Heal th Financi		PORTER-STARK				ieu of Form CMS-2552-10
	s required by law (42 USC 13 since the beginning of the					im FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022
HOSPITAL AND H AND SETTLEMEN	HOSPITAL HEALTH CARE COMPLE) T SUMMARY	COST REPORT CERTIFIC	ATION Prov	ider CCN: 15-405	2 Period: From 07/01/202 To 06/30/202	
PART I - COST	REPORT STATUS					
Provi der use onl y	 [X] Electronically prepared of an and the second sec	cost report ded report enter the n	umber of ti or "L" for	mes the provide 「low.	Date: 11/28 r resubmitted this	· · · · ·
Contractor use only	5. [1]Cost Report Status (1) As Submitted (2) Settled without Audi (3) Settled with Audit (4) Reopened (5) Amended	7 Contractor No	ort for thi t for this	s Provider CCN1	0.NPR Date: 1.Contractor's Ve 2.[0]If line 5, number of 1	ndor Code: 4 column 1 is 4: Enter times reopened = 0-9.
PART LL - CER	TIFICATION BY A CHIEF FINANC	CLAL OFFICER OR ADMINI	STRATOR OR	PROVIDER(S)		
MI SREPRESENTA ADMI NI STRATI VE PROVI DED OR PE	TION OR FALSIFICATION OF ANY E ACTION, FINE AND/OR IMPRIS ROCURED THROUGH THE PAYMENT E ACTION, FINES AND/OR IMPRI	/ INFORMATION CONTAINED CONMENT UNDER FEDERAL D DIRECTLY OR INDIRECTLY	D IN THIS C _AW. FURTH	COST REPORT MAY HERMORE, IF SERV	ICES IDENTIFIED IN	N THIS REPORT WERE
CERTI	FICATION BY CHIEF FINANCIAL	OFFICER OR ADMINISTRA	TOR OF PRON	/I DER(S)		
el ect State peri o state appl i regard	EBY CERTIFY that I have read ronically filed or manually ment of Revenue and Expenses d beginning 07/01/2021 and o ment are true, correct, comp cable instructions, except a ding the provision of health ded in compliance with such	submitted cost report s prepared by PORTER-S ending 06/30/2022 and of ete and prepared fro as noted. I further ce n care services, and t	and submit TARKE SERVI to the best m the books rtify that	tted cost report CES, INC (15-4 t of my knowledg s and records of I am familiar w	and the Balance S 052) for the cos e and belief, this the provider in a ith the laws and n	Sheet and t reporting s report and accordance with regulations
SI GNATUR	E OF CHIEF FINANCIAL OFFICE	R OR ADMINISTRATOR	CHECKBOX		ELECTRONI C	
	1		2	S	IGNATURE STATEMEN	

	SIGNATURE OF CHIEF FINA	ANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Andr	rew Nielsen	ř	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	Andrew Nielsen			2
3	3 Signatory Title CFO				3
4	Date	(Dated when report is electronica			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 Hospital	0	0	0	0	31, 843	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
200. 00 Total	0	0	0	0	31, 843	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.

	TAL AND HOSPITAL HEALTH CARE COMPLEX			ler CCN:		Period: From 07/01/ To 06/30/	2022	Workshe Part I Date/Ti 11/28/2		epare
	1.00	2.00		3.00		4	4.00			
	Hospital and Hospital Health Care Co									
0	Street: 601 WALL ST	PO Box:								1.
0	City: VALPARAISO	State: IN	Zip Cod	e: 46385	- Count	y: PORTER				2.
		Component Name	CCN	CBSA	Provi der	Date	Payme	nt Syst	em (P,	
			Number	Number	r Type	Certified	Г,	0, or	N)	
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0	Subprovider - IPF	THE								4
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0	Subprovider - IRF									5
С	Subprovider - (Other)									6
C	Swing Beds - SNF									7
C	Swing Beds - NF									8
5	Hospital -Based SNF									9
00	Hospital -Based NF									10
00	Hospital-Based OLTC									11
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00	Separately Certified ASC									13
00	Hospital-Based Hospice									14
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	Type of Control (see instructions)					2				21
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	disproportionate share hospital adju			ĸ						
	§412.106? In column 1, enter "Y" fo									
	Ifacility subject to 12 CED Section 8									
	Induiting Subject to 42 Circ Section S	§412.106(c)(2)(Pickle am	endment							
	hospital?) In column 2, enter "Y" for		endment							
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OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA I	<u>CES, INC</u> Provider CC	N: 15-4052	Peri od:	In Lieu	Worksh	ieet S-2	
				From 07/0 To 06/3	30/2022	Part I Date/T 11/28/	ime Pre 2022 2:	epared
	In-State Medicaid paid days	In-State Medicaid eligible unpaid	Out-of State Medicaid paid days	Out-of State Medicaid eligible	Medica HMO da	ys Me)ther di cai d days	
	1.00	days	2.00	unpai d	F 00		(00	4
1.00 If this provider is an IPPS hospital, enter the	1.00	2.00	3.00	4.00	5.00	0	<u>6.00</u>	24.0
 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. O0 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 3, out-of-state 	0	0		c		0		25.0
HMO paid and eligible but unpaid days in column 5.					Rural S		<u>J</u>	
5.00 Enter your standard geographic classification (not w	age) status	at the be	ginning of		00 1	۷.	00	26.0
cost reporting period. Enter "1" for urban or "2" fo 7.00 Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif	age) status r "2" for r	ural. If a		st	1			27.0
5.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status i	n	0			35.0
periode in the dest reporting period.				Begi r			i ng:	
5.00 Enter applicable beginning and ending dates of SCH s	tatus. Subs	cript line	36 for num		00	Ζ.	00	36.0
of periods in excess of one and enter subsequent date 7.00 If this is a Medicare dependent hospital (MDH), ente is in effect in the cost reporting period.		er of perio	ds MDH stat	us	0			37.0
7.01 Is this hospital a former MDH that is eligible for that accordance with FY 2016 OPPS final rule? Enter "Y" finstructions)								37.0
3. 00 If line 37 is 1, enter the beginning and ending date: greater than 1, subscript this line for the number o enter subsequent dates.								38.0
		II excess 0						
					/N		/N	
Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)	l payment a), (ii), or the mileage ii)? Enter	djustment (iii)? En e requireme in column	for low vol ter in colu nts in 2 "Y" for y	ume 1. mn es	/N 00 N	2.	<u>/N</u> 00 N	39. (
Description of the inpatient hospital for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii))	l payment a), (ii), or the mileage ii)? Enter n adjustmer ber 1. Ente	djustment (iii)? En e requireme in column ht? Enter " er "Y" for	for low vol ter in colu nts in 2 "Y" for y Y" for yes	ume 1. mn es or 1	00	2.	00	39. (40. (
 Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) O0 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol 	l payment a), (ii), or the mileage ii)? Enter n adjustmer ber 1. Ente	djustment (iii)? En e requireme in column ht? Enter " er "Y" for	for low vol ter in colu nts in 2 "Y" for y Y" for yes	ume 1. mn es or 1	00	2.	00 N N XI X	
 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Do Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to October 1 Prospective Payment System (PPS)-Capital 	l payment a), (ii), or the mileage ii)? Enter n adjustmen ber 1. Ente . (see inst	djustment (iii)? En requireme in column ht? Enter " ructions)	for low vol ter in colu nts in 2 "Y" for y Y" for yes yes or "N"	and the second s	00 N N <u>V</u> 1.00	2. XVIII 2.00	00 N XI X 3. 00	40.0
 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) OI Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1 Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymee with 42 CFR Section §412.320? (see instructions) OI Is this facility eligible for additional payment exc. 	I payment a), (ii), or the mileage ii)? Enter n adjustmer ber 1. Ente . (see inst . (see inst nt for disp eption for	djustment (iii)? En requireme in column r? Enter " ructions) proportiona extraordin	for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums	1. ume 1 es or 1 for 2 accordanc tances	00 N N V 1.00 e N N	2.	00 N N XI X	40.0
 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Do Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1 Prospective Payment System (PPS)-Capital 5.00 Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Do Is this facility eligible for additional payment except to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. 	I payment a), (ii), or the mileage ii)? Enter n adjustmer ber 1. Ente . (see inst . (see inst nt for disp eption for t. L, Pt. I	djustment (iii)? En requireme in column rt? Enter " ructions) proportiona extraordin II and Wks	for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt.	accordance I through	00 N N 1.00 e N N	2. XVIIII 2.00 N N	00 N N 3.00	40. (45. (46. (
 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) OI Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1 Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymee with 42 CFR Section §412.320? (see instructions) OI Is this facility eligible for additional payment excorpursuant to 42 CFR §412.348(f)? If yes, complete Wks 	I payment a), (ii), or the mileage ii)? Enter n adjustmen ber 1. Ente . (see inst nt for disp eption for t. L, Pt. I capital? E	djustment (iii)? En requireme in column t? Enter " ructions) proportiona extraordin II and Wks	for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N	1. ume mn es or for accordanc tances I through " for no.	00 N N V 1.00 e N N	2. XVIIII 2.00 N	00 N N 3.00	40. 1 45. 1 46. 1 47. 1
 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Do Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1 Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions) OI Is this a facility eligible for additional payment exception yoursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Tool Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment in the	I payment a), (ii), or the mileage ii)? Enter n adjustmer ber 1. Enter . (see inst . (see inst . (see inst nt for disp eption for t. L, Pt. I capital? E t? Enter " approved G e to columr rograms in cable CRS) lumn 2.	djustment (iii)? En requireme in column at? Enter "' ructions) proportiona extraordin II and Wks inter "Y fo Y" for yes ME program 1 is "Y", the prior MA direct	for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen GME payment	1. ume mn es or for accordanc tances I through " for no. no. " for yes hospital ul timate reduction	00 N V 1.00 e N N N N N Or N	2. XVIII 2.00 N N	00 N N 3.00	40. 1 45. 1 46. 1 48. 1 56. 1
 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Do Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1 Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excorpursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. this a new hospital under 42 CFR §412.300(b) PPS 18.00 Is this a new hospital under 42 CFR §412.300(b) PPS 18.00 Is this a nospital since full federal capital paymen Teaching Hospitals Is this a hospital since full federal capital paymen Teaching Hospitals Mathematical formation of the facility electing full federal capital paymen trace formation of the facility electing full federal capital paymen teaching Hospitals Mathematical formation of the facility electing full federal capital paymen teaching Hospitals Mathematical formation of the facility formation of the facility electing full federal capital paymen teaching Hospitals Mathematical formation of the facility electing full federal capital paymen teaching Hospitals Mathematical formation of the facility electing full federal capital paymen teaching Hospitals Mathematical formation of the facility electing full federal capital paymen teaching Hospitals Mathematical formation of the facility electing full federal capital paymen teaching Hospitals Mathematical formation of the facility electing full federal capital paymen teaching Hospital formation of the facility electing full federal capital paymen teaching Hospital formation of the facility elec	I payment a), (ii), or the mileage ii)? Enter n adjustmer ber 1. Ente . (see inst nt for disp eption for t. L, Pt. I capital? E t? Enter " approved G e to columr rograms in cable CRs) lumn 2. period duri r yes or "N th of this Y", complet	djustment (iii)? En requireme in column r"Y" for ructions) roportiona extraordin II and Wks nter "Y for y" for yes ME program 1 is "Y", the prior MA direct ng which r " for no i cost repor	for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or if this year or pen GME payment esidents in n column 1. ting period	1. ume mn es or for accordanc tances I through " for no. no. " for yes hospital ultimate reduction approved If column ? Enter "	00 N V 1.00 e N N N N N ? ? 1 Y"	2. XVIII 2.00 N N	00 N N 3.00	40.0
 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Do Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1 Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Do Is this a new hospital under 42 CFR §412.300(b) PPS of this a new hospital under 42 CFR §412.300(b) PPS of Is this a new hospital under 42 CFR §412.300(b) PPS of Is this a new hospital involved in training residents in approved GME p year, and are you are impacted by CR 11642 (or application of the column 1. For column 2, if the responsives involved in training residents in approved GME p year, and are you are impacted by CR 11642 (or application of the column 5, is this the first cost reporting GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 2. If column 2 is "" 	I payment a), (ii), or the mileage ii)? Enter n adjustmer ber 1. Ente . (see inst nt for disp eption for t. L, Pt. I capital? E t? Enter " approved G e to columr rograms in cable CRs) lumn 2. period duri r yes or "N th of this Y", complet I, if appli bursement f	djustment (iii)? En requireme in column er "Y" for ructions) oroportiona extraordin II and Wks inter "Y fo Y" for yes ME program 1 is "Y", the prior MA direct ng which r " for no i cost repor e Workshee cable. or physici	for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen GME payment esidents in n column 1. ting period t E-4. If c	1. ume mn es or for accordanc tances 1 through for no. no. "for yes hospital ultimate reduction approved lf column ? Enter " olumn 2 is	00 N V 1.00 e N N N N N ? 1 Y"	2. XVIII 2.00 N N	00 N N 3.00	40. 1 45. 1 46. 1 48. 1 56. 1

Health Financial Systems PORTER-ST	TARKE S	ERVICES, INC		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider C	CN: 15-4052	Peri od: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part I Date/Time Pre 11/28/2022 2:	pared:
			NAHE 413.85 Y/N	5 Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in col	85? (s umn 1. CR) NAHI	see If column 1	N			60.00
	Y/N	IME	Direct GME		Direct GME	
	1.00	2.00	3.00	4.00	5.00	
 61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 				0.00	0.00	61.00
FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						01.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line (1.04 minute time (1.02)) (consider the surgery FTE counts)						61.05
 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) 						61.06
	Pro	ogram Name	Program Cod	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	(1.10
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0. 00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Ser					1	
62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct		d in this cost	reporting pe	eriod for which	0.00	62.00
62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	a Teachi gram. (s	see instructio		to your hospital	0.00	62.01
63.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, completing	ettings	during this o			N	63.00

alth Financial Systems SPITAL AND HOSPITAL HEALTH CARE COMPL	PORTER-S EX IDENTIFICATION D			eri od:	Worksheet S-2	
				om 07/01/2021	Part I	pared:
			Unweighted	Unweighted	Ratio (col.	
			FTEs Nonprovider	FTEs in Hospital	1/ (col . 1 + col . 2))	
			Si te 1.00	2.00	2 00	-
Section 5504 of the ACA Base Year	FTF Residents in N	lonnrovider Settinas-			<u> </u>	
period that begins on or after Ju			ini s base year	rs your cost	reporting	
.00 Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column ²	er of unweighted no ations occurring in number of unweighte nr hospital. Enter i	n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64.0
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
	r r ogr ann rianno		FTEs	FTEs in	3/ (col. 3 +	
			Nonprovi der	Hospi tal	col. 4))	
			Si te			
	1.00	2.00	3.00	4.00	5.00	
.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00 Unweighted	Unwei ghted	Ratio (col.	65.0
			FTEs Nonprovider Site	FTEs in Hospital	1/ (col . 1 + col . 2))	
Section 5504 of the ACA Current	ear FTE Residents i	n Nonnrovider Setting	1.00	2.00	<u> </u>	
beginning on or after July 1, 20		n nonprovider setting	jo Enective I	or cost report	ing perious	
.00 Enter in column 1 the number of u FTEs attributable to rotations of Enter in column 2 the number of u	nweighted non-prima ccurring in all nonp nweighted non-prima	rovider settings. ry care resident	0.00	0.00	0. 000000	66. C
FTEs that trained in your hospita (column 1 divided by (column 1 +						
,	Program Name	Program Code	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	Si te	4.00	F 00	-
.00 Enter in column 1, the program	1.00	2.00	3.00	4.00	5.00 0.000000	67 /
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						

Heal th	Financial Systems PORTER-STARKE SERVICES, INC	In l	ieu of	Form	CMS-2	2552-10
HOSPI T		eriod: com 07/01/20 o 06/30/20	21 Par [.] 22 Date	t I e/Tin		pared: 27 pm
		1	. 00 2.			
70 00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF sub		Y			70.00
	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in			N	0	71.00
71.00	recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teac program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for Column 3: If column 2 is Y, indicate which program year began during this cost reportin (see instructions)	no. (see hi ng no.	N		0	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF		N			75.00
76.00	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes o no. Column 2: Did this facility train residents in a new teaching program in accordance CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y indicate which program year began during this cost reporting period. (see instructions)	r "N" for with 42			0	76.00
				1.00)	
00.00	Long Term Care Hospital PPS			NI		00.00
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no.	period? Ent	er	N N		80.00 81.00
86.00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Sectio		10.	N		85.00 86.00
	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			Ν		87.00
		V 1.00		XI X 2. 00		
90.00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	Y		N		90.00
91.00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			Ν		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		Ν		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		Ν		94.00
	IF line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	0. 00 N		0. 00 N)	95.00 96.00
	If line 96 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	0. 00 Y		0. 00 Y)	97.00 98.00
98. 01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98.01
	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1	N		Ν		98.03
98.04	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Ν		98.04
98. 05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in	Y		Y		98.05
98.06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98.06
105.00	Rural Providers Does this hospital qualify as a CAH?	N				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an	N				107.00
	approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)					

Health Financial Systems PORTER-STARKE SE	ERVICES, INC		In Lieu	u of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C			Worksheet S-2 Part I Date/Time Pro 11/28/2022 2	epared:
			V 1.00	XI X 2.00	-
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	edul e? See 42	N		108.00
	Physi cal	Occupati onal	Speech	Respi ratory	
109.00 If this hospital qualifies as a CAH or a cost provider, are	1.00 N	2.00 N	3.00 N	4.00 N	109.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					
110.00 Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	Y" for yes o	r "N" for no. I	f yes,	<u>1.00</u> N	110.00
			1.00	2.00	-
111.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ac for tele-health services.	ost reporting olumn 1 is Y, rticipating in	period? Enter enter the n column 2.	N		111.00
		1.00	2.00	3.00	-
112.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cear participation in the demonstration, if applicable.	period? s "Y", enter ne	N			112.00
Miscellaneous Cost Reporting Information 115.00 s this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub.15-1, chapter 22, §2208.1.	3, or E only) 93" percent (includes	N			0115.00
116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116.00
117.00 Is this facility legally-required to carry malpractice insur	ance? Enter	Y			117.00
"Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claims-made or occurrence pol if the policy is claim-made. Enter 2 if the policy is occurr	2	2			118.00
		Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1.00	2.00	3.00	0118.01
The offerst amounts of marpractice premi and para rosses.		07,000	-		
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schec and amounts contained therein.			1.00 N	2.00	118.02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendment "Tetra in reducer 2. "Y" for your for your for the former.	n column 1, "N ualifies for t	Y" for yes or the Outpatient	Ν	Ν	119.00 120.00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	antable device	es charged to	Ν		121.00
122.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.			Ν		122.00
Transplant Center Information 125.00Does this facility operate a transplant center? Enter "Y" for	or yes and "N	'for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, er	nter the certi	fication date			126.00
in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, ent	2.				127.00
in column 1 and termination date, if applicable, in column 2	2.				127.00
128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified lung transplant center, enter	2.				128.00
column 1 and termination date, if applicable, in column 2.					

IIth Financial Systems SPITAL AND HOSPITAL HEALTH CARE COMPL		E SERVICES, INC Provider CC	N: 15-4052	Peri od	:	Worksheet S	-2
					7/01/2021 6/30/2022	Part I	repared
					1.00	2.00	_
D.00 f this is a Medicare certified p			ification		1.00	2.00	130.
date in column 1 and termination 1.00 If this is a Medicare certified i			erti fi cati	on			131.0
date in column 1 and termination							100
2.00 If this is a Medicare certified i in column 1 and termination date,			cation da	τe			132.
 3. OO Removed and reserved 4. OO If this is an organ procurement of and termination date, if applicate 	organization (OPO), ente		n column	1			133. 134.
All Providers 0.00 Are there any related organizatic chapter 10? Enter "Y" for yes or	"N" for no in column 1.	If yes, and home	office co		N		140.
are claimed, enter in column 2 th 1.00		<u>ber. (see instruct</u> 2.00	i ons)		3.00		_
If this facility is part of a cha	ain organization, enter	on lines 141 throu	ugh 143 th	ie name ar		of the home	
office and enter the home office 1.00 Name:	Contractor name and con Contractor's Name:		Contra	ctor's Nu	mber:		141.
2.00 Street:	P0 Box:				inder .		142.
3. 00 Ci ty:	State:		Zip Co	de:			143.
						1.00	-
4.00 Are provider based physicians' co	osts included in Workshe	et A?				Y	144.
					1.00	2.00	-
5.00 If costs for renal services are c inpatient services only? Enter "Y no, does the dialysis facility ir period? Enter "Y" for yes or "N"	(" for yes or "N" for no nclude Medicare utilizati	in column 1. If c	olumn 1 i				145.
	ogy changed from the pre- n column 1. (See CMS Pul			If	N		146.
5.00Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/	ogy changed from the pre n column 1. (See CMS Pul <u>(dd/yyyy) in column 2.</u>	b. 15-2, chapter 4	i0, §4020)	lf	N	1.00	146.
 OOHas the cost allocation methodol c Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7.00Was there a change in the statist 	ogy changed from the pre- n column 1. (See CMS Pul <u>(dd/yyyy) in column 2.</u> tical basis? Enter "Y" fo	b. 15-2, chapter 4	0, §4020) no.	If	N	N	147.
 OOHas the cost allocation methodol c Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ OOWas there a change in the statist OOWas there a change in the order c 	bgy changed from the pre- n column 1. (See CMS Pul (dd/yyyy) in column 2. tical basis? Enter "Y" fo of allocation? Enter "Y"	b. 15-2, chapter 4 for yes or "N" for for yes or "N" for	10, §4020) no. pr no. es or "N"	for no.		N N N	147. 148.
 OO Has the cost allocation methodol c Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ OO Was there a change in the statist OO Was there a change in the order c 	bgy changed from the pre- n column 1. (See CMS Pul (dd/yyyy) in column 2. tical basis? Enter "Y" fo of allocation? Enter "Y"	b. 15-2, chapter 4 or yes or "N" for for yes or "N" fo ? Enter "Y" for ye Part A	no. pr no. pr no. es or "N" Part E	for no.	itle V	N N Title XIX	147. 148.
 b. 00 Has the cost allocation methodol c Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ c. 00 Was there a change in the statist d. 00 Was there a change in the order c d. 00 Was there a change to the simplif 	bgy changed from the pre n column 1. (See CMS Pul /dd/yyyy) in column 2. tical basis? Enter "Y" fo f allocation? Enter "Y" fied cost finding method vider that qualifies for	b. 15-2, chapter 4 for yes or "N" for for yes or "N" for ? Enter "Y" for yes Part A 1.00 an exemption from	no. pr no. es or "N" Part E 2.00 n the appl	for no. 3 T ication d	itle V 3.00 of the low	N N Title XIX 4.00 er of costs	147. 148.
 D0 Has the cost allocation methodol c Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ COO Was there a change in the statist D0 Was there a change in the order c D0 Was there a change to the simplif Does this facility contain a provor charges? Enter "Y" for yes or 	bgy changed from the pre n column 1. (See CMS Pul /dd/yyyy) in column 2. tical basis? Enter "Y" fo f allocation? Enter "Y" fied cost finding method vider that qualifies for	b. 15-2, chapter 4 for yes or "N" for ? Enter "Y" for yes Part A 1.00 an exemption from ponent for Part A	no. or no. or no. <u>es or "N" Part E 2.00</u> n the appl and Part	for no. 3 T ication d	itle V 3.00 of the low 42 CFR §41	N N Title XIX 4.00 er of costs 3.13)	147. 148. 149.
 D0 Has the cost allocation methodol c Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ C.00 Was there a change in the statist B.00 Was there a change in the order c D0 Was there a change to the simplif Does this facility contain a provor charges? Enter "Y" for yes or D0 Hospital 	bgy changed from the pre n column 1. (See CMS Pul /dd/yyyy) in column 2. tical basis? Enter "Y" fo f allocation? Enter "Y" fied cost finding method vider that qualifies for	b. 15-2, chapter 4 for yes or "N" for for yes or "N" for ? Enter "Y" for yes Part A 1.00 an exemption from	no. pr no. es or "N" Part E 2.00 n the appl	for no. 3 T ication d	itle V 3.00 of the low	N N Title XIX 4.00 er of costs	147. 148. 149. 155.
 D0 Has the cost allocation methodol c Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ O0 Was there a change in the statist 00 Was there a change in the order of 00 Was there a change to the simplif Does this facility contain a provor charges? Enter "Y" for yes or 00 Hospital 00 Subprovider - IPF 00 Subprovider - IRF 	bgy changed from the pre n column 1. (See CMS Pul /dd/yyyy) in column 2. tical basis? Enter "Y" fo f allocation? Enter "Y" fied cost finding method vider that qualifies for	b. 15-2, chapter 4	no. pr no. pr no. so or "N" Part E 2.00 m the appl and Part N	for no. 3 T ication d	itle V 3.00 of the low 42 CFR §41 N	N N Title XIX 4.00 er of costs 3.13) N	147. 148. 149. 155. 155. 156. 157.
 0.00 Has the cost allocation methodol c Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7.00 Was there a change in the statist 8.00 Was there a change in the order of 9.00 Was there a change to the simplif 00 Was there a change to the simplif 00 Boes this facility contain a provor charges? Enter "Y" for yes or 5.00 Hospital 00 Subprovider - IPF 8.00 SUBPROVIDER 	bgy changed from the pre n column 1. (See CMS Pul /dd/yyyy) in column 2. tical basis? Enter "Y" fo f allocation? Enter "Y" fied cost finding method vider that qualifies for	b. 15-2, chapter 4	no. or no. or no. <u>rs or "N" Part E 2.00</u> n the appl <u>and Part</u> N N N	for no. 3 T ication d	itle V 3.00 of the low 42 CFR §41 N N N	N N Title XIX 4.00 er of costs 3.13) N N N	147. 148. 149. 155. 155. 156. 157. 158.
 00 Has the cost allocation methodol c Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 00 Was there a change in the statist 00 Was there a change in the order of 00 Was there a change to the simplif 00 Subprovider - IPF 00 SUBPROVIDER 00 SNF 	bgy changed from the pre n column 1. (See CMS Pul /dd/yyyy) in column 2. tical basis? Enter "Y" fo f allocation? Enter "Y" fied cost finding method vider that qualifies for	b. 15-2, chapter 4	no. or no. or no. <u>s or "N"</u> <u>Part E</u> <u>2.00</u> n the appl <u>and Part</u> N N N	for no. 3 T ication d	itle V 3.00 of the low 12 CFR §41 N N N N	N N Title XIX 4.00 er of costs 3.13) N N N	147. 148. 149. 155. 156. 156. 157. 158. 159.
 DO Has the cost allocation methodol c Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ DO Was there a change in the statist DO Was there a change in the order of 0.00 Was there a change to the simplif Does this facility contain a provor charges? Enter "Y" for yes or 0.00 Subprovider - IPF DO Subprovider - IPF DO Subprovider - IRF DO SUBPROVIDER DO SNF DO HOME HEALTH AGENCY 	bgy changed from the pre n column 1. (See CMS Pul /dd/yyyy) in column 2. tical basis? Enter "Y" fo f allocation? Enter "Y" fied cost finding method vider that qualifies for	b. 15-2, chapter 4	no. or no. or no. <u>rs or "N" Part E 2.00</u> n the appl <u>and Part</u> N N N	for no. 3 T ication d	itle V 3.00 of the low 42 CFR §41 N N N	N N Title XIX 4.00 er of costs 3.13) N N N	147. 148. 149. 155. 156. 156. 157. 158. 159. 160.
 DO Has the cost allocation methodol c Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ DO Was there a change in the statist DO Was there a change in the order of 0.00 Was there a change to the simplif Does this facility contain a provor charges? Enter "Y" for yes or 0.00 Subprovider - IPF DO Subprovider - IPF DO Subprovider - IRF DO SUBPROVIDER DO SNF DO HOME HEALTH AGENCY 	bgy changed from the pre n column 1. (See CMS Pul /dd/yyyy) in column 2. tical basis? Enter "Y" fo f allocation? Enter "Y" fied cost finding method vider that qualifies for	b. 15-2, chapter 4	no. or no. or no. <u>or so or "N"</u> <u>Part E</u> <u>2.00</u> m the appl <u>and Part</u> N N N N N	for no. 3 T ication d	Title V 3.00 of the low 42 CFR §41 N N N N N	N N Title XIX 4.00 er of costs 3.13) N N N N N	147. 148. 149. 155. 156. 156. 157. 158. 159. 160.
 5. 00 Has the cost allocation methodol c Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7. 00 Was there a change in the statist 8. 00 Was there a change in the order of 0. 00 Was there a change to the simplif Does this facility contain a provor charges? Enter "Y" for yes or 5. 00 Hospital 5. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVIDER 9. 00 SNF 0. 00 HOME HEALTH AGENCY 1. 00 CMHC 	bgy changed from the pre n column 1. (See CMS Pul /dd/yyyy) in column 2. tical basis? Enter "Y" fo of allocation? Enter "Y" fied cost finding method /ider that qualifies for "N" for no for each com	b. 15-2, chapter 4	no. or no. or no. <u>so or "N"</u> <u>Part E</u> <u>2.00</u> n the appl <u>and Part</u> N N N N N N	for no. 3 T i cati on (B. (See 4	itle V 3.00 of the low 42 CFR §41 N N N N N N N	N N N Title XIX 4.00 rer of costs 3.13) N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161.
 b. 00 Has the cost allocation methodol c Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ c. 00 Was there a change in the statist d. 00 Was there a change in the order of 0. 00 Was there a change to the simplif Does this facility contain a provor charges? Enter "Y" for yes or d. 00 Hospital d. 00 Subprovider - IPF d. 00 Subprovider - IRF d. 00 SUBPROVIDER 00 SUBPROVIDER 00 OHOME HEALTH AGENCY Multicampus 	bgy changed from the pre n column 1. (See CMS Pul /dd/yyyy) in column 2. tical basis? Enter "Y" fo of allocation? Enter "Y" fied cost finding method /ider that qualifies for "N" for no for each com	b. 15-2, chapter 4	no. or no. or no. <u>so or "N"</u> <u>Part E</u> <u>2.00</u> n the appl <u>and Part</u> N N N N N N	for no. 3 T i cati on (B. (See 4	itle V 3.00 of the low 42 CFR §41 N N N N N N N	N N Title XIX 4.00 er of costs 3.13) N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161.
 .00 Has the cost allocation methodol c Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ .00 Was there a change in the statist .00 Was there a change in the order of .00 Was there a change to the simplif Does this facility contain a provor charges? Enter "Y" for yes or .00 Hospital .00 Subprovider - IPF .00 Subprovider - IRF .00 SNF .00 HOME HEALTH AGENCY .00 CMHC 	begy changed from the pre- n column 1. (See CMS Pul (dd/yyyy) in column 2. tical basis? Enter "Y" fo of allocation? Enter "Y" Fied cost finding method vider that qualifies for "N" for no for each com	b. 15-2, chapter 4	no. pr no. pr no. so or "N" Part E 2.00 m the appl and Part N N N N N N N N N N N N N	for no. i cati on o B. (See 4) fferent C Zi p Code	itle V 3.00 of the low 42 CFR §41 N N N N N N SBSAs? CBSA	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N T.00	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 161.
.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ .00 Was there a change in the statist .00 Was there a change in the order of .00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or .00 Hospital .00 Subprovider - IPF .00 Subprovider - IPF .00 Subprovider - IRF .00 SNF .00 HOME HEALTH AGENCY .00 CMHC Multicampus .00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	begy changed from the pre- n column 1. (See CMS Pul (dd/yyyy) in column 2. tical basis? Enter "Y" fo of allocation? Enter "Y" fied cost finding method vider that qualifies for "N" for no for each com	b. 15-2, chapter 4	no. pr no. pr no. so or "N" Part E 2.00 m the appl and Part N N N N N N N N N N	for no. T i cati on (B. (See 4) fferent (itle V 3.00 of the low 12 CFR §41 N N N N N N N SBSAS?	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N T.00 FTE/Campus 5.00	147 148 149 155 156 157 158 159 160 161
 b. 00 Has the cost allocation methodol of Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/state) of the statist s	begy changed from the pre- n column 1. (See CMS Pul (dd/yyyy) in column 2. tical basis? Enter "Y" fo of allocation? Enter "Y" Fied cost finding method vider that qualifies for "N" for no for each com	b. 15-2, chapter 4	no. pr no. pr no. so or "N" Part E 2.00 m the appl and Part N N N N N N N N N N N N N	for no. i cati on o B. (See 4) fferent C Zi p Code	itle V 3.00 of the low 42 CFR §41 N N N N N N SBSAs? CBSA	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N T.00 FTE/Campus 5.00	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 165.
 .00 Has the cost allocation methodol c Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ .00 Was there a change in the statist .00 Was there a change in the order of .00 Was there a change to the simplif Does this facility contain a provor or charges? Enter "Y" for yes or .00 Hospital .00 Subprovider - IPF .00 Subprovider - IRF .00 SUBPROVI DER .00 SNF .00 HALTH AGENCY .00 CMHC Multicampus .00 If line 165 is yes, for each campus enter the name in column 3, CBSA in column 4, FTE/Campus in 	begy changed from the pre- n column 1. (See CMS Pul (dd/yyyy) in column 2. tical basis? Enter "Y" fo of allocation? Enter "Y" Fied cost finding method vider that qualifies for "N" for no for each com	b. 15-2, chapter 4	no. pr no. pr no. so or "N" Part E 2.00 m the appl and Part N N N N N N N N N N N N N	for no. i cati on o B. (See 4) fferent C Zi p Code	itle V 3.00 of the low 42 CFR §41 N N N N N N SBSAs? CBSA	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N T.00 FTE/Campus 5.00	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 165.
 00 Has the cost allocation methodol c Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 00 Was there a change in the statist 00 Was there a change in the order of 00 Was there a change to the simplif Does this facility contain a provor charges? Enter "Y" for yes or 00 Subprovi der - IPF 00 Subprovi der - IPF 00 Subprovi der - IRF 00 SUBPROVI DER 00 SNF 00 HOME HEALTH AGENCY 00 CMHC Multicampus 00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	by changed from the pre- n column 1. (See CMS Pul (dd/yyyy) in column 2. tical basis? Enter "Y" fo of allocation? Enter "Y" Fied cost finding method vider that qualifies for "N" for no for each com "N" for no for each com ampus hospital that has Name 0 1 1) incentive in the Ame	b. 15-2, chapter 4	no. pr no. pr no. so or "N" Part E 2.00 m the appl and Part N N N N N N N N N N N N N	for no. ication of B. (See 4 Fferent C Zip Code 3.00	itle V 3.00 of the low 42 CFR §41 N N N N N N SBSAs? CBSA	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 161. 161. 165. 00 166.
 b. 00 Has the cost allocation methodol c Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7. 00 Was there a change in the statist 8. 00 Was there a change in the order of 9. 00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 6. 00 Hospital b. 00 Subprovi der - IPF c0 Subprovi der - IRF 8. 00 SUBPROVI DER c0 OB UBPROVI DER c0 OHOME HEALTH AGENCY c0 OC MHC Multicampus 5. 00 If line 165 is yes, for each campus enter the name in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 7. 00 Is this provider a meaningful use 	anged from the prein column 1. (See CMS Pul/dd/yyyy) in column 2. tical basis? Enter "Y" for fallocation? Enter "Y" fied cost finding method? vider that qualifies for "N" for no for each com anpus hospital that has Name 0 1 1 incentive in the Ame and size (n)? Enter	b. 15-2, chapter 4	no. pr no. pr no. so or "N" Part E 2.00 m the appl and Part N N N N N N N N N N N N N	for no. 3 T i cati on o B. (See 4 Fferent C Zip Code 3.00 ment Act	itle V 3.00 of the low 42 CFR §41 N N N N N BSAs? CBSA 4.00	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 165. 00 166. 00 166.
 5. 00 Has the cost allocation methodol c Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7. 00 Was there a change in the statist 8. 00 Was there a change in the order of 2. 00 Was there a change to the simplif Does this facility contain a provor charges? Enter "Y" for yes or 5. 00 Subprovider - IPF 7. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVI DER 9. 00 SNF 9. 00 HOME HEALTH AGENCY 9. 00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 5. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 	by changed from the pre- n column 1. (See CMS Pul (dd/yyyy) in column 2. tical basis? Enter "Y" fo of allocation? Enter "Y" Fied cost finding method vider that qualifies for "N" for no for each com "N" for no for each com campus hospital that has Name 0 1 1) incentive in the Ame er under §1886(n)? Enter HIT assets (see instruc	b. 15-2, chapter 4	IO, \$4020)	for no. 3 T i cati on o B. (See 4 Fferent C Zi p Code 3. 00 ment Act Y"), ente	itle V 3.00 of the low 12 CFR §41 N N N N N N N N N N N N N	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 161.

Health Financial Systems	PORTER-STARKE SEF	RVICES, INC	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA		Period:	Worksheet S-2	
			From 07/01/2021		
			To 06/30/2022	Date/Time Pre 11/28/2022 2:	
			Begi nni ng	Ending	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR begi period respectively (mm/dd/yyyy)	nning date and ending da	ate for the reporting			170.00
			1.00	2.00	1
171.00 If line 167 is "Y", does this provide	er have any days for indi	viduals enrolled in	N	0	171.00
section 1876 Medicare cost plans repo	orted 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, e	enter the number of sectio	n		
1876 Medicare days in column 2. (see	instructions)				

IOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-4052	Period: From 07/01/2021 To 06/30/2022	Worksheet S- Part II Date/Time Pr 11/28/2022 2	epared
				Y/N	Date	_
		fair all NO is		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	FOR ALL NU P	esponses. Ent	er all dates in	the	
	COMPLETED BY ALL HOSPITALS					-
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the			N		1.0
	reporting period? If yes, enter the date of the change in c	olumn 2. (see	Y/N	Date	V/I	-
			1.00	2.00	3.00	-
2. 00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.0
8. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe relationships? (see instructions)	ffices, drug er or its f the board	N			3.0
			Y/N	Туре	Date	
			1.00	2.00	3.00	
1.00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled, ilable in	Y	A		4.0
5.00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.0
	The first of the first function of the first first for the			Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities					-
b. 00	Column 1: Are costs claimed for a nursing program? Column is the legal operator of the program?	2: If yes, I	s the provide	er N		6.0
7.00 3.00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve		wed during th	ne N		7. C 8. C
9. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	graduate medi	cal education	n N		9.0
0.00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o	S.		N		10.0
1.00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an Ap	proved	N		11.0
					Y/N	
					1.00	
2.00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			cost reporting	Y N	12. 0 13. 0
4.00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	nts waived? I	fyes, see ir	nstructions.	N	14.0
5.00	Did total beds available change from the prior cost reporti				N	15.0
	-	Y/N	t A Date	Y/N	t B Date	
	-	1.00	2.00	3.00	4.00	
	PS&R Data					
6.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions)	Y	09/07/2022	Y	09/07/2022	16.0
7.00	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	Ν		N		17.0
8.00	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	Ν		Ν		18.0
9.00	cost report? If yes, see instructions.	Ν		N		19.0

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider (CN: 15-4052	Period: From 07/01/2021 To 06/30/2022		repared:
			i pti on	Y/N	Y/N	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1.00 N	3.00 N	20.00
20.00	Report data for Other? Describe the other adjustments:			IN IN	IN IN	20.00
		Y/N	Date	Y/N	Date	
21 00	Was the cost report prepared only using the provider's	1.00 N	2.00	3.00 N	4.00	21.00
1.00	records? If yes, see instructions.	11		i v		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHI LDRENS	HOSPI TALS)		1.00	
	Capital Related Cost				1	
2.00 3.00	Have assets been relifed for Medicare purposes? If yes, se Have changes occurred in the Medicare depreciation expense			ring the cost		22.00
5.00	reporting period? If yes, see instructions.		Sar S made du	The cost		20.00
4.00	Were new leases and/or amendments to existing leases enter	ed into during	, this cost r	eporting period?		24.00
5.00	If yes, see instructions Have there been new capitalized leases entered into during	, the cost repo	orting period	?lfves see		25.00
	instructions.		•	-		
6. 00	Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.	he cost report	ing period?	lfyes, see		26.00
7.00	Has the provider's capitalization policy changed during th	e cost reporti	ng period? I	fyes, submit		27.00
	сору.	· .				
8 00	Interest Expense Were new Loans, mortgage agreements or letters of credit e	ntered into du	ring the cos	t reporting		28.0
0.00	period? If yes, see instructions.		in the cos	t reporting		20.0
9.00	Did the provider have a funded depreciation account and/or	bond funds (D	ebt Service	Reserve Fund)		29.0
0. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat		/debt?lfve	S SEE		30.0
	instructions.	3	5			
1. 00	Has debt been recalled before scheduled maturity without i instructions.	ssuance of new	/debt?lfye	s, see		31.00
	Purchased Services					
2.00	5 5 1		ed through c	ontractual		32.00
3.00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap		na to compet	itive bidding? L	f	33.0
	no, see instructions.					
1 00	Provi der-Based Physi ci ans	rrongoment wit	h nrovidor h	and physicians?	1	- 24 0
4.00	Are services furnished at the provider facility under an a If yes, see instructions.	irrangement wit	in provider-b	aseu physicians?		34.0
5.00	If line 34 is yes, were there new agreements or amended ex		ents with the	provi der-based		35.0
	physicians during the cost reporting period? If yes, see i	nstructions.		Y/N	Date	_
				1.00	2.00	
	Home Office Costs				1	
	Were home office costs claimed on the cost report?	repared by the	home office	2		
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions.	repared by the	e home office	?		
7.00	If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	fice different	from that o			37.00
87.00 8.00	If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en	fice different d of the home	from that o office.	f		37.00 38.00
7.00 8.00 9.00	If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions.	fice different d of the home er chain compc	from that o office. ments? If ye	f s,		37.00 38.00 39.00
7.00 8.00 9.00	If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions. If line 36 is yes, did the provider render services to the	fice different d of the home er chain compc	from that o office. ments? If ye	f s,		37.00 38.00 39.00
	If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions.	fice different d of the home er chain compo	from that o office. onents? If ye If yes, see	f s,		36.00 37.00 38.00 39.00 40.00
7.00 8.00 9.00	If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions. If line 36 is yes, did the provider render services to the instructions.	fice different d of the home er chain compo	from that o office. ments? If ye	f s,	00	37.00 38.00 39.00
7.00 8.00 9.00 0.00	If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions. If line 36 is yes, did the provider render services to the	fice different d of the home er chain compo	from that o office. onents? If ye If yes, see	f s,	00	37.00 38.00 39.00 40.00
7.00 8.00 9.00 0.00	If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	fice different d of the home er chain compo home office?	from that o office. onents? If ye If yes, see	f s, 2.	00	37.00 38.00 39.00
 37. 00 38. 00 39. 00 40. 00 41. 00 	If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	fice different d of the home er chain compo home office?	from that o office. Inents? If ye If yes, see	f s, 2.	00	37.00 38.00 39.00 40.00 41.00
 37.00 38.00 39.00 40.00 	If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	fice different d of the home er chain compo home office?	from that o office. Inents? If ye If yes, see	f s, 2.	00	37.00 38.00 39.00 40.00

Heal th	Financial Systems PORTER-STAR	KE SEF	RVI CES,	I NC		In Lieu	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provi	der CCN: 15-4052		eriod:	Worksheet S-2	
					T		Part II Date/Time Pre 11/28/2022 2:	pared: 27 pm
				3.00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position	MA	NAGER					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 cos	t						43.00
	report preparer in columns 1 and 2, respectively.							

Component Worksheet A. Line Number No. of Beds Bed Days Available CAH Hours I/P Days / CAH Hours I/P Days / CAH Hours I/P Days / CAH Hours 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and B exclude Swing Bed, Obsorvation Bed and Hospice days) (see instructions) 30.00 16 5,840 0.00 5.00 2.00 JUO HOM and other (see instructions) 30.00 16 5,840 0.00 1.00 1.00 Hospital Adults & Peds. Swing Bed SNF 6.00 1.00 16 5,840 0.00 1.4 2.00 JUO HAM and ther (see Listications) 16 5,840 0.00 0 1.4 3.00 HMO IPF Supprovider 16 5,840 0.00 0 1.4 3.00 INTENSIVE CARE UNIT 16 5,840 0.00 0 1.0 3.00 INTENSIVE CARE UNIT 16 5,840 0.00 1.1 1.1 3.00 INTENSIVE CARE UNIT 16 5,840 0.00 1.1 1.1 3.00 INTENSIVE CARE UNIT 16 5,840		Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	PORTER-STARKE S CAL DATA	Provider C	CN: 15-4052	Peri od:	u of Form CMS-2 Worksheet S-3	
Component Worksheet A Line Number No. of Beds Bed Days Available CAH Hours I/P Days / OP Visits / Trips 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and Be exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of Lip Proon available beds) 30.00 16 5.840 0.00 1.00 2.00 HM0 and other (see instructions) 30.00 16 5.840 0.00 1.0 2.00 HM0 and other (see instructions) 30.00 16 5.840 0.00 1.0 2.00 HM0 and other (see instructions) 30.00 16 5.840 0.00 0 1.0 0.00 HM0 IR Subprovider 1.00 1.00 INTERSIX CARE UNIT 1.00 1.6 5.840 0.00 0 7.0 10.00 DORMANTESSEW 1.00 1.0 5.840 0.00 0 7.0 10.00 SUBPROVIDER - IPF 1.00 1.6 5.840 0.00 0 1.1 10.00 SUBPROVIDER - IPF 1.00 SUBPROVIDER 1.06 SUBPROVIDER <th></th> <th></th> <th></th> <th></th> <th></th> <th>From 07/01/2021 To 06/30/2022</th> <th></th> <th></th>						From 07/01/2021 To 06/30/2022		
Component Worksheet A Line Number No. of Bads No. of Bads Bed Days Available CAH Hours At Hours Title V 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and Beschulde Swing Bed. Observation Bed and Beschulde Swing Bed. Observation Bed and Beschulde Swing Bed. Observations for col. 2 for the portion of LDP room available beds) 30.00 16 5,840 0.00 0 1.00 1.00 H00 and other (see instructions) 30.00 16 5,840 0.00 0 1.0 1.00 H00 and other (see instructions) 30.00 16 5,840 0.00 0 5.0 0 5.0 0.5 0 0.5 2.0 1.00 H00 IPF Subprovider 16 5,840 0.00 0 7.1 3.0 0 7.8 0.0 0 5.0 0.0 0 7.8 0.0 0.0 0.7 7.8 0.00 INTERSIVE CARE UNIT 10 0.0 16 5.840 0.00 0 1.1 1.1 1.1 1.2 1.2 1.2 1.2 1.2 1.2 1.2							I/P Days /	27 piii
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Line Number Available Image: Normal State Sta		Component	Worksheet A	No of Beds	Bed Dave	CAH Hours		
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8 exclude Swing Bed. Observation Bed and Hospited asys (see instructions for col. 2 for the portion of LDP room available beds) 2. 2.00 HW0 and other (see instructions) 3. 3.00 HW0 FF Subprovider 3. 4.00 HW0 IPF Subprovider 3. 5.00 Hospital Adults & Peds. Swing Bed NF 0 5.00 Hospital Adults & Peds. (exclude observation beds) (see instructions) 16 5. 8.00 INTENSIVE CARE UNIT 0. 0. 9.00 COROMARY CARE UNIT 0. 0. 11.00 BURS INTENSIVE CARE UNIT 0. 0. 11.00 BURS INTENSIVE CARE UNIT 0. 10. 11.00 SURGICAL INTENSIVE CARE UNIT 10. 11. 12.00 OTHER SPECIAL CARE (SPECIFY) 11. 11. 13.00 NURSERY 16 5.840 0.00 0 15.00 CARE UNIT 10. 11. 12. 13. 16.00 SUBPROVIDER - IFF 11. 10. 13. 17.00 SUBPROVIDER - IFF 14. 15. 16. 17.00 SUBPROV				2.00		4.00	5.00	
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8.00 INTERSIVE CARE UNIT 8.0 9.00 CORONARY CARE UNIT 9.0 10.00 BURR INTENSIVE CARE UNIT 9.0 11.00 SURGICAL INTENSIVE CARE UNIT 10.0 11.00 SURGICAL INTENSIVE CARE UNIT 11.1 12.00 OTHER SPECIAL CARE (SPECIFY) 11.1 13.00 NURSERY 13.0 14.00 Total (see instructions) 16 5,840 0.00 0 15. 15.00 CAH visits 01 15. 16.1 17.0 18.0 18.00 SUBPROVIDER - IPF 16 5,840 0.00 0 15. 16. 19.00 SKILED NURSING FACILITY 20.0 18.0 18.0 19.0 20.0 18.0 20.0 20.0 18.0 20.0 2	7.00			10	5,0	+0 0.00	0	7.00
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10.00 BURN INTENSIVE CARE UNIT 10.0 11.00 SURGICAL INTENSIVE CARE UNIT 11.0 12.00 OTHER SPECIAL CARE (SPECIFY) 12.0 13.00 NURSERY 13.0 14.00 Total (see instructions) 16 5,840 0.00 0 15.00 CAR visits 0 15.0 0 16.00 SUBPROVIDER - IPF 16.0 17.0 0 18.0 0 15.0 0 16.0 0.00 0 14.0 17.0 0 SUBPROVIDER - IPF 16.0 17.0 17.0 18.0 SUBPROVIDER - IRF 16.0 17.0 18.0 SUBPROVIDER 18.0 19.0 19.0 19.0 10.0 11.0 10.0 10.0 10.0 10.0 10.0 10.0 10.0 10.0 10.0 10.0 10.0 10.0 10.0 10.0	9.00							9.00
11.00 SURGICAL INTENSIVE CARE UNIT 11.0 12.00 OTHER SPECIAL CARE (SPECIFY) 12.0 13.00 NURSERY 13.1 14.00 Total (see instructions) 16 5,840 0.00 0 15.00 CAH visits 0 0 16 5,840 0.00 0 14.0 15.00 CAH visits 0 16 5,840 0.00 0 14.0 15.00 SUBPROVIDER - IPF 16 5,840 0.00 0 16.0 17.00 SUBPROVIDER - IRF 18.0 19.0 11.0 19.0 19.0 19.0 11.0 11.0 10.0 10.00								10.00
12.00 OTHER SPECIAL CARE (SPECIFY) 12.0 13.00 NURSERY 13.0 14.00 Total (see instructions) 16 5,840 0.00 014.0 15.00 CAH visits 16 5,840 0.00 015.0 16.00 SUBPROVIDER - IPF 16 16.0 17.0 17.00 SUBPROVIDER - IRF 16 17.0 17.0 18.00 SKILLED NURSING FACILITY 19.0 20.0 17.0 19.0 21.00 0THER LONG TERM CARE 21.0 20.0 19.0 21.0 19.0 22.0 19.0 22.0 19.0 22.0 19.0 22.0 19.0 22.0 19.0 22.0 23.0 23.0 24.0 22.0 23.0 24.0 22.0 23.0 24.0 22.4 24.0 22.4 24.0 22.4 24.0 22.0 24.0 22.0 24.0 22.0 24.0 25.0 24.0 25.0 24.0 25.0 24.0 24.0 25.0 24.0 25.0 24.0 25.0 26.0 26.0 26.0 26.0 26	11.00							11.00
13.00 NURSERY 13.0 14.00 Total (see instructions) 16 5,840 0.00 0 14.0 15.00 CAH visits 16 5,840 0.00 0 14.0 15.00 SUBPROVIDER - IPF 16 5,840 0.00 0 16.0 17.00 SUBPROVIDER - IRF 17.0 18.0 18.0 18.0 18.0 18.0 18.0 18.0 19.00 19.00 19.0	12.00							12.00
15.00 CAH visits 0 15.00 16.00 SUBPROVIDER - IPF 16.0 17.00 SUBPROVIDER 17.0 18.00 SUBPROVIDER 17.0 19.00 SKILLED NURSING FACILITY 20.0 20.00 NURSING FACILITY 21.0 21.00 OTHER LONG TERM CARE 21.0 22.00 HOME HEALTH AGENCY 22.0 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.0 24.00 HOSPICE 24.0 25.00 CMIC - CMHC 25.0 26.00 RURAL HEALTH CLINIC 25.0 26.02 FEDERALLY QUALIFIED HEALTH CENTER 89.00 27.00 Total (sum of lines 14-26) 16 28.00 Desrvation Bed Days 29.0 29.00 Ambulance Trips 30.0 30.00 Employee discount days (see instruction) 30.0 31.00 Employee discount days (see instructions) 0 0 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 30.0 33.0 33.00 LTCH non-covered days 33.0 <td< td=""><td>13.00</td><td></td><td></td><td></td><td></td><td></td><td></td><td>13.00</td></td<>	13.00							13.00
16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D. P.) 24.00 HOSPICE (non-distinct part) 25.00 CMHC 24.00 HOSPICE (som - distinct part) 25.00 CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 Stiller Distinct part) 30.00 24.0 25.00 CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 State of the stat-26) 26.00 Total (sum of lines 14-26) 27.00 Total (sum of lines 14-26) 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.00 Labor & delivery days (see instructions) 32.00 Labor & delivery days (see instructions) 32.	14.00	Total (see instructions)		16	5, 8	40 0.00	0	14.00
17.00 SUBPROVIDER - IRF 17.00 18.00 SUBPROVIDER 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 HOSPICE 24.00 24.00 HOSPICE 24.00 25.00 CMHC - CMHC 25.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 89.00 27.00 Total (sum of lines 14-26) 16 27.00 28.00 Observation Bed Days 0 28.00 29.00 29.00 Ambulance Trips 29.00 29.00 29.00 29.00 0 28.00 29.00 29.00 29.00 29.00 30.00 29.00 30.00 29.00 30.00 29.00 30.00 29.00 30.00 29.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00	15.00	CAH visits					0	15.00
18.00 SUBPROVIDER 18.0 19.00 SKILLED NURSING FACILITY 19.0 20.00 NURSING FACILITY 20.0 21.00 OTHER LONG TERM CARE 21.0 22.00 HOME HEALTH AGENCY 23.0 23.00 MUBULATORY SURGICAL CENTER (D. P.) 23.0 24.00 HOSPICE 24.0 25.00 CMHC - CMHC 24.0 26.25 FEDERALLY QUALIFIED HEALTH CENTER 89.00 27.00 Total (sum of lines 14-26) 16 27.00 Observation Bed Days 0 29.00 Ambulance Trips 30.00 30.00 Employee discount days (see instruction) 31.0 31.00 Employee discount days (see instructions) 0 0 32.01 Total ancillary labor & delivery room 32.0 33.0 33.00 LTCH non-covered days 33.0 33.0	16.00							16.00
19.00 SKILLED NURSING FACILITY 19.0 20.00 NURSING FACILITY 20.0 21.00 OTHER LONG TERM CARE 21.0 22.00 HOME HEALTH AGENCY 22.0 23.00 AMBULATORY SURGICAL CENTER (D.P.) 23.0 24.00 HOSPICE 24.0 25.00 CMRC - CMHC 24.0 26.00 RURAL HEALTH CLINIC 24.0 26.00 RURAL HEALTH CENTER 89.00 26.00 Stilled scount days 26.0 27.00 Total (sum of lines 14-26) 16 28.00 Observation Bed Days 29.0 29.00 Ambulance Trips 30.00 30.00 Employee discount days (see instruction) 30.0 31.00 Employee discount days - IRF 30.0 30.0 32.00 Labor & delivery days (see instructions) 0 0 32.0 32.00 Labor & delivery days (see instructions) 0 0 32.0 33.00 LTCH non-covered days 33.0 33.0 33.0								17.00
20.00NURSING FACILITY20.0021.00OTHER LONG TERM CARE21.0022.00HOME HEALTH AGENCY23.0023.00AMBULATORY SURGICAL CENTER (D.P.)23.0024.00HOSPICE24.0024.10HOSPICE (non-distinct part)30.0025.00CMHC - CMHC25.0026.00RURAL HEALTH CLINIC26.0026.25FEDERALLY QUALIFIED HEALTH CENTER89.0027.00Total (sum of lines 14-26)1628.00Observation Bed Days029.00Ambulance Trips30.0030.00Employee discount days (see instruction)30.0031.00Employee discount days - IRF31.032.01Total ancillary labor & delivery room outpatient days (see instructions)0033.00LTCH non-covered days33.00								18.00
21.00OTHER LONG TERM CARE21.0022.00HOME HEALTH AGENCY22.0023.00AMBULATORY SURGICAL CENTER (D. P.)23.0024.00HOSPICE24.0024.10HOSPICE (non-distinct part)30.0025.00CMHC - CMHC25.0026.00RURAL HEALTH CLINIC26.0026.25FEDERALLY QUALIFIED HEALTH CENTER89.0027.00Total (sum of lines 14-26)1628.00Observation Bed Days029.00Ambulance Trips30.0030.00Employee discount days (see instruction)31.0031.00Employee discount days (see instructions)0032.01Total ancillary labor & delivery room outpatient days (see instructions)0033.00LTCH non-covered days33.00								19.00
22.00 HOME HEALTH AGENCY 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 24.00 HOSPICE 24.00 24.10 HOSPICE (non-distinct part) 30.00 25.00 CMHC - CMHC 25.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 89.00 27.00 Total (sum of lines 14-26) 16 28.00 Observation Bed Days 29.00 29.00 Ambulance Trips 30.00 31.00 Employee discount days (see instruction) 31.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 0 0 33.00 LTCH non-covered days 33.00 33.00								20.00
23.00AMBULATORY SURGICAL CENTER (D. P.)23.0024.00HOSPICE24.0024.10HOSPICE (non-distinct part)30.0025.00CMHC - CMHC25.0026.00RURAL HEALTH CLINIC26.25FEDERALLY QUALIFIED HEALTH CENTER89.0027.00Total (sum of lines 14-26)1628.00Observation Bed Days029.00Ambulance Trips30.0030.00Employee discount days (see instruction)31.0031.00Employee discount days - IRF31.0032.01Total ancillary labor & delivery room outpatient days (see instructions)0033.00LTCH non-covered days33.00								
24.00HOSPICE24.024.10HOSPICE (non-distinct part)30.0025.00CMHC - CMHC25.026.00RURAL HEALTH CLINIC26.00RURAL HEALTH CLINIC26.25FEDERALLY QUALIFIED HEALTH CENTER27.00Total (sum of lines 14-26)28.00Observation Bed Days29.00Ambulance Trips30.00Employee discount days (see instruction)31.00Employee discount days (see instructions)32.01Total ancillary labor & delivery room012.01Total ancillary labor & delivery room02.03UTCH non-covered days33.00LTCH non-covered days								
24.10HOSPICE (non-distinct part)30.0024.225.00CMHC - CMHC25.026.00RURAL HEALTH CLINIC26.226.25FEDERALLY QUALIFIED HEALTH CENTER89.0027.00Total (sum of lines 14-26)1628.00Observation Bed Days27.029.00Ambulance Trips30.0030.00Employee discount days (see instruction)30.0031.00Employee discount days (see instructions)032.01Total ancillary labor & delivery room outpatient days (see instructions)033.00LTCH non-covered days33.00								23.00
25.00CMHC - CMHC25.0026.00RURAL HEALTH CLINIC26.2026.25FEDERALLY QUALIFIED HEALTH CENTER89.0027.00Total (sum of lines 14-26)1628.00Observation Bed Days029.00Ambulance Trips29.0030.00Employee discount days (see instruction)30.031.00Employee discount days (see instructions)0032.01Total ancillary labor & delivery room outpatient days (see instructions)0033.00LTCH non-covered days33.00			30.00					24.00
26.00RURAL HEALTH CLINIC26.026.25FEDERALLY QUALIFIED HEALTH CENTER89.0027.00Total (sum of lines 14-26)1628.00Observation Bed Days26.029.00Ambulance Trips28.030.00Employee discount days (see instruction)30.031.00Employee discount days - IRF31.032.00Labor & delivery days (see instructions)032.01Total ancillary labor & delivery room outpatient days (see instructions)33.033.00LTCH non-covered days33.0			30.00					25.00
26.25FEDERALLY QUALIFIED HEALTH CENTER89.00026.227.00Total (sum of lines 14-26)1627.028.00Observation Bed Days028.029.00Ambulance Trips29.030.00Employee discount days (see instruction)30.031.00Employee discount days (see instructions)032.01Total ancillary labor & delivery room outpatient days (see instructions)033.00LTCH non-covered days33.0								26.00
27.00Total (sum of lines 14-26)1627.0028.00Observation Bed Days028.0029.00Ambulance Trips29.0030.00Employee discount days (see instruction)30.0031.00Employee discount days - IRF31.0032.00Labor & delivery days (see instructions)0032.01Total ancillary labor & delivery room32.0133.00LTCH non-covered days33.00	26.25		89.00				0	26.25
28.00Observation Bed Days028.029.00Ambulance Trips29.030.00Employee discount days (see instruction)30.031.00Employee discount days - IRF31.032.00Labor & delivery days (see instructions)0032.01Total ancillary labor & delivery room32.033.00LTCH non-covered days33.0	27.00			16				27.00
30.00Employee discount days (see instruction)30.031.00Employee discount days - IRF31.032.00Labor & delivery days (see instructions)0032.01Total ancillary labor & delivery room outpatient days (see instructions)32.033.00LTCH non-covered days33.0	28.00						0	28.00
31.00 Employee discount days - IRF 31.0 32.00 Labor & delivery days (see instructions) 0 0 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.0 32.0 33.00 LTCH non-covered days 33.0	29.00	3						29.00
32.00 Labor & delivery days (see instructions) 0 0 32.0 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.0 32.0 33.00 33.00 LTCH non-covered days 33.0 33.0	30.00							30.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.0 33.00 LTCH non-covered days 33.0	31.00							31.00
outpatient days (see instructions) 33.00 LTCH non-covered days 33.00	32.00			0		0		32.00
33.00 LTCH non-covered days 33.0	32.01							32.01
5	22.00							
ss. or je tom si te neutral days and discharges 33.0								33.00
	33.01	Internetial days and discualiges	l l		I		I I	<u>3</u> 3.0

HOSPI TAL	AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Part I Date/Time Pre 11/28/2022 2:	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
8 e Hos	spital Adults & Peds. (columns 5, 6, 7 and exclude Swing Bed, Observation Bed and spice days)(see instructions for col. 2 r the portion of LDP room available beds)	348	95	1, 89	8		1.00
2.00 HMC	0 and other (see instructions) 0 IPF Subprovider	0 0	538 0				2.00 3.00
	0 IRF Subprovi der	0	0				4.00
	spital Adults & Peds. Swing Bed SNF	0	0		0		5.00
7.00 Tot	spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation ds) (see instructions)	348	0 95	1, 89	0 8		6.00 7.00
9.00 COF 10.00 BUF 11.00 SUF	TENSIVE CARE UNIT RONARY CARE UNIT RN INTENSIVE CARE UNIT RGICAL INTENSIVE CARE UNIT HER SPECIAL CARE (SPECIFY)						8.00 9.00 10.00 11.00 12.00
	RSERY						13.00
	tal (see instructions)	348	95	1, 89		281.60	•
	H visits BPROVIDER - IPF	0	0		0		15.00 16.00
	BPROVIDER - IRF						17.00
	BPROVIDER						18.00
	ILLED NURSING FACILITY						19.00
20. 00 NUF	RSING FACILITY						20.00
	HER LONG TERM CARE						21.00
	ME HEALTH AGENCY						22.00
	BULATORY SURGI CAL CENTER (D. P.) SPI CE						23.00
	SPICE (non-distinct part)				0		24.00
	HC - CMHC				0		25.00
26.00 RUF	RAL HEALTH CLINIC						26.00
	DERALLY QUALIFIED HEALTH CENTER	0	0		0.00	0.00	
	tal (sum of lines 14-26)		-		0.00	281.60	
	servation Bed Days		0		0		28.00
	bulance Trips ployee discount days (see instruction)	0			0		29.00
	ployee discount days (see first detron)				0		31.00
	bor & delivery days (see instructions)	0	0		0		32.00
	tal ancillary labor & delivery room		-		0		32.01
out	tpatient days (see instructions)						
	CH non-covered days	0					33.00
33.01 LI(CH site neutral days and discharges	0			1		33.0

	Financial Systems I AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	PORTER-STARKE SE AL DATA	Provi der C	CN: 15-4052	Peri od:	u of Form CMS-2 Worksheet S-3	
	AL AND NOT THE HEALTH GARLE COMPLEX STATISTIC			50. 10 4002	From 07/01/2021 To 06/30/2022	Part I Date/Time Pre 11/28/2022 2:3	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Patients	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00	13.00	14.00 49 22	15.00 393	1.00
$\begin{array}{c} 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 11. \ 00\\ 13. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 14. \ 00\\ 15. \ 00\\ 14. \ 00\\ 15. \ 00\\ 20. \ 00\\ 21. \ 00\\ 20. \ 00\\ 21. \ 00\\ 22. \ 00\\ 23. \ 00\\ 24. \ 10\\ 24. \ 10\\ 25. \ 00\\ \end{array}$	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE (non-distinct part) CMHC - CMHC	0.00	0		0 110 0 0 10 0	393	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ \end{array}\\\\ \begin{array}{c} 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 21.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 24.\ 10\\ 25.\ 00\\ \end{array}$
26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00 32.01	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room	0. 00 0. 00					26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00 32.01
33.00	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0 0		33. 00 33. 01

Health Financial Systems	PORTER-STARKE SEF	RVICES, INC		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider C		Period:	Worksheet A	
				From 07/01/2021 To 06/30/2022	Date/Time Pre	nared
				10 00/ 30/ 2022	11/28/2022 2:	
Cost Center Description	Sal ari es	Other		Recl assi fi cat		
			+ col. 2)	ions (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS	1		((0.0)		((0.0(0	1
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT		669, 869			669, 869	1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	272, 282	207, 785			480, 067	4.00
5.00 00500 ADMINI STRATI VE & GENERAL	2, 591, 340	1, 882, 998			4, 474, 338	
7.00 00700 OPERATION OF PLANT	255, 104	151, 436			406, 540	1
9.00 00900 HOUSEKEEPI NG	165, 824	84, 654			250, 478	
16.00 01600 MEDI CAL RECORDS & LI BRARY	413, 629	143, 705	557, 33	4 0	557, 334	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	2, 105, 658	977, 317	3, 082, 97	5 0	3, 082, 975	30.00
ANCI LLARY SERVICE COST CENTERS	1					
60. 00 06000 LABORATORY	0	114, 740	114, 74	0 0	114, 740	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	120, 451	120, 45	1 0	120, 451	73.00
OUTPATIENT SERVICE COST CENTERS	T					
90. 00 09000 CLINIC	3, 679, 513	2, 672, 611	6, 352, 12	4 0	6, 352, 124	90.00
SPECIAL PURPOSE COST CENTERS	T					
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	9, 483, 350	7, 025, 566	16, 508, 91	6 0	16, 508, 916	118.00
NONREI MBURSABLE COST CENTERS	T			- 1		
194. 00 07950 RESI DENTI AL	1,062,510	1, 480, 050			2, 542, 560	1
194.01 07951 OTHER NONREI MBURSABLE COST CENTERS	3, 412, 180	2,012,362			5, 424, 542	
194.0207952 FQHC - MARRAM	3, 672, 106	2, 245, 217			5, 917, 323	
200.00 TOTAL (SUM OF LINES 118 through 199)	17, 630, 146	12, 763, 195	30, 393, 34	1 0	30, 393, 341	200.00

Health Financial Systems	PORTER-STARKE	SERVICES, INC		In Lieu	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	OF EXPENSES	Provider CC	CN: 15-4052	Peri od:	Worksheet A
				From 07/01/2021 To 06/30/2022	Date/Time Prepared: 11/28/2022 2:27 pm
Cost Center Description	Adjustments	Net Expenses			
	(See A-8)	For			
		Allocation			
	6.00	7.00			
GENERAL SERVICE COST CENTERS					
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	-283, 136				1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	480, 067			4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	-601, 625				5.00
7.00 00700 OPERATION OF PLANT	-5, 336				7.00
9. 00 00900 HOUSEKEEPI NG	0	250, 478			9.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	557, 334			16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS	-335, 620	2, 747, 355			30.00
ANCI LLARY SERVICE COST CENTERS	-				
60. 00 06000 LABORATORY	0	114, 740			60.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0			71.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS	0	120, 451			73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	-2, 023, 332	4, 328, 792			90.00
SPECIAL PURPOSE COST CENTERS					
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-3, 249, 049	13, 259, 867			118.00
NONREI MBURSABLE COST CENTERS					
194. 00 07950 RESI DENTI AL	0	2, 542, 560			194.00
194.0107951 OTHER NONREI MBURSABLE COST CENTERS	0	5, 424, 542			194.01
194.0207952 FQHC - MARRAM	0	5, 917, 323			194.02
200.00 TOTAL (SUM OF LINES 118 through 199)	-3, 249, 049	27, 144, 292			200.00

Heal th	Financial Systems	I Systems PORTER-STARKE SERVICES, INC					In Lieu of Form CMS-2552-10		
RECLASS	SI FI CATI ONS			Provider (CCN: 15-4052	Period: From 07/01/2021	Worksheet A-	6	
							Date/Time Pr 11/28/2022 2	epared: :27 pm	
		Increases							
	Cost Center	Line #	Sal ary	0ther					
	2.00	3.00	4.00	5.00					
	A – DEFAULT								
1.00		0.00	0	0				1.00	
	0		0	0					
500.00	Grand Total: Increases		0	0				500.00	
	1				1				

Heal th	Financial Systems		PORTER-STARKE	SERVICES, INC		In Lieu	u of Form CMS-	2552-10
RECLASS	SI FI CATI ONS			Provi der	CCN: 15-4052	Period: From 07/01/2021	Worksheet A-0	6
					_		Date/Time Pre 11/28/2022 2:	epared: 27 pm
		Decreases						
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref	·.		
	6.00	7.00	8.00	9.00	10.00			
	A – DEFAULT							
1.00		0.00	0	()	0		1.00
	0		0	()			
500.00	Grand Total: Decreases		0	()			500.00

Heal th	Financial Systems	PORTER-STARKE S	SERVICES, INC		In Lie	eu of Form CMS-2	2552-10
	ILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 07/01/2021 To 06/30/2022		pared:
				Acquisition			
		Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	F BALANCES					
1.00	Land	965, 693	176, 000		0 176,000	0	1.00
2.00	Land Improvements	741, 665	26, 528		0 26, 528	0	2.00
3.00	Buildings and Fixtures	11, 483, 776	649, 369		0 649, 369	0	3.00
4.00	Building Improvements	0	0		0 0	0	4.00
5.00	Fixed Equipment	4, 573, 276	55, 058		0 55, 058	0	5.00
6.00	Movable Equipment	0	0		0 0	0	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	17, 764, 410	906, 955		0 906, 955	0	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	17, 764, 410	906, 955		0 906, 955	0	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	F BALANCES					
1.00	Land	1, 141, 693	0				1.00
2.00	Land Improvements	768, 193	0				2.00
3.00	Buildings and Fixtures	12, 133, 145	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	4, 628, 334	0				5.00
6.00	Movable Equipment	0	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	18, 671, 365	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	18, 671, 365	0				10.00

Health Financial Systems	PORTER-STARKE S	SERVICES, INC		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-4052	Period: From 07/01/2021	Worksheet A-7 Part II	
				To 06/30/2022		
		SL	JMMARY OF CAP	I TAL	11/20/2022 2.	
Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
				(see	instructions)	
				instructions)		
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WO	RKSHEET A, COLUN	MN 2, LINES 1 a	and 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	669, 869	0		0 0	0	1.00
3.00 Total (sum of lines 1-2)	669, 869	0		0 0	0	3.00
	SUMMARY 0	F CAPI TAL				
Cost Center Description	Other	Total (1)				
	Capi tal -Rel at					
	ed Costs (see	9 through 14)				
	instructions)					
	14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WO	RKSHEET A, COLUN	<u>/N 2, LINES 1 a</u>	and 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	669, 869				1.00
3.00 Total (sum of lines 1-2)	0	669, 869				3.00

Health Financial Systems	PORTER-STARKE	SERVICES, INC		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 07/01/2021 To 06/30/2022		pared:
	COMF	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS		•			
1.00 NEW CAP REL COSTS-BLDG & FIXT	18, 671, 364	0	18, 671, 36	4 1.000000	0	1.00
3.00 Total (sum of lines 1-2)	18, 671, 364		18, 671, 36	4 1.000000	0	3.00
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at				
		ed Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C			1			
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	-		0 669, 869		1.00
3.00 Total (sum of lines 1-2)	0	0		0 669, 869	-283, 136	3.00
		SL	JMMARY OF CAPI			
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)			
		instructions)		ed Costs (see instructions)	9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					_
1.00 NEW CAP REL COSTS-BLDG & FIXT	0			0 0	,	1.00
3.00 Total (sum of lines 1-2)	0	0	1 0	0 0	386, 733	3.00

	Financial Systems		PORTER-STARKE			u of Form CMS-2	
ADJUSTI	MENTS TO EXPENSES				eriod: rom 07/01/2021	Worksheet A-8	
					06/30/2022	Date/Time Pre 11/28/2022 2:	pared: 27 pm
				Expense Classification on To/From Which the Amount is			27 pm
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Ínvestment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
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
	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Tel ephone services (pay stations excluded) (chapter 21)		0		0. 00	0	7.00
	Tel evision and radio service (chapter 21)		0		0.00	0	8.00
	Parking lot (chapter 21) Provider-based physician	A-8-2	0 -1, 559, 977		0.00	0 0	
11. 00	adjustment Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	
15.00	Cafeteria-employees and guests Rental of quarters to employee and others		0		0.00 0.00	0 0	
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
17.00	patients Sale of drugs to other than patients		0		0.00	0	17.00
	Sale of medical records and		0		0.00	0	18.00
	abstracts Nursing and allied health education (tuition, fees,		0		0. 00	0	19.00
20. 00	books, etc.) Vending machines		0		0.00	0	20.00
	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0. 00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	Ο	22.00
	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	66.00		24.00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
26. 00	(chapter 21) Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-BLDG &	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	FIXT *** Cost Center Deleted ***	2.00	0	27.00
	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant	A-8-3	0	*** Cost Center Deleted ***	0.00		29.00 30.00
	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-0-3			67.00		
	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDI ATRI CS	30.00		30.99

In Lieu of Form CMS-2552-10 Worksheet A-8

ADJUST	ADJUSTMENTS TO EXPENSES			Period: From 07/01/2021	Worksheet A-8		
					To 06/30/2022	Date/Time Pre 11/28/2022 2:	
	·			Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		(2)	0.00	2.00	4.00	Ref.	
21 00	Adjustment for speech	1.00 A-8-3	2.00	3.00 *** Cost Center Deleted ***	4.00	5.00	31.00
31.00	Adjustment for speech	A-8-3	0	Cost Center Dereted	68.00		31.00
	pathology costs in excess of limitation (chapter 14)						
32,00			0		0.00	0	32.00
32.00	Depreciation and Interest		0		0.00	0	32.00
33.00	LEASE INCOME	В	-280 016	NEW CAP REL COSTS-BLDG &	1.00	10	33.00
55.00		D		FIXT	1.00	10	33.00
33. 01	PHONE INCOME	В		ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	OTHER INC MISC	В		ADMI NI STRATI VE & GENERAL	5.00	0	
33.03	OTHER INC MISC	В		OPERATION OF PLANT	7.00	0	
33.04	OTHER INC MISC	В		ADULTS & PEDIATRICS	30.00	0	1
33.05	OTHER INC MISC	В	-13, 982		90.00	0	
33.06	OTHER SALARY REIMBURSEMENT	В	-5, 227	OPERATION OF PLANT	7.00	0	33.06
33.07	OTHER INCOME PORTER HOSPITAL	В	-120, 000	ADULTS & PEDIATRICS	30.00	0	33.07
33.08	COMMUNITY RELATIONS	А	-14, 365	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	COMMUNITY RELATIONS	A	0	ADULTS & PEDIATRICS	30.00	0	33.09
33.10	COMMUNITY RELATIONS	A	0	CLINIC	90.00	0	001.10
33.11	HOSPITAL ASSESSMENT FEES	A	-664, 832		90.00	0	
33.12	PROMOTIONAL ADVERTISING	A		ADMINISTRATIVE & GENERAL	5.00		
33.14		В		ADMI NI STRATI VE & GENERAL	5.00		
33.15	INTEREST OFFSET	A		NEW CAP REL COSTS-BLDG &	1.00	10	33.15
				FIXT			
33.16		A		ADMINISTRATIVE & GENERAL	5.00	0	000
50.00	TOTAL (sum of lines 1 thru 49)		-3, 249, 049				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						1

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Syste	ms	PORTER-STARKE	SERVICES, INC		In Lie	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSICI	AN ADJUSTMENT		Provider (CCN: 15-4052	Period:	Worksheet A-8	3-2
						From 07/01/2021 To 06/30/2022		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remunerati on	Component	Component		ider Component	
	1.00	2.00	3.00	4,00	5.00	6.00	Hours 7.00	
1.00		ADULTS & PEDIATRICS	388, 478	138, 029	250, 44			1.00
2.00	90.000		2, 487, 318	1, 055, 237	1, 432, 08			
3.00	0.00		2, 107, 010	1,000,207	1, 102, 00		0	
4.00	0, 00		0	0	(-	
5.00	0.00		0	0	(0 0	0	5.00
6.00	0.00		0	0	(o o	0	6.00
7.00	0.00		0	0	(0 0	0	7.00
8.00	0.00		0	0	(0 0	0	8.00
9.00	0.00		0	0	(0 0	0	9.00
10.00	0.00		0	0	(-	0	10.00
200.00			2, 875, 796					200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
	1.00	2.00	8.00	9.00	Education 12.00	12 13.00	14.00	
1.00		ADULTS & PEDIATRICS	173,019	9.00		0 0		1.00
2.00	90.000		1, 142, 800	57, 140				
3.00	0.00		1, 142, 000	0			0	
4.00	0, 00		0	0			0	
5.00	0, 00		0	0	(0	
6.00	0, 00		0	0	(0 0	0	6.00
7.00	0.00		0	0	(0 0	0	
8.00	0.00		0	0	(o o	0	8.00
9.00	0.00		0	0	(0 0	0	9.00
10.00	0.00		0	0	(0 0	0	
200.00			1, 315, 819	65, 791			0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14 15.00	16.00	17.00	18.00		
1.00		ADULTS & PEDIATRICS	15.00	173, 019				1.00
2.00	90.000		0		289, 28			2.00
3.00	0.00		0	0	207,20			3.00
4.00	0, 00		0	0	(4.00
5.00	0.00		0	0	(5.00
6.00	0.00		0	0	(0 0		6.00
7.00	0.00		0	0	(0 0		7.00
8.00	0.00		0	0	(0 0		8.00
9.00	0.00		0	0	(0 0		9.00
10.00	0.00		0	0	(°		10.00
200.00			0	1, 315, 819	366, 71	1, 559, 977		200.00

lealth Financial Systems	PORTER-STARKE	SERVICES, INC		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 07/01/2021 To 06/30/2022	Worksheet B Part I Date/Time Pre 11/28/2022 2:	
		CAPI TAL				
		RELATED COSTS				
Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI V	
	for Cost	FLXT	BENEFITS		E & GENERAL	
	Allocation		DEPARTMENT			
	(from Wkst A					
	col. 7)					
	0	1.00	4.00	4A	5.00	
GENERAL SERVICE COST CENTERS	001 700	00/ 700		-		
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	386, 733					1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	480, 067					4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	3, 872, 713					5.00
7.00 00700 OPERATION OF PLANT	401, 204					
9. 00 00900 HOUSEKEEPI NG	250, 478					
16. 00 01600 MEDICAL RECORDS & LIBRARY	557, 334	5, 174	11, 53	574, 038	101, 538	16.00
30. 00 03000 ADULTS & PEDIATRICS	2, 747, 355	47, 824	58, 69	2, 853, 874	504, 802	30.00
ANCI LLARY SERVICE COST CENTERS	2, 141, 300	47,024	30,05	2,003,074	304, 802	30.00
60. 00 06000 LABORATORY	114, 740	0		0 114, 740	20, 296	60.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	20, 270	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	120, 451	0		0 120, 451	21, 306	
OUTPATIENT SERVICE COST CENTERS	120, 431	0		120,401	21, 300	/ 5.00
90. 00 09000 CLINIC	4, 328, 792	55, 059	102, 56	4, 486, 413	793, 570	90.00
SPECIAL PURPOSE COST CENTERS	1,020,772		102,00	1, 100, 110	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10100
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 13, 259, 867	254, 123	256, 75	12, 900, 165	1, 560, 186	118.00
NONREI MBURSABLE COST CENTERS						
194. 0007950 RESIDENTIAL	2, 542, 560	51, 239	29, 61	7 2, 623, 416	464, 038	194.00
194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS	5, 424, 542					
194.0207952 FQHC - MARRAM	5, 917, 323		102, 36			
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)						

Health Financial Systems	PORTER-STARKE S	SERVICES, INC		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 07/01/2021 To 06/30/2022	Worksheet B Part I Date/Time Pre 11/28/2022 2:	epared: 27 pm
Cost Center Description	OPERATI ON OF PLANT	HOUSEKEEPI NG	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	7.00	9.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FLXT 4.00 00400 EMPLOYEE BENEFLTS DEPARTMENT 5.00 00500 ADMLNI STRATI VE & GENERAL						1.00 4.00 5.00
7.00 00700 OPERATION OF PLANT	484, 764					7.00
9. 00 00900 HOUSEKEEPI NG	7, 755					9.00
16.00 01600 MEDICAL RECORDS & LIBRARY	10, 255			1		16.00
INPATIENT ROUTINE SERVICE COST CENTERS		•, • = •	,	·		
30. 00 03000 ADULTS & PEDI ATRI CS	94, 788	62, 114	108, 15	4 3, 623, 732	0	30.00
ANCI LLARY SERVICE COST CENTERS					-	
60. 00 06000 LABORATORY	0	0	6, 16	8 141, 204	0	60.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	1
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	6, 47	6 148, 233	0	73.00
OUTPATI ENT SERVI CE COST CENTERS						
90. 00 09000 CLINIC	109, 129	71, 512	166, 35	6 5, 626, 980	0	1 90. 00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	221, 927	140, 346	287, 15	4 9, 540, 149	0	1118.00
NONREI MBURSABLE COST CENTERS						
194. 00 07950 RESIDENTIAL	101, 557	66, 550	77, 93	7 3, 333, 498	0	194.00
194.0107951 OTHER NONREI MBURSABLE COST CENTERS	69, 643					194.01
194.0207952 FQHC - MARRAM	91, 637	60, 050			0	194.02
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	484, 764	312, 583	692, 55	1 27, 144, 292		202.00
			•			

Heal th	Financial Systems	PORTER-STARKE SE	RVICES, INC	In Lieu of Form CM	S-2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-4052	Period: Worksheet E From 07/01/2021 Part I To 06/30/2022 11/28/2022	Prepared:
	Cost Center Description	Total 26.00			
	GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500 ADMI NI STRATI VE & GENERAL				5.00
7.00	00700 OPERATION OF PLANT				7.00
9.00	00900 HOUSEKEEPI NG				9.00
16.00	01600 MEDICAL RECORDS & LIBRARY				16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	3, 623, 732			30.00
	ANCILLARY SERVICE COST CENTERS				
60.00	06000 LABORATORY	141, 204			60.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	148, 233			73.00
	OUTPATIENT SERVICE COST CENTERS				
	09000 CLINIC	5, 626, 980			90.00
	SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	9, 540, 149			118.00
	NONREIMBURSABLE COST CENTERS				
194.00	07950 RESI DENTI AL	3, 333, 498			194.00
194.01	07951 OTHER NONREI MBURSABLE COST CENTERS	6, 791, 046			194.01
194.02	07952 FQHC - MARRAM	7, 479, 599			194.02
200.00	Cross Foot Adjustments	0			200.00
201.00	Negative Cost Centers	0			201.00
202.00	TOTAL (sum lines 118 through 201)	27, 144, 292			202.00

Health Financial Systems	PORTER-STARKE	SERVICES, INC		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO	F	Period: From 07/01/2021 To 06/30/2022	Worksheet B Part II Date/Time Pre 11/28/2022 2:	pared: 27 pm
Cost Center Description	Directly Assigned New	CAPI TAL RELATED COSTS NEW BLDG & FI XT	Subtotal	BENEFITS	ADMI NI STRATI V E & GENERAL	
	Capital Related Costs 0	1.00	2A	DEPARTMENT	5.00	
GENERAL SERVICE COST CENTERS	0	1.00	ZA	4.00	5.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	3, 779	3, 779	3, 779		4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	0	134, 784				4.00 5.00
7. 00 00700 OPERATION OF PLANT	0	3, 590				7.00
9. 00 00900 HOUSEKEEPING	0	3, 913				
16. 00 01600 MEDICAL RECORDS & LIBRARY	0					16.00
INPATIENT ROUTINE SERVICE COST CENTERS	0	5,174	5,174	70	5, 300	10.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	47, 824	47, 824	459	16, 747	30.00
ANCI LLARY SERVICE COST CENTERS	0	47,024	47,024	437	10,747	30.00
60. 00 06000 LABORATORY	0	0	C	0	673	60.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-		-	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	707	73.00
OUTPATIENT SERVICE COST CENTERS	-	-	-			
90. 00 09000 CLINIC	0	55, 059	55, 059	796	26, 326	90.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	254, 123	254, 123	2, 002	51, 758	118.00
NONREI MBURSABLE COST CENTERS						
194. 00 07950 RESI DENTI AL	0	51, 239	51, 239	232	15, 394	194.00
194.0107951 OTHER NONREI MBURSABLE COST CENTERS	0	35, 137	35, 137	744	32, 596	194.01
194.0207952 FQHC - MARRAM	0	46, 234	46, 234	801	35, 601	194.02
200.00 Cross Foot Adjustments			C)		200.00
201.00 Negative Cost Centers		0	C	0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	386, 733	386, 733	3, 779	135, 349	202.00

ALLOCATION OF CAPITAL RELATED COSTS Provider CN: 15-4052 Period: From 07/01/2021 To 06/30/2022 Worksheet B Part II Date/Time Prepared: 12/22/222 2: 27 pm Cost Center Description OPERATION OF PLANT HOUSEKEEPING PLANT MEDICAL RECORDS & LIBRARY Subtotal Records & LIBRARY Intern & Records & LIBRARY Intern & Records & LIBRARY GENERAL SERVICE COST CENTERS 7.00 9.00 16.00 24.00 25.00 0.00 00000 EMPLOYEE BENFFITS DEPARTMENT 5.00 0.00 6.063 5.00 5.00 0.00 00000 CMUSKEEPING 97 5.566 9.00 1.00 16.00 01600 MEDICAL RECORDS & LIBRARY 128 1.20 8.880 10.00 16.00 00000 LABRATRICE COST CENTERS 1.186 1.106 30.00 30.00 00 00000 LABRATRICE COST CENTERS 0 0 71.00 71.00 16.00 1.00 1.106 1.388 68,710 0 0 00 0.00 0 0 79 752 0 0 10.00 00000 LABRATRICE COST CENTERS	Health Financial Systems	PORTER-STARKE	SERVICES, INC		In Lieu	u of Form CMS-	2552-10
PLANT PLANT RECORDS & LIBRARY Residents Cost & Post Stepdown Adjustments 1.00 00100 NEW CAP REL COST CENTERS 7.00 9.00 16.00 24.00 25.00 6ENERAL SERVICE COST CENTERS 7.00 9.00 16.00 24.00 25.00 000100 NEW CAP REL COSTS-BLDG & FIXT 1.00 4.00 0.0000 MEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 0.0000 MEW CAP REL COST SUPPARTMENT 0.00 0.00 0.00 5.00 9.00 00000 DUSCKEPI NG 9.7 5.566 9.00 9.00 16.00 1600 BEDI CAL RECORDS & LIBRARY 128 120 8.880 16.00 16.00 01600 MEDI CAL RECORDS & LIBRARY 128 1.006 1.388 68.710 0 0.00 02000 AUDIT NE SERVICE COST CENTERS 0 0 0 0 0 0 7.3.00 0.00 0000 CAL ABCRATORY 0 0 79 752 0 60.00 1.00 0.00 0 0 0 0 0	ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		From 07/01/2021	Part II Date/Time Pre	
GENERAL SERVICE COST CENTERS 1 0	Cost Center Description		HOUSEKEEPI NG	RECORDS &	Subtotal	Residents Cost & Post Stepdown	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMI NI STRATI VE & GENERAL 7 7.00 00700 OPERATION OF PLANT 6.063 9.00 00000 HOUSEKEEPI NG 97 9.00 00000 HOUSEKEEPI NG 97 30.00 00000 ADULTS & PEDIATRICS 1.186 1.00 ANCILLARY SERVICE COST CENTERS 1.186 1.106 30.00 00000 LABORATORY 0 0 71.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 00000 CABORATORY 1.365 1.273 2.135 86.954 0 00000 DOUTON 1.365 1.273 2.135 86.954 0 0 00000 SPECI AL PURPOSE COST CENTERS 1.365 1.273 2.135 86.954 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		7.00	9.00	16.00	24.00	25.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINI STRATI VE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 6,063 5.00 7.00 00900 HOUSEKEEPI NG 97 5,566 9.00 16.00 01600 MEDI CAL RECORDS & LIBRARY 128 120 8,880 16.00 1NPATI ENT ROUTINE SERVICE COST CENTERS 1,186 1,106 1,388 68,710 0 30.00 03000 ADULTS & PEDI ATRICS 1,186 1,106 1,388 68,710 0 60.00 06000 LABORATORY 0 0 71.00 0 0 0 0 0 73.00 71.00 7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 73.00 0 73.00 0 73.00 0 73.00 0 73.00 0 <td>GENERAL SERVICE COST CENTERS</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	GENERAL SERVICE COST CENTERS						
7.00 00700 OPERATION OF PLANT 6,063 7.00 9.00 00900 HOUSEKEEPING 97 5,566 9.00 16.00 1600 MEDI CAL RECORDS & LIBRARY 128 120 8,880 16.00 19.00 03000 ADULTS & PEDI ATRICS 1,186 1,106 1,388 68,710 0 30.00 03000 ADULTS & PEDI ATRICS 1,186 1,106 1,388 68,710 0 0 40.00 06000 LABORATORY 0 0 79 752 0 60.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 73.00 90.00 039000 CLINIC 1,365 1,273 2,135 86,954 0 90.00 90.00 SPECI AL PURPOSE COST CENTERS 1,365 1,273 2,499 3,685 157,206 0 18.00 NORREI MBURSABLE COST CENTERS 1,270 1,185 1,000 70,320 194.00 194.01 194.01 194.02 194.02 07952 FRI ENDIRAM 1,146<	4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
9.00 00900 HOUSEKEEPING 97 5,566 9.00 16.00 MODI CAL RECORDS & LIBRARY 128 120 8,880 16.00 INPATI ENT ROUTINE SERVICE COST CENTERS 1,186 1,106 1,388 68,710 0 30.00 30.00 03000 ADULTS & PEDIATRICS 1,186 1,106 1,388 68,710 0 30.00 ANCILLARY SERVICE COST CENTERS 0 0 79 752 0 60.00 71.00 0 0 0 71.00 73.00 0 0 0 0 71.00 73.00 0 73.00 0 73.00 0 73.00	7.00 00700 OPERATION OF PLANT	6,063					1
16.00 01600 MEDI CAL RECORDS & LI BRARY 128 120 8,880 16.00 INPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 03000 (ADULTS & PEDI ATRI CS 1,186 1,106 1,388 68,710 0 ANCI LLARY SERVICE COST CENTERS 0 0 79 752 0 60.00 0 00000 (LABORATORY 0 0 0 0 71.00 71.00 07300 (DRUGS CHARGED TO PATI ENTS 0 0 0 73.00 0 07300 (DRUGS CHARGED TO PATI ENTS 0 0 0 73.00 0 00000 (CLI NI C 1,365 1,273 2,135 86,954 0 90.00 090000 (CLI NI C 1,365 1,273 2,499 3,685 157,206 0 118.00 NORREI MBURSABLE COST CENTERS 1,270 1,185 1,000 70,320 0 194.00 194.01 07952 RESI DENTI AL 1,270 1,185 1,000 70,320 0 194.01 194.02 07952 FGHC - MARAM 1,146 1,069 2,419 87,270			5 566				
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 1, 186 1, 106 1, 388 68, 710 0 30. 00 ANCI LLARY SERVI CE COST CENTERS 0 0 79 752 0 60. 00 60. 00 06000 LABORATORY 0 0 79 752 0 60. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 73. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 83 790 0 73. 00 00 0000 CLI NI C 1, 365 1, 273 2, 135 86, 954 0 90. 00 90. 00 SPECI AL PURPOSE COST CENTERS 1, 365 1, 273 2, 135 86, 954 0 90. 00 118. 00 SPECI AL PURPOSE COST CENTERS 1, 270 1, 185 1, 000 70, 320 0 194. 00 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 871 813 1, 776 71, 937 0 194. 01				8 88	0		
30. 00 03000 ADULTS & PEDIATRICS 1, 186 1, 106 1, 388 68, 710 0 30. 00 ANCI LLARY SERVICE COST CENTERS 0 0 79 752 0 60. 00 60. 00 04000 LABORATORY 0 <t< td=""><td></td><td></td><td>1</td><td>-,</td><td>-</td><td></td><td></td></t<>			1	-,	-		
ANCI LLARY SERVICE COST CENTERS 60.00 06000 LABORATORY 0 0 79 752 0 60.00 71.00 OTIO0 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 71.00 73.00 O7300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 71.00 73.00 OT300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 73.00 OUTPATI ENT SERVICE COST CENTERS 0 0 0 83 790 0 73.00 90.00 CLI NI C 1,365 1,273 2,135 86,954 0 90.00 SPECIAL PURPOSE COST CENTERS 1 1,365 1,273 2,499 3,685 157,206 0 118.00 NONREI MBURSABLE COST CENTERS 1,270 1,185 1,000 70,320 0 194.00 194.01 07950 RESI DENTI AL 1,270 1,185 1,000 70,320 0		1, 186	1, 106	1.38	8 68, 710	0	30.00
60.00 06000 LABORATORY 0 0 79 752 0 60.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 83 790 0 73.00 00 09000 CLINIC 1,365 1,273 2,135 86,954 0 90.00 90.00 09000 CLINIC 1,365 1,273 2,499 3,685 157,206 0 118.00 NONREL MBURSABLE COST CENTERS 118.00 70950 RESI DENTI AL 1,270 1,185 1,000 70,320 0 194.00 194.00 07950 RESI DENTI AL 1,270 1,185 1,000 70,320 0 194.01 194.02 07952 FOHC - MARRAM 1,146 1,069 2,419 87,270 0 194.01 194.02		.,	.,	.,			
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 71.00 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 83 790 0 73.00 0UTPATIENT SERVICE COST CENTERS 0 0 1,365 1,273 2,135 86,954 0 90.00 SUBTOTALS (SUM OF LINES 1 through 117) 2,776 2,499 3,685 157,206 0 118.00 NONREI MBURSABLE COST CENTERS 1,270 1,185 1,000 70,320 194.00 194.01 194.00 07950 RESI DENTI AL 1,270 1,185 1,000 70,320 194.01 194.02 07952 FOHC - MARRAM 1,146 1,069 2,419 87,270 0 194.01 194.02 07952 FOHC - MARRAM 1,146 1,069 2,419 87,270 0 194.02 200.00 Cross Foot Adj ustments 0 0 0 0 0 200.00		0	0	7	9 752	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 83 790 0 73.00 OUTPATIENT SERVICE COST CENTERS 0 0 83 790 0 73.00 0 90.00 0000 CLINIC 1,365 1,273 2,135 86,954 0 90.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 2,776 2,499 3,685 157,206 0 118.00 NONREI MBURSABLE COST CENTERS 194.00 07950 RESI DENTIAL 1,270 1,185 1,000 70,320 0 194.01 194.01 07950 RESI DENTIAL 1,270 1,185 1,000 70,320 0 194.01 194.02 07952 FOHC - MARRAM 1,146 1,069 2,419 87,270 0 194.02 200.00 Cross Foot Adj ustments 0 0 0 0 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00 <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td>0</td> <td></td>		0	0			0	
OUTPATI ENT SERVICE COST CENTERS 0 0 0 90.00 0 0000 CLINIC 1,365 1,273 2,135 86,954 0 90.00 SPECIAL PURPOSE COST CENTERS 1 2,776 2,499 3,685 157,206 0 118.00 NONREI MBURSABLE COST CENTERS 1 1,270 1,185 1,000 70,320 0 194.00 194.00 07950 RESI DENTIAL 1,270 1,185 1,000 70,320 0 194.00 194.01 07951 0THER NONREI MBURSABLE COST CENTERS 871 813 1,776 71,937 0 194.01 194.02 07952 FOHC - MARRAM 1,146 1,069 2,419 87,270 0 194.02 200.00 Cross Foot Adj ustments 0		0	0	8	3 790	0	73.00
90.00 09000 CLINIC 1,365 1,273 2,135 86,954 0 90.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 2,776 2,499 3,685 157,206 0 118.00 NONREI MBURSABLE COST CENTERS 194.00 07950 RESI DENTI AL 1,270 1,185 1,000 70,320 0 194.01 194.01 07951 OTHER NONREI MBURSABLE COST CENTERS 871 813 1,776 71,937 0 194.01 194.02 07952 FQHC - MARRAM 1,146 1,069 2,419 87,270 0 194.02 200.00 Cross Foot Adj ustments 0 0 0 0 0 200.00 201.00 Negati ve Cost Centers 0 0 0 0 0 201.00					<u> </u>		
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 2,776 2,499 3,685 157,206 0 194.00 07950 RESI DENTI AL 1,270 1,185 1,000 70,320 0 194.00 194.01 07951 OTHER NONREI MBURSABLE COST CENTERS 871 813 1,776 71,937 0 194.01 194.02 07952 FOHC - MARRAM 1,146 1,069 2,419 87,270 0 194.02 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00		1, 365	1, 273	2, 13	5 86, 954	0	90.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 2,776 2,499 3,685 157,206 0 118.00 NONREI MBURSABLE COST CENTERS 1,270 1,185 1,000 70,320 0 194.00 194.01 07950 RESI DENTI AL 1,270 1,185 1,000 70,320 0 194.00 194.02 07952 FOHC - MARRAM 1,146 1,069 2,419 87,270 0 194.01 200.00 Cross Foot Adj ustments 0 0 0 0 200.00 0 0 0 0 200.00	SPECIAL PURPOSE COST CENTERS		· · · · · ·		i		1
NONREI MBURSABLE COST CENTERS 194. 00 07950 RESI DENTI AL 1, 270 1, 185 1, 000 70, 320 0 194. 00 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 871 813 1, 776 71, 937 0 194. 01 194. 02 07952 FQHC - MARRAM 1, 146 1, 069 2, 419 87, 270 0 194. 02 200. 00 Cross Foot Adj ustments 0 0 0 0 200. 00 201. 00 Negati ve Cost Centers 0 0 0 0 201. 00		2,776	2, 499	3, 68	5 157, 206	0	1118.00
194.01 07951 0THER NONREI MBURSABLE COST CENTERS 871 813 1,776 71,937 0 194.01 194.02 07952 FOHC - MARRAM 1,146 1,069 2,419 87,270 0 194.02 200.00 Cross Foot Adjustments 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00					· · · · · · ·		
194. 01 07951 0THER NONREI MBURSABLE COST CENTERS 871 813 1,776 71,937 0 194. 01 194. 02 07952 FOHC - MARRAM 1,146 1,069 2,419 87,270 0 194. 02 200. 00 Cross Foot Adjustments 0 0 0 0 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 201. 00	194, 00 07950 RESI DENTI AL	1,270	1, 185	1,00	0 70, 320	0	194.00
194.02 07952 FOHC - MARRAM 1,146 1,069 2,419 87,270 0 194.02 200.00 Cross Foot Adjustments 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00							
200.00 Cross Foot Adjustments 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00	194.0207952 FQHC - MARRAM	1, 146	1,069	2, 41	9 87, 270	0	194.02
201.00 Negative Cost Centers 0 0 0 0 0 0 201.00	200.00 Cross Foot Adjustments				0	0	200.00
		0	О		0 0		
		6, 063	5, 566	8, 88	386, 733	0	202.00

					0550 40
	· · · · J · · · ·	PORTER-STARKE SE		In Lieu of Form CMS	-2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CCN: 15-4052	Period: Worksheet B	
				From 07/01/2021 Part II To 06/30/2022 Date/Time Pr	oparod
					2:27 pm
	Cost Center Description	Total			
		26.00			
	GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500 ADMINI STRATI VE & GENERAL				5.00
7.00	00700 OPERATION OF PLANT				7.00
9.00	00900 HOUSEKEEPI NG				9.00
16.00	01600 MEDICAL RECORDS & LIBRARY				16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	· ·			
30.00	03000 ADULTS & PEDIATRICS	68, 710			30.00
	ANCILLARY SERVICE COST CENTERS	· ·			
60.00	06000 LABORATORY	752			60.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	790			73.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	86, 954			90.00
	SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	157, 206			118.00
	NONREIMBURSABLE COST CENTERS				
194.00	07950 RESIDENTIAL	70, 320			194.00
194.01	07951 OTHER NONREI MBURSABLE COST CENTERS	71, 937			194.01
194.02	07952 FQHC - MARRAM	87, 270			194.02
200.00	Cross Foot Adjustments	0			200.00
201.00	Negative Cost Centers	0			201.00
202.00	TOTAL (sum lines 118 through 201)	386, 733			202.00

		PORTER-STARKE S				J of Form CMS-2552-	
COST ALLO	CATION - STATISTICAL BASIS		Provider C		Period: From 07/01/2021	Worksheet B-1	
					To 06/30/2022	Date/Time Pre 11/28/2022 2:	
		CAPI TAL					
	Cost Center Description	RELATED COSTS NEW BLDG &	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	OPERATION OF	
	best benter beschiption	FLXT	BENEFITS	n	E & GENERAL	PLANT	
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
		FEET)	(GROSS		COST)	FEET)	
			SALARI ES)				
051		1.00	4.00	5A	5.00	7.00	
	IERAL SERVICE COST CENTERS	75, 416		1			1 1.00
	100 EMPLOYEE BENEFITS DEPARTMENT	737	17, 357, 864				4.00
	00 ADMINI STRATI VE & GENERAL	26, 284	2, 591, 340		1 23, 064, 561		5.00
	700 OPERATION OF PLANT	700	2, 371, 340		0 411, 905	47,695	
	200 HOUSEKEEPING	763	165, 824		0 259, 013	763	
	600 MEDICAL RECORDS & LIBRARY	1,009	413, 629		0 574,038	1,009	
	PATIENT ROUTINE SERVICE COST CENTERS	.,		I		.,	1
30.00 030	000 ADULTS & PEDI ATRI CS	9, 326	2, 105, 658		0 2, 853, 874	9, 326	30. 00
	CILLARY SERVICE COST CENTERS						
	DOO LABORATORY	0	0		0 114, 740	0	
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	1
73.00 073	BOO DRUGS CHARGED TO PATIENTS	0	0		0 120, 451	0	73.00
	PATIENT SERVICE COST CENTERS	10 707	2 (70 512		0 4 404 410	10 707	
90.00 090	CIAL PURPOSE COST CENTERS	10, 737	3, 679, 513		0 4, 486, 413	10, 737	90.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	49, 556	9, 211, 068	-4, 079, 73	1 8, 820, 434	21, 835	1118 00
	IREI MBURSABLE COST CENTERS	47, 330	9,211,000	-4,077,73	0, 020, 434	21,033	110.00
	P50 RESIDENTIAL	9, 992	1,062,510		0 2, 623, 416	9 992	194.00
	251 OTHER NONREI MBURSABLE COST CENTERS	6, 852	3, 412, 180		0 5, 554, 794		194.01
194.02079	952 FQHC - MARRAM	9,016	3, 672, 106		0 6, 065, 917		194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	386, 733	483, 846		4, 079, 731	484, 764	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	5. 127997	0. 027875		0. 176883	10. 163833	203.00
204.00	Cost to be allocated (per Wkst. B,		3, 779		135, 349		204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part		0. 000218		0. 005868	0. 127120	205.00
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

Health Financial Sy		PORTER-STARKE SI			In Lie	In Lieu of Form CMS-2552-1		
COST ALLOCATION -	STATI STI CAL BASI S		Provider CO	CN: 15-4052	Period: From 07/01/2021 To 06/30/2022			
Coot C	onton Doconinti on	HOUSEKEEPING	MEDI CAL			11/28/2022 2: 27	<u>/ pm</u>	
COST C	enter Description	(SQUARE	RECORDS &					
		FEET)	LI BRARY					
			(GROSS					
			CHARGES)					
		9.00	16.00					
GENERAL SERV	ICE COST CENTERS			•				
1.00 00100 NEW CA	P REL COSTS-BLDG & FIXT						1.00	
4.00 00400 EMPLOY	EE BENEFITS DEPARTMENT						4.00	
	STRATIVE & GENERAL						5.00	
7.00 00700 OPERAT	ION OF PLANT						7.00	
9.00 00900 HOUSEK	EEPI NG	46, 932					9.00	
	L RECORDS & LIBRARY	1, 009	18, 630, 774			1	16.00	
	UTINE SERVICE COST CENTERS							
30.00 03000 ADULTS		9, 326	2, 909, 546			3	30.00	
	RVICE COST CENTERS	,						
60.00 06000 LABORA		0	165, 944				60.00	
	L SUPPLIES CHARGED TO PATIENTS	0	0				71.00	
	CHARGED TO PATIENTS	0	174, 204			7	73.00	
	ERVICE COST CENTERS			1				
90.00 09000 CLINIC		10, 737	4, 475, 312			9	90.00	
	OSE COST CENTERS							
	ALS (SUM OF LINES 1 through 117)	21,072	7, 725, 006			11	18.00	
	BLE COST CENTERS	0.000	0.00/ / 10				o 4 o 6	
194.0007950 RESIDE	NTTAL NONREIMBURSABLE COST CENTERS	9, 992 6, 852	2, 096, 649 3, 723, 861				94.00 94.01	
							94. 01 94. 02	
194.0207952 FQHC - 200.00 Cross		9, 016	5,085,258				94.02 00.00	
	Foot Adjustments ve Cost Centers						00.00 01.00	
	o be allocated (per Wkst. B,	312, 583	692, 551				01.00 02.00	
Part I		312, 303	092, 001			20	J2. UC	
) ost multiplier (Wkst. B, Part I)	6. 660338	0. 037172			20	03.00	
	o be allocated (per Wkst. B,	5, 566	8, 880				03.00 04.00	
Part I		5,500	0,000			20	54.00	
	ost multiplier (Wkst. B, Part	0, 118597	0. 000477			20	05.00	
		0.1100//	0.000477			20		
	djustment amount to be allocated					20	06.00	
	kst. B-2)					20		
	nit cost multiplier (Wkst. D,					20	07.00	
	III and IV)							

Health Financial Systems	PORTER-STARKE S	SERVICES, INC		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			CN: 15-4052	Period: From 07/01/2021 To 06/30/2022		
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	3, 623, 732		3, 623, 73	32 77, 429	3, 701, 161	30.00
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	141, 204		141, 20	04 0	141, 204	60.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	148, 233		148, 23	33 0	148, 233	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	5, 626, 980		5, 626, 98	289, 281	5, 916, 261	90.00
200.00 Subtotal (see instructions)	9, 540, 149	0	9, 540, 14	19 366, 710	9, 906, 859	200.00
201.00 Less Observation Beds	0			0	0	201.00
202.00 Total (see instructions)	9, 540, 149	0	9, 540, 14	19 366, 710	9, 906, 859	202.00

Health Financial Systems	PORTER-STARKE SERVICES, INC			In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period:	Worksheet C		
				From 07/01/2021 To 06/30/2022	Part I Date/Time Pre	epared:	
					11/28/2022 2:27 pm		
	Title XVIII		XVIII	Hospi tal	PPS		
Cost Center Description	Inpatient	Outpati ent		Cost or Other	TEFRA		
			+ col. 7)	Rati o	Inpati ent		
					Ratio		
	6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			1			
30. 00 03000 ADULTS & PEDI ATRI CS	3, 474, 469		3, 474, 46	9		30.00	
ANCILLARY SERVICE COST CENTERS				1			
60. 00 06000 LABORATORY	165, 944	0	165, 94				
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0. 000000	0. 000000		
73.00 07300 DRUGS CHARGED TO PATIENTS	174, 204	0	174, 20	4 0. 850916	0. 000000	73.00	
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLINIC	0	5, 239, 986	5, 239, 98	6 1.073854	0. 000000	90.00	
200.00 Subtotal (see instructions)	3, 814, 617	5, 239, 986	9, 054, 60	3		200.00	
201.00 Less Observation Beds						201.00	
202.00 Total (see instructions)	3, 814, 617	5, 239, 986	9, 054, 60	3		202.00	

Health Financial Systems	PORTER-STARKE SI	ERVICES, INC	In Lieu	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-4052	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Pre 11/28/2022 2:	epared: 27 pm
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS					30.00
ANCILLARY SERVICE COST CENTERS					
60. 00 06000 LABORATORY	0.850914				60.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.850916				73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	1. 129060				90.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems	PORTER-STARKE S	ERVICES, INC		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			CN: 15-4052	Period: From 07/01/2021 To 06/30/2022		pared: 27 pm
		Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	(from Wkst.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	B, Part I,					
	col . 26) 1.00	2.00	3.00	4,00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS	3, 623, 732		3, 623, 7	32 77, 429	3, 701, 161	30.00
ANCILLARY SERVICE COST CENTERS	· · · · · ·					1
60. 00 06000 LABORATORY	141, 204		141, 2	04 0	141, 204	60.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	148, 233		148, 2	33 0	148, 233	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	5, 626, 980		5, 626, 9	30 289, 281		•
200.00 Subtotal (see instructions)	9, 540, 149	0	9, 540, 1	49 366, 710		•
201.00 Less Observation Beds	0			0		201.00
202.00 Total (see instructions)	9, 540, 149	0	9, 540, 1	49 366, 710	9, 906, 859	202.00

Health Financial Systems	PORTER-STARKE S	SERVICES, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 07/01/2021	Worksheet C Part I	
				To 06/30/2022	Date/Time Pre	
					11/28/2022 2:	27 pm
		Titl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	3, 474, 469		3, 474, 46	9		30.00
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	165, 944	0	165, 94	4 0. 850914	0.000000	60.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0. 000000	0.000000	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	174, 204	0	174, 20	4 0. 850916	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	5, 239, 986	5, 239, 98	6 1. 073854	0.00000	90.00
200.00 Subtotal (see instructions)	3, 814, 617	5, 239, 986	9, 054, 60	3	ł	200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	3, 814, 617	5, 239, 986	9, 054, 60	3	ł	202.00

Health Financial Systems	PORTER-STARKE SI	ERVICES, INC	In Lieu	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-4052	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Pre 11/28/2022 2:	epared: 27 pm
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
ANCILLARY SERVICE COST CENTERS					
60. 00 06000 LABORATORY	0. 000000				60.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 000000				90.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems	PORTER-STARKE	SERVICES, INC		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 07/01/2021 To 06/30/2022	Worksheet D Part I Date/Time Pre 11/28/2022 2:	
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst.	Swing Bed Adjustment	Reduced Capi tal Rel ated Cost	Total Patient Days	Per Diem (col. 3 / col. 4)	
	B, Part II, col. 26)		(col . 1 - col . 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	68, 710	0	68, 71	0 1, 898	36.20	30.00
200.00 Total (lines 30 through 199)	68, 710		68, 71	0 1, 898		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						
30. 00 ADULTS & PEDIATRICS	348	12, 598				30.00
200.00 Total (lines 30 through 199)	348	12, 598				200.00

Health Financial Systems	PORTER-STARKE	SERVICES, INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider CO		Period: From 07/01/2021 To 06/30/2022	Worksheet D Part II Date/Time Pre 11/28/2022 2:	pared:
		Title	XVIII	Hospi tal	PPS	27 pm
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	752	165, 944	0.00453	2 0	0	60.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.00000	0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	790	174, 204	0.00453	5 25, 837	117	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	86, 954	5, 239, 986	0. 01659	4 0	0	90.00
200.00 Total (lines 50 through 199)	88, 496	5, 580, 134		25, 837	117	200.00

Health Financial Systems	PORTER-STARKE	SERVICES, INC		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provider C		Period:	Worksheet D	
				From 07/01/2021		nored.
				To 06/30/2022	Date/Time Pre 11/28/2022 2:	
		Title	e XVIII	Hospi tal	PPS	27 pm
Cost Center Description	Nursi ng	Nursing		Allied Health	All Other	
	Program	Program	Post-Stepdow	n Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			_			
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien		Inpati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
		minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	1, 89			30.00
200.00 Total (lines 30 through 199)		0	1, 89	8	348	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8) 9.00					
	9.00					
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
200.00 Total (lines 30 through 199)	0					200.00
200.00 Total (Thes 30 through 199)	0					I∠00.00

Health Financial Systems	PORTER-STARKE	SERVICES, INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PAS	S Provider C	CN: 15-4052	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Pre 11/28/2022 2:	pared: 27 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0 0	0	90.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00

Health Financial Systems	PORTER-STARKE	SERVICES, INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C	CN: 15-4052	Period:	Worksheet D	
THROUGH COSTS				From 07/01/2021 To 06/30/2022	Part IV Date/Time Pre	pared:
					11/28/2022 2:	
			XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Education	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	cols. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	0	0		0 165, 944	0.00000	60.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0.00000	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 174, 204	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 5, 239, 986	0.00000	90.00
200.00 Total (lines 50 through 199)	0	0		0 5, 580, 134		200. 00

Health Financial Systems	PORTER-STARKE SE	RVICES, INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-4052	Period: From 07/01/2021	Worksheet D Part IV	
THROUGH COSTS				To 06/30/2022		pared:
					11/28/2022 2:	27 pm
		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-Throug	n Charges	Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	0. 000000	0		0 0	0	60.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	25, 837		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	0		0 147, 973	0	90.00
200.00 Total (lines 50 through 199)		25, 837		0 147, 973	0	200.00

Health Financial Systems	PORTER-STARKE	SERVICES, INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND) VACCINE COST	Provider C	CN: 15-4052	Period: From 07/01/2021 To 06/30/2022		
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins	. Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
60. 00 06000 LABORATORY	0. 850914	0		0 0	0	60.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 850916	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	1.073854	147, 973		0 0	158, 901	90.00
200.00 Subtotal (see instructions)		147, 973		0 0	158, 901	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		147, 973		0 0	158, 901	202.00

Health Financial Systems	PORTER-STARKE	SERVICES, INC		In Lieu	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider CC	CN: 15-4052	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Pre 11/28/2022 2:	
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	0	0				60.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0				90.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	0				202.00
					'	-

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-4052	Peri od: From 07/01/2021 To 06/30/2022 Hospi tal	Worksheet D-1 Date/Time Pre 11/28/2022 2: PPS	pare
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	avaluding nauharn)		1, 898	1.
	Inpatient days (including private room days, excluding swing-bed days			1, 898	
	Private room days (excluding swing-bed and observation bed day		orivate room days,	0	
	do not complete this line.		-	1 000	
00 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		or 21 of the cost	1, 898 0	45
50	reporting period	il days) thi ough becenic		0	
00	Total swing-bed SNF type inpatient days (including private roo	m days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	dave) through December	r 21 of the cost	0	7
00	reporting period	days) through becenibe	a si oi the cost	0	'
00	Total swing-bed NF type inpatient days (including private room	days) after December	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excludin	ig swing-bed and	348	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on	ly (including private	room days)	0	10
	through December 31 of the cost reporting period (see instruct				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en		room days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		ite room days)	0	12
	through December 31 of the cost reporting period				
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			0	13
00	Medically necessary private room days applicable to the Progra			0	14
	Total nursery days (title V or XIX only)			0	
	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	s through December 31	of the cost	0.00	1 17
. 00	reporting period	s through becchiber of		0.00	''
. 00	Medicare rate for swing-bed SNF services applicable to service	s after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 c	of the cost	0.00	10
. 00	reporting period	thi bugh becember of e		0.00	'
. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of	the cost	0.00	20
00	reporting period Total general inpatient routine service cost (see instructions)		3, 701, 161	21
	Swing-bed cost applicable to SNF type services through Decembe		ting period (line		
	5 x line 17)				
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporti	ng period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December	31 of the cost report	ing period (line	0	24
	7 x line 19)	·			
	Swing-bed cost applicable to NF type services after December 3	1 of the cost reportir	ng period (line 8	0	25
	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3, 701, 161	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed c	narges)	0	28
	Semi -private room charges (excluding swing-bed charges)			0	30
00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.00000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
1	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	us line 33)(see instru	ictions)	0.00 0.00	
	Average per diem private room cost differential (line 34 x lin			0.00	
	Private room cost differential adjustment (line 3 x line 35)	· · ·		0	36
. 00	General inpatient routine service cost net of swing-bed cost a	nd private room cost c	lifferential (line	3, 701, 161	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
+	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	STMENTS			1
	Adjusted general inpatient routine service cost per diem (see	-		1, 950. 03	
	Program general inpatient routine service cost (line 9 x line Medically percessary private room cost applicable to the Progra	-		678, 610	
111	Medically necessary private room cost applicable to the Progra	+ line 40)		0	40

	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-4052	Period:	Worksheet D-	
					From 07/01/2021 To 06/30/2022		epared:
			Title	e XVIII	Hospi tal	PPS	. <i>21</i> pili
	Cost Center Description	Total I npati ent	Total I npati ent	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
		<u>Cost</u> 1.00	Days 2.00	÷ col. 2) 3.00	4.00	<u>col. 4)</u> 5.00	
42.00	NURSERY (title V & XIX only)		2.00	3.00	4.00	3.00	42.00
43.00	Intensive Care Type Inpatient Hospital Units						43.00
44.00	CORONARY CARE UNIT						44.00
	BURN I NTENSI VE CARE UNI T						45.00
46.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46.00
	Cost Center Description	· · · · ·		•		1 00	
48.00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3	3. Line 200)			1.00	5 48.00
	Total Program inpatient costs (sum of lines			ons)		700, 595	
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routing	sorvicos (fro	www.kst D. sur	n of Parts L and	12, 598	3 50.00
50.00	<pre>III ough costs appreable to riogram fit III)</pre>		services (iic	m wrst. D, Su		12, 570	5 50.00
51.00	Pass through costs applicable to Program inp and IV)	batient ancilla	ry services (f	rom Wkst. D, s	sum of Parts II	117	51.00
52.00	Total Program excludable cost (sum of lines					12, 715	52.00
53.00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		elated, non-ph	ysician anesth	netist, and	687,880	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	
55.00 56.00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
57.00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (line 56 minus	line 53)	C	
58.00	Bonus payment (see instructions)		and an 100(0	
59.00	Lesser of lines 53/54 or 55 from the cost remarket basket	eporting period	ending 1996,	updated and co	ompounded by the	0.00	59.0
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	
61.00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that	es 55, 59 or 60 an expected cost	enter the les ts (lines 54 x	ser of 50% of (60) or 1% of	the amount by f the target	C	61.00
	amount (line 56), otherwise enter zero (see				the target		
62.00 63.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ant (see instru	uctions)				
55.00	PROGRAM INPATIENT ROUTINE SWING BED COST	lent (see mistre					03.00
64.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts through Dece	ember 31 of th	e cost reporti	ng period (See	C	64.00
65.00	Medicare swing-bed SNF inpatient routine cos	sts after Decemb	per 31 of the	cost reporting	g period (See	C	65.00
66.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	no costs (lino	64 plus lipo	65) (+i +l o XV/I I		C	66.00
50.00	CAH (see instructions)				-		
67.00	Title V or XIX swing-bed NF inpatient routir (line 12 x line 19)	ne costs through	n December 31	of the cost re	eporting period	C	67.00
68.00	Title V or XIX swing-bed NF inpatient routir	ne costs after [December 31 of	the cost repo	orting period	C	68.00
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + lir	e 68)		C	69.00
	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	, AND ICF/IID	ONLY			
70.00 71.00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of)		70.00
72.00	Program routine service cost (line 9 x line		The 70 ÷ The	: 2)			72.00
73.00	Medically necessary private room cost applic						73.00
74.00 75.00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				Part II column		74.00
	26, line 45)			indi Kaneet D, 1			
76.00 77.00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76.00
78.00	Inpatient routine service cost (line 74 minu						78.00
79.00	Aggregate charges to beneficiaries for exces						79.0
30.00 31.00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		cost limitatic	n (line 78 mir	nus Line 79)		80.0
31.00 32.00	Inpatient routine service cost per drem finm Inpatient routine service cost limitation (I		1)				81.0
33.00	Reasonable inpatient routine service costs (· .				83.0
84.00	Program inpatient ancillary services (see in						84.00
85.00 86.00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85.00 86.00
JU. UU	PART IV - COMPUTATION OF OBSERVATION BED PAS						00.00
00 FC	Total observation bed days (see instructions	5)				C	
87.00 88.00	Adjusted general inpatient routine cost per	diem (line 27 -	Eline 2)			0.00	88.00

Health Financial Systems	PORTER-STARKE S	SERVICES, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
				From 07/01/2021 To 06/30/2022		pared: 27 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	68, 710	3, 701, 161	0. 01856	04 0	0	90.00
91.00 Nursing Program cost	0	3, 701, 161	0.0000	0 0	0	91.00
92.00 Allied health cost	0	3, 701, 161	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 701, 161	0.00000	0 0	0	93.00

COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-4052	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1 Date/Time Pre	
		Title XIX	Hospi tal	<u>11/28/2022 2:</u> Cost	
	Cost Center Description		- Hospi tui		
	PART I - ALL PROVIDER COMPONENTS			1.00	
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	excluding newborn)		1, 898	1.00
2.00 3.00	Inpatient days (including private room days, excluding swing-b Private room days (excluding swing-bed and observation bed day	ed and newborn days)	orivate room days,	1, 898 0	2.00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	d davs)		1, 898	4.00
5. 00	Total swing-bed SNF type inpatient days (including private roc reporting period	5 /	per 31 of the cost	0	5.00
6. 00	Total swing-bed SNF type inpatient days (including private roc reporting period (if calendar year, enter 0 on this line)	m days) after December	31 of the cost	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room reporting period	days) through Decembe	er 31 of the cost	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)	days) after December	31 of the cost	0	8.00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excludir	ng swing-bed and	95	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruct		room days)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en	ly (including private	room days) after	0	11.0
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period		ite room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			0	13.0
14.00 15.00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)			0	
16.00	Nursery days (title V or XIX only)			-	16.00
17.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31	of the cost	0.00	17.00
18.00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18.0
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 c	of the cost	0.00	19.0
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of	the cost	0.00	20.0
21.00 22.00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe	·	ting period (line	3, 623, 732 0	
23.00	5×1 ine 17) Swing-bed cost applicable to SNF type services after December			0	
24.00	Swing-bed cost applicable to NF type services through December			0	
25.00	7×1 ine 19) Swing-bed cost applicable to NF type services after December 3		5 T X	-	25.0
26.00	x line 20) Total swing-bed cost (see instructions)		ig period (Trile 0	0	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3, 623, 732	
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	l and observation bed c	harges)	0	28.0
29.00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi-private room charges (excluding swing-bed charges)	1		0	30.0
31.00 32.00	General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3)	TThe 28)		0. 000000 0. 00	
33.00	Average semi-private room per diem charge (line 29 ÷ line 3)				33.0
3.00	Average per diem private room charge differential (line 32 min	us line 33)(see instru	uctions)		34.0
35.00	Average per diem private room cost differential (line 34 x lin	, ,		0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0.00	
37.00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	nd private room cost c	lifferential (line	-	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	STMENTS			
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU		I	1 000 04	20 0
38.00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	-		1, 909. 24	
20 00	PLOGIAM DEDECAL LIDATIENT FOUTINE SERVICE COST (LINE Y X LINE	30)		181, 378	1 37.01
39.00 40.00	Medically necessary private room cost applicable to the Progra			0	

	Financial Systems TATION OF INPATIENT OPERATING COST	PORTER-STARKE		CCN: 15-4052	In Lie Period:	u of Form CMS- Worksheet D-1	
COMPUT	ATTON OF INPATIENT OPERATING COST		Provider (CN. 15-4052	From 07/01/2021 To 06/30/2022		epared:
		1		le XIX	Hospi tal	Cost	27 pm
	Cost Center Description	Total Inpatient	Total Inpati ent	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
		Cost	Days	÷ col. 2)		col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
43.00	Intensive Care Type Inpatient Hospital Unit: INTENSIVE CARE UNIT	S					43.00
44.00	CORONARY CARE UNIT						44.00
							45.00
46.00	SURGI CAL INTENSI VE CARE UNI T						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
	cost center bescription					1.00	
48.00	Program inpatient ancillary service cost (W	kst. D-3, col.	3, line 200)			0	48.00
49.00	Total Program inpatient costs (sum of lines	41 through 48)	(see instructi	ons)		181, 378	3 49. OC
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program in	patient routine	services (fro	om Wkst. D, su	m of Parts I and	0	50.00
51.00	Pass through costs applicable to Program in	patient ancilla	rv services (f	rom Wkst. D.	sum of Parts II	C	51.00
	and IV)		J				
52.00	Total Program excludable cost (sum of lines					0	
53.00	Total Program inpatient operating cost excl		elated, non-ph	nysician anest	hetist, and	0	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00	Program di scharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	
57.00	Difference between adjusted inpatient opera	ting cost and ta	arget amount (line 56 minus	line 53)	0	
58.00 59.00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost r	enorting period	ending 1006	undated and c	ompounded by the	0. 00	
57.00	market basket	eporting period	enuring 1990,	updated and c	Shipounded by the	0.00	/ <i>37.00</i>
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, u	odated by the	market basket		0.00	60.00
61.00	If line 53/54 is less than the lower of lin	es 55, 59 or 60	enter the les	ser of 50% of	the amount by	0	61.00
	which operating costs (line 53) are less th amount (line 56), otherwise enter zero (see		ts (lines 54 >	(60), or 1% o	f the target		
62.00	Relief payment (see instructions)	Thistructrons)				C	62.00
63.00	Allowable Inpatient cost plus incentive pay	ment (see instru	uctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine co	sts through Dece	ember 31 of th	ne cost report	ing period (See	0	64.00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co	sts after Decem	her 31 of the	cost reportin	a period (See	C	65.00
00.00	instructions) (title XVIII only)				g period (see	0	00.00
66.00	Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 plus line	65)(title XVI	II only). For	0	66.00
(7.00	CAH (see instructions)		D				
67.00	Title V or XIX swing-bed NF inpatient routi (line 12 x line 19)	ne costs through	n December 31	or the cost r	eporting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routi	ne costs after l	December 31 of	the cost rep	orting period	C	68.00
	(line 13 x line 20)				51		
69.00	Total title V or XIX swing-bed NF inpatient					0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER Skilled nursing facility/other nursing faci)		70.00
70.00	Adjusted general inpatient routine service						71.00
72.00	Program routine service cost (line 9 x line			,			72.00
73.00	Medically necessary private room cost appli						73.00
74.00	Total Program general inpatient routine ser				Dart II column		74.00
75.00	Capital-related cost allocated to inpatient 26, line 45)	routine service	E CUSIS (TROM	worksneet B,	raitii, coiumn		75.00
76.00	Per diem capital-related costs (line 75 ÷ l	ine 2)					76.00
77.00	Program capital-related costs (line 9 x lin	e 76)					77.00
78.00	Inpatient routine service cost (line 74 min						78.00
79.00	Aggregate charges to beneficiaries for exce Total Program routine service costs for com				pus lino 70)		79.00
80.00 81.00	Inpatient routine service costs for com	•			nus IIIE /7)		80.00
82.00	Inpatient routine service cost limitation (1)				82.00
83.00	Reasonable inpatient routine service costs	•	ns)				83.00
84.00	Program inpatient ancillary services (see i		>				84.00
85.00	Utilization review - physician compensation Total Program inpatient operating costs (su						85.00 86.00
JU. UU	PART IV - COMPUTATION OF OBSERVATION BED PA						_ 00.00
87.00	Total observation bed days (see instruction					0	87.00
88.00	Adjusted general inpatient routine cost per	•					88.00
~~	Observation bed cost (line 87 x line 88) (s	on instructions	`			0	89.00

Health Financial Systems	PORTER-STARKE S	SERVICES, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
				From 07/01/2021 To 06/30/2022		pared: 27 pm
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	68, 710	3, 623, 732	0. 01896	1 0	0	90.00
91.00 Nursing Program cost	0	3, 623, 732	0.00000	0 0	0	91.00
92.00 Allied health cost	0	3, 623, 732	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 623, 732	0.00000	0 0	0	93.00

Health Financial Systems	PORTER-STARKE SERVICES, INC		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Period:	Worksheet D-3	
			From 07/01/2021 To 06/30/2022	Date/Time Pre 11/28/2022 2:	pared: 27 pm
	Title	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS			501, 300		30.00
ANCI LLARY SERVI CE COST CENTERS			_		
60. 00 06000 LABORATORY		0.85091	4 0	0	60.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000	0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0.85091	6 25, 837	21, 985	73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		1. 12906	0 0	0	90.00
200.00 Total (sum of lines 50 through 94 and	96 through 98)		25, 837	21, 985	200.00
201.00 Less PBP Clinic Laboratory Services-Pr	rogram only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)	-		25, 837		202.00

Health Financial Systems	PORTER-STARKE SERVICES, INC		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	
			From 07/01/2021 To 06/30/2022	Date/Time Pre 11/28/2022 2:	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cost	Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
			_	col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		_			
30.00 03000 ADULTS & PEDIATRICS			152, 857		30.00
ANCILLARY SERVICE COST CENTERS		_			
60. 00 06000 LABORATORY		0. 85091	4 0	0	60.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000	0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 85091	6 0	0	73.00
OUTPATIENT SERVICE COST CENTERS					1
90. 00 09000 CLINIC		1.07385	4 0	0	90.00
200.00 Total (sum of lines 50 through 94 and	96 through 98)		0	0	200.00
201.00 Less PBP Clinic Laboratory Services-P	rogram only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			0		202.00

CALCUL		5, INC vider CCN: 15-4052	Peri od:	Worksheet E	2552-1
			From 07/01/2021 To 06/30/2022	Part B Date/Time Pre	pared:
		T		11/28/2022 2:	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			0	1 1 0
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruction:	5)		0 158, 901	
3.00	OPPS payments	5)		498, 098	
4.00	Outlier payment (see instructions)			0	
4.01	Outlier reconciliation amount (see instructions)	>		0	
5.00 5.00	Enter the hospital specific payment to cost ratio (see instruction Line 2 times line 5	ns)		0.000	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
3.00	Transitional corridor payment (see instructions)			0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, (col. 13, line 200		0	
10.00 11.00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0	
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			0	11.0
	Reasonabl e charges				
	Ancillary service charges	(0)			12.0
13.00 14.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line Total reasonable charges (sum of lines 12 and 13)	59)		0	
14.00	Customary charges			0	14.0
15.00	Aggregate amount actually collected from patients liable for paym	ent for services on	a charge basi s	0	15.00
16.00	Amounts that would have been realized from patients liable for pay	yment for services	on a chargebasis	0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17 00
18.00	Total customary charges (see instructions)			0.000000	
19.00	Excess of customary charges over reasonable cost (complete only i	fline 18 exceeds l	ine 11) (see	0	19.00
	instructions)				
20.00	Excess of reasonable cost over customary charges (complete only i instructions)	Fline 11 exceeds I	ine 18) (see	0	20.00
21.00	Lesser of cost or charges (see instructions)			0	21.00
22.00	Interns and residents (see instructions)			0	22.0
	Cost of physicians' services in a teaching hospital (see instruct	i ons)		0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			498, 098	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			130, 907	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24	(for CAH, see inst	ructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus	the sum of lines 2	2 and 23] (see	367, 191	27.0
28.00	instructions) Direct graduate medical education payments (from Wkst. E-4, line !	50)		0	28.0
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	50)		0	
30.00	Subtotal (sum of lines 27 through 29)			367, 191	
31.00	Primary payer payments			0	
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			367, 191	32.00
33.00	Composite rate ESRD (from Wkst. 1-5, line 11)			0	33.00
	Allowable bad debts (see instructions)			0	
35.00	Adjusted reimbursable bad debts (see instructions)			0	
36.00 37.00	Allowable bad debts for dual eligible beneficiaries (see instruct Subtotal (see instructions)	i ons)		0 367, 191	
	MSP-LCC reconciliation amount from PS&R			0	
39.00	OTHER ADJUSTMENTS			63	
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39.5
39.97 39.98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced (devices (see instru	ctions)	0	
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	
40.00	Subtotal (see instructions)			367, 254	40.0
	Sequestration adjustment (see instructions)			918	
10.02 10.03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40.0
41.00	Interim payments			366, 336	
41.01	Interim payments-PARHM				41.0
	Tentative settlement (for contractors use only)			0	
42.01 43.00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)			0	42.0 43.0
43.00 43.01	Balance due provider/program-PARHM (see instructions)			0	43.0
44.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	chapter 1,	0	
	§115. 2				1
00 00	TO BE COMPLETED BY CONTRACTOR			0	
90.00 91.00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90.00 91.0
	The rate used to calculate the Time Value of Money				92.0
93.00	Time Value of Money (see instructions)			0	93.0
11 00	Total (sum of lines 91 and 93)			0	94.0

Health Financial Systems	PORTER-STARKE SERVICES, INC	In Lieu	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-4052	Period:	Worksheet E	
		From 07/01/2021 To 06/30/2022	Date/Time Pre	pared:
			11/28/2022 2:	27 pm
	Title XVIII	Hospi tal	PPS	
			1.00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			0	200.00

	I Financial Systems PORTER-STARKE S SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der C	CN: 15-4052	Peri od:	u of Form CMS-2 Worksheet E-1	-552-
				From 07/01/2021 To 06/30/2022	Date/Time Pre	
		Titlo	XVIII	Hospi tal	11/28/2022 2: PPS	27 pi
		Inpatien			T B	
		mm/dd/yyyy 1.00	Amount 2.00		Amount 4.00	
00	Total interim payments paid to provider	1.00	2.00		4.00	1.
00	Interim payments payable on individual bills, either		247, 7	0	0	2.
	submitted or to be submitted to the contractor for			-	_	
	services rendered in the cost reporting period. If none,					
~ ~	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3.
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
01	ADJUSTMENTS TO PROVIDER			0	0	3
)2				0	0	3
03				0	0	3
04				0	0	3
05	Provider to Program			0	0	3
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	3
52				0	0	3
53				0	0	3
54				0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		249, 79	0.4	244 224	4
00	(transfer to Wkst. E or Wkst. E-3, line and column as		249, 1	94	366, 336	4
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR				•	
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
)1	TENTATI VE TO PROVIDER			0	0	5
02				0	0	5
03				0	0	5
	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5
77	5. 50-5. 98)			0	0	5
00	Determined net settlement amount (balance due) based on					6
D1	the cost report. (1) SETTLEMENT TO PROVIDER			0	0	6
01	SETTLEMENT TO PROVIDER			0	0	6
00	Total Medicare program liability (see instructions)		249, 79	-	366, 336	7
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	

Heal th	Financial Systems PORTER-STARKE SE	ERVICES, INC	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-4052	Period: From 07/01/2021 To 06/30/2022	Worksheet E-3 Part II Date/Time Pre	pared:
		Title XVIII	Hospi tal	11/28/2022 2: PPS	27 pm_
			nospi tui	110	
				1.00	
1.00	PART II - MEDICARE PART A SERVICES - IPF PPS Net Federal IPF PPS Payments (excluding outlier, ECT, and me	dical education navments	>	301, 860	1.00
2.00	Net IPF PPS Outlier Payments	edical education payments)	301, 800	2.00
3.00	Net IPF PPS ECT Payments			0	3.00
4.00	Unweighted intern and resident FTE count in the most recent 15, 2004. (see instructions)	cost report filed on or	before November	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE couprogram or hospital closure, that would not be counted with CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	4.01
5.00	New Teaching program adjustment. (see instructions)			0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs ir	n the new program growth	period of a "new	0.00	6.00
7.00	teaching program" (see instuctions) Current year's unweighted I&R FTE count for residents within	n the new program growth	period of a "new	0.00	7.00
8.00	teaching program" (see instuctions) Intern and resident count for IPF PPS medical education adju	istment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions))	5. 200000	
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to	o the power of .5150 -1}.		0.000000	
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0	
12.00 13.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11) Nursing and Allied Health Managed Care payment (see instruct			301, 860 0	12.00 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0	14.00
	Cost of physicians' services in a teaching hospital (see ins	structions)		0	15.00
16.00	Subtotal (see instructions)			301, 860	
	Primary payer payments			0	17.00
18.00 19.00	Subtotal (line 16 less line 17). Deductibles			301, 860 51, 608	
20.00	Subtotal (line 18 minus line 19)			250, 252	
21.00	Coinsurance			0	
22.00	Subtotal (line 20 minus line 21)			250, 252	
23.00	Allowable bad debts (exclude bad debts for professional serv Adjusted reimbursable bad debts (see instructions)	vices) (see instructions)		0	23.00 24.00
24.00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		0	24.00
	Subtotal (sum of lines 22 and 24)			250, 252	
27.00	Direct graduate medical education payments (see instructions	5)		0	
28.00	Other pass through costs (see instructions)			0	28.00
29.00 30.00	Outlier payments reconciliation OTHER ADJUSTMENTS			0 168	
30.50	Pioneer ACO demonstration payment adjustment (see instruction	ons)		0	30.50
30. 98	Recovery of accel erated depreciation.	, ,		0	30. 98
30.99	Demonstration payment adjustment amount before sequestration	ו		0	30.99
31.00 31.01	Total amount payable to the provider (see instructions)			250, 420	
	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			626 0	
	Interim payments			249, 794	
33.00	Tentative settlement (for contractor use only)			0	
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.	· ·		0	34.00
35.00	Protested amounts (nonallowable cost report items) in accord \$115.2	dance with CMS Pub. 15-2,	chapter 1,	0	35.00
50.00	TO BE COMPLETED BY CONTRACTOR Original outlier amount from Worksheet E-3, Part II, line 2			0	50 00
50.00 51.00	Outlier reconciliation adjustment amount (see instructions)			0	50.00 51.00
52.00	The rate used to calculate the Time Value of Money			0.00	
53.00	Time Value of Money (see instructions) FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AN	ID REGINNING REFORE THE E	ND OF THE COVID 1	0	53.00
99.00	Teaching Adjustment Factor for the cost reporting period imm			0.000000	99.00
	Cal cul ated Teaching Adjustment Factor for the current year.	• •	,·	0. 000000	

	Financial Systems PORTER-STARKE SEI ATION OF REIMBURSEMENT SETTLEMENT	RVICES, INC Provider CCN: 15-4052	Peri od:	u of Form CMS-2 Worksheet E-3	
			From 07/01/2021 To 06/30/2022	Part VII	
			10 00/30/2022	11/28/2022 2:	
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpatient	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH S	EDVICES EOD TITLES V OD		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	ERVICES FOR TITLES V OR	ATA SERVICES		
00	Inpati ent hospital/SNF/NF services		181, 378		1 1.
00	Medical and other services			0	
00	Organ acquisition (certified transplant centers only)		0		3.
00	Subtotal (sum of lines 1, 2 and 3)		181, 378	0	
00	Inpatient primary payer payments		0	0	5.
00	Outpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6)		101 270	0	
00	COMPUTATION OF LESSER OF COST OR CHARGES		181, 378	0	- ^
	Reasonable Charges				
00	Routi ne servi ce charges		152, 857		8.
00	Ancillary service charges		0	0	9
	Organ acquisition charges, net of revenue		0		10
	Incentive from target amount computation		0	_	11
. 00	Total reasonable charges (sum of lines 8 through 11)		152, 857	0	12
. 00	CUSTOMARY CHARGES Amount actually collected from patients liable for payment f	or services on a charge	0	0	13
. 00	basis	or services on a charge	0	0	13
00	Amounts that would have been realized from patients liable f	or payment for services	on 0	0	14
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	
	Total customary charges (see instructions)		152, 857	0	
. 00	Excess of customary charges over reasonable cost (complete o	nly if line 16 exceeds	0	0	17
. 00	line 4) (see instructions)	nly if line 4 exceeds li	DO 20 E21	0	18
. 00	Excess of reasonable cost over customary charges (complete o 16) (see instructions)	The 4 exceeds Th	ne 28, 521	0	
. 00	Interns and Residents (see instructions)		0	0	19
	Cost of physicians' services in a teaching hospital (see ins	tructions)	0	0	
	Cost of covered services (enter the lesser of line 4 or line		152, 857	0	21
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	e completed for PPS prov	i ders.		
	Other than outlier payments		0	0	
	Outlier payments		0	0	
	Program capital payments Capital exception payments (see instructions)		0		24
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
	Titles V or XIX (sum of lines 21 and 27)		152, 857	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		28, 521	0	
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and	6)	152, 857	0	
. 00	Deductibles		2, 251	0	
	Coinsurance		135	0	
. 00	Allowable bad debts (see instructions) Utilization review		0	0	35
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 a	nd 33)	150, 471	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 ± line 37)		150, 471	0	
	Direct graduate medical education payments (from Wkst. E-4)		0		39
	Total amount payable to the provider (sum of lines 38 and 39)	150, 471	0	
	Interim payments		118, 628	0	
	Balance due provider/program (line 40 minus line 41)		31, 843	0	
3.00	Protested amounts (nonallowable cost report items) in accord	ance with CMS Pub 15-2.	0	0	43

	Financial Systems PORTER-STARKE S E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		riod: om 07/01/2021	Worksheet G	2552
nly)			Тс	06/30/2022	11/28/2022 2:	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	15, 930, 704		0	0	
00	Temporary investments	6, 417, 153		0	0	
00 00	Notes receivable Accounts receivable	854, 801 1, 290, 587	0	0	0	
00	Other receivable	1, 515, 327	0	0	0	
00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6
00	Inventory	0	0	0	0	
00 00	Prepaid expenses Other current assets	399, 124 0	0	0	0	
	Due from other funds	0	0	0	0	
I. 00	Total current assets (sum of lines 1-10)	26, 407, 696	0	0	0	11
	FI XED ASSETS					1
	Land Land improvements	0		0	0	
	Accumulated depreciation	0	-	0	0	
	Bui I di ngs	7, 979, 672	0	0	0	
	Accumulated depreciation	0	-	0	0	
	Leasehold improvements Accumulated depreciation	0	0	0	0	
	Fixed equipment	0	0	0	0	
	Accumulated depreciation	0	0	0	0	20
	Automobiles and trucks	0	0	0	0	21
	Accumulated depreciation	0	-	0	0	
	Major movable equipment	0	0	0	0	
	Accumulated depreciation Minor equipment depreciable	0	0	0	0	
	Accumulated depreciation	0	0	0	0	
	HIT designated Assets	0	0	0	0	27
	Accumulated depreciation	0	0	0	0	
	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	0 7, 979, 672	0	0	0	
. 00	OTHER ASSETS	1, 777, 072	0	0		
	Investments	48, 150		0	0	
	Deposits on Leases	0		0	0	
	Due from owners/officers Other assets	2, 138, 591	0	0	0	
	Total other assets (sum of lines 31-34)	2, 186, 741		0	0	
	Total assets (sum of lines 11, 30, and 35)	36, 574, 109		0	0	
	CURRENT LI ABI LI TI ES		-	-1		
	Accounts payable	1, 075, 571 2, 878, 554	0	0	0	
	Salaries, wages, and fees payable Payroll taxes payable	2, 878, 554		0	0	
	Notes and Loans payable (short term)	0	0	0	0	
	Deferred income	0	0	0	0	
	Accel erated payments	0			0	42
	Due to other funds Other current liabilities	962, 989 141, 510		0	0	
	Total current liabilities (sum of lines 37 thru 44)	5, 058, 624		0	0	
	LONG TERM LIABILITIES					
	Mortgage payable	0	-	0	0	
	Notes payable	854, 801	0	0	0	
	Unsecured Loans Other Long term liabilities	48, 150 2, 138, 591	0	0	0	
	Total long term liabilities (sum of lines 46 thru 49)	3, 041, 542		0	0	
	Total liabilities (sum of lines 45 and 50)	8, 100, 166		0	0	51
	CAPI TAL ACCOUNTS			I		I
	General fund balance	28, 473, 943	0			52
	Specific purpose fund Donor created - endowment fund balance - restricted		0	0		54
	Donor created - endowment fund balance - unrestricted			0		55
6.00	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	
3. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58
9.00	Total fund balances (sum of lines 52 thru 58)	28, 473, 943	0	0	0	59
				0		1 2 /

		PORTER-STARKE SERVICES, INC					J of Form CMS-2552-10			
STATEMENT OF CHANGES IN FUND BALANCES			Provider CO	CN: 15-4052		iod: m 07/01/2021 06/30/2022			repared:	
		General	Fund	Speci al	Purp	oose Fund	Endowment Fund			
		1.00								
1.00	Fund balances at beginning of period	1.00	2.00 25,626,355	3.00	_	4.00	5.00	_	1.00	
2.00	Net income (loss) (from Wkst. G-3, line 29)		2, 847, 586			-			2.00	
3.00 4.00	Total (sum of line 1 and line 2) ROUNDING	3	28, 473, 941		0	0		0	3.00 4.00	
4.00 5.00	ROUNDING	0			0			0	5.00	
6.00		0			0			0	6.00	
7.00		0			0			0	7.00	
8.00		0			0			0	8.00	
9.00		0			0			0	9.00	
10.00	Total additions (sum of line 4-9)		3			0			10.00	
11.00	Subtotal (line 3 plus line 10)		28, 473, 944		~	0		_	11.00	
12.00 13.00	Deductions (debit adjustments) (specify)	0			0 0			0 0	12.00 13.00	
14.00		0			0			0	14.00	
15.00		Ő			0			0	15.00	
16.00		0			0			0	16.00	
17.00		0			0			0	17.00	
18.00	Total deductions (sum of lines 12-17)		0			0			18.00	
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		28, 473, 944			0			19.00	
		Endowment	PI ant	Fund						
		Fund			_					
		6.00	7.00	8.00						
1.00	Fund balances at beginning of period	0			0				1.00	
2.00	Net income (loss) (from Wkst. G-3, line 29)				~				2.00	
3.00 4.00	Total (sum of line 1 and line 2) ROUNDING	0	0		0				3.00 4.00	
4.00 5.00	KOUNDING		0						5.00	
6.00			0						6.00	
7.00			0						7.00	
8.00			0						8.00	
9.00			0						9.00	
10.00	Total additions (sum of line 4-9)	0			0				10.00	
11.00 12.00	Subtotal (line 3 plus line 10)	0	0		0				11.00 12.00	
12.00	Deductions (debit adjustments) (specify)		0						12.00	
14.00			0						14.00	
15.00			0						15.00	
			0						16.00	
16.00			0						17.00	
16.00 17.00			0							
17.00 18.00	Total deductions (sum of lines 12-17)	0			0				18.00	
17.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0			0 0				18.00 19.00	

STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-4052	In Lie Period: From 07/01/2021 To 06/30/2022		Worksheet G-2 Parts I & II Date/Time Pre 11/28/2022 2:	2 epared	
	Cost Center Description		I npati ent		Outpati ent	Total		
			1.00		2.00	3.00		
	PART I – PATIENT REVENUES							
	General Inpatient Routine Services		1					
1.00	Hospi tal		3, 249, 6	94		3, 249, 694	1.0	
2.00	SUBPROVIDER - IPF						2.0	
3.00	SUBPROVIDER - IRF						3.0	
4.00	SUBPROVIDER						4.0	
5.00	Swing bed - SNF			0		0	5.C	
5.00	Swing bed - NF			0		0	6.0	
7.00	SKILLED NURSING FACILITY						7.0	
3.00	NURSING FACILITY						8.0	
9.00	OTHER LONG TERM CARE						9.0	
10.00	Total general inpatient care services (sum of lines 1-9)		3, 249, 6	94		3, 249, 694	10. C	
	Intensive Care Type Inpatient Hospital Services		1					
11.00	I NTENSI VE CARE UNI T						11.0	
	CORONARY CARE UNIT						12.0	
	BURN INTENSIVE CARE UNIT						13.0	
	SURGI CAL I NTENSI VE CARE UNI T						14.0	
	OTHER SPECIAL CARE (SPECIFY)			-			15.0	
16.00	Total intensive care type inpatient hospital services (sum	of lines		0		0	16. C	
	11-15)							
	Total inpatient routine care services (sum of lines 10 and	16)	3, 249, 6		-	3, 249, 694	17.0	
	Ancillary services			0	0	0	18.0	
	Outpatient services			0	9, 579, 299	9, 579, 299		
	RURAL HEALTH CLINIC			0	0	0	20.0	
	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	21.0	
	HOME HEALTH AGENCY						22.0	
	AMBULANCE SERVICES						23.0	
24.00							24.0	
	AMBULATORY SURGICAL CENTER (D. P.)						25.0	
	HOSPI CE				11 170 005	44 470 005	26.0	
	OTHER NONREI MBURSABLE		0.040.4	0	11, 470, 295	11, 470, 295		
28.00	Total patient revenues (sum of lines 17-27)(transfer column	n 3 to WKST.	3, 249, 6	94	21, 049, 594	24, 299, 288	28.0	
	G-3, line 1) PART II - OPERATING EXPENSES						-	
29.00	Operating expenses (per Wkst. A, column 3, line 200)		1	-	30, 393, 341		29.0	
30.00	ADD (SPECIFY)			0	30, 393, 341		30.0	
1.00	ADD (SPECIFF)			0			31.0	
32.00				0			32.0	
32.00				0			32.0	
3.00				0			34.0	
5.00				0			35.0	
35.00 36.00	Tatal additions (our of lines 20.25)			0	0		35.0	
	Total additions (sum of lines 30-35)			~	0			
7.00	DEDUCT (SPECIFY)			0			37.0	
88.00				0			38.0	
39.00				0 0			39.0	
0.00				0			40.0	
1.00	Tatal deductions (our of lines 27 (1)			U			41.0	
	Total deductions (sum of lines 37-41)	(1) (+f			0		42.0	
3.00	Total operating expenses (sum of lines 29 and 36 minus line	e 4∠)(transfer	1		30, 393, 341		43.0	

Heal th	Financial Systems P	PORTER-STARKE SERVICES, INC	In Lie	u of Form CMS-2	2552-10
		From 07/01/2021	Worksheet G-3 Date/Time Pre 11/28/2022 2:	pared:	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part	L. column 3. Line 28)		24, 299, 288	1.00
2.00	Less contractual allowances and discounts on			6, 134, 382	2.00
3.00	Net patient revenues (line 1 minus line 2)			18, 164, 906	3.00
4.00	Less total operating expenses (from Wkst. G-2	2, Part II, line 43)		30, 393, 341	
5.00	Net income from service to patients (line 3 m			-12, 228, 435	5.00
	OTHER INCOME			· · ·	
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaned	ous communication services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and gues	sts		0	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical sup	oplies to other than patients		0	16.00
17.00	Revenue from sale of drugs to other than pati	ents		0	17.00
18.00	Revenue from sale of medical records and abst	tracts		0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, e	etc.)		0	19.00
	Revenue from gifts, flowers, coffee shops, ar	nd canteen		0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	PUBLIC SUPPORT			13, 253, 195	24.00
24.01	OTHER REVENUE			1, 210, 602	24.01
24.02	MI SC GRANTS			57, 315	24.02
24.50	COVID-19 PHE Funding			554, 909	24.50
	Total other income (sum of lines 6-24)			15, 076, 021	25.00
	Total (line 5 plus line 25)			2, 847, 586	
	OTHER EXPENSES (SPECIFY)			0	27.00
	Total other expenses (sum of line 27 and subs			0	28.00
29.00	Net income (or loss) for the period (line 26	minus line 28)		2, 847, 586	29.00