 00 |
| 34. 00           | Average per diem private room charge differential (line 32 mi)   | nus line 33)(see instruc    | tions)           | 0.00             | •                |
| 35. 00           | Average per diem private room cost differential (line 34 x li  |                             | - /              | 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 di    | fferential (line | 3, 987, 154      | 37. 00           |
|                  | 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY   |                             |                  |                  |                  |
|                  | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU   | ISTMENTS                    |                  |                  |                  |
| 38. 00           | Adjusted general inpatient routine service cost per diem (see  |                             |                  | 1, 075. 57       | 38. 00           |
| 39. 00           | Program general inpatient routine service cost (line 9 x line  |                             |                  | 112, 935         |                  |
| 40. 00           | Medically necessary private room cost applicable to the Progra   | ,                           |                  | 0                |                  |
| 41. 00           | Total Program general inpatient routine service cost (line 39  | + line 40)                  | ļ                | 112, 935         | 41.00            |

| Description      | Heal th | Financial Systems                             | PORTER REGIONA   | L HOSPITAL     |                    | In Lie           | eu of Form CMS-: | 2552-10 |
|--|---------|---|------------------|----------------|--------------------|------------------|------------------|---------|
| Continued Cont   | COMPUT  | ATION OF INPATIENT OPERATING COST             |                  | Provi der C    | CCN: 15-0035       | Peri od:         | Worksheet D-1    |         |
| Till R XIX   Subprovider   Cost  |         |   |                  | Component      | CCN: 15-T035       |                  | Date/Time Pre    |         |
| Total  |         |   |                  | Ti t           | le XIX             |                  |                  | o piii  |
|  |         | Cost Center Description                       | Total            | Total          | Average Per        |                  | Program Cost     |         |
| 1.00   2.200   3.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00     |         | cost center beserver on                       |                  |                | Diem (col. 1       |                  | (col. 3 x col.   |         |
| Interest section   Topic   Impatt ent   Integrated   Interest      |         |   | 1.00             | 2. 00          |                    | 4. 00            |                  |         |
|  | 42. 00  |   | 0                | (              | 0. (               | 00 0             | 0                | 42. 00  |
|  | 43. 00  |   | 0                | (              | 0.0                | 00               | 0                | 43.00   |
| SURRELINTENSIVE CARE UNIT  |         | 1   |                  |                |                    |                  | 1                |         |
| 46.00   SURGICAL INTERSIVE CABE UNIT   44.700   THER SPECIAL CARE (SPECITY)   45.00   TOTAL PROGRAM INSTITUTE (SPECIAL CARE    |         |   |                  |                |                    |                  |                  | 1       |
| 47.00   OTHER SPECIAL CARE (SPECIFY)   |         | •   |                  |                |                    |                  | •                | 1       |
| 1.00   |         |   |                  |                |                    |                  |                  | 1       |
| 8-0.00   Program Inpati ent and Illary service cost (West. D-3. col. 3. line 200)   245, 140   46.00   749, 00   Total Program Inpati ent costs (cymor d'Inex. 4. line 1940)   749, 00     |         | Cost Center Description                       |                  |                | •                  |                  |                  |         |
| 19.00   Total Program Inpartient costs (sum of Fines 4) through 48)(see Instructions)   356,075   49.00  | 48 00   | Program innationt ancillary service cost (Wks | st D-3 col 3     | Line 200)      |                    |                  |                  | 48.00   |
| PASS THROUGH COST ADJUSTNERN'S   0   50.00   Pass through costs applicable to Program inpatient routine services (from Wkst. D. sum of Parts I and   1   1   1   1   1   1   1   1   1   |         |   |                  |                | ons)               |                  | 1                | 1       |
| III)   Sas through costs applicable to Program Inpatient ancillary services (from Wkst. D., sum of Parts II   0.51.00 and IV)   Science   Sas through costs applicable cost (sum of lines 50 and 51)   0.52.00   Total Program excludable cost (sum of lines 50 and 51)   0.52.00   Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and   0.52.00   Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and   0.52.00   Total Program inpatient operating cost and target amount per discharges   0.50.00   Cost   Cos   |         | PASS THROUGH COST ADJUSTMENTS                 | <u> </u>         |                | ,                  |                  |                  |         |
| 51.00   and Introgram excludable to Program inpatient ancillary services (from Wkst. D., sum of Parts II   52.00   Total Program excludable cost (sum of Ilines 50 and 51)   52.00   Total Program excludable cost (sum of Ilines 50 and 51)   52.00   Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and   0.53.00   medical education costs (tine 40 minus line 52)   7.50      | 50. 00  | ] 3 11  | atient routine s | ervices (fror  | m Wkst. D, sur     | n of Parts I and | 0                | 50. 00  |
| Transport   Tran   | 51. 00  | 1 '   | atient ancillary | services (fi   | rom Wkst. D, s     | sum of Parts II  | 0                | 51. 00  |
| Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and ended education costs (line 49 minus line 52)   |         |   |                  |                |                    |                  | _                |         |
| medical education costs (line 4º ninus line 52)  |         | ,   | ,                | atod non nh    | usician anosti     | notict and       | 1                | 1       |
| 54.00   Program discharges   0   54.00   55.00   Target amount per discharge   0.00   55.00   Target amount per discharge   0.00   55.00   Target amount (line 54 x line 55)   0   Target amount (line 54 x line 55)   0   55.00   Target amount (line 54 x line 55)   0   55.00   Target amount (line 54 x line 55)   0   55.00   Target amount (line 54 x line 55)   0   55.00   Target amount (line 54 x line 55)   0   55.00   Target amount (line 54 x line 53)   0   55.00   Target amount (line 54 x line 53)   0   57.00   Target amount (line 55 x) for from the cost reporting period ending 1996, updated and compounded by the market basket   0.00   60.00   Target to the second of the second o   | 55.00   |   |                  | ateu, non-prij | ysi ci aii ailesti | letist, and      |                  | 33.00   |
| 55.00   Target amount per discharge   0.00   55.00   0.00   55.00   0.   |         | TARGET AMOUNT AND LIMIT COMPUTATION           | •                |                |                    |                  | 1                |         |
| 56. 00   Target amount (line 54 x line 55)   0   56. 00   05. 00   0   05. 00   0   0   0   0   0   0   0   0   0  |         |   |                  |                |                    |                  |                  |         |
| 57.00   Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)   0   57.00   |         |   |                  |                |                    |                  | 1                | 1       |
| Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the month of the month of the cost report, updated by the market basket   0.00   6   |         | ,   | ng cost and tar  | get amount (I  | line 56 minus      | line 53)         |                  | 1       |
| market basket  0.00   0.00   1   1   1   1   1   1   1   1   1   |         |   |                  | " 4007         |                    |                  |                  |         |
| Lesser of Lines 53/54 or 55 from prior year cost report, updated by the market basket   0.00   60.00   | 59.00   |   | porting period e | enaing 1996, i | updated and co     | ompounded by the | 0.00             | 59.00   |
| 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)  0. 62.00  Relief payment (see instructions)  0. 63.00  Allowable Inpatient costs plus incentive payment (see instructions)  0. 63.00  PROGRAM INPATIENT ROUTINE SWING BED COST  (4.00  64.00  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 NF inpatient routine costs (line 64 plus line 65) (title XVIII only). For Cline 12 x line 19)  67.00  Given 11 the Vor XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (See Cline 12 x line 19)  68.00  Title Vor XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (See Cline 12 x line 19)  69.00  Total Ittle Vor XIX swing-bed NF inpatient routine costs (Line 67 + Line 68)  PARTIII - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID DNLY  70.00  71.00  72.00  73.00  73.00  74.00  75.00  76.00  77.0 | 60.00   | 1   | cost report, upd | lated by the r | market basket      |                  | 0.00             | 60.00   |
| amount (line 56), otherwise enter zero (see instructions)   0 62.00  | 61. 00  |   |                  |                |                    |                  | 0                | 61. 00  |
| 62.00   Relief payment (see Instructions)   0 62.00  |         |   |                  | (TITIES 54 X   | 60), 01 1% 0       | the target       |                  |         |
| PROGRAM INPATIENT ROUTINE SWING BED COST   | 62.00   | 1   | ,                |                |                    |                  | 0                | 62. 00  |
| 64.00   Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)   Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)   Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (See instructions)   | 63. 00  |   | ent (see instruc | tions)         |                    |                  | 0                | 63. 00  |
| instructions) (title XVIII only) 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 12 x line 20) 69.00 Total 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)  69.00 PART III - SKILLED NURSING FACILITY. OTHER NURSING FACILITY, AND ICF/IID DNLY  70.00 SKILIed nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 71.00 Program routine service cost (line 9 x line 71) 72.00 Otal Program general inpatient routine service costs (line 72 + line 73) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Program capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost (see instructions) 81.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient ancillary service costs (see instructions) 84.00 Program inpatient ancillary service costs (see instructions) 85.00 Utill Program inpatient operating cost | 64. 00  |   | ts through Decem | ber 31 of the  | e cost reporti     | na period (See   | 0                | 64.00   |
| Instructions) (title XVIII only)   Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)   CAH (see    |         | instructions) (title XVIII only)              | Ü                |                | ·                  |                  |                  |         |
| 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)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 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 26, line 45) 76.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 77.00 Program capital -related costs (line 75 + line 2) 77.00 Program capital -related costs (line 78 x line 76) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 81.00 Inpatient routine service cost film limitation (line 78 minus line 79) 81.00 Inpatient routine service cost film limitation (line 81) 82.00 Reasonable inpatient routine service (see instructions) 83.00 Reasonable inpatient routine service (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) 86.00 Total Program inpatient posts (sum of lines 83 through 85) 87.00 Routine Service in patient routine cost per diem (line 27 + line 2) 87.00 Routine Service on the cost reporting posts (sum of lines 81 throu | 65. 00  |   | ts after Decembe | er 31 of the d | cost reporting     | g period (See    | 0                | 65. 00  |
| CAH (see instructions)  7. 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)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 75 + line 2)  77.00 Program applial-related costs (line 74 minus line 77)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79)  82.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79)  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)  88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)  87.00 Resource of the cost reporting patient routin | 66. 00  |   | ne costs (line 6 | 4 plus line o  | 65)(title XVI      | I only). For     | 0                | 66. 00  |
| (line 12 x line 19) 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)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 75 ÷ line 2) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 87.00 Adjusted general inpatient routine cost service cost per diem (line 27 + line 2)  |         |   |                  |                |                    |                  | _                |         |
| 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   | 67.00   |   | e costs through  | December 31 (  | of the cost re     | eporting period  | 0                | 67.00   |
| 69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, ADMICE/IID ONLY 70.00 SKIlled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 71.00 Program routine service cost (line 9 x line 71) 72.00 Program general inpatient routine service costs (line 14 x line 35) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 75 ÷ line 2) 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) 80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost limitation 82.00 Reasonable inpatient routine services (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 86.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)   | 68. 00  | ,   | e costs after De | cember 31 of   | the cost repo      | orting period    | 0                | 68. 00  |
| PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital -related costs (line 75 ÷ line 2)  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)  80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Reasonable inpatient routine service costs (see instructions)  83.00 Reasonable inpatient routine service (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  86.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)  87.00 Adjusted general inpatient routine service not in limitation (line 27 + line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)   | 40.00   | ,   | souting soots (I | ino (7 i lini  | . (0)              |                  |                  | (0.00   |
| 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 75 + line 2) 78.00 Inpatient routine service cost (line 74 minus line 77) 80.00 Inpatient routine service cost (line 75 + line 75) 81.00 Inpatient routine service cost (line 74 minus line 77) 82.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 83.00 Inpatient routine service cost limitation (line 9 x line 81) 84.00 Inpatient routine service cost (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  10.00 Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine service in cost per diem (line 27 + line 2) 87.00 Adjusted general inpatient routine routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00   | 09.00   |   |                  |                |                    |                  | 0                | 1 09.00 |
| 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 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) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost limitation 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  |         | Skilled nursing facility/other nursing facili | ty/ICF/IID rout  | ine service (  | cost (line 37)     | )                |                  | 1       |
| 73.00  74.00  75.00  76.00  76.00  77.00  78.00  79.00  70 |         | , ,   |                  | ne 70 ÷ line   | 2)                 |                  |                  | 1       |
| Total Program general inpatient routine service costs (line 72 + line 73)  75.00  75.00  76.00  76.00  76.00  77.00  78.00  79.00  79.00  79.00  70.00  80.0 |         |   |                  | (line 14 x li  | ine 35)            |                  |                  |         |
| 26, line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service cost (line 74 minus line 77)  80.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Inpatient 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 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00  |         | ,       |                  | •              |                    |                  |                  |         |
| 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient 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) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)   | 75. 00  | 1 .   | routine service  | costs (from \  | Worksheet B, I     | Part II, column  |                  | 75. 00  |
| 77. 00 78. 00 1npatient routine service cost (line 9 x line 76) 79. 00 20 20 20 20 20 20 20 20 20 20 20 20 2   | 76. 00  |   | ne 2)            |                |                    |                  |                  | 76. 00  |
| 79.00 80.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 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) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  79.00 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Reasonable inpatient routine cost scale instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 87.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inp | 77. 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) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 OB  80.00 OB 81.00 OB 81.00 OB 81.00 OB 82.00 OB 82.00 OB 82.00 OB 83.00 OB 84.00 OB 85.00 OB 86.00 OB 87.00 OB 88.00 OB 8 |         | 1   |                  |                | -1->               |                  |                  | 1       |
| 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) 85.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 OBSERVATION OF OBSERVATION OF OBSERVATIONS  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  89.00 OBSERVATION OF OBSERVATIONS  89.00 OBSERVATION OF OBSERVATIONS  89.00 OBSERVATIONS  80.00 OBSERVATIONS   |         | 00 0  |                  |                | *                  | nus line 79)     |                  | 1       |
| 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)  85.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Reasonable inpatient routine service costs (see instructions)  84.00 84.00 85.00 85.00 85.00 86.00   |         | ,   |                  | 141.01         | ,                  | / /              |                  | 1       |
| 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  Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Responsible to the control of the cost per diem (line 27 ÷ line 2) 88.00 Responsible to the cost per diem (line 27 ÷ line 2) 88.00 Responsible to the cost per diem (line 27 ÷ line 2) 88.00 Responsible to the cost per diem (line 27 ÷ line 2)  |         |   |                  |                |                    |                  |                  | 1       |
| 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  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Beson |         |   |                  | •)             |                    |                  |                  | 1       |
| PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  87.00 88.00  |         |   |                  | ıs)            |                    |                  |                  | 1       |
| 87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  87.00 88.00 87.00 88.00  | 86. 00  |   |                  | ough 85)       |                    |                  |                  | 86. 00  |
| 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 0.00 88.00   | 87 ∩∩   |   |                  |                |                    |                  | <u> </u>         | 87 00   |
|  |         |   |                  | line 2)        |                    |                  |                  | 1       |
|  | 89. 00  | Observation bed cost (line 87 x line 88) (see | e instructions)  |                |                    |                  | 0                | 89. 00  |

| Health Financial Systems                    | PORTER REGION | AL HOSPITAL    |              | In Lie          | u of Form CMS-2              | 2552-10  |
|---|---------------|----------------|--------------|-----------------|------------------------------|----------|
| COMPUTATION OF INPATIENT OPERATING COST     |               | Provi der CO   |              | Peri od:        | Worksheet D-1                |          |
|   |               |                |              | From 01/01/2021 | D 1 (T' D                    |          |
|   |               | Component      | CCN: 15-T035 | To 12/31/2021   | Date/Time Pre 5/30/2022 6: 2 |          |
|   |               | Ti tl          | e XIX        | Subprovi der -  | Cost                         | <u>Б</u> |
|   |               |                |              | IRF             |                              |          |
| Cost Center Description                     | Cost          | Routine Cost   | column 1 ÷   | Total           | Observati on                 |          |
|   |               | (from line 21) | column 2     | Observati on    | Bed Pass                     |          |
|   |               |                |              | Bed Cost (from  |                              |          |
|   |               |                |              | line 89)        | (col. 3 x col.               |          |
|   |               |                |              |                 | 4) (see                      |          |
|   |               |                |              |                 | instructions)                |          |
|   | 1.00          | 2.00           | 3.00         | 4. 00           | 5. 00                        |          |
| COMPUTATION OF OBSERVATION BED PASS THROUGH |               |                |              |                 |                              |          |
| 90.00 Capital-related cost                  | 435, 067      | 3, 987, 154    | 0. 10911     | 7 0             | 0                            | 90.00    |
| 91.00 Nursing Program cost                  | 0             | 3, 987, 154    | 0. 00000     | 0               | 0                            | 91. 00   |
| 92.00 Allied health cost                    | 0             | 3, 987, 154    | 0. 00000     | 0 0             | 0                            | 92.00    |
| 93.00 All other Medical Education           | 0             | 3, 987, 154    | 0. 00000     | 0               | 0                            | 93.00    |

|   | ER REGIONAL HOSPITAL |              |                                  | u of Form CMS-2 |                |
|---|----------------------|--------------|----------------------------------|-----------------|----------------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT  | Provi der CO         |              | Peri od:                         | Worksheet D-3   |                |
|   |                      |              | From 01/01/2021<br>To 12/31/2021 | Date/Time Pre   | narod:         |
|   |                      |              | 10 12/31/2021                    | 5/30/2022 6: 2  | pareu.<br>8 nm |
|   | Title                | XVIII        | Hospi tal                        | PPS             | о р            |
| Cost Center Description                         |                      | Ratio of Cos |                                  | Inpatient       |                |
| · ·   |                      | To Charges   | Program                          | Program Costs   |                |
|   |                      |              | Charges                          | (col. 1 x col.  |                |
|   |                      |              | Ů                                | 2)              |                |
|   |                      | 1.00         | 2. 00                            | 3. 00           |                |
| INPATIENT ROUTINE SERVICE COST CENTERS          |                      |              |                                  |                 |                |
| 30. 00   03000   ADULTS & PEDI ATRI CS          |                      |              | 55, 425, 610                     |                 | 30.00          |
| 31. 00 03100 INTENSIVE CARE UNIT                |                      |              | 11, 121, 862                     |                 | 31.00          |
| 31. 01 03101 NEONATAL INTENSIVE CARE UNIT       |                      |              | 0                                |                 | 31. 01         |
| 41. 00   04100   SUBPROVI DER - I RF            |                      |              | 0                                |                 | 41.00          |
| 43. 00 04300 NURSERY                            |                      |              |                                  |                 | 43.00          |
| ANCILLARY SERVICE COST CENTERS                  |                      |              |                                  |                 |                |
| 50. 00   05000 OPERATI NG ROOM                  |                      | 0.06732      |                                  | 3, 470, 893     | 50.00          |
| 51. 00   05100   RECOVERY ROOM                  |                      | 0.00000      | 00                               | 0               | 51.00          |
| 52.00   05200   DELIVERY ROOM & LABOR ROOM      |                      | 0. 33027     |                                  | 5, 217          |                |
| 53. 00   05300   ANESTHESI OLOGY                |                      | 0.00783      |                                  |                 |                |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C        |                      | 0. 06594     | 5 26, 268, 746                   | 1, 732, 292     |                |
| 54. 01   05401   ULTRASOUND                     |                      | 0.00000      |                                  | 0               |                |
| 56. 00   05600   RADI 0I SOTOPE                 |                      | 0.00000      |                                  | 0               |                |
| 57. 00   05700   CT   SCAN                      |                      | 0.00000      |                                  | 0               |                |
| 58. 00   05800   MRI                            |                      | 0.00000      |                                  | 0               |                |
| 60. 00   06000   LABORATORY                     |                      | 0. 06872     |                                  |                 |                |
| 65. 00 06500 RESPI RATORY THERAPY               |                      | 0. 08577     |                                  | 1, 738, 748     |                |
| 66. 00 06600 PHYSI CAL THERAPY                  |                      | 0. 18964     |                                  |                 |                |
| 67. 00 06700 OCCUPATI ONAL THERAPY              |                      | 0. 09106     |                                  |                 |                |
| 68. 00 06800 SPEECH PATHOLOGY                   |                      | 0. 19953     |                                  |                 |                |
| 69. 00 06900 ELECTROCARDI OLOGY                 |                      | 0. 05439     |                                  |                 |                |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT |                      | 0. 06053     |                                  | 523, 481        |                |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS      |                      | 0. 14610     |                                  | 5, 891, 670     |                |
| 73.00 07300 DRUGS CHARGED TO PATIENTS           |                      | 0. 14876     |                                  |                 |                |
| 74. 00 07400 RENAL DIALYSIS                     |                      | 0. 21448     |                                  |                 |                |
| 76. 00   03950   ANCI LLARY                     |                      | 0. 00000     |                                  | 0               |                |
| 76. 01 03610 SLEEP LAB                          |                      | 0.00000      |                                  | 0               |                |
| 76. 03 03951 WOUND CARE                         |                      | 0. 24135     | 329, 258                         | 79, 467         | 76. 03         |
| OUTPATIENT SERVICE COST CENTERS                 |                      |              |                                  |                 | 1              |
|   |                      | 0 00000      | 0                                | Ι               |                |

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287, 530, 316

287, 530, 316

2, 869, 725

568, 380

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92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART
200.00 Total (sum of lines 50 through 94 and 96 through 98)
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)

Net charges (line 200 minus line 201)

91. 00 09100 EMERGENCY

| NPATI EI | Financial Systems PORTER REGIONAL H NT ANCILLARY SERVICE COST APPORTIONMENT | Provi der C | CN: 15-0035                | Peri od:                         | Worksheet D-3                          |             |
|----------|---|-------------|----------------------------|----------------------------------|--|-------------|
|          |   | Component   | CCN: 15-T035               | From 01/01/2021<br>To 12/31/2021 | Date/Time Pre                          |             |
|          |   | Titl∈       | e XVIII                    | Subprovi der -                   | 5/30/2022 6: 2<br>PPS                  | <u>8 pm</u> |
|          | Cost Center Description   |             | Ratio of Cos<br>To Charges | t Inpatient                      | Inpatient Program Costs (col. 1 x col. |             |
|          |   |             | 1.00                       | 2. 00                            | 2)<br>3. 00                            |             |
| I        | NPATIENT ROUTINE SERVICE COST CENTERS                                       |             | 1.00                       | 2.00                             | 0.00                                   |             |
| so. oo 🔽 | 03000 ADULTS & PEDIATRICS   |             |                            |                                  |  | 30. (       |
| 1.00 0   | D3100 INTENSIVE CARE UNIT   |             |                            |                                  |  | 31.         |
| 1. 01 0  | 03101 NEONATAL INTENSIVE CARE UNIT  |             |                            |                                  |  | 31.         |
|          | 04100 SUBPROVI DER - I RF   |             |                            | 6, 728, 280                      |  | 41.         |
|          | 04300 NURSERY   |             |                            |                                  |  | 43.         |
|          | ANCILLARY SERVICE COST CENTERS  |             |                            |                                  |  |             |
|          | D5000 OPERATING ROOM  |             | 0. 0673                    | · ·                              | 3, 696                                 |             |
|          | D5100 RECOVERY ROOM   |             | 0.0000                     |                                  | 0                                      | 1           |
|          | D5200 DELIVERY ROOM & LABOR ROOM  |             | 0. 3302                    |                                  | 0                                      | 1           |
|          | D5300 ANESTHESI OLOGY   |             | 0. 0078                    |                                  | 23                                     |             |
|          | D5400 RADI OLOGY-DI AGNOSTI C   |             | 0. 0659                    |                                  | 14, 477                                |             |
|          | D5401 ULTRASOUND  |             | 0.0000                     |                                  | 0                                      |             |
|          | D5600 RADI OI SOTOPE  |             | 0.0000                     |                                  | 0                                      |             |
|          | D5700 CT SCAN   |             | 0.0000                     |                                  | 0                                      |             |
|          | D5800 MRI   |             | 0.0000                     |                                  | 0                                      | 1           |
|          | D6000 LABORATORY  |             | 0. 0687                    |                                  |  |             |
|          | D6500 RESPI RATORY THERAPY  |             | 0. 0857                    | · ·                              | 252                                    |             |
|          | D6600 PHYSI CAL THERAPY   |             | 0. 1896                    |                                  | 419, 087                               |             |
|          | 06700 OCCUPATI ONAL THERAPY   |             | 0. 0910                    |                                  | 215, 680                               |             |
|          | D6800 SPEECH PATHOLOGY  |             | 0. 1995                    |                                  |  |             |
|          | D6900 ELECTROCARDI OLOGY  |             | 0. 0543                    | · ·                              | 3, 587                                 | 1           |
| - 1      | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                                   |             | 0. 0605                    |                                  | 2                                      |             |
|          | 07200 I MPL. DEV. CHARGED TO PATIENTS                                       |             | 0. 1461                    |                                  | 1, 816                                 |             |
|          | D7300 DRUGS CHARGED TO PATIENTS   |             | 0. 1487                    |                                  | 157, 707                               |             |
|          | 07400 RENAL DI ALYSI S  |             | 0. 2144                    |                                  | 10, 516                                |             |
|          | 03950 ANCI LLARY  |             | 0.0000                     |                                  | 0                                      |             |
|          | 03610 SLEEP LAB   |             | 0.0000                     |                                  | 0                                      |             |
|          | 03951 WOUND CARE  |             | 0. 2413                    | 53 3, 280                        | 792                                    | 76.         |
|          | OUTPATIENT SERVICE COST CENTERS   |             | 0.0000                     | 00 0                             |  | 1 00        |
|          | 09000 CLINIC  |             | 0.0000                     |                                  | 0                                      |             |
|          | 09100 EMERGENCY   |             | 0. 0986                    | 1                                | 8, 325                                 |             |
| - 1      | 09200 OBSERVATION BEDS (NON-DISTINCT PART                                   |             | 0. 2485                    |                                  | 0                                      | 1           |
| 00.00    | Total (sum of lines 50 through 94 and 96 through 98)                        | (1)         |                            | 8, 120, 431                      | 1, 040, 458                            |             |
| 01.00    | Less PBP Clinic Laboratory Services-Program only charges                    | (IIne 61)   |                            | 0                                |  | 201         |
| 02.00    | Net charges (line 200 minus line 201)                                       |             | 1                          | 8, 120, 431                      | l                                      | 202         |

|   | REGIONAL HOSPITAL | ON 45 0005   |  | eu of Form CMS-2 |                  |
|---|-------------------|--------------|--|------------------|------------------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT                                | Provi der C       |              | Peri od:<br>From 01/01/2021  | Worksheet D-3    |                  |
|   | Component         | CCN: 15-U035 | To 12/31/2021  | Date/Time Pre    | pared:           |
|   | ·                 |              |  | 5/30/2022 6: 2   |                  |
|   | Ti tl e           |              | Swing Beds - SNF   |                  |                  |
| Cost Center Description   |                   | Ratio of Cos | The state of the s | Inpati ent       |                  |
|   |                   | To Charges   | Program  | Program Costs    |                  |
|   |                   |              | Charges  | (col. 1 x col.   |                  |
|   |                   | 4 00         | 0.00   | 2)               |                  |
| INDATI FAIT POLITIME CERVILOE COCT OFFITERS                                   |                   | 1.00         | 2. 00  | 3. 00            |                  |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS                                    |                   | 1            |  |                  |                  |
| 30. 00   03000   ADULTS & PEDI ATRI CS  |                   |              |  |                  | 30.00            |
| 31. 00   03100   INTENSIVE CARE UNIT  |                   |              |  |                  | 31.00            |
| 31. 01   03101   NEONATAL INTENSIVE CARE UNIT                                 |                   |              |  |                  | 31.01            |
| 41. 00   04100   SUBPROVI DER - I RF<br>43. 00   04300   NURSERY              |                   |              |  |                  | 41. 00<br>43. 00 |
| 43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS                         |                   |              |  |                  | 43.00            |
|   |                   | 0.06732      | 6 0  | 0                | 50.00            |
| 50.00   05000   0PERATING ROOM<br>51.00   05100   RECOVERY ROOM               |                   | 0.00732      |  | 0                |                  |
| 52. 00   05100   RECOVERT ROOM<br>52. 00   05200   DELIVERY ROOM & LABOR ROOM |                   | 0. 33027     |  | 0                |                  |
| 53. 00   05200   DELT VERT ROOM & LABOR ROOM                                  |                   | 0. 33027     |  | 0                |                  |
| 54. 00   05400   RADI OLOGY - DI AGNOSTI C                                    |                   | 0.06594      |  | _                |                  |
| 54. 00   05400   RADI OLOGI - DI AGNOSTI C<br>54. 01   05401   ULTRASOUND     |                   | 0.00000      |  | 0                |                  |
| 56. 00   05600   RADI 0I SOTOPE   |                   | 0.00000      |  | 0                |                  |
| 57. 00   05700   CT   SCAN  |                   | 0.00000      |  | 0                |                  |
| 58. 00   05800   MRI  |                   | 0. 00000     |  | 0                |                  |
| 60. 00   06000   LABORATORY   |                   | 0. 06872     |  | _                |                  |
| 65. 00 06500 RESPI RATORY THERAPY   |                   | 0. 08577     | · ·  |                  |                  |
| 66. 00 06600 PHYSI CAL THERAPY  |                   | 0. 18964     | · ·  |                  |                  |
| 67. 00 06700 OCCUPATI ONAL THERAPY  |                   | 0. 09106     | · ·  |                  |                  |
| 68. 00 06800 SPEECH PATHOLOGY   |                   | 0. 19953     | · ·  |                  | 1                |
| 69. 00 06900 ELECTROCARDI OLOGY   |                   | 0. 05439     |  |                  | 1                |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                              |                   | 0. 06053     |  |                  |                  |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS                                  |                   | 0. 14610     |  | 0                |                  |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS  |                   | 0. 14876     |  | 5, 236           |                  |
| 74. 00 07400 RENAL DI ALYSI S   |                   | 0. 21448     |  | 0,200            |                  |
| 76. 00   03950   ANCI LLARY   |                   | 0.00000      |  | ō                |                  |
| 76. 01   03610   SLEEP LAB  |                   | 0.00000      |  | ō                |                  |
| 76. 03   03951   WOUND CARE   |                   | 0. 24135     |  |                  |                  |
| OUTPATIENT SERVICE COST CENTERS   |                   |              |  |                  | 1                |
| 90. 00 09000 CLI NI C   |                   | 0.00000      | 00 0   | 0                | 90.00            |
| 01 00 00100 EMERCENCY   |                   | 0 00060      | 0  |                  | 01 00            |

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166, 996

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18, 759 200. 00 201. 00 202. 00

91. 00 09100 EMERGENCY

92.00 | 09200 | SERVATION BEDS (NON-DISTINCT PART 200.00 | Total (sum of lines 50 through 94 and 96 through 98) | Less PBP Clinic Laboratory Services-Program only charges (line 61) | Net charges (line 200 minus line 201)

| Health Financial Systems PORTER REG                                    | IONAL HOSPITAL |                      | In Lie                           | eu of Form CMS-2  | 2552-10          |
|--|----------------|----------------------|----------------------------------|-------------------|------------------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT                         | Provi der C    |                      | Peri od:                         | Worksheet D-3     |                  |
|  |                |                      | From 01/01/2021<br>To 12/31/2021 | Date/Time Pre     | nared:           |
|  |                |                      |                                  | 5/30/2022 6: 28   |                  |
|  | Ti tl          | e XIX                | Hospi tal                        | Cost              |                  |
| Cost Center Description  |                | Ratio of Cos         |                                  | Inpatient         |                  |
|  |                | To Charges           | Program                          | Program Costs     |                  |
|  |                |                      | Charges                          | (col. 1 x col. 2) |                  |
|  |                | 1.00                 | 2. 00                            | 3.00              |                  |
| INPATIENT ROUTINE SERVICE COST CENTERS                                 |                | 1.00                 | 2.00                             | 3.00              |                  |
| 30. 00   03000   ADULTS & PEDI ATRI CS                                 |                |                      | 21, 972, 439                     |                   | 30. 00           |
| 31. 00 03100 I NTENSI VE CARE UNI T                                    |                |                      | 5, 361, 994                      |                   | 31. 00           |
| 31. 01   03101   NEONATAL INTENSIVE CARE UNIT                          |                |                      | 9, 016, 101                      |                   | 31. 01           |
| 41. 00   04100   SUBPROVI DER - I RF                                   |                |                      | 0                                |                   | 41.00            |
| 43. 00   04300   NURSERY   |                |                      | 1, 383, 347                      |                   | 43.00            |
| ANCILLARY SERVICE COST CENTERS   |                |                      |                                  |                   |                  |
| 50. 00   05000   OPERATI NG ROOM                                       |                | 0. 06732             |                                  | 1, 257, 960       | 50.00            |
| 51. 00   05100   RECOVERY ROOM   |                | 0.00000              |                                  | 0                 | 51.00            |
| 52.00   05200   DELIVERY ROOM & LABOR ROOM                             |                | 0. 33027             |                                  |                   | 52.00            |
| 53. 00   05300   ANESTHESI OLOGY                                       |                | 0. 00783             |                                  |                   | 53.00            |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C                               |                | 0. 06594             |                                  | 702, 318          | 54.00            |
| 54. 01   05401   ULTRASOUND  |                | 0.00000              |                                  | 0                 | 54. 01           |
| 56. 00   05600   RADI 0I SOTOPE  |                | 0. 00000             |                                  | 0                 | 56. 00           |
| 57. 00   05700   CT   SCAN   |                | 0.00000              |                                  | 0                 | 57. 00           |
| 58. 00   05800   MRI   |                | 0.00000              |                                  | 0                 | 58.00            |
| 60. 00   06000   LABORATORY<br>65. 00   06500   RESPI RATORY   THERAPY |                | 0. 06872<br>0. 08577 |                                  |                   | 60. 00<br>65. 00 |
| 66. 00   06600 PHYSI CAL THERAPY                                       |                |                      |                                  |                   | 66. 00           |
| 67. 00   06700   OCCUPATI ONAL THERAPY                                 |                | 0. 18964<br>0. 09106 |                                  |                   | 67. 00           |
| 68. 00   06800   SPEECH PATHOLOGY                                      |                | 0. 19953             |                                  |                   | 68. 00           |
| 69. 00   06900   ELECTROCARDI OLOGY                                    |                | 0. 17733             |                                  |                   | 69. 00           |
| 71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT                |                | 0.06053              |                                  |                   | 71. 00           |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS                           |                | 0. 14610             |                                  | 800, 875          | 71.00            |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS                                 |                | 0. 14876             |                                  |                   | 73. 00           |
| 74. 00 07400 RENAL DI ALYSI S  |                | 0. 21448             |                                  |                   | 74. 00           |
| 76. 00   03950   ANCI LLARY  |                | 0.00000              |                                  | 0                 | 76. 00           |
| 76. 01   03610   SLEEP LAB   |                | 0. 00000             |                                  | Ö                 | 76. 01           |
| 76. 03   03951   WOUND CARE  |                | 0. 24135             |                                  | 24, 415           | 76. 03           |
| OUTDATI ENT SERVICE COST CENTERS                                       |                | •                    | <u> </u>                         |                   |                  |

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12, 657, 082 1, 132, 888

108, 443, 814

108, 443, 814

1, 248, 090

281, 573

11, 115, 816 200. 00

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OUTPATIENT SERVICE COST CENTERS

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Net charges (line 200 minus line 201)

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

09000 CLI NI C

91. 00 09100 EMERGENCY

90.00

200.00

201.00

202.00

| Health Financial Systems PORTER REGIONAL                       | HOSPI TAL   |                            | In Lie                           | eu of Form CMS-:                               | 2552-10 |
|--|-------------|----------------------------|----------------------------------|--|---------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT                 |             | CN: 15-0035                | Peri od:                         | Worksheet D-3                                  |         |
|  | Component   | CCN: 15-T035               | From 01/01/2021<br>To 12/31/2021 | Date/Time Pre<br>5/30/2022 6:2                 |         |
|  | Titl        | e XIX                      | Subprovi der -<br>I RF           | Cost   |         |
| Cost Center Description  |             | Ratio of Cos<br>To Charges | Inpatient Program Charges        | Inpatient Program Costs (col. 1 x col. 2) 3.00 |         |
| INPATIENT ROUTINE SERVICE COST CENTERS                         |             | 1.00                       | 2.00                             | 3.00   |         |
| 30. 00   03000   ADULTS & PEDI ATRI CS                         |             |                            |                                  |  | 30.00   |
| 31. 00   03100   NTENSI VE CARE UNI T                          |             |                            |                                  |  | 31.00   |
| 31. 01   03101   NEONATAL   NTENSI VE CARE UNI T               |             |                            |                                  |  | 31. 01  |
| 41. 00   04100   SUBPROVI DER -   I RF                         |             |                            | 1, 388, 532                      |  | 41.00   |
| 43. 00   04300   NURSERY                                       |             |                            | 1, 300, 332                      |  | 43.00   |
| ANCI LLARY SERVI CE COST CENTERS                               |             |                            |                                  |  | +3.00   |
| 50. 00 05000 OPERATI NG ROOM                                   |             | 0. 0673                    | 26 10, 203                       | 687  | 50.00   |
| 51. 00   05100  RECOVERY ROOM                                  |             | 0.0000                     |                                  | 0.07   |         |
| 52. 00   05200   DELIVERY ROOM & LABOR ROOM                    |             | 0. 3302                    |                                  | 0  |         |
| 53. 00   05300   ANESTHESI OLOGY                               |             | 0. 0078                    |                                  | 0  |         |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C                       |             | 0.0659                     |                                  | 2, 691   |         |
| 54. 01   05400   RADI 0LOGT - DI AGNOSTI C                     |             | 0.0000                     | · ·                              | 2, 091   | •       |
|  |             | 1                          |                                  | 0  |         |
| 56. 00   05600   RADI 0I SOTOPE<br>57. 00   05700   CT SCAN    |             | 0.00000                    |                                  | 0  |         |
|  |             | 0.00000                    |                                  | 1  |         |
| 58. 00   05800   MRI   |             | 0.00000                    |                                  | 0  |         |
| 60. 00   06000   LABORATORY                                    |             | 0. 06872                   | · ·                              | 20, 355  |         |
| 65. 00 06500 RESPI RATORY THERAPY                              |             | 0. 0857                    |                                  | 0  |         |
| 66. 00   06600   PHYSI CAL THERAPY                             |             | 0. 1896                    |                                  | 89, 873  |         |
| 67. 00 06700 OCCUPATI ONAL THERAPY                             |             | 0. 0910                    | · ·                              | 43, 218  |         |
| 68. 00   06800   SPEECH PATHOLOGY                              |             | 0. 1995                    | · ·                              | 21, 678  |         |
| 69. 00 06900 ELECTROCARDI OLOGY                                |             | 0. 05439                   | · ·                              | 468  |         |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT               |             | 0. 06053                   |                                  | 0  |         |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS                   |             | 0. 14610                   |                                  | 233  |         |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS                         |             | 0. 1487                    | · ·                              | 43, 976  |         |
| 74. 00 07400 RENAL DIALYSIS                                    |             | 0. 21448                   | · ·                              | 18, 569  |         |
| 76. 00   03950   ANCI LLARY                                    |             | 0. 00000                   |                                  | 0  |         |
| 76. 01   03610   SLEEP LAB                                     |             | 0. 00000                   |                                  | 0  |         |
| 76. 03 03951 WOUND CARE  |             | 0. 2413                    | 53 3, 280                        | 792  | 76. 03  |
| OUTPATIENT SERVICE COST CENTERS                                |             |                            |                                  |  |         |
| 90. 00   09000   CLI NI C                                      |             | 0.00000                    |                                  | 0  |         |
| 91. 00   09100   EMERGENCY                                     |             | 0. 09860                   | · ·                              | 1  | 91.00   |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART               |             | 0. 2485                    |                                  | 0  |         |
| 200.00 Total (sum of lines 50 through 94 and 96 through 98)    |             |                            | 1, 806, 066                      | 243, 140                                       | 200.00  |
| 201.00 Less PBP Clinic Laboratory Services-Program only charge | s (line 61) |                            | 0                                |  | 201. 00 |
| 202.00 Net charges (line 200 minus line 201)                   |             |                            | 1, 806, 066                      | I  | 202.00  |

| Health Financial Systems PORTER REG             | SIONAL HOSPITAL |              | In Lie           | eu of Form CMS-2            | 2552-10 |
|---|-----------------|--------------|------------------|-----------------------------|---------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT  | Provi der C     |              | Peri od:         | Worksheet D-3               |         |
|   |                 |              | From 01/01/2021  | 5 . (7) 5                   |         |
|   | Component       | CCN: 15-U035 | To 12/31/2021    | Date/Time Pre 5/30/2022 6:2 |         |
|   | Ti +1           | e XIX        | Swing Beds - SNF |                             | в рііі  |
| Cost Center Description                         |                 | Ratio of Cos |                  | Inpati ent                  |         |
| cost center bescription                         |                 | To Charges   | Program          | Program Costs               |         |
|   |                 | 10 onar ges  | Charges          | (col. 1 x col.              |         |
|   |                 |              | onal goo         | 2)                          |         |
|   |                 | 1.00         | 2. 00            | 3. 00                       |         |
| INPATIENT ROUTINE SERVICE COST CENTERS          |                 |              |                  |                             |         |
| 30. 00 03000 ADULTS & PEDI ATRI CS              |                 |              |                  |                             | 30.00   |
| 31.00 03100 INTENSIVE CARE UNIT                 |                 |              |                  |                             | 31.00   |
| 31. 01 03101 NEONATAL INTENSIVE CARE UNIT       |                 |              |                  |                             | 31. 01  |
| 41. 00   04100   SUBPROVI DER - I RF            |                 |              |                  |                             | 41.00   |
| 43. 00   04300   NURSERY                        |                 |              |                  |                             | 43.00   |
| ANCILLARY SERVICE COST CENTERS                  |                 |              |                  |                             |         |
| 50. 00   05000   OPERATI NG ROOM                |                 | 0. 06732     |                  |                             | 50. 00  |
| 51. 00   05100   RECOVERY ROOM                  |                 | 0.00000      | 00               | 0                           | 51. 00  |
| 52.00   05200   DELIVERY ROOM & LABOR ROOM      |                 | 0. 33027     | 74 0             | 0                           | 52. 00  |
| 53. 00   05300   ANESTHESI OLOGY                |                 | 0. 00783     |                  | 0                           | 53. 00  |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C        |                 | 0. 06594     |                  | 0                           | 54.00   |
| 54. 01   05401   ULTRASOUND                     |                 | 0.00000      |                  | 0                           | 54. 01  |
| 56. 00   05600   RADI 0I SOTOPE                 |                 | 0.00000      |                  | 0                           | 56. 00  |
| 57. 00  05700 CT SCAN                           |                 | 0.00000      |                  | 0                           | 57. 00  |
| 58. 00   05800   MRI                            |                 | 0.00000      |                  | 0                           | 58. 00  |
| 60. 00   06000   LABORATORY                     |                 | 0. 06872     |                  | 0                           | 60.00   |
| 65. 00 06500 RESPI RATORY THERAPY               |                 | 0. 08577     |                  | 0                           | 65. 00  |
| 66. 00 06600 PHYSI CAL THERAPY                  |                 | 0. 18964     |                  | 0                           | 66. 00  |
| 67. 00 06700 OCCUPATI ONAL THERAPY              |                 | 0. 09106     |                  | 0                           | 67. 00  |
| 68. 00 06800 SPEECH PATHOLOGY                   |                 | 0. 19953     |                  | 0                           | 68. 00  |
| 69. 00 06900 ELECTROCARDI OLOGY                 |                 | 0. 05439     |                  | 0                           | 69. 00  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT |                 | 0. 06053     |                  | 0                           | 71.00   |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS      |                 | 0. 14610     |                  | 0                           | 72. 00  |
| 73.00 07300 DRUGS CHARGED TO PATIENTS           |                 | 0. 14876     |                  | 0                           | 73. 00  |
| 74. 00   07400   RENAL DI ALYSI S               |                 | 0. 21448     |                  | 0                           | 74. 00  |
| 76. 00   03950   ANCI LLARY                     |                 | 0.00000      |                  | 0                           | 76. 00  |
| 76. 01   03610   SLEEP LAB                      |                 | 0.00000      |                  |                             | 76. 01  |
| 76. 03 03951 WOUND CARE                         |                 | 0. 24135     | 53 0             | 0                           | 76. 03  |

0. 000000 0. 098608

0. 248544

00000

0

0

0 92.00 0 200. 00 201. 00 202. 00

90. 00 91. 00

OUTPATIENT SERVICE COST CENTERS

92.00 | 09200 | SERVATION BEDS (NON-DISTINCT PART 200.00 | Total (sum of lines 50 through 94 and 96 through 98) | Less PBP Clinic Laboratory Services-Program only charges (line 61) | Net charges (line 200 minus line 201)

90.00

09000 CLI NI C

91. 00 09100 EMERGENCY

| Health Financial Systems                | PORTER REGIONAL HOSPITAL |         | In Lie                                      | u of Form CMS-2552-10   |
|---|--------------------------|---------|---|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN:            | 15-0035 | Period:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet E<br>Part A<br>Date/Time Prepared:<br>5/30/2022 6:28 pm |

| PART A.  |        |   |   | 10 12/31/2021     | 5/30/2022 6: 2 |        |
|--|--------|---|---|-------------------|----------------|--------|
| ART A - INPATIENT ROSPITAL SERVICES WORK IPPS  |        |   | Title XVIII                             | Hospi tal         | PPS            |        |
| ART A - INPATIENT ROSPITAL SERVICES WORK IPPS  |        |   |   |                   | 1 00           |        |
| 1.00   |        | PART A - INPATIENT HOSPITAL SERVICES LINDER LPPS              |   |                   | 1.00           |        |
| 1.01   BRS amounts other than outlier payments for discharges occurring prior to October 1 (see   28,897,666   1.01   Instructions)   1.02   INSK amounts other than outlier payments for discharges occurring on an after October 1 (see   9.891,161   1.02   1.03   1.03   1.03   1.04   1.05       | 1.00   |   |   |                   | 0              | 1.00   |
| DRG amounts other than outlier payments for discharges occurring on or after October 1 (see   9,498,161   1.02   Instructions)   1.03   RRG for federal specific operating payment for Wodel 4 BPCI for discharges occurring prior to October 1 (see Instructions)   1.03   Control (see Instructions)   1.04   Control (see Instructions)   1.04   Control (see Instructions)   1.05   Control (see       |        |   | ing prior to October 1 (                | see               |                |        |
| Instructions   1.03   Bid For Federal specific operating payment for Model 4 BPCI for discharges occurring prior to October   0   1.03   |        | instructions)   |   |                   |                |        |
| DRG For Federal Specific Operating payment for Woodel 4 BPCI for discharges occurring prior to October 1 (see instructions) 1 (see instructions) 2 (a. 1.0.4)  | 1. 02  | . ,   | ing on or after October                 | 1 (see            | 9, 698, 161    | 1. 02  |
| 1 (see instructions)   | 4 00   |   |   |                   |                | 4 00   |
| 1.04   Oktober   1,06e Instructions   2.00   0.104   0.000         | 1.03   |   | or discharges occurring                 | prior to October  | 0              | 1.03   |
| October 1 (see Instructions)   0   | 1 04   |   | or discharges occurring                 | on or after       | 0              | 1 04   |
| 2.00   Outlier payments for discharges (see Instructions)   0.20   0.2       | 1.04   |   | or arsenarges occurring                 |                   | O              | 1.04   |
| Outlier reconciliation amount   0   2.01   | 2.00   |   |   |                   |                | 2. 00  |
| 2.03   Outlier payments for discharges occurring prior to October 1 (see instructions)   534,002   2.04   Outlier payments for discharges occurring on or after October 1 (see instructions)   128,153   2.03   2.03   2.04   Outlier payments for discharges occurring on or after October 1 (see instructions)   224,093,444   3.00   24,093,444   3.00   Outlier payments for discharges occurring on or after October 1 (see instructions)   224,094   3.00   Outlier payments for discharges occurring period (see instructions)   224,094   3.00   Outlier payments did vided by number of days in the cost reporting period ending on or before 1/23/1/996 (see instructions)   0.00   5.00   Outlier payments of the most recent cost reporting period ending on or before 1/23/1/996 (see instructions)   0.00   6.00   Outlier payments of the payment of the paym       |        | Outlier reconciliation amount                                 |   |                   | 0              | 2. 01  |
| 2.04   Outlier payments for discharges occurring on a rafter October 1 (see instructions)   128, 153   2.04  | 2.02   | Outlier payment for discharges for Model 4 BPCI (see instruct | i ons)                                  |                   | 0              | 2. 02  |
| Managed Car's Simulated Payments   | 2.03   | Outlier payments for discharges occurring prior to October 1  | (see instructions)                      |                   | 584, 092       | 2. 03  |
| Bed days available divided by number of days in the cost reporting period (see instructions)   224.06   6.00   Indirect Medical Education Adjustment   5.00   FTE count for all lopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)   6.00   7.00       |        | Outlier payments for discharges occurring on or after October | 1 (see instructions)                    |                   | 128, 153       |        |
| Indirect Medical Education Adjustment  |        |   |   |                   |                | ı      |
| FIE count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996, (see instructions)  | 4.00   |   | rting period (see instru                | ctions)           | 224. 06        | 4. 00  |
| or before 12/31/19%. (See Instructions)  6.00 FEE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)  7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions affiliated programs for affiliated programs in accordance with 42 CFR 413.75(d), 413.79(c) (2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).  8.01 The amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.  8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions)  9.00 Sim of lines \$ plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see under \$ 5506 of ACA. (see instructions)  10.00 FTE count for allopathic and osteopathic programs in the current year from your records  11.00 FTE count for residents in dental and podiatric programs.  12.00 Current year all lowable FTE (see Instructions)  13.00 Total all womable FTE count for the prior year.  14.00 Current year all lowable FTE count for the prior year.  15.00 Sun of lines 12 through 14 divided by 3.  16.00 Adjustment for residents displaced by program or hospital closure  17.00 Adjustment for residents displaced by program or hospital closure  18.00 Adjustment for residents (see instructions)  18.00 Interest year all lowable FTE count for the penul timate year if that year ended on or after September 30, 1997.  18.00 Interest year all lowable FTE count for the penul timate year lift had year ended on or after September 30, 1997.  18.00 Interest year residents displaced by program or hospital closure  18.00 A distancent for residents displaced by program or hospital closure  18.00 A distancent for residents displaced by program or hospital closure  18.00 A distancent for residents displaced |        |   |   |                   |                |        |
| TEC count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)   7.00   MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(1)   7.00      | 5.00   |   | t recent cost reporting                 | period ending on  | 0.00           | 5.00   |
| new programs in accordance with 42 CFR 413.79(e)  7.00 MM Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions after its depth of the cost report straddles July 1, 2011 then see instructions after its depth of the cost report straddles July 1, 2011 then see instructions after its depth of the cost report straddles July 1, 2011 then see instructions are instructions and 7 FR 50069 (August 1, 2002).  8. 01 The amount of increase if the hospit all was awarded FTE cap slots under \$ 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.  8. 02 The amount of increase if the hospit all was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions)  9. 03 Sum of lines \$ 50 of ACA. (see instructions)  10. 00 FTE count for all opathic and osteopathic programs in the current year from your records  10. 00 FTE count for all opathic and osteopathic programs in the current year from your records  10. 00 FTE count for all owable FTE (see instructions)  10. 01 Total allowable FTE count for the prior year.  10. 02 Total allowable FTE count for the prior year.  10. 03 Interest year allowable FTE count for the prior year.  10. 04 Interest year allowable FTE count for the prior year.  10. 05 Interest year allowable FTE count for the prior year.  10. 06 Interest year allowable FTE count for the prior year.  10. 07 Interest year seldent in initial years of the program  10. 08 Interest year year year year year year year year  | 6 00   | ·   | ho critoria for an add o                | n to the can for  | 0.00           | 6.00   |
| 7.00         MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2)         0.00         7.00           7.01         ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(i)(iv)(B)(B)(2) If the cost report straddles July 1, 2011 then see instructions.         0.00         40 Justement (increase or decrease) to the FIE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12. 1998), and 67 FR 50069 (Mayust 1, 2002).         0.00         8.00           8.01         The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.         0.00         8.01           8.02         The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)         0.00         1.00           9.00         Sum of Lines 5 plus 6 minus Lines (7 and 7.01) plus/minus Lines (8, 8, 01 and 8, 02) (see instructions)         0.00         1.00           10.00         FTE count for allopathic and osteopathic programs in the current year from your records         0.00         1.00           10.00         FTE count for allopathic and osteopathic programs.         0.00         1.00           10.00         FTE count for allopathic and osteopathic programs in the current year from your records         0.00         1.00           10.00         FTE count for the price ye  | 0.00   |   | ne criteria for an add-o                | ii to the cap for | 0.00           | 0.00   |
| ACA \$ 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(v)(B)(2) If the cost report straddles July 1, 2011 then see instructions.  | 7. 00  |   | under 42 CFR §412.105(f)                | (1) (i v) (B) (1) | 0.00           | 7. 00  |
| cost report straddles July 1, 2011 then see instructions. 8. 00 Ajustment (increase or decrease) to the FTE count for all opathic and osteopathic programs for affil lated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50099 (Mugust 1, 2002). 8. 01 The amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8. 02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions). 8. 02 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see O.00 0.00 instructions). 9. 03 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see O.00 0.00 instructions). 9. 04 Current year allowable FTE (see instructions). 9. 05 Current year allowable FTE (see instructions). 9. 06 Current year allowable FTE count for the prior year. 9. 07 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, otherwise enter zero. 9. 08 Sum of lines 12 through 14 divided by 3. 9. 09 Courrent year residents in initial years of the program O.00 17,00 Adjustment for residents in initial years of the program O.00 17,00 Adjustment for residents in initial years of the program O.00 17,00 Adjustment for residents of the following of the program O.00 17,00 Current year resident to bed ratio (see instructions) 9. 0. 00 Occupied to be program or hospital closure Occupied Occupie   |        |   |   |                   |                | ı      |
| Adjustment (Increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12. 1998), and 67 FR 50069 (August 1, 2002).  |        |   |   | , ( , ( , )       |                |        |
| 1998), and 67 FR 5009 (August 1, 2002).  | 8.00   | Adjustment (increase or decrease) to the FTE count for allopa | thic and osteopathic pro                | grams for         | 0.00           | 8. 00  |
| 8.01   The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report stradile sully 1, 2011, see instructions.   1.02   The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)   9.00   Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)   1.00   FTE count for residents in dental and podiatric programs in the current year from your records   0.00 10.00        |        |   | 79(c)(2)(iv), 64 FR 2634                | 0 (May 12,        |                |        |
| report straddles July 1, 2011, see instructions.   |        |   |   |                   |                |        |
| 8.02   The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)  | 8. 01  |   | ots under § 5503 of the                 | ACA. If the cost  | 0.00           | 8. 01  |
| under \$ 5506 of ACA. (see instructions)   9.00  | 0.00   |   | -+- <i>6</i>    + :                     |                   | 0.00           | 0.00   |
| Sum of   lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see   0.00   9.00   9.00   10.00   FTE count for allopathic and osteopathic programs in the current year from your records   0.00   10.00   11.00   FTE count for residents in dental and podiatric programs.   0.00   12.00   12.00   12.00   13.00   14.00         | 8. 02  |   | ots from a closed teachi                | ng nospi tai      | 0.00           | 8.02   |
| Instructions   | 9 00   |   | es (8 8 01 and 8 02) (                  | 992               | 0.00           | 9 00   |
| 10.00   FTE count for all opathic and osteopathic programs in the current year from your records   0.00   10.00  | 7. 00  |   | cs (0, 0,01 and 0,02) (                 | 300               | 0.00           | 7.00   |
| 11.00   FTE count for residents in dental and podiatric programs.   0.00   11.00   11.00   12.00   12.00   13.00   10.01   13.00   10.01   13.00   10.01   13.00   10.01   13.00   10.01   13.00   10.01   13.00   10.01   13.00   10.01   13.00   10.01   13.00   10.01   13.00   10.01   13.00   10.01   13.00   10.01   13.00   10.01   13.00   10.00   1       | 10.00  |   | ent year from your recor                | ds                | 0.00           | 10.00  |
| 13.00   Total allowable FTE count for the prior year.   0.00   13.00   14.00   15.00   15.00   16.00       | 11.00  |   | 3                                       |                   | 0.00           | 11. 00 |
| 14.00   Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.   15.00   Sum of lines 12 through 14 divided by 3.   0.00   15.00   16.00   Adjustment for residents in initial years of the program   0.00   16.00   17.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   18.00   Adjustment for residents displaced by program or hospital closure   0.00   18.00   Adjustment for residents of the program   0.00   18.00   Adjustment for resident to bed ratio (line 18 divided by line 4).   0.000000   19.0       | 12.00  | Current year allowable FTE (see instructions)                 |   |                   | 0.00           | 12. 00 |
| Otherwise enter zero.   Othe       | 13.00  | Total allowable FTE count for the prior year.                 |   |                   | 0.00           | 13. 00 |
| 15.00   Sum of lines 12 through 14 divided by 3.   0.00   15.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   17.00   17.00   18.00   18.00   18.00   18.00   19       | 14.00  |   | ar ended on or after Sep                | tember 30, 1997,  | 0.00           | 14. 00 |
| 16.00   Adjustment for residents in initial years of the program   0.00   16.00   17.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00         |        |   |   |                   |                |        |
| 17.00  |        |   |   |                   |                | ı      |
| 18.00       Adjusted rolling average FTE count       0.00       18.00         19.00       Current year resident to bed ratio (line 18 divided by line 4).       0.0000000       19.00         20.00       Prior year resident to bed ratio (see instructions)       0.000000       20.00         21.00       Enter the lesser of lines 19 or 20 (see instructions)       0.000000       21.00         22.00       IME payment adjustment (see instructions)       0.22.00         1 IME payment adjustment - Managed Care (see instructions)       0.00       22.01         1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA       0.00       23.00         23.00       Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105       0.00       23.00         (f)(1)(iv)(c).       0.00       24.00       1ME FTE Resident Count Over Cap (see instructions)       0.00       24.00         25.00       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see       0.00       25.00         26.00       Resident to bed ratio (divide line 25 by line 4)       0.000000       26.00         27.00       IME payments adjustment amount (see instructions)       0.000000       27.00         28.01       IME add-on adjustment amount (see instructions)       0.28.01         29.0   |        |   |   |                   |                |        |
| 19.00       Current year resident to bed ratio (line 18 divided by line 4).       0.000000       19.00         20.00       Prior year resident to bed ratio (see instructions)       0.000000       20.00         21.00       Enter the lesser of lines 19 or 20 (see instructions)       0.000000       21.00         22.01       IME payment adjustment (see instructions)       0.000000       22.00         22.01       IME payment adjustment - Managed Care (see instructions)       0.00       22.01         Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA       0.00       23.00         (f)(1)(iv)(c).       0.00       23.00         4.00       IME FTE Resident Count Over Cap (see instructions)       0.00       24.00         25.00       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)       0.00       25.00         26.00       Resident to bed ratio (divide line 25 by line 4)       0.000000       27.00       0.000000       27.00         27.00       IME payments adjustment factor. (see instructions)       0.000000       27.00       0.000000       28.00         28.01       IME add-on adjustment amount - Managed Care (see instructions)       0.000000       29.00         29.01       Total IME payment - Managed Care (sum of lines 22 and 28)       0.29.00   |        |   | sure                                    |                   |                |        |
| 20.00   Prior year resident to bed ratio (see instructions)   0.000000   20.00   21.00   Enter the lesser of lines 19 or 20 (see instructions)   0.000000   21.00   0.000000   21.00   0.000000   21.00   0.000000   21.00   0.000000   22.00   0.000000   21.00   0.000000   22.00   0.000000   22.00   0.0000000   0.0000000   0.0000000   0.00000000  |        |   | `                                       |                   |                |        |
| 21.00   Enter the lesser of lines 19 or 20 (see instructions)   0.000000   21.00     22.00   IME payment adjustment (see instructions)   0.22.00     1ME payment adjustment - Managed Care (see instructions)   0.22.01     1 Imid rect Medical Education Adjustment for the Add-on for § 422 of the MMA     23.00   Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA     23.00   Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA     24.00   IME FTE Resident Count Over Cap (see instructions)   0.000   24.00     25.00   If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see   0.00   25.00     26.00   Resident to bed ratio (divide line 25 by line 4)   0.000000   26.00     27.00   IME payments adjustment factor. (see instructions)   0.000000   27.00     28.00   IME add-on adjustment amount (see instructions)   0.28.00     29.00   Total IME payment (sum of lines 22 and 28)   0.00000   0.000000     29.00   Total IME payment - Managed Care (sum of lines 22.01 and 28.01)   0.000000   0.000000     29.00   0.000000   0.000000   0.000000   0.000000     29.00   0.0000000   0.0000000   0.00000000  |        | ,   | ).                                      |                   |                |        |
| 22.00   IME payment adjustment (see instructions)  |        | ,                       |   |                   |                | ı      |
| 22. 01 IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412. 105 (f) (1) (iv) (C).  24. 00 IME FTE Resident Count Over Cap (see instructions)  25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions)  26. 00 Resident to bed ratio (divide line 25 by line 4)  27. 00 IME payments adjustment factor. (see instructions)  28. 00 IME add-on adjustment amount (see instructions)  29. 00 IME add-on adjustment amount (see instructions)  29. 00 Total IME payment (sum of lines 22 and 28)  29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30. 00 Sum of lines 30 and 31  Allowable disproportionate share percentage (see instructions)  8. 35 33.00   |        |   |   |                   |                |        |
| Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 (f) (1) (iv) (C).  24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 instructions)  26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME payments adjustment amount (see instructions) 0.000000 27.00 IME add-on adjustment amount (see instructions) 0.000000 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.00000 29.01 Total IME payment (sum of lines 22 and 28) 0.00 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0.00000 29.01 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 2.46 30.00 31.00 Sum of lines 30 and 31 23.00 Allowable disproportionate share percentage (see instructions) 8.35 33.00   |        |   |   |                   |                |        |
| (f)(1)(iv)(C).  24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  8.35 33.00  |        |   | 2 of the MMA                            |                   |                |        |
| 24. 00 IME FTE Resident Count Over Cap (see instructions) 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26. 00 Resident to bed ratio (divide line 25 by line 4) 27. 00 IME payments adjustment factor. (see instructions) 28. 00 IME add-on adjustment amount (see instructions) 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29. 01 Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 20. 01 Sum of lines 30 and 31 20. 02 Sum of lines 30 and 31 31. 00 32. 00 Allowable disproportionate share percentage (see instructions) 33. 00 Allowable disproportionate share percentage (see instructions) 34. 00 Sum of lines 30 and 31 35. 00 Allowable disproportionate share percentage (see instructions) 36. 00 Sum of lines 30 and 31 37. 00 Allowable disproportionate share percentage (see instructions) 37. 00 Sum of lines 30 and 31 38. 35. 33. 00   | 23.00  | Number of additional allopathic and osteopathic IME FTE resid | ent cap slots under 42 C                | FR 412. 105       | 0.00           | 23. 00 |
| 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  0.00 25.00 instructions)  Resident to bed ratio (divide line 25 by line 4)  1. ME payments adjustment factor. (see instructions)  1. ME payments adjustment amount (see instructions)  28.00 IME add-on adjustment amount (see instructions)  29.00 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  29.01 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Sum of lines 30 and 31  32.00 Allowable disproportionate share percentage (see instructions)  8.35 33.00   |        | (f)(1)(iv)(C).  |   |                   |                |        |
| Instructions   Resident to bed ratio (divide line 25 by line 4)   0.000000   26.00   | 24. 00 |   |   |                   |                | ł      |
| 26. 00       Resident to bed ratio (divide line 25 by line 4)       0.000000       26. 00         27. 00       IME payments adjustment factor. (see instructions)       0.000000       27. 00         28. 00       IME add-on adjustment amount (see instructions)       0       28. 00         28. 01       IME add-on adjustment amount - Managed Care (see instructions)       0       28. 01         29. 00       Total IME payment (sum of lines 22 and 28)       0       29. 00         29. 01       Total IME payment - Managed Care (sum of lines 22.01 and 28.01)       0       29. 01         Disproportionate Share Adjustment       9       29. 01         30. 00       Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)       2. 46       30. 00         31. 00       Percentage of Medicaid patient days (see instructions)       20. 73       31. 00         32. 00       Sum of lines 30 and 31       23. 19       32. 00         33. 00       Allowable disproportionate share percentage (see instructions)       8. 35       33. 00  | 25. 00 |   | lower of line 23 or line                | 24 (see           | 0. 00          | 25. 00 |
| 27. 00       IME payments adjustment factor. (see instructions)       0.000000       27. 00         28. 00       IME add-on adjustment amount (see instructions)       0 28. 00         28. 01       IME add-on adjustment amount - Managed Care (see instructions)       0 28. 01         29. 00       Total IME payment (sum of lines 22 and 28)       0 29. 00         29. 01       Total IME payment - Managed Care (sum of lines 22.01 and 28.01)       0 29. 01         Disproportionate Share Adjustment       29. 01         30. 00       Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)       2. 46       30. 00         31. 00       Percentage of Medicaid patient days (see instructions)       20. 73       31. 00         32. 00       Sum of lines 30 and 31       23. 19       32. 00         33. 00       Allowable disproportionate share percentage (see instructions)       8. 35       33. 00  |        |   |   |                   |                |        |
| 28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.00 Percentage of Medicaid patient days (see instructions)  30.00 Sum of lines 30 and 31  30.00 Allowable disproportionate share percentage (see instructions)  |        | ,   |   |                   |                |        |
| 28. 01 IME add-on adjustment amount - Managed Care (see instructions)  29. 00  29. 01 Total IME payment (sum of lines 22 and 28)  Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31. 00 Percentage of Medicaid patient days (see instructions)  32. 00 Sum of lines 30 and 31  33. 00 Allowable disproportionate share percentage (see instructions)  33. 00 Allowable disproportionate share percentage (see instructions)  33. 00 Allowable disproportionate share percentage (see instructions)  34. 01 Sum of lines 30 and 31  35. 02 Sum of lines 30 and 31  36. 03 Sum of lines 30 and 31  37. 04 Sum of lines 30 and 31  38. 35 Sum of lines 30 and 31   |        | · ·   |   |                   |                | •      |
| 29. 00 29. 01 Total IME payment (sum of lines 22 and 28)  Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30. 00 Percentage of SI recipient patient days to Medicare Part A patient days (see instructions)  31. 00 Percentage of Medicaid patient days (see instructions)  32. 00 Sum of lines 30 and 31  33. 00 Allowable disproportionate share percentage (see instructions)  33. 00  29. 00 29. 00 29. 01 29. 01 29. 01 29. 01 29. 01 29. 01 29. 01 29. 00 29. 01 20. 01 20. 01 20. 01 20. 01 20. 01 20. 01 20. 01 20. 01 20. 01 20. 01 20. 01 20. 01 20. 01 20. 01 20. 01 20. 01 20. 01     |        |   | `                                       |                   |                |        |
| 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31. 00 Percentage of Medicaid patient days (see instructions)  20. 73 31. 00  32. 00 Sum of lines 30 and 31  33. 00 Allowable disproportionate share percentage (see instructions)  29. 01  29. 01  29. 01  29. 01  29. 01  20. 73 30. 00  20. 73 31. 00  20. 73 31. 00  20. 73 31. 00  20. 73 32. 00  |        |   | )                                       |                   |                | •      |
| Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  2. 46 30.00  31.00 Percentage of Medicaid patient days (see instructions)  20. 73 31.00  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  8. 35 33.00   |        |   | 1)                                      |                   |                |        |
| 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  2. 46 30.00 31.00 Percentage of Medicaid patient days (see instructions)  20. 73 31.00 32.00 Sum of lines 30 and 31  32.00 Allowable disproportionate share percentage (see instructions)  8. 35 33.00  | _,.01  |   | • ,                                     |                   | 0              | 1 0 '  |
| 31.00 Percentage of Medicaid patient days (see instructions) 20.73 31.00 32.00 Sum of lines 30 and 31 23.19 32.00 Allowable disproportionate share percentage (see instructions) 8.35 33.00  | 30.00  |   | atient days (see instruc                | tions)            | 2. 46          | 30.00  |
| 32.00 Sum of lines 30 and 31 23.19 32.00 Allowable disproportionate share percentage (see instructions) 8.35 33.00   |        |   | J (1111 1111 1111 1111 1111 1111 1111 1 | <i>,</i>          |                | 1      |
|  |        | ,                       |   |                   |                |        |
| 34.00   Disproportionate share adjustment (see instructions) 805,688   34.00   |        |   | )                                       |                   |                |        |
|  | 34. 00 | Disproportionate share adjustment (see instructions)          |   |                   | 805, 688       | 34.00  |

| Heal th          | Financial Systems PORTER REGIONAL   | HOSPI TAI                | In lie                                       | u of Form CMS-2   | 2552-10          |
|------------------|---|--------------------------|--|---|------------------|
|                  | ATION OF REIMBURSEMENT SETTLEMENT   | Provi der CCN: 15-0035   | Peri od:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet E<br>Part A<br>Date/Time Pre<br>5/30/2022 6:2 | pared:           |
|                  |   | Title XVIII              | Hospi tal                                    | PPS   |                  |
|                  |   |                          | Prior to 10/1<br>1.00                        | 2.00  |                  |
|                  | Uncompensated Care Adjustment   |                          | 1.00   | 2.00  |                  |
| 35.00            | Total uncompensated care amount (see instructions)  |                          | 8, 290, 014, 521                             | 7, 192, 008, 710  | 35. 00           |
| 35. 01           | Factor 3 (see instructions)   |                          | 0. 000131341                                 | 0. 000133205  | 35. 01           |
| 35. 02           | Hospital uncompensated care payment (If line 34 is zero, enter instructions)  | r zero on this line) (se | e 1, 088, 819                                | 958, 012  | 35. 02           |
| 35. 03           | Pro rata share of the hospital uncompensated care payment amou  | unt (see instructions)   | 814, 377                                     | 241, 472  | 35. 03           |
| 36. 00           | Total uncompensated care (sum of columns 1 and 2 on line 35.0)  |                          | 1, 055, 849                                  |   | 36. 00           |
|                  | Additional payment for high percentage of ESRD beneficiary dis  | scharges (lines 40 throu |  |   |                  |
| 40. 00           | Total Medicare discharges (see instructions)  |                          | 0  |   | 40. 00           |
| 41. 00           | Total ESRD Medicare discharges (see instructions)   | i ons)                   | 0  |   | 41.00            |
| 41. 01           | Total ESRD Medicare covered and paid discharges (see instructi  |                          | _  |   | 41. 01           |
| 42. 00<br>43. 00 | Divide line 41 by line 40 (if less than 10%, you do not quality Total Medicare ESRD inpatient days (see instructions) | ry for adjustment)       | 0.00   |   | 42. 00<br>43. 00 |
| 44. 00           | Ratio of average length of stay to one week (line 43 divided l  | by line 41 divided by 7  | 0. 000000                                    |   | 44. 00           |
| 44.00            | days)   | by Title 41 divided by 7 | 0.000000                                     |   |                  |
| 45. 00           | Average weekly cost for dialysis treatments (see instructions)  |                          | 0.00   |   | 45. 00           |
| 46. 00           | Total additional payment (line 45 times line 44 times line 41.  | . 01)                    | 0  |   | 46. 00           |
| 47. 00           | Subtotal (see instructions)   |                          | 41, 169, 609                                 |   | 47. 00           |
| 48. 00           | Hospital specific payments (to be completed by SCH and MDH, s   | mall rural hospitals     | 0  |   | 48. 00           |
|                  | only. (see instructions)  |                          |  | Amount  |                  |
|                  |   |                          |  | 1. 00   |                  |
| 49. 00           | Total payment for inpatient operating costs (see instructions)  | )                        |  | 41, 169, 609  | 49. 00           |
| 50. 00           | Payment for inpatient program capital (from Wkst. L, Pt. I and  |                          |  | 3, 134, 873   |                  |
| 51.00            | Exception payment for inpatient program capital (Wkst. L, Pt.   |                          |  | 0   | 51. 00           |
| 52.00            | Direct graduate medical education payment (from Wkst. E-4, li   |                          |  | 0   | 52.00            |
| 53.00            | Nursing and Allied Health Managed Care payment  |                          |  | 0   | 53.00            |
| 54.00            | Special add-on payments for new technologies  |                          |  | 463, 408  | 54.00            |
| 54. 01           | Islet isolation add-on payment  |                          |  | 0   | 54. 01           |
| 55.00            | Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6   |                          |  | 0   | 55.00            |
| 56. 00           | Cost of physicians' services in a teaching hospital (see intr   |                          |  | 0   | 56. 00           |
| 57. 00           | Routine service other pass through costs (from Wkst. D, Pt. I)  |                          | hrough 35).                                  | 0   | 57. 00           |
| 58. 00           | Ancillary service other pass through costs from Wkst. D, Pt.  | IV, col. 11 line 200)    |  | 0   | 58. 00           |
| 59. 00           | Total (sum of amounts on lines 49 through 58)   |                          |  | 44, 767, 890  |                  |
| 60. 00<br>61. 00 | Primary payer payments<br>Total amount payable for program beneficiaries (line 59 minus                               | lino 60)                 |  | 12, 095<br>44, 755, 795                                 |                  |
| 62. 00           | Deductibles billed to program beneficiaries   | 111le 80)                |  | 3, 660, 424   |                  |
| 63. 00           | Coinsurance billed to program beneficiaries   |                          |  | 206, 772  | 63. 00           |
| 64. 00           | Allowable bad debts (see instructions)  |                          |  | 233, 723  |                  |
| 65. 00           | Adjusted reimbursable bad debts (see instructions)  |                          |  | 151, 920  | 65. 00           |
| 66. 00           | Allowable bad debts for dual eligible beneficiaries (see insti  | ructions)                |  | 46, 188   |                  |
| 67.00            | Subtotal (line 61 plus line 65 minus lines 62 and 63)   | •                        |  | 41, 040, 519  | 67. 00           |
|                  | Credits received from manufacturers for replaced devices for a  | applicable to MS-DRGs (s | ee instructions)                             | 0   | 68. 00           |
| 69.00            | Outlier payments reconciliation (sum of lines 93, 95 and 96).   | (For SCH see instruction | s)   | 0   | 69. 00           |
| 70.00            | OTHER PS&R ADJUSTMENT   |                          |  | -12, 981  | 70.00            |
| 70. 50           | Rural Community Hospital Demonstration Project (§410A Demonst   | ration) adjustment (see  | instructions)                                | 0   | 70. 50           |
| 70. 87           | Demonstration payment adjustment amount before sequestration  |                          |  | 0   | 70. 87           |
| 70. 88           | SCH or MDH volume decrease adjustment (contractor use only)   |                          |  | 0   | 70. 88           |
| 70. 89           | Pioneer ACO demonstration payment adjustment amount (see insti  | ructions)                |  |   | 70. 89           |
| 70. 90           | HSP bonus payment HVBP adjustment amount (see instructions)   |                          |  | 0   | 70. 90           |
| 70. 91<br>70. 92 | HSP bonus payment HRR adjustment amount (see instructions)  |                          |  | 0   | 70. 91<br>70. 92 |
| 70. 92<br>70. 93 | Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)                  |                          |  | -176, 720   |                  |
| 70. 93<br>70. 94 | HRR adjustment amount (see instructions)  |                          |  | -216, 630   |                  |
|                  | Recovery of accelerated depreciation  |                          |  |   | 70. 95           |
|                  | , J   |                          |  | ٥١  | · · · ·          |

| Heal th          | Financial Systems PORTER REGIONAL  | HOSPI TAL                               |         | In Lie                     | u of Form CMS-:                | 2552-1    |
|------------------|--|---|---------|----------------------------|--------------------------------|-----------|
|                  | ATION OF REIMBURSEMENT SETTLEMENT  | Provi der Co                            |         | Period:<br>From 01/01/2021 | Worksheet E<br>Part A          |           |
|                  |  |   |         | To 12/31/2021              | Date/Time Pre<br>5/30/2022 6:2 |           |
|                  |  | Title                                   | e XVIII | Hospi tal                  | PPS                            | .o piii   |
|                  |  |   |         | (уууу)                     | Amount                         |           |
|                  |  |   |         | 0                          | 1.00                           |           |
| 70. 96           | Low volume adjustment for federal fiscal year (yyyy) (Enter in   | column 0                                |         | 0                          | 0                              | 70. 9     |
|                  | the corresponding federal year for the period prior to 10/1)   |   |         |                            |                                |           |
| 70. 97           | Low volume adjustment for federal fiscal year (yyyy) (Enter in   |   |         | 0                          | 0                              | 70. 9     |
| <b>70 00</b>     | the corresponding federal year for the period ending on or aft   | er 10/1)                                |         |                            |                                |           |
| 70. 98           | Low Volume Payment-3   |   |         |                            | 0                              | 1         |
| 70. 99           | HAC adjustment amount (see instructions)   | 0 0 70)                                 |         |                            | 0                              | 1         |
| 71.00            | Amount due provider (line 67 minus lines 68 plus/minus lines 6   | 9 & 70)                                 |         |                            | 40, 634, 188                   |           |
| 71. 01           | Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration                      |   |         |                            | 0                              | 1         |
|                  | Sequestration adjustment-PARHM pass-throughs   |   |         |                            | U                              | 71.0      |
|                  | Interim payments   |   | •       |                            | 39, 946, 184                   | 1         |
|                  | Interim payments Interim payments-PARHM  |   |         |                            | 37, 740, 104                   | 72.0      |
| 73. 00           | Tentative settlement (for contractor use only)   |   |         |                            | 0                              | 1         |
| 73. 01           | Tentative settlement-PARHM (for contractor use only)   |   |         |                            | O                              | 73. (     |
| 74. 00           | Balance due provider/program (line 71 minus lines 71.01, 71.02   | 72 and                                  |         |                            | 688, 004                       | 1         |
| , ,, ,,          | 73)  | , |         |                            | 000,001                        | ' \       |
| 74. 01           | Balance due provider/program-PARHM (see instructions)  |   |         |                            |                                | 74.0      |
| 75. 00           | Protested amounts (nonallowable cost report items) in accordan   | ce with                                 |         |                            | 4, 531, 871                    | 75.0      |
|                  | CMS Pub. 15-2, chapter 1, §115.2   |   |         |                            |                                |           |
|                  | TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)  |   |         |                            |                                |           |
| 90. 00           | Operating outlier amount from Wkst. E, Pt. A, line 2, or sum o   | f 2.03                                  |         |                            | 0                              | 90.0      |
|                  | plus 2.04 (see instructions)   |   |         |                            |                                |           |
| 91. 00           | Capital outlier from Wkst. L, Pt. I, line 2  |   |         |                            | 0                              | 1 ' ' ' ' |
| 92.00            | Operating outlier reconciliation adjustment amount (see instru   |   |         |                            | 0                              |           |
|                  | Capital outlier reconciliation adjustment amount (see instruct   |   |         |                            | 0                              | 1 / 0     |
| 94. 00<br>95. 00 | The rate used to calculate the time value of money (see instru   | ctions)                                 |         |                            | 0.00                           |           |
| 95. 00<br>96. 00 | Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct | i one)                                  |         |                            | 0                              |           |
| 70.00            | Time value of money for capital related expenses (see firstruct  | 1 0115)                                 |         | Prior to 10/1              | On/After 10/1                  | 70. 0     |
|                  |  |   |         | 1, 00                      | 2.00                           |           |
|                  | HSP Bonus Payment Amount   |   |         | 55                         |                                |           |
| 100. 00          | HSP bonus amount (see instructions)  |   |         | 0                          | 0                              | 100.0     |
|                  | HVBP Adjustment for HSP Bonus Payment  |   |         |                            |                                |           |
| 101. 00          | HVBP adjustment factor (see instructions)  |   |         | 0.0000000000               | 0.000000000                    | ]101. (   |
|                  | HVBP adjustment amount for HSP bonus payment (see instructions   | )                                       |         | 0                          | 0                              | 102. 0    |
|                  | HRR Adjustment for HSP Bonus Payment   |   |         |                            |                                |           |
|                  | HRR adjustment factor (see instructions)   |   |         | 0.0000                     | 0. 0000                        |           |
| 104.00           | HRR adjustment amount for HSP bonus payment (see instructions)   |   |         | 0                          | 0                              | 104. (    |
|                  | Rural Community Hospital Demonstration Project (§410A Demonstr   |   |         |                            |                                |           |
| 200. 00          | Is this the first year of the current 5-year demonstration per   | iod under t                             | he 21st |                            |                                | 200. (    |
|                  | Century Cures Act? Enter "Y" for yes or "N" for no.  |   |         |                            |                                | 1         |
|                  | Cost Reimbursement   | 10)                                     |         |                            |                                |           |
| :UT. OC          | Medicare inpatient service costs (from Wkst. D-1, Pt. II, line   | 49)                                     |         |                            |                                | 201. (    |

| 72.00  | Interim payments   |                  | 39, 946, 184  | 72.00   |
|--------|--|------------------|---------------|---------|
| 72. 01 | Interim payments-PARHM   |                  |               | 72. 01  |
| 73.00  | Tentative settlement (for contractor use only)   |                  | 0             | 73.00   |
| 73. 01 | Tentative settlement-PARHM (for contractor use only)                                   |                  |               | 73. 01  |
| 74.00  | Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and                |                  | 688, 004      | 74.00   |
|        | 73)  |                  | •             |         |
| 74. 01 | Balance due provider/program-PARHM (see instructions)                                  |                  |               | 74. 01  |
| 75. 00 | Protested amounts (nonallowable cost report items) in accordance with                  |                  | 4, 531, 871   | 75. 00  |
|        | CMS Pub. 15-2, chapter 1, §115.2   |                  | .,,           |         |
|        | TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)                                    |                  |               |         |
| 90.00  | Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03                   |                  | 0             | 90.00   |
|        | plus 2.04 (see instructions)   |                  | _             |         |
| 91.00  | Capital outlier from Wkst. L, Pt. I, line 2  |                  | 0             | 91.00   |
| 92. 00 | Operating outlier reconciliation adjustment amount (see instructions)                  |                  | 0             | 92.00   |
| 93. 00 | Capital outlier reconciliation adjustment amount (see instructions)                    |                  | 0             |         |
| 94. 00 | The rate used to calculate the time value of money (see instructions)                  |                  | 0.00          |         |
|        | , ,  |                  | 0.00          | 1       |
|        | Time value of money for operating expenses (see instructions)                          |                  |               |         |
| 96. 00 | Time value of money for capital related expenses (see instructions)                    | D:: -:- +- 10 /1 |               | 96. 00  |
|        |  | Prior to 10/1    |               |         |
|        | luon n   | 1. 00            | 2. 00         |         |
|        | HSP Bonus Payment Amount   |                  |               |         |
| 100.00 | HSP bonus amount (see instructions)  | 0                | 0             | 100. 00 |
|        | HVBP Adjustment for HSP Bonus Payment  | _                |               |         |
|        | HVBP adjustment factor (see instructions)  | 0.0000000000     | 0.0000000000  |         |
| 102.00 | HVBP adjustment amount for HSP bonus payment (see instructions)                        | 0                | 0             | 102. 00 |
|        | HRR Adjustment for HSP Bonus Payment   |                  |               |         |
| 103.00 | HRR adjustment factor (see instructions)   | 0.0000           | 0.0000        | 103. 00 |
| 104.00 | HRR adjustment amount for HSP bonus payment (see instructions)                         | 0                | 0             | 104. 00 |
|        | Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment        |                  |               |         |
| 200.00 | Is this the first year of the current 5-year demonstration period under the 21st       |                  |               | 200. 00 |
|        | Century Cures Act? Enter "Y" for yes or "N" for no.                                    |                  |               |         |
|        | Cost Reimbursement   | <u> </u>         |               |         |
| 201.00 | Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)                     |                  |               | 201. 00 |
|        | Medicare discharges (see instructions)   |                  |               | 202. 00 |
|        | Case-mix adjustment factor (see instructions)  |                  |               | 203. 00 |
| 200.00 | Computation of Demonstration Target Amount Limitation (N/A in first year of the curren | t 5-vear demonst |               | 200.00  |
|        | period)  | t o year acmonst | 1 4 1 7 0 1 1 |         |
| 204 00 | Medicare target amount   |                  |               | 204. 00 |
|        | Case-mix adjusted target amount (line 203 times line 204)                              |                  |               | 205. 00 |
|        | Medicare inpatient routine cost cap (line 202 times line 205)                          |                  |               | 206.00  |
| 200.00 | Adjustment to Medicare Part A Inpatient Reimbursement                                  |                  |               | 200.00  |
| 207.00 | Program reimbursement under the §410A Demonstration (see instructions)                 | T                |               | 207. 00 |
|        |  |                  |               | 208.00  |
|        | Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)                 |                  |               |         |
|        | Adjustment to Medicare IPPS payments (see instructions)                                |                  |               | 209. 00 |
|        | Reserved for future use  |                  |               | 210. 00 |
| 211.00 | Total adjustment to Medicare IPPS payments (see instructions)                          |                  |               | 211. 00 |
|        | Comparision of PPS versus Cost Reimbursement   |                  |               |         |
|        | Total adjustment to Medicare Part A IPPS payments (from line 211)                      |                  |               | 212. 00 |
|        | Low-volume adjustment (see instructions)   |                  |               | 213. 00 |
| 218.00 | Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)    |                  |               | 218. 00 |
|        | (line 212 minus line 213) (see instructions)   |                  |               |         |
|        |  |                  |               |         |
|        |  |                  |               |         |
|        |  |                  |               |         |

| Health Financial Systems                | PORTER REGIONAL HOSPITAL | In Lie          | u of Form CMS-2552-10                                    |
|---|--------------------------|-----------------|--|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-0035   | From 01/01/2021 | Worksheet E Part B Date/Time Prepared: 5/30/2022 6:28 pm |

| Page 201 and other services (see Instructions)   |        | Title Will   | 5/30/2022 6: 2 | 8 pm   |
|--|--------|--|----------------|--------|
| MRI S - MEDICAL AND ORDER HEALT SERVICES   1.00   Mode and other services (see instructions)   1.00   539   1.00   |        | Title XVIII Hospital                                 | PPS            |        |
| Medical and other services (see instructions)  |        |  | 1. 00          |        |
| Medical and other services reinlandersed under OPPS (see instructions)   34,988,228   2.00   0.00   6.00   0.00   1.00    |        |  |                |        |
| 0.000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000   |        | · · · · · · · · · · · · · · · · · · ·                |                |        |
| 0.011   Fire payment (see instructions)  |        |  |                |        |
| 0.001   Continue   C   |        |  |                |        |
| Enter the hospit all specific payment to cost ratio (see instructions)   0.000   5.00  |        |  |                |        |
| Line 2 Titles   Line 5   |        | · · · · · · · · · · · · · · · · · · ·                |                |        |
| Transitional corridor payment (see Instructions)   0   8.00   0   | 6.00   |  | 0              |        |
|  |        |  | 1              |        |
| 0   10.00  |        |  |                |        |
| 1.00   Total cost (sun of lines 1 and 10) (see Instructions)   100,539   11.00   |        |  |                |        |
| COMPUTATION OF LESSER OF LOSS ON CHARKES   Reasonable charges   Reason   |        |  |                |        |
| Reasonable charges   736,343   12.00   Ancil Tary service charges   736,343   12.00   Ancil Tary service charges   736,343   12.00   736,343   13.00   736   | 11.00  |  | 107,007        | 11.00  |
| 13.00   organ acquisition charges (from Wist. D-4, Pt. III, col. 4, line 69)   0.13.00   736,343   14.00   Total reasonable charges (sum of Tines 12 and 12)   736,343   14.00   Total reasonable charges (sum of Tines 12 and 12)   736,343   14.00   |        |  |                |        |
| 1.4 00   |        |  |                |        |
| Customary charges  |        |  |                |        |
| 15.00   Aggregate amount actually collected from patients Haible for payment for services on a charge basis   0   15.00  | 14. 00 |  | 736, 343       | 14.00  |
| 16.00   Andunits that would have been realized from patients   Italia for payment for services on a chargebasis   0   16.00   Not payment been maded in accordance with 42 CFR \$413.13(e)   0   0   0   0   0   0   0   0   0   | 15 00  |  | 0              | 15 00  |
| had such payment been made in accordance with 42 CFR §413.13(e)  |        |  |                |        |
| 18.00   Total customery charges (see instructions)   736. 343   18.00   19.00   20.0   |        |  |                |        |
| 19. 00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see   19. 00   1   | 17. 00 | Ratio of line 15 to line 16 (not to exceed 1.000000) | 0. 000000      | 17. 00 |
| Instructions   |        |  |                |        |
| 20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20.00   | 19. 00 |  | 626, 804       | 19. 00 |
| Instructions   109,539   21.00   | 20.00  |  |                | 20.00  |
| 1.00   Lesser of cost or charges (see Instructions)   100,539   21.00   22.00   23.00   Cost of physicians' services in a teaching hospital (see instructions)   0.23.00   2   | 20.00  |  |                | 20.00  |
| 23.00   Cost of physicians' services in a teaching hospital (see instructions)   37,054,900   24.00   COMPUTATION OF REIMBURSEMENT SETTLEMENT   37,054,900   24.00   COMPUTATION OF REIMBURSEMENT SETTLEMENT   37,054,900   24.00   COMPUTATION OF REIMBURSEMENT SETTLEMENT   37,054,900   24.00   Computation of consurance amounts (for CAH, see instructions)   6,028,121   26.00   Computation of consurance amounts relating to amount on line 24 (for CAH, see instructions)   6,028,121   26.00   Computation of consurance amounts relating to amount on line 24 (for CAH, see instructions)   6,028,121   26.00   Instructions)   6,028,121   26.00   Computation of consurance amounts (from Wkst. E-4, line 50)   0,28.00   Computation of consurance amounts (from Wkst. E-4, line 50)   0,28.00   Computation of consurance amounts (from Wkst. E-4, line 36)   0,29.00   Computation of lines 27 through 29)   0,29.00   Computation of lines 27 through 29)   0,29.00   0,29.00   Computation of lines 27 through 29)   0,29.00   0,29.   | 21. 00 |  | 109, 539       | 21. 00 |
| 24. 00   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   37,054,900   24. 00  | 22. 00 | Interns and residents (see instructions)             | 0              | 22. 00 |
| COMPUTATION OF RELIMBURSEMENT SETTLEMENT   Compute computers of the computer   |        |  |                |        |
| 25.00   Deductible sand coinsurance amounts (for CAH, see instructions)   6.028, 121   26.00   | 24. 00 |  | 37, 054, 906   | 24. 00 |
| 26. 00   Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   26. 00   31.071,952   27.00   27.00   27.00   28.00   | 25 00  |  | 64 372         | 25 00  |
| 27.00   Subtotal [(I lnes 21 and 24 minus the sum of I ines 25 and 26) plus the sum of I ines 22 and 23] (see   31,071,952   27.00   |        |  |                |        |
| 28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   0   28.00   0   29.00   28.00   SERD direct medical education costs (from Wkst. E-4, line 36)   0   29.00   30.00   Subtotal (sum of lines 27 through 29)   31,071,952   30.00   31.00   Primary payer payments   22.685   31.00   31.00   22.685   31.00   31.00   22.685   31.00   31.00   22.685   31.00   31.00   22.685   31.00   33.00   22.685   31.00   33.00   22.685   31.00   22.685   31.00   23.   |        | · · · · · · · · · · · · · · · · · · ·                |                |        |
| 29.00   ESRD direct medical education costs (from Wkst. E-4, line 36)   29.00   31.01   31.071,952   30.00   31.01   31.071,952   30.00   31.00   7   7   7   7   7   7   7   7   7  |        |  |                |        |
| Subtotal (sum of lines 27 through 29)   31,071,952   30,00   |        |  | 1              |        |
| 31.00  |        |  |                |        |
| 32.00  |        |  |                |        |
| ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. I -5, line 11)   34.00   33.00   33.00   Adjusted reimbursable bad debts (see instructions)   311,711   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   202,612   35.00   203,610   203,6   |        |  |                |        |
| 34. 00   All owable bad debts (see instructions)   311, 711   34. 00   35. 00   Adj usted reimbursable bad debts (see instructions)   202, 612   36. 00   All owable bad debts for dual eligible beneficiaries (see instructions)   162, 479   36. 00   37. 00   Subtotal (see instructions)   31, 251, 879   37. 00   38. 00   MSP-LCC reconciliation amount from PS&R   37. 00   39. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   39. 00   39. 50   Pioneer ACO demonstration payment adj ustment (see instructions)   39. 97   Demonstration payment adj ustment teser sequestration   39. 97   39. 98   Partial or full credits received from manufacturers for replaced devices (see instructions)   39. 99   39. 99   RECOVERY OF ACCELERATED DEPRECIATION   39. 99   ACCOVERY OF ACCELERATED DEPRECIATION   39. 99   39. 99   ACCOVERY OF ACCELERATED DEPRECIATION   39. 99   39. 99   ACCOVERY OF ACCELERATED DEPRECIATION   39. 99   39. 90      |        |  | 0.70.77        |        |
| 35.00   Adj usted reimbursable bad debts (see instructions)   202, 612   35.00   36.00   Adj usted reimbursable bad debts for dual eligible beneficiaries (see instructions)   162, 479   36.00   37.00   Subtotal (see instructions)   31, 251, 879   37.00   38.00   MSP-LCC reconciliation amount from PS&R   -142   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.50   Ploneer ACO demonstration payment adjustment (see instructions)   39.50   39.97   Demonstration payment adjustment amount before sequestration   93.99   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.99   39.99   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.99   40.00   Subtotal (see instructions)   31,252,021   40.00   40.01   Sequestration adjustment (see instructions)   0   40.01   40.01   40.02   Demonstration payment adjustment amount after sequestration   40.01   40.02   Demonstration payment adjustment amount after sequestration   40.01   40.02   40.03   4   | 33.00  |  | 0              |        |
| 36. 00   |        | · · · · · · · · · · · · · · · · · · ·                |                |        |
| 37.00   Subtotal (see instructions)   31, 251, 879   37.00   38.00   MSP-LCC reconciliation amount from PS&R   -142   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0 39.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.97   Demonstration payment adjustment amount before sequestration   0 39.97   Partial or full credits received from manufacturers for replaced devices (see instructions)   0 39.98   39.99   Partial or full credits received from manufacturers for replaced devices (see instructions)   0 39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0 39.99   40.00   Subtotal (see instructions)   0 30.99   40.00   Sequestration adjustment (see instructions)   0 40.01   40.02   Demonstration payment adjustment amount after sequestration   0 40.01   40.02   40.02   40.02   40.03     |        | , ,  |                |        |
| 38. 00   MSP-LCC reconciliation amount from PS&R   -142   38. 00   39. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39. 00   39. 00   39. 00   39. 00   39. 00   39. 00   39. 00   39. 00   39. 00   39. 97   39. 98   39. 97   Demonstration payment adjustment amount before sequestration   0   39. 97   39. 98   RECOVERY OF ACCELERATED DEPRECIATION   0   39. 98   39. 9   |        |  |                |        |
| 39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   39.00   39.00   39.50   90.00   39.50   90.00   39.50   90.00   39.50   90.00   39.50   90.00   90.   |        |  |                |        |
| 39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.50  |        |  |                |        |
| 39. 98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39. 98         39. 99       RECOVERY OF ACCELERATED DEPRECIATION       0       39. 99         40. 00       Subtotal (see instructions)       31, 252, 021       40. 00         40. 01       Demonstration adjustment (see instructions)       0       40. 01         40. 02       Demonstration payment adjustment amount after sequestration       0       40. 02         40. 03       Sequestration adjustment-PARHM pass-throughs       40. 02         41. 01       Interim payments       31, 434, 181       41. 00         42. 00       Tentative settlement (for contractors use only)       0       42. 00         42. 01       Tentative settlement-PARHM (for contractor use only)       42. 01         43. 00       Bal ance due provider/program (see instructions)       -182, 160       43. 00         43. 01       Bal ance due provider/program-PARHM (see instructions)       43. 01         44. 00       Fortested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0       44. 00         90. 00       Original outlier amount (see instructions)       0       90. 00         91. 00       The rate used to calculate the Time Value of Money       0. 00       92. 00 <td< td=""><td>39. 50</td><td>· · · · · · · · · · · · · · · · · · ·</td><td></td><td></td></td<>   | 39. 50 | · · · · · · · · · · · · · · · · · · ·                |                |        |
| 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 31, 252, 021 40. 00 40. 01 Sequestration adjustment (see instructions) 0 40. 02 40. 03 Demonstration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment-PARHM pass-throughs 40. 03 41. 00 Interim payments   |        |  |                |        |
| 40.00   Subtotal (see instructions)   31, 252, 021   40.00   40.01   40.02   40.00   40.01   40.02   40.03   40.03   40.03   40.03   40.01   40.01   40.01   40.01   40.02   40.03     |        | · · · · · · · · · · · · · · · · · · ·                | 1              |        |
| 40.01 Sequestration adjustment (see instructions)  40.02 Demonstration payment adjustment amount after sequestration  5equestration adjustment amount after sequestration  6 40.02  40.03 Sequestration adjustment-PARHM pass-throughs  41.00 Interim payments  41.01 Interim payments-PARHM  42.00 Tentative settlement (for contractors use only)  42.01 Tentative settlement-PARHM (for contractor use only)  43.00 Bal ance due provider/program (see instructions)  43.01 Bal ance due provider/program-PARHM (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  5115.2  TO BE COMPLETED BY CONTRACTOR  90.00 Outlier reconciliation adjustment amount (see instructions)  91.00 The rate used to calculate the Time Value of Money  72.00 Time Value of Money (see instructions)  93.00 Time Value of Money (see instructions)  94.00 Og 40.01  40.02  40.02  40.02  40.03  41.01  41.01  41.01  42.00  42.01  43.00  43.01  44.00  44.00  5115.2  69.00  90.00  91.00  91.00  92.00  71 ime Value of Money (see instructions)  99.00  93.00   |        |  |                |        |
| 40.02 Demonstration payment adjustment amount after sequestration  Sequestration adjustment-PARHM pass-throughs  41.00 Interim payments  Interim payments-PARHM  1.00 Interim payments-PARHM  Interim payments-PARHM  Tentative settlement (for contractors use only)  42.00 Tentative settlement (for contractor use only)  42.00 Tentative settlement-PARHM (for contractor use only)  43.00 Balance due provider/program (see instructions)  43.01 Balance due provider/program-PARHM (see instructions)  44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00    91.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  79.00 The rate used to calculate the Time Value of Money  79.00 Time Value of Money (see instructions)  70.00 Time Value of Money (see instructions)  80.00 Value of Money (see instructions)  |        |  |                |        |
| 40. 03   Sequestration adjustment-PARHM pass-throughs   40. 03   41. 00   1nterim payments   41. 00   41. 01   1nterim payments   42. 00   42. 00   42. 00   42. 00   42. 01   43. 00   8al ance due provider/program (see instructions)   43. 01   44. 00   44. 00   45. 20   44. 00   44 |        |  |                |        |
| 1.00   |        |  |                |        |
| 42.00   Tentative settlement (for contractors use only)   0   42.00     42.01   Tentative settlement-PARHM (for contractor use only)   42.01     43.00   Balance due provider/program (see instructions)   -182,160   43.00     44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   44.00     5115.2   TO BE COMPLETED BY CONTRACTOR   0   90.00     90.00   Outlier reconciliation adjustment amount (see instructions)   0   91.00     91.00   Outlier reconciliation adjustment amount (see instructions)   0   91.00     92.00   Time Value of Money (see instructions)   0   93.00     93.00   Time Value of Money (see instructions)   0   93.00     93.00   0   0   0     94.00   0   0   0     94.00   0   0   0     94.00     |        | 1 '  | 31, 434, 181   |        |
| 42.01  43.00  43.01  Balance due provider/program (see instructions)  43.01  44.00  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515.2  TO BE COMPLETED BY CONTRACTOR  90.00  Original outlier amount (see instructions)  91.00  Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money  70.00  Time Value of Money (see instructions)  Tentative settlement-PARHM (for contractor use only)  42.01  43.00  43.00  43.01  44.00  90.00  91.00  91.00  91.00  92.00  93.00  | 41. 01 | Interim payments-PARHM                               |                | 41. 01 |
| 43.00 Balance due provider/program (see instructions)  43.01 Balance due provider/program-PARHM (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00    91.50 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  94.00 Og 93.00   |        |  | 0              |        |
| 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00    90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 O 93.00  |        | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,              | 102 1/0        |        |
| 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$\frac{\f      |        |  | - 182, 160     |        |
| \$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 utlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 1 ime Value of Money (see instructions) 0 93.00  |        |  | n              |        |
| TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  10 90.00  91.00  92.00  93.00 Time Value of Money (see instructions)  0 93.00  | 00     |  |                | 00     |
| 91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  0 91.00  92.00  93.00   |        | TO BE COMPLETED BY CONTRACTOR                        |                |        |
| 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00   |        |  |                |        |
| 93.00 Time Value of Money (see instructions) 0 93.00   |        | ·  |                |        |
|  |        |  |                |        |
| ) 74. 00   |        |  |                |        |
|  |        |  | ,              |        |

| Health Financial Systems                | PORTER REGIONAL HOSPITAL | In Lie                      | u of Form CMS-2552-10 |
|---|--------------------------|-----------------------------|-----------------------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-0035   | Peri od:<br>From 01/01/2021 | Worksheet E           |
|   | Component CCN: 15-T035   |                             | Date/Time Prepared:   |
|   |                          |                             | 5/30/2022 6: 28 pm    |
|   | Title XVIII              | Subprovi der -              | PPS                   |

| MART B _ METICAL_AND DIRECTION   New York  |        | litte XVIII   Subprovider -   IRF                                    | PPS      |        |
|--|--------|--|----------|--------|
| Medit Cell and Other services (see instructions)   |        |  | 1.00     |        |
| Nedical and other services (see instructions)  |        | PART B - MEDICAL AND OTHER HEALTH SERVICES                           | 1.00     |        |
| 200   OPPS pagements   3.0   |        |  | 665      | 1. 00  |
| 0.01   in in payment (see instructions)  |        | · · · · · · · · · · · · · · · · · · ·                                | 1        |        |
| Dutier reconcilitation arount (see instructions)   0   |        | 1 ' 4  | 1        |        |
| Line 2 Times   Line 5   0   0   0   0   0   0   0   0   0  |        |  |          |        |
| Sum or Fines 3, 4, and 4.01, divided by Line 6   0.00   7.00   |        |  | 0. 000   |        |
| Transit floral corridor payment (see instructions)   0   8.00   0   0   0   0   0   0   0   0   0  |        |  | 1        |        |
|  |        |  | 1        |        |
| 1.00   |        |  | 1        |        |
| COMPUTATION OF LISSER OF LOST OR CHARGES   |        |  | 1        |        |
| Reasonable charges   | 11. 00 |  | 665      | 11. 00 |
| 12.00   Ancillary service charges   4, 470   12.00   12.00   10.00   |        |  |          |        |
| 14.00  |        | Ancillary service charges  | 4, 470   |        |
| Coustomary charges   Coustom |        | Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) | 1        |        |
| 15.00   Aggregate amount actually collected from patients   I able for payment for services on a charge basis   0   15.00  | 14.00  |  | 4, 470   | 14.00  |
| had such payment been made in accordance with 42 CFR §413.13(e)*   0.000000   17.00  | 15. 00 |  | 0        | 15. 00 |
| 17.00   Ratio of line 15 to line 16 (not to exceed 1.000000)   17.00 | 16. 00 |  | 0        | 16. 00 |
| 18.00   Total customary charges (see Instructions)   4, 470   18.00   19.00   Excess of customary charges over reasonable cost (complete only if fine 18 exceeds line 11) (see instructions)   0.00   Excess of reasonable cost over customary charges (complete only if fine 11 exceeds line 18) (see instructions)   0.00   Excess of reasonable cost over customary charges (complete only if fine 11 exceeds line 18) (see instructions)   0.00   Excess of reasonable cost over customary charges (complete only if fine 11 exceeds line 18) (see instructions)   0.00   22.00   Excess of cost or charges (see instructions)   0.00   22.00   Excess of cost or charges (see instructions)   0.00   22.00   Excess of physicians services in a teaching hospital (see instructions)   0.00   23.00   Excess of physicians services in a teaching hospital (see instructions)   0.00   23.00   Excess of physicians services in a teaching hospital (see instructions)   0.00   23.00   24.00   Excess of cost of physicians services in a teaching hospital (see instructions)   0.00   25.00  | 17 00  |  | 0.000000 | 17 00  |
| 19.00   Excess of customarry charges over reasonable cost (complete only if line 18 exceeds line 11) (see   19.00   19.00   18.00   18.00   19.00   18.00   18.00   18.00   19.00   18.00    |        |  |          |        |
| 20.00   Excess of reasonable cost over customary charges (complete only If line 11 exceeds line 18) (see   0   20.00   Instructions)   665   21.00   21.00   22.00   23.00   23.00   20.00   |        |  | 1        |        |
| Instructions    665   21.00     22.00   Interns and residents (see instructions)   0.22.00     23.00   Coto f physic lands' services in a teaching hospital (see instructions)   0.23.00     24.00   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   304     25.00   Deductibles and colinsurance amounts (for CAH, see instructions)   0.26.00     26.00   Deductibles and colinsurance amounts (for CAH, see instructions)   0.26.00     27.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   0.26.00     28.00   Deductibles and colinsurance amounts (from Wkst. E-4, line 50)   0.29.00     28.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   0.29.00     28.00   Defuction   1.00   1.00   1.00     28.00   1.00   1.00   1.00   1.00     28.00   1.00   1.00   1.00   1.00     28.00   1.00   1.00   1.00   1.00     28.00   1.00   1.00   1.00   1.00     28.00   1.00   1.00   1.00   1.00     28.00   1.00   1.00    | 20.00  |  |          | 20.00  |
| 21.00   Lesser of cost or charges (see instructions)   0.22.00   | 20.00  |  | 0        | 20.00  |
| 23.00   Cost of physicians' services in a teaching hospital (see instructions)   302   24.00   24.00   Computation OF RELIMBURSEMENT SETTLEMENT   302   24.00   Computation OF RELIMBURSEMENT SETTLEMENT   303   24.00   Computation OF RELIMBURSEMENT SETTLEMENT   300   Computation OF RELIMBURSEMENT   300   Computation OF RELIMBU | 21. 00 |  | 665      | 21. 00 |
| 24. 00   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   24. 00   COMPUTATION OF REIMBURSEMENT SETTLEMENT   |        |  | 1        |        |
| COMPUTATION OF RELIMBURSEMENT SETTLEMENT   |        |  | 1        |        |
| 26. 00   Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   0   26. 00  | 24.00  | COMPUTATION OF REIMBURSEMENT SETTLEMENT                              | 304      | 24.00  |
| 27. 00   Subtotal   ([lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see   969   27. 00   1   1   1   1   1   1   1   1   1   |        |  | 1        |        |
| Instructions   |        | · · · · · · · · · · · · · · · · · · ·                                |          |        |
| 28.00   Direct graduate medical education payments (From Wkst. E-4, line 50)   0   28.00   0   29.00   29.00   Sbd direct medical education costs (From Wkst. E-4, line 36)   0   29.00   30.00   30.00   Subtotal (sum of lines 27 through 29)   30.00   70.00   Primary payer payments   0   31.00   31.00   31.00   32.00   32.00   32.00   33.00   33.00   33.00   33.00   34.00 | 27.00  |  | 909      | 27.00  |
| Subtotal (sum of lines 27 through 29)   969   30, 00   31. 00   31. 00   31. 00   32. 00   32. 00   32. 00   32. 00   32. 00   32. 00   33. 00   33. 00   33. 00   33. 00   34. 00    |        | Direct graduate medical education payments (from Wkst. E-4, line 50) | 1        |        |
| 31.00   Subtotal (line 30 minus line 31)   969   32.00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. I-5, line 11)   0.33.00   34.00   Allowable bad debts (see instructions)   0.35.00   35.00   Adjusted reimbursable bad debts (see instructions)   0.35.00   36.00   Allowable bad febts for dual eligible beneficiaries (see instructions)   0.36.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0.36.00   38.00   MSP-LCC reconciliation amount from PS&R   0.38.00   MSP-LCC reconciliation amount from PS&R   0.38.00   MSP-LCC reconciliation amount from PS&R   0.38.00   MSP-LCC reconciliation amount from PS&R   0.39.00   Pioneer ACO demonstration payment adjustment (see instructions)   0.39.95   MSP-LCC reconciliation amount from PS&R   0.39.95   MSP-LCC reconciliation payment adjustment (see instructions)   0.39.95   MSP-LCC reconciliation payment adjustment (see instructions)   0.39.97   MSP-LCC reconciliation payment adjustment (see instructions)   0.39.97   MSP-LCC reconciliation adjustment (see instructions)   0.39.99   MSP-LCC reconciliation adjustment amount after sequestration   0.40.02   MSP-LCC reconciliation adjustment amount after sequestration   0.40.02   MSP-LCC reconciliation adjustment amount see instructions)   0.40.02   MSP-LCC reconciliation adjustment amount see instructions   0.40.02   MSP-LCC reconciliation adjus |        | · · · · · · · · · · · · · · · · · · ·                                | 1        |        |
| Subtotai (i ine 30 minus line 31)   969   32.00  |        | · · · · · · · · · · · · · · · · · · ·                                | 1        |        |
| 33.00   Composite rate ESRD (from Wkst. I - 5, line 11)   0   34.00   34.00   All owable bad debts (see instructions)   0   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   0   35.00   36.00   All lowable bad debts for dual eligible beneficiaries (see instructions)   0   36.00   37.00   Subtotal (see instructions)   969   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   3 |        |  | 1        |        |
| 34.00  |        | ,  |          |        |
| 35.00  |        |  | 1        |        |
| 37. 00   Subtotal (see instructions)   969   37. 00   38. 00   MSP-LCC reconciliation amount from PS&R   0   38. 00   39. 00   MSP-LCC reconciliation amount from PS&R   0   38. 00   39. 00   |        | 1  | 1        |        |
| 38. 00   MSP-LCC reconciliation amount from PS&R   0   38. 00   39. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39. 00   39. 00   39. 50   39. 50   39. 50   39. 50   39. 50   39. 50   39. 50   39. 97   Demonstration payment adjustment (see instructions)   0   39. 97   39. 98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39. 98   39. 98   RECOVERY OF ACCELERATED DEPRECIATION   0   39. 99   40. 00   Subtotal (see instructions)   969   40. 00   40. 01   Sequestration adjustment (see instructions)   0   40. 01   Sequestration adjustment amount after sequestration   0   40. 01   40. 02   40. 03   80. 80   40. 03   80. 80   40. 03   80. 80   40. 03   80. 80   40. 03   80. 80   40. 03   80. 80   40. 03   80. 80   40. 03   80. 80   40. 03   80. 80   40. 03   80. 80   40. 03   80. 80   40. 03   80. 80   40. 03   80. 80   40. 03   80. 80   40. 03   80. 80   40. 03   80. 80   40. 03   80. 80   40. 03   80. 80   40. 80    |        |  | 1        |        |
| 39. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   39. 50   90   90   90   90   90   90   90  |        |  | 1        |        |
| 39. 50   Pi oneer ACO demonstration payment adjustment (see instructions)   39. 50   39. 97   39. 97   39. 98   39. 98   39. 99   39. 98   39. 99   Acceptable and a payment adjustment amount before sequestration   0. 39. 98   39. 99   39. 99   Acceptable and a payment adjustment amount before sequestration   0. 39. 99   39. |        |  | 1        |        |
| 39. 98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39. 98         39. 99       RECOVERY OF ACCELERATED DEPRECIATION       0       39. 99         40. 00       Subtotal (see instructions)       969       40. 00         40. 01       Sequestration adjustment (see instructions)       0       40. 01         40. 02       Demonstration payment adjustment amount after sequestration       0       40. 02         40. 03       Sequestration adjustment-PARHM pass-throughs       40. 03         41. 01       Interim payments       1, 198       41. 00         41. 01       Interim payments-PARHM       41. 01       41. 01         42. 01       Tentative settlement (for contractors use only)       42. 00         42. 01       Tentative settlement-PARHM (for contractor use only)       42. 01         43. 00       Bal ance due provider/program (see instructions)       -229       43. 00         44. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0       44. 00         415. 2       TO BE COMPLETED BY CONTRACTOR       0       90. 00         90. 00       Original outlier amount (see instructions)       0       90. 00         91. 00       The rate used to calculate the Time Value of Mone   |        |  |          | 39. 50 |
| 39. 99 40. 00 50   |        |  | 1        |        |
| 40.00       Subtotal (see instructions)       969       40.00         40.01       Sequestration adj ustment (see instructions)       0       40.01         40.02       Demonstration payment adj ustment amount after sequestration       0       40.02         40.03       Sequestration adj ustment-PARHM pass-throughs       0       40.03         41.00       Interim payments       1, 198       41.00         41.01       Tentative settlement (for contractors use only)       0       42.00         42.01       Tentative settlement (for contractor use only)       42.01         43.00       Bal ance due provider/program (see instructions)       -229       43.00         43.01       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 04.00       44.00         90.00       For BE COMPLETED BY CONTRACTOR       0       40.00         90.00       Outlier amount (see instructions)       0       90.00         91.00       The rate used to calculate the Time Value of Money       0       90.00         93.00       Time Value of Money (see instructions)       0       93.00  |        |  | 1        |        |
| 40. 01 Sequestration adjustment (see instructions) 0 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment-PARHM pass-throughs 40. 03 41. 00 Interim payments 1,198 41. 00 41. 01 Interim payments-PARHM 1,101 42. 00 Tentative settlement (for contractors use only) 42. 01 43. 01 Tentative settlement-PARHM (for contractor use only) 42. 01 43. 01 Bal ance due provider/program (see instructions) 43. 01 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00  44. 00 Si15. 2  TO BE COMPLETED BY CONTRACTOR  90. 00 Outlier reconciliation adjustment amount (see instructions) 0 91. 00 91. 00 The rate used to calculate the Time Value of Money 10 93. 00  93. 00 Time Value of Money (see instructions) 0 93. 00   |        |  | 1        |        |
| 40. 03   Sequestration adjustment-PARHM pass-throughs   40. 03   41. 00   Interim payments   1, 198   41. 00   41. 01   Interim payments-PARHM   41. 01   42. 00   Tentative settlement (for contractor use only)   42. 01   43. 00   Balance due provider/program (see instructions)   42. 01   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, chapter 1,   0   44. 00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   44. 00   Original outlier amount (see instructions)   90. 00   91. 00   Outlier reconciliation adjustment amount (see instructions)   91. 00   92. 00   The rate used to calculate the Time Value of Money   92. 00   93. 00   Time Value of Money (see instructions)   0   93. 00  |        | Sequestration adjustment (see instructions)                          | 1        |        |
| 41. 00   |        | Demonstration payment adjustment amount after sequestration          | 0        |        |
| 41. 01   |        | '  | 1 100    |        |
| 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 42.00 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 43.00 42.01 43.00 43.01 44.00 91.00 91.00 90.00 91.00 92.00 93.00  |        |  | 1, 190   |        |
| 43.00 Balance due provider/program (see instructions)  43.01 Balance due provider/program-PARHM (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00    §115.2  | 42.00  | Tentative settlement (for contractors use only)                      | 0        | 42. 00 |
| 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 \$\frac{115.2}{5115.2}\$  70 BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00   |        |  | 200      |        |
| 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 The rate used to calculate the Time Value of Money 0.00 92.00 Time Value of Money (see instructions) 0 93.00  |        |  | -229     |        |
| \$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00  |        |  | 0        |        |
| 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00  |        | §115. 2  |          | l      |
| 91. 00 Outlier reconciliation adjustment amount (see instructions)  92. 00 The rate used to calculate the Time Value of Money  93. 00 Time Value of Money (see instructions)  0 91. 00  92. 00  93. 00   | 90 00  |  | 0        | 90 00  |
| 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00 93.00   |        |  | 1        |        |
|  |        | The rate used to calculate the Time Value of Money                   | 1        | 92. 00 |
| 94. 00   Total (Suill OF TIMES 41 and 43)  |        |  | 1        |        |
|  | 94.00  | Tiotal (Suii oi Titles 41 allu 43)                                   | 1 0      | 94. UU |

Health Financial Systems POR ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der CCN: 15-0035

| 2.00 Interim submitte services write "N List sep amount b for the payment. Program              | nterim payments paid to provider payments payable on individual bills, either ed or to be submitted to the contractor for s rendered in the cost reporting period. If none, NONE" or enter a zero parately each retroactive lump sum adjustment pased on subsequent revision of the interim rate cost reporting period. Also show date of each If none, write "NONE" or enter a zero. (1) to Provider ENTS TO PROVIDER | Title<br>Inpatien<br>mm/dd/yyyy<br>1.00 | XVIII<br>t Part A<br>Amount<br>2.00<br>39,946,184<br>0 | Hospital Par mm/dd/yyyy 3.00 | PPS t B  Amount 4.00 31,434,181 0 | 1.00  |
|---|--|---|--|------------------------------|-----------------------------------|-------|
| 2.00 Interim submitte services write "N List sep amount b for the payment.                      | payments payable on individual bills, either ed or to be submitted to the contractor for sendered in the cost reporting period. If none, WONE" or enter a zero parately each retroactive lump sum adjustment based on subsequent revision of the interim rate cost reporting period. Also show date of each lif none, write "NONE" or enter a zero. (1) to Provider  | mm/dd/yyyy                              | Amount<br>2.00   | mm/dd/yyyy                   | Amount<br>4.00<br>31,434,181      |       |
| 2.00 Interim submitte services write "N List sep amount b for the payment.                      | payments payable on individual bills, either ed or to be submitted to the contractor for sendered in the cost reporting period. If none, WONE" or enter a zero parately each retroactive lump sum adjustment based on subsequent revision of the interim rate cost reporting period. Also show date of each lif none, write "NONE" or enter a zero. (1) to Provider  |   | 2. 00  |                              | 4. 00<br>31, 434, 181             |       |
| 2.00 Interim submitte services write "N List sep amount b for the payment.                      | payments payable on individual bills, either ed or to be submitted to the contractor for sendered in the cost reporting period. If none, WONE" or enter a zero parately each retroactive lump sum adjustment based on subsequent revision of the interim rate cost reporting period. Also show date of each lif none, write "NONE" or enter a zero. (1) to Provider  | 1.00                                    |  | 3.00                         | 31, 434, 181                      |       |
| 2.00 Interim submitte services write "N List sep amount b for the payment.                      | payments payable on individual bills, either ed or to be submitted to the contractor for sendered in the cost reporting period. If none, WONE" or enter a zero parately each retroactive lump sum adjustment based on subsequent revision of the interim rate cost reporting period. Also show date of each lif none, write "NONE" or enter a zero. (1) to Provider  |   | 39, 946, 184<br>0                                      |                              |                                   |       |
| submitte<br>services<br>write "N<br>3.00 List sep<br>amount b<br>for the<br>payment.<br>Program | ed or to be submitted to the contractor for some rendered in the cost reporting period. If none, NONE" or enter a zero parately each retroactive lump sum adjustment passed on subsequent revision of the interim rate cost reporting period. Also show date of each lif none, write "NONE" or enter a zero. (1) to Provider   |   | 0  |                              | 0                                 | 2. 00 |
| 3.00 List sep<br>amount b<br>for the<br>payment.<br>Program                                     | parately each retroactive lump sum adjustment based on subsequent revision of the interim rate cost reporting period. Also show date of each lf none, write "NONE" or enter a zero. (1) to Provider  |   |  |                              |                                   | 1     |
|   |  |   |  |                              |                                   | 3. 00 |
|   |  |   |  |                              | _                                 |       |
|   | ENTS TO PROVIDER   |   | 0  |                              | 0                                 |       |
| 3. 02   |  |   | 0  |                              | 0                                 |       |
| 3. 03   |  |   | 0  |                              | 0                                 |       |
| 3. 04   |  |   | 0  |                              | 0                                 |       |
| 3. 05   |  |   | 0  |                              | 0                                 | 3. 05 |
|   | to Program   |   |  |                              |                                   |       |
|   | ENTS TO PROGRAM  |   | 0  |                              | 0                                 |       |
| 3. 51   |  |   | 0  |                              | 0                                 | 0.0.  |
| 3. 52   |  |   | 0  |                              | 0                                 |       |
| 3. 53   |  |   | 0  |                              | 0                                 |       |
| 3. 54   | ,  |   | 0  |                              | 0                                 |       |
|   | (sum of lines 3.01-3.49 minus sum of lines   |   | 0  |                              | 0                                 | 3. 99 |
| 3. 50-3. 9<br>4. 00 Total in  | 98)<br>nterim payments (sum of lines 1, 2, and 3.99)   |   | 39, 946, 184   |                              | 31, 434, 181                      | 4. 00 |
| (transfe  | er to Wkst. E or Wkst. E-3, line and column as ate)  |   |  |                              |                                   |       |
|   | MPLETED BY CONTRACTOR  |   |  |                              |                                   | 1     |
|   | parately each tentative settlement payment after   |   |  |                              |                                   | 5.00  |
| desk rev  | view. Also show date of each payment. If none,<br>NONE" or enter a zero. (1)   |   |  |                              |                                   |       |
|   | to Provider  |   |  |                              |                                   |       |
| 5. 01 TENTATI V   | /E TO PROVIDER   |   | 0  |                              | 0                                 | 5. 01 |
| 5. 02   |  |   | 0  |                              | o                                 | 5. 02 |
| 5. 03   |  |   | 0  |                              | o                                 | 5. 03 |
| Provi der   | to Program   |   |  |                              |                                   | 1     |
| 5. 50 TENTATI V   | /E TO PROGRAM  |   | 0  |                              | 0                                 | 5. 50 |
| 5. 51   |  |   | 0  |                              | 0                                 | 5. 51 |
| 5. 52   |  |   | 0  |                              | 0                                 | 5. 52 |
| 5. 99 Subtotal<br>5. 50-5. 9  | (sum of lines 5.01-5.49 minus sum of lines   |   | 0  |                              | 0                                 | 5. 99 |
| 6.00 Determin   | ned net settlement amount (balance due) based on t report. (1)   |   |  |                              |                                   | 6. 00 |
|   | ENT TO PROVIDER  |   | 688, 004   |                              | 0                                 | 6. 01 |
| 1   | ENT TO PROGRAM   |   | 000, 004   |                              | 182, 160                          | l     |
| 1   | edicare program liability (see instructions)   |   | 40, 634, 188   |                              | 31, 252, 021                      |       |
| 7.00   TOTAL ME   | eurcare program frability (see mistructions)   |   | 40, 034, 188   | Contractor                   | NPR Date                          | 7.00  |
|   |  |   |  | Number                       | (Mo/Day/Yr)                       |       |
|   |  | (                                       | )  | 1. 00                        | 2. 00                             |       |
| 8.00 Name of  | Contractor   |   |  |                              |                                   | 8. 00 |

Component CCN: 15-T035

Title XVIII

|                |   | Titl∈      | xVIII       | Subprovi der -<br>I RF | PPS                 |                |
|----------------|---|------------|-------------|------------------------|---------------------|----------------|
|                |   | Inpatier   | it Part A   |                        | 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   |            | 4, 073, 476 |                        | 1, 198              | 1. 00          |
| 2.00           | Interim payments payable on individual bills, either                                  |            | C           | )                      | 0                   | 2. 00          |
|                | submitted or to be submitted to the contractor for                                    |            |             |                        |                     |                |
|                | services rendered in the cost reporting period. If none, write "NONE" or enter a zero |            |             |                        |                     |                |
| 3.00           | List separately each retroactive lump sum adjustment                                  |            |             |                        |                     | 3. 00          |
|                | amount based on subsequent revision of the interim rate                               |            |             |                        |                     |                |
|                | for the cost reporting period. Also show date of each                                 |            |             |                        |                     |                |
|                | payment. If none, write "NONE" or enter a zero. (1)                                   |            |             |                        |                     |                |
| 0.04           | Program to Provider   |            | 1           |                        |                     | 0.04           |
| 3. 01<br>3. 02 | ADJUSTMENTS TO PROVIDER   |            |             |                        | 0 0                 | 3. 01<br>3. 02 |
| 3.02           |   |            |             |                        |                     | 3. 02          |
| 3. 04          |   |            |             |                        |                     | 3. 04          |
| 3. 05          |   |            | ĺ           |                        | l ol                | 3. 05          |
|                | Provider to Program   |            |             | •                      |                     |                |
| 3.50           | ADJUSTMENTS TO PROGRAM  |            | C           |                        | 0                   | 3. 50          |
| 3. 51          |   |            | C           |                        | 0                   | 3. 51          |
| 3. 52          |   |            | C           |                        | 0                   | 3. 52          |
| 3. 53<br>3. 54 |   |            | C           |                        | 0                   | 3. 53<br>3. 54 |
| 3. 99          | Subtotal (sum of lines 3.01-3.49 minus sum of lines                                   |            |             |                        |                     | 3. 99          |
|                | 3. 50-3. 98)  |            |             |                        |                     |                |
| 4.00           | Total interim payments (sum of lines 1, 2, and 3.99)                                  |            | 4, 073, 476 |                        | 1, 198              | 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          |
| 3.00           | desk review. Also show date of each payment. If none,                                 |            |             |                        |                     | 3.00           |
|                | write "NONE" or enter a zero. (1)   |            |             |                        |                     |                |
|                | Program to Provider   |            |             |                        |                     |                |
| 5. 01          | TENTATI VE TO PROVI DER   |            | C           |                        | 0                   | 5. 01          |
| 5. 02<br>5. 03 |   |            |             |                        | 0                   | 5. 02<br>5. 03 |
| 5.03           | Provider to Program   |            |             | <u>/</u>               | U                   | 5.03           |
| 5. 50          | TENTATI VE TO PROGRAM   |            | C           |                        | 0                   | 5. 50          |
| 5. 51          |   |            | c           | )                      | 0                   | 5. 51          |
| 5. 52          |   |            | C           | )                      | 0                   | 5. 52          |
| 5. 99          | Subtotal (sum of lines 5.01-5.49 minus sum of lines                                   |            | C           | )                      | 0                   | 5. 99          |
|                | 5. 50-5. 98)  |            |             |                        |                     | 4 00           |
| 6. 00          | Determined net settlement amount (balance due) based on the cost report. (1)          |            |             |                        |                     | 6. 00          |
| 6. 01          | SETTLEMENT TO PROVIDER  |            | 84, 095     | 5                      | 0                   | 6. 01          |
| 6. 02          | SETTLEMENT TO PROGRAM   |            | 0           | )                      | 229                 | 6. 02          |
| 7.00           | Total Medicare program liability (see instructions)                                   |            | 4, 157, 571 |                        | 969                 | 7. 00          |
|                |   |            |             | Contractor             | NPR Date            |                |
|                |   |            | <br>O       | Number<br>1.00         | (Mo/Day/Yr)<br>2.00 |                |
| 8. 00          | Name of Contractor  |            | J           | 1.00                   | 2.00                | 8. 00          |
| 0.00           | manio or contractor   | l          |             | I                      | ı                   | 0.00           |

| Heal th        | Financial Systems PORTER REGION   | IAL HOSPITAL       |           | In Li€                                      | eu of Form CMS-: | 2552-10 |
|----------------|---|--------------------|-----------|---|------------------|---------|
| ANALYS         | SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED  | Provider Component |           | Period:<br>From 01/01/2021<br>Fo 12/31/2021 |                  | pared:  |
|                |   | Title              | e XVIII S | Swing Beds - SNF                            |                  |         |
|                |   | I npati en         | nt Part A | Par   | t B              |         |
|                |   | mm/dd/yyyy         | Amount    | mm/dd/yyyy                                  | Amount           |         |
|                |   | 1.00               | 2.00      | 3. 00                                       | 4. 00            |         |
| 1. 00<br>2. 00 | Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero       |                    | 43, 97    | 3   | 0                |         |
| 3.00           | List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider |                    |           |   |                  | 3. 00   |
| 3. 01          | ADJUSTMENTS TO PROVIDER   |                    |           | 1   | 0                | 3. 01   |
| 3. 02          | ADJUSTIMENTS TO TROVIDER  |                    |           | <u></u>                                     | 0                | 3. 02   |
| 3. 02          |   |                    |           | )<br>)                                      | 0                | 3. 02   |
| 3. 04          |   |                    |           | <u></u>                                     | 0                |         |
| 3. 05          |   |                    |           | <u></u>                                     | 0                |         |
| 0.00           | Provider to Program   |                    |           | <u> </u>                                    |                  | 0.00    |
| 3.50           | ADJUSTMENTS TO PROGRAM  |                    |           | o   | 0                | 3.50    |
| 3. 51          |   |                    |           |   | 0                |         |
| 3. 52          |   |                    |           | )   | 0                | 3. 52   |
| 3. 53          |   |                    |           | D   | 0                | 3. 53   |
| 3.54           |   |                    |           | o   | 0                | 3. 54   |
| 3. 99          | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)  |                    |           | D   | 0                | 3. 99   |
| 4. 00          | Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   |                    | 43, 97    | 3   | 0                | 4. 00   |

TO BE COMPLETED BY CONTRACTOR

List separately each tentative settlement payment after

5.00

| Heal th | Financial Systems PORTER REGIONAL                             | HOSPI TAI                | In lie                                      | u of Form CMS-2          | 2552-10 |
|---------|---|--------------------------|---|--------------------------|---------|
|         | ATION OF REIMBURSEMENT SETTLEMENT FOR HIT                     | Provi der CCN: 15-0035   | Period:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet E-1<br>Part II | pared:  |
|         |   | Title XVIII              | Hospi tal                                   | PPS                      |         |
|         |   |                          |   |                          |         |
|         |   |                          |   | 1. 00                    |         |
|         | TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS    |                          |   |                          |         |
|         | HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION |                          |   |                          | 1       |
| 1. 00   | Total hospital discharges as defined in AARA §4102 from Wkst. |                          |   |                          | 1. 00   |
| 2.00    | Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and  | 8 through 12, and plus f | for cost                                    |                          | 2. 00   |
|         | reporting periods beginning on or after 10/01/2013, line 32)  |                          |   |                          |         |
| 3.00    | Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2       |                          |   |                          | 3. 00   |
| 4.00    | Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines  | 1, and 8 through 12, and | plus for cost                               |                          | 4. 00   |
|         | reporting periods beginning on or after 10/01/2013, line 32)  |                          |   |                          |         |
| 5.00    | Total hospital charges from Wkst C, Pt. I, col. 8 line 200    |                          |   |                          | 5. 00   |
| 6.00    | Total hospital charity care charges from Wkst. S-10, col. 3 l |                          |   |                          | 6. 00   |
| 7.00    | CAH only - The reasonable cost incurred for the purchase of c | ertified HIT technology  | Wkst. S-2, Pt. I                            |                          | 7. 00   |
|         | line 168  |                          |   |                          |         |
| 8. 00   | Calculation of the HIT incentive payment (see instructions)   |                          |   |                          | 8. 00   |
| 9.00    | Sequestration adjustment amount (see instructions)            |                          |   |                          | 9. 00   |
| 10.00   | Calculation of the HIT incentive payment after sequestration  | (see instructions)       |   |                          | 10. 00  |
|         | INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH              |                          |   |                          |         |
| 30.00   | Initial/interim HIT payment adjustment (see instructions)     |                          |   |                          | 30. 00  |
| 31.00   | Other Adjustment (specify)                                    |                          |   |                          | 31.00   |
| 32. 00  | Balance due provider (line 8 (or line 10) minus line 30 and l | ine 31) (see instruction | s)  |                          | 32. 00  |

| THE WILL   Soring Beart A   Part B   1.00   2.00   1.00   1.00   1.00   2.00   1.00   1.00   1.00   2.00   1.00  |        |  | Component CCN: 15-U035      | To 12/31/2021     | Date/Time Pre 5/30/2022 6:2 |         |
|--|--------|--|-----------------------------|-------------------|-----------------------------|---------|
| COMPUTATION OF NET COST OF COVERED SERVICES   1.00   Inpartient routine services   selfig bee-SW (see Instructions)   2.00   1.00   1.00   2.00   2.00   1.00   2 |        |  | Title XVIII                 | Swing Beds - SNF  |                             | Орш     |
| DOPPLIATION OF MIT COST OF CONTRID SERVICES   1.00   1.0 |        |  |                             |                   |                             |         |
| 1.00   Inpatient routine services - swing bed-SNE (see instructions)   |        |  |                             | 1. 00             | 2. 00                       |         |
| 1.   |        |  |                             |                   | _                           |         |
| Ancil Hary services (from West, 0-3, col. 3, line 200, for Part A, and sum of West, 0, part V, cols, 6 and 7, line 200, for Part B) (for Colk and swinp-dep pass-through, see instructions)  3.01 3.01 3.01 3.02 3.03 3.03 3.04 3.07 3.07 3.08 3.09 3.09 3.00 3.00 3.00 3.00 3.00 3.00   |        |  |                             | 44, 901           | 0                           |         |
| Part V. Cols 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)   3.01  |        |  | t A and sum of Wkst D       | 0                 | _                           |         |
| Instructions   | 3.00   |  |                             |                   |                             | 3.00    |
| 3.01   Nursing and all field heal th payment-PARHW (see instructions)   3.01   4.00  |        |  | ig bed pass till oagil, see |                   |                             |         |
| instructions   | 3.01   | 1  |                             |                   |                             | 3. 01   |
| Program days   | 4.00   |  | ng program (see             |                   | 0.00                        | 4. 00   |
| Interns and residents not in approved teaching program (see instructions)  |        |  |                             |                   | _                           |         |
|  |        |  |                             | 57                | •                           | 1       |
| Subtotal (sum of lines 1 through 3 plus lines 6 and 7)   |        |  |                             | 0                 | 0                           |         |
| Primary payer payments (see instructions)  |        |  | thod only                   | 44 901            | 0                           | 1       |
| 10.00   Subtotal (fine 8 minus line 9)   0   10.00   0   11.00   0   0   11.00   0   0   11.00   0   0   11.00   0   0   11.00   0   0   11.00   0   0   11.00   0   0   11.00   0   0   11.00   0   0   11.00   0   0   12.00   0   0   12.00   0   13.00   0   13.00   0   13.00   0   13.00   0   13.00   0   13.00   0   13.00   0   13.00   0   13.00   0   13.00   0   13.00   0   14.00   0   13.00   0   14.00   0   14.00   0   14.00   0   14.00   0   15.00   0   |        | ,  |                             | 44, 701           |                             |         |
| 11.00   Deductible's billed to program patients (exclude amounts applicable to physician   0   0   11.00   0   11.00   12.00   12.00   13.00   coloraveroes)   14.4,901   0   12.00   13.00   coloravence billed to program patients (from provider records) (exclude coloravance   928   0   13.00   13.00   coloravence billed to program patients (from provider records) (exclude coloravance   928   0   13.00  |        |  |                             | 44, 901           | l                           | 1       |
| 2.00   Subtotal (line 10 minus line 11)   12,00   22,00   13,00   20   20   20   20   20   20   20   | 11.00  |  | cable to physician          | 0                 | 0                           | 11. 00  |
| 13.00   Colinsurance billed to program patients (from provider records) (exclude coinsurance for for physical an professional services)   14.00   80% of Part B costs (line 12 x 80%)   0.14.00   0. |        | professional services)   |                             |                   |                             |         |
| For physician professional services    14.00 80% of Part B costs (line 12 x 80%)   0   14.00 80% of Part B costs (line 12 x 80%)   0   14.00 80% of Part B costs (line 12 x 80%)   0   15.00 80% of Part B costs (line 12 x 80%)   0   15.00 80% of Part B costs (line 12 x 80%)   0   15.00 80% of Part B costs (line 12 x 80%)   0   15.00 80% of Part B costs (line 12 x 80%)   0   15.00 80% of Pioneer ACO demonstration payment digustment (see instructions)   0   16.50 80% of Pioneer ACO demonstration payment adjustment (see instructions)   0   16.50 adjustment (see instructions)   0   16.50 adjustment (see instructions)   0   16.50 adjustment (see instructions)   0   17.00   1 |        |  |                             |                   | l .                         | 1       |
| 14.00   80% of Part B costs (line 12 x 80%)   0   14.00  | 13. 00 |  | (excl ude coi nsurance      | 928               | 0                           | 13. 00  |
| 15.00   Subtatal (see Instructions)   (15.00   0.16.00   0.16.00   0.16.00   0.16.00   0.16.00   0.16.00   0.16.00   0.16.00   0.16.00   0.16.50   0.16.50   0.16.50   0.16.50   0.16.50   0.16.55   0.56.50   0.16.50   0.16.55   0.56.50   0.16.50   0.16.55   0.56.50   0.16.90   0.17.00 | 14 00  | ' '  |                             |                   |                             | 14 00   |
| 16.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   16.00   16.00   16.50   16.55   16.55   16.55   18.00   16.50   16.55   |        |  |                             | 13 073            | l                           |         |
| 16.50   Ploneer ACO demonstration payment adjustment (see instructions)   16.50  |        |  |                             | 43, 773           |                             |         |
| 16.55   Rural community hospital demonstration project (§410A Demonstration) payment   0   |        |  | 5)                          |                   | Ĭ                           | 1       |
| 16.99   Demonstration payment adjustment amount before sequestration   0   0   16.99   0   17.00   0   17.00   0   17.00   0   0   17.00   0   17.00   0   17.01   0   0   17.01   0   0   17.01   0   0   17.01   0   0   17.01   0   0   17.01   0   0   18.00   0   17.01   0   0   18.00   0   17.01   0   0   18.00   0   17.01   0   0   18.00   0   17.01   0   0   18.00   0   17.01   0   0   18.00   0   17.01   0   0   17.01   0   0   18.00   0   17.01   0   0   19.00   0 |        |  | •                           | 0                 |                             | 1       |
| 17. 00   |        |  |                             |                   |                             |         |
| 17. 01   Adjusted relimbursable bad debts (see instructions)   0   17. 01  |        |  |                             | 0                 |                             |         |
| 18. 00   |        |  |                             | 0                 |                             |         |
| 19. 00   Total (see instructions)   3   43,973   0   19. 00     19. 01   Sequestration adjustment (see instructions)   0   0   19. 01     19. 02   Demonstration payment adjustment amount after sequestration   0   0   19. 01     19. 03   Sequestration adjustment-PARHM pass-throughs   19. 02     19. 03   Sequestration for non-claims based amounts (see instructions)   0   0   19. 02     19. 03   Sequestration for non-claims based amounts (see instructions)   0   0   19. 02     20. 00   Interim payments   43,973   0   20. 00     10. 01   Interim payments   43,973   0   20. 00     11. 01   Tentative settlement (for contractor use only)   0   0   21. 00     12. 00   Tentative settlement (for contractor use only)   0   0   21. 00     12. 00   Balance due provider/program (line 19 minus lines 19. 01, 19. 02, 19. 25, 20, and 21)   0   0   22. 00     12. 01   Balance due provider/program (line 19 minus lines 19. 01, 19. 02, 19. 25, 20, and 21)   0   0   22. 00     22. 01   Balance due provider/program PARHM (see instructions)   22. 01     23. 00   Protested amounts (nonall owable cost report items) in accordance with CMS Pub. 15-2,   0   0   23. 00     23. 00   Chapter 1, §115.2   2   2   2   2     20. 01   2   2   2   2   2   2   2   2   2   |        | ,                        |                             | 0                 |                             | 1       |
| 19. 01   Sequestration adjustment (see Instructions)   0   19. 01     19. 02   Demonstration payment adjustment amount after sequestration)   0   0   19. 02     19. 03   Sequestration for non-claims based amounts (see instructions)   0   0   19. 03     19. 25   Sequestration for non-claims based amounts (see instructions)   0   0   19. 03     19. 25   Sequestration for non-claims based amounts (see instructions)   0   0   19. 03     19. 20. 00   Interim payments   43, 973   0. 20. 00     10. 01   Interim payments   PARHM (for contractor use only)   0   0. 21. 00     10. 01   Tentative settlement (for contractor use only)   0   0. 21. 00     10. 01   Tentative settlement   PARHM (for contractor use only)   0   0. 22. 00     10. 02   10. 02   10. 02   10. 02     10. 02   10. 03   10. 03   10. 03     10. 03   10. 04   10. 05   10. 05     10. 04   10. 05   10. 05   10. 05     10. 05   10. 05   10. 05     10. 05   10. 05   10. 05     10. 05   10. 05   10. 05     10. 06   10. 05   10. 05     10. 07   10. 05   10. 05     10. 08   10. 05   10. 05     |        | , ,  | uctions)                    | 42 072            | l .                         |         |
| 19. 02   Demonstration payment adjustment amount after sequestration  0   19. 02     19. 03   Sequestration adjustment-PARHM pass-throughs   19. 03     19. 03   Sequestration for non-claims based amounts (see instructions)   0   0   19. 25     20. 00   Interim payments   43, 973   0   20. 00     20. 00   Interim payments -PARHM   20. 01     21. 00   Tentative settlement (for contractor use only)   0   0   21. 00     21. 00   Tentative settlement (for contractor use only)   21. 01     22. 01   Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)   0   0   22. 00     22. 01   Balance due provider/program-PARHM (see instructions)   22. 01     23. 00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,   0   0. 23. 00     23. 00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,   0   0. 23. 00     23. 00   St his sthe first year of the current 5-year demonstration period under the 21st   200. 01     20. 01   St his sthe first year of the current 5-year demonstration period under the 21st   200. 00     20. 01   Century Gures Act? Enter "Y" for yes or "N" for no.   200. 01     20. 00   Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-1, Pt. II, line   201. 00   66 (title WIII hospital)   202. 00   203. 00   204. 00   Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line   200. 00   2 |        |  |                             | 43, 7/3           |                             |         |
| 19. 03   Sequestration adjustment-PARHM pass-throughs   19. 03   19. 25   Sequestration for non-claims based amounts (see instructions)   0   0   19. 25   19. 25   20. 00   1   1   1   1   1   1   1   20   20   |        |  |                             | 0                 |                             |         |
| 19. 25   Sequestration for non-claims based amounts (see instructions)   0   0   19. 25  |        | 1  |                             |                   |                             |         |
| 20.01   Interim payments-PARHM   20.01   Tentative settlement (for contractor use only)   21.00   Tentative settlement (for contractor use only)   21.01   Tentative settlement-PARHM (for contractor use only)   21.01   Tentative settlement-PARHM (for contractor use only)   21.01   22.00   Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)   0   0   22.00   22.00   23.00   Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2,   0   0   23.00   Chapter 1, §115.2   2   Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment   200.00   Is this the first year of the current 5-year demonstration period under the 21st   200.00   Century Cures Act? Enter "Y" for yes or "N" for no.   200.00   Contury Cures Act? Enter "Y" for yes or "N" for no.   200.00   Contury Cures Act? Enter "Y" for yes or "N" for no.   200.00   Contury Cures Act? Enter "Y" for yes or "N" for no.   200.00   Contury Cures Act? Enter "Y" for yes or "N" for no.   200.00   Contury Cures Act? Enter "Y" for yes or "N" for no.   200.00   Contury Cures Act? Enter "Y" for yes or "N" for no.   200.00   Contury Cures Act? Enter "Y" for yes or "N" for no.   200.00   Contury Cures Act? Enter "Y" for yes or "N" for no.   200.00   Contury Cures Act? Enter "Y" for yes or "N" for no.   200.00   Contury Cures Act? Enter "Y" for yes or "N" for no.   200.00   Contury Cures Act? Enter "Y" for yes or "N" for no.   200.00   Contury Cures Act? Enter "Y" for yes or "N" for no.   200.00   Contury Cures Act? Enter "Y" for yes or "N" for no.   200.00   Contury Cures Act? Enter "Y" for yes or "N" for no.   200.00   Contury Cures Act? Enter "Y" for yes or "N" for no.   200.00   200.00   Contury Cures Act? Enter "Y" for yes or "N" for no.   200.00   200.00   Contury Cures Act? Enter "Y" for yes or "N" for no.   200.00   200.00   Contury Cures Act? Enter "Y" for yes or "N" for no.   200.00   200.00   Contury Cures Act? Enter "Y" for yes or "N" for no.   200.00   200.00   Contury Cures Act? Ent | 19. 25 |  |                             | 0                 | 0                           | 19. 25  |
| 21.00 Tentative settlement (for contractor use only) 21.01 Tentative settlement (for contractor use only) 21.01 Tentative settlement (for contractor use only) 21.01 Tentative settlement (for contractor use only) 22.00 Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21) 23.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0 chapter 1, §115.2  Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment  200.00 Is this the first year of the current 5-year demonstration period under the 21st century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement  201.00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital)) 202.00 (title XVIII swing-bed SNF)) 203.00 Total (sum of lines 201 and 202) 204.00 Medicare swing-bed SNF discharges (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)  205.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  207.00 Program reimbursement under the \$410A Demonstration (see instructions)  208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  209.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)  209.00 Reserved for future use  Comparision of PPS versus Cost Reimbursement  215.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see   | 20.00  | Interim payments   |                             | 43, 973           | 0                           | 20. 00  |
| 21. 01 Tentative settlement-PARHM (for contractor use only) 22. 00 Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21) 22. 01 Balance due provider/program-PARHM (see instructions) 22. 01 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2,  Quantum Community Hospital Demonstration Project (\$410A Demonstration) Adjustment  200. 00 Is this the first year of the current 5-year demonstration period under the 21st  Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  201. 00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, Line 66 (title XVIII swing-bed SNF)) 202. 00 (title XVIII swing-bed SNF)) 203. 00 Total (sum of lines 201 and 202) 204. 00 Medicare swing-bed SNF discharges (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)  205. 00 Medicare swing-bed SNF target amount  206. 00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  207. 00 Program reimbursement under the \$410A Demonstration (see instructions) 208. 00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3) 209. 00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 200. 00 Reserved for future use 200. 00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see  |        |  |                             |                   |                             | 1       |
| 22.00 Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21) 0 0 22.00 22.01 Balance due provider/program-PARHM (see instructions) 22.01 23.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, 0 0 23.00 Chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment  200.00 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  201.00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))  202.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))  203.00 Total (sum of lines 201 and 202)  204.00 Medicare swing-bed SNF discharges (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)  205.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)  Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  207.00 Program reimbursement under the §410A Demonstration (see instructions)  208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  209.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)  200.00 Reserved for future use  Comparision of PPS versus Cost Reimbursement  215.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see  |        | ,  |                             | 0                 | 0                           | 1       |
| 22. 01 Balance due provider/program-PARHM (see instructions) 23. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0 0 23. 00 chapter 1, §115. 2  Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment  200. 00 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  201. 00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 6 (title XVIII hospital))  202. 00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))  203. 00 Total (sum of lines 201 and 202)  204. 00 Medicare swing-bed SNF discharges (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)  205. 00 Medicare swing-bed SNF target amount  206. 00 Medicare swing-bed SNF target amount  207. 00 Program reimbursement under the §410A Demonstration (see instructions)  208. 00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)  Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  207. 00 Program reimbursement under the §410A Demonstration (see instructions)  208. 00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  209. 00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)  200. 00 Reserved for future use  Comparision of PPS versus Cost Reimbursement  215. 00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see   |        |  | 10.05.00 21)                |                   |                             |         |
| 23. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, 0 0 23. 00 chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment  200. 00 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  201. 00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 6 (title XVIII hospital))  202. 00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 202. 00 (title XVIII swing-bed SNF))  203. 00 Total (sum of lines 201 and 202)  204. 00 Medicare swing-bed SNF discharges (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)  205. 00 Medicare swing-bed SNF target amount  206. 00 Medicare swing-bed SNF target amount  207. 00 Program reimbursement under the §410A Demonstration (see instructions)  208. 00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  209. 00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)  209. 00 Reserved for future use  Comparision of PPS versus Cost Reimbursement  215. 00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see   |        |  | 2, 19.25, 20, and 21)       | 0                 | 0                           |         |
| chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment  200.00 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement  201.00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))  202.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 202.00 (title XVIII swing-bed SNF))  203.00 Total (sum of lines 201 and 202)  204.00 Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)  205.00 Medicare swing-bed SNF target amount 206.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  207.00 Program reimbursement under the §410A Demonstration (see instructions) 208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  209.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 210.00 Comparision of PPS versus Cost Reimbursement 215.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see   |        | ,                        | nce with CMS Pub 15-2       | 0                 | 0                           |         |
| Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment  200. 00 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement  201. 00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))  202. 00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))  203. 00 Total (sum of lines 201 and 202)  204. 00 Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)  205. 00 Medicare swing-bed SNF target amount 205. 00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  207. 00 Program reimbursement under the §410A Demonstration (see instructions) 208. 00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  209. 00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 210. 00 Reserved for future use Comparision of PPS versus Cost Reimbursement 215. 00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see  | 23.00  |  | ice wi tii ows rub. 13 2,   |                   |                             | 25.00   |
| Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement  201.00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))  202.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 202.00 203.00 Total (sum of lines 201 and 202)  203.00 Total (sum of lines 201 and 202)  204.00 Medicare swing-bed SNF discharges (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)  205.00 Medicare swing-bed SNF target amount  205.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)  Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  207.00 Program reimbursement under the \$410A Demonstration (see instructions)  208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  209.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)  209.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215.00  |        |  | ration) Adjustment          | •                 | •                           | 1       |
| Cost Reimbursement  201. 00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 6 (title XVIII hospital))  202. 00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))  203. 00 Total (sum of lines 201 and 202)  204. 00 Medicare swing-bed SNF discharges (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)  205. 00 Medicare swing-bed SNF target amount  206. 00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)  Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  207. 00 Program reimbursement under the §410A Demonstration (see instructions)  208. 00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  209. 00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)  209. 00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)  209. 00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215. 00   | 200.00 | Is this the first year of the current 5-year demonstration per | riod under the 21st         |                   |                             | 200. 00 |
| 201. 00 66 (title XVIII hospital)) 202.00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 203.00 (title XVIII hospital)) 203.00 Total (sum of lines 201 and 202) 204.00 Medicare swing-bed SNF discharges (see instructions) 205.00 Medicare swing-bed SNF discharges (see instructions) 206.00 Medicare swing-bed SNF target amount 207.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) 207.00 Program reimbursement under the \$410A Demonstration (see instructions) 208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 208.00 Medicare swing-bed SNF PPS payments (see instructions) 209.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 210.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see  |        |  |                             |                   |                             |         |
| 66 (title XVIII hospital))  202.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 202.00 (title XVIII swing-bed SNF))  203.00 Total (sum of lines 201 and 202)  204.00 Medicare swing-bed SNF discharges (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)  205.00 Medicare swing-bed SNF target amount  206.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)  Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  207.00 Program reimbursement under the \$410A Demonstration (see instructions)  208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 208.00 and 3)  209.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)  209.00 Reserved for future use  Comparision of PPS versus Cost Reimbursement  215.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215.00  | 004 00 |  |                             |                   | Γ                           | 004 00  |
| 202. 00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))  203. 00 Total (sum of lines 201 and 202)  204. 00 Medicare swing-bed SNF discharges (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)  205. 00 Medicare swing-bed SNF target amount  206. 00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)  Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  207. 00 Program reimbursement under the \$410A Demonstration (see instructions)  208. 00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 208. 00 and 3)  209. 00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)  209. 00 Reserved for future use  Comparision of PPS versus Cost Reimbursement  215. 00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215. 00   | 201.00 |  | WKST. D-I, PT. II, IINE     |                   |                             | 201.00  |
| 203. 00 Total (sum of lines 201 and 202) 204. 00 Medicare swing-bed SNF discharges (see instructions)  205. 00 Medicare swing-bed SNF target Amount Limitation (N/A in first year of the current 5-year demonstration period)  205. 00 Medicare swing-bed SNF target amount  206. 00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)  Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  207. 00 Program reimbursement under the §410A Demonstration (see instructions)  208. 00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  209. 00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)  209. 00 Reserved for future use  Comparision of PPS versus Cost Reimbursement  215. 00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215. 00  | 202 00 |  | n Wkst D_3 col 3 lin        | IA.               |                             | 202 00  |
| 203. 00 204. 00 Medicare swing-bed SNF discharges (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)  205. 00 Medicare swing-bed SNF target amount  206. 00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)  Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  207. 00 Program reimbursement under the \$410A Demonstration (see instructions)  208. 00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1  207. 00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)  209. 00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)  209. 00 Reserved for future use  Comparision of PPS versus Cost Reimbursement  215. 00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see   | 202.00 |  | WK31. B 3, COL. 3, TT       |                   |                             | 202.00  |
| Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)  205.00 Medicare swing-bed SNF target amount  206.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)  Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  207.00 Program reimbursement under the \$410A Demonstration (see instructions)  208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  209.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)  209.00 Reserved for future use  Comparision of PPS versus Cost Reimbursement  215.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215.00  | 203.00 |  |                             |                   |                             | 203. 00 |
| peri od)  205. 00 Medi care swing-bed SNF target amount  206. 00 Medi care swing-bed SNF inpatient routine cost cap (line 205 times line 204)  Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  207. 00 Program reimbursement under the \$410A Demonstration (see instructions)  208. 00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  209. 00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)  209. 00 Reserved for future use  Comparision of PPS versus Cost Reimbursement  215. 00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215. 00  | 204.00 |  |                             |                   |                             | 204. 00 |
| 205. 00 Medicare swing-bed SNF target amount 206. 00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)  Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  207. 00 Program reimbursement under the §410A Demonstration (see instructions)  208. 00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  209. 00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)  209. 00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)  209. 00 Reserved for future use  Comparision of PPS versus Cost Reimbursement  215. 00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215. 00  |        |  | first year of the curre     | nt 5-year demonst | trati on                    |         |
| 206. 00  Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)  Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  207. 00 Program reimbursement under the §410A Demonstration (see instructions)  208. 00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  209. 00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)  209. 00 Reserved for future use  Comparision of PPS versus Cost Reimbursement  215. 00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215. 00  |        | ,  |                             |                   | I                           |         |
| Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  207.00 Program reimbursement under the §410A Demonstration (see instructions)  208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1  209.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)  209.00 Reserved for future use  Comparision of PPS versus Cost Reimbursement  215.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215.00   |        |  | 1. 004)                     |                   |                             |         |
| 207.00 Program reimbursement under the §410A Demonstration (see instructions)  208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1  208.00 and 3)  209.00 Adj ustment to Medicare swing-bed SNF PPS payments (see instructions)  209.00 Reserved for future use  Comparision of PPS versus Cost Reimbursement  215.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215.00  | 206.00 |  |                             |                   |                             | 206. 00 |
| 208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3) 209.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 209.00 Reserved for future use 210.00 Comparision of PPS versus Cost Reimbursement 215.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215.00   | 207.00 |  |                             |                   |                             | 207 00  |
| and 3) 209. 00 Adj ustment to Medicare swing-bed SNF PPS payments (see instructions) 210. 00 Reserved for future use Comparision of PPS versus Cost Reimbursement 215. 00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215. 00   |        |  |                             | 1                 |                             | 1       |
| 209. 00 Adj ustment to Medicare swing-bed SNF PPS payments (see instructions)  209. 00 210. 00 Reserved for future use  Comparision of PPS versus Cost Reimbursement  215. 00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215. 00   | 200.00 | ,                        | E, COI. I, Suil OI ITTIES   | '                 |                             | 200.00  |
| 210.00 Reserved for future use 210.00 Comparision of PPS versus Cost Reimbursement 215.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215.00  | 209.00 |  | ctions)                     |                   |                             | 209. 00 |
| Comparision of PPS versus Cost Reimbursement  215.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215.00   |        | , ,  | <u> </u>                    |                   |                             | 1       |
|  |        | Comparision of PPS versus Cost Reimbursement                   |                             |                   |                             |         |
| instructions)  | 215.00 |  | 209 plus line 210) (see     |                   |                             | 215. 00 |
|  |        | I NSTructi ons)  |                             | l                 | I                           | I       |

Component CCN: 15-U035 12/31/2021 Date/Time Prepared: 5/30/2022 6:28 pm Title XIX Swing Beds - SNF Cost Part B Part A 1.00 2.00 COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions) 0 1.00 0 Inpatient routine services - swing bed-NF (see instructions) 2.00 2.00 Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, 0 3.00 3.00 Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see Nursing and allied health payment-PARHM (see instructions) 3.01 3.01 4.00 Per diem cost for interns and residents not in approved teaching program (see 0.00 4.00 instructions) 5. 00 Program days 5.00 6.00 Interns and residents not in approved teaching program (see instructions) 0 6.00 7.00 Utilization review - physician compensation - SNF optional method only 0 0 0 7.00 Subtotal (sum of lines 1 through 3 plus lines 6 and 7) 8 00 8 00 Primary payer payments (see instructions) 9.00 9.00 10.00 Subtotal (line 8 minus line 9) 10.00 0 11.00 Deductibles billed to program patients (exclude amounts applicable to physician 11.00 professional services) 0 12 00 Subtotal (line 10 minus line 11) 12 00 Coinsurance billed to program patients (from provider records) (exclude coinsurance 0 13.00 13.00 for physician professional services) 14.00 80% of Part B costs (line 12 x 80%) 0 14.00 15.00 Subtotal (see instructions) 0 15.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16.00 16.00 16.50 Pioneer ACO demonstration payment adjustment (see instructions) 16.50 Rural community hospital demonstration project (§410A Demonstration) payment 16.55 16.55 adjustment (see instructions) 16. 99  ${\tt Demonstration}\ \ {\tt payment}\ \ {\tt adjustment}\ \ {\tt amount}\ \ {\tt before}\ \ {\tt sequestration}$ 16.99 0 17.00 Allowable bad debts (see instructions) 0 0 0 0 0 17.00 Adjusted reimbursable bad debts (see instructions) 17.01 17.01 18.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 18.00 19.00 Total (see instructions) 19 00 19. 01 Sequestration adjustment (see instructions) 19.01 19.02 Demonstration payment adjustment amount after sequestration) 19.02 19. 03 Sequestration adjustment-PARHM pass-throughs 19.03 19. 25 Sequestration for non-claims based amounts (see instructions) 0 19. 25 20.00 Interim payments 20.00 20.01 Interim payments-PARHM 20.01 21.00 Tentative settlement (for contractor use only) 21 00 Tentative settlement-PARHM (for contractor use only) 21.01 22. 00 Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21) 22.00 Balance due provider/program-PARHM (see instructions) 22.01 22.01 23.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 23.00 chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment 200.00 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. 200.00 Cost Reimbursement 201.00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 201.00 66 (title XVIII hospital)) 202.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 202.00 200 (title XVIII swing-bed SNF)) 203.00 Total (sum of lines 201 and 202) 203 00 204.00 Medicare swing-bed SNF discharges (see instructions) 204.00 Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration peri od) 205.00 Medicare swing-bed SNF target amount 205. 00 206.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) 206.00 Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement 207.00 Program reimbursement under the §410A Demonstration (see instructions) 207.00 208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 208. 00 and 3) 209.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 209.00 210.00 Reserved for future use 210.00 Comparision of PPS versus Cost Reimbursement

215.00

215.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see

instructions)

| Health Financial Systems                | PORTER REGIONAL HOSPITAL | In Lie          | eu of Form CMS-2552-10 |
|---|--------------------------|-----------------|------------------------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-0035   |                 | Worksheet E-3          |
|   |                          | From 01/01/2021 |                        |
|   | Component CCN: 15-T035   | To 12/31/2021   | Date/Time Prepared:    |
|   | ·                        |                 | 5/30/2022 6:28 pm      |
|   | Title XVIII              | Subprovi der -  | PPS                    |
|   |                          | LDE             | I                      |

|        | IRF  |             |       |
|--------|--|-------------|-------|
|        |  | 1. 00       |       |
|        | PART III - MEDICARE PART A SERVICES - IRF PPS  | 1.00        |       |
| 1. 00  | Net Federal PPS Payment (see instructions)   | 3, 947, 031 | 1. 0  |
| 2. 00  | Medicare SSI ratio (IRF PPS only) (see instructions)   | 0. 0276     | 2. 0  |
| 3. 00  | Inpatient Rehabilitation LIP Payments (see instructions)   | 196, 562    | 3. 0  |
| 4. 00  | Outlier Payments   | 52, 620     | 4. 0  |
| 5. 00  | Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)   | 0.00        | 5. 0  |
| 5. 01  | Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions) | 0. 00       | 5. 0  |
| 5. 00  | New Teaching program adjustment. (see instructions)  | 0.00        | 6. 0  |
| 7. 00  | Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)  | 0.00        | 7. 0  |
| 3. 00  | Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)  | 0.00        | 8. 0  |
| 9. 00  | Intern and resident count for IRF PPS medical education adjustment (see instructions)  | 0.00        | 9. 0  |
| 10. 00 | Average Daily Census (see instructions)  | 10. 156164  |       |
| 11.00  | Teaching Adjustment Factor (see instructions)  | 0.000000    |       |
| 12.00  | Teaching Adjustment (see instructions)   | o           | 12. 0 |
| 3.00   | Total PPS Payment (see instructions)   | 4, 196, 213 | 13. 0 |
| 4. 00  | Nursing and Allied Health Managed Care payments (see instruction)  | 0           | 14. 0 |
| 5. 00  | Organ acqui si ti on (DO NOT USE THIS LINE)  |             | 15. 0 |
| 6.00   | Cost of physicians' services in a teaching hospital (see instructions)   | 0           | 16. 0 |
| 7. 00  | Subtotal (see instructions)  | 4, 196, 213 | 17. 0 |
| 8. 00  | Pri mary payer payments  | 0           | 18.0  |
| 9. 00  | Subtotal (line 17 less line 18).   | 4, 196, 213 | 19.0  |
| 0. 00  | Deducti bl es  | 11, 796     | 20.0  |
| 1.00   | Subtotal (line 19 minus line 20)   | 4, 184, 417 | 21.0  |
| 2.00   | Coi nsurance   | 33, 457     | 22. 0 |
| 3.00   | Subtotal (line 21 minus line 22)   | 4, 150, 960 | 23. 0 |
| 4. 00  | Allowable bad debts (exclude bad debts for professional services) (see instructions)   | 10, 170     | 24. 0 |
| 5. 00  | Adjusted reimbursable bad debts (see instructions)   | 6, 611      | 25. 0 |
| 6. 00  | Allowable bad debts for dual eligible beneficiaries (see instructions)   | 0           | 26. 0 |
| 7. 00  | Subtotal (sum of lines 23 and 25)  | 4, 157, 571 | 27. 0 |
| 8. 00  | Direct graduate medical education payments (from Wkst. E-4, line 49)   | 0           | 28. 0 |
| 9.00   | Other pass through costs (see instructions)  | 0           | 29. 0 |
| 0.00   | Outlier payments reconciliation  | 0           | 30.0  |
| 1.00   | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   | 0           | 31.0  |
| 1. 50  | Pioneer ACO demonstration payment adjustment (see instructions)  | 0           | 31. 5 |
| 1. 98  | Recovery of accel erated depreciation.   | 0           | 31. 9 |
| 1. 99  | Demonstration payment adjustment amount before sequestration   | 0           | 31. 9 |
| 2. 00  | Total amount payable to the provider (see instructions)  | 4, 157, 571 | 32. 0 |
| 2. 01  | Sequestration adjustment (see instructions)  | 0           | 32. 0 |
| 2. 02  | Demonstration payment adjustment amount after sequestration  | 0           | 32. 0 |
| 3.00   | Interim payments   | 4, 073, 476 | 33.0  |
| 4. 00  | Tentative settlement (for contractor use only)   | 0           | 34.0  |
| 5. 00  | Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  | 84, 095     | 35. 0 |
| 6. 00  | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2   | 12, 630     | 36. 0 |
|        | TO BE COMPLETED BY CONTRACTOR  |             |       |
| 0.00   | Original outlier amount from Wkst. E-3, Pt. III, line 4  | 52, 620     | 50.0  |
| 1. 00  | Outlier reconciliation adjustment amount (see instructions)  | 0           | 51. 0 |
| 2. 00  | The rate used to calculate the Time Value of Money   | 0. 00       | 52. 0 |
| 3. 00  | Time Value of Money (see instructions)   | 0           | 53.0  |
|        | FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19   | PHE         |       |
| 9.00   | Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  | 0.000000    | 99. 0 |
| ,,, 00 |  |             |       |

| Health Financial Systems CALCULATION OF REIMBURSEMENT SETTLEMENT | PORTER REGIONAL HOSPITAL  Provider CCN: 15-0035 | In Lieu of Form CMS-255: Period: Worksheet E-3 |            |               |
|--|---|--|------------|---------------|
| CALCULATION OF REFMBORDEMENT SETTLEMENT                          | 11 OVI del CON. 13-0033                         | From 01/01/2021                                |            | pared:        |
|  | Title XIX                                       | Hospi tal                                      | Cost       | <u>о рііі</u> |
|  |   | Innationt                                      | Outpationt |               |

|        |   |                          | 10 12/31/2021 | 5/30/2022 6: 2 |        |
|--------|---|--------------------------|---------------|----------------|--------|
|        |   | Title XIX                | Hospi tal     | Cost           |        |
|        |   |                          | I npati ent   | Outpati ent    |        |
|        |   |                          | 1. 00         | 2.00           |        |
|        | PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER                        | VICES FOR TITLES V OR XI | SERVICES      |                |        |
|        | COMPUTATION OF NET COST OF COVERED SERVICES   |                          |               |                | 1      |
| 1.00   | Inpatient hospital/SNF/NF services  |                          | 13, 934, 489  |                | 1.00   |
| 2.00   | Medical and other services  |                          |               | 15, 458, 700   | 2.00   |
| 3.00   | Organ acquisition (certified transplant centers only)                                 |                          | ol            |                | 3.00   |
| 4.00   | Subtotal (sum of lines 1, 2 and 3)  |                          | 13, 934, 489  | 15, 458, 700   | 4.00   |
| 5.00   | Inpatient primary payer payments  |                          | o             |                | 5.00   |
| 6.00   | Outpatient primary payer payments   |                          |               | 0              | 6.00   |
| 7.00   | Subtotal (line 4 less sum of lines 5 and 6)   |                          | 13, 934, 489  | 15, 458, 700   | 7. 00  |
|        | COMPUTATION OF LESSER OF COST OR CHARGES  |                          |               |                |        |
|        | Reasonabl e Charges   |                          |               |                |        |
| 8.00   | Routi ne servi ce charges   |                          | 1, 388, 532   |                | 8.00   |
| 9.00   | Ancillary service charges   |                          | 108, 443, 814 | 172, 771, 699  | 9. 00  |
| 10.00  | Organ acquisition charges, net of revenue   |                          | 0             |                | 10.00  |
| 11. 00 | Incentive from target amount computation  |                          | 0             |                | 11. 00 |
| 12.00  | Total reasonable charges (sum of lines 8 through 11)                                  |                          | 109, 832, 346 | 172, 771, 699  | 12. 00 |
|        | CUSTOMARY CHARGES   |                          |               |                |        |
| 13.00  | Amount actually collected from patients liable for payment for                        | services on a charge     | 0             | 0              | 13. 00 |
|        | basi s  |                          |               |                |        |
| 14. 00 | Amounts that would have been realized from patients liable for                        |                          | 0             | 0              | 14. 00 |
|        | a charge basis had such payment been made in accordance with 4                        | 12 CFR §413.13(e)        |               |                |        |
| 15. 00 | Ratio of line 13 to line 14 (not to exceed 1.000000)                                  |                          | 0.000000      | 0.000000       | 15.00  |
| 16.00  | Total customary charges (see instructions)  |                          | 109, 832, 346 | 172, 771, 699  | 16.00  |
| 17. 00 | Excess of customary charges over reasonable cost (complete onl                        | y IT line 16 exceeds     | 95, 897, 857  | 157, 312, 999  | 17. 00 |
| 10 00  | line 4) (see instructions)  | v if lime 4 avecade lime | 0             | 0              | 18. 00 |
| 18. 00 | Excess of reasonable cost over customary charges (complete onl 16) (see instructions) | y II Time 4 exceeds Time | ٩             | Ü              | 18.00  |
| 19. 00 | Interns and Residents (see instructions)  |                          | 0             | 0              | 19. 00 |
| 20. 00 | Cost of physicians' services in a teaching hospital (see instr                        | cuctions)                |               | 0              | 20.00  |
| 21. 00 | Cost of covered services (enter the lesser of line 4 or line 1                        |                          | 13, 934, 489  | 15, 458, 700   | 21.00  |
| 21.00  | PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be                         |                          |               | 13, 430, 700   | 21.00  |
| 22. 00 | Other than outlier payments   | Compreted for 113 provid | 0             | 0              | 22. 00 |
| 23. 00 | Outlier payments  |                          | o             | 0              | 23.00  |
| 24. 00 | Program capital payments  |                          | o             | Ü              | 24. 00 |
| 25. 00 | Capital exception payments (see instructions)   |                          | o             |                | 25. 00 |
| 26. 00 | Routine and Ancillary service other pass through costs                                |                          | o             | 0              | 26. 00 |
| 27. 00 | Subtotal (sum of lines 22 through 26)   |                          | o             | 0              | 27. 00 |
| 28.00  | Customary charges (title V or XIX PPS covered services only)                          |                          | o             | 0              | 28. 00 |
| 29.00  | Titles V or XIX (sum of lines 21 and 27)  |                          | 13, 934, 489  | 15, 458, 700   | 29. 00 |
|        | COMPUTATION OF REIMBURSEMENT SETTLEMENT   |                          |               |                |        |
| 30.00  | Excess of reasonable cost (from line 18)  |                          | 0             | 0              | 30.00  |
| 31.00  | Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)                        | l .                      | 13, 934, 489  | 15, 458, 700   | 31.00  |
| 32.00  | Deducti bl es   |                          | 0             | 0              | 32. 00 |
| 33.00  | Coi nsurance  |                          | 0             | 0              | 33. 00 |
| 34.00  | Allowable bad debts (see instructions)  |                          | 0             | 0              | 34. 00 |
| 35.00  | Utilization review  |                          | 0             |                | 35. 00 |
| 36.00  |   |                          | 13, 934, 489  | 15, 458, 700   | 36. 00 |
| 37. 00 |   |                          | -13, 934, 489 | -15, 458, 700  |        |
| 38. 00 | ·   |                          | 0             | 0              | 38. 00 |
| 39. 00 |   |                          | 0             |                | 39. 00 |
| 40. 00 | Total amount payable to the provider (sum of lines 38 and 39)                         |                          | 0             | 0              | 40. 00 |
| 41. 00 | Interim payments  |                          | 0             | 0              | 41. 00 |
| 42. 00 | Balance due provider/program (line 40 minus line 41)                                  |                          | 0             | 0              | 42. 00 |
| 43. 00 | Protested amounts (nonallowable cost report items) in accordan                        | nce with CMS Pub 15-2,   | 0             | 0              | 43. 00 |
|        | chapter 1, §115.2   |                          | 1             |                | l      |

| Health Financial Systems                | PORTER REGIONAL HOSPITAL | In Lie                           | u of Form CMS-2552-10                 |
|---|--------------------------|----------------------------------|---------------------------------------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-0      | 0035 Peri od:<br>From 01/01/2021 | Worksheet E-3<br>Part VII             |
|   | Component CCN: 15-       | To 12/31/2021                    | Date/Time Prepared: 5/30/2022 6:28 pm |
|   | Title XIX                | Subprovi der -                   | Cost                                  |

|                  |  | II tie xix               | I RF        | Cost        |                  |
|------------------|--|--------------------------|-------------|-------------|------------------|
|                  |  |                          | 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                      |                          |             |             |                  |
| 1.00             | Inpatient hospital/SNF/NF services                               |                          | 356, 075    |             | 1. 00            |
| 2.00             | Medical and other services                                       |                          |             | 0           | 2. 00            |
| 3.00             | Organ acquisition (certified transplant centers only)            |                          | 0           | _           | 3. 00            |
| 4. 00            | Subtotal (sum of lines 1, 2 and 3)                               |                          | 356, 075    | 0           | 4. 00            |
| 5.00             | Inpatient primary payer payments                                 |                          | 0           |             | 5. 00            |
| 6.00             | Outpatient primary payer payments                                |                          |             | 0           | 6. 00            |
| 7.00             | Subtotal (line 4 less sum of lines 5 and 6)                      |                          | 356, 075    | 0           | 7. 00            |
|                  | COMPUTATION OF LESSER OF COST OR CHARGES                         |                          |             |             |                  |
|                  | Reasonable Charges   |                          |             |             |                  |
| 8.00             | Routine service charges  |                          | 0           |             | 8. 00            |
| 9.00             | Ancillary service charges  |                          | 1, 806, 066 | 0           | 9. 00            |
| 10.00            | Organ acquisition charges, net of revenue                        |                          | o           |             | 10.00            |
| 11. 00           | Incentive from target amount computation                         |                          | 0           |             | 11. 00           |
| 12.00            | Total reasonable charges (sum of lines 8 through 11)             |                          | 1, 806, 066 | 0           | 12.00            |
|                  | CUSTOMARY CHARGES  |                          |             |             |                  |
| 13.00            | Amount actually collected from patients liable for payment for   | services on a charge     | 0           | 0           | 13.00            |
|                  | basis  |                          |             |             |                  |
| 14.00            | Amounts that would have been realized from patients liable for   | payment for services on  | 0           | 0           | 14.00            |
|                  | a charge basis had such payment been made in accordance with 42  | CFR §413.13(e)           |             |             |                  |
| 15. 00           | Ratio of line 13 to line 14 (not to exceed 1.000000)             |                          | 0.000000    | 0.000000    | 15.00            |
| 16. 00           | Total customary charges (see instructions)                       |                          | 1, 806, 066 | 0           | 16. 00           |
| 17. 00           | Excess of customary charges over reasonable cost (complete only  | if line 16 exceeds       | 1, 449, 991 | 0           | 17. 00           |
|                  | line 4) (see instructions)                                       |                          |             |             |                  |
| 18. 00           | Excess of reasonable cost over customary charges (complete only  | if line 4 exceeds line   | 0           | 0           | 18. 00           |
| 40.00            | 16) (see instructions)   |                          |             |             | 40.00            |
| 19. 00           | Interns and Residents (see instructions)                         |                          | 0           | 0           | 19. 00           |
| 20.00            | Cost of physicians' services in a teaching hospital (see instru  |                          | 0           | 0           | 20.00            |
| 21. 00           | Cost of covered services (enter the lesser of line 4 or line 16  |                          | 356, 075    | 0           | 21. 00           |
| 22.00            | PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be c  | ompreted for PPS provide |             | 0           | 22.00            |
| 22. 00<br>23. 00 | Other than outlier payments                                      |                          | 0           | 0           | 22. 00<br>23. 00 |
| 24. 00           | Outlier payments Program capital payments                        |                          | 0           | U           | 24. 00           |
| 25. 00           | Capital exception payments (see instructions)                    |                          | 0           |             | 25. 00           |
| 26. 00           | Routine and Ancillary service other pass through costs           |                          | 0           | 0           | 26. 00           |
| 27. 00           | Subtotal (sum of lines 22 through 26)                            |                          | 0           | 0           | 27. 00           |
| 28. 00           | Customary charges (title V or XIX PPS covered services only)     |                          | o o         | 0           | 28. 00           |
| 29. 00           | Titles V or XIX (sum of lines 21 and 27)                         |                          | 356, 075    | 0           | 29. 00           |
| 27.00            | COMPUTATION OF REIMBURSEMENT SETTLEMENT                          |                          | 330, 073    | 0           | 27.00            |
| 30.00            | Excess of reasonable cost (from line 18)                         |                          | 0           | 0           | 30. 00           |
| 31. 00           | Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)   |                          | 356, 075    | 0           | 31. 00           |
| 32. 00           | Deducti bl es  |                          | 0           | 0           | 32. 00           |
| 33.00            | Coinsurance  |                          | o           | 0           | 33. 00           |
| 34. 00           | Allowable bad debts (see instructions)                           |                          | o           | 0           | 34.00            |
| 35.00            | Utilization review   |                          | o           |             | 35. 00           |
| 36.00            | Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and   | 33)                      | 356, 075    | 0           | 36. 00           |
| 37.00            | SETTLEMENT ADJUSTMENT  | •                        | -356, 075   | 0           | 37. 00           |
| 38. 00           | Subtotal (line 36 ± line 37)                                     |                          | o           | 0           | 38. 00           |
| 39. 00           | Direct graduate medical education payments (from Wkst. E-4)      |                          | o           |             | 39. 00           |
| 40.00            | Total amount payable to the provider (sum of lines 38 and 39)    |                          | 0           | 0           | 40.00            |
| 41.00            | Interim payments   |                          | 0           | 0           | 41.00            |
| 42.00            | Balance due provider/program (line 40 minus line 41)             |                          | 0           | 0           | 42.00            |
| 43.00            | Protested amounts (nonallowable cost report items) in accordance | e with CMS Pub 15-2,     | 0           | 0           | 43.00            |
|                  | chapter 1, §115.2  |                          |             |             |                  |
|                  |  |                          |             |             |                  |

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

Provider CCN: 15-0035 F

Peri od: Worksheet G From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/30/2022 6:28 pm

| OH y)            |   |                               |                          |                | 5/30/2022 6: 2 | 8 pm             |
|------------------|---|-------------------------------|--------------------------|----------------|----------------|------------------|
|                  |   | General Fund                  | Specific<br>Purpose Fund | Endowment Fund | Plant Fund     |                  |
|                  |   | 1.00                          | 2.00                     | 3. 00          | 4. 00          |                  |
| 1 00             | CURRENT ASSETS  | 47.450                        | 8 0                      |                | 0              | 1 00             |
| 1. 00<br>2. 00   | Cash on hand in banks Temporary investments                               | -67, 458                      | 0                        | _              |                | 1. 00<br>2. 00   |
| 3.00             | Notes recei vabl e  |                               | o o                      |                |                | 3.00             |
| 4. 00            | Accounts receivable   | 66, 572, 898                  | 0                        | 0              | 0              | 4. 00            |
| 5.00             | Other recei vable   | 0                             | 0                        | 0              | 0              | 5. 00            |
| 6.00             | Allowances for uncollectible notes and accounts receivable                | -14, 860, 619                 |                          | 0              | 0              | 6. 00            |
| 7.00             | Inventory   | 12, 081, 407                  |                          | 0              | 0              | 7. 00            |
| 8. 00<br>9. 00   | Prepaid expenses Other current assets                                     | 3, 819, 257<br>-70, 954       |                          | 0              | 0              | 8. 00<br>9. 00   |
| 10.00            | Due from other funds  | -70, 754                      |                          | _              | 0              | 10.00            |
| 11. 00           | Total current assets (sum of lines 1-10)                                  | 67, 474, 531                  |                          |                |                | 11.00            |
|                  | FI XED ASSETS   |                               |                          | -              |                |                  |
| 12.00            | Land  | 11, 543, 687                  | 0                        | 0              | 0              | 12. 00           |
| 13. 00           | Land improvements   | 5, 103, 271                   | 1                        | _              |                | 13. 00           |
| 14. 00           | Accumulated depreciation  | -3, 149, 381                  | 1                        |                |                | 14.00            |
| 15.00            | Buildings Accumulated depreciation  | 191, 817, 192                 | 1                        | 0              | 0              | 15.00            |
| 16. 00<br>17. 00 | Leasehold improvements  | -43, 511, 921<br>9, 936, 189  |                          | 0              | 0              | 16. 00<br>17. 00 |
| 18. 00           | Accumulated depreciation  | -3, 953, 468                  |                          | _              | 0              | 18.00            |
| 19. 00           | Fi xed equipment  | 7, 235, 764                   | 1                        | _              | Ö              | 19. 00           |
| 20.00            | Accumulated depreciation  | -6, 010, 917                  | 1                        | 0              | 0              | 20. 00           |
| 21. 00           | Automobiles and trucks  | 274, 961                      | 1                        | 0              | 0              | 21. 00           |
| 22. 00           | Accumul ated depreciation   | -220, 484                     | 1                        | 0              | 0              | 22. 00           |
| 23. 00           | Major movable equipment   | 53, 617, 638                  | 1                        | 0              | 0              | 23. 00           |
| 24. 00<br>25. 00 | Accumulated depreciation Minor equipment depreciable                      | -46, 460, 310<br>17, 102, 427 |                          | _              | 0              | 24. 00<br>25. 00 |
| 26. 00           | Accumulated depreciation  | -15, 228, 040                 |                          | _              | 0              | 26.00            |
| 27. 00           | HIT designated Assets   | 0                             | o o                      | Ö              | ő              | 27. 00           |
| 28. 00           | Accumul ated depreciation   | 0                             | 0                        | 0              | 0              | 28. 00           |
| 29. 00           | Mi nor equi pment-nondepreci abl e  | 0                             | 0                        | 0              | _              | 29. 00           |
| 30. 00           | Total fixed assets (sum of lines 12-29)                                   | 178, 096, 608                 | 0                        | 0              | 0              | 30. 00           |
| 21 00            | OTHER ASSETS  |                               | ) 0                      | 0              |                | 21 00            |
| 31. 00<br>32. 00 | Investments Deposits on Leases  | 0                             |                          | I              | _              | 31. 00<br>32. 00 |
| 33. 00           | Due from owners/officers  |                               |                          | _              | 0              | 33. 00           |
| 34. 00           | Other assets  | 18, 232, 157                  | 1                        | _              | o o            | 34.00            |
| 35.00            | Total other assets (sum of lines 31-34)                                   | 18, 232, 157                  |                          | 0              | 0              | 35. 00           |
| 36. 00           | Total assets (sum of lines 11, 30, and 35)                                | 263, 803, 296                 | 0                        | 0              | 0              | 36. 00           |
|                  | CURRENT LIABILITIES   |                               |                          |                | 1              |                  |
| 37. 00           | Accounts payable  | 13, 746, 347                  | 1                        |                |                | 37. 00           |
| 38. 00<br>39. 00 | Salaries, wages, and fees payable<br>Payroll taxes payable                | 14, 064, 544<br>263           | 1                        | 0              | 0              | 38. 00<br>39. 00 |
| 40. 00           | Notes and Loans payable (short term)                                      | 3, 629, 016                   | •                        | 0              | 0              | 40.00            |
| 41. 00           | Deferred income   | 3,027,010                     |                          | 0              | ő              | 41.00            |
| 42. 00           | Accel erated payments   | 0                             |                          | _              |                | 42.00            |
| 43.00            | Due to other funds  | -389, 989, 326                | 0                        | 0              | 0              | 43. 00           |
| 44. 00           | Other current liabilities   | 3, 547, 663                   | 1                        |                | 0              | 44. 00           |
| 45. 00           | Total current liabilities (sum of lines 37 thru 44)                       | -355, 001, 493                | 0                        | 0              | 0              | 45. 00           |
| 44 00            | LONG TERM LIABILITIES   | 1 0                           | 0                        | 0              | 1 0            | 1 44 00          |
| 46. 00<br>47. 00 | Mortgage payable Notes payable  |                               |                          |                | _              | 46. 00<br>47. 00 |
| 48. 00           | Unsecured Loans   |                               |                          |                |                | 48. 00           |
| 49. 00           | Other long term liabilities   | 24, 371, 368                  |                          |                |                | 49. 00           |
| 50.00            | Total long term liabilities (sum of lines 46 thru 49)                     | 24, 371, 368                  |                          | 0              | 0              | 50. 00           |
| 51.00            | Total liabilities (sum of lines 45 and 50)                                | -330, 630, 125                | 0                        | 0              | 0              | 51.00            |
|                  | CAPITAL ACCOUNTS  |                               | 1                        |                | 1              |                  |
| 52. 00           | General fund balance  | 594, 433, 421                 |                          |                |                | 52.00            |
| 53. 00<br>54. 00 | Specific purpose fund Donor created - endowment fund balance - restricted |                               | 0                        | 0              |                | 53. 00<br>54. 00 |
| 55. 00           | Donor created - endowment fund balance - restricted                       |                               |                          | 0              |                | 55.00            |
| 56. 00           | Governing body created - endowment fund balance                           |                               |                          | 0              |                | 56.00            |
| 57. 00           | Plant fund balance - invested in plant                                    |                               |                          |                | 0              | 57. 00           |
| 58. 00           | Plant fund balance - reserve for plant improvement,                       |                               |                          |                | 0              | 58. 00           |
|                  | repl acement, and expansion   |                               |                          |                |                |                  |
| 59.00            | Total fund balances (sum of lines 52 thru 58)                             | 594, 433, 421                 |                          | 0              | 0              | 59.00            |
| 60. 00           | Total liabilities and fund balances (sum of lines 51 and 59)              | 263, 803, 296                 | 0                        |                | 0              | 60. 00           |
|                  | l∝,\  | I                             | I                        | I              | I              | I                |

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0035

Peri od: Worksheet G-1 From 01/01/2021

17.00

18.00

19.00

0

0

12/31/2021 Date/Time Prepared: 5/30/2022 6:28 pm General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 507, 823, 592 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 86, 668, 215 2.00 3.00 Total (sum of line 1 and line 2) 594, 491, 807 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 5.00 0 0 0 0 0 5.00 6.00 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) 10.00 594, 491, 807 Subtotal (line 3 plus line 10) 0 11.00 11.00 BEGINNING STOCKHOLDERS' EQUITY ADJ 12.00 58, 386 0 12.00 13.00 13.00 14.00 0 0 0 0 14.00 0 15.00 0 15.00 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 58, 386 18.00 Fund balance at end of period per balance 594, 433, 421 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 11.00 0 0 Subtotal (line 3 plus line 10) 11.00 12.00 BEGINNING STOCKHOLDERS' EQUITY ADJ 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00

0

17.00

18.00

19.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

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

| Test  |        |   |                   | То   | 12/31/2021       | Date/Time Prep 5/30/2022 6: 28 |        |
|--|--------|---|-------------------|------|------------------|--------------------------------|--------|
| PART   - PATIENT REVENUES   1.00   2.00   3.00   |        | Cost Center Description   | Innatient         |      | Outnati ent      |                                | J PIII |
| PART I - PATIENT REVENUES  |        | oust defiter beservetion  |                   |      |                  |                                |        |
| Seneral Inpatient Routine Services   1.00   Hospital   1.00   1.00   Hospital   1.00   |        | PART I - PATIENT REVENUES   | 1.00              |      | 2.00             | 3.00                           |        |
| 1.00   Mospital   1.02, 456, 348   1.02, 450, 348   1.00   2.00   3.00   3USPROVIDER - IPF   11, 165, 484   11, 165, 484   11, 165, 484   3.00   4.00   3USPROVIDER - IRF   11, 165, 484   11, 165, 484   3.00   4.00   4.00   5   |        |   |                   |      |                  |                                |        |
| SUBPROVIDER   TIPE   11, 165, 484   11, 165, 484   11, 165, 484   4, 00   0   0   0   0   0   0   0   0   0  | 1 00   |   | 163 456 3         | 248  |                  | 163 456 348                    | 1 00   |
| 3.00   SUBPROVIDER   TIRE   11, 165, 484   11, 165, 484   3.00   4.00   5.00  |        |   | 100, 100, 0       | , 10 |                  | 100, 100, 010                  |        |
| A. 00   SUBPROVIDER  |        |   | 11 165 4          | 184  |                  | 11 165 484                     |        |
| 5.00   Swing bed   SNF   0   0   0   0   0   0   0   0   0   |        |   | 11,100,           |      |                  | 11, 100, 101                   |        |
| 0.00   Swing bed - NF   0.00   |        |   |                   | Ο    |                  | 0                              |        |
| 7. 00  |        |   |                   | -    |                  | -                              |        |
| 8.00   NURSI NG FACILITY   |        |   |                   | Ŭ    |                  | · ·                            |        |
| 0.00   |        |   |                   |      |                  |                                |        |
| 10.00  |        |   |                   |      |                  |                                |        |
| Intensive Care Type Inpatient Hospital Services  |        |   | 174 621 8         | 332  |                  | 174 621 832                    |        |
| 11. 00   INTENSIVE CARE UNIT   34, 125, 600   13, 00   11. 00   18, 941, 053   11. 00   12. 00   13, 000   18, 941, 053   11. 00   12. 00   13, 000   13, 000   13, 000   14. 00   13, 000   14. 00   14. 00   15. 00   15. 000   17. 00  |        |   | 171702170         | ,02  |                  | 17 17 02 17 002                | 10.00  |
| 11. 01   NEONATAL INTENSIVE CARE UNIT   18, 941, 053   11. 01   12. 00   2000ABY CARE UNIT   18, 941, 053   11. 01   12. 00   13. 00   14. 00   15. 00   1   | 11. 00 |   | 34, 125, 6        | 500  |                  | 34, 125, 600                   | 11. 00 |
| 12.00   CORONARY CARE UNIT   |        |   |                   |      |                  |                                |        |
| 13. 00   BURN INTENSIVE CARE UNIT   13. 00   13. 00   14. 00   15. 00   17. 00   1   |        |   | ,.                |      |                  |                                |        |
| 14. 00   SURGICAL INTENSIVE CARE UNIT   14. 00   15. 00   16. 00   17. 00   |        |   |                   |      |                  |                                |        |
| 15.00   OTHER SPECIAL CARE (SPECIFY)   15.00   Total intensive care type inpatient hospital services (sum of lines 10 and 16)   11-15)   17.00   Total inpatient routine care services (sum of lines 10 and 16)   227, 688, 485   227, 688, 485   17.00   10-15   18.00   19.00   00   00   00   00   00   00   00   |        |   |                   |      |                  |                                |        |
| 16.00   Total intensive care type inpatient hospital services (sum of lines 11-15)   17.00   Total inpatient routine care services (sum of lines 10 and 16)   227, 688, 485   17.00   227, 688, 485   17.00   18.00   Ancillary services   89,002,922   158, 767, 152   247, 770, 774   19.00   20.0   |        |   |                   |      |                  |                                |        |
| 11-15    Total inpatient routine care services (sum of lines 10 and 16)   Total inpatient routine care services (sum of lines 10 and 16)   Total inpatient routine care services (sum of lines 10 and 16)   Total inpatient routine care services (sum of lines 10 and 16)   Total inpatient routine care services (sum of lines 10 and 16)   Total inpatient routine care services (sum of lines 10 and 16)   Total inpatient routine care services (sum of lines 10 and 16)   Total inpatient routine care services (sum of lines 10 and 16)   Total inpatient routine care services (sum of lines 10 and 16)   Total inpatient routine care services (sum of lines 10 and 16)   Total inpatient routine care services (sum of lines 10 and 16)   Total inpatient routine care services (sum of lines 10 and 16)   Total inpatient routine care services (sum of lines 10 and 16)   Total inpatient routine care services (sum of lines 10 and 16)   Total inpatient routine care services (sum of lines 10 and 16)   Total inpatient routine care services (sum of lines 10 and 16)   Total inpatient routine care services (sum of lines 10 and 16)   Total inpatient routine care services (sum of lines 10 and 16)   Total inpatient routine care services (sum of lines 10 and 16)   Total inpatient routine care services (sum of lines 10 and 16)   Total inpatient routine care services (sum of lines 10 and 16)   Total inpatient routine care services (sum of lines 10 and 16)   Total inpatient routine care services (sum of lines 10 and 16)   Total inpatient routine care services (sum of lines 10 and 16)   Total inpatient routine care services (sum of lines 10 and 16)   Total inpatient routine care services (sum of lines 10 and 16)   Total inpatient routine services (sum of lines 10 and 16)   Total inpatient routine services (sum of lines 10 and 16)   Total inpatient routine services (sum of lines 10 and 16)   Total inpatient routine services (sum of lines 10 and 16)   Total inpatient routine services (sum of lines 10 and 16)   Total inpatient routine services (sum of line   |        |   | 53, 066, 6        | 553  |                  | 53, 066, 653                   |        |
| 17. 00   |        |   | 33,333,3          |      |                  | ,,                             |        |
| 18.00   Ancillary services   759, 656, 508   1, 160, 216, 009   1, 919, 872, 517   18.00   19.00   20.00   RURAL HEALTH CLINIC   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0   | 17. 00 |   | 227, 688, 4       | 185  |                  | 227, 688, 485                  | 17. 00 |
| 19.00  | 18.00  |   |                   |      | 1, 160, 216, 009 |                                | 18. 00 |
| 21. 00   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   21. 00   22. 00   HOME HEALTH AGENCY   23. 00   AMBULANCE SERVICES   24. 00   24. 00   24. 00   25. 00   AMBULATORY SURGICAL CENTER (D.P.)   25. 00   AMBULATORY SURGICAL CENTER (D.P.)   26. 00   0   0   0   0   0   0   0   0   0  | 19.00  | Outpati ent servi ces   |                   |      |                  |                                | 19. 00 |
| 22. 00   HOME HEALTH AGENCY   23. 00   23. 00   24. 00   24. 00   25. 00   25. 00   25. 00   26. 00   27. 00   28. 00   28. 00   29. 00   20. 00  | 20.00  | RURAL HEALTH CLINIC   |                   | 0    | 0                | 0                              | 20. 00 |
| 22. 00   HOME HEALTH AGENCY   23. 00   23. 00   24. 00   24. 00   25. 00   25. 00   26. 00   27. 00   28. 00   28. 00   29. 00   20. 00  | 21.00  | FEDERALLY QUALIFIED HEALTH CENTER                                     |                   | 0    | o                | 0                              | 21. 00 |
| 24. 00   25. 00   AMBULATORY SURGICAL CENTER (D.P.)   26. 00   25. 00   27. 00   27. 00   27. 00   27. 00   28. 00   27. 00   27. 00   28. 00   27. 00   28. 00   27. 00   28. 00   29.   |        | HOME HEALTH AGENCY  |                   |      |                  |                                | 22. 00 |
| 24. 00   25. 00   AMBULATORY SURGICAL CENTER (D. P.)   26. 00   40. 00   40. 00   42. 00   42. 00   25. 00   42. 00   25. 00   42. 00   25. 00   26   | 23.00  | AMBULANCE SERVICES  |                   |      |                  |                                | 23. 00 |
| 26. 00   HOSPICE   OTHER (SPECIFY)   O   O   O   O   O   O   O   O   O   | 24.00  |   |                   |      |                  |                                | 24. 00 |
| 26. 00   HOSPICE   OTHER (SPECIFY)   O   O   O   O   O   O   O   O   O   | 25.00  | AMBULATORY SURGICAL CENTER (D. P. )                                   |                   |      |                  |                                | 25. 00 |
| 28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst.   1,076,347,915   1,318,983,161   2,395,331,076   28.00   29.00   30.00   30.00   30.00   31.00   32.00   33.00   33.00   34.00   35.00   35.00   36.00   36.00   37.00   38.00   37.00   38.00   39.00   40.00   40.00   41.00   42.00   Total additions (sum of lines 37-41)   | 26.00  |   |                   |      |                  |                                | 26. 00 |
| G-3, line 1) PART II - OPERATING EXPENSES  Operating expenses (per Wkst. A, column 3, line 200)  ADD (SPECIFY)  O 31.00 32.00 33.00 34.00 35.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY)  O 36.00 0 37.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0   | 27.00  | OTHER (SPECIFY)   |                   | 0    | 0                | 0                              | 27. 00 |
| PART II - OPERATING EXPENSES  29.00 Operating expenses (per Wkst. A, column 3, line 200)  ADD (SPECIFY)  O  30.00 31.00 32.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY)  O  Total deductions (sum of lines 37-41)  Description:  Descrip   | 28.00  | Total patient revenues (sum of lines 17-27) (transfer column 3 to Wks | t. 1, 076, 347, 9 | 915  | 1, 318, 983, 161 | 2, 395, 331, 076               | 28. 00 |
| 29. 00 30. 00 30. 00 31. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41)  265, 189, 998 29. 00 30. 00 30. 00 31. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41)   |        | G-3, line 1)  |                   |      |                  |                                |        |
| 30.00   ADD (SPECIFY)   0   30.00   31.00   32.00   33.00   32.00   33   |        | PART II - OPERATING EXPENSES  |                   |      |                  |                                |        |
| 31.00 32.00 33.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41)  0 31.00 32.00 33.00 33.00 34.00 35.00 36.00 37.00 37.00 38.00 39.00 40.00 41.00 42.00   | 29. 00 |   |                   |      | 265, 189, 998    |                                | 29. 00 |
| 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41)  0 32. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41)  | 30.00  | ADD (SPECIFY)   |                   |      |                  |                                | 30.00  |
| 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY)  0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41)   | 31.00  |   |                   | 0    |                  |                                | 31. 00 |
| 34.00<br>35.00<br>36.00 Total additions (sum of lines 30-35)<br>37.00 DEDUCT (SPECIFY)<br>0 37.00<br>38.00<br>39.00<br>40.00<br>41.00<br>42.00 Total deductions (sum of lines 37-41)   | 32.00  |   |                   | 0    |                  |                                | 32.00  |
| 35.00 36.00 Total additions (sum of lines 30-35) 37.00 DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 0 35.00 36.00 37.00 37.00 38.00 39.00 40.00 41.00  | 33.00  |   |                   | 0    |                  |                                | 33. 00 |
| 36.00 Total additions (sum of lines 30-35) 37.00 DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 0 36.00 37.00 37.00 38.00 0 38.00 0 40.00 41.00 0 42.00  |        |   |                   | 0    |                  |                                |        |
| 37. 00   DEDUCT (SPECIFY)   0   37. 00   38. 00   39. 00   0   40. 00   41. 00   42. 00   Total deductions (sum of lines 37-41)   0   42. 00   0   42. 00   0   42. 00   0   42. 00   0   42. 00   0   0   0   0   0   0   0   0   0   |        |   |                   | 0    |                  |                                |        |
| 38.00<br>39.00<br>40.00<br>41.00<br>42.00 Total deductions (sum of lines 37-41)  |        | ,   |                   |      | 0                |                                |        |
| 39.00<br>40.00<br>41.00<br>42.00 Total deductions (sum of lines 37-41)   |        | DEDUCT (SPECIFY)  |                   | 0    |                  |                                |        |
| 40.00<br>41.00<br>42.00 Total deductions (sum of lines 37-41) 0 40.00<br>41.00 42.00   |        |   |                   | -    |                  |                                |        |
| 41.00<br>42.00 Total deductions (sum of lines 37-41) 0 41.00<br>42.00  |        |   |                   | - 1  |                  |                                |        |
| 42.00 Total deductions (sum of lines 37-41) 0 42.00  |        |   |                   | 0    |                  |                                |        |
|  |        |   |                   | 0    |                  |                                |        |
| $42.00$ Hotal operating expenses (sum of lines $20$ and $26$ minus line $42$ ) (transfor $\frac{1}{2}$ = |        |   |                   |      | 0                |                                |        |
|  | 43. 00 | Total operating expenses (sum of lines 29 and 36 minus line 42)(tran  | ster              |      | 265, 189, 998    |                                | 43. 00 |
| to Wkst. G-3, line 4)  |        | TO WKST. G-3, TIME 4)   | I                 |      | l                |                                |        |

| STATEMENT OF REVENUES AND EXPENSES  Provider CCN: 15-0035   Period: From 01/01/2021   To 12/31/2021   Date 5/30 | F Form CMS-2: rksheet G-3 te/Time Prep 30/2022 6: 28 1.00 395, 331, 076 | pared: |
|---|---|--------|
| To 12/31/2021 Date 5/30   | 30/2022 6: 28<br>1. 00<br>395, 331, 076                                 |        |
|   | 1. 00<br>395, 331, 076  |        |
|   | 395, 331, 076   |        |
| 1.00 Total patient revenues (from Wkst. G-2. Part L. column 3. Line 28)   |   |        |
|   |   | 1.00   |
|   | 042, 788, 924   | 2.00   |
|   | 352, 542, 152   | 3.00   |
| 4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43)   | 265, 189, 998   | 4.00   |
| 5.00 Net income from service to patients (line 3 minus line 4)  | 87, 352, 154  | 5.00   |
| OTHER I NCOME   |   |        |
| 6.00   Contributions, donations, bequests, etc  | 0   | 6.00   |
| 7.00 Income from investments  | 0   | 7. 00  |
| 8.00 Revenues from telephone and other miscellaneous communication services                                     | 0   | 8.00   |
| 9.00 Revenue from television and radio service  | 0   | 9. 00  |
| 10.00 Purchase discounts  | - 1   | 10.00  |
| 11.00 Rebates and refunds of expenses   |   | 11. 00 |
| 12.00 Parking lot receipts  |   | 12.00  |
| 13.00 Revenue from Laundry and Linen service  | - 1   | 13.00  |
| 14.00 Revenue from meals sold to employees and guests   |   | 14.00  |
| 15.00 Revenue from rental of living quarters  | - 1   | 15.00  |
| 16.00 Revenue from sale of medical and surgical supplies to other than patients                                 | - 1   | 16.00  |
| 17.00 Revenue from sale of drugs to other than patients   |   | 17. 00 |
| 18.00 Revenue from sale of medical records and abstracts  | - 1   | 18. 00 |
| 19.00 Tuition (fees, sale of textbooks, uniforms, etc.)   | - 1   | 19. 00 |
| 20.00 Revenue from gifts, flowers, coffee shops, and canteen  | - 1   | 20.00  |
| 21.00 Rental of vending machines  |   | 21. 00 |
| 22.00 Rental of hospital space  |   | 22. 00 |
| 23.00 Governmental appropriations   |   | 23. 00 |
| 24. 00 OTHER I NCOME  |   |        |
|   | -1, 456, 608  | 24.50  |
| 25.00 Total other income (sum of lines 6-24)  |   |        |
|   |   |        |
| 27. 00 OTHER EXPENSES (SPECIFY)   |   | 27.00  |
| 28.00   Total other expenses (sum of line 27 and subscripts)  |   | 28.00  |
| 29.00 Net income (or loss) for the period (line 26 minus line 28)   | 86, 668, 215  | 29. 00 |

| Heal th        | Financial Systems PORTER REGI   | ONAL HOSPITAL                 | In lie                                       | u of Form CMS-2  | 2552-10 |  |
|----------------|---|-------------------------------|--|--|---------|--|
|                | ATION OF CAPITAL PAYMENT  | Provi der CCN: 15-0035        | Peri od:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet L<br>Parts I-III<br>Date/Time Pre<br>5/30/2022 6:2 | pared:  |  |
|                |   | Title XVIII                   | Hospi tal                                    | PPS  |         |  |
|                |   |                               |  |  |         |  |
|                |   |                               |  | 1. 00  |         |  |
|                | PART I - FULLY PROSPECTIVE METHOD   |                               |  |  |         |  |
| 4 00           | CAPITAL FEDERAL AMOUNT  |                               |  | 0.0(0.000  | 4 00    |  |
| 1.00           | Capital DRG other than outlier  |                               |  | 2, 963, 022<br>0   | 1       |  |
| 1. 01          | ·   |                               |  |  |         |  |
| 2. 00<br>2. 01 | Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments  |                               |  | 29, 330<br>0   |         |  |
| 3. 00          | Total inpatient days divided by number of days in the cos   | t reporting period (see inst  | rusti ons)                                   | 156. 61  |         |  |
| 4. 00          | Number of interns & residents (see instructions)  | t reporting period (see inst  | ructrons)                                    | 0.00   |         |  |
| 5.00           | Indirect medical education percentage (see instructions)  |                               |  | 0.00   |         |  |
| 6. 00          | Indirect medical education adjustment (multiply line 5 by   | the sum of lines 1 and 1 01   | columns 1 and                                | 0.00   |         |  |
| 0.00           | 1.01) (see instructions)  | the sum of fiftes f and f. of | , cordinis r and                             |  | 0.00    |  |
| 7. 00          | Percentage of SSI recipient patient days to Medicare Part 30) (see instructions)                                    | A patient days (Worksheet E   | , part A line                                | 2. 46  | 7. 00   |  |
| 8. 00          | Percentage of Medicaid patient days to total days (see in   | structions)                   |  | 20. 73   | 8. 00   |  |
| 9. 00          | Sum of lines 7 and 8  | structions)                   |  | 23. 19   | 1       |  |
| 10.00          | Allowable disproportionate share percentage (see instruct   | i ons)                        |  | 4. 81  |         |  |
| 11. 00         | Disproportionate share adjustment (see instructions)  |                               |  | 142, 521   | 11. 00  |  |
|                | Total prospective capital payments (see instructions)   |                               |  | 3, 134, 873  | 1       |  |
|                |   |                               |  |  |         |  |
|                |   |                               |  | 1. 00  |         |  |
|                | PART II - PAYMENT UNDER REASONABLE COST   |                               |  |  |         |  |
| 1.00           | Program inpatient routine capital cost (see instructions)   |                               |  | 0  |         |  |
| 2.00           | Program inpatient ancillary capital cost (see instruction   | •                             |  | 0  |         |  |
| 3.00           | Total inpatient program capital cost (line 1 plus line 2)   |                               |  | 0  |         |  |
| 4. 00          | Capital cost payment factor (see instructions)  |                               |  | 0  |         |  |
| 5. 00          | Total inpatient program capital cost (line 3 x line 4)  |                               |  | 0  | 5. 00   |  |
|                |   |                               |  | 1. 00  |         |  |
|                | PART III - COMPUTATION OF EXCEPTION PAYMENTS  |                               |  |  |         |  |
| 1.00           | Program inpatient capital costs (see instructions)  |                               |  | 0  |         |  |
| 2. 00          | Program inpatient capital costs for extraordinary circums   | ,                             |  | 0  |         |  |
| 3.00           | Net program inpatient capital costs (line 1 minus line 2)   |                               |  | 0  | 1 0.00  |  |
| 4.00           | Applicable exception percentage (see instructions)  |                               |  | 0.00   |         |  |
| 5.00           | Capital cost for comparison to payments (line 3 x line 4)   |                               |  | 0<br>0.00  |         |  |
| 6. 00<br>7. 00 | Percentage adjustment for extraordinary circumstances (se Adjustment to capital minimum payment level for extraordi | ,                             | lino 4)                                      | 0.00   |         |  |
| 7. 00<br>8. 00 | Capital minimum payment level (line 5 plus line 7)  | nary circumstances (fine 2 x  | . Title 6)                                   | 0  |         |  |
| 9. 00          | Current year capital payments (from Part I, line 12, as a   | nnli cable)                   |  | 0  |         |  |
| 10. 00         | Current year comparison of capital minimum payment level  |                               | Loce Line O)                                 | 0  |         |  |
| 11. 00         | Carryover of accumulated capital minimum payment level ov   |                               |  | 0  |         |  |
|                | Worksheet L, Part III, line 14)   |                               | ,  |  |         |  |
| 12.00          | Net comparison of capital minimum payment level to capital  |                               |  | 0  |         |  |
| 13.00          | Current year exception payment (if line 12 is positive, e   |                               |  | 0  |         |  |
| 14. 00         | Carryover of accumulated capital minimum payment level ov (if line 12 is negative, enter the amount on this line)   | er capital payment for the f  | ollowing period                              | 0  | 14. 00  |  |
| 15. 00         |   |                               |  | 0  | 15. 00  |  |
| 16. 00         | 1   | s)                            |  | 0  |         |  |
| 17. 00         | Current year exception offset amount (see instructions)   |                               |  | 0  | 17. 00  |  |
|                |   |                               |  |  |         |  |