PORTER MEMORIAL HOSPITAL

 IAL HOSPITAL
 In Lieu of Form CMS-2552-10

 Failure to report can result in all interim FORM APPROVED

	s required by law (42 USC 1395g)				n FORM APPROVED
payments made	since the beginning of the cost	t reporting period being	deemed overpayments	(42 USC 1395g).	OMB NO. 0938-0050
					EXPIRES 05-31-2019
HOSPI TAL AND I	HOSPITAL HEALTH CARE COMPLEX COS	ST REPORT CERTIFICATION	Provider CCN: 15-0035	5 Period:	Worksheet S
AND SETTLEMEN	F SUMMARY			From 01/01/2014	
				To 12/31/2014	Date/Time Prepared:
					12/13/2017 7:58 am
PART I - COST	REPORT STATUS				
Provi der	1. [X]Electronically filed c	ost report		Date:	Time:
use only	2. [] Manually submitted cos	t report			
	3. [0] If this is an amended	report enter the number	of times the provide	r resubmitted this o	cost report
	4. [F]Medicare Utilization.	Enter "F" for full or "L	_" for low. '		·
Contractor	5. [2]Cost Report Status 6	. Date Received:	09/30/2016 1	0.NPR Date:	03/31/2017
use only	(1) Ås Submitted 7	. Contractor No.	08001 1	1.Contractor's Vende	or Code: 4
	(2) Settled without Audit 8	. [N] Initial Report fo	or this Provider CCN1	2.[0] fline 5, co	olumn 1 is 4: Enter
	(3) Settled with Audit 9	. [N] Final Report for	this Provider CCN	number of tin	nes reopened = 0-9.
	(4) Reopened				-
	(5) Amended				

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PORTER MEMORIAL HOSPITAL (15-0035) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)

Officer or Administrator of Provider(s)

SR VICE PRESIDENT-REVENUE MANAGEMENT

Title

09/29/2016

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY			_			
1.00	Hospi tal	0	0	0	16, 052	0	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	16, 052	0	200.00

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

	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DA	ATA	Provider CO	CN: 15-0035	Period: From 01/0 To 12/3	1/2014	Workshe Part I Date/Ti		
	1.00					10 12/3		12/13/2		
	1.00 Hospital and Hospital Health Care Co		00	3.00			4.00			
1.00	Street: 85 EAST US HI GHWAY 6	P0 Box:								1.00
2.00	Ci ty: VALPARAI SO	State: I		p Code: 463		inty: PORTER	_			2.00
		Component Na			SA Provid			nt Syst		
			NU	mber Num	ber Type	Certifie		0, or XVIII		-
		1.00		. 00 3.	00 4.00	5.00	6.00	7.00		+
	Hospital and Hospital-Based Componer				00 1100	0100	1 01 00	1 // 00	1 01 00	
3.00	Hospi tal	PORTER MEMORIAL	15	0035 238	344 1	07/01/196	6 N	Р	0	3.00
1 00		HOSPI TAL								1 00
4.00 5.00	Subprovi der – IPF Subprovi der – IRF	PORTER REHAB UNI	т 15	T035 238	344 5	01/01/200	9 N	Р	0	4.00
6.00	Subprovider - (Other)	I ONTER REHAD ONT		230	5	017017200		'		6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital -Based SNF									9.00
10.00 11.00	Hospital-Based NF Hospital-Based OLTC									10.00
12.00	Hospital -Based HHA									12.00
	Separately Certified ASC									13.00
14.00	Hospi tal -Based Hospi ce									14.00
	Hospital -Based Health Clinic - RHC									15.00
16.00 17.00	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I									16.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						Fro		To		-
20.00	Cost Reporting Period (mm/dd/yyyy)					1. C		2.0		20.00
	Type of Control (see instructions)					4		12/01/	2011	21.00
	Inpatient PPS Information]
22.00	Does this facility qualify and is it							N		22.00
	share hospital adjustment, in accord for yes or "N" for no. Is this facil									
	amendment hospital?) In column 2, en				0(0)(2)(110					
22.01	Did this hospital receive interim un	compensated care	payments f	or this co		ng Y		Y		22.01
	period? Enter in column 1, "Y" for y									
	reporting period occurring prior to for no for the portion of the cost r									
	(see instructions)	eporting period	occurring c	n or arter	october 1.					
22.02	Is this a newly merged hospital that							N		22.02
	determined at cost report settlement									
	or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for	1 5								
	or after October 1.	no, for the port	for or the	0031 10001	ting period					
22.03	Did this hospital receive a geograph	nic reclassificat	ion from ur	ban to rur	al as a res	sult N		N		22.03
	of the OMB standards for delineating					er				
	in column 1, "Y" for yes or "N" for prior to October 1. Enter in column					the				
	cost reporting period occurring on c	or after October	1. (see ins	structions)	Does this					
	hospital contain at least 100 but no	ot more than 499	beds (as co			vi th				
23.00	42 CFR 412.105)? Enter in column 3,			l/or 25 bol	ow? In colu	Imp	2	N		23.00
23.00	Which method is used to determine Me 1, enter 1 if date of admission, 2 i						3	IN IN		23.00
	method of identifying the days in th	nis cost reportin	g period di	fferent fr	rom the meth	nod				
	used in the prior cost reporting per	riod? In column					Mark	d C	there	
			In-State Medicaid	In-State Medicaid	Out-of State	Out-of State	Medicai HMO day		ther li cai d	
			pai d days	el i gi bl e	Medi cai d	Medi cai d			lays	
				unpai d	paid days	eligible				
			1 00	days	2.00	unpai d	E OO	,	. 00	-
24 00	If this provider is an IPPS hospital	enter the	1.00 3,310	2.00	3.00 20	4.00	<u>5.00</u> 4,5		0. 00 237	24.00
27.00	in-state Medicaid paid days in colum		3,310	1, 024	20	24	4,0		237	27.00
	Medicaid eligible unpaid days in col	umn 2,								
	out-of-state Medicaid paid days in c									
	out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu									
	r, mearcara nimo para ana erryrbre bu	i column 6.								
	column 5, and other Medicaid days in							16		1 25 00
25.00	column 5, and other Medicaid days in If this provider is an IRF, enter th	ne in-state	160	36	6 0	0		10		25.00
25. 00	If this provider is an IRF, enter th Medicaid paid days in column 1, the	in-state	160	36		0				25.00
25.00	If this provider is an IRF, enter th Medicaid paid days in column 1, the Medicaid eligible unpaid days in col	in-state umn 2,		36						25.00
25.00	If this provider is an IRF, enter th Medicaid paid days in column 1, the	in-state umn 2, n 3, out-of-state		36						25.00

	Financial Systems PORTER N TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT		AL HOSPITAL Provider CC	N: 15-0035		eriod:		ı of Forr Workshe		
						om 01/01/		Part I Date/Ti	me Pre	pared:
						Urban/Rur	al S	<u>12/13/2</u> Date of		
26.00	Enter your standard geographic classification (not way	ta (an	atus at the he		f the	1.00	1	2.0	0	26.00
	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not way reporting period. Enter in column 1, "1" for urban or	rural ge) st "2" f	atus at the en or rural. If a	d of the (cost		1			27.00
35.00	enter the effective date of the geographic reclassified of this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status	in		0			35.00
					-	Begi nni r	ng:	Endi ı		
36.00	Enter applicable beginning and ending dates of SCH sta	atus.	Subscript line	36 for n	umber	1.00		2.0	0	36.00
37.00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter		umber of perio	ds MDH sta	atus		О			37.00
37. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)					Ν				37.01
38.00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.									38.00
					-	Y/N		Y/I		-
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii) or "N" for no. Does the facility meet the mileage requ)? Ĕnt uireme	er in column 1 nts in accorda	"Y" for y	yes 42	<u>1.00</u> N		2.0 N	0	39.00
	CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octobe no in column 2, for discharges on or after October 1.	adjus er 1.	tment? Enter " Enter "Y" for	Y" for yes	s or	Ν		Ν		40.00
							V 1.00	XVIII 2.00	XI X 3. 00	
	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen	t for	di sproporti ona	te share i	in aco	cordance	N	Y	N	45.00
46.00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excep pursuant to 42 CFR §412.348(f)? If yes, complete Wkst	ption	for extraordin	ary circu	mstand	ces	Ν	N	Ν	46.00
47.00	Pt. III. Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment Teaching Hospitals						N N	N N	N N	47.00 48.00
56.00	Is this a hospital involved in training residents in a	approv	ed GME program	s? Enter	"Y" f	for yes	N			56.00
57.00	or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first month for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II,	yes o h of t ", com	r "N" for no i his cost repor plete Workshee	n column [:] ting perio	1. If od? E	column 1 Enter "Y"				57.00
	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes, o	urseme comple	nt for physici te Wkst. D-5.		ices a	as	Ν			58.00
	Are costs claimed on line 100 of Worksheet A? If yes, Are you claiming nursing school and/or allied health o				s the		N N			59.00 60.00
	provider-operated criteria under §413.85? Enter "Y"	for ye Y/N	<u>s or "N" for n</u> IME	o. (see i Direct	nstruc	ctions) IME		Direct	GME	
	-	1.00	2.00	3.00	1	4.00		5.0	0	-
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	N	2.00	0.00		1.00	0.00			61.00
61.01	column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0.00		0. 00					61.01
	instructions) 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		0.00		0. 00					61.02
61.03	ACA). (see instructions) 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		0.00		0. 00					61.03
	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions)		0.00		0. 00					61.04
61.05	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's		0.00		0. 00					61.05

OSPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA	ATA	Provider CC		eriod: .om 01/01/2014	u of Form CMS-2 Worksheet S-2 Part I	
				То	0 12/31/2014	Date/Time Pre 12/13/2017 7:	
		Y/N	I ME	Direct GME	I ME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
.06 Enter the amount of ACA §5503 aw used for cap relief and/or FTEs care or general surgery. (see in:	that are nonprimary		0.00	0.00			61.0
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
.10 Of the FTEs in line 61.05, speci specialty, if any, and the number for each new program. (see instri- column 1, the program name, enter program code, enter in column 3, unweighted count and enter in co FTE unweighted count.	r of FTE residents uctions) Enter in r in column 2, the the IME FTE				0. 00	0.00	61.
.20 Of the FTEs in line 61.05, speci- program specialty, if any, and the residents for each expanded prog- instructions) Enter in column 1, enter in column 2, the program co 3, the IME FTE unweighted count 4, direct GME FTE unweighted count	he number of FTE ram. (see the program name, ode, enter in column and enter in column				0. 00	0. 00	61.2
						1.00	
ACA Provisions Affecting the Hea					ind for which		(2)
2.00 Enter the number of FTE resident: your hospital received HRSA PCRE				reporting per	I OU TOF WHICH	0.00	62.0
2.01 Enter the number of FTE residents during in this cost reporting per Teaching Hospitals that Claim Re	riod of HRSA THC pro	gram. (<u>see instructio</u>		your hospital	0.00	62.0
B. 00 Has your facility trained resident "Y" for yes or "N" for no in colu	nts in nonprovider s	ettings	during this c		period? Enter	Ν	63.0
	anni i. I'i yes, compr		<u>es 04-07. (see</u>	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Base Yea period that begins on or after J				This base year	is your cost	reporti ng	
1.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column)	yes, or your facili ber of unweighted no tations occurring in number of unweighte ur hospital. Enter i	ty trai n-prima all no d non-p n colum	ned residents ry care nprovider rimary care n 3 the ratio	0.00	0. 00	0. 000000	64.(
	Program Name		ogram Ćode	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00		2.00	3.00	4.00	5.00	
5.00 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				0.00	0.00	0. 000000	65.0

Health Financial Systems			MEMORIAL HOSE			In	n Lieu	u of For	m CMS-2	2552-10
HOSPITAL AND HOSPITAL HEAL	TH CARE COMPLEX IDE	NTIFICATION DAT	FA Pro	vider CCN:	F	Period: From 01/01/ Fo 12/31/		Workshe Part I Date/Ti 12/13/2	me Pre	pared:
					Unweighted FTEs Nonprovider Site	Unweigh FTEs i Hospita	n al	Ratio 1/ (col col.	(col . . 1 + 2))	
Section 5504 of the	ACA Current Year FT	E Residents in	Nonprovi der	Settings-	1.00 Effective	2.00 for cost re		3.C ing peri		
beginning on or afte 66.00 Enter in column 1 th FTEs attributable to Enter in column 2 th FTEs that trained in (column 1 divided by	r July 1, 2010 e number of unweigh rotations occurrin e number of unweigh your hospital. Ent	ted non-primary g in all nonpro ted non-primary er in column 3	y care resid ovider setti y care resid the ratio o	ent ngs. ent	0.0		0.00		000000	66.00
		gram Name	Program (Unweighted FTEs Nonprovider Site	Unweigh FTEsi Hospita	n	Ratio 3/ (col col.	. 3 +	
		1.00	2.00		3.00	4.00		5.0	00	
67.00 Enter in column 1, t name associated with your primary care pr which you trained re Enter in column 2, t code. Enter in colum number of unweighted care FTE residents a to rotations occurri non-provider setting column 4, the number unweighted primary c resident FTEs that t your hospital. Enter 5, the ratio of (col divided by (column 3 4)). (see instructio	each of ograms in sidents. he program n 3, the primary ttributable ng in all s. Enter in of are rained in in column umn 3 + column				0.0	0	0.00	0.	000000	67.00
		L. L.					1 00		0.00	
Inpatient Psychiatri	c Facility PPS						1.00	2.00	3.00	
70.00 Is this facility an Enter "Y" for yes or 71.00 If line 70 yes: Colu recent cost report f 42 CFR 412.424(d)(1) program in accordanc Column 3: If column (see instructions)	"N" for no. mn 1: Did the facil iled on or before N (iii)(c)) Column 2: e with 42 CFR 412.4 2 is Y, indicate wh	ity have an app ovember 15, 200 Did this faci 24 (d)(1)(iii)	proved GME t 04? Enter " lity train r (D)? Enter "	eaching pr Y" for yes esidents i Y" for yes	rogram in th s or "N" for n a new tea s or "N" for	e most no. (see ching no.	Ν		0	70. 00 71. 00
75.00 Is this facility an		ation Facility	(IRF), or d	oes it cor	ntain an IRF		Y			75.00
subprovider? Enter 76.00 If line 75 yes: Colu recent cost reportin no. Column 2: Did th CFR 412.424 (d)(1)(i indicate which progr	"Y" for yes and "N" mn 1: Did the facil g period ending on is facility train r ii)(D)? Enter "Y" f	for no. ity have an app or before Nove esidents in a p or yes or "N"	proved GME t mber 15, 200 new teaching for no. Colu	eaching pr 4? Enter " program i mn 3: If c	rogram in th 'Y" for yes n accordanc column 2 is '	e most or "N" for e with 42 Y,	N		0	76.00
								1. 0	0	
Long Term Care Hospi 80.00 s this a long term 81.00 s this a LTCH co-lo "Y" for yes and "N"	care hospital (LTCH cated within anothe					g period? E	Inter	N		80. 00 81. 00
TEFRA Providers85.00Is this a new hospit86.00Did this facility es	al under 42 CFR Sec tablish a new Other	subprovi der (no.	N		85.00 86.00
\$413.40(f)(1)(ii)? 87.00 s this hospital a "	Enter "Y" for yes a subclause (II)" LTC	nd "N" for no. H classified u	nder section	1886(d)(1	I)(B)(iv)(II))? Enter "Y	/"	N		87.00
for yes or "N" for n	0.					V		XL	X	
Title V and VIV C						1.00		2.0		
90.00 Does this facility h	ave title V and/or		hospital ser	vi ces? Ent	er "Y" for	N		Y		90.00
yes or "N" for no in 91.00 Is this hospital rei			rough the co	st report	either in	N		N		91.00
full or in part? Ent 92.00 Are title XIX NF pat	er "Y" for yes or "	N" for no in th	he applicabl	e column.				N		92.00
instructions) Enter	"Y" for yes or "N"	for no in the a	applicable c	olumn.		. NI				
93.00 Does this facility o "Y" for yes or "N" f	or no in the applic	able column.				N		N		93.00
94.00 Does title V or XIX applicable column.	reduce capital cost	/ Enter "Y" fo	r yes, and "	N' FOR NO	in the	N		N		94.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCM		eriod: rom 01/01/	2014	Workshe Part I Date/Ti	et S-2 me Pre	epared:
		V		<u>12/13/2</u> XI		58 am
		1.00		2.0		-
95.00 If line 94 is "Y", enter the reduction percentage in the applicable column 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no applicable column.		0. 00 N		0. C N	0	95.00 96.00
97.00 If line 96 is "Y", enter the reduction percentage in the applicable column Rural Providers	ו.	0.00		0.0	0	97.00
105.00 Does this hospital qualify as a critical access hospital (CAH)? 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive meth for outpatient services? (see instructions)	nod of payment	N N				105.00 106.00
107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement training programs? Enter "Y" for yes or "N" for no in column 1. (see instr yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the pr reimbursed. If yes complete Wkst. D-2, Pt. II.	ructions) lf	N				107.00
108.00 Is this a rural hospital qualifying for an exception to the CRNA fee sched CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N	_	Descie	- +	108.00
Physi cal 1.00	Occupational 2.00	Speecl 3.00		Respir 4.(-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	2.00	0.00				109.00
			ŀ	1.0	0	-
110.00 Did this hospital participate in the Rural Community Hospital Demonstratio	on project (41	OA Demo)fc	or	N		110.00
the current cost reporting period? Enter "Y" for yes or "N" for no.						
Miscellaneous Cost Reporting Information			1.00	2.00	3.00	
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in is yes, enter the method used (A, B, or E only) in column 2. If column 2 i 3 either "93" percent for short term hospital or "98" percent for long ter psychiatric, rehabilitation and long term hospitals providers) based on th Pub. 15-1, chapter 22, §2208.1.	s "E", enter m care (inclu	in column des	N		0	115.00
116.00 is this facility classified as a referral center? Enter "Y" for yes or "N" 117.00 is this facility legally-required to carry malpractice insurance? Enter "Y no.		"N" for	N N			116.00 117.00
 118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 i claim-made. Enter 2 if the policy is occurrence. 	f the policy	is	1			118.00
	Premiums	Losses	5	Insur	ance	
-	1.00	2.00		3.0	0	-
118.01 List amounts of malpractice premiums and paid losses:	411, 760	419	9, 724		(0118.01
		1.00		2.0	0	_
118.02 Are malpractice premiums and paid losses reported in a cost center other t Administrative and General? If yes, submit supporting schedule listing co and amounts contained therein.		1.00 N		2.0		118.02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov		N		Ν		119.00 120.00
§3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for th Hold Harmless provision in ACA §3121 and applicable amendments? (see instr	ne Outpatient					
§3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for th	ne Outpatient ructions)	Y				121.00
 §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for th Hold Harmless provision in ACA §3121 and applicable amendments? (see instr Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? Enter "Y" for for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A where these taxes are included. 	ne Outpatient ructions) s charged to yes or "N"	Ŷ				121.00 122.00
 §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for th Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? Enter "Y" for for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" 	ne Outpatient Fuctions) s charged to yes or "N" line number					
§3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instru- Enter in column 2, "Y" for yes or "N" for no. 121.00D id this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? Enter "Y" for for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certif in column 1 and termination date, if applicable, in column 2.	ne Outpatient Fuctions) s charged to yes or "N" line number for no. If fication date	N				122.00 125.00 126.00
§3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instru- Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state heal th or similar taxes? Enter "Y" for for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2.	ne Outpatient Fuctions) s charged to yes or "N" line number for no. If fication date cation date	N				122.00 125.00 126.00 127.00
 §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? Enter "Y" for for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified liver transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified liver transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2. 	ne Outpatient ructions) s charged to yes or "N" line number for no. If fication date cation date	N				122.00 125.00 126.00
 §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for th Hold Harmless provision in ACA §3121 and applicable amendments? (see instr Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? Enter "Y" for for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified liver transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified liver transplant center, enter the certifi column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified liver transplant center, enter the certific in column 1 and termination date, if applicable, in column 2. 	ne Outpatient Fuctions) s charged to yes or "N" line number for no. If fication date cation date cation date in	N				122.00 125.00 126.00 127.00 128.00
 §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for th Hold Harmless provision in ACA §3121 and applicable amendments? (see instr Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? Enter "Y" for for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified liver transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified liver transplant center, enter the certifi column 1 and termination date, if applicable, in column 2. 	ne Outpatient Fuctions) s charged to yes or "N" line number for no. If fication date cation date cation date in tification ertification	N				122.00 125.00 126.00 127.00 128.00 129.00

ealth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTII	PORTER MEMORIA	Provider CCN	: 15-0035		1/01/2014	u of Form CMS Worksheet S- Part I	-2
				To 12	2/31/2014	Date/Time Pr 12/13/2017 7	repared: 7:58 am
					1.00	2.00	-
33.00 f this is a Medicare certified other tran in column 1 and termination date, if appli			cation date		1.00	2.00	133.00
34.00 If this is an organ procurement organizati and termination date, if applicable, in co All Providers	on (OPO), enter t		n column 1				134.00
40.00 Are there any related organization or home chapter 10? Enter "Y" for yes or "N" for n are claimed, enter in column 2 the home of	o in column 1. If	yes, and home	office cost	s	Y	449008	140.00
	2.0				3.00		
If this facility is part of a chain organi office and enter the home office contracto			gh 143 the	name an	d address	of the home	
INC		SCONSIN PHYSICIA RVICES	AN Contract	tor's Nu	mber: 5228	0	141.0
42.00 Street: 4000 MERIDIAN BLVD PO E 43.00 City: FRANKLIN Sta	Box: te: TN		Zip Code	9:	3706	7	142.0 143.0
14 00 Are provider based physicians' costs inclu	dad in Warkshoot	12				1.00 Y	144.0
44.00 Are provider based physicians' costs inclu	ded in workSneet	<u></u>				T	144.0
					1.00	2.00	
45.00 If costs for renal services are claimed on inpatient services only? Enter "Y" for yes no, does the dialysis facility include Med period? Enter "Y" for yes or "N" for no i	or "N" for no in icare utilization	column 1. If co	olumn 1 is		Y		145.0
46.00 Has the cost allocation methodology change Enter "Y" for yes or "N" for no in column yes, enter the approval date (mm/dd/yyyy)	d from the previo 1. (See CMS Pub.			f	N		146. 0
						1.00	_
47.00 Was there a change in the statistical basi						N	147.0
48.00Was there a change in the order of allocat 49.00Was there a change to the simplified cost				nr no		N	148.0 149.0
	rinding mothodi 2	Part A	Part B		itle V	Title XIX	
		1.00	2.00		3.00	4.00	
Does this facility contain a provider that or charges? Enter "Y" for yes or "N" for n							
55. 00 Hospi tal		N	N		N	N	155.0
56.00 Subprovi der – IPF		N	N		Ν	N	156.0
57.00 Subprovider - IRF		N	N		N	N	157.0
58. 00 SUBPROVI DER 59. 00 SNF		N	N		Ν	N	158.0 159.0
60.00HOME HEALTH AGENCY		N N	N		N	N	160.0
61. OOCMHC			N		N	N	161.0
		I				1.00	_
Multicampus						1.00	
65.00 Is this hospital part of a Multicampus hos Enter "Y" for yes or "N" for no.	pital that has on	e or more campus	ses in diff	erent Cl	BSAs?	Ν	165.0
1	Vame	County		p Code	CBSA	FTE/Campus	_
(4 00) f line 1/F is you for each	0	1.00	2.00	3.00	4.00	5.00	01// 0
b6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0. (00166.0
	1				1	1.00	_
Health Information Technology (HIT) incent	ive in the Americ	an Recovery and	Reinvestme	ent Act		1.00	
67.00 s this provider a meaningful user under §	1886(n)? Enter "	Y" for yes or "I	N" for no.		r the	Y	167.0 0168.0
68.00 If this provider is a CAH (line 105 is "Y"			107 13 1				
	s (see instructio ningful user, doe	ns) s this provider	qualify fo	or a har			168.0

Health Financial Systems	PORTER MEMORIAL	HOSPI TAL	In Lieu	」of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDEN	Period:	Worksheet S-	2		
			From 01/01/2014 To 12/31/2014		epared: 58 am
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginn period respectively (mm/dd/yyyy)	ing date and ending da	te for the reporting	07/01/2014	09/30/2014	170.00
					_
			1.00	2.00	
171.00 If line 167 is "Y", does this provider			N		0171.00
section 1876 Medicare cost plans report					
"Y" for yes and "N" for no in column 1. 1876 Medicare days in column 2. (see in:	on				
provo meurcare days fil corumniz. (See fil			I. I.		

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OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0035	Period: From 01/01/2014 To 12/31/2014	Worksheet S- Part II Date/Time Pr 12/13/2017 7	epared
				Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO r	esponses. En	ter all dates in	the	
	mm/dd/yyyy format.					-
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					-
. 00	Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.0
. 00	reporting period? If yes, enter the date of the change in c					
			Y/N	Date	V/I	
			1.00	2.00	3.00	
. 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.	5	N			2.0
. 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	offices, drug ler or its of the board	Y			3.0
	of directors through ownership, control, or family and othe relationships? (see instructions)					
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports		-			
. 00 . 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe	or Compiled, Milable in	N			4.0
. 00	those on the filed financial statements? If yes, submit rec		IN IN			5.0
			1	Y/N 1.00	Legal Oper. 2.00	
. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is t	he provider	is Y	Y	6.0
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the	Y N		7. (8. (
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	n N		9.
	Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.	or renewed in		Ν		10.
1.00	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	Y/N	11.
					1.00	
	Bad Debts					
2.00 3.00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.	s, see instruc oolicy change	tions. during this o	cost reporting	Y N	12. 13.
4.00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? I	fyes, see i	nstructions.	N	14.
5.00	Did total beds available change from the prior cost reporti				Y	15.
		Par Y/N	t A Date	Par Y/N		
		1.00	2.00	3.00	Date 4.00	
	PS&R Data		2.00	0.00		
5.00	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	04/23/2015	Y	04/23/2015	16.
. 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		Ν		17.
3. 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.
9.00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	Ν		Ν		19.

	Financial Systems PORTER MEMORI		15 0025		u of Form CMS-	
USPI I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN:	10-0035	Period: From 01/01/2014 To 12/31/2014	Worksheet S- Part II Date/Time Pr 12/13/2017 7	epared
		Descripti	i on	Y/N	Y/N	
		0	-	1.00	3.00	
0.00	If line 16 or 17 is yes, were adjustments made to PS&R			N	Ν	20.0
	Report data for Other? Describe the other adjustments:	Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
1.00	Was the cost report prepared only using the provider's	N		N		21. (
	records? If yes, see instructions.					
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC Capital Related Cost	EPT CHILDRENS HOSI	PLIALS)			-
2.00	Have assets been relifed for Medicare purposes? If yes, se	e instructions			N	22.
3.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		s made dur	ring the cost	N	23.
4.00	Were new leases and/or amendments to existing leases enter If yes, see instructions	red into during th	is cost re	eporting period?	Ν	24.
5.00	Have there been new capitalized leases entered into during instructions.	the cost reporti	ng periodî	?lfyes, see	Ν	25.
6.00	Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost reporting	period? I	f yes, see	Ν	26.
7.00	instructions. Has the provider's capitalization policy changed during th	ne cost reporting	period? If	fyes, submit	Ν	27.
8.00	copy. Interest Expense Were new Loans, mortgage agreements or letters of credit e	entered into durin	a the cost	t reporting	N	28.
	period? If yes, see instructions. Did the provider have a funded depreciation account and/or				N	20.
	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat	ructions		,		
	instructions.				N	30.
1.00	Has debt been recalled before scheduled maturity without i instructions.	ssuance of new de		s, see	N	31.
2.00	Purchased Services Have changes or new agreements occurred in patient care se		through co	ontractual	Y	32.
3.00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		to competi	tive bidding? If	Ŷ	33.
4 00	Provi der-Based Physi ci ans				N/	1 24
	Are services furnished at the provider facility under an a If yes, see instructions.	0		1 5	Y	34.
5.00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		with the		Y	35.
				Y/N 1.00	Date 2.00	
	Home Office Costs			1.00	2.00	
	Were home office costs claimed on the cost report?			Y		36.
7.00	If line 36 is yes, has a home office cost statement been p	prepared by the ho	me office?	? Y		37.
3. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of			F N	12/31/2013	38.
9. 00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth			s, N		39.
0. 00	see instructions. If line 36 is yes, did the provider render services to the instructions.	e home office? If	yes, see	Ν		40.
		1.00		2	00	_
	Cost Report Preparer Contact Information	1.00		Ζ.	~~~	
1. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	VI CTORI A		ROMANKO		41.
	respecti vel y.					
2.00	Enter the employer/company name of the cost report preparer.	COMMUNI TY HEALTH	SYSTEMS			42.

Heal th	Financial Systems PORT	TER MEMORIA	L HOSPI TAL		In Lieu	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTION	NNAI RE	Provider CCN		Period:	Worksheet S-2	
					From 01/01/2014 To 12/31/2014	Date/Time Pre	nared
						12/13/2017 7:	58 am
			3.00)			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/pos	sition R	EVENUE MANAGER				41.00
	held by the cost report preparer in columns 1, 2,	and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost repor	-t					42.00
	preparer.						
43.00	Enter the telephone number and email address of t	the cost					43.00
	report preparer in columns 1 and 2, respectively.						

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IFS Si	upplemental Information	Provider CCN: 15-0035	Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 12/13/2017 7:	epared
			Title V	Title XIX	
			1.00	2.00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Intern stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in and Y/N in column 2 for Title XIX.		Y	Y	1.0
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the repor- Part I (e.g. net of Physician's component)? Enter Y/N in colum in column 2 for Title XIX.			Y	2.0
8. 00	Do Title V or XIX follow Medicare (Title XVIII) for the calcul Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for 2 for Title XIX.			Y	3.0
3. 01	Do Title V or XIX use W/S D-1 for reimbursement?		Ν	N	3.0
			I npati ent	Outpati ent	
			1.00	2.00	
	CRITICAL ACCESS HOSPITALS				
1. 00	Does Title V follow Medicare (Title XVIII) for Critical Access reimbursed 101% of cost? Enter Y or N in column 1 for inpatien for outpatient.		2 N	N	4.0
. 00	Does Title XIX follow Medicare (Title XVIII) for Critical Accorreimbursed 101% of cost? Enter Y or N in column 1 for inpatien for outpatient.			N	5.0
			Title V	Title XIX	
			1.00	2.00	
	RCE DI SALLOWANCE		·	•	
. 00	Do Title V or XIX follow Medicare and add back the RCE Disallo column 4? Enter Y/N in column 1 for Title V and Y/N in column PASS THROUGH COST		Y	Y	6.0
. 00	Do Title V or XIX follow Medicare when cost reimbursed (paymen worksheets D, parts I through IV? Enter Y/N in column 1 for Ti 2 for Title XIX.		ץ ו	Y	7.0
. 00	RHC Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Title V and Y/N in column 2 for Title XIX.	er Y/N in column 1 for	N	N	8.
. 00	FOHC For fiscal year beginning on/after 10/01/2014, use M-series fo	or Title V and/or Title	N	N	9.
7. UU	XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for		IN	IN IN	Y.

Heal th	Financial Systems	PORTER MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	CAL DATA	Provider C	CN: 15-0035	Peri od: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part I Date/Time Pre	pared:
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	12/13/2017 7: I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00 2.00 3.00 4.00 5.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider HOspital Adults & Peds. Swing Bed SNF		192	70, 08		0	1.00 2.00 3.00 4.00 5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		192	70, 08	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	32			0	8.00
8. 01 9. 00 10. 00 11. 00 12. 00	NEONATAL INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	31.01	14	5, 1	0.00	0	8. 01 9. 00 10. 00 11. 00 12. 00
13.00 14.00 15.00 16.00	NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF	43.00	238	86, 87	0.00	0 0 0	13.00 14.00 15.00 16.00
17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 24.10	SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part)	41. 00 30. 00	11	4, 0	15	0	17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 24.10
24. 10 25. 00 26. 00 26. 25	CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	24. 10 25. 00 26. 00 26. 25
27.00 28.00 29.00 30.00 31.00 32.00 32.01	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 outpatient days (see instructions) LTCH non-covered days		249 0		0	0	27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01 33. 00

1.00	Component	I/P Days	/ N/P Visits		To 12/31/2014	Date/Time Pre 12/13/2017 7:	pared:
1. 00	Component		/ 0/1 /13/13	/ Trips	Full Time I	Equi val ents	
1.00		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
1.00		6.00	7.00	8.00	9.00	10.00	
	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	24, 456	2, 908	47, 49	97		1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider	4, 957 0	3, 947 0				2.00 3.00
4.00	HMO IRF Subprovider	183	16				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0		0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	24, 456	2, 908	47, 49	97		7.00
8.00	INTENSIVE CARE UNIT	4, 058	113	7,79	91		8.00
8.01	NEONATAL INTENSIVE CARE UNIT	0	0	1, 21	15		8.01
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	00 544	1, 982	1, 98		1 0 1 7 0 7	13.00
14.00	Total (see instructions)	28, 514	5, 003	58, 48		1, 347. 85	
15.00	CAH visits	0	0		0		15.00
16.00	SUBPROVIDER - IPF	0 107	10/	2.2	0 00	10.05	16.00
17.00 18.00	SUBPROVI DER – I RF SUBPROVI DER	2, 127	196	3, 30	⁵⁹ 0.00	13.95	17.00 18.00
18.00	SUBPROVIDER SKILLED NURSING FACILITY						18.00
20.00	NURSING FACILITY						20.00
20.00	OTHER LONG TERM CARE						20.00
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)	0	0		0		24.10
25.00	CMHC - CMHC	-	-		-		25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	1, 361. 80	27.00
28.00	Observation Bed Days		0	3, 55	54		28.00
29.00	Ambul ance Trips	0					29.00
30.00	Employee discount days (see instruction)				0		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)	0	237	23			32.00
32.01	Total ancillary labor & delivery room				0		32.01
	outpatient days (see instructions) LTCH non-covered days	0					33.00

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	PORTER MEMORIAL AL DATA	Provi der C	CN: 15-0035	Peri od:	u of Form CMS-2 Worksheet S-3	
					From 01/01/2014 To 12/31/2014	Part I Date/Time Pre 12/13/2017 7:	
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	5, 3		12, 988	1.00
2.00	HMO and other (see instructions)			88	86 0		2.00
3.00	HMO I PF Subprovi der				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)						6.00 7.00
8.00	INTENSIVE CARE UNIT						8.00
8.01	NEONATAL INTENSIVE CARE UNIT						8.0
9.00	CORONARY CARE UNIT						9.00
10.00	BURN I NTENSI VE CARE UNI T						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	5, 3	36 1, 278	12, 988	
15.00	CAH visits		-	-, -,	.,	,	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	10	94 14	328	17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00

	Financial Systems AL WAGE INDEX INFORMATION			Provider C	F	eriod: rom 01/01/2014 o 12/31/2014	Worksheet S-3 Part II Date/Time Pre 12/13/2017 7:	pared:
		Worksheet A Line Number	Amount Reported	Reclassificat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							-
00	Total salaries (see	200.00	87, 429, 000	0	87, 429, 000	2, 830, 761. 00	30. 89	1.00
00	instructions) Non-physician anesthetist Part		0	C	0	0.00	0.00	2.00
00	A Non-physician anesthetist Part B		0	C	0	0.00	0.00	3.00
00	Physician-Part A - Administrative		247, 343	C	247, 343	1, 664. 00	148.64	4.00
01 00	Physicians - Part A - Teaching Physician and Non		0 0	0	-		0. 00 0. 00	
00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC services		0	o	0	0.00	0. 00	6.00
00	Interns & residents (in an approved program)	21.00	0	C	0	0.00	0.00	7.00
01	Contracted interns and residents (in an approved programs)		0	O	0	0.00	0.00	7.01
00	Home office and/or related organization personnel		0	C	0	0.00	0.00	8.00
00). 00	SNF Excluded area salaries (see instructions)	44.00	0 1, 057, 189	0 306, 991	0 1, 364, 180	0. 00 37, 940. 00		
1.00	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient Care		3, 137, 085	C	3, 137, 085	47, 126. 00	66.57	11.00
2.00	Contract labor: Top level management and other management and administrative		0	O	0	0.00	0.00	12.00
3. 00	services Contract Labor: Physician-Part		381, 410	C	381, 410	3, 622. 00	105.30	13.00
4.00	A - Administrative Home office and/or related orgainzation salaries and wage-related costs		5, 413, 231	C	5, 413, 231	88, 980. 00	60. 84	14.0
	Home office salaries		0	0	0			14.0
	Related organization salaries Home office: Physician Part A		0 0	0	0	0.00 0.00		14.0 15.0
5. 00	- Administrative Home office and Contract Physicians Part A - Teaching		0	C	0	0.00	0.00	16.0
7.00	WAGE-RELATED COSTS Wage-related costs (core) (see instructions)		21, 721, 456	C	21, 721, 456			17.0
3. 00	Wage-related costs (other) (see instructions)		0	C	0			18.0
9.00).00	Excluded areas Non-physician anesthetist Part		323, 410 0	0				19.0 20.0
1.00	A Non-physician anesthetist Part		1, 562	C	1, 562			21.0
2. 00	в Physician Part A - Administrative		22, 289	0	22, 289			22.0
4.00	Physician Part A - Teaching Physician Part B Wage-related costs (RHC/FQHC)		0 0 0	0 0 0	0 0 0			22.0 23.0 24.0
5.00 5.50	Interns & residents (in an approved program) Home office wage-related		0	0	0			25.0 25.5
5. 51 5. 52	Related orgainzation wage-related Home office: Physician Part A							25.5 25.5
	- Administrative - wage-related							25.5
J. DJ	Home office & Contract Physicians Part A - Teaching - wage-related							25.5

Heal th	Financial Systems		PORTER MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part II Date/Time Pre 12/13/2017 7:	pared:
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1.00	2.00	3.00	4.00	5.00	6.00	
	OVERHEAD COSTS - DIRECT SALARI	ES						
26.00	Employee Benefits Department	4.00	503, 264		503, 26	4 13, 107. 00	38.40	26.00
27.00	Administrative & General	5.00	12, 259, 232	-705, 820	11, 553, 41	2 415, 438. 00	27.81	27.00
28.00	Administrative & General under		788, 556	0	788, 55	6 6, 595. 00	119.57	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	0	0		0.00	0.00	29.00
30.00	Operation of Plant	7.00	1, 767, 066	0	1, 767, 06	6 63, 617. 00	27.78	30.00
31.00	Laundry & Linen Service	8.00	123, 592	0	123, 59	2 8, 220. 00	15.04	31.00
32.00	Housekeepi ng	9.00	2,064,136	0	2, 064, 13	6 157, 645. 00	13.09	32.00
33.00	Housekeeping under contract (see instructions)		164, 071	0	164, 07	1 5, 916. 00	27.73	33.00
34.00	Dietary	10.00	2, 132, 204	-1, 307, 557	824, 64	7 50, 007. 00	16.49	34.00
35.00	Dietary under contract (see instructions)		320, 386	0	320, 38	6 8, 736. 00	36.67	35.00
36.00	Cafeteria	11.00	0	1, 307, 557	1, 307, 55	7 79, 290. 00	16.49	36.00
37.00	Maintenance of Personnel	12.00	0	0		0.00	0.00	37.00
38.00	Nursing Administration	13.00	3, 381, 328	398, 829	3, 780, 15	7 83, 141. 00	45.47	38.00
39.00	Central Services and Supply	14.00	883, 056	0	883, 05	55, 185. 00	16.00	39.00
40.00	Pharmacy	15.00	2, 930, 041	0	2, 930, 04	1 58, 059. 00	50.47	40.00
41.00	Medi cal Records & Medi cal Records Li brary	16.00	1, 706, 722	0	1, 706, 72	2 71,000.00	24.04	41.00
42.00	Soci al Servi ce	17.00	0	0		0.00	0.00	42.00
43.00	Other General Service	18.00	0	0		0.00	0.00	43.00

Heal th	Financial Systems		PORTER MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI 1	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2014 To 12/31/2014		pared:
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		88, 702, 013	0	88, 702, 01	3 2, 852, 008. 00	31.10	1.00
	instructions)							
2.00	Excluded area salaries (see		1, 057, 189	306, 991	1, 364, 18	0 37, 940. 00	35.96	2.00
	instructions)							
3.00	Subtotal salaries (line 1		87, 644, 824	-306, 991	87, 337, 83	3 2, 814, 068. 00	31.04	3.00
	minus line 2)							
4.00	Subtotal other wages & related		8, 931, 726	0	8, 931, 72	6 139, 728. 00	63. 92	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		21, 743, 745	0	21, 743, 74	5 0.00	24.90	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		118, 320, 295	-306, 991	118, 013, 30	4 2, 953, 796. 00	39.95	6.00
7.00	Total overhead cost (see		29, 023, 654	-306, 991	28, 716, 66	3 1, 075, 956. 00	26.69	7.00
	instructions)							

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Heal th	Financial Systems	PORTER MEMORIAL	HOSPI TAL	In Lieu	ı of Form CMS-2	2552-10
	AL WAGE RELATED COSTS		Provi der CCN: 15-0035	Period: From 01/01/2014	Worksheet S-3 Part IV Date/Time Pre 12/13/2017 7:	pared:
					Amount Reported	
				-	1.00	
	PART IV - WAGE RELATED COSTS					
	Part A - Core List					
	RETIREMENT COST					
1.00	401K Employer Contributions				1, 681, 045	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contrik	oution			0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see	instructions)			0	3.00
4.00	Qualified Defined Benefit Plan Cost (see ins				0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External	Organi zati on)				
5.00	401K/TSA Plan Administration fees				0	5.00
6.00	Legal /Accounting/Management Fees-Pension PLa				0	6.00
7.00	Employee Managed Care Program Administration	n Fees			0	7.00
	HEALTH AND INSURANCE COST					
8.00	Health Insurance (Purchased or Self Funded)				11, 298, 953	8.00
8.01	Health Insurance (Self Funded without a Thir					8.01
8.02	Health Insurance (Self Funded with a Third F	Party Administrato	ır)			8.02
8.03	Health Insurance (Purchased)					8.03
9.00	Prescription Drug Plan				0	9.00
10.00	Dental, Hearing and Vision Plan				388, 214	
11.00	Life Insurance (If employee is owner or bene				68, 629	
12.00	Accident Insurance (If employee is owner or				286, 799	
13.00	Disability Insurance (If employee is owner of				0	13.00
14.00	Long-Term Care Insurance (If employee is owr	ner or beneficiary	')		0	14.00
15.00	'Workers' Compensation Insurance				942, 015	
16.00	Retirement Health Care Cost (Only current ye	ear, not the extra	ordinary accrual requir	ed by FASB 106.	0	16.00
	Non cumulative portion)					
	TAXES					
	FICA-Employers Portion Only				5, 016, 984	
18.00	Medicare Taxes - Employers Portion Only				1, 173, 002	
19.00	Unemployment Insurance					19.00
20.00	State or Federal Unemployment Taxes				911, 610	20.00
	OTHER				-	
21.00	Executive Deferred Compensation (Other Than instructions))	Retirement Cost R	eported on lines 1 thro	ugh 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances				0	22.00
23.00	Tuition Reimbursement				301, 466	
24.00	Total Wage Related cost (Sum of lines 1 -23)	l			22, 068, 717	24.00
	Part B - Other than Core Related Cost					
25.00	OTHER WAGE RELATED COSTS (SPECIFY)				0	25.00

Health Financial Systems	PORTER MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0035	Period: From 01/01/2014		
		To 12/31/2014	12/13/2017 7:	
Cost Center Description		Contract	Benefit Cost	
		Labor 1,00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Iden				
1.00 Total facility's contract labor and benefi	t cost	0	0	1.00
2.00 Hospital		0	0	2.00
3.00 Subprovider - IPF				3.00
4.00 Subprovider - IRF		0	0	4.00
5.00 Subprovider - (Other)		0	0	5.00
6.00 Swing Beds - SNF		0	0	6.00
7.00 Swing Beds - NF		0	0	7.00
8.00 Hospital-Based SNF				8.00
9.00 Hospital-Based NF				9.00
10.00 Hospital-Based OLTC				10.00
11.00 Hospital-Based HHA				11.00
12.00 Separately Certified ASC				12.00
13.00 Hospital-Based Hospice				13.00
14.00 Hospital-Based Health Clinic RHC				14.00
15.00 Hospital-Based Health Clinic FQHC				15.00
16.00 Hospital-Based-CMHC				16.00
17.00 Renal Dialysis		0	0	
18.00 Other		0	0	18.00

Heal th	Financial Systems	PORTER MEMORIAL HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA		rovider CC	N: 15-0035	Peri od:	Worksheet S-1	
					From 01/01/2014 To 12/31/2014		narod
					10 12/31/2014	12/13/2017 7:	
		1				1.00	
1.00	Uncompensated and indigent care cost computati Cost to charge ratio (Worksheet C, Part I line		idod by Li		n 9)	0. 158327	1.00
1.00	Medicaid (see instructions for each line)				11 0)	0. 150527	1.00
2.00	Net revenue from Medicaid					18, 157, 685	2.00
3.00	Did you receive DSH or supplemental payments	from Medicaid?				Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH		ayments fr	om Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH or supplementa	al payments from Me	edi cai d			-2, 863, 372	5.00
6.00	Medi cai d charges					131, 849, 100	6.00
7.00	Medicaid cost (line 1 times line 6)					20, 875, 272	7.00
8.00	Difference between net revenue and costs for I < zero then enter zero)	1 0 1			nes 2 and 5; if	5, 580, 959	8.00
	Children's Health Insurance Program (CHIP) (se	ee instructions for	r each lin	e)		r	
9.00	Net revenue from stand-alone CHIP					2,805	9.00
	Stand-alone CHIP charges					22, 618	
	Stand-alone CHIP cost (line 1 times line 10)	stand along CULD (ling 11 mi		f . Jong then	3, 581	
12.00	Difference between net revenue and costs for senter zero)	Stand-arone CHIP (ine n m	nus i i ne 9;	n < zero then	776	12.00
	Other state or local government indigent care	program (see inst	ructions f	or each line)	I	
13.00	Net revenue from state or local indigent care					447, 628	13.00
14.00	Charges for patients covered under state or lo					4, 554, 780	
	10)	-					
	State or local indigent care program cost (lin					721, 145	
16.00	Difference between net revenue and costs for s	state or local indi	igent care	program (li	ne 15 minus line	273, 517	16.00
	<u>13; if < zero then enter zero)</u> Grants, donations and total unreimbursed cost	for Modicaid CHI) and stat	o/Local indi	ant caro progra		
	instructions for each line)	TOT MEdicald, Chir	anu stat		gent care progra	anis (see	
17.00	Private grants, donations, or endowment income	e restricted to fu	nding char	ity care		0	17.00
18.00	Government grants, appropriations or transfers	s for support of h	ospital op	erations		0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and 1()	nd state and local	i ndi gent	care program	s (sum of lines	5, 855, 252	19.00
	8, 12 and 16)			Uni nsured	Insured	Total (col. 1	
				patients	patients	+ col . 2)	
				1.00	2.00	3.00	
	Uncompensated Care (see instructions for each						
20.00	Charity care charges and uninsured discounts (see instructions)	for the entire fac	ility	17, 720, 3	1 123, 878	17, 844, 249	20.00
21.00	Cost of patients approved for charity care and instructions)	d uninsured discou	nts (see	2,805,6	3 123, 878	2, 929, 491	21.00
22.00	Payments received from patients for amounts p	reviously written o	off as	34, 88	5, 070	39, 956	22.00
22.00	charity care			0 770 7	110 000	2 000 525	22.00
23.00	Cost of charity care (line 21 minus line 22)			2, 770, 72	118, 808	2, 889, 535	23.00
						1.00	
24.00	Does the amount in line 20 column 2 include cl	harges for patient	days beyo	nd a length	of stay limit	N	24.00
	imposed on patients covered by Medicaid or oth	her indigent care	orogram?	-			
25.00	If line 24 is yes, enter the charges for paties stay limit	ent days beyond the	e indigent	care progra	m's length of	0	25.00
26.00	Total bad debt expense for the entire hospital	l complex (see ins	tructions)			42, 703, 067	26.00
27.00	Medicare reimbursable bad debts for the entire	•		ructions)		257, 890	
27.01	Medicare allowable bad debts for the entire he					396, 754	
28.00	Non-Medicare bad debt expense (line 26 minus	line 27.01)				42, 306, 313	28.00
29.00	Cost of non-Medicare and non-reimbursable Medi		ense (see	instructions)	6, 837, 096	
30.00	Cost of uncompensated care (line 23 column 3					9, 726, 631	
31.00	Total unreimbursed and uncompensated care cos	st (line 19 plus lin	ne 30)			15, 581, 883	31.00

CLAS	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	PORTER MEMORIA OF EXPENSES	Provider C	CN: 15-0035	Peri od:	u of Form CMS-: Worksheet A	
					From 01/01/2014 To 12/31/2014	Date/Time Pre	epar
	Cost Conton Description	Colorian	0+6-1-	Total (set 1	Dool oo-i-file it	12/13/2017 7:	58
	Cost Center Description	Sal ari es	Other		Reclassi fi cat		
				+ col. 2)	i ons (See	Trial Balance	
					A-6)	(col. 3 +-	
						col . 4)	-
		1.00	2.00	3.00	4.00	5.00	-
	GENERAL SERVICE COST CENTERS		4 500 (10	1 500 (1		(750 00(1.
00	00100 CAP REL COSTS-BLDG & FIXT		4, 503, 619				
00	00200 CAP REL COSTS-MVBLE EQUIP		12, 537, 039	12, 537, 03			2
00	00400 EMPLOYEE BENEFITS DEPARTMENT	503, 264	638, 558	1, 141, 82	2 12, 943, 333	14, 085, 155	4
00	00500 ADMI NI STRATI VE & GENERAL	12, 259, 232	106, 672, 921	118, 932, 15	3 -18, 153, 543	100, 778, 610	5
00	00700 OPERATION OF PLANT	1,767,066	7, 666, 117	9, 433, 18	3 -12, 588	9, 420, 595	1 7
00	00800 LAUNDRY & LINEN SERVICE	123, 592	1, 563, 160	1, 686, 75		1, 686, 752	
00	00900 HOUSEKEEPI NG	2,064,136	1, 507, 905	3, 572, 04		3, 571, 831	
00	01000 DI ETARY	2, 132, 204	1,073,839	3, 206, 04			
	01100 CAFETERIA						
00		0	0		0 1, 962, 752	1, 962, 752	
00	01300 NURSING ADMINISTRATION	3, 381, 328	631, 347	4, 012, 67		4, 410, 579	
00	01400 CENTRAL SERVICES & SUPPLY	883, 056	28, 278, 420	29, 161, 47		1, 536, 704	
00	01500 PHARMACY	2, 930, 041	17, 499, 496	20, 429, 53		3, 418, 473	15
00	01600 MEDICAL RECORDS & LIBRARY	1, 706, 722	1, 384, 202	3, 090, 92	4 0	3, 090, 924	16
00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0 0	0	23
	INPATIENT ROUTINE SERVICE COST CENTERS	• •					
00	03000 ADULTS & PEDIATRICS	15, 246, 096	4, 927, 989	20, 174, 08	5 -713, 250	19, 460, 835	30
00	03100 I NTENSI VE CARE UNI T	5, 893, 621	1, 698, 655	7, 592, 27		7, 574, 484	
01	03101 NEONATAL INTENSIVE CARE UNIT	1, 744, 671	566, 716	2, 311, 38		2, 311, 387	
00	04100 SUBPROVIDER - IRF	1,001,489	1,062,732	2,064,22		1, 255, 002	
00	04300 NURSERY	358	76, 033	76, 39	1 397, 055	473, 446	43
	ANCI LLARY SERVICE COST CENTERS						1
00	05000 OPERATING ROOM	6, 278, 674	5, 830, 100				
00	05100 RECOVERY ROOM	2, 133, 269	385, 829	2, 519, 09		0	
00	05200 DELIVERY ROOM & LABOR ROOM	1, 636, 184	455, 278	2, 091, 46	2 244, 577	2, 336, 039	52
00	05300 ANESTHESI OLOGY	0	1, 397, 232	1, 397, 23	2 -21, 961	1, 375, 271	53
00	05400 RADI OLOGY-DI AGNOSTI C	4, 508, 257	1, 771, 327	6, 279, 58	4 3, 038, 484	9, 318, 068	54
01	05401 ULTRASOUND	473, 861	94, 969	568, 83		0	
00	05600 RADI OI SOTOPE	451, 512	855, 527	1, 307, 03			
00	05700 CT SCAN	549, 302	257, 591	806, 89			
00	05800 MRI	246, 290	111, 082	357, 37		0	
00	06000 LABORATORY	4, 987, 297	7, 350, 078	12, 337, 37		11, 936, 574	
00	06500 RESPI RATORY THERAPY	2, 160, 365	551, 242	2, 711, 60	7 –135, 921	2, 575, 686	
00	06600 PHYSI CAL THERAPY	0	1, 483, 839	1, 483, 83	9 2, 046, 634	3, 530, 473	66
00	06700 OCCUPATI ONAL THERAPY	0	970, 512	970, 51	2 -970, 512	0	6
00	06800 SPEECH PATHOLOGY	0	274, 431	274, 43	1 -274, 431	0	68
00	06900 ELECTROCARDI OLOGY	4,093,306	1, 816, 071	5, 909, 37		6, 184, 183	69
00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		1, 966, 516		
00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		25, 055, 133		
00	07300 DRUGS CHARGED TO PATIENTS	70, 853	459, 394	530, 24			
00	07400 RENAL DI ALYSI S						
		0	626, 642	626, 64		626, 642	
	03950 ANCI LLARY	0	0		0 0		76
	03610 SLEEP LAB	374, 636	75, 141				76
03	03951 WOUND CARE	577, 040	738, 057	1, 315, 09	7 0	1, 315, 097	76
	OUTPATIENT SERVICE COST CENTERS						
00	09000 CLI NI C	0	0	(0 0	0	90
00	09100 EMERGENCY	7, 195, 578	1, 784, 634	8, 980, 21	2 0	8, 980, 212	91
00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92
	SPECIAL PURPOSE COST CENTERS						
3. 00	SUBTOTALS (SUM OF LINES 1-117)	87, 373, 300	219, 577, 724	306, 951, 02	4 -1, 324, 534	305, 626, 490	118
	NONREI MBURSABLE COST CENTERS						1
), ()(19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190
	19200 PHYSI CLANS' PRI VATE OFFICES		1, 058	1, 05		1, 058	
			1, 058				192
	19201 OTHER NONREL MBURSABLE	0	0		0 0		
	07950 NONREI MBURSABLE	0	0		0 0		194
	07951 MARKETI NG	0	0		0 1, 324, 534		
4.02	07952 SENIOR CIRCLE	55, 700	34, 265	89, 96	5 0	89, 965	
4 O'	07953 OTHER NONREIMB COST C - REGENCY LTA	0	0	(0 0		194
1.0		1	_				194
	07954 VACANT UNFINISHED AREA	0	0		0 0	0 307, 042, 047	

CLASSIFICATION AND ADJUSTMENTS OF TRIAL B	ALANCE OF EXPENSES	Provider C	CN: 15-003	35 Period:	Worksheet A
				From 01/01/201	4
				To 12/31/201	4 Date/Time Prepar 12/13/2017 7:58
Cost Center Description	Adjustments	Net Expenses		I	12/10/2017 1.00
	(See A-8)	For			
		Allocation			
	6.00	7.00			
GENERAL SERVICE COST CENTERS		1			
00 00100 CAP REL COSTS-BLDG & FIXT	9, 714				1
00 00200 CAP REL COSTS-MVBLE EQUIP	-2, 369, 750				2
00 00400 EMPLOYEE BENEFITS DEPARTMENT	-7, 232				4
00 00500 ADMINI STRATI VE & GENERAL	-54, 085, 885				5
00 00700 OPERATION OF PLANT	-74, 406				7
00 00800 LAUNDRY & LINEN SERVICE	0				8
00 00900 HOUSEKEEPI NG	0				ç
00 01000 DI ETARY	0	.,,			10
00 01100 CAFETERIA	-119, 681				11
00 01300 NURSI NG ADMI NI STRATI ON	-47, 633				13
00 01400 CENTRAL SERVICES & SUPPLY	0				14
00 01500 PHARMACY	0				15
00 01600 MEDICAL RECORDS & LIBRARY	-1, 632				16
00 02300 PARAMED ED PRGM-(SPECIFY)	0	0			23
INPATIENT ROUTINE SERVICE COST CENTER		47			
00 03000 ADULTS & PEDIATRICS	-1, 605, 291				30
00 03100 I NTENSI VE CARE UNI T	-88, 286				31
01 03101 NEONATAL INTENSIVE CARE UNIT	-307, 900				31
00 04100 SUBPROVIDER - IRF	-57, 815				41
00 04300 NURSERY	0	473, 446			43
ANCI LLARY SERVICE COST CENTERS	447.500	11.010.07			
00 05000 OPERATING ROOM	-447, 500				50
00 05100 RECOVERY ROOM	0				51
00 05200 DELIVERY ROOM & LABOR ROOM	0				52
00 05300 ANESTHESI OLOGY	-1, 202, 750				53
00 05400 RADI OLOGY-DI AGNOSTI C	0				54
01 05401 ULTRASOUND	0				54
00 05600 RADI OI SOTOPE	0	-			56
00 05700 CT SCAN	-1,650				57
00 05800 MRI 00 06000 LABORATORY	0	-			58
00 06000 LABORATORY 00 06500 RESPI RATORY THERAPY	-21,000				65
00 06600 PHYSICAL THERAPY	-8, 820				66
	0				67
			-		68
00 06800 SPEECH PATHOLOGY 00 06900 ELECTROCARDI OLOGY	0				69
00 07100 MEDICAL SUPPLIES CHARGED TO PAT					71
00 07200 IMPL. DEV. CHARGED TO PATIENTS	0				72
00 07200 TMPL. DEV. CHARGED TO PATTENTS					
00 07400 RENAL DIALYSIS	-11, 927 0				73
00 03950 ANCI LLARY	0				76
01 03610 SLEEP LAB		0			76
03 03951 WOUND CARE	0				76
OUTPATIENT SERVICE COST CENTERS	0	1, 515, 097			//
00 09000 CLINIC	0	0			90
00 09100 EMERGENCY	-16, 801				90
00 09200 OBSERVATION BEDS (NON-DISTINCT		0,703,411			92
SPECIAL PURPOSE COST CENTERS		I			92
3.00 SUBTOTALS (SUM OF LINES 1-117)	-60, 466, 245	245, 160, 245			118
NONREI MBURSABLE COST CENTERS	-00, 400, 245	243, 100, 243			
0. 00 19000 GIFT, FLOWER, COFFEE SHOP & CAN	ITEEN O	0			190
2. 00 19000 PHYSI CLANS' PRI VATE OFFICES	O O	-			190
2. 01 19200 PHYSICIANS PRIVATE OFFICES 2. 01 19201 OTHER NONRELMBURSABLE		1, 058			192
	0				192
I. 00 07950 NONREI MBURSABLE I. 01 07951 MARKETI NG	0				194
1. 02 07951 MARKETING 1. 02 07952 SENIOR_CIRCLE		.,			
			1		194 194
4. 03 07953 OTHER NONREIMB COST C - REGENCY 4. 04 07954 VACANT UNFINISHED AREA	LTA 0				194
	-60, 466, 245	-			200
D. 00 TOTAL (SUM OF LINES 118-199)					

	Financial Systems	PORTER MEMORIAL HOSPITAL Provider	CCN: 15-0035	Peri od:	u of Form CM Worksheet N	
0001 0			CON. 13 0000	From 01/01/2014	Date/Time F	Prepared
	Cost Center Description		CMS Code	Standard	<u>12/13/2017</u> _abel For	7:58 am
				Non-Standa	ard Codes	
			1.00	2.0	0	
	GENERAL SERVICE COST CENTERS		1.00	2.0	00	
1.00	CAP REL COSTS-BLDG & FIXT		00100			1.0
2.00	CAP REL COSTS-MVBLE EQUIP		00200			2.0
4.00	EMPLOYEE BENEFITS DEPARTMENT		00400			4.0
5.00 7.00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT		00500 00700			5.0
3.00	LAUNDRY & LINEN SERVICE		00800			8.0
9.00	HOUSEKEEPING		00900			9.0
10.00	DI ETARY		01000			10.0
11.00	CAFETERIA		01100			11.0
13.00	NURSI NG ADMI NI STRATI ON		01300			13.0
14.00 15.00	CENTRAL SERVICES & SUPPLY PHARMACY		01400 01500			14.0
16.00	MEDICAL RECORDS & LIBRARY		01600			16.0
23.00	PARAMED ED PRGM-(SPECIFY)		02300			23.0
20.00	INPATIENT ROUTINE SERVICE COST CENTERS		02000			
30.00	ADULTS & PEDIATRICS		03000			30.0
31.00	INTENSIVE CARE UNIT		03100			31.0
31.01	NEONATAL INTENSIVE CARE UNIT		03101			31.0
41.00	SUBPROVIDER - IRF		04100			41.0
43.00	NURSERY ANCI LLARY SERVI CE COST CENTERS		04300			43.0
50.00	OPERATING ROOM		05000			50.0
51.00	RECOVERY ROOM		05100			51.0
52.00	DELIVERY ROOM & LABOR ROOM		05200			52.0
53.00	ANESTHESI OLOGY		05300			53.0
54.00	RADI OLOGY-DI AGNOSTI C		05400			54.0
54.01			05401			54.0
56.00 57.00	RADI OI SOTOPE CT SCAN		05600 05700			56.0 57.0
58.00	MRI		05800			58.0
60.00	LABORATORY		06000			60.0
65.00	RESPI RATORY THERAPY		06500			65.0
66.00	PHYSI CAL THERAPY		06600			66.0
67.00	OCCUPATIONAL THERAPY		06700			67.0
68.00 69.00	SPEECH PATHOLOGY		06800			68.0
71.00	ELECTROCARDI OLOGY MEDI CAL SUPPLI ES CHARGED TO PATI ENT		06900 07100			69.0
72.00	IMPL. DEV. CHARGED TO PATIENTS		07200			72.0
73.00	DRUGS CHARGED TO PATIENTS		07300			73.0
74.00	RENAL DI ALYSI S		07400			74.0
	ANCILLARY		03950			76.0
76.01	SLEEP LAB		03610	SLEEP LAB		76.0
76.03			03951			76.0
90.00	OUTPATIENT SERVICE COST CENTERS		09000			90.0
	EMERGENCY		09000			90.0
	OBSERVATION BEDS (NON-DISTINCT PART		09200			92.0
	SPECIAL PURPOSE COST CENTERS		·			
118.00	SUBTOTALS (SUM OF LINES 1-117)					118.0
100 07	NONREI MBURSABLE COST CENTERS		10000			100.0
	GIFT, FLOWER, COFFEE SHOP & CANTEEN		19000			190.0
	PHYSICIANS' PRIVATE OFFICES		19200 19201			192.0 192.0
	NONREI MBURSABLE		07950			192.0
	MARKETING		07951			194.0
	SENI OR CI RCLE		07952			194.0
	OTHER NONREIMB COST C - REGENCY LTA		07953			194.0
	VACANT UNFINISHED AREA		07954			194.0
	TOTAL (SUM OF LINES 118-199)		1	1		200.0

	Financial Systems SFFICATIONS		PORTER MEMORI	AL HOSPITAL Provider CCN	15 0025 D	In Lie	eu of Form CMS Worksheet A-	
RECLAS				PLOVIDEL CON		om 01/01/2014	4	
		Increases					12/13/2017	7:58 am
	Cost Center 2.00	Li ne # 3. 00	Salary 4.00	0ther 5.00				
	A - EMPLOYEE BENEFITS	0.00	1.00	0.00				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	<u>12, 943, 333</u>				1.00
	TOTALS B - OXYGEN COSTS		U	12, 943, 333				-
1.00	MEDI CAL SUPPLIES CHARGED TO	71.00	0	59, 018				1.00
		+						
	TOTALS C - RENTAL AND LEASE EXPENSES		U	59, 018				-
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	640, 509				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2, 604, 907				2.00
3.00 4.00		0. 00 0. 00	0	0				3.00
5.00		0.00	0	0				5.00
6.00		0.00	0	0				6.00
7.00 8.00		0. 00 0. 00	0	0				7.00
9.00		0.00	0	0				9.00
10.00		0.00	О	0				10.00
11.00		0.00	0	0				11.00
12.00 13.00		0. 00 0. 00	0	0				12.00 13.00
14.00		0.00	0	0				14.00
15.00		0.00	0	0				15.00
16.00 17.00		0. 00 0. 00	0	0				16.00 17.00
18.00		0.00	0	0				18.00
19.00		0.00	o	0				19.00
			0	3, 245, 416				-
1.00	D - OTHER CAPITAL COSTS CAP REL COSTS-BLDG & FIXT	1.00	0	283, 665				1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 331, 513				2.00
3.00	CAP REL COSTS-MVBLE EQUIP		•	102,951				3.00
	TOTALS E - MARKETING DEPARTMENT		0	1, 718, 129				-
1.00	MARKETING	194.01	30 <u>6, 9</u> 91	1,017,543				1.00
	TOTALS		306, 991	1, 017, 543				_
1.00	F - CHIEF NURSING OFFICER COST NURSING ADMINISTRATION	13.00	398, 829	0				1.00
	TOTALS		398, 829					
1 00	G - MEDICAL SUPPLIES	74.00		1 007 100				1 00
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	1, 907, 498				1.00
2.00	IMPL. DEV. CHARGED TO	72.00	О	25, 055, 133				2.00
2.00	PATIENTS	50.00		E 47 174				2.00
3.00	OPERATING ROOM	<u>50.00</u>	0	<u>547, 1</u> 74 27, 509, 805				3.00
	H - COST OF DRUGS/IV SOLUTION		-					
1.00	DRUGS CHARGED TO PATIENTS	73.00 0.00	0	17, 295, 776				1.00
2.00 3.00		0.00	0	0 0				2.00 3.00
	TOTALS			17, 295, 776				
1 00	I - LABOR AND DELIVERY COSTS	20.00		25 4/7				1 00
1.00 2.00	ADULTS & PEDIATRICS NURSERY	30. 00 43. 00	0 387, 888	25, 467 9, 167				1.00 2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	280, 637	0				3.00
	TOTALS		668, 525	34, 634				
1.00	J - PT, OT, AND ST COSTS PHYSICAL THERAPY	66.00	0	1, 238, 178				1.00
2.00		0.00		0				2.00
	TOTALS		0	1, 238, 178				
1.00	K - RECOVERY ROOM OPERATING ROOM	50.00	2, 133, 269	385, 829				1.00
1.00	TOTALS		2, 133, 269	<u>385, 829</u> 385, 829				1.00
	L - OTHER RADIOLOGY COST							
1.00	RADI OLOGY-DI AGNOSTI C	54.00	1, 720, 965	1, 317, 519				1.00
2.00 3.00		0. 00 0. 00	0	0				2.00
4.00	$\square _ _ _ _ _ _ _$	0.00	0	0				4.00
	TOTALS	A	1, 720, 965	1, 317, 519				_
1.00	M - DIETARY COSTS TO CAFETERIA	11.00	1, 307, 557	655, 195				1.00
	TOTALS		1, 307, 557	655, 195				

Heal th	Financial Systems		PORTER MEMORI	AL HOSPITAL		In Lieu	u of Form CMS	-2552-10
RECLAS	SI FI CATI ONS			Provider C	CCN: 15-0035	Period: From 01/01/2014	Worksheet A-	6
						To 12/31/2014	Date/Time Pr 12/13/2017 7	epared: :58 am
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
	N – REHAB THERAPY COSTS							
1.00	PHYSI CAL THERAPY	66.00	0	808, 542				1.00
	TOTALS		0	808, 542				
	0 - SLEEP LAB COSTS TO EKG							
1.00	ELECTROCARDI OLOGY	69.00	374, 636	67, 535				1.00
	TOTALS		374, 636	67, 535				
	P - PARAMEDICAL EDUCATION							
1.00	PARAMED ED PRGM-(SPECIFY)	23.00	0	53, 317				1.00
	TOTALS		0	53, 317				
	Q - REMOVE PARAMEDICAL ED							
1.00	EMERGENCY	<u>91.</u> 00	0	5 <u>3, 3</u> 17				1.00
			0	53, 317				
500.00	Grand Total: Increases		6, 910, 772	68, 403, 086				500.00

C: \TEMP\Cori \reopenings HFS\150035 123114\150035. 12312014. R1. mcax

LASS	SI FI CATI ONS			Provi der (CCN: 15-0035	Peri od:	Worksheet A-6
						From 01/01/2014 To 12/31/2014	Date/Time Prepare
		Decreases					12/13/2017 7:58 a
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref		
	6.00	7.00	8.00	9.00	10.00	-	
	A - EMPLOYEE BENEFITS						
0	ADMI NI STRATI VE & GENERAL	<u>5.</u> 00	0	<u>12, 943, 3</u> 33		이	1
	TOTALS		0	12, 943, 333			
0	B - OXYGEN COSTS RESPI RATORY THERAPY	45.00	0	59, 018		0	1
U	TOTALS	<u>65.</u> 00	0	<u>59,018</u> 59,018	<u> </u>	<u>o</u>	1
	C - RENTAL AND LEASE EXPENSES		0	37,010	1		
0	ADMI NI STRATI VE & GENERAL	5.00	0	1, 768, 718	1	0	1
0	OPERATION OF PLANT	7.00	0	12, 588	1	o	2
0	DI ETARY	10.00	0	5, 426		0	3
0	NURSING ADMINISTRATION	13.00	0	925		0	4
0	CENTRAL SERVICES & SUPPLY	14.00	0	120, 807		0	5
0	PHARMACY ADULTS & PEDI ATRI CS	15.00 30.00	0	155, 951		0	6
0	INTENSIVE CARE UNIT	30.00	0	70, 192 17, 792		0	8
0	SUBPROVIDER - IRF	41.00	0	677		0	9
	OPERATI NG ROOM	50.00	0	413, 939		0	10
00	LABORATORY	60.00	0	400, 801		0	11
00	RESPI RATORY THERAPY	65.00	0	76, 903		0	12
	ELECTROCARDI OLOGY	69.00	0	161, 525		0	13
	DRUGS CHARGED TO PATIENTS	73.00	0	23, 079		0	14
	SLEEP LAB	76.01	0	7,606		0	15
	HOUSEKEEPING	9.00	0	210		0	16
00 00	DELIVERY ROOM & LABOR ROOM	52.00 66.00	0	1, 426 86		0	17
00	OCCUPATI ONAL THERAPY	67.00	0	6, 765		0	10
00	TOTALS		0	3, 245, 416		1	
	D - OTHER CAPITAL COSTS					1	
0	ADMI NI STRATI VE & GENERAL	5.00	0	1, 718, 129			1
0		0.00	0	C		3	2
0		0.00	0	0	1	2	3
			0	1, 718, 129			
0	E - MARKETI NG DEPARTMENT ADMI NI STRATI VE & GENERAL	5.00	306, 991	1,017,543		0	1
U	TOTALS	<u></u>	306, 991	1,017,543			
	F - CHIEF NURSING OFFICER COST		000,771	1/01//010			
0	ADMI NI STRATI VE & GENERAL	5.00	398, 829	C		0	1
	TOTALS		398, 829			1	
	G - MEDICAL SUPPLIES				1	-	
0	CENTRAL SERVICES & SUPPLY	14.00	0	27, 503, 965		0	1
0	ELECTROCARDI OLOGY	69.00	0	5, 840		0	2
0	TOTALS	0.00	0	27, 509, 805		<u>o</u>	3
	H - COST OF DRUGS/IV SOLUTIONS		0	27, 509, 805			
0	DRUGS CHARGED TO PATIENTS	73.00	0	418, 702		0	1
0	PHARMACY	15.00	0	16, 855, 113		0	2
0	ANESTHESI OLOGY	53.00	0	21, 961		0	3
	TOTALS		0	17, 295, 776			
	I - LABOR AND DELIVERY COSTS				1		
0	ADULTS & PEDIATRICS	30.00	668, 525	0		0	1
0	DELIVERY ROOM & LABOR ROOM	52.00	0	34, 634		0	2
0	TOTALS	0.00	668, 525			Q	3
	J - PT, OT, AND ST COSTS		006, 525	34, 034	•		
0	OCCUPATIONAL THERAPY	67.00	0	963, 747		0	1
0	SPEECH PATHOLOGY	68.00	Ō	274, 431		0	2
	TOTALS		0	1, 238, 178			
	K - RECOVERY ROOM						
0	RECOVERY ROOM	<u>51.00</u>	<u>2, 133, 269</u>	<u>385, 8</u> 29		Q	1
			2, 133, 269	385, 829	1		
0	L - OTHER RADIOLOGY COST	E4 04	470.074	04.010	1	0	
0	ULTRASOUND RADI OI SOTOPE	54.01 56.00	473, 861 451, 512	94, 969 855 527		0	1
0	CT SCAN	56.00 57.00	451, 512 549, 302	855, 527 255, 941		o	3
0	MRI	58.00	246, 290	111, 082		0	4
5	TOTALS	<u>55.00</u>	1, 720, 965	1, 317, 519		Ť	4
	M - DIETARY COSTS TO CAFETERIA		.,0,,00	., 51., 51.			
0	DI ETARY	10.00	1, 307, 557	655, 195		0	1
	TOTALS		1, 307, 557	655, 195		<u> </u>	
	N - REHAB THERAPY COSTS						
0	SUBPROVI DER – I RF	41.00	0	808, 542		0	1

Heal th	Financial Systems		PORTER MEMORI	AL HOSPITAL		In Lie	u of Form CMS	-2552-10
RECLAS	SI FI CATI ONS			Provi der (CCN: 15-0035	Period: From 01/01/2014 To 12/31/2014	Worksheet A- Date/Time Pr 12/13/2017 7	epared:
		Decreases					12/13/2017 7	
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref	·		
	6.00	7.00	8.00	9.00	10.00			
	0 - SLEEP LAB COSTS TO EKG							
1.00	SLEEP LAB		374, 636	6 <u>7, 5</u> 35		0		1.00
	TOTALS		374, 636	67, 535				
	P - PARAMEDICAL EDUCATION							
1.00	EMERGENCY	91.00	0	5 <u>3, 3</u> 17		0		1.00
	TOTALS		0	53, 317				
	Q - REMOVE PARAMEDICAL ED							
1.00	PARAMED ED PRGM-(SPECIFY)	23.00	0	5 <u>3, 3</u> 17		0		1.00
			0	53, 317				
500.00	Grand Total: Decreases		6, 910, 772	68, 403, 086				500.00

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Heal th	Fi nanci al	Systems
RECLAS	SI FI CATI ON	S

PORTER MEMORIAL HOSPITAL

Provider CCN: 15-0035

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 01/01/2014 Non-CMS Worksheet To 12/01/2014 Non-CMS Worksheet

						F T	rom 01/01/2014 o 12/31/2014	Non-CMS Works Date/Time Pre 12/13/2017 7:	epared:
		Incre	ases			Decre	ases		
	Cost Center	Line #	Sal ary	Other	Cost Center	Line #	Sal ary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
1 00	A - EMPLOYEE BENEFITS EMPLOYEE BENEFITS	4 00	0	12 042 222		E OO	0	10 040 000	1 00
1.00	DEPARTMENT	4.00	0	12, 943, 333	ADMI NI STRATI VE & GENERAL	5.00	0	12, 943, 333	1.00
	TOTALS		— — — d	12, 943, 333		<u> </u>	— — — d	12, 943, 333	
	B - OXYGEN COSTS	I		, ,		1 1			
1.00	MEDI CAL SUPPLI ES	71.00	0	59, 018	RESPI RATORY THERAPY	65.00	0	59, 018	1.00
	CHARGED TO PATIENT					<u> </u>	+		
	TOTALS	VDENCEC	0	59, 018	TOTALS		0	59, 018	
1.00	C - RENTAL AND LEASE E CAP REL COSTS-BLDG &	1.00	0	640 500	ADMI NI STRATI VE &	5.00	0	1, 768, 718	1.00
1.00	FLXT	1.00	0	040, 309	GENERAL	5.00	Ŭ	1,700,710	1.00
2.00	CAP REL COSTS-MVBLE	2.00	0	2, 604, 907	OPERATION OF PLANT	7.00	0	12, 588	2.00
	EQUI P								
3.00		0.00	0		DI ETARY	10.00	0	5, 426	3.00
4.00		0.00	0	0	NURSI NG	13.00	0	925	4.00
5.00		0.00	0	0	ADMI NI STRATI ON CENTRAL SERVI CES &	14.00	o	120, 807	5.00
5.00		0.00	0	0	SUPPLY	14.00	0	120, 007	5.00
6.00		0.00	0	0	PHARMACY	15.00	0	155, 951	6.00
7.00		0.00	0		ADULTS & PEDIATRICS	30.00	0	70, 192	7.00
8.00		0.00	0		INTENSIVE CARE UNIT	31.00	0	17, 792	8.00
9.00		0.00	0		SUBPROVIDER - IRF	41.00	0	677	9.00
10. 00 11. 00		0.00	0		OPERATING ROOM	50.00 60.00	0	413, 939	10. 00 11. 00
12.00		0.00	0		RESPI RATORY THERAPY	65.00	0	400, 801 76, 903	12.00
13.00		0.00	0		ELECTROCARDI OLOGY	69.00	0	161, 525	13.00
14.00		0.00	Ö		DRUGS CHARGED TO	73.00	0	23, 079	14.00
					PATI ENTS				
15.00		0.00	0		SLEEP LAB	76.01	0	7, 606	
16.00		0.00	0		HOUSEKEEPING	9.00	0	210	16.00
17.00		0.00	0	0	DELIVERY ROOM & LABOR	52.00	0	1, 426	17.00
18.00		0.00	0	0	ROOM PHYSI CAL THERAPY	66.00	0	86	18.00
19.00		0.00	0		OCCUPATIONAL THERAPY	67.00	0	6, 765	19.00
	TOTALS		<u> </u>	3, 245, 416			— — — ö	3, 245, 416	
	D - OTHER CAPITAL COST	S							
1.00	CAP REL COSTS-BLDG &	1.00	0	283, 665	ADMINISTRATIVE &	5.00	0	1, 718, 129	1.00
0.00	FIXT	1 00		4 004 540	GENERAL	0.00			0.00
2.00	CAP REL COSTS-BLDG &	1.00	0	1, 331, 513		0.00	0	0	2.00
3.00	CAP REL COSTS-MVBLE	2.00	0	102, 951		0.00	0	0	3.00
0.00	EQUI P	2.00	Ű	102, 701		0.00	Ŭ	Ū	01.00
	TOTALS			1, 718, 129	TOTALS			1, 718, 129	
	E - MARKETING DEPARTME				1				
1.00	MARKETING	194.01	306, 991	1, 017, 543	ADMI NI STRATI VE &	5.00	306, 991	1, 017, 543	1.00
	TOTALS		306, 991	1,017,543	GENERAL	<u> </u>	306, 991	1,017,543	
	F - CHIEF NURSING OFFI	CER COS		1,017,343	TOTALS		300, 991	1,017,343	
1.00	NURSING	13.00	. 398, 829	0	ADMI NI STRATI VE &	5.00	398, 829	0	1.00
	ADMI NI STRATI ON				GENERAL				
	TOTALS		398, 829	0	TOTALS		398, 829	0	
1 00	G - MEDICAL SUPPLIES	74.00	a	1 007 100			a	07 500 0/5	1 00
1.00	MEDI CAL SUPPLI ES CHARGED TO PATI ENT	71.00	0	1, 907, 498	CENTRAL SERVICES & SUPPLY	14.00	0	27, 503, 965	1.00
2.00	IMPL. DEV. CHARGED TO	72.00	0	25 055 133	ELECTROCARDI OLOGY	69.00	0	5, 840	2.00
2.00	PATI ENTS	72.00	Ŭ	20,000,100		07.00	Ŭ	5, 040	2.00
3.00	OPERATING ROOM	50.00	0	547, 174		0.00	0	0	3.00
	TOTALS		0	27, 509, 805	TOTALS		o	27, 509, 805	
	H - COST OF DRUGS/IV S								
1.00	DRUGS CHARGED TO	73.00	0	17, 295, 776	DRUGS CHARGED TO	73.00	0	418, 702	1.00
2 00	PATI ENTS	0.00	0	0	PATI ENTS PHARMACY	15 00		14 OFE 110	2 00
2.00 3.00		0.00 0.00	0		ANESTHESI OLOGY	15.00 53.00	0	16, 855, 113 21, 961	2.00 3.00
5.00	TOTALS		— — — 0	<u>17, 295, 776</u>		- 33.00	— — — (<u>21, 901</u> 17, 295, 776	5.00
	I - LABOR AND DELIVERY	COSTS	V	, _, 0, , , 0		· · · · ·		,2,3,,,0	
1.00	ADULTS & PEDIATRICS	30.00	0	25, 467	ADULTS & PEDIATRICS	30.00	668, 525	0	1.00
2.00	NURSERY	43.00	387, 888		DELIVERY ROOM & LABOR	52.00	0	34, 634	2.00
					ROOM				
3.00	DELIVERY ROOM & LABOR	52.00	280, 637	0		0.00	0	0	3.00
	TOTALS	\vdash $+$	668, 525		TOTALS	\vdash $+$	668, 525		
	I OTALO	i I	000, 525	54, 034	I O INEO	i I	000, 020	54, 034	

PORTER MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 15-0035 Period: Worksheet A-6 From 01/01/2014 Non-CMS Worksheet To 12/31/2014 Date/Time Prepared:

							12/01/2011	12/13/2017 7:	58 am
		Increas	ses			Decrea	ses	•	
	Cost Center	Line #	Sal ary	0ther	Cost Center	Line #	Sal ary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	J - PT, OT, AND ST COS								
1.00	PHYSI CAL THERAPY	66.00	0		OCCUPATI ONAL THERAPY	67.00	0	963, 747	1.00
2.00		0.00	0	`	SPEECH PATHOLOGY	68.00	0	27 <u>4, 4</u> 31	2.00
	TOTALS		0	1, 238, 178	TOTALS		0	1, 238, 178	
	K - RECOVERY ROOM	1 1							
1.00	OPERATING ROOM	50.00	2, 133, 269		RECOVERY ROOM	51.00	<u>2, 133, 2</u> 69	<u>385, 8</u> 29	1.00
	TOTALS		2, 133, 269	385, 829	TOTALS		2, 133, 269	385, 829	
	L - OTHER RADIOLOGY CO				1				
1.00	RADI OLOGY-DI AGNOSTI C	54.00	1, 720, 965		ULTRASOUND	54.01	473, 861	94, 969	
2.00		0.00	0		RADI OI SOTOPE	56.00	451, 512	855, 527	2.00
3.00		0.00	0		CT SCAN	57.00	549, 302	255, 941	3.00
4.00		0.00	0		MRI	58.00	246, 290	<u>111, 082</u>	4.00
	TOTALS		1, 720, 965	1, 317, 519	TOTALS		1, 720, 965	1, 317, 519	
	M - DIETARY COSTS TO C				1				
1.00		11.00	<u>1, 307, 5</u> 57		DI ETARY	10.00	<u>1, 307, 5</u> 57	<u>655, 1</u> 95	1.00
	TOTALS		1, 307, 557	655, 195	TOTALS		1, 307, 557	655, 195	
	N - REHAB THERAPY COST								
1.00	PHYSICAL THERAPY	66.00	0		SUBPROVI DER - I RF	41.00	0	<u>808, 5</u> 42	1.00
	TOTALS		0	808, 542	TOTALS		0	808, 542	
	0 - SLEEP LAB COSTS TO				1				
1.00	ELECTROCARDI OLOGY	69.00	37 <u>4,6</u> 36		SLEEP_LAB	76.01	37 <u>4,6</u> 36	6 <u>7, 5</u> 35	
	TOTALS		374, 636	67, 535	TOTALS		374, 636	67, 535	
	P - PARAMEDI CAL EDUCAT				1				
1.00	PARAMED ED	23.00	0	53, 317	EMERGENCY	91.00	0	53, 317	1.00
	PRGM-(SPECIFY)	L	+				+		
	TOTALS		0	53, 317	TOTALS		0	53, 317	
	Q - REMOVE PARAMEDICAL					- I - I - I			
1.00	EMERGENCY	91.00	0		PARAMED ED	23.00	0	53, 317	1.00
	<u> </u>	\vdash \perp			PRGM-(SPECIFY)	\vdash	+		
			0	53, 317			0	53, 317	
500.00	Grand Total:		6, 910, 772		Grand Total:		6, 910, 772	68, 403, 086	500.00
	Increases				Decreases				

Heal th	Financial Systems	PORTER MEMORI	AL HOSPI TAL			In Lie	u of Form CMS-2	2552-10
	ILIATION OF CAPITAL COSTS CENTERS		Provi der CO	CN: 15-0035		riod: om 01/01/2014	Worksheet A-7 Part I	pared:
				Acqui si ti on	IS			
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES						
1.00	Land	9, 133, 669	0		0	0	0	1.00
2.00	Land Improvements	3, 491, 416	2, 895, 137		0	2, 895, 137	0	2.00
3.00	Buildings and Fixtures	248, 221, 995	144, 661		0	144, 661	3, 018, 158	3.00
4.00	Building Improvements	19, 351, 838	484, 656		0	484, 656	610, 904	4.00
5.00	Fixed Equipment	31, 678, 590	84, 522		0	84, 522	6, 102	5.00
6.00	Movable Equipment	144, 971, 162	5,052,608		0	5,052,608	7, 156, 074	6.00
7.00	HIT designated Assets	8, 564, 787	14, 772, 555		0	14, 772, 555		
8.00	Subtotal (sum of lines 1-7)	465, 413, 457	23, 434, 139		0	23, 434, 139	16, 275, 393	8.00
9.00	Reconciling Items	0	0		0	0		9.00
10.00	Total (line 8 minus line 9)	465, 413, 457	23, 434, 139		0	23, 434, 139	16, 275, 393	
		Endi ng	Fully					
		Bal ance	Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES						
1.00	Land	9, 133, 669	0					1.00
2.00	Land Improvements	6, 386, 553	0					2.00
3.00	Buildings and Fixtures	245, 348, 498	0					3.00
4.00	Building Improvements	19, 225, 590	0					4.00
5.00	Fixed Equipment	31, 757, 010	0					5.00
6.00	Movable Equipment	142, 867, 696	0					6.00
7.00	HIT designated Assets	17, 853, 187	0					7.00
8.00	Subtotal (sum of lines 1-7)	472, 572, 203	0					8.00
9.00	Reconciling Items	0	0					9.00
	Total (line 8 minus line 9)	472, 572, 203	0					10.00

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Health Financial Systems	PORTER MEMO	REAL HOSPETAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS	CENTERS	Provider C		Period: From 01/01/2014	Worksheet A-7 Part II	
					Date/Time Pre 12/13/2017 7:	pared: 58 am
		SL	JMMARY OF CAPI	TAL		
Cost Center Descript	on Depreciation	n Lease	Interest	Insurance	Taxes (see	
				(see instructions)	instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION O	F AMOUNTS FROM WORKSHEET A, COL	UMN 2, LINES 1	and 2			
1.00 CAP REL COSTS-BLDG & FIXT	4, 503, 61	9 0)	0 0	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	11, 921, 77	7 575, 011		0 0	40, 251	2.00
3.00 Total (sum of lines 1-2)	16, 425, 39	575, 011		0 0	40, 251	3.00
	SUMMARY	OF CAPITAL				
Cost Center Descript	on Other	Total (1)				
	Capital-Rela	t (sum of cols.				
		e 9 through 14)				
	instructions	/				
	14.00	15.00				
	F AMOUNTS FROM WORKSHEET A, COL					
1.00 CAP REL COSTS-BLDG & FIXT		0 4, 503, 619				1.00
2.00 CAP REL COSTS-MVBLE EQUIP		0 12, 537, 039				2.00
3.00 Total (sum of lines 1-2)		0 17,040,658				3.00

Health Financial Systems	PORTER MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2014 To 12/31/2014		pared:
	COMF	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 -			
	1.00	2.00	col. 2) 3.00	4,00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	3.00	4.00	5.00	
1.00 CAP REL COSTS-BLDG & FIXT	280, 094, 310	0	280, 094, 310	0. 592702	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	192, 477, 893		192, 477, 893		0	2.00
3.00 Total (sum of lines 1-2)	472, 572, 203		472, 572, 203			3.00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPI TAL	
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						
1.00 CAP REL COSTS-BLDG & FIXT	0		(3, 831, 499		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	-	(9, 552, 027		2.00
3.00 Total (sum of lines 1-2)	0	0	IMMARY OF CAPI	13, 383, 526	3, 820, 427	3.00
		50	JWWARY OF CAPT	IAL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)	Capi tal -Rel at		
		instructions)		ed Costs (see	9 through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C 1.00 CAP REL COSTS-BLDG & FIXT	681, 834	283, 665	1, 331, 513		6, 769, 020	1.00
2.00 CAP REL COSTS-BLDG & FIXT	081, 834				6, 769, 020 12, 875, 147	2.00
3.00 Total (sum of lines 1-2)	681, 834				12, 875, 147	2.00
	001,034	1 300,010	1 1, 571, 70	'I 0	17, 077, 107	5.00

Health Financial Systems

DJUSTMENTS TO EXPENSES		PORTER MEMORI		eriod:	Worksheet A-8	
				rom 01/01/2014		pared:
			Expense Classification on To/From Which the Amount is			
Cost Center Descriptio	on Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
00 Investment income - other	2)	0		0.00	0	3.00
(chapter 2) 00 Trade, quantity, and time		0		0.00	0	4.00
discounts (chapter 8) 00 Refunds and rebates of		0		0.00	0	5.00
expenses (chapter 8) 00 Rental of provider space by		0		0.00	0	6.00
suppliers (chapter 8)		0			-	
00 Telephone services (pay stations excluded) (chapter 21)	A	-114, 667	ADMI NI STRATI VE & GENERAL	5.00	0	7.00
.00 Television and radio servic	e A	-74, 406	OPERATION OF PLANT	7.00	0	8.00
(chapter 21) .00 Parking lot (chapter 21)		0		0.00	0	9.00
D. 00 Provider-based physician adjustment	A-8-2	-4, 958, 517			0	10.00
1.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
2.00 Related organization transactions (chapter 10)	A-8-1	-11, 349, 162			0	12.0
3.00 Laundry and linen service 4.00 Cafeteria-employees and que	sts B	-119 681	CAFETERI A	0. 00 11. 00	0	
5.00 Rental of quarters to emplo		0	OALETENTA	0.00	0	
5.00 Sale of medical and surgical supplies to other than	I	0		0.00	0	16.00
patients 7.00 Sale of drugs to other than patients	в	-11, 927	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
8.00 Sale of medical records and	В	-1, 632	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
abstracts 9.00 Nursing school (tuition, fe books, etc.)	es,	0		0.00	0	19. 00
0.00 Vending machines		0		0.00	-	
1.00 Income from imposition of interest, finance or penalt charges (chapter 21)	У	0		0.00	0	21.00
 O0 Interest expense on Medicar overpayments and borrowings repay Medicare overpayments 	to	0		0.00	0	22.00
3.00 Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
4.00 I imitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
5.00 Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
(chapter 21) 5.00 Depreciation - CAP REL	А	-801, 952	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
COSTS-BLDG & FIXT 7.00 Depreciation - CAP REL	А		CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
COSTS-MVBLE EQUIP					,	
3.00 Non-physician Anesthetist 9.00 Physicians' assistant		0	*** Cost Center Deleted ***	19.00 0.00	0	28.00 29.00
0.00 Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67.00	-	30.00
limitation (chapter 14) D.99 Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 9
instructions) 1.00 Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
pathology costs in excess c limitation (chapter 14)				00.00		

Health Financial Systems			PORTER MEMORI	AL HOSPI TAL	In Lieu of Form CMS-2552-10		
ADJUSTMENTS TO EXPENSES				Provider CCN: 15-0035 Period:		Worksheet A-8	
					rom 01/01/2014 o 12/31/2014	Date/Time Pre	narod
					0 12/31/2014	12/13/2017 7:	58 am
				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	
	cost center bescription	(2)	Anourt		Erne "	Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
	Depreciation and Interest						
	TRAINING REVENUE	В		NURSING ADMINISTRATION	13.00		00.00
	MISC. NON PATIENT REVENUE	В		ADMINISTRATIVE & GENERAL	5.00	0	00.0.
33.02	HOSPI TAL BAD DEBT	A		ADMINISTRATIVE & GENERAL	5.00	0	00.02
33.03	PATIENT PHONES WAGE COSTS	A		ADMI NI STRATI VE & GENERAL	5.00	0	33.03
	PATIENT PHONES BENEFITS COSTS	A		EMPLOYEE BENEFITS DEPARTMENT		0	33.04
	PATIENT TV DEPRECIATION	A		CAP REL COSTS-MVBLE EQUIP	2.00		33.05
	MARKETING	A		ADMI NI STRATI VE & GENERAL	5.00		
	PHYSI CI AN RECRUI TI NG	A		ADMINISTRATIVE & GENERAL	5.00		00.07
33.08	LOBBYING EXPENSE IN	A	-13, 343	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	ASSOCIATION DUES CHARITABLE CONTRIBUTIONS	٨	102 221	ADMI NI STRATI VE & GENERAL	5.00	0	33.09
	COUNTRY CLUB DUES	A A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5.00	-	
	MINORITY INTEREST	A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5.00		
	PATIENT PHONE DEPRECIATION	A		CAP REL COSTS-MVBLE EQUIP	2.00		
	NON-ALLOWABLE LEGAL FEES (DOJ)	A		ADMINISTRATIVE & GENERAL	2.00		
33. 13 50. 00	TOTAL (sum of lines 1 thru 49)	A	-60, 466, 245		5.00	0	50.00
50.00	(Transfer to Worksheet A,		-00, 400, 245				50.00
	column 6, line 200.)						
	COLUMN 0, TITIC 200. J		I	1	1		L

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

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

C: \TEMP\Cori \reopenings HFS\150035 123114\150035. 12312014. R1. mcax

Heal th	Financial Systems	PORTER MEMOR	RI AL HOSPI TAL	In Lie	u of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO		Period:	Worksheet A-8	3-1
OFFICE COSTS From 01/01/2014 To 12/31/2014 Date/T						narod
				10 12/31/2014	12/13/2017 7:	
	Line No. Cost Center		Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOW					
1.00	OFFICE COSTS:	CAP REL COSTS-BLDG & FIXT	DIRECT ALLOCATION - CAPITAL	681, 834	0	1.00
2.00			PASI OPERATING COSTS	1, 613, 484	0	2.00
3.00			PASI OPERATING COSTS PASI CAPITAL COSTS	62, 992	0	2.00
4.00		CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX		0	4.00
4.00		CAP REL COSTS-BEDG & TTXT	NEW CAPITAL - MOVABLE EQUIPM		0	4.00
4.01		ADMINISTRATIVE & GENERAL	NON-CAPITAL - MOVABLE EQUIPM		0	4.01
4.02		ADMINI STRATI VE & GENERAL	MALPRACTICE COSTS	831, 484	1, 209, 103	4.02
4.03			CIG LEASED EQUIPMENT	567,085	615, 261	4.03
4.04			INTEREST EXPENSE	507,085	12, 086, 022	4.04
4.05		ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	3, 410, 678	4.05
4.00		ADMINISTRATIVE & GENERAL	401K FEES	0	5, 567	4.00
4.07			AUDIT FEES	0	108, 141	4.07
4.00			MIS FEES	0	1, 262, 078	4.00
4.10			MANAGED CARE	0	1, 202, 070	4.10
4.11		ADMINI STRATI VE & GENERAL	CASE MANAGEMENT	0	348, 173	4.11
4.12			PURCHASE & ANCI LLARY	0	20, 023	4.12
4.13		ADMI NI STRATI VE & GENERAL	EMERGENCY ROOM	0	208, 278	4.13
4.14			PPSI FEES	0	28, 477	4.14
4.15		ADMI NI STRATI VE & GENERAL	COMPLIANCE/HIM/CCA FEES	0	92,675	4.15
4.16		ADMI NI STRATI VE & GENERAL	SENI OR CI RCLE	0	57, 392	4.16
4.17			PASI COLLECTION FEES	0	1,058,596	4.17
4.18			PASI LIEN UNIT COLLECTION FE	0	235, 404	4.18
4.19			EBOS FEES	0	15, 848	4.19
4.20		ADMI NI STRATI VE & GENERAL	CONVERSION COSTS	53, 386	0	4.20
4.21			PRE-ACQUI SI TI ON CAP COSTS-BL		0	4.21
4.22		CAP REL COSTS-MVBLE EQUIP	PRE-ACQUISITION CAP COSTS-MC		0	4.22
5.00	TOTALS (sum of lines 1-4).			9, 539, 889	20, 889, 051	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

nas no	been posted to worksheet A,	corumns r anu/or z, the amo	unt arrowable si		4 01 this part.	1
				Related Organization(s) and/	or Home Office	
		N		News		<u> </u>
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownership		Ownershi p	
	1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

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

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
 B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.

 E. Individual is director, officer, administrator, or key person of provider and related organization.
 F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

Health Financial Systems	PORTER MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RE OFFICE COSTS	ELATED ORGANIZATIONS AND HOME Provider CCN: 15-0035	Peri od: From 01/01/2014 To 12/31/2014 Date/Time Prepared: 12/21/2014

			12/13/2017 7	:58 am
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME	
	OFFICE COSTS:			
1.00	681, 834	11		1.00
2.00	1, 613, 484			2.00
3.00	62, 992			3.00
4.00	54, 568			4.00
4.01	362, 370	9		4.01
4.02	5, 227, 950	0		4.02
4.03	-377, 619	0		4.03
4.04	-48, 176			4.04
4.05	-12, 086, 022			4.05
4.06	-3, 410, 678			4.06
4.07	-5, 567			4.07
4.08	-108, 141			4.08
4.09	-1, 262, 078			4.09
4.10	-127, 335			4.10
4.11	-348, 173			4.11
4.12	-20, 023			4.12
4.13	-208, 278			4.13
4.14	-28, 477			4.14
4.15	-92, 675			4.15
4.16	-57, 392			4.16
4.17	-1, 058, 596			4.17
4.18	-235, 404			4.18
4.19	-15, 848			4.19
4.20	53, 386			4.20
4.21	12, 272			4.21
4.22	72, 464			4.22
5.00	-11, 349, 162			5.00

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

nas no	been posted to worksheet A,	COLUMNS	Z, U	le allouitt	arrowabre	siloui u be	- Thui cateu	4 UI U	mis part.	
	Related Organization(s)									
	and/or Home Office									
	Type of Business	1								
	6.00	1								
			C) ANI		OFFLCE.					

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE: The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

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

reriibu		
6.00	HOME OFFICE	6.00
7.00 8.00		7.00
8.00		8.00
9. 00 10. 00 <u>100. 00</u>		9.00
10.00		10.00
100.00		100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

 C. Provider has financial interest in corporation, partnership, or other organization.
 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

	Financial Syste		PORTER MEMOR				eu of Form CMS-	
PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provider (Period: From 01/01/2014	Worksheet A-8	3-2
						To 12/31/2014		epared:
							12/13/2017 7:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		l denti fi er	Remuneration	Component	Component		ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		NURSING ADMINISTRATION	77, 500					1.00
2.00		ADULTS & PEDIATRICS	1, 605, 291	1, 605, 291	(2.00
3.00	31.01	NEONATAL INTENSIVE CARE UNIT	307, 900	307, 900	(150, 200	0	3.00
4.00		OPERATING ROOM	447, 500	447, 500	(167, 500	0	4.00
5.00		ANESTHESI OLOGY	1, 202, 750		(5.00
6.00		RESPI RATORY THERAPY	8, 820		(6.00
7.00		LABORATORY	21,000		(7.00
8.00		CT SCAN	1, 650		(8.00
9.00			16, 801	16, 801	(9.00
10.00		ADMI NI STRATI VE & GENERAL	1, 174, 678					10.00
11.00 12.00		SUBPROVI DER – I RF I NTENSI VE CARE UNI T	57, 815 88, 286					11.00 12.00
200.00	31.00	INTENSIVE CARE UNIT	5, 009, 991	4, 932, 491	77, 500	100/200	670	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	200.00
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
			2	Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		NURSING ADMINISTRATION	51, 474	2, 574	(
2.00		ADULTS & PEDIATRICS	0					
3.00		NEONATAL INTENSIVE CARE UNIT	0				s a	3.00
4.00 5.00		OPERATI NG ROOM ANESTHESI OLOGY	0	-			-	4.00 5.00
5.00 6.00		RESPIRATORY THERAPY					0	5.00 6.00
7.00		LABORATORY	0	-	(0	7.00
8.00		CT SCAN	0	-	(0	8.00
9.00		EMERGENCY	0	-	(-	0	9.00
10.00	5.00	ADMI NI STRATI VE & GENERAL	0	0	(0	0	10.00
11.00	41.00	SUBPROVIDER – IRF	0	0	(0 0	0	11.00
12.00	31.00	INTENSIVE CARE UNIT	0	0	(0	0	12.00
200.00			51, 474		(°	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. 14					
	1.00	2.00	15.00	16.00	17.00	18.00	-	
1.00		NURSING ADMINISTRATION	0					1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0		1, 605, 291		2.00
3.00	31.01	NEONATAL INTENSIVE CARE UNIT	0	0	(307, 900		3.00
4.00		OPERATING ROOM	0	-				4.00
5.00		ANESTHESI OLOGY	0	-	(5.00
6.00		RESPI RATORY THERAPY	0					6.00
7.00			0					7.00
8.00 9.00		CT SCAN EMERGENCY	0	-	(8.00 9.00
9.00 10.00		ADMI NI STRATI VE & GENERAL	0 0					9.00 10.00
10.00		SUBPROVIDER – IRF	0					10.00
12.00		INTENSIVE CARE UNIT			(12.00
200.00	51.00		0	-				200.00
	1	1						

COST ALLOCATION - GENERAL SERVICE COSTS Provider COS I: 50-003 Provid	Health Financial Systems	PORTER MEMORI		·		u of Form CMS-	2552-10
Cast Center Description Net Expenses From Casts (rrow Wist in col 7) APPLICE (rrow Wist in col 7) MetL Expenses (rrow Wist in col 7) Description Subtotal 0 1.00 2.00 4.00 4.00 4.00 0.00 0.00 2.00 4.00 4.00 4.00 0.00 0.00 2.00 4.00 4.00 4.00 0.00 0.00 2.00 4.00 4.00 4.00 0.00 0.00 4.00 4.00 4.00 4.00 0.00 0.000 4.00 4.00 4.00 4.00 4.00 0.0000 0.0000 0.0000 1.00.0	COST ALLOCATION - GENERAL SERVICE COSTS		Provider C				
Cost Center Description Not Expense BLC 6 # FixT IVPLE ECUIP DEPLOYTE ESUIP Sublicity 0 0 0 2.00 4.00 4.00 4.00 4.00 0 0 0 2.00 2.00 4.00 4.00 4.00 4.00 4.00 0 0.00000 (AB FIL CSTS.MWB F FOLIP 12.875, 147 1.00 2.00 4.00 4.00 4.00 2.00 2.00 0.00001 (AB FIL CSTS.MWB F FOLIP 12.875, 147 1.00, 141, 153, 137 0.0001 (AB FIL CSTS.MWB F FOLIP 12.875, 147 1.00, 141, 150, 147 1.00, 141, 150, 147 2.00 2.00 2.00 2.00 2.00 2.01, 13, 137, 150, 100 2.00 1.00, 114, 143, 133, 107, 100 1.00, 110, 143, 143, 120, 100, 110, 133, 122, 100, 130, 134, 134, 134, 134, 134, 134, 134, 134						Date/Time Pre	epared:
Locat Center Description Net Expenses (Final Cention (From Wate) NULL F A FLXT MULL F TUUP Expension Description Subtotal 0.00 <t< td=""><td></td><td></td><td></td><td>ATED COSTS</td><td></td><td>12/13/2017 7:</td><td><u>58 am</u></td></t<>				ATED COSTS		12/13/2017 7:	<u>58 am</u>
Image: construction of the service cost centres Image: cost centres Image: cost centres Image: cost centres 0 0 0 1.00 2.00 4.00 4. 0 0 0 0.00 0.00 4.00 4. 0 0 0.00			CAFITAL KL	LATED COSTS			
Image: Provide cost contracts All cost in cost 7). DPPARTMENT 00 0000 (CAP PI LOSTS MIRS & FLVT COSTS MIRS & FLVT ADD 0000 (CAP PIL COST CENTERS END 00000 (EMPLORE EDUIP DEDUID (CAP PIL COST CENTERS END 00000 (EMPLORE EDUIP DEDUIP DEDUID (CAP PIL COST CENTERS END 00000 (EMPLORE EDUIP DEDUID (CAP PIL COST CENTERS END 00000 (EMPLORE EDUIP DEDUIP (CAP PIL COST CENTERS END 000000 (EMPLORE EDUIP DEDUIP (CAP PIL COST CENTERS END 00000 (CAP PIL COST CENTERS END 000000 (CAP PIL COST CENTERS END 0000000 (CAP PIL COST CENTERS END 000000 (CAP PIL COST CENTERS END	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
Image: state of the s							
Col T) Col 1.00 2.00 4.00 4.00 0.00 00100 CAP FEL COST - SLUG A FIXT 6.769,020 12.1179,147 14.151,373 -0.00					DEPARIMENT		
OPERAL SERVICE COST CENTERS 0 1.00 2.00 4.00 4.00 4.00 1.00 COUND CAP REL COST CENTERS 6.769,020 1.203 1.00 1.00 0.00 COUND CAP REL COST SHILLS, A FIXT 6.769,020 1.203 1.203 1.203 1.203 0.00 COUND CAP REL COST CENTERS 4.00 4.00 4.00 4.00 4.00 0.00 COUND CAPTERIAN 0.71,973 2.37,294 700,048 128,034 4.00,40 4.00 0.00 COUND CANCERLEN NO 1.666,752 6.431 18,033 4.004,449 70 1.00 130,048 20,012 1,733,333 8.00 0.000 4.000,418 4.000,41 130,034 4.044,449 130,04 130,04 4.000,41 4							
1.00 ODIOD CAP REL COSTS-BLIDG & FIXT 6, 769, 520 1 1 0 0.00 ODZOC CAP REL COSTS-MURL ESUP 12, 875, 147 12, 875, 147 12, 875, 147 12, 875, 147 12, 875, 147 14, 151, 393 4 0			1.00	2.00	4.00	4A	
2.00 02000 CAP FEL COSTS 4.00 04000 FEL COSTS 4.00 4.00 5.00 OSGOO ADMIN IN STRATI VE & GENERAL 46.692, 725 327, 294 700, 048 1.800, 884 49, 600, 615 5.00 0.00 OCOSTO CHEMIC VE STREVENT 1, 777, 923 327, 294 700, 048 1.801, 884 49, 600, 615 5.00 6.00 700, 048 1.801, 884 49, 600, 615 5.00 6.00 700, 048 1.802, 384 314, 647 1.133, 317 8.00 700, 048 1.00, 1400, 448 1.733, 317 8.00 700, 048 1.733, 317 8.00 700, 700, 700, 700, 710, 700 1.00 710, 700, 710, 711, 713, 711, 711, 713, 711, 711, 711				T			
4.00 DOUCOD EUPLOYCE ENERFEITS DEPARTMENT 14, 077, 922 23, 402 50, 064 14, 151, 929 4.00 7.00 DOTOD OPENTION OF FLANT 9, 346, 189 1, 449, 649 3, 100, 648 1, 883, 322, 121 1, 733, 338 80 90, 00, 000 1, 111, 111, 112, 111 1, 111, 111, 112, 111 1, 111, 111, 112, 111 1, 111, 111, 112, 111 1, 111, 111, 112, 111 1, 111, 111, 112, 111 1, 111, 111, 112, 111 1, 111, 111, 112, 111 1, 111, 111, 112, 111 1, 111, 111, 112, 111 1, 111, 111, 112, 111 1, 111, 111, 112, 111 1, 111, 111, 111, 111, 111, 111, 111,							
5.00 00000 LAMINI STRATI VE & CENERAL 46, 692, 725 327, 294 700, 048 1, 800, 894 49, 600, 951 5.00 8.00 00000 LAURORY & LINEN SERVICE 1, 686, 752 8, 431 18, 00, 648 28, 677 14, 184, 163 7.00 9.00 00700 LUNEXLEEP IN 1, 237, 863 170, 591 364, 197 134, 282 1, 907, 544 10, 00 10.00 10100 DIETAKY 1, 237, 863 170, 591 364, 197 134, 282 1, 907, 544 10, 00 10.00 10100 DIETAKY 1, 363, 776 14, 886 244, 222 143, 700 84, 1470 10.00 10100 DIETAKY 2, 1087, 776 4, 100, 100 10, 00 2, 003, 943 14, 000 10, 00 2, 003, 943 14, 000 10, 00 2, 003, 943 14, 000 16, 00 2, 003, 943 16, 00 30, 00 31, 00 31, 00 31, 00 31, 00 31, 00 31, 00 31, 00 31, 00 31, 00 31, 00 31, 00 31, 00 31, 00 31, 00 31, 00 31, 00, 00 31, 00, 00<							
7.00 DOTCO DOTCO DEPENTION OF PLANT 9.346.189 1.449.464 3.100.468 227.677 14,184.163 7.00 9.00 DOSCO DEPENTION OF PLANT 1.466.752 8.431 100.184.221 1.700.511 336.039 4.084.248 9.00 9.00 DOSCO DETAM 1.237.865 101.00 1.24.864 7.00 84.431 4.084.222 1.700.511 344.874 54.521 11.00 11.00 11.00 1.700.511 34.884 4.00.440 11.00						49 600 951	
8.00 000000 LAUNDRY & LINEN SERVICE 1, 646, 752 9, 431 18, 003 20, 121 1, 733, 33 8.00 0.00 000000 LOUSEXEEP IN 10.00 11000 LITARY 1, 237, 865 170, 591 344, 876 134, 252 1, 995, 584 10, 00 11.00 011000 LETREY 1, 334, 307 0 0 212, 869 2, 655, 540 11, 00 11.00 011000 CHETREN KINTAL SERVICES & SUPPLY 1, 356, 704 113, 00 254, 222 143, 771 28, 771, 831 13, 00 13, 00 15, 00 1300 15, 00 130, 00 15, 00 130, 00 254, 222 14, 170, 00 4, 100, 140 15, 00 15, 00 15, 00 16, 00 15, 00 15, 00 15, 00 15, 00 15, 00 15, 00 15, 00 15, 00 15, 00 15, 00 16, 00, 40 15, 00 16, 00, 40 16, 00, 40 16, 00, 40 16, 00, 40, 41 15, 00 16, 00, 40, 40 16, 00, 40 16, 00, 40, 40 16, 00, 40, 40, 40 16, 00, 40, 40, 40, 40 16, 00, 40, 40, 40, 40, 40 16, 00, 40, 40, 40, 40, 40, 40, 40, 40							
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	202.00 TOTAL (sum lines 118-201)	246, 575, 802	6, 769, 020	12, 875, 147	14, 151, 393	246, 575, 802	202.00

Heal th	Financial Systems	PORTER MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST /	ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2014 To 12/31/2014	Worksheet B Part I Date/Time Pre 12/13/2017 7:	epared: 58 am
	Cost Center Description	ADMI NI STRATI V E & GENERAL	PLANT	LAUNDRY & LINEN SERVICI		DI ETARY	
	GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	49, 600, 951					5.00
7.00	00700 OPERATION OF PLANT	3, 571, 771					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	436, 479					8.00
9.00	00900 HOUSEKEEPI NG	1, 028, 471			0 5, 320, 532		9.00
10.00	01000 DI ETARY	480, 356			0 191, 628	3, 210, 470	
11.00		517, 714			0 0 0	0	
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 320, 604			0 95, 198	0	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	517, 111 1, 032, 473				0	
16.00	01600 MEDICAL RECORDS & LIBRARY	866, 187			0 25, 997	0	1
	02300 PARAMED ED PRGM- (SPECIFY)	000, 107			0 23, 77	0	1
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	0		<u>/</u>	0 0	0	23.00
30.00	03000 ADULTS & PEDI ATRI CS	5, 866, 402	3, 614, 617	827, 12	1, 097, 892	1, 944, 111	30.00
31.00	03100 I NTENSI VE CARE UNI T	2, 263, 928				183, 916	1
31.01	03101 NEONATAL INTENSIVE CARE UNIT	628, 272				5, 677	
41.00	04100 SUBPROVI DER – I RF	427, 990				79, 777	1
43.00	04300 NURSERY	151, 703				0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	4, 403, 525	2, 125, 696	319, 57	1 645, 651	4, 534	50.00
51.00	05100 RECOVERY ROOM	0	0)	0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	757, 251	423, 089	63, 32	6 128, 507	24, 612	52.00
53.00	05300 ANESTHESI OLOGY	51, 286			0 11, 146	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 925, 565	1, 514, 943	169, 63		1, 261	
54.01	05401 ULTRASOUND	0	0		0 0	0	
56.00	05600 RADI OI SOTOPE	0	0)	0 0	0	
57.00	05700 CT SCAN	0	0)	0 0	0	
58.00		0			0 0	0	
60.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	3, 328, 186				0	
65.00 66.00	06600 PHYSI CAL THERAPY	760, 601				0	1
67.00	06700 OCCUPATI ONAL THERAPY	1, 014, 541			4 178, 383 0 0	0	1
68.00	06800 SPEECH PATHOLOGY	0			0 0	0	
69.00	06900 ELECTROCARDI OLOGY	1, 951, 314	986, 731	131, 51	0	14, 389	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	495, 196			0 0	0	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	6, 309, 160			0 0	0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 377, 497			0 0	0	
74.00	07400 RENAL DI ALYSI S	162, 360			0 6, 484	0	1
76.00	03950 ANCI LLARY	0			0 0	0	76.00
76.01	03610 SLEEP LAB	0			0 0	0	
76.03	03951 WOUND CARE	380, 362	119, 529	24, 73	0 36, 305	0	76.03
	OUTPATIENT SERVICE COST CENTERS		1				
	09000 CLINIC	0			0 0	0	
	09100 EMERGENCY	2, 790, 220	1, 114, 177	318, 71	8 338, 416	40, 236	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS	40.044.505			4 9 49 995	0.000 510	1
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	48, 816, 525	14, 554, 121	2, 200, 99	6 4, 348, 025	2, 298, 513	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6, 678		5	0 9, 490		190.00
	19200 PHYSICIANS' PRIVATE OFFICES	341, 525			0 811, 321	185, 624	
	19201 OTHER NONREI MBURSABLE	2, 108			0 2, 996		192.01
	07950 NONREI MBURSABLE	0	-		0 0		194.00
	07951 MARKETI NG	346, 121			0 0		194.01
	207952 SENIOR CIRCLE	24, 938			0 0		194.02
	07953 OTHER NONREIMB COST C - REGENCY LTA	33, 334		2	0 148, 700		
	07954 VACANT UNFINISHED AREA	29, 722	0		0 0	0	194.04
200.00		-	_			-	200.00
201.00		0	-	0.000.00			201.00
202.00) TOTAL (sum lines 118-201)	49, 600, 951	17, 755, 934	2, 200, 99	5, 320, 532	3, 210, 470	1202.00

Health Financial Systems		PORTER MEMORI	AL HOSPITAL		In Lieu	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL	SERVI CE COSTS		Provider CC		eriod: rom 01/01/2014 o 12/31/2014	Worksheet B Part I Date/Time Pre 12/13/2017 7:	pared: 58 am
Cost Center De	scription	CAFETERI A	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST 1.00 00100 CAP REL COSTS-							1.00
2.00 00200 CAP REL COSTS- 4.00 00400 EMPLOYEE BENEF 5.00 00500 ADMI NI STRATI VE 7.00 00700 OPERATI ON OF P 8.00 00800 LAUNDRY & LI NE 9.00 00900 HOUSEKEEPI NG	MVBLE EQUI P I TS DEPARTMENT & GENERAL LANT						2.00 4.00 5.00 7.00 8.00 9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A		2, 573, 654					10.00 11.00
13. 00 01300 NURSI NG ADMI NI	STRATION	104, 619	7, 078, 208				13.00
14.00 01400 CENTRAL SERVIC		69, 441	0	3, 303, 072			14.00
15.00 01500 PHARMACY		73, 053	381, 096	0	5, 914, 756		15.00
16.00 01600 MEDI CAL RECORD		89, 333	0	0		4, 506, 897	16.00
23.00 02300 PARAMED ED PRG		0	0	0	0	0	23.00
30.00 03000 ADULTS & PEDIA		630, 202	1, 896, 024	0	ol	363, 909	30.00
31.00 03100 INTENSIVE CARE		191, 832	766, 554	0		93, 671	30.00
31.01 03101 NEONATAL INTEN		56, 380	226, 921	0		47,985	
41. 00 04100 SUBPROVI DER -		36, 513	130, 259	0		23, 261	41.00
43.00 04300 NURSERY		13, 663	50, 497	0	0	8, 118	43.00
ANCILLARY SERVICE CO					1		
50.00 05000 OPERATING ROOM		303, 179	1,094,099	1, 976		928, 807	50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM	A LAROD DOOM	0 67, 478	240 211	0		0 40, 082	51.00 52.00
53. 00 05300 DELIVERT ROOM		07,470	249, 311	0	0	40, 082	
54. 00 05400 RADI OLOGY-DI AG		214, 002	810, 204	0	0	594, 764	54.00
54.01 05401 ULTRASOUND		0	0	0	0	0	54.01
56. 00 05600 RADI 0I SOTOPE		0	0	0	0	0	56.00
57.00 05700 CT SCAN		0	0	0	0	0	57.00
58.00 05800 MRI		0	0	0	0	0	58.00
60. 00 06000 LABORATORY		249, 024	0	234, 551	0	493, 124	
65.00 06500 RESPI RATORY TH 66.00 06600 PHYSI CAL THERA		84, 700 0	0	0	0	49, 206 85, 096	1
67. 00 06700 OCCUPATI ONAL T		0	0	0	0	05,040	67.00
68.00 06800 SPEECH PATHOLO		0	Ő	0	0	0	68.00
69.00 06900 ELECTROCARDI OL	.0GY	152, 178	537, 350	0	0	331, 109	69.00
	ES CHARGED TO PATIENT	0	0	162, 875		101, 612	
72.00 07200 I MPL. DEV. CHA		0	0	2, 903, 670		457, 782	
73.00 07300 DRUGS CHARGED		1, 230	0	0		447, 794 9, 445	1
74.00 07400 RENAL DIALYSIS 76.00 03950 ANCI LLARY		0	0	0	0	9, 445 0	
76. 01 03610 SLEEP LAB		0	0	0	0	0	
76.03 03951 WOUND CARE		20, 678	0	0		17, 978	
OUTPATIENT SERVICE C	COST CENTERS				· · · · · · · · · · · · · · · · · · ·		
90.00 09000 CLINIC		0	0	0		0	
91.00 09100 EMERGENCY	DC (NON DICTINCT DADT	204, 894	935, 893	0	0	372, 408	
92.00 09200 OBSERVATION BE SPECIAL PURPOSE COST							92.00
	OF LINES 1-117)	2, 562, 399	7, 078, 208	3, 303, 072	5, 914, 756	4, 506, 897	118.00
190.00 19000 GIFT, FLOWER,	COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00 19200 PHYSI CI ANS' PR		0	0	0	0		192.00
192. 01 19201 OTHER NONRELIMB		0	0	0	0		192.01
194. 00 07950 NONREI MBURSABL 194. 01 07951 MARKETI NG	E	0 8, 899	0	0	0		194.00 194.01
194. 02 07952 SENI OR CI RCLE		8, 899 2, 356	0	0			194.01
194. 03 07953 OTHER NONRELMB	COST C - REGENCY LTA	2,000	0	0	0		194.03
194.04 07954 VACANT UNFINIS		0	Ō	0	0	0	194.04
200.00 Cross Foot Adj							200.00
201.00 Negative Cost		0	0	0	0		201.00
202.00 TOTAL (sum lin	es 118-201)	2, 573, 654	7,078,208	3, 303, 072	5, 914, 756	4, 506, 897	202.00

COST ALLOCATION - GENERAL SERVICE COSTS Provider COR: 15-003	Health Fina	ancial Systems	PORTER MEMORIA	AL HOSPLTAL		Inlie	u of Form CMS-2552-10
Lintern A (PROUND F) (PROUND F)					1	Period: From 01/01/2014	Worksheet B Part I Date/Time Prepared:
CHREAL SERVICE COST CENTERS 1.00 0.0000 CAP REL COSTS-BURG & FLIXT 2.00 2.000 00200 CAP REL COSTS-BURG & FLIXT 2.00 2.000 00200 CAP REL COSTS-BURG & FLIXT 2.00 7.000 00200 CAP REL COSTS-BURG & FLIXT 7.00 7.000 00200 CAP REL COSTS-BURG & FLIXT 7.00 7.000 00200 CHARY 1.000 CHARY 8.000 00200 CHARY 0 8.000 01200 CHARY 0 8.000 01200 CHARY 0 8.000 01200 CHARY 0		Cost Center Description	PRGM		Residents Cost & Post Stepdown Adjustments		
1.00 00100 CAP REL COSTS-BLIG & FIXT 1.00 2.00 00200 CAP REL COSTS-BLIG & FIXT 2.00 2.00 00200 CAP REL COSTS-BLIG & FIXT 7.00 1.00 0100 CAP REL COSTS CAPTERS 7.00 1.00 0100 CAP REL COSTS CAPTERS 7.00 1.00 00	CENE		23.00	24.00	25.00	26.00	
30:00 03000 ADULTS & PEDIATRICS 0 39, 536, 852 0 39, 536, 852 0 30, 736, 852 0 30, 736, 852 0 30, 736, 852 0 30, 736, 852 0 30, 736, 852 0 30, 736, 852 0 30, 736, 852 0 31, 00 10 0100 (NTRES) VE CARE UNIT 0 37, 789, 366 31, 00 31, 00 31, 00 31, 00 31, 00 37, 739, 366 31, 00 31, 00 31, 00 31, 00 37, 739, 366 31, 00 31, 00 43, 00 941, 658 0 941, 658 0 941, 658 0 941, 658 0 941, 658 0 941, 658 90 941, 658 90 941, 658 90 <t< td=""><td>1.00 0010 2.00 0020 4.00 0040 5.00 0050 7.00 0070 8.00 0080 9.00 0090 10.00 0100 11.00 0110 13.00 0130 14.00 0140 15.00 0150 16.00 0160 23.00 0230</td><td>0 CAP REL COSTS-BLDG & FIXT 10 CAP REL COSTS-MVBLE EQUIP 10 EMPLOYEE BENEFITS DEPARTMENT 10 ADMINI STRATI VE & GENERAL 10 OPERATION OF PLANT 10 LAUNDRY & LINEN SERVICE 10 HOUSEKEEPING 10 DI ETARY 10 CAFETERIA 10 NURSI NG ADMINI STRATION 10 CENTRAL SERVICES & SUPPLY 10 PHARMACY 10 MEDICAL RECORDS & LIBRARY 10 PARAMED ED PRGM-(SPECIFY)</td><td>0</td><td></td><td></td><td></td><td>1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 23.00</td></t<>	1.00 0010 2.00 0020 4.00 0040 5.00 0050 7.00 0070 8.00 0080 9.00 0090 10.00 0100 11.00 0110 13.00 0130 14.00 0140 15.00 0150 16.00 0160 23.00 0230	0 CAP REL COSTS-BLDG & FIXT 10 CAP REL COSTS-MVBLE EQUIP 10 EMPLOYEE BENEFITS DEPARTMENT 10 ADMINI STRATI VE & GENERAL 10 OPERATION OF PLANT 10 LAUNDRY & LINEN SERVICE 10 HOUSEKEEPING 10 DI ETARY 10 CAFETERIA 10 NURSI NG ADMINI STRATION 10 CENTRAL SERVICES & SUPPLY 10 PHARMACY 10 MEDICAL RECORDS & LIBRARY 10 PARAMED ED PRGM-(SPECIFY)	0				1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 23.00
31.00 03100[INTENSIVE CARE UNIT 0 13.482,706 31.00 31.01 0310[INTENSIVE CARE UNIT 0 37.99,366 0.2,970,902 41.058 41.00 04100[SUBPROVIDER - IRF 0 2.970,902 0 2.970,902 41.058 ANCILLARY SERVICE COST CENTERS			0	39, 536, 852		39, 536, 852	30.00
50. 00 05000 00 27, 314, 249 0 27, 314, 249 00 0	31.00 0310 31.01 0310 41.00 0410 43.00 0430	0 INTENSIVE CARE UNIT 11 NEONATAL INTENSIVE CARE UNIT 10 SUBPROVIDER - IRF 10 NURSERY	0 0 0	13, 482, 706 3, 789, 366 2, 970, 902		13, 482, 706 3, 789, 366 2, 970, 902	31. 00 31. 01 41. 00 43. 00
51.00 DO			0	27 314 249		27 314 249	50.00
57.00 05700 05700 05700 05700 057.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 58.00 60.00 0 0 0 58.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 68.00 68.00 68.00 68.00 68.00 68.00 69.00 69.00 69.00 69.00 69.00	51.00 0510 52.00 0520 53.00 0530 54.00 0540 54.01 0540	0 RECOVERY ROOM 0 DELIVERY ROOM & LABOR ROOM 0 ANESTHESIOLOGY 10 RADIOLOGY-DIAGNOSTIC 11 ULTRASOUND	0 0 0	0 4, 760, 841 343, 540 18, 308, 480		0 0 0 4, 760, 841 0 343, 540 0 18, 308, 480	50.00 51.00 52.00 53.00 54.00 54.01
67.00 06700 0000CUPATIONAL THERAPY 0 <	57.00 0570 58.00 0580 60.00 0600 65.00 0650	O CT SCAN O MRI O LABORATORY O RESPI RATORY THERAPY	-	18, 273, 863 4, 071, 549		0 0 0 18, 273, 863 0 4, 071, 549	56.00 57.00 58.00 60.00 65.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 28, 125, 127 0 28, 125, 127 73.00 74.00 07400 RENAL DI ALYSI S 0 844, 400 0 844, 400 74.00 76.00 03950 ANCI LLARY 0 0 0 0 76.00 76.01 03610 SLEEP LAB 0 0 0 0 76.00 76.03 03951 WOUND CARE 0 0 0 0 76.00 00.00 00000 CLI NI C 0 0 0 0 76.00 09000 OPODO CLI NI C 0 0 0 0 90.00 <td>67.00 0670 68.00 0680 69.00 0690 71.00 0710</td> <td>0 OCCUPATI ONAL THERAPY 10 SPEECH PATHOLOGY 10 ELECTROCARDI OLOGY 10 MEDI CAL SUPPLI ES CHARGED TO PATI ENT</td> <td>0 0 0</td> <td>0 0 12, 153, 324 2, 726, 199</td> <td></td> <td>0 0 0 12, 153, 324 0 2, 726, 199</td> <td>66.00 67.00 68.00 69.00 71.00 72.00</td>	67.00 0670 68.00 0680 69.00 0690 71.00 0710	0 OCCUPATI ONAL THERAPY 10 SPEECH PATHOLOGY 10 ELECTROCARDI OLOGY 10 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0 0 0	0 0 12, 153, 324 2, 726, 199		0 0 0 12, 153, 324 0 2, 726, 199	66.00 67.00 68.00 69.00 71.00 72.00
90.00 09000 CLINIC 0	74.00 0740 76.00 0395 76.01 0361 76.03 0395	0 RENAL DI ALYSI S 0 ANCI LLARY 0 SLEEP LAB 1 WOUND CARE	0 0 0	844, 400 0 0	(28, 125, 127 844, 400 0 0 0 0 0 0	73.00 74.00 76.00 76.01 76.03
SUBTOTALS SUBTOTALS <t< td=""><td>90.00 0900 91.00 0910 92.00 0920</td><td>0 CLINIC 0 EMERGENCY 0 OBSERVATION BEDS (NON-DISTINCT PART</td><td></td><td></td><td></td><td>0 17, 195, 444</td><td>90.00 91.00 92.00</td></t<>	90.00 0900 91.00 0910 92.00 0920	0 CLINIC 0 EMERGENCY 0 OBSERVATION BEDS (NON-DISTINCT PART				0 17, 195, 444	90.00 91.00 92.00
190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 73,931 0 73,931 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 5,365,864 0 5,365,864 192.00 192.01 19201 OTHER NONREI MBURSABLE 0 23,338 0 23,338 192.01 194.00 07950 NONREI MBURSABLE 0 0 0 0 194.00 194.01 07951 MARKETI NG 0 1,729,532 0 1,729,532 194.00 194.02 07952 SENI OR CI RCLE 0 126,327 0 126,327 194.02 194.02 07953 OTHER NONREI MB COST C - REGENCY LTA 0 1,530,312 0 1,530,312 194.02 194.02 07954 VACANT UNFI NI SHED AREA 0 1,530,312 0 1,47,754 194.02 194.04 07954 VACANT UNFI NI SHED AREA 0 147,754 0 147,754 194.02 194.04 07954 VACANT UNFI NI SHED AREA 0 0 0 0 200.00 0 0	118.00	SUBTOTALS (SUM OF LINES 1-117)	0	237, 578, 744	(237, 578, 744	118.00
194.03 07953 0THER NONREI MB COST C - REGENCY LTA 0 1,530,312 0 1,530,312 194.03 194.04 07954 VACANT UNFINISHED AREA 0 147,754 0 147,754 194.04 200.00 Cross Foot Adjustments 0 0 0 200.00 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00	190. 00 1900 192. 00 1920 192. 01 1920 194. 00 0795 194. 01 0795	0 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 PHYSI CI ANS' PRI VATE OFFI CES 11 OTHER NONREI MBURSABLE 0 NONREI MBURSABLE 1 MARKETI NG	1	5, 365, 864 23, 338 0 1, 729, 532		5,365,864 23,338 0 0 0 1,729,532	190. 00 192. 00 192. 01 194. 00 194. 01
	194. 03 0795 194. 04 0795 200. 00 201. 00	3 OTHER NONREIMB COST C - REGENCY LTA 4 VACANT UNFINISHED AREA Cross Foot Adjustments Negative Cost Centers		1, 530, 312 147, 754 0 0		0 1, 530, 312 0 147, 754 0 0 0 0	194. 03 194. 04 200. 00 201. 00

Heal th	Financial Systems	PORTER MEMORIAL	HOSPI TAL		In Lieu	u of Form CMS	-2552-10
COST A	LLOCATION STATISTICS		Provider C	CN: 15-0035	Period:	Worksheet No	n-CMS W
					From 01/01/2014 To 12/31/2014	Date/Time Pr 12/13/2017 7	
	Cost Center Description			Stati sti cs	Stati sti cs	Description	
				Code			
				1.00	2.	00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT			1	SQUARE FEET		1.00
2.00	CAP REL COSTS-MVBLE EQUIP			2	DOLLAR VALUE		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT			S	GROSS SALARI ES		4.00
5.00	ADMI NI STRATI VE & GENERAL			-1	ACCUM. COST		5.00
7.00	OPERATION OF PLANT			3	SQUARE FEET		7.00
8.00	LAUNDRY & LINEN SERVICE			4	POUNDS OF LAUNI	DR	8.00
9.00	HOUSEKEEPING			3	SQUARE FEET		9.00
10.00	DI ETARY			6	MEALS SERVED		10.00
11.00	CAFETERIA			7	FTE' S		11.00
13.00	NURSING ADMINISTRATION			8	NURSING WA GES		13.00
14.00	CENTRAL SERVICES & SUPPLY			9	COSTED REQUIS.		14.00
15.00	PHARMACY			10	COSTED REQUIS.		15.00
16.00	MEDI CAL RECORDS & LI BRARY			С	GROSS CHAR GES		16.00
23.00	PARAMED ED PRGM-(SPECIFY)			12	ASSI GNED TI ME		23.00

From Close Cent Control Expland From Close From	Health Financial Systems	PORTER MEMORI				u of Form CMS-2	2552-10	
Cost Center Description Directly Assigned New Cost Server Description Directly BLIG & F1X1 NWRL EDUP Subtrol ENVENTE BENETIS DEPARTMENT 0 00000 APR EL 003T-END.0 & F1XT 0 1.00 0.00 20.	ALLOCATION OF CAPITAL RELATED COSTS		Provider C	F	rom 01/01/2014	Date/Time Pre		
Assigned feer Assigned feer Constrained DEPARTMENT 1.00 0.00 0.00 2.00 2A 4.00 1.00 0.000 CAV REL COSTS RULGS & FLIX 0 2.00 2A 4.00 0.000 CORD REL COSTS RULGS & FLIX & FLIX 0 2.3, 400 50, 0.04 7.9, 470 7.3, 470 4.00 0.000 CORD RULOVES EBREFITS DEPARTMENT 0 2.3, 400 50, 0.04 7.9, 470 7.7, 470			CAPI TAL REI	LATED COSTS		12/13/2017 /:	58 am	
ENERGY SERVICE OST CENTERS 0 1.00 2.	Cost Center Description	Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	BENEFI TS		
1.00 DOTOG CAP EFL COSTS-HURC & FLYT 1.00 0.00 DOSO OF REL COSTS-HURC FOULP 2.0 4.00 DOROOD OF REL COSTS-HURC FOULP 0 23, 406 50, 064 73, 470 4.00 0.0000 OF REL COSTS-HURC FOULP 0 23, 406 50, 064 1, 43, 440 4.00 2.0 0.0000 OF RATION OF FLANT 0 1, 440, 460 3.100, 468 4.550, 297 1, 440 4.77 0.0000 OF RATION OF FLANT 0 1, 440, 460 3.100, 468 4.550, 297 1, 440 1, 400 1, 400, 460 3.100, 468 4.550, 297 1, 440 1, 600 1, 100 100, 00 100, 00 0 0, 100, 100 1, 100, 100, 110, 100, 110, 100, 110, 100, 110, 100, 110, 100, 110, 100, 110, 100, 110, 100, 110, 100, 110, 100, 110, 100, 110, 100, 110, 1			1.00	2.00	2A	4.00		
2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 0.00 00000 0000 0000 <t< td=""><td></td><td></td><td>1</td><td>1</td><td></td><td></td><td></td></t<>			1	1				
4.00 Device[EMPLOYEE BENEFITS DEPARTMENT 0 23. 406 50. 064 73. 470 73.							1.00	
5.00 00500 ADMIN IS STRATI V.E. & CENERAL 0 3.27, 294 7.00, 048 4, 5.02, 3.42 9, 7.63 5.0 0.00 00500 ADMIN IS SERVICE 0 8, 49, 494 31, 00, 648 4, 5.02 7.43 7.0 0.00 00500 ADMESKEEN IG 0 6, 191 120, 187 170, 378 1, 7.44 9.0 0.00 00500 ADMESKEEN IG 0 6, 191 120, 187 176, 378 1, 7.44 18.0 0.00 00500 ADMESING ADMINISTRATION 0 84, 7.47 181, 2.65 266, 072 3.144 13.0 11.00 01400 CENTRAL SPRVICES & SUPLY 0 138, 65 254, 223 236, 078 2.144 14.00 0.00 00200 ADMARACE DE PROCH, SPECI VEPT 0		0	23 406	50 064	73 470	73 470		
7.00 00/00		-						
9.00 00000 HOUSEXEEPING 0 0 0.0000 HOUSEXEEPING 0 170.577 1.76.378 1.74.4 9.0 0.00000 HOUSEXEEPING 0 170.579 1.20.176.378 1.74.67 10.74.778 1.74.378 1.74.67 10.75.110.00 1000 MARSING ADMI MISTRATION 0 4.747 110.265 2.064.012 3.73.078 7.46 1.4.0 1.00 1000 CENTRAL SERVICES & SUPPLY 0 118.856 2264.222 373.078 7.46 1.4.0 1.50 01500 MEDICAL EXERVICES & SUPPLY 0 18.856 2264.222 373.078 7.46 1.4.0 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0						
10.00 DITODD DIFTARY 0 170.07 364.87 6.25, 4.67 6.07 10.0 11.00 OTIOD CAFTERIA 0	8.00 00800 LAUNDRY & LINEN SERVICE	0						
11.00 0.11100 CAFETERIA 0 0 0 0 0 1.05 11.05		0	56, 191	120, 187	176, 378	1, 744	9.00	
13.00 01300 NURSI NG ADMINISTRATION 0 84, 747 113.265 266,012 3.194 13.0 15.00 D1500 FHARAL SERV LOS & SUPPLY 0 65, 201 139,44 14.0 14.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00		0						
14.00 [01400] CENTRAL SERVICES & SUPPLY 0 118, 856 252, 422 373, 076 746 14.0 15.00 11500 MEDICAL RECORDS & LIBRARY 0 23, 143 49, 501 72, 644 1, 442 16.00 10.00 MARITE RECORDS & LIBRARY 0		0	e e e e e e e e e e e e e e e e e e e	-	-			
15.00 OISSOD [HARMACY 0 6.5.201 139.458 204.659 2.476 15.20 15.00 OISSOD [ARAMED ED PRCM. (SPECIFY) 0 <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>		0						
16.00 01600 NEDICAL RECORDS & LIBRARY 0 23, 143 94, 501 72, 644 1, 442 16.00 23, 00 10.00 00 <		0					1	
22.00 02300 PARAMED EDP REQUE (SPCIEFY) 0 0 <t< td=""><td></td><td>0</td><td></td><td></td><td></td><td></td><td></td></t<>		0						
20.00 03000 ADULTS & PEDIATRICS 0 77, 364 2, 090, 481 3, 06, 7, 446 12, 337 30, 400 31.00 03101 INTENSIVE CARE UNIT 0 173, 565 371, 273 594, 4002 4, 402 4, 903 31, 01 31.00 03101 INTENSIVE CARE UNIT 0 106, 096 141, 372 207, 468 1, 474 31, 04 31.01 03101 INTENSIVE CARE UNIT 0 108, 127 231, 273 394, 4802 4, 693 39, 400 846 41, 03 31.01 03001 DISDOD (DELIVERY COM ROM 0 574, 771 1, 129, 377 1, 804, 148 7, 108 50, 00 51, 00 51, 00 50, 00 5200 05200 DELIVERY ROM & LABOR ROM 0 114, 400 244, 689 359, 089 1, 622 52, 04 51, 00 55, 04 54, 00 55, 04 54, 00 54, 00 54, 00 54, 00 56, 00 56, 00 56, 00 56, 00 56, 00 56, 00 56, 00 56, 00 56, 00 56, 00 56, 00 56, 00 56, 00 56, 00 56, 00 56, 00								
31: 00 00:3100 NTERSIVE CARE UNIT 0 173: 565 371: 227 544. 802 4.980 31. 0 31: 00 03:001 NTERSIVE CARE UNIT 0 66.096 141. 372 227. 468 1.74 31. 0 41: 00 04:000 NURSERY 0 106. 127 231. 273 339. 400 846 41. 03 ANCILLARY SERVICE COST CENTERS 0 20, 959 44. 828 65. 787 328. 43. 0 50: 00 05:000 PERATI ING ROM 0 574. 771 1.29, 377 1.804. 148 7.185. 50. 0 51. 00 51. 00 520. 00 53. 00 520. 00	INPATIENT ROUTINE SERVICE COST CENTERS							
31.01 03101 NEOMATAL INTENSIVE CARE UNIT 0 66.096 141.372 207.468 1.474 31.01 41.00 041000 SUBPROVIDER - IKF 0 20.999 41.828 65.787 328 43.0 ANCILLARY SERVICE COST CENTERS 0 20.999 44.828 65.787 328 43.0 50.00 05000 DEELVIEW ROOM 0 0 0 0 51.0 51.00 51.00 51.00 51.00 51.00 52.00 052.00 PEAJ INC ROOM 0 9.922 21.223 31.145 0 53.0 54.00 054.00 65.00 0 0 0 54.00 056.00 65.00 0 0 0 54.00 0 0 0 0 54.00 0 0 0 0 55.00 0 65.00 0 65.00 0 0 0 0 0 0 0 0 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.01 57.01<		0					30.00	
11:00 04100 SUBPROVI DER - I RF 0 108, 127 231, 273 339, 400 846 41.0 00 04300 NARCI LLARY SERVI CE COST CENTERS		-						
43. 00 04300 NURSERY 0 20. 959 44. 828 65. 787 328 43. 0 ANCILLARY SERVICE COST CENTERS 0 574. 771 1. 804.148 7. 108 50. 00 5000 PECAVIEN REOM 0 0 0 0 0 0 0 0 0 51. 00 51.00 51.00 50.00 50.00 65.00 9.820 21.223 31.145 0 53. 00 53.00 53.00 53.00 53.00 55.00 54.00 06400 RADI LICSV-DI AGNOSTI C 0 409.628 876.153 1.285.781 52.264 54.00 55.00 65.00 65.00 65.00 65.00 66.00 66.00 65.00 57.00 56.		-					1	
ANCI LLARY SERVICE COST CENTERS							1	
50. 00 500.00 574. 711 1. 229. 377 1. 804. 148 7. 108 50. 00 51.00 05000 0FECOVERY ROM 0 <td< td=""><td></td><td>0</td><td>20, 959</td><td>44,828</td><td>03, 787</td><td>328</td><td>43.00</td></td<>		0	20, 959	44,828	03, 787	328	43.00	
51.00 65100 RECOVERY ROOM 0		0	574, 771	1, 229, 377	1, 804, 148	7, 108	50.00	
53:00 053:00 NESTHESI OLOGY 0 9,922 21,223 31,145 0 53:00 53:0 54:00 05400 RADI OLOSYDIA GNOSTIC 0 00 0 0 54:00 525:00 52:00 52:00 52:00 52:00 52:00 52:00 52:00 0 0 0 0 56:00 0 0 0 0 56:00 56:00 56:00 56:00 56:00 56:00 56:00 56:00 58:00 0 0 0 0 57:00 57:00 58:00 58:00 58:00 66:00 66:00 66:00 66:00 58:00 59:00 58:00 58:00 59:00 66:00								
54.00 054.00 RADI OLOGY-DI AGNOSTI C 0 409,628 876,153 1,285,781 5,264 54.00 64.01 05601 NADI OI SOTOPE 0 0 0 0 56.00 56.00 05000 CT SCAN 0 0 0 0 0 56.00 56.00 05000 RESOR RATORY 0 155,896 333,446 489,342 4,214 60.00 66.00 06000 RESPI RATORY THERAPY 0 32,469 69,448 101,917 1,826,571 66,50 66.00 06000 RESPI RATORY THERAPY 0 158,800 339,657 498,457 0 67.00 67.00 06700 0COD OCCUPATI NAUAL THERAPY 0 266,804 570,667 837,471 3,775 69.0 00 0 0 0 0 0 0 0 71.0 71.00 0700 INFLOCAL SURGED TO PATI ENTS 0 0 0 0 73.0 73.0 73.0	52.00 05200 DELIVERY ROOM & LABOR ROOM	0	114, 400	244, 689	359, 089	1, 620	52.00	
54.01 054.01 ULTRASQUND 0 0 0 0 54.00 55.00 CT		0					53.00	
56. 00 OS600 RADI 01 SOTOPE 0 0 0 0 0 57. 00 05700 CT 05700 CT 0		0	409, 628					
57. 00 057.00 CT SCAN 0 0 0 0 0 57. 00 058.00 0580.00 0580.00 0580.00 0580.00 0580.00 0580.00 0580.00 0580.00 0 0 0 0 58. 00 0580.00 0580.00 0		0	0	0	0			
58.00 OSB00 MRI O O O O S8.00 O S8.00 O S8.00 S33.446 489,342 44.81 S8.00 S33.246 499.457 C6.00 C6.00 C0 C0 C6.00 C7.00 C7.00 <thc< td=""><td></td><td>0</td><td>0</td><td>0</td><td>0</td><td>-</td><td></td></thc<>		0	0	0	0	-		
60.00 06000 LABDRATORY 0 155.896 333.446 499.342 4.214 60.0 65.00 06500 RESPIRATORY THERAPY 0 32,469 69.448 101,917 1,86 66.0 66.00 06600 PHYSI CAL THERAPY 0 158.800 339.557 498.457 0 66.0 67.00 00 0 0 0 0 0 67.00 0 0 0 67.00 66.00 68.00 570.667 837.471 3,775 69.0 71.00 0 0 0 0 0 72.0 72.00 72.00 70.00 0 0 0 72.0 72.00 73.00 0.00 0 0 0 74.0 74.00		0			0			
65.00 06500 RESPIRATORY THERAPY 0 32,469 69,448 101,917 1,826 65.0 66.00 06600 PHYSICAL THERAPY 0 158,800 339,657 498,457 0 66.0 66.00 0CCUPATIONAL THERAPY 0 0 0 0 67.0 67.00 0CCOCUPATIONAL THERAPY 0 0 0 0 67.0 68.00 0EGTOO 0CCUPATIONAL THERAPY 0 0 0 67.0 69.00 0FOOO CCUPATIONAL THERAPY 0 0 0 0 67.0 69.00 0FOOO ELECTROCARDIOLOGY 0 0 0 0 71.0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 73.0 73.00 07300 0RAGIO HALDIALYSIS 0 5,773 12,347 18,120 74.0 74.00 03610 SLEEP LAB 0 32,320 69,129 101,449 488 76.0 76.01 0		0	e e e e e e e e e e e e e e e e e e e	, s	-			
67.00 OCCUPATI ONAL THERAPY O <td>65. 00 06500 RESPI RATORY THERAPY</td> <td>0</td> <td></td> <td></td> <td>101, 917</td> <td></td> <td></td>	65. 00 06500 RESPI RATORY THERAPY	0			101, 917			
68.00 OBSOND SPEECH PATHOLOGY O		0	158, 800	339, 657	498, 457	0	66.00	
69.00 06900 ELECTROCARDIOLOGY 0 266, 804 570, 667 837, 471 3, 775 69.0 71.00 07100 IMPLICAL SUPPLIES CHARGED TO PATIENTS 0		0	0		-			
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 71.0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 7300 R70300 RROS CHARGED TO PATIENTS 0 0 0 0 73.0 74.00 07400 RENAL DI ALYSIS 0 5,773 12,347 18,120 0 74.0 76.00 03610 SLEEP LAB 0 0 0 0 0 76.0 76.01 03610 SLEEP LAB 0 0 0 0 0 76.0 0 03951 WOUND CARE 0 32,320 69,129 101,449 488 76.0 0 09100 EMEGENCY 0 301,264 644,374 945,638 6.080 91.0 92.0 92.00 OBSERVATION BEDS (NON-DI STINCT PART 0 5.735,667 12,268,003 18,003,670 73.164 118.0 192.00 19200 GIFT. FLOWER, COFFEE SHOP & CANTEEN 0 77.830 583.370		0	0	-	-			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72.0 73.00 DRUGS CHARGED TO PATIENTS 0<		0	266, 804					
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.0 73.0 74.00 07400 RENAL DI ALYSIS 0 5,773 12,347 18,120 0 74.0 76.00 03950 ANCILLARY 0 0 0 0 0 76.0 03610 SLEEP LAB 0 0 0 0 0 76.0 03951 WOUND CARE 0 32,320 69,129 101,449 488 76.0 001 0000 CLINIC 0 0 0 0 0 90.0 <t< td=""><td></td><td>0</td><td></td><td>-</td><td>-</td><td></td><td></td></t<>		0		-	-			
74.00 07400 RENAL DI ALYSI S 0 5,773 12,347 18,120 0 74.0 76.00 03950 ANCI LLARY 0 0 0 0 0 76.0 76.01 03610 SLEEP LAB 0 0 0 0 0 76.0 76.03 03951 WOUND CARE 0 32,320 69,129 101,449 488 76.0 00176.01 09000 CLINIC 0 0 0 0 90.0		0	0					
76. 01 03610 SLEEP LAB 0 0 0 0 76. 0 76. 0 0176. 03 03951 WOUND CARE 0 32, 320 69, 129 101, 449 488 76. 0 0017PATI ENT SERVICE COST CENTERS 0 0 0 0 0 0 0 0 90. 0 90. 0 0 0 0 0 90. 0 90. 0 90. 0 0 0 0 0 90. 0 <td< td=""><td>74.00 07400 RENAL DI ALYSI S</td><td>0</td><td>5, 773</td><td>12, 347</td><td>18, 120</td><td></td><td></td></td<>	74.00 07400 RENAL DI ALYSI S	0	5, 773	12, 347	18, 120			
76. 03 03951 WOUND CARE 0 32, 320 69, 129 101, 449 488 76. 0 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 0 0 90. 0 <		0	0	0	0	0	76.00	
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 </td <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td>1</td>		0	0	0	0		1	
90.00 09000 CLINIC 0 0 0 0 0 0 90.0		0	32, 320	69, 129	101, 449	488	76.03	
91.00 09100 EMERGENCY 0 301, 264 644, 374 945, 638 6, 080 91.0 92.0 92.00 0BSERVATION BEDS (NON-DISTINCT PART 0 0 0 92.0<		0	0		0	0		
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.0 SPECIAL PURPOSE COST CENTERS 5 5 5 5 735,667 12,268,003 18,003,670 73,164 118.0 NONREI MBURSABLE COST CENTERS 5 5 5 735,667 12,268,003 18,003,670 73,164 118.0 NONREI MBURSABLE COST CENTERS 5 5 5 5 100.0 190.00 6 5,735,667 12,268,003 18,003,670 73,164 118.0 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 8,448 18,070 26,518 0 190.0 192.01 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 771,830 583,370 1,355,200 0 192.0 194.00 07950 NONREI MBURSABLE 0 0 0 0 0 192.0 194.01 07951 MARKETI NG 0 0 0 0 0 194.0 194.02 07952 SENIOR CI RCLE								
SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) O 5, 735, 667 12, 268, 003 18, 003, 670 73, 164 NONREI MBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 8, 448 18, 003 18, 003, 670 73, 164 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 771, 830 583, 370 1, 355, 200 0 190.00 192.01 PHYSI CI ANS' PRI VATE OFFICES 0 771, 830 583, 370 1, 355, 200 0 192.01 192.01 OTHER NONREI MBURSABLE 0 0 771, 830 583, 370 1, 355, 200 0 194.00 194.00 194.00 194.00 194.00 194.00 <th col<="" td=""><td></td><td>0</td><td>501, 204</td><td>044, 374</td><td>945, 038</td><td>0,000</td><td></td></th>	<td></td> <td>0</td> <td>501, 204</td> <td>044, 374</td> <td>945, 038</td> <td>0,000</td> <td></td>		0	501, 204	044, 374	945, 038	0,000	
SUBTOTALS SUBTOTALS <t< td=""><td></td><td></td><td>1</td><td>1</td><td>0</td><td></td><td>/2.00</td></t<>			1	1	0		/2.00	
190.00 I9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 8, 448 18, 070 26, 518 0 190.0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 771, 830 583, 370 1, 355, 200 0 192.0 192.01 19201 OTHER NONREI MBURSABLE 0 2, 667 5, 704 8, 371 0 192.0 194.00 07950 NONREI MBURSABLE 0 0 0 0 0 194.0 194.01 07951 MARKETI NG 0 0 0 0 259 194.0 194.02 07952 SENI OR CIRCLE 0 0 0 0 2759 194.0 194.03 07953 OTHER NONREI MB COST C - REGENCY LTA 0 132, 376 0 132, 376 0 194.0 194.03 07953 OTHER NONREI MB COST C - REGENCY LTA 0 132, 376 0 194.0 194.0 194.04 07954 VACANT UNFINI SHED AREA 0 118, 032 0 194.0 200.0 200.00 Negati ve Cost Centers 0		0	5, 735, 667	12, 268, 003	18, 003, 670	73, 164	118.00	
192.00 19200 PHYSICLANS' PRIVATE OFFICES 0 771,830 583,370 1,355,200 0 192.0 192.01 19201 OTHER NONREI MBURSABLE 0 2,667 5,704 8,371 0 192.0 194.00 07950 NONREI MBURSABLE 0 0 0 0 194.0 194.01 07951 MARKETI NG 0 0 0 0 259 194.0 194.02 07952 SENIOR CIRCLE 0 0 0 0 47 194.0 194.03 07953 OTHER NONREI MB COST C - REGENCY LTA 0 132,376 0 194.0 194.04 07954 VACANT UNFINISHED AREA 0 132,376 0 194.0 194.04 07954 VACANT UNFINISHED AREA 0 118,032 0 194.0 200.00 Cross Foot Adjustments 0 0 0 0 200.0 201.00 Negative Cost Centers 0 0 0 0 0 201.0	NONREI MBURSABLE COST CENTERS							
192.01 19201 OTHER NONREI MBURSABLE 0 2,667 5,704 8,371 0 192.0 194.00 07950 NONREI MBURSABLE 0 0 0 0 194.0 194.01 07951 MARKETI NG 0 0 0 0 259 194.0 194.02 07952 SENIOR CIRCLE 0 0 0 47 194.0 194.03 07953 OTHER NONREI MB COST C - REGENCY LTA 0 132,376 0 132,376 194.0 194.04 07954 VACANT UNFI NI SHED AREA 0 118,032 0 194.0 200.0 200.0 200.0 200.0 0 0 200.0 0 0 200.0 0 0 0 200.0 0 0 0 200.0 0 200.0 0 200.0 0 0 0 0 200.0 0 200.0 0 200.0 0 200.0 0 200.0 0 200.0 0 200.0 0 200.0 0 201.0 0 201.0 0 <td< td=""><td>190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN</td><td>0</td><td></td><td></td><td></td><td></td><td></td></td<>	190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0						
194.00 07950 NONREI MBURSABLE 0 0 0 194.00 194.0 194.01 07951 MARKETI NG 0 0 0 259 194.0 194.02 07952 SENI OR CIRCLE 0 0 0 47 194.0 194.03 07953 OTHER NONREI MB COST C - REGENCY LTA 0 132,376 0 132,376 194.0 194.04 07954 VACANT UNFINI SHED AREA 0 118,032 0 194.0 200.00 Cross Foot Adjustments 0 0 0 0 200.0 201.00 Negative Cost Centers 0 0 0 0 0 201.0		0						
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194. 02 07952 SENIOR CIRCLE 0 0 0 47 194. 0 194. 03 07953 OTHER NONREI MB COST C - REGENCY LTA 0 132, 376 0 132, 376 0 194. 0 194. 04 07954 VACANT UNFINI SHED AREA 0 118, 032 0 194. 0 200. 00 Cross Foot Adjustments 0 0 0 200. 0 201. 00 Negative Cost Centers 0 0 0 0 201. 0					0			
194.03 07953 OTHER NONREI MB COST C - REGENCY LTA 0 132,376 0 132,376 0 194.0 194.04 07954 VACANT UNFINI SHED AREA 0 118,032 0 118,032 0 194.0 200.00 Cross Foot Adjustments 0 0 0 200.0 0 0 0 200.0					0			
194.04 07954 VACANT UNFINISHED AREA 0 118,032 0 118,032 0 194.0 200.00 Cross Foot Adjustments 0 118,032 0 200.0 200.0 200.0 0 200.0 <td>194. 03 07953 OTHER NONRELMB COST C - REGENCY LTA</td> <td>0</td> <td>132, 376</td> <td>0</td> <td>132, 376</td> <td></td> <td></td>	194. 03 07953 OTHER NONRELMB COST C - REGENCY LTA	0	132, 376	0	132, 376			
200.00 Cross Foot Adjustments 0 200.0 201.00 Negative Cost Centers 0 0 0 0 0 0 201.0	194. 04 07954 VACANT UNFINI SHED AREA	0						
							200.00	
202.00 TUTAL (SUM FINES TT8-20T) 0 6,769,020 12,875,147 19,644,167 73,470 202.0			0	-	0			
	202.00 101AL (sum lines 118-201)	0	6, 769, 020	12, 875, 147	19, 644, 167	73, 470	J202.00	

ALLUCA	Financial Systems TION OF CAPITAL RELATED COSTS	PORTER MEMORI	Provi der C		Period:	u of Form CMS-2 Worksheet B	2002 10
					From 01/01/2014 To 12/31/2014	Part II Date/Time Pre 12/13/2017 7:	pared: 58 am
	Cost Center Description	ADMI NI STRATI V E & GENERAL	OPERATI ON OF PLANT	LAUNDRY & LINEN SERVICE		DI ETARY	
	CENEDAL SEDVICE COST CENTEDS	5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL	1, 037, 105					5.00
7.00	00700 OPERATION OF PLANT	74, 680	4, 626, 470				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	9, 126	8, 124	43, 818			8.00
9.00	00900 HOUSEKEEPING	21, 504	54, 148	0		710 704	9.00
	01000 DI ETARY 01100 CAFETERI A	10, 043	164, 387 0			719, 734	10.00
	01300 NURSI NG ADMI NI STRATI ON	10, 825 27, 612	81, 665			0	13.00
	01400 CENTRAL SERVICES & SUPPLY	10, 812	114, 534	1, 790		0	14.00
	01500 PHARMACY	21, 587	62, 830	271		0	15.00
	01600 MEDICAL RECORDS & LIBRARY	18, 110	22, 302			0	16.00
	02300 PARAMED ED PRGM-(SPECIFY)	0	0	C		0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	122, 656	941, 821	16, 467		435, 836	30.00
	03100 I NTENSI VE CARE UNI T	47, 335	167, 253			41, 231	31.00
	03101 NEONATAL INTENSIVE CARE UNIT	13, 136	63, 692	208		1, 273	
	04100 SUBPROVIDER - IRF	8, 949	104, 195	1, 038		17, 885	
	04300 NURSERY	3, 172	20, 197	282	2 1, 123	0	43.00
	ANCI LLARY SERVICE COST CENTERS	92, 070	553, 869	6, 362	2 30, 796	1,016	50.00
	05100 RECOVERY ROOM	,070	033,009	0, 302		1,010	51.00
	05200 DELIVERY ROOM & LABOR ROOM	15, 833	110, 240	1, 261		5, 518	
53.00	05300 ANESTHESI OLOGY	1,072	9, 561	(532	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	61, 169	394, 732	3, 377		283	54.00
	05401 ULTRASOUND	0	0	C	0 0	0	54.01
56.00	05600 RADI OI SOTOPE	0	0	C	0 0	0	56.00
	05700 CT SCAN	0	0	C	-	0	57.00
	05800 MRI	0	0	C		0	58.00
	06000 LABORATORY	69, 587	150, 227	ç	-,	0	60.00
65.00		15, 903	31, 288	0		0	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	21, 212	153, 025 0	203		0	66.00 67.00
	06800 SPEECH PATHOLOGY	0	0			0	68.00
	06900 ELECTROCARDI OLOGY	40, 799	257, 102	2, 618		3, 226	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 354	207,102	2,010		0, 220	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	131, 945	0	C	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	91, 526	0	C	0 0	0	73.00
74.00	07400 RENAL DIALYSIS	3, 395	5, 563	C	309	0	74.00
76.00	03950 ANCI LLARY	0	0	C	0 0	0	76.00
	03610 SLEEP LAB	0	0	C		0	76.01
	03951 WOUND CARE	7, 953	31, 144	492	2 1, 732	0	76.03
	OUTPATI ENT SERVI CE COST CENTERS	0	0			0	
	09100 EMERGENCY	0 58, 339	0 290, 309	6, 345		0 9, 020	90.00 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	50, 557	270, 307	0, 340	10, 141	9, 020	92.00
	SPECIAL PURPOSE COST CENTERS				II		72.00
118.00		1,020,704	3, 792, 208	43, 818	3 207, 387	515, 288	118.00
	NONREI MBURSABLE COST CENTERS					,	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	140	8, 141	C	453	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	7, 141	695, 989	C	38, 698	41, 614	192.00
	19201 OTHER NONREI MBURSABLE	44	2, 570	C) 143		192.01
194.00	07950 NONREI MBURSABLE	0	0	C			194.00
	07951 MARKETI NG	7,237	0	C	0 0		194.01
	07952 SENIOR CIRCLE	521	0	0			194.02
194.02							
194. 02 194. 03	07953 OTHER NONREIMB COST C - REGENCY LTA	697	127, 562	0	7,093		194.03
194. 02 194. 03 194. 04	07953 OTHER NONREIMB COST C - REGENCY LTA 07954 VACANT UNFINISHED AREA	697 621	127, 562 0		0 7,093		194.04
194. 02 194. 03	07953 OTHER NONREIMB COST C - REGENCY LTA 07954 VACANT UNFINISHED AREA Cross Foot Adjustments		127, 562 0		0 0	0	

Health Financial Systems	PORTER MEMORI				u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		eriod: rom 01/01/2014 o 12/31/2014	Worksheet B Part II Date/Time Pre 12/13/2017 7:	pared: 58 am
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS	[[]		1
1. 00 00100 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP						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
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	11, 930					10.00 11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	485					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	322		507, 650			14.00
15. 00 01500 PHARMACY	339	20, 648				15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY	414				116, 152	16.00
23. 00 02300 PARAMED ED PRGM- (SPECI FY)	0	0	0	0	0	23.00
30. 00 03000 ADULTS & PEDIATRICS	2, 922	102, 736	0	0	9, 331	30.00
31. 00 03100 I NTENSI VE CARE UNI T	889				2, 402	1
31.01 03101 NEONATAL INTENSIVE CARE UNIT	261				1, 230	
41.00 04100 SUBPROVI DER – I RF	169	7,057			596	41.00
43. 00 04300 NURSERY	63	2,736	0	0	208	43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	1 405	E0.270	304	0	24 407	50.00
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM	1, 405 0				24, 407 0	50.00 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	313				1, 028	
53.00 05300 ANESTHESI OLOGY	0	0	0	0	1, 045	1
54.00 05400 RADI OLOGY-DI AGNOSTI C	992		0	-	15, 250	1
54. 01 05401 ULTRASOUND	0	-	0	-	0	54.01
56. 00 05600 RADI OI SOTOPE 57. 00 05700 CT SCAN	0	-	0		0	56.00 57.00
58. 00 05800 MRI	0	-	0		0	58.00
60. 00 06000 LABORATORY	1, 154	0			12, 644	
65. 00 06500 RESPI RATORY THERAPY	393	0	0	0	1, 262	65.00
66. 00 06600 PHYSI CAL THERAPY	0		0	0	2, 182	1
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	-	-	0	0	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	705			0	8, 490	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		25, 032	-	2,605	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	446, 266	0	11, 738	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	6	0	0		11, 482	1
74. 00 07400 RENAL DI ALYSI S 76. 00 03950 ANCI LLARY	0	0	0	0	242	1
76.01 03610 SLEEP LAB	0	0	0		0	
76. 03 03951 WOUND CARE	96	0			461	
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0				0	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	950	50, 707	0	0	9, 549	91.00 92.00
SPECIAL PURPOSE COST CENTERS						92.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	11, 878	383, 509	507, 650	316, 303	116, 152	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	-				192.00
192. 01 19201 OTHER NONREI MBURSABLE 194. 00 07950 NONREI MBURSABLE	0	-	-	-		192.01 194.00
194. 01 07951 MARKETI NG	41	0	0	0		194.00
194. 02 07952 SENI OR CI RCLE	11	0	0	0	0	194.02
194.03 07953 OTHER NONREIMB COST C - REGENCY LTA	0	0	0	0		194.03
194.0407954 VACANT UNFINISHED AREA	0	0	0	0		194.04
200.00Cross Foot Adjustments201.00Negative Cost Centers	_		_	_	0	200. 00 201. 00
202.00 TOTAL (sum Lines 118-201)	11, 930	383, 509	507, 650	316, 303	116, 152	
	, ,00		, .,	0.0,000		1 : 00

Heal th	Finar	ncial Systems	PORTER MEMORI	AL HOSPLTAL		Inlie	u of Form CMS-2552-10
		OF CAPITAL RELATED COSTS		Provi der C	CN: 15-0035	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II
		Cost Center Description	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments		
			23.00	24.00	25.00	26.00	
1.00 2.00 4.00 5.00 7.00 8.00	00100 00200 00400 00500 00700 00800	AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL OPERATION OF PLANT LAUNDRY & LINEN SERVICE					1.00 2.00 4.00 5.00 7.00 8.00
10.00 11.00 13.00 14.00 15.00 16.00	01000 01100 01300 01400 01500 01600 02300	HOUSEKEEPING DI ETARY CAFETERIA NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY PARAMED ED PRGM-(SPECIFY)	0				9.00 10.00 11.00 13.00 14.00 15.00 16.00 23.00
30.00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS		4, 764, 318		0 4, 764, 318	30.00
31. 00 31. 01	03100 03101	INTENSI VE CARE UNI T NEONATAL INTENSI VE CARE UNI T SUBPROVI DER - I RF		4, 704, 318 862, 818 304, 578 485, 928		0 862, 818 0 304, 578 0 485, 928	31. 00 31. 01 41. 00
		NURSERY		93, 896		0 93, 896	43.00
		LARY SERVICE COST CENTERS			1		
		OPERATING ROOM RECOVERY ROOM		2, 580, 764 0		0 2, 580, 764 0 0	50.00 51.00
	•	DELIVERY ROOM & LABOR ROOM		514, 539		0 514, 539	52.00
	1	ANESTHESI OLOGY		43, 355		0 43, 355	53.00
54.00	05400	RADI OLOGY-DI AGNOSTI C		1, 832, 692		0 1, 832, 692	54.00
	•	ULTRASOUND		0		0 0	54.01
	•	RADI OI SOTOPE		0		0 0	56.00
		CT SCAN		0		0 0	57.00
	05800	LABORATORY		0 771, 578		0 0 0 771, 578	58.00 60.00
		RESPIRATORY THERAPY		154, 329		0 154, 329	65.00
	1	PHYSI CAL THERAPY		683, 587		0 683, 587	66.00
		OCCUPATIONAL THERAPY		0		0 0	67.00
	4	SPEECH PATHOLOGY		0		0 0	68.00
	4	ELECTROCARDI OLOGY		1, 197, 595		0 1, 197, 595	69.00
	4	MEDICAL SUPPLIES CHARGED TO PATIENT		37, 991		0 37, 991	71.00
		I MPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS		589, 949 419, 377		0 589, 949 0 419, 377	72.00 73.00
		RENAL DI ALYSI S		27, 629		0 27, 629	74.00
		ANCILLARY		0		0 0	76.00
76.01	03610	SLEEP LAB		0		0 0	76.01
76.03		WOUND CARE		143, 815		0 143, 815	76.03
00.00		TIENT SERVICE COST CENTERS		0			
		EMERGENCY		0 1, 393, 078		0 0 0 1, 393, 078	
		OBSERVATION BEDS (NON-DISTINCT PART		1, 393, 070		0 1, 393, 070	92.00
		AL PURPOSE COST CENTERS	1 1		1	-	
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	16, 901, 816		0 16, 901, 816	118.00
		I MBURSABLE COST CENTERS	1		1		
	•	GIFT, FLOWER, COFFEE SHOP & CANTEEN		35, 252		0 35, 252	
		PHYSICIANS' PRIVATE OFFICES OTHER NONREIMBURSABLE		2, 138, 642 11, 128		0 2, 138, 642 0 11, 128	192.00 192.01
		NONREI MBURSABLE		11, 120		0 0	192.01
		MARKETING		7, 537		0 7, 537	194.00
		SENI OR CI RCLE		579		0 579	194.02
		OTHER NONREIMB COST C - REGENCY LTA		430, 560		0 430, 560	
		VACANT UNFINISHED AREA		118, 653		0 118, 653	194.04
200.00		Cross Foot Adjustments	0	0		0 0	200.00
201.00 202.00		Negative Cost Centers TOTAL (sum lines 118-201)	0	0 19, 644, 167		0 0 0 19, 644, 167	201.00 202.00
202.00	I		, v	17, 044, 107	I	5, 17, 044, 107	1202.00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	PORTER MEMORIA	AL HOSPITAL Provider CO	N. 15-0035	In Lie Period:	u of Form CMS-2 Worksheet B-1	
			F	rom 01/01/2014 o 12/31/2014		
	CAPI TAL REL	ATED COSTS			12/13/2017 7:	58 am
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconciliatio n	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	
	1.00	2.00	4. 00	5A	5.00	
GENERAL SERVICE COST CENTERS	771 575					1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMI NI STRATI VE & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DI ETARY 11.00 01100 CAFETERIA 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY	771, 575 2, 668 37, 307 165, 240 961 6, 405 19, 445 0 9, 660 13, 548 7, 432 2, 638	686, 143 2, 668 37, 307 165, 240 961 6, 405 19, 445 0 9, 660 13, 548 7, 432 2, 638	86, 925, 736 11, 553, 412 1, 767, 066 123, 592 2, 064, 136 824, 647 1, 307, 557 3, 780, 157 883, 056 2, 930, 041 1, 706, 722	-49, 600, 951 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	196, 974, 851 14, 184, 163 1, 733, 337 4, 084, 248 1, 907, 584 2, 055, 940 5, 244, 364 2, 053, 543 4, 100, 140 3, 439, 789	10.00 11.00 13.00 14.00 15.00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	C	0	0	23.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 INTENSI VE CARE UNI T 31. 01 03101 NEONATAL INTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER - IRF 43. 00 NURSERY ANCI LLARY SERVI CE COST CENTERS	111, 406 19, 784 7, 534 12, 325 2, 389	111, 406 19, 784 7, 534 12, 325 2, 389	14, 577, 571 5, 893, 621 1, 744, 671 1, 001, 489 388, 246		23, 296, 570 8, 990, 476 2, 494, 986 1, 699, 628 602, 439	31.00 31.01 41.00
ANGLEART SLAVICE COST CLANTERS 50.00 05000 OPERATI NG ROOM S 51.00 05100 RECOVERY ROOM S 52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY-DI AGNOSTI C 54.01 05400 RADI OLOGY-DI AGNOSTI C 54.01 05400 RADI OLOGY-DI AGNOSTI C 56.00 05600 RADI OL SOTOPE 57.00 05700 CT SCAN 58.00 05800 MRI 60.00 06500 RESPI RATORY THERAPY 65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 0CCUPATI ONAL THERAPY	65, 516 0 13, 040 1, 131 46, 692 0 0 0 0 17, 770 3, 701 18, 101 0	65, 516 0 13, 040 1, 131 46, 692 0 0 0 17, 770 3, 701 18, 101	8, 411, 943 C 1, 916, 821 6, 229, 222 C C C 4, 987, 297 2, 160, 365 C C C C C C C C C C C C C C C C C C C		17, 487, 211 0 3, 007, 185 203, 666 11, 617, 960 0 0 13, 216, 843 3, 020, 488 4, 028, 930 0	53.00 54.00 54.01 56.00 57.00 58.00 60.00 65.00
68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73.00 07300 DRUGS CHARGED TO PATI ENTS 74.00 07400 RENAL DI ALYSI S 76.00 03950 ANCI LLARY 76.01 03610 SLEEP LAB 76.03 03951 WOUND CARE	0 30, 412 0 0 658 0 0 3, 684	0 30, 412 0 0 658 0 0 3, 684	0 4, 467, 942 0 70, 853 0 0 0 577, 040		0 7, 749, 030 1, 966, 516 25, 055, 133 17, 383, 850 644, 762 0 0 1, 510, 488	71.00 72.00 73.00 74.00 76.00 76.01
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0 34, 340	0 34, 340	C 7, 195, 578	-	0 11, 080, 482	90.00 91.00 92.00
SPECI AL PURPOSE COST CENTERS118.00SUBTOTALS (SUM OF LINES 1-117)	653, 787	653, 787	86, 563, 045	-49, 600, 951	193, 859, 751	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19201 OTHER NONREI MBURSABLE 194. 00 07950 NONREI MBURSABLE 194. 01 07951 MARKETI NG 194. 02 07952 SENI OR CI RCLE 194. 03 07953 OTHER NONREI MB COST C - REGENCY LTA	963 87, 978 304 0 0 0 15, 089	963 31, 089 304 0 0 0 0			26, 518 1, 356, 258 8, 371	190.00 192.00 192.01 194.00 194.01 194.02
194.0407954VACANT UNFINISHED AREA200.00Cross Foot Adjustments201.00Negative Cost Centers202.00Cost to be allocated (per Wkst. B,	6, 769, 020	0 12, 875, 147	C 14, 151, 393		118, 032 49, 600, 951	194. 04 200. 00 201. 00
Part I) 203.00 204.00 204.00 205.00 206.00 207.00 2	8. 772990	18. 764524	0. 162799 73, 470		0. 251814 1, 037, 105	
205.00 Part II) Unit cost multiplier (Wkst. B, Part II)			0.000845	5	0.005265	205.00

Health Financial Systems	PORTER MEMORI		014 d5 0005 D		u of Form CMS-	
COST ALLOCATION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2014 p 12/31/2014	Worksheet B-1 Date/Time Pre 12/13/2017 7:	epared:
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERIA (FTE' S)	
	7.00	8.00	9.00	10.00	11.00	
GENERAL SERVI CE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT 8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY 23. 00 02300 PARAMED ED PROM - (SPECI FY)	547, 255 961 6, 405 19, 445 0 9, 660 13, 548 7, 432 2, 638 0	1, 913, 697 0 0 0 78, 158 11, 840 0	539, 889 19, 445 0 9, 660 13, 548 7, 432 2, 638	244, 317 0 0 0 0 0 0 0 0 0	98, 327 3, 997 2, 653 2, 791 3, 413 0	13.00 14.00 15.00 16.00
30. 00 03000 ADULTS & PEDI ATRI CS	111, 406	719, 160	111, 406	147, 947	24, 077	30.00
31.00 03100 I NTENSI VE CARE UNI T 31.01 03101 NEONATAL I NTENSI VE CARE UNI T 41.00 04100 SUBPROVI DER - I RF 43.00 04300 NURSERY	19, 784 7, 534 12, 325 2, 389	135, 167 9, 089 45, 319	19, 784 7, 534 12, 325	13, 996 432 6, 071 0	7, 329 2, 154 1, 395 522	31.00 31.01 41.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	65, 516	277, 857	65, 516	345	11, 583	50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY S	0 0 13, 040 1, 131 46, 692 0 0	0 55, 060 0 147, 495 0	0 13, 040 1, 131 46, 692 0	0 0 1,873 0 96 0 0	0 2, 578 0 8, 176 0 0	51.00 52.00 53.00 54.00 54.01
57. 00 05700 CT SCAN 58. 00 05800 MRI 60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0 0 17, 770 3, 701 18, 101 0 0	0 398 0 8, 855 0	0 17, 770 3, 701 18, 101 0		0 0 9, 514 3, 236 0 0	58.00 60.00 65.00 66.00 67.00
69.00 06900 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 72.00 07200 I MPL. DEV. 73.00 07300 DRUGS CHARGED TO PATI ENTS 74.00 07400 RENAL DI ALYSI S 76.00 03950 ANCI LLARY 76.01 03951 WOUND CARE	30, 412 0 0 658 0 0 3, 684		0 0 658 0 0	1,095 0 0 0 0 0 0 0 0	5, 814 0 0 47 0 0 0 0 0	69.00 71.00 72.00 73.00
OUTPATIENT SERVICE COST CENTERS		· ·				
90.00 09000 CLINIC 91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS	0 34, 340			0 3, 062	0 7, 828	90.00 91.00 92.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	448, 572	1, 913, 697	441, 206	174, 917	97, 897	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19201 OTHER NONREI MBURSABLE 194. 00 07950 NONREI MBURSABLE 194. 01 07951 MARKETI NG	963 82, 327 304 0 0	0 0 0	82, 327 304 0	0 14, 126 0 0 0	0 0 0	190. 00 192. 00 192. 01 194. 00 194. 01
194.0207952SENIOR CIRCLE194.0307953OTHER NONREIMB COST C - REGENCY LTA194.0407954VACANT UNFINISHED AREA200.00Cross Foot Adjustments201.00Negative Cost Centers	0 15, 089 0	0		0 55, 274 0	90 0	194. 02 194. 03 194. 04 200. 00 201. 00
202.00 Cost to be allocated (per Wkst. B,	17, 755, 934	2, 200, 996	5, 320, 532	3, 210, 470	2, 573, 654	1
Part I) 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) Part II)	32. 445449 4, 626, 470			13. 140592 719, 734	26. 174438 11, 930	203. 00 204. 00
205.00 Unit cost multiplier (Wkst. B, Part	8. 453957	0. 022897	0. 470048	2.945902	0. 121330	205. 00

	ancial Systems CATION - STATISTICAL BASIS	PORTER MEMORIA	AL HOSPITAL Provider CC	N· 15-0035	Period:	u of Form CMS-2 Worksheet B-1	
JI ALLUU	ATTOR - STATISTICAL DASIS			M. 13-0030	From 01/01/2014 To 12/31/2014		
					10 12/31/2014	Date/Time Pre 12/13/2017 7:	par 58
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	PARAMED ED	
		ADMI NI STRATI O N	SERVICES & SUPPLY	(COSTED REQUIS.)	RECORDS & LI BRARY	PRGM (ASSI GNED	
		(NURSING WA	(COSTED	KLUUI S.)	(GROSS CHAR	TI ME)	
		GES)	REQUIS.)		GES)	, , , , , , , , , , , , , , , , , , , ,	
CEN		13.00	14.00	15.00	16.00	23.00	-
	ERAL SERVICE COST CENTERS						1 1
	00 CAP REL COSTS-MVBLE EQUIP						2
	00 EMPLOYEE BENEFITS DEPARTMENT						4
	00 ADMI NI STRATI VE & GENERAL						5
	00 OPERATION OF PLANT						7
	00 LAUNDRY & LINEN SERVICE 00 HOUSEKEEPING						8
	00 DI ETARY						10
	00 CAFETERI A						11
00 0130	00 NURSING ADMINISTRATION	54, 420, 597					13
	00 CENTRAL SERVICES & SUPPLY	0	28, 709, 761				14
00 0150	00 PHARMACY	2, 930, 041	0	18, 103, 3			15
	00 MEDICAL RECORDS & LIBRARY	0	0		0 1, 500, 556, 736	100	16
	00 PARAMED ED PRGM-(SPECIFY) ATIENT ROUTINE SERVICE COST CENTERS	0	0		0 0	100	23
	00 ADULTS & PEDIATRICS	14, 577, 571	0		0 121, 181, 800	0	30
	00 INTENSIVE CARE UNIT	5, 893, 621	0		0 31, 192, 560	0	
01 0310	01 NEONATAL INTENSIVE CARE UNIT	1, 744, 671	0		0 15, 979, 107	0	31
	00 SUBPROVI DER – I RF	1, 001, 489	0		0 7, 746, 008	0	
		388, 246	0		0 2, 703, 433	0	43
	ILLARY SERVICE COST CENTERS	8, 411, 942	17, 177		0 309, 051, 296	0	50
	00 RECOVERY ROOM	0,411,942	0		0 0 0	0	
	OO DELIVERY ROOM & LABOR ROOM	1, 916, 821	0		0 13, 347, 208	0	
	00 ANESTHESI OLOGY	0	0		0 13, 568, 533	0	53
	00 RADI OLOGY-DI AGNOSTI C	6, 229, 221	0		0 198, 056, 522	0	
	01 ULTRASOUND	0	0		0 0	0	
	00 RADI OI SOTOPE	0	0		0 0	0	
	00 CT_SCAN 00 MRI	0	0		0 0	0	57
	00 LABORATORY	0	2,038,686		0 164, 210, 401	0	
	00 RESPIRATORY THERAPY	0	0		0 16, 385, 463	0	
00 0660	00 PHYSI CAL THERAPY	0	0		0 28, 336, 954	0	66
	00 OCCUPATI ONAL THERAPY	0	0		0 0	0	
	00 SPEECH PATHOLOGY	0	0		0 0	0	
		4, 131, 396	0		0 110, 259, 569	0	
	00 MEDICAL SUPPLIES CHARGED TO PATIENT 00 IMPL. DEV. CHARGED TO PATIENTS	0	1, 415, 686 25, 238, 212		0 33, 836, 779 0 152, 441, 656	0	
	00 DRUGS CHARGED TO PATIENTS	0	25, 256, 212	18, 103, 3		0	
	00 RENAL DIALYSIS	0	0	10, 100, 00	0 3, 145, 343	0	
	50 ANCI LLARY	0	0		0 0	0	
	10 SLEEP LAB	0	0		0 0	0	76
	51 WOUND CARE	0	0		0 5, 986, 589	0	76
	PATIENT SERVICE COST CENTERS	0	0		0 0	0	90
	00 EMERGENCY	7, 195, 578	0		0 124, 011, 932	100	
	00 OBSERVATION BEDS (NON-DISTINCT PART	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0			100	92
SPE	CIAL PURPOSE COST CENTERS	· · · · ·					
3. 00	SUBTOTALS (SUM OF LINES 1-117)	54, 420, 597	28, 709, 761	18, 103, 35	50 1, 500, 556, 736	100	118
	REIMBURSABLE COST CENTERS OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190
	00 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192
	01 OTHER NONREI MBURSABLE	0	0		0 0		192
. 00 079	50 NONREI MBURSABLE	0	0		0 0	0	194
	51 MARKETI NG	0	0		0 0		194
	52 SENI OR CI RCLE	0	0		0 0		194
	53 OTHER NONREIMB COST C - REGENCY LTA 54 VACANT UNFINISHED AREA	0	0				194 194
1. 04 079:). 00	Cross Foot Adjustments	0	0		0		200
1.00	Negative Cost Centers						200
2.00	Cost to be allocated (per Wkst. B,	7, 078, 208	3, 303, 072	5, 914, 75	56 4, 506, 897		202
	Part I)	, , , , , , , , , , , , , , , , , , , ,	, ,				
3. 00	Unit cost multiplier (Wkst. B, Part I)	0. 130065	0. 115050	0. 32672			
4. 00	Cost to be allocated (per Wkst. B,	383, 509	507, 650	316, 30	03 116, 152	0	204
- 00	Part II)	0.0070/7	0.017/00	0 047.5		0.000000	000
5.00	Unit cost multiplier (Wkst. B, Part	0.007047	0. 017682	0.0174	0. 000077	0.000000	1205

Heal th	Financial Systems	PORTER MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 15-0035	Period: From 01/01/2014	Worksheet C	
					To 12/31/2014	Part I Date/Time Pre	pared.
					10 12/01/2011	Date/Time Pre 12/13/2017 7:	58 am
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
		(from Wkst.	Adj.		Di sal I owance		
		B, Part I,					
		col. 26)					
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1	1			
	03000 ADULTS & PEDIATRICS	39, 536, 852		39, 536, 8		39, 536, 852	
	03100 I NTENSI VE CARE UNI T	13, 482, 706		13, 482, 70		13, 482, 706	
31.01	03101 NEONATAL INTENSIVE CARE UNIT	3, 789, 366		3, 789, 3		3, 789, 366	
	04100 SUBPROVI DER – I RF	2, 970, 902		2, 970, 90		2, 970, 902	
43.00	04300 NURSERY	941, 658		941, 6	58 0	941, 658	43.00
	ANCI LLARY SERVI CE COST CENTERS	1	1	1			
50.00	05000 OPERATING ROOM	27, 314, 249		27, 314, 24		27, 314, 249	
51.00	05100 RECOVERY ROOM	0			0 0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	4, 760, 841		4, 760, 84		4, 760, 841	
53.00	05300 ANESTHESI OLOGY	343, 540		343, 54		343, 540	
54.00	05400 RADI OLOGY-DI AGNOSTI C	18, 308, 480		18, 308, 4	30 0	18, 308, 480	
54.01	05401 ULTRASOUND	0			0 0	0	
56.00	05600 RADI OI SOTOPE	0			0 0	0	
	05700 CT SCAN	0			0 0	0	
58.00	05800 MRI	0			0 0	0	
60.00	06000 LABORATORY	18, 273, 863		18, 273, 8		18, 273, 863	
65.00	06500 RESPI RATORY THERAPY	4,071,549		4, 071, 5		4, 071, 549	
66.00	06600 PHYSI CAL THERAPY	5, 904, 429	0	5, 904, 42	29 0	5, 904, 429	
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	
	06900 ELECTROCARDI OLOGY	12, 153, 324		12, 153, 3		12, 153, 324	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 726, 199		2, 726, 1		2, 726, 199	
	07200 IMPL. DEV. CHARGED TO PATIENTS	34, 725, 745		34, 725, 74		34, 725, 745	
73.00	07300 DRUGS CHARGED TO PATIENTS	28, 125, 127		28, 125, 12		28, 125, 127	
	07400 RENAL DI ALYSI S	844, 400		844, 40	0 00	844, 400	
76.00	03950 ANCI LLARY	0			0 0	0	
76.01	03610 SLEEP LAB	0			0 0	0	
76.03	03951 WOUND CARE	2, 110, 070		2, 110, 0	70 0	2, 110, 070	76.03
	OUTPATIENT SERVICE COST CENTERS	1		1	-		
	09000 CLINIC	0			0 0	0	
91.00	09100 EMERGENCY	17, 195, 444		17, 195, 4		17, 195, 444	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 752, 431		2, 752, 4		2, 752, 431	
200.00		240, 331, 175	0			240, 331, 175	
201.00		2, 752, 431	_	2, 752, 4		2, 752, 431	
202.00	Total (see instructions)	237, 578, 744	0	237, 578, 7	14 0	237, 578, 744	202.00

Health Financial Systems	PORTER MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0035	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre 12/13/2017 7:	pared: 58 am
		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1 1		1			
30. 00 03000 ADULTS & PEDIATRICS	113, 192, 216		113, 192, 21			30.00
31.00 03100 INTENSIVE CARE UNIT	31, 192, 560		31, 192, 56			31.00
31.01 03101 NEONATAL INTENSIVE CARE UNIT	15, 979, 107		15, 979, 10			31.01
41. 00 04100 SUBPROVI DER – I RF	7, 746, 008		7, 746, 00			41.00
43. 00 04300 NURSERY	2, 703, 433		2, 703, 43	33		43.00
ANCILLARY SERVICE COST CENTERS			1			
50.00 05000 OPERATING ROOM	147, 293, 133	161, 758, 163	309, 051, 29		0.000000	•
51.00 05100 RECOVERY ROOM	0	0		0 0.000000	0.00000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	12, 900, 564	446, 644	13, 347, 20	0. 356692	0.00000	52.00
53. 00 05300 ANESTHESI OLOGY	6, 750, 285	6, 818, 248	13, 568, 53	0. 025319	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	42, 616, 177	155, 440, 345	198, 056, 52	0. 092441	0.000000	54.00
54.01 05401 ULTRASOUND	0	0		0 0.000000	0.000000	54.01
56. 00 05600 RADI 0I SOTOPE	0	0		0 0.000000	0.000000	56.00
57.00 05700 CT SCAN	0	0		0 0.000000	0.000000	57.00
58. 00 05800 MRI	0	0		0 0.000000	0.000000	58.00
60.00 06000 LABORATORY	65, 286, 590	98, 923, 811	164, 210, 40	0. 111283	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	14,604,696	1, 780, 767	16, 385, 46	0. 248485	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	20, 669, 957	7,666,997	28, 336, 95	0. 208365	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0.000000	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0.000000	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	42, 236, 455	68,023,114	110, 259, 56		0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	19, 309, 866	14, 526, 913			0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	95, 321, 590	57, 120, 066			0.000000	
73.00 07300 DRUGS CHARGED TO PATI ENTS	58, 109, 275	91,006,308			0.000000	
74.00 07400 RENAL DIALYSIS	3, 033, 364	111, 979			0.000000	
76. 00 03950 ANCI LLARY	0,000,001	0	07.1070	0 0.000000	0. 000000	
76. 01 03610 SLEEP LAB	0	0		0 0.000000	0.000000	
76.03 03951 WOUND CARE	331,603	5, 654, 986	5, 986, 58		0.000000	
OUTPATIENT SERVICE COST CENTERS	001,000	0,001,700	0,700,00	0.002100	0.000000	/0.00
90. 00 09000 CLINIC	0	0		0 0.000000	0.000000	90.00
91. 00 09100 EMERGENCY	34, 300, 703	89, 711, 229			0.000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	897, 433	7, 092, 151			0.000000	
200.00 Subtotal (see instructions)	734, 475, 015	766, 081, 721			0.000000	200.00
201.00 Less Observation Beds	, , , , , , , , , , , , , , , , , , , ,	,00,001,721	, 500, 550, 70			200.00
202.00 Total (see instructions)	734, 475, 015	766 081 721	1, 500, 556, 73	86		201.00
	/34, 4/3, 015	700,001,721	1, 500, 550, 75			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0035 Period: From 01/01/2014 To 12/31/2014 Worksheet C Part I Date/Time Prepare 12/13/2017 7:58 Cost Center Description PPS Inpatient Ratio 11.00 Hospital PPS INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30	red:
Cost Center Description PPS Inpatient Ratio 11.00	aiii
Ratio 11.00	
11.00	
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00 03000 ADULTS & PEDI ATRI CS 30	
	0.00
31.00 03100 INTENSIVE CARE UNIT	1.00
31. 01 03101 NEONATAL INTENSIVE CARE UNIT 31	1.01
41. 00 04100 SUBPROVI DER - I RF 41	1.00
	3.00
ANCI LLARY SERVICE COST CENTERS	
	0.00
	1.00
	2.00
	3.00
	4.00
	4.00
	4.01 6.00
	7.00
	8.00
	0.00
	5.00
	6.00
	7.00
	8.00
	9.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.080569 71	1.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0. 227797 72	2.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 188613 73	3.00
74. 00 07400 RENAL DI ALYSI S 0. 268460 74	4.00
76. 00 03950 ANCI LLARY 0. 000000 76	6.00
76. 01 03610 SLEEP LAB 0. 000000 76	6. 01
	6.03
OUTPATIENT SERVICE COST CENTERS	
	0.00
	1.00
	2.00
	2.00 0.00
	1.00
	2.00
	<u>+</u> .00

Health Financial Systems	PORTER MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period:	Worksheet D	
				From 01/01/2014 To 12/31/2014		narod
				10 12/31/2014	12/13/2017 7:	58 am
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.	-	Related Cost	-	col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	4, 764, 318	C	4, 764, 31	8 51, 051	93.32	30.00
31. 00 I NTENSI VE CARE UNI T	862, 818		862, 81	8 7, 791	110. 75	31.00
31.01 NEONATAL INTENSIVE CARE UNIT	304, 578		304, 57	8 1, 215	250.68	31.01
41. 00 SUBPROVIDER – IRF	485, 928	C	485, 92	8 3, 369	144.24	41.00
43.00 NURSERY	93, 896		93, 89	6 1, 982	47.37	43.00
200.00 Total (lines 30-199)	6, 511, 538		6, 511, 53	8 65, 408		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	24, 456					30.00
31.00 INTENSIVE CARE UNIT	4, 058		1			31.00
31.01 NEONATAL INTENSIVE CARE UNIT	0					31.01
41. 00 SUBPROVI DER – I RF	2, 127	306, 798	3			41.00
43.00 NURSERY	0	C)			43.00
200.00 Total (lines 30-199)	30, 641	3, 038, 456				200.00

Health Financial Systems	PORTER MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-0035	Peri od:	Worksheet D	
				From 01/01/2014		
				To 12/31/2014	Date/Time Pre 12/13/2017 7:	pared: 58 am
		Title	XVIII	Hospi tal	PPS	<u>50 alli</u>
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)	-		
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1			- 1		
50.00 05000 OPERATING ROOM	2, 580, 764	309, 051, 296				
51.00 05100 RECOVERY ROOM	0	0	0,00000		Ũ	
52.00 05200 DELIVERY ROOM & LABOR ROOM	514, 539	13, 347, 208				•
53. 00 05300 ANESTHESI OLOGY	43, 355	13, 568, 533				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 832, 692	198, 056, 522			251, 082	
54. 01 05401 ULTRASOUND	0	0	0.00000		0	54.01
56. 00 05600 RADI OI SOTOPE	0	0	0.00000		0	56.00
57.00 05700 CT SCAN	0	0	0.00000		0	57.00
58.00 05800 MRI	0	0	0.00000		0	58.00
60. 00 06000 LABORATORY	771, 578					60.00
65. 00 06500 RESPI RATORY THERAPY	154, 329	16, 385, 463				
66. 00 06600 PHYSI CAL THERAPY	683, 587	28, 336, 954			214, 698	
67.00 06700 OCCUPATI ONAL THERAPY	0	0	0.00000		0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.00000		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 197, 595					
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	37, 991	33, 836, 779	0. 00112	8, 822, 108	9, 907	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	589, 949	152, 441, 656	0.00387	41, 653, 649	161, 200	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	419, 377	149, 115, 583	0. 00281			73.00
74.00 07400 RENAL DIALYSIS	27, 629	3, 145, 343			16, 964	
76. 00 03950 ANCI LLARY	0	0	0.00000	0 0	0	76.00
76.01 03610 SLEEP LAB	0	0	0.00000		0	76.01
76.03 03951 WOUND CARE	143, 815	5, 986, 589	0. 02402	133, 486	3, 207	76.03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0	0.00000		Ũ	
91. 00 09100 EMERGENCY	1, 393, 078					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	331, 676					92.00
200.00 Total (lines 50-199)	10 721 054	1, 329, 743, 412	1	262, 234, 876	1, 956, 850	200 00

Health Financial Systems	PORTER MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS			Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 12/13/2017 7:	
			XVIII	Hospi tal	PPS	
Cost Center Description		Allied Health		Swi ng-Bed	Total Costs	
	School	Cost	Medi cal	Adj ustment	(sum of cols.	
			Educati on	Amount (see	1 through 3,	
			Cost	instructions)	minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	000
31.01 03101 NEONATAL INTENSIVE CARE UNIT	0	0		0	0	
41.00 04100 SUBPROVI DER – I RF	0	0		0 0	0	1
43. 00 04300 NURSERY	0	0		0	0	1 101 00
200.00 Total (lines 30-199)	0	0		0		200.00
Cost Center Description	Total Patient	Per Diem	I npati ent	Inpati ent	PSA Adj.	
	Days	(col. 5 ÷	Program Day		Nursi ng	
		col. 6)		Pass-Through	School	
				Cost (col. 7		
				x col. 8)		
	6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS	51.051			- /		
30. 00 03000 ADULTS & PEDI ATRI CS	51, 051				0	
31.00 03100 INTENSIVE CARE UNIT	7, 791				0	
31. 01 03101 NEONATAL INTENSIVE CARE UNIT	1, 215			0 0	0	1 0 0 .
41.00 04100 SUBPROVIDER - IRF	3, 369				0	
43.00 04300 NURSERY	1, 982			0 0	0	
200.00 Total (lines 30-199)	65, 408		30, 6	41 0	0	200.00
Cost Center Description	PSA Adj.	PSA Adj. All				
	Allied Health					
	Cost	Education				
	10.00	Cost	-			
	12.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS	-		1			1 20 00
30. 00 03000 ADULTS & PEDI ATRI CS	0	0				30.00
31.00 03100 INTENSIVE CARE UNIT	0	0				31.00
31.01 03101 NEONATAL INTENSIVE CARE UNIT	0	0				31.01
41.00 04100 SUBPROVIDER - IRF	0	0				41.00
41.00 04100 SUBPROVIDER - IRF 43.00 04300 NURSERY 200.00 Total (lines 30-199)	0	0				41.00 43.00 200.00

Health Financial Systems	PORTER MEMORIAL	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS		CN: 15-0035	Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 12/13/2017 7:	pared: 58 am
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Allied Healt		Total Cost	
	Anesthetist	School		Medi cal	(sum of col 1	
	Cost			Educati on	through col.	
				Cost	4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS					1	
50.00 O5000 OPERATING ROOM	0	C)	0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	C)	0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	(0	0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0	C)	0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C)	0 0	0	54.00
54. 01 05401 ULTRASOUND	0	C)	0 0	0	54.01
56. 00 05600 RADI 0I SOTOPE	0	C)	0 0	0	56.00
57.00 05700 CT SCAN	0	C)	0 0	0	57.00
58. 00 05800 MRI	0	0	D	0 0	0	58.00
60. 00 06000 LABORATORY	0	0	D	0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0	D	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	D	0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	D	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	(D	0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	D	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	D	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	D	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	D	0 0	0	73.00
74.00 07400 RENAL DI ALYSI S	0	C	D	0 0	0	74.00
76. 00 03950 ANCI LLARY	0	0	D	0 0	0	76.00
76.01 03610 SLEEP LAB	0	0	D	0 0	0	76.01
76.03 03951 WOUND CARE	0	(0 0	0	76.03
OUTPATIENT SERVICE COST CENTERS	1 .1			-	1	
90. 00 09000 CLINIC	0	(2	0 0		
91.00 09100 EMERGENCY	0	C	י	0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C		0 0	0	
200.00 Total (lines 50-199)	0	C	ע	0 0	0	200.00

Health Financial Systems	PORTER MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2014	Part IV	
				To 12/31/2014	Date/Time Pre 12/13/2017 7:	pared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Total	Total Charges	Ratio of Cos	t Outpatient	I npati ent	
· ·	Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
	Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
	col. 2, 3 and	col. 8)	col. 7)	(col. 6 ÷	-	
	4)			col. 7)		
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS	1					
50.00 05000 OPERATING ROOM	0	309, 051, 296				
51.00 05100 RECOVERY ROOM	0	0			0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	13, 347, 208				
53.00 05300 ANESTHESI OLOGY	0	13, 568, 533			2, 339, 286	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	198, 056, 522			27, 135, 230	
54. 01 05401 ULTRASOUND	0	0	0.00000		0	54.01
56. 00 05600 RADI OI SOTOPE	0	0	0.00000		0	56.00
57.00 05700 CT SCAN	0	0	0.00000		0	57.00
58. 00 05800 MRI	0	0	0.00000		0	58.00
60. 00 06000 LABORATORY	0	164, 210, 401			33, 568, 234	
65. 00 06500 RESPI RATORY THERAPY	0	16, 385, 463	0.00000	0.00000	8, 360, 182	
66. 00 06600 PHYSI CAL THERAPY	0	28, 336, 954			8, 899, 771	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	0.00000	0.00000	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.00000	0.00000	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	110, 259, 569	0.00000	0.00000	21, 199, 065	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	33, 836, 779			8, 822, 108	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	152, 441, 656			41, 653, 649	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	149, 115, 583	0.00000	0.00000	28, 528, 342	73.00
74.00 07400 RENAL DIALYSIS	0	3, 145, 343	0.00000	0.00000	1, 931, 272	74.00
76. 00 03950 ANCI LLARY	0	0	0.00000	0.00000	0	76.00
76.01 03610 SLEEP LAB	0	0	0.00000	0.00000	0	76.01
76.03 03951 WOUND CARE	0	5, 986, 589	0.00000	0.00000	133, 486	76.03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	-				
91. 00 09100 EMERGENCY	0					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	7, 989, 584	0.00000	0.00000	892, 434	
200.00 Total (lines 50-199)	0	1, 329, 743, 412			262, 234, 876	200.00

Health Financial Systems	PORTER MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider C	CN: 15-0035	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2014		
				To 12/31/2014		pared:
			xvi i	Hospi tal	12/13/2017 7: PPS	<u>58 am</u>
Cost Center Description	Inpatient	Outpatient	Outpatient	PSA Adj. Non	PSA Adj.	
cost center bescription	Program	Program	Program	Physi ci an	Nursing	
	Pass-Through	Charges	Pass-Through		School	
	Costs (col. 8	charges	Costs (col.		301001	
	x col. 10)		x col. 12)	² 0031		
	11.00	12.00	13.00	21.00	22.00	
ANCI LLARY SERVI CE COST CENTERS	11.00	12.00	10.00	21.00	22.00	
50. 00 05000 OPERATING ROOM	0	55, 290, 678		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	00,000		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	956		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	1,701,035		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	45, 984, 722		0 0	0	54.00
54. 01 05401 ULTRASOUND	0	0		0 0	0	54.01
56. 00 05600 RADI 0I SOTOPE	0	0		0 0	0	56.00
57. 00 05700 CT SCAN	0	0		0 0	0	57.00
58. 00 05800 MRI	0	0		0 0	0	58.00
60. 00 06000 LABORATORY	0	11,040,611		0 0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0	482, 522		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0	10, 388		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	28,603,638		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	5, 263, 404		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	27, 664, 916		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	39, 932, 788		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	83, 286		0 0	0	74.00
76. 00 03950 ANCI LLARY	0	0		0 0	0	76.00
76.01 03610 SLEEP LAB	0	0		0 0	0	76.01
76.03 03951 WOUND CARE	0	2, 319, 803		0 0	0	76.03
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91.00 09100 EMERGENCY	0	16, 373, 213		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2, 289, 755		0 0	0	92.00
200.00 Total (lines 50-199)	0	237, 041, 715		0 0	0	200.00

Health Financial Systems	PORTER MEMORIA	L HOSPI TAL		In Lieu	ı of Form CMS∙	-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	6 Provider C	CN: 15-0035	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Pr 12/13/2017 7	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	PSA Adj. Allied Health (PSA Adj. All Other Medical Education				
		Cost				
	23.00	24.00				_
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0				50.00
51.00 05100 RECOVERY ROOM	0	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
54. 01 05401 ULTRASOUND	0	0				54.01
56. 00 05600 RADI OI SOTOPE	0	0				56.00
57. 00 05700 CT SCAN	0	0				57.00
58. 00 05800 MRI 60. 00 06000 LABORATORY	0	0				58.00 60.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66.00 06600 PHYSICAL THERAPY	0	0				66.00
67. 00 06700 0CCUPATI ONAL THERAPY	0	0				67.00
68. 00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
74. 00 07400 RENAL DI ALYSI S	0	0				74.00
76. 00 03950 ANCI LLARY	0	0				76.00
76.01 03610 SLEEP LAB	0	0				76.01
76.03 03951 WOUND CARE	0	0				76.03
OUTPATIENT SERVICE COST CENTERS	· · · ·					
90. 00 09000 CLI NI C	0	0				90.00
91.00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
200.00 Total (lines 50-199)	0	0				200.00

Health Financial Systems	PORTER MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period:	Worksheet D	
				From 01/01/2014		
				To 12/31/2014	Date/Time Pre 12/13/2017 7:	58 am
		Title	XVIII	Hospi tal	PPS	<u>50 alli</u>
			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	
ANCILLARY SERVICE COST CENTERS						
50.00 O5000 OPERATING ROOM	0. 088381			0 0	4, 886, 645	
51.00 05100 RECOVERY ROOM	0. 000000			0 C	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 356692	956		0 0	341	52.00
53.00 05300 ANESTHESI OLOGY	0. 025319	1, 701, 035		0 0	43, 069	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 092441	45, 984, 722		0 0	4, 250, 874	54.00
54. 01 05401 ULTRASOUND	0. 000000	0		0 0	0	54.01
56. 00 05600 RADI 0I SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00 05800 MRI	0. 000000	0		0 0	0	58.00
60. 00 06000 LABORATORY	0. 111283	11, 040, 611		0 0	1, 228, 632	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 248485	482, 522		0 0	119, 899	65.00
66.00 06600 PHYSI CAL THERAPY	0. 208365	10, 388		0 0	2, 164	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 110225	28, 603, 638		0 0	3, 152, 836	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 080569	5, 263, 404		0 0	424, 067	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 227797	27, 664, 916		0 0	6, 301, 985	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 188613	39, 932, 788	35	7 198, 180	7, 531, 843	73.00
74.00 07400 RENAL DI ALYSI S	0. 268460	83, 286		0 0	22, 359	74.00
76. 00 03950 ANCI LLARY	0. 000000	0		0 0	0	76.00
76.01 03610 SLEEP LAB	0. 000000	0		0 0	0	76.01
76.03 03951 WOUND CARE	0. 352466	2, 319, 803		0 0	817, 652	76.03
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0. 000000	0		0 C	0	90.00
91.00 09100 EMERGENCY	0. 138660	16, 373, 213		0 0	2, 270, 310	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 344502	2, 289, 755		0 0	788, 825	92.00
200.00 Subtotal (see instructions)		237, 041, 715	35	7 198, 180	31, 841, 501	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		237, 041, 715	35	7 198, 180	31, 841, 501	202.00

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Health Financial Systems	PORTER MEMORI	AL HOSPITAL		In Lieu	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0035	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Pr 12/13/2017 7	epared: :58 am
		Title	e XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)	4			
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00		· · · · · ·		
50. 00 05000 OPERATING ROOM	0	0	1			50.00
	0		1			50.00
	0					51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0					52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0					54.00
54. 01 05400 RADIOLOGI - DI AGNOSTI C 54. 01 05401 ULTRASOUND	0					54.00
56. 00 05600 RADI 0I SOTOPE	0					56.00
57. 00 05700 CT SCAN	0					57.00
58. 00 05800 MRI	0					58.00
60. 00 06000 LABORATORY	0					60.00
65. 00 06500 RESPIRATORY THERAPY	0					65.00
66. 00 06600 PHYSI CAL THERAPY	0					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0					67.00
68. 00 06800 SPEECH PATHOLOGY	0					68.00
69. 00 06900 ELECTROCARDI OLOGY	0					69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0					71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	67	37, 379				73.00
74.00 07400 RENAL DI ALYSI S	0	0				74.00
76. 00 03950 ANCI LLARY	0	0				76.00
76.01 03610 SLEEP LAB	0	0				76.01
76.03 03951 WOUND CARE	0	0				76.03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0)			90.00
91. 00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
200.00 Subtotal (see instructions)	67	37, 379				200. 00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0					201.00
202.00 Net Charges (line 200 +/- line 201)	67	37, 379				202.00

Health Financial Systems	PORTER MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provider C Component		Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Pre 12/13/2017 7:	
		Title	e XVIII	Subprovider - IRF	PPS	<u>50 alli</u>
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2, 580, 764	309, 051, 296			414	
51.00 05100 RECOVERY ROOM	0	0	0.0000		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	514, 539	13, 347, 208			0	52.00
53. 00 05300 ANESTHESI OLOGY	43, 355	13, 568, 533	0.00319	2, 346	7	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 832, 692	198, 056, 522	0.00925	53 263, 862	2, 442	54.00
54.01 05401 ULTRASOUND	0	0	0.0000	0 0	0	54.01
56. 00 05600 RADI 0I SOTOPE	0	0	0.0000	0 0	0	56.00
57.00 05700 CT SCAN	0	0	0.0000	0 0	0	57.00
58.00 05800 MRI	0	0	0.0000	0 0	0	58.00
60. 00 06000 LABORATORY	771, 578	164, 210, 401	0.00469	712, 529	3, 348	60.00
65. 00 06500 RESPI RATORY THERAPY	154, 329	16, 385, 463	0.00941	9 217, 083	2,045	65.00
66. 00 06600 PHYSI CAL THERAPY	683, 587	28, 336, 954	0. 02412	3, 538, 443	85, 361	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	0.0000	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.0000	0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 197, 595	110, 259, 569	0. 01086	37, 814	411	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	37, 991	33, 836, 779	0.00112	95, 911	108	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	589, 949	152, 441, 656	0.00387	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	419, 377	149, 115, 583	0.0028	2 948, 884	2, 668	73.00
74.00 07400 RENAL DIALYSIS	27, 629	3, 145, 343	0.00878	33, 312	293	74.00
76. 00 03950 ANCI LLARY	0	0	0.0000	0 0	0	76.00
76.01 03610 SLEEP LAB	0	0	0.0000	0 0	0	76.01
76.03 03951 WOUND CARE	143, 815	5, 986, 589	0. 02402	23 0	0	76.03
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0	0	0.0000	0 0	0	90.00
91.00 09100 EMERGENCY	1, 393, 078	124, 011, 932	0. 01123	33 78	1	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	7, 989, 584	0.0000	2, 274	0	92.00
200.00 Total (lines 50-199)	10, 390, 278	1, 329, 743, 412		5, 902, 154	97, 098	200.00

Health Financial Systems	PORTER MEMORIAL	_ HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0035	Peri od:	Worksheet D	
THROUGH COSTS		Component	CON. 15 TO25	From 01/01/2014		norod.
		component	CCN: 15-T035	To 12/31/2014	Date/Time Pre 12/13/2017 7:	
		Title	e XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Non Physician	Nursi ng	Allied Healt		Total Cost	
	Anestheti st	School		Medi cal	(sum of col 1	
	Cost			Educati on	through col.	
	1.00	2.00	2.00	Cost	4)	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	0	(1	0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0				0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0				0	52.00
53. 00 05300 ANESTHESI OLOGY	0				0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C C		0 0	0	54.00
54. 01 05401 ULTRASOUND	0	(0 0	0	54.01
56. 00 05600 RADI 0I SOTOPE	0	Ċ		0 0	0	56.00
57.00 05700 CT SCAN	0	C		0 0	0	57.00
58.00 05800 MRI	0	C		0 0	0	58.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C)	0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C	D	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C	0	0 0	0	73.00
74.00 07400 RENAL DI ALYSI S	0	C	0	0 0	0	74.00
76. 00 03950 ANCI LLARY	0	C	0	0 0	0	76.00
76.01 03610 SLEEP LAB	0	(0 0	0	76.01
76. 03 03951 WOUND CARE OUTPATIENT SERVICE COST CENTERS	0	Ĺ		0 0	0	76.03
90. 00 09000 CLINIC	0	(0 0	0	90.00
91. 00 09100 EMERGENCY	0	C C	Ś		0	90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C C		0 0	0	
200.00 Total (lines 50-199)	0	C C		0 0	-	200.00
			1	-1 0	0	

Health Financial Systems	PORTER MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C		Period:	Worksheet D	
THROUGH COSTS		Component		From 01/01/2014 To 12/31/2014	Part IV Date/Time Pre	pared:
		•			12/13/2017 7:	
		Title	XVIII	Subprovider -	PPS	
Cost Center Description	Total	Total Charges	Patio of Cos	I RF Outpatient	Inpati ent	
cost center bescription	Outpatient	(from Wkst.	to Charges	Ratio of Cost	Program	
	Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
	col. 2, 3 and		col. 7)	(col. 6 ÷	ondriges	
	4)			col. 7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	309, 051, 296	0.00000	0 0. 000000	49, 618	50.00
51.00 05100 RECOVERY ROOM	0	0	0. 00000	0. 000000	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	13, 347, 208	0.00000	0.000000	0	52.00
53.00 05300 ANESTHESI OLOGY	0	13, 568, 533	0.00000	0.000000	2, 346	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	198, 056, 522	0.00000	0 0. 000000	263, 862	54.00
54. 01 05401 ULTRASOUND	0	0	0.00000		0	54.01
56. 00 05600 RADI OI SOTOPE	0	0	0.00000		0	56.00
57. 00 05700 CT SCAN	0	0	0.00000		0	57.00
58. 00 05800 MRI	0	0	0.00000		0	58.00
60. 00 06000 LABORATORY	0	164, 210, 401	0.00000		712, 529	60.00
65. 00 06500 RESPI RATORY THERAPY	0	16, 385, 463			217, 083	65.00
66. 00 06600 PHYSI CAL THERAPY	0	28, 336, 954			3, 538, 443	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	0.00000		0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.00000		0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	110, 259, 569			37, 814	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	33, 836, 779			95, 911	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	149, 115, 583			948, 884	73.00
74.00 07400 RENAL DI ALYSI S	0	3, 145, 343			33, 312	74.00
76. 00 03950 ANCI LLARY	0	0	0.00000		0	76.00
76.01 03610 SLEEP LAB	0	0	0.00000		0	76.01
76.03 03951 WOUND CARE	0	5, 986, 589	0.00000	0 0. 000000	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0				0	90.00
91.00 09100 EMERGENCY	0				78	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	7, 989, 584		0 0. 000000	2,274	
200.00 Total (lines 50-199)	0	1, 329, 743, 412	I		5, 902, 154	200.00

Health Financial Systems	PORTER MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS		Component		From 01/01/2014 To 12/31/2014		anarod
		component	CCN. 13-1033	10 12/31/2014	12/13/2017 7:	
		Title	e XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Inpati ent	Outpati ent	Outpati ent	PSA Adj. Non	PSA Adj.	
	Program	Program	Program	Physi ci an	Nursing	
	Pass-Through	Charges	Pass-Through		School	
	Costs (col. 8		Costs (col.	9 Cost		
	x col. 10) 11.00	12.00	x col. 12) 13.00	21.00	22.00	
ANCI LLARY SERVI CE COST CENTERS	11.00	12.00	13.00	21.00	22.00	
50. 00 05000 OPERATING ROOM	0	0		0 0	C	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0		
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	(
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	6, 807		0 0		
54.01 05401 ULTRASOUND	0	0		0 0	C	54.01
56. 00 05600 RADI OI SOTOPE	0	0		0 0	C	56.00
57.00 05700 CT SCAN	0	0		0 0	C	57.00
58.00 05800 MRI	0	0		0 0	C	58.00
60. 00 06000 LABORATORY	0	2, 957		0 0	C	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	C	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	C	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	C	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	C	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	3, 541		0 0	C	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	462		0 0	C	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	C	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	10, 115		0 0	C	
74.00 07400 RENAL DIALYSIS	0	0		0 0	C	
76. 00 03950 ANCI LLARY	0	0		0 0	C	
76.01 03610 SLEEP LAB	0	0		0 0	C	
76.03 03951 WOUND CARE	0	0		0 0	C	76.03
OUTPATIENT SERVICE COST CENTERS	-1			-		
90. 00 09000 CLINIC	0	0		0 0	C	
91.00 09100 EMERGENCY	0	424		0 0	C	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0	C	
200.00 Total (lines 50-199)	0	24, 306	I	0 0		200.00

Health Financial Systems	PORTER MEMORIA	L HOSPI TAL		In Lieu	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	5 Provider C	CN: 15-0035	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T035	From 01/01/2014 To 12/31/2014	Part IV Date/Time Pre	anarod
		component	CCN. 15-1055	10 12/31/2014	12/13/2017 7:	58 am
		Title	XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description		PSA Adj. All				
	Allied Health (Education				
		Cost				
	23.00	24.00				
ANCILLARY SERVICE COST CENTERS	201000	21100				
50.00 05000 OPERATING ROOM	0	0				50.00
51.00 05100 RECOVERY ROOM	0	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
54.01 05401 ULTRASOUND	0	0				54.01
56. 00 05600 RADI OI SOTOPE	0	0				56.00
57.00 05700 CT SCAN	0	0				57.00
58.00 05800 MRI	0	0				58.00
60. 00 06000 LABORATORY	0	0				60.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68. 00 06800 SPEECH PATHOLOGY	0	0				68.00 69.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
74. 00 07400 RENAL DI ALYSI S	0	0				74.00
76. 00 03950 ANCI LLARY	0	0				76.00
76. 01 03610 SLEEP LAB	0	0				76.01
76. 03 03951 WOUND CARE	0	0				76.03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0				90.00
91.00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
200.00 Total (lines 50-199)	0	0				200.00

	ncial Systems	PORTER MEMORI			In Lie	u of Form CMS-	2552-10
APPORTI ONMEI	NT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0035	Peri od:	Worksheet D	
			Component	CCN: 15-T035	From 01/01/2014 To 12/31/2014	Part V Date/Time Pre	narod
			component	CON. 13-1033	10 12/31/2014	12/13/2017 7:	58 am
			Title	e XVIII	Subprovider -	PPS	
					I RF		
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Reimbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see		Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins			
		9	0.00	(see inst.)	(see inst.)	F 00	
ANGLL		1.00	2.00	3.00	4.00	5.00	
	LARY SERVICE COST CENTERS	0. 088381		1	0 0	0	50.00
			C		0 0	-	
	RECOVERY ROOM	0. 000000	C		0 0	0	
	DELIVERY ROOM & LABOR ROOM	0. 356692			0 0	0	
	ANESTHESI OLOGY	0. 025319	0		0 0	0	53.00
	RADI OLOGY-DI AGNOSTI C	0. 092441 0. 000000	6, 807		0 0	629	
	ULTRASOUND RADI OI SOTOPE	0. 000000			0 0	0	
	CT SCAN	0. 000000			0 0	0	
58.00 05800		0. 000000			0 0	0	
	LABORATORY	0. 111283	2,957		0 0	329	
	RESPIRATORY THERAPY	0. 248485	2,937		0 0	0	
	PHYSICAL THERAPY	0. 248485			0 0	0	66.00
	OCCUPATIONAL THERAPY	0. 208303			0 0	0	
	SPEECH PATHOLOGY	0. 000000		,	0 0	0	
	ELECTROCARDI OLOGY	0. 110225	3, 541		0 0	390	
	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 080569	462			370	
	IMPL. DEV. CHARGED TO PATIENTS	0. 227797			0 0	0	
	DRUGS CHARGED TO PATIENTS	0. 188613	10, 115		0 1, 520	1, 908	
	RENAL DI ALYSI S	0. 268460			0 0	0	1
	ANCI LLARY	0. 000000			0 0	0	1
	SLEEP LAB	0. 000000	-		0 0	0	1
	WOUND CARE	0. 352466			0 0	0	
	TI ENT SERVICE COST CENTERS		-		-		
	CLINIC	0. 000000	C)	0 0	0	90.00
91.00 09100	EMERGENCY	0. 138660	424	Ļ	0 0	59	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0. 344502	l c		0 0	0	92.00
200.00	Subtotal (see instructions)		24, 306		0 1, 520	3, 352	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)		24, 306		0 1, 520	3, 352	202.00

ealth Financial Systems		PORTER MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10		
PPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COST	Provider C Component	CN: 15-0035 CCN: 15-T035	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prep 12/13/2017 7:5	pared:	
		Title	× XVIII	Subprovider -	PPS	<u>50 am</u>	
				IRF			
	Cos						
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				<u> </u>	
ANCI LLARY SERVICE COST CENTERS		0				50.0	
0. 00 05000 OPERATING ROOM	0	0	•			50.00	
1.00 05100 RECOVERY ROOM	0	0				51.00	
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00	
3. 00 05300 ANESTHESI OLOGY	0	0				53.0	
4.00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.0	
4. 01 05401 ULTRASOUND	0	0				54.0	
66. 00 05600 RADI OI SOTOPE	0	0				56.0	
57.00 05700 CT SCAN	0	0				57.0	
i8. 00 05800 MRI	0	0				58.0	
0. 00 06000 LABORATORY	0	0				60.0	
5. 00 06500 RESPI RATORY THERAPY	0	0				65.0	
6. 00 06600 PHYSI CAL THERAPY	0	0				66.0	
7. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.0	
8. 00 06800 SPEECH PATHOLOGY	0	0				68.0	
9. 00 06900 ELECTROCARDI OLOGY	0	0				69.0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.0	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.0	
3.00 07300 DRUGS CHARGED TO PATIENTS	0	287				73.0	
4.00 07400 RENAL DIALYSIS	0	0				74.0	
6. 00 03950 ANCI LLARY	0	0				76.0	
6.01 03610 SLEEP LAB	0	0				76.0	
76.03 03951 WOUND CARE	0	0				76.0	
OUTPATIENT SERVICE COST CENTERS							
0. 00 09000 CLINIC	0	0				90.0	
01.00 09100 EMERGENCY	0	0				91.0	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.0	
200.00 Subtotal (see instructions)	0	287				200.0	
201.00 Less PBP Clinic Lab. Services-Program	0					201.0	
Only Charges					ľ		
202.00 Net Charges (line 200 +/- line 201)	0	287	1			202.00	

	Financial Systems PORTER MEMORIAL ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0035	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2014 To 12/31/2014		
		THE		12/13/2017 7:	
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATI ENT DAYS				
00	Inpatient days (including private room days and swing-bed day			51, 051	
00 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		rivate room davs.	51, 051 0	2
	do not complete this line.				
00 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro	er 31 of the cost	47, 497 0	45	
50	reporting period	oni days) thi dagn becenib		0	
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private roc	om days) through Decembe	r 31 of the cost	0	7
	reporting period				
00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	8
00	Total inpatient days including private room days applicable t	o the Program (excludin	g swing-bed and	24, 456	9
00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	nlv (including private	room days)	0	10
00	through December 31 of the cost reporting period (see instruc	tions)	<u> </u>	0	
00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11
00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
	through December 31 of the cost reporting period	<u> </u>		_	
00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only)			0	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es through December 31	of the cost	0.00	17
. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20
~ ~	reporting period	,			
00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting period (line	39, 536, 852 0	
. 00	5 x line 17)		ting period (rine	Ũ	
. 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 7 x line 19)	er 31 of the cost report	ing period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25
. 00	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)		39, 536, 852	
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	d and observation bod o	harnes)	0	28
. 00 . 00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	a and observation bed C	nai yes <i>)</i>	0	
00	Semi-private room charges (excluding swing-bed charges)			0	30
00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
00 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0.00	
00	Average per diem private room cost differential (line 34 x li			0.00	
00	Private room cost differential adjustment (line 3 x line 35)			0	
00	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	39, 536, 852	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				1
	Adjusted general inpatient routine service cost per diem (see	-		774.46	
. 00 . 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			18, 940, 194 0	
	modically necessary private room cost appricable to the riogr	9 + line 40)		18, 940, 194	1 +0

alth Financial Systems F MPUTATION OF INPATIENT OPERATING COST	ONTER MEMORIA	L HOSPITAL	CN: 15-0035	Period:	u of Form CMS-2 Worksheet D-1			
WI OTATION OF THEAT OF ERATING COST				From 01/01/2014				
			То		Date/Time Pre 12/13/2017 7:			
			e XVIII	Hospi tal	PPS			
Cost Center Description	Total	Total	Average Per		Program Cost			
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)			
	1.00	2.00	3.00	4.00	5.00			
.00 NURSERY (title V & XIX only)	0	0	0.0	00 0	0	42.0		
Intensive Care Type Inpatient Hospital Units	12 402 70/	7 701	1 700 1		7 000 570	1 42 4		
. 00 INTENSIVE CARE UNIT . 01 NEONATAL INTENSIVE CARE UNIT	13, 482, 706 3, 789, 366	7, 791 1, 215						
. 00 CORONARY CARE UNIT	5,709,500	1,215	3, 110. 0	0		44.0		
. 00 BURN INTENSIVE CARE UNIT						45.0		
. 00 SURGI CAL I NTENSI VE CARE UNI T						46.0		
. 00 OTHER SPECIAL CARE (SPECIFY)						47.0		
Cost Center Description					1.00			
.00 Program inpatient ancillary service cost (Wkst	. D-3, col. 3,	line 200)			36, 859, 951	48.0		
.00 Total Program inpatient costs (sum of lines 41			ons)		62, 822, 717	49.0		
PASS THROUGH COST ADJUSTMENTS								
.00 Pass through costs applicable to Program inpat	ient routine s	services (fro	m Wkst. D, su	m of Parts I and	2, 731, 658	50.0		
.00 Pass through costs applicable to Program inpat	ient ancillary	v services (f	rom Wkst. D.	sum of Parts II	1, 956, 850	51.		
and IV)		,						
.00 Total Program excludable cost (sum of lines 50					4, 688, 508			
.00 Total Program inpatient operating cost excludi	0 1	lated, non-ph	ysician anest	hetist, and	58, 134, 209	53.		
medical education costs (line 49 minus line 52 TARGET AMOUNT AND LIMIT COMPUTATION)					-		
. 00 Program di scharges					0	54.		
.00 Target amount per discharge					0.00			
.00 Target amount (line 54 x line 55)					0			
	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							
.00 Bonus payment (see instructions) .00 Lesser of lines 53/54 or 55 from the cost repo	rting period e	endina 1996	undated and c	ompounded by the	0.00			
market basket	ring period (sharing 1770,	apaatea ana e	ompounded by the	0.00	0,		
.00 Lesser of lines 53/54 or 55 from prior year co					0.00			
.00 If line 53/54 is less than the lower of lines					0	61.		
which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see in		s (lines 54 x	60), or 1% o	r the target				
. 00 Relief payment (see instructions)	0	62.						
p3.00 Allowable Inpatient cost plus incentive payment (see instructions)								
PROGRAM INPATIENT ROUTINE SWING BED COST						1		
.00 Medicare swing-bed SNF inpatient routine costs instructions)(title XVIII only)	through Decer	mber 31 of th	e cost report	ing period (See	0	64.		
. 00 Medicare swing-bed SNF inpatient routine costs	after Decembe	er 31 of the	cost reportin	a period (See	0	65.		
instructions)(title XVIII only)								
	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For							
	CAH (see instructions)							
(line 12 x line 19)	10 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period							
(line 12 x line 19) 00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period						68.		
(line 13 x line 20)								
.00 Total title V or XIX swing-bed NF inpatient ro					0	69.		
PART III - SKILLED NURSING FACILITY, OTHER NUR .00 Skilled nursing facility/other nursing facilit)		70.		
.00 Skilled nursing facility/other nursing facilit .00 Adjusted general inpatient routine service cos	,		•)		70.		
.00 Program routine service cost (line 9 x line 71			,			72.		
3 31 11	Medically necessary private room cost applicable to Program (line 14 x line 35)							
.00 Total Program general inpatient routine servic	•			Dont II!		74.		
.00 Capital-related cost allocated to inpatient ro 26, line 45)	uline service	COSIS (Trom	worksneet B,	Part II, Column		75.		
.00 Per diem capital-related costs (line 75 ÷ line	2)					76.		
.00 Program capital-related costs (line 9 x line 7		77.						
. 00 Inpatient routine service cost (line 74 minus		78.						
.00 Aggregate charges to beneficiaries for excess .00 Total Program routine service costs for compar				nus lino 70)		79. 80.		
.00 Inpatient routine service costs for compar .00 Inpatient routine service cost per diem limita		Jac i i mi tati O		nus IIIe /4)		80.		
.00 Inpatient routine service cost per drem rimita)				82.		
.00 Reasonable inpatient routine service costs (se						83.		
.00 Program inpatient ancillary services (see inst						84.		
.00 Utilization review - physician compensation (s						85.		
.00 Total Program inpatient operating costs (sum o PART IV - COMPUTATION OF OBSERVATION BED PASS		ougn 85)				86.		
					3, 554	87.		
.00 Total observation bed days (see instructions)								
 .00 Total observation bed days (see instructions) .00 Adjusted general inpatient routine cost per di .00 Observation bed cost (line 87 x line 88) (see 		line 2)			774.46 2,752,431			

Health Financial Systems	PORTER MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10					
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1				
				From 01/01/2014 To 12/31/2014		pared: 58 am			
		Title	Title XVIII		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	4, 764, 318	39, 536, 852	0. 12050	3 2, 752, 431	331, 676	90.00			
91.00 Nursing School cost	0	39, 536, 852	0.00000	0 2, 752, 431	0	91.00			
92.00 Allied health cost	0	39, 536, 852	0.00000	0 2, 752, 431	0	92.00			
93.00 All other Medical Education	0	39, 536, 852	0.00000	0 2, 752, 431	0	93.00			

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)MPLIT	ATION OF INPATIENT OPERATING COST	HOSPITAL Provider CCN: 15-0035	Period:	Worksheet D-1	
		Component CCN: 15-T035	From 01/01/2014 To 12/31/2014	Date/Time Pre	pare
		Title XVIII	Subprovider -	12/13/2017 7: PPS	<u>58 a</u>
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS		1		
00	Inpatient days (including private room days and swing-bed day			3, 369	1.
00	Inpatient days (including private room days, excluding swing-	5,		3, 369	2.
00	Private room days (excluding swing-bed and observation bed da	ays). If you have only p	rivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	(ave)		3, 369	4
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	3, 309	5
00	reporting period	Som days) through become		0	
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)	-			
00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	7
~~	reporting period				
00	Total swing-bed NF type inpatient days (including private roc reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	8
00	Total inpatient days including private room days applicable t	to the Program (excludin	a swina-bed and	2, 127	9
00	newborn days)		g swing bed and	2, 127	Ĺ
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private	room days)	0	10
	through December 31 of the cost reporting period (see instruc	ctions)			
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11
00	December 31 of the cost reporting period (if calendar year, e				1.0
. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	x only (including priva	te room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	13
. 00	after December 31 of the cost reporting period (if calendar y			0	
. 00	Medically necessary private room days applicable to the Progr			0	14
. 00	Total nursery days (title V or XIX only)		-	0	15
. 00	Nursery days (title V or XIX only)			0	16
00	SWING BED ADJUSTMENT	and through December 21	of the east	0.00	17
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces through becember 31	of the cost	0.00	
. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19
00	reporting period	a ofter December 21 of	the east	0.00	20
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es al tel December 31 01	the cost	0.00	20
. 00	Total general inpatient routine service cost (see instruction	าร)		2, 970, 902	21
. 00	Swing-bed cost applicable to SNF type services through Decemb		ting period (line		22
	5 x line 17)				
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	ng period (line 6	0	23
00	x line 18) Swing had cast applicable to NE type convises through Decembe	or 21 of the cost report	ing pariod (line	0	24
. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	ar ar or the cost report	ing period (inne	0	24
5.00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	a period (line 8	0	25
	x line 20)		5 1 2 2 2		
. 00	Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 970, 902	27
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		h = u= u = 1		0
. 00 . 00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	tu anu ubservation bed C		0	28 29
. 00	Semi-private room charges (excluding swing-bed charges)			0	30
. 00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
. 00	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
. 00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
o. 00 7. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	-	36 37
. 50	27 minus line 36)	and private room cost u		2, 710, 702	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
	Adjusted general inpatient routine service cost per diem (see	e instructions)		881.83	38
. 00		20)	1	1 075 /50	200
. 00 . 00 . 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			1, 875, 652 0	39 40

	Financial Systems TION OF INPATIENT OPERATING COST	PORTER MEMORIA		CN: 15-0035	In Lie Period:	u of Form CMS- Worksheet D-	
				CCN: 15-T035	From 01/01/2014 To 12/31/2014	Date/Time Pre	epared
			Title	e XVIII	Subprovider -	12/13/2017 7: PPS	:58 am
		T . 1. 1			IRF		
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)		Program Cost (col. 3 x col. 4)	
2 00 1	WUDSEDV (title V & VIV entry)	1.00	2.00	3.00	4.00	5.00	12.0
	NURSERY (title V & XIX only) ntensive Care Type Inpatient Hospital Units	U	Ĺ	0.	00 0		42.0
	NTENSI VE CARE UNI T	0	C				
	NEONATAL INTENSIVE CARE UNIT CORONARY CARE UNIT	0	C	0.	00 0	C	43.0
	BURN I NTENSI VE CARE UNI T						45.0
6.00 5	SURGICAL INTENSIVE CARE UNIT						46.0
7.00 0	OTHER SPECIAL CARE (SPECIFY)						47.0
	Cost Center Description					1.00	+
8.00 F	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			1, 099, 962	2 48.
	Total Program inpatient costs (sum of lines	41 through 48)(see instructi	ons)		2, 975, 614	49.
	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst D si	m of Parts L and	306, 798	3 50.0
			301 11 003 (110	m mk3t. D, 3t		300,770	50.0
	Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	97, 098	3 51.0
	and IV) Total Program excludable cost (sum of lines	50 and 51				403, 896	52.0
	Total Program inpatient operating cost exclu		lated, non-ph	vsician anest	thetist, and	2, 571, 718	
n	medical education costs (line 49 minus line		·····				
-	ARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges Farget amount per discharge					0.00	
	Target amount (line 54 x line 55)					0.00	
	Difference between adjusted inpatient operat	ing cost and ta	irget amount (line 56 minus	s line 53)	C	
	Bonus payment (see instructions)	nerting period	anding 100(undated and	compounded by the	0	
	_esser of lines 53/54 or 55 from the cost re market basket	porting period	ending 1996,	updated and d	compounded by the	0.00	59.
	_esser of lines 53/54 or 55 from prior year	cost report, up	dated by the	market basket	t	0.00	60.
	fline 53/54 is less than the lower of line					C) 61.
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		is (lines 54 x	60), or 1% (of the target		
	Relief payment (see instructions)					0	62.
	Allowable Inpatient cost plus incentive paym	ent (see instru	ictions)			C	63.0
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	to through Door	mbor 21 of th	a cast report	ting pariod (Saa	C	64.
	nstructions)(title XVIII only)	ts through bece		e cost repor	ting period (see		04.
5.00 N	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportin	ng period (See	C	65.0
1	nstructions)(title XVIII only)	na anata (lina	(1 plup line	(E) (+; + o V)/		C C	
	Fotal Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (inne	o4 prus rrite	os)(title xvi	i i i oniy). Foi) 66.0
7.00 1	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost i	reporting period	C	67.0
	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	o costs after D	locombor 21 of	the cost ro	porting poriod	c c	68.0
	(line 13 x line 20)		ecember 31 01	the cost rep	boi ting period		00.1
9.00 1	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + lin	e 68)		0	69.0
	Y <u>ART III – SKILLED NURSING FACILITY, OTHER N</u> Skilled nursing facility/other nursing facil				7\		70.0
	Adjusted general inpatient routine service c				/)		70.
	Program routine service cost (line 9 x line			_,			72.
	Medically necessary private room cost applic						73.
1	Fotal Program general inpatient routine serv Capital-related cost allocated to inpatient				Part II column		74. 75.
	26, line 45)	Foutthe service		WOLKSHEEL D,	Fait II, Corumn		/5.
1	Per diem capital-related costs (line 75 ÷ li						76.
	Program capital-related costs (line 9 x line						77.
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovider recor	ds)			78. 79.
1	Total Program routine service costs for comp				nus line 79)		80.
1	npatient routine service cost per diem limi		、				81.
	Inpatient routine service cost limitation (I		· .				82.
	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		13)				83. 84.
	Jtilization review - physician compensation		ns)				85.
6.00 1	Total Program inpatient operating costs (sum	of lines 83 th					86.
	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					C	87.0
	Adjusted general inpatient routine cost per	·	line 2)				87.0
		e instructions)	/				89.0

Health Financial Systems	PORTER MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2014	Worksheet D-1	
		Component (CCN: 15-T035	To 12/31/2014		
		Title	XVIII	Subprovider -	PPS	
				IRF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST				-	
90.00 Capital-related cost	485, 928	2, 970, 902	0. 16356	52 0	0	90.00
91.00 Nursing School cost	0	2, 970, 902	0.0000	0 0	0	91.00
92.00 Allied health cost	0	2, 970, 902	0.0000	0 0	0	92.00
93.00 All other Medical Education	0	2, 970, 902	0.0000	00 0	0	93.00

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INPATIENT ANCIELLARY SERVICE COST APPORTIONMENT Provider CON: 15-0035 Period: Tron 01/01/2014 To 12/31/2017 7.186 an Worksheet D-3 Date/Time Prepared: 100/12/12/017 7.186 an Cost Center Description Title XVIII Ratio of Cost Cost Center Cost Center Description Inpatient Program Charges Inpatient Program Charges Inpatient Program Cost Center Description Inpatient Program Charges Inpatient Program Charges	Health Financial Systems	PORTER MEMORIAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
To 12/31/2014 Date/Time Prepared: 2/31/2017.58 am Cost Center Description Title XVIII Hospital Inpatient Program Charges Inpatient Program (col. 1 x col. 2) INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 0.00 03000 ADULTS & PEDIATRICS 55,540,196 30.00 0.10 031.00 INTENSIVE CARE UNIT 16,960,712 31.00 0.10 031.00 INTENSIVE CARE UNIT 16,960,712 31.01 0.43.00 04100 SUBPROVIDER - IRF 0 43.00 0.00 050000 AREATING ROMM 0.088381 61,528,567 5,437,956 50.00 050000 025000 DELEYERY ROOM 0 0 43.00 30.00 032000 INTENSIVE CARE UNIT 0.088381 61,528,567 5,437,956 50.00 50.00 050000 RECONTRY ROOM 0.0000000 0 51.00 51.00 050000 RECONTRY ROOM 0.000000 0 52.00 51.00 050000 0.000000	INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0035			
Import Intervention Title XVIII Hospital PP Cost Center Description Ratio of Cost To Charges Inpatient Program Charges Inp				From 01/01/2014	Data (Time Dres	
Title XVIII Hospital PPS Cost Center Description Rafition of Cost To Charges Inpatient Program Charges				10 12/31/2014	12/12/2017 7	pared: 58 am
Cost Center Description Ratio of Cost To Charges Inpatient Program Inpatient Program Inpatient Program Inpatient Program 30.00 030000 ADULTS & PEDIATRICS 1.00 2.00 3.00 31.00 031001 INTENSI VE CARE UNIT 16,960,712 31.00 41.00 04100 SUBPROVIDER - IRF 0 0 41.00 AND OLIS CONDOR DELVIEW ROM 0.088381 61,528,557 5,437,956 50.00 50.00 05000 OPERATINE ROM 0.088381 61,528,557 5,437,956 50.00 51.00 05000 OPERATINE ROM 0.025319 2.339,286 59,228 53.00 50.00 05000 RADOR ROM 0.025319 2.339,286 59,228 53.00 51.00 05000 RADOR ROM ROM 0.000000 0 0 54.01 51.00 055000 CT SCOM 0.000000 0 0 54.01 52.00 052000 RADOR ROMO ROM 0.000000 0 54.01 55.00 53.00 05300 ARESTHESIQUEY 0.000000 0 0 55.00		Title	× X//	Hosni tal		<u>50 am</u>
INPATIENT ROUTINE SERVICE COST CENTERS To Charges Program Costs (col. 1 x) (col. 2) 30.00 03000 AUULTS & PEDIATRICS 30.00 30.00 31.01 03100 INTENSIVE CARE UNIT 58,540,196 30.00 31.00 03000 INTENSIVE CARE UNIT 16,960,712 31.00 31.00 03000 INTENSIVE CARE UNIT 16,960,712 31.00 31.00 03000 INTENSIVE CARE UNIT 0 41.00 41.00 04100 SUBPROVIDER - IRF 0 43.00 43.00 04300 NURSERY 0.088381 61,528,567 5.437,956 50.00 50.00 05100 RECOVERY ROOM 0.088381 0.217 52.00 51.00 51.00 05100 RECOVERY ROOM 0.025319 2.39,286 59,228 53.00 54.00 05400 RADICLARY SERVICE 0.000000 0 55.03 56.00 54.00 05000 RADICLARY SERVICE 0.000000 0 55.00 50.00 55.00 05700 CT SCAN 0.000000 0 55.00 55.00 56.00 05000 RESPI RA	Cost Center Description	intre				
Import Entry Routh Received States Col. 2 Col. 2 1.00 2.00 3.00 30.00 03000 ADULTS & PEDIATRICS 3.00 31.00 03100 INTENSIVE CARE UNIT 16,960,712 31.01 41.00 04100 SUBPROVIDER - IRF 0 31.01 43.00 05100 RECOVERY ROOM 0.088381 61,528,567 5,437,956 50.00 05000 OPERATING ROOM 0.088381 61,528,567 5,437,956 50.00 51.00 05100 RECOVERY ROOM 0.008000 0 0 51.00 52.00 052000 DELIVERY ROOM 0.056692 28,643 10,217 52.00 54.00 05400 RADIOLOCY-DI AGNOSTI C 0.000000 0 0 54.00 54.00 05600 RESPI RATORY 0.0000000 0 55.00 55.00 50.00 05000 RESPI RATORY 0.0000000 0 55.00 56.00 54.00 05400 RADIOLOCY-DI AGNOSTI C 0.0000000 0 55.00 56.00 50.00 05600 RESPI RATORY 0.00000000						
INPATIENT ROUTINE SERVICE COST CENTERS col. 20 col. 20 30.00 03000 ADULTS & PEDIATRICS 58,540,196 30.00 31.01 03101 INTENSIVE CARE UNIT 16,960,712 31.00 31.00 03100 INTENSIVE CARE UNIT 0 0 31.00 31.01 03101 INTENSIVE CARE UNIT 16,960,712 31.00 31.00 03000 INTENSIVE CARE UNIT 0 0 31.00 43.00 043300 INTERSIVE CARE UNIT 0 0 31.00 43.00 04300 RURSERY 0 0 0 51.00 50.00 05000 DEPATI INC ROOM 0.088381 61.528,567 5.437,956 50.00 51.00 05300 ANESTHESI OLOGY 0.035692 28,643 10.217 52.00 52.00 05400 RADI OLOGY-DI AGNOSTIC 0.092441 27.135,230 2.566,408 54.00 54.00 05400 RADI SOTOPE 0.000000 0 0 55.00 50.00 05700 CT SCAN 0.000000 0 0 57.00 50.00			10 ondriges	U		
INPATI ENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 30.00 03000 ADULTS & PEDI ATRI CS 58,540,196 30.00 31.00 03100 INTENSI VE CARE UNI T 16,960,712 31.00 41.00 04100 SUBPROVI DER - IRF 0 41.00 31.01 43.00 05000 OPECATI INTENSI VE CARE UNI T 0 43.00 43.00 04300 NURSERY 0 43.00 ANCI LLARY SERVICE COST CENTERS 0.0883811 61,528,567 5,437,956 50.00 50.00 05000 OPECATI NG ROOM 0.02519 2,339,286 59,228 53.00 51.00 054.00 0.05000 INCY DIA RADONICI 0.02241 27,135,230 2,508,408 54.00 54.00 05600 RESPI RATORY 0.000000 0 0 57.00 56.00 54.00 05400 RADI ULTS SUND 0.000000 0 0 57.00 58.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.0				onal ges		
INPATIENT ROUTINE SERVICE COST CENTERS 58,540,196 30.00 30.00 03000 ADULTS & PEDIATRICS 58,540,196 31.00 31.00 03101 INTENSIVE CARE UNIT 16,960,712 31.00 31.00 03101 INTENSIVE CARE UNIT 16,960,712 31.00 31.00 03100 INTENSIVE CARE UNIT 16,960,712 31.00 41.00 OURDWIDER - I FF 0 0 43.00 ANCILLARY SERVICE COST CENTERS 0 0 55.00 05.000 [OPERATING ROOM 0.088381 61,528,567 5,437,956 50.00 51.00 05000 [OPERATING ROOM 0.356692 28,643 10,217 52.00 55.00 53.00 05300 [ANESTHESI OLOGY 0.022319 2,339,286 59,228 53.00 54.01 054.01 0.000000 0 54.01 55.00 5			1.00	2.00		
30.00 03000 ADULTS & PEDIATRICS 58, 540, 196 30.00 31.00 03100 INTENSIVE CARE UNIT 16, 960, 712 31.00 41.00 04100 SUBPROVIDER - IFF 0 41.00 43.00 05000 [PERATING ROOM 0 0 43.00 43.00 04300 [NURSERY 0 0 43.00 43.00 05200 [PERATING ROOM 0.088381 61, 528, 567 5, 437, 956 50.00 51.00 05100 [RCOVERY ROOM 0.000000 0 0 51.00 530.00 (S300 [ABCSTHEST LOLOGY 2, 359, 266 59, 228, 54.00 54.00 54.00 05400 [RADIOLOGY-DI AGNOSTIC 0.092441 27, 135, 230 2, 508, 408 54.00 54.01 05400 [LUTRASUMD 0.000000 0 0 56.00 54.01 05500 [RADIOLOGY-DI AGNOSTIC 0.000000 0 0 57.00 55.00 05000 [RADIOLOGY-DI AGNOSTIC 0.000000 0 0 56.00 54.01 05500 [RADIOLOGY-DI AGNOSTIC 0.000000 0 0 56.00	INPATIENT ROUTINE SERVICE COST CENTERS					
31.00 03100 INTENSI VE CARE UNI T 16,960,712 31.01 31.01 03101 NEONATAL INTENSI VE CARE UNI T 0 0 31.01 41.00 04100 SUBPROVI DER - IRF 0 0 31.01 ANDURSERY 0 0.00000 DERATI NG ROOM 0.08331 61,528,567 5,437,956 50.00 50.00 05000 OPERATI NG ROOM 0.05200 DELI VERY ROOM & 0.356692 28,643 10,217 52.00 52.00 05200 DELI VERY ROOM & 0.05200 ADI COCY - DI AGNOSTI C 0.092441 27, 339, 286 59, 228 53.00 54.00 05401 QI TRASOUND 0.000000 0 0 54.00 56.00 54.00 05401 QI TRASOUND 0.000000 0 0 54.00 56.00 55.00 05500 RADI OI SOTOPE 0.000000 0 0 57.00 57.00 56.00 05500 CRATORY 0.0117283 33,568,234 3,73,5574 60.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00				58 540 196		30.00
31.01 03101 NEONATAL INTENSIVE CARE UNIT 31.01 <						
41.00 04100 SUBPROVI DER - I RF 41.00 43.00 043000 SUBPROVI DER - I RF 41.00 ANCI LLARY SERVI CE COST CENTERS 0.088381 61.528.567 5.437.956 50.00 50.00 05000 DPERATI NG ROOM 0.000000 0 0 51.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.0356692 28.643 10.217 52.00 53.00 05300 ARESTHESI OLOGY 0.025319 2.339.286 59.228 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 0 0 54.01 55.00 05500 MRI 0.000000 0 0 57.00 57.00 55.00 05600 RADI OLOGY-DI AGNOSTI C 0.000000 0 0 57.00 56.00 05600 MRI 0.000000 0 0 57.00 57.00 56.00 06500 RESPI RATORY THERAPY 0.111283 33,568,234 3,735,574 60.00 66.00 06000 CUPATI NAR CRY 0.000000 0 0 67.00 67.00 CCANATORY 0.000000 0 0 67.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
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90. 00 09000 CLI NI C 0.00000 0 0 90. 00 91. 00 09100 EMERGENCY 0.138660 17, 214, 607 2, 386, 977 91. 00			0.3524	133, 480	47,049	76.03
91. 00 09100 EMERGENCY 0. 138660 17, 214, 607 2, 386, 977 91. 00			0,0000	20 0	0	
					-	
72. UU IU72UUIUDSEKVATTUM DEUS UNUN-DISTINUT PART I U. 3445UZI 872. 434I 3U7. 4451 72. UU			1			
		(through 08)	0. 3445			
200.00 Total (sum of lines 50 through 94 and 96 through 98) 262, 234, 876 36, 859, 951 200.00 201.00 Less PDD (linis Leberatory Services Program only shares (line (1)) 201.00					30, 859, 951	•
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 202.00 Net charges (line 200 minus line 201) 262,234,876 202.00		gram only charges (Time 61)		Ű		
202.00 Net charges (line 200 minus line 201) 262, 234, 876 202.00	202.00 Net charges (The 200 minus The 201)		I	202, 234, 8/0	I	202.00

	IORIAL HOSPITAL			u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0035	Peri od:	Worksheet D-3	3
	Component (CCN: 15-T035	From 01/01/2014 To 12/31/2014		epared: 58 am
	Title	XVIII	Subprovider -	PPS	
			I RF		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
31. 01 03101 NEONATAL INTENSIVE CARE UNIT			0		31.0
41. 00 04100 SUBPROVI DER - I RF			4, 693, 984		41.00
43.00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 0883	81 49, 618	4, 385	50.00
51.00 05100 RECOVERY ROOM		0.0000	00 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 3566		0	
53. 00 05300 ANESTHESI OLOGY		0. 0253	19 2, 346	59	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 0924		24, 392	
54. 01 05401 ULTRASOUND		0.0000		0	
56. 00 05600 RADI 0I SOTOPE		0.0000		0	
57. 00 05700 CT SCAN		0.0000		0	
58.00 05800 MRI		0.0000		0	
60. 00 06000 LABORATORY		0. 1112			
65. 00 06500 RESPIRATORY THERAPY		0. 2484			
66. 00 06600 PHYSI CAL THERAPY		0.2083		737, 288	
67. 00 06700 OCCUPATI ONAL THERAPY		0.0000		e e e e e e e e e e e e e e e e e e e	
68. 00 06800 SPEECH PATHOLOGY		0.0000		0	
69.00 06900 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0. 1102		4, 168	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 0805 0. 2277		7,727	
72.00 07200 TMPL. DEV. CHARGED TO PATTENTS 73.00 07300 DRUGS CHARGED TO PATTENTS		0. 2277			
74. 00 07400 RENAL DI ALYSI S		0. 1886		8, 943	
76. 00 03950 ANCI LLARY		0.0000		0, 743	
76. 01 03610 SLEEP LAB		0.0000			
76. 03 03951 WOUND CARE		0. 3524			
OUTPATI ENT SERVICE COST CENTERS		0. 3324	00 0	0	, , 0. 0.
90. 00 09000 CLINIC		0.0000	00 0	0	90.00
91. 00 09100 EMERGENCY		0. 1386		-	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 3445		783	
200.00 Total (sum of lines 50 through 94 and 96 through 9	98)		5, 902, 154	1, 099, 962	
201.00 Less PBP Clinic Laboratory Services-Program only of			0		201.00
202.00 Net charges (line 200 minus line 201)		1	, i i i i i i i i i i i i i i i i i i i		202.00

ALCUL	Financial Systems PORTER MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT	HOSPITAL Provider CCN: 15-0035	In Lie Period: From 01/01/2014	Worksheet E Part A	
			To 12/31/2014	Date/Time Pre	
		Title XVIII	Hospi tal	12/13/2017 7: PPS	00 alli
			0	1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
00 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr	ing prior to October 1		0 33, 514, 548	1.0 1.0
02	(see instructions) DRG amounts other than outlier payments for discharges occurr (see instructions)	ing on or after October	1	11, 421, 970	1.0
03	DRG for federal specific operating payment for Model 4 BPCI f prior to October 1 (see instructions)	or di scharges occurri ng		0	1.0
04	DRG for federal specific operating payment for Model 4 BPCI f on or after October 1 (see instructions)	or di scharges occurri ng		0	
00 01 02	Outlier payments for discharges. (see instructions) Outlier reconciliation amount	i onc)		3, 629, 816 0	2.0
02 00 00	Outlier payment for discharges for Model 4 BPCI (see instruct Managed Care Simulated Payments Bed days available divided by number of days in the cost repo			0 0 228. 26	3.0
00	instructions) Indirect Medical Education Adjustment			220.20	4.0
00	FTE count for allopathic and osteopathic programs for the mos period ending on or before 12/31/1996. (see instructions)	t recent cost reporting		0.00	5.0
00	FTE count for allopathic and osteopathic programs which meet add-on to the cap for new programs in accordance with 42 CFR	413.79(e)		0.00	
00	MMA Section 422 reduction amount to the IME cap as specified $\$412.105(f)(1)(iv)(B)(1)$	under 42 CFR		0.00	
01	ACA Section 5503 reduction amount to the IME cap as specified \$412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, instructions.			0.00	7.0
00	Adjustment (increase or decrease) to the FTE count for allopa programs for affiliated programs in accordance with 42 CFR 41	3.75(b),		0.00	8.0
01	413. $79(c)(2)(iv)$, 64 FR 26340 (May 12, 1998), and 67 FR 50069 The amount of increase if the hospital was awarded FTE cap sl	ots under section 5503 o	f	0.00	8.0
02	the ACA. If the cost report straddles July 1, 2011, see instr The amount of increase if the hospital was awarded FTE cap sl teaching hospital under section 5506 of ACA. (see instruction	ots from a closed		0.00	8.0
00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin (see instructions)			0.00	9.0
0. 00	FTE count for allopathic and osteopathic programs in the curr records	ent year from your		0.00	10.0
1.00 2.00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)			0.00	11.0 12.0
3.00 1.00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that ye September 30, 1997, otherwise enter zero.	ar ended on or after			13.0 14.0
5.00	Sum of lines 12 through 14 divided by 3.				15.0
	Adjustment for residents in initial years of the program Adjustment for residents displaced by program or hospital clo	sure			16.0 17.0
3. 00	Adjusted rolling average FTE count			0.00	18.0
9.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	
). 00 I. 00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0. 000000 0. 000000	
2.00	IME payment adjustment (see instructions)			0.000000	
2. 01	IME payment adjustment - Managed Care (see instructions)			0	
3.00	Indirect Medical Education Adjustment for the Add-on for Sect Number of additional allopathic and osteopathic IME FTE resid			0.00	23.0
1.00 5.00	Sec. 412.105 (f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the	lower of line 23 or line		0.00 0.00	24.0 25.0
5. 00	24 (see instructions) Resident to bed ratio (divide line 25 by line 4)			0. 000000	
7.00	IME payments adjustment factor. (see instructions)			0.000000	
3.00	IME add-on adjustment amount (see instructions)	、 、		0	
3.01	IME add-on adjustment amount - Managed Care (see instructions)		0	
9.00 9.01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0 Disproportionate Share Adjustment	1)		0	
0. 00	Percentage of SSI recipient patient days to Medicare Part A p instructions)	atient days (see		2. 71	30.0
1.00	Percentage of Medicaid patient days (see instructions)			15.64	
2.00 3.00	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)		18.35 4.68	
	Disproportionate share adjustment (see instructions))			33.0

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0035	Peri od:	Worksheet E	2552-1
			From 01/01/2014 To 12/31/2014	Date/Time Pre	pared
		Title XVIII	Hospi tal	12/13/2017 7: PPS	58 am
			Prior to	On/After	
			October 1	October 1	
	Uncompensated Care Adjustment	0	1.00	2.00	
	Total uncompensated care amount (see instructions)		9,046,380,143	7, 647, 644, 885	35.0
. 01	Factor 3 (see instructions)		0. 000282242	0.000238457	
. 02	Hospital uncompensated care payment (If line 34 is zero,		2, 553, 267	1, 823, 632	35.0
. 03	enter zero on this line) (see instructions) Pro rata share of the hospital uncompensated care payment		1, 909, 703	459, 656	35.0
	amount (see instructions)		.,,	,	
. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		2, 369, 359		36.0
	Additional payment for high percentage of ESRD beneficiary of	discharges (lines 40 thro	ugh 46)		
. 00	Total Medicare discharges on Worksheet S-3, Part I		0		40.0
	excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				
. 00	Total ESRD Medicare discharges excluding MS-DRGs 652,		0		41.0
	682, 683, 684 an 685. (see instructions)				
. 01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.0
. 00	Divide line 41 by line 40 (if less than 10%, you do not		0.00		42.0
	qualify for adjustment)				
. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		43.0
. 00	Ratio of average length of stay to one week (line 43		0. 000000		44.0
00	divided by line 41 divided by 7 days)				45 5
. 00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.0
. 00	Total additional payment (line 45 times line 44 times line		0		46.0
00	41.01)		F1 4/1 4F0		47.0
. 00 . 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and		51, 461, 450 0		47.0 48.0
	MDH, small rural hospitals only. (see instructions)				
. 00	Total payment for inpatient operating costs (see instructions)		51, 461, 450		49.0
. 00	Payment for inpatient program capital (from Wkst. L, Pt. I		3, 880, 521		50.0
	and Pt. II, as applicable)		-,, -		
. 00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.0
. 00	Direct graduate medical education payment (from Wkst. E-4,		0		52.0
	line 49 see instructions).				
	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies		0 1, 705		53.0 54.0
. 01	Islet isolation add-on payment		1,703		54.0
. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,		0		55.C
. 00	line 69) Cost of physicians' services in a teaching hospital (see		0		56.0
	intructions)				
. 00	Routine service other pass through costs (from Wkst. D,		0		57.0
. 00	Pt. III, column 9, lines 30 through 35). Ancillary service other pass through costs from Wkst. D,		0		58.0
	Pt. IV, col. 11 line 200)				
. 00 . 00	Total (sum of amounts on lines 49 through 58) Primary payer payments		55, 343, 676 16, 582		59.0 60.0
. 00	Primary payer payments Total amount payable for program beneficiaries (line 59		55, 327, 094		60.0
	minus line 60)				
	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries		4, 527, 488 296, 856		62.0 63.0
	Allowable bad debts (see instructions)		290, 850 139, 904		64.0
. 00	Adjusted reimbursable bad debts (see instructions)		90, 938		65.0
. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)		98, 774		66.0
. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		50, 593, 688		67. C
	Credits received from manufacturers for replaced devices		0		68. C
. 00	for applicable to MS-DRGs (see instructions) Outlier payments reconciliation (sum of lines 93, 95 and		0		69. C
. 50	96). (For SCH see instructions)				57.0
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.0
. 50 . 88	RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment		0		70.5 70.8
. 80 . 89	Pioneer ACO demonstration payment adjustment amount (see		0		70.8
	instructions)				
. 90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.9
. 91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.9
	Bundled Model 1 discount amount (see instructions)		0		70.9

Heal th	Financial Systems PORTER MEMORIA	AL HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0035	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Pre 12/13/2017 7:	
		Title XVIII	Hospi tal	PPS	
			Prior to	On/After	
			October 1	October 1	
		0	1.00	2.00	
70.94	HRR adjustment amount (see instructions)		-86, 820		70.94
70.95	Recovery of accelerated depreciation		0		70.95
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the	0	0		70.96
70.07	period prior to 10/1)	0	0		70.07
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70. 98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		50, 557, 661		71.00
71.01	Sequestration adjustment (see instructions)		1, 011, 153		71.01
72.00	Interim payments		49, 524, 440		72.00
73.00	Tentative settlement (for contractor use only)		22, 068		73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		0		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0		75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		3, 597, 639		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		164, 043		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
	HSP Bonus Payment Amount				
	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment		0	0	100.00
	HVBP adjustment factor (see instructions)		0.000000000	0. 000000000	101 00
	HVBP adjustment amount for HSP bonus payment (see instructi	ons)	0.0000000000000000000000000000000000000		102.00
102.00	HRR Adjustment for HSP Bonus Payment	0137	0	0	102.00
103 00	HRR adjustment factor (see instructions)		0.0000	0,0000	103.00
	HRR adjustment amount for HSP bonus payment (see instruction	ns)	0.0000		103.00
101.00				0	1.51.00

CALCUL	Financial Systems ATION OF DSH PAYMENT PERCENTAGE	PORTER MEMORIA	Provider C	CN: 15-0035	Period: From 01/01/2014 To 12/31/2014	u of Form CMS-2 Worksheet DSH Date/Time Pre 12/13/2017 7:	pared:
			Title	XVIII	Hospi tal	PPS	
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	o Overri de Val ue	Revi sed Val ue	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF THE DSH PAYMENT PERCENTAGE						
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	2. 71	2.71	2.	71 0.00	2. 71	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	15.64	15.64			15.64	2.00
3. 00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	18. 35	18.35			18.35	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban	Urban			Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	228. 26	228. 26			228.26	5.00
5.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	4.68	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes	Yes			Yes	7.00
3.00	S-2, Line 22	Yes	Yes			Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes	No			No	9.00
10.00	S-2, Line 45	Yes	Yes			Yes	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I,	Yes	Yes			Yes	11.00
12.00	line 1 geater than -O-) Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	2. 71	2. 71	2.	71 0.00	2. 71	12.00
13.00	· · · · · · · · · · · · · · · · · · ·	Yes	Yes			Yes	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	1.31	1. 31	1.	31 0.00	1. 31	14.00
1 - 00	CALCULATION OF THE PERCENTAGE OF MEDICALD DAY			1		2 210	1 - 0
15.00	line 24, column 1)	3, 310	3, 310			-	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	1, 024	1, 024			-	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	20	20				17.00
18.00 18.01	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4) N/A	24 0	24 0			24 0	
	Medicaid HMO days (Worksheet S-2, line 24, column 5)	4, 572	4, 572				19.00
20. 00	Other Medicaid days (Worksheet S-2, line 24, column 6)	237	237			237	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	9, 187	9, 187			9, 187	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	58, 485	58, 485			58, 485	22.00
23. 00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	237	237			237	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25. 00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	О	0			0	25.00
26. 00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	58, 722	58, 722			58, 722	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	15.64	15.64			15.64	27.00

Heal th	Financial Systems	PORTER MEMORIA	AL_HOSPI TAL		In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF DSH PAYMENT PERCENTAGE		Provider CO	CN: 15-0035	Period: From 01/01/2014 To 12/31/2014	Worksheet DSH Date/Time Pre 12/13/2017 7:	pared:
			Title	XVIII	Hospi tal	PPS	
		Original .m	crx Values	Adj usted	.mcax Values	Revi sed	
		Condi ti on	Percentage	Condi ti on	Percentage	Condi ti on	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE						
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	Fal se	0.00	Fal se	0.00	Fal se	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	True	4.68	True	4. 68	True	29.00
30.00	Line 28 or 29 as applicable		4.68		4.68		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise		0.00		0.00		31.00
	enter line 30.	0.1.1.1			0		
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Val ue	Revi sed Val ue	
		1.00	2.00	3.00	4.00	5.00	
	DETERMINATION OF PROVIDER TYPE				-		
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	Fal se	Fal se			Fal se	32.00
33.00	ls This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	Fal se	Fal se			Fal se	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	Fal se	Fal se			Fal se	34.00
35.00	s this a Sole Cummunity hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	Fal se	Fal se			Fal se	35.00
36.00	s this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban	Urban			Urban	36.00

Health Financial Systems	PORTER MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 15-0035	Period: From 01/01/2014	Worksheet DSH	l
				Date/Time Pre 12/13/2017 7:	pared: 58 am
		Title XVIII	Hospi tal	PPS	
	Revi sed				
	Percentage				
	6.00				
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAG	E				
28.00 If line 3 is greater than 20.2% - 5.88% plus	s 0.00				28.00
82.5% of the difference between 20.2% and					
line 3					
29.00 If line 3 is less than 20.2% - 2.5% plus 65%	4.68				29.00
of the difference between 15% and line 3					
30.00 Line 28 or 29 as applicable	4.68				30.00
31.00 If Urban and fewer than 100 beds, Rural and	0.00				31.00
fewer than 500 beds, or an SCH the lower of					
line 30 or .1200, if RRC, MDH or otherwise					
enter line 30.					

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Heal th	Financial Systems		PORTER MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
LOW VO	LUME CALCULATION EXHIBIT 4			Provider C		eriod: rom 01/01/2014 o 12/31/2014		pared:
				Title	XVIII	Hospi tal	PPS	<u>00 dili</u>
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier	1.00	0	0	0	0	0	1.00
1.01	payments DRG amounts other than outlier payments for discharges	1.01	33, 514, 548	0	33, 514, 548		33, 514, 548	1.01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	11, 421, 970	0		11, 421, 970	11, 421, 970	1.02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1.03	0	0	0		0	1.03
1.04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	3, 629, 816	0	2, 960, 556			2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2. 01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adj							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0.00000	0. 000000	0. 000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6. 01	IME payment adjustment for managed care (see	22. 01	0	0	0	0	0	6. 01
	instructions) Indirect Medical Education Adj	ustment for th	a Add an far Sa	ation 100 of	the MMA			-
7.00	IME payment adjustment factor	27.00	0. 000000			0. 000000		7.00
8.00	(see instructions) IME adjustment (see	28.00	0	0		0		
8. 01	instructions) IME payment adjustment add on	28. 01	0	0	0	0	0	8.01
0.00	for managed care (see instructions)	20.00				0		0.00
9. 00 9. 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed	29. 00 29. 01	0	0		0	0	
9.01	care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustm		· · · · · · · · · · · · · · · · · · ·		-			
10. 00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0468	0. 0468	0. 0468	0. 0468		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	525, 757	0	392, 120	133, 637	525, 757	11.00
11.01	Uncompensated care payments	36.00	2, 369, 359		1, 909, 703	459, 656	2, 369, 359	11.01
12.00	Additional payment for high pe Total ESRD additional payment	rcentage of ES 46.00	beneficiary 0	di scharges 0	0	0	0	12.00
13. 00 14. 00	(see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH,	47.00 48.00	51, 461, 450 0	0 0	38, 776, 927 0	12, 684, 523 0	51, 461, 450 0	1
15.00	(see instructions) Total payment for inpatient operating costs (see	49.00	51, 461, 450	0	38, 776, 927	12, 684, 523	51, 461, 450	15.00
16.00	instructions) Payment for inpatient program	50.00	3, 880, 521	0	2, 858, 936	1, 021, 585	3, 880, 521	16.00
17.00	capital Special add-on payments for	54.00	1, 705	0	0	1, 705	1, 705	17.00
17. 01 17. 02	new technologies Net organ aquisition cost Credits received from manufactureors for rool acod	68.00	0	0	0	0	0	17.01 17.02
	manufacturers for replaced devices for applicable MS-DRGs							

Heal th	Financial Systems		PORTER MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
LOW VC	LUME CALCULATION EXHIBIT 4			Provider C		Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 12/13/2017 7:	epared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions) SUBTOTAL	93.00	0	0	41, 635, 86	0 0 03 13, 707, 813		
17.00	SUBTUTAL	W/S L, line	(Amounts from	0	41,055,00	13, 107, 013	33, 343, 070	19.00
		WJL, THE	L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier		3, 577, 583	0	2,667,67			20.00
20. 01	Model 4 BPCI Capital DRG other than outlier		0	0		0 0		1
21.00	Capital DRG outlier payments	2.00	167, 348	0	90, 15	52 77, 196	167, 348	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	C	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	C	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0379	0. 0379	0. 037	0. 0379		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	135, 590	0	101, 10	34, 485	135, 590	25.00
26.00	Total prospective capital payments (see instructions)	12.00	3, 880, 521	0	2, 858, 93	36 1, 021, 585	3, 880, 521	26.00
		W/S E, Part A	(Amounts to					
		line	E, Part A)					
	1	0	1.00	2.00	3.00	4.00	5.00	
27.00 28.00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70. 96			0. 00000	0 0.000000	c	27.00 28.00
29.00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70. 97				0	с	29.00
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

	Financial Systems AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	PORTER MEMORI TION EXHIBIT 5	5 Provider CC		Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 12/13/2017 7:	t 5 pared:
				XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	33, 514, 548	33, 514, 54	18	33, 514, 548	1.01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	11, 421, 970		11, 421, 970	11, 421, 970	1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0		0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	3, 629, 816	2, 960, 55	669, 260	3, 629, 816	2.00
2. 01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2. 01
3.00	Operating outlier reconciliation	2.01	0		0 0	0	3.00
4.00	Managed care simulated payments	3.00	0		0 0	0	4.00
5.00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21	21.00	0. 000000	0. 00000	0.00000		5.00
6.00	(see instructions) IME payment adjustment (see instructions)	22.00	0		0 0	0	6.00
6. 01	IME payment adjustment (see first detrois) IME payment adjustment for managed care (see instructions)		0		0 0	0	6.00
	Indirect Medical Education Adjustment for the	e Add-on for S	ection 422 of 1	the MMA			
7.00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0. 00000	0. 000000		7.00
8. 00 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)	28. 00 28. 01	0		0 0 0 0	0	8. 00 8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9.00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0		0 0	0	9. 01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0468				10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	525, 757	392, 12		525, 757	
11.01	Uncompensated care payments Additional payment for high percentage of ES	36.00	2, 369, 359	1, 909, 70	459, 656	2, 369, 359	11.01
12.00	Total ESRD additional payment (see instructions)	46. 00	0 of scharges		0 0	0	12.00
13 00	Subtotal (see instructions)	47.00	51, 461, 450	38, 776, 92	12, 684, 523	51, 461, 450	13 00
	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)		0	,,	0 0		14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	51, 461, 450	38, 776, 92	12, 684, 523	51, 461, 450	15.00
16.00	Payment for inpatient program capital	50.00	3, 880, 521	2, 858, 93	1, 021, 585		
17.00	Special add-on payments for new technologies	54.00	1, 705		0 1, 705	1, 705	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0		17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	
19.00	SUBTOTAL			41, 635, 86	13, 707, 813	55, 343, 676	19.00

Health Financial Systems	PORTER MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCUL	ATION EXHIBIT 5			Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 12/13/2017 7:	pared:
			XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3.00	4.00	
20.00 Capital DRG other than outlier	1.00	3, 577, 583	2, 667, 67	909, 904	3, 577, 583	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	, v	
21.00 Capital DRG outlier payments	2.00	167, 348	90, 15	52 77, 196	167, 348	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	21.01
22.00 Indirect medical education percentage (see instructions)	5.00	0.0000	0.000	0.0000		22.00
23.00 Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00 Allowable disproportionate share percentage (see instructions)	10. 00	0. 0379	0. 037	0. 0379		24.00
25.00 Disproportionate share adjustment (see instructions)	11.00	135, 590	101, 10	34, 485	135, 590	25.00
26.00 Total prospective capital payments (see instructions)	12.00	3, 880, 521	2, 858, 93	1, 021, 585	3, 880, 521	26.00
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
	0	1.00	2.00	3.00	4.00	
27.00						27.00
28.00 Low volume adjustment prior to October 1	70. 96	0		0	0	28.00
29.00 Low volume adjustment on or after October 1	70. 97	0		0	0	29.00
30.00 HVBP payment adjustment (see instructions)	70. 93	50, 793	51, 61	4 -821	50, 793	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 01
31.00 HRR adjustment (see instructions)	70, 94	-86, 820		0 -86, 820	-86, 820	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0		
					(Amt. to	
					Wkst. E, Pt. A)	
	0	1.00	2.00	3.00	4.00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	32.00
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.	ס	Y				100.00

	Financial Systems PORTER MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0035	Peri od:	u of Form CMS-2 Worksheet E	2002
			From 01/01/2014 To 12/31/2014	Date/Time Pre	pare
		Title XVIII	Hospi tal	12/13/2017 7: PPS	58 a
			nospi tui	J	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
00	Medical and other services (see instructions)			37, 446	
00	Medical and other services reimbursed under OPPS (see instru	ictions)		31, 841, 501	2.
00 00	PPS payments Outlier payment (see instructions)			29, 973, 092 220, 764	
00	Enter the hospital specific payment to cost ratio (see instr	ructions)		0.000	
00	Line 2 times line 5			0	6
00	Sum of line 3 plus line 4 divided by line 6			0.00	
00 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt.	1)/ col 12 lino 200		0	8
. 00	Organ acquisitions	TV, COL. 13, TTHE 200		0	
. 00	Total cost (sum of lines 1 and 10) (see instructions)			37, 446	
	COMPUTATION OF LESSER OF COST OR CHARGES				
~ ~	Reasonable charges			100 507	
. 00 . 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4,	Lipo (9)		198, 537 0	12
. 00	Total reasonable charges (sum of lines 12 and 13)	THE 09)		198, 537	
	Customary charges			1707007	1
. 00	Aggregate amount actually collected from patients liable for				15
. 00	Amounts that would have been realized from patients liable f		on a chargebasis	0	16
. 00	had such payment been made in accordance with 42 CFR §413.13 Ratio of line 15 to line 16 (not to exceed 1.000000)	s(e)		0.000000	17
. 00	Total customary charges (see instructions)			198, 537	18
. 00	Excess of customary charges over reasonable cost (complete o	nly if line 18 exceeds l	ine 11) (see	161, 091	19
	instructions)			_	
. 00	Excess of reasonable cost over customary charges (complete o instructions)	only if line 11 exceeds l	ine 18) (see	0	20
00	Lesser of cost or charges (line 11 minus line 20) (for CAH s	ee instructions)		37, 446	21
	Interns and residents (see instructions)			0	22
. 00	Cost of physicians' services in a teaching hospital (see ins	structions)		0	23
. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			30, 193, 856	24
5.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions)			71	25
. 00	Deductibles and Coinsurance relating to amount on line 24 (f	or CAH, see instructions)	6, 124, 366	
. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 2	2 and 23] (see	24, 106, 865	27
00	instructions) Direct graduate medical education payments (from Wkst. E-4,	Line FO)		0	2
. 00 . 00	ESRD direct medical education costs (from Wkst. E-4, line 36			0	
. 00	Subtotal (sum of lines 27 through 29)	·)		24, 106, 865	
. 00	Primary payer payments			22, 453	31
. 00	Subtotal (line 30 minus line 31)			24, 084, 412	32
00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERV Composite rate ESRD (from Wkst. I-5, line 11)	TCES)		0	33
	Allowable bad debts (see instructions)			256, 839	
	Adjusted reimbursable bad debts (see instructions)			166, 945	35
. 00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		236, 386	
. 00 . 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			24, 251, 357 -191	37
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			- 191 0	39
. 50	Pioneer ACO demonstration payment adjustment (see instructio	ons)		0	39
. 98	Partial or full credits received from manufacturers for repl	aced devices (see instru	ctions)	0	39
. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39
. 00 . 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			24, 251, 548 485, 031	
. 00	Interim payments			23, 852, 881	
. 00	Tentative settlement (for contractors use only)			-86, 364	
00	Balance due provider/program (see instructions)			0	
00	Protested amounts (nonallowable cost report items) in accord	lance with CMS Pub. 15-2,	chapter 1,	0	44
	\$115.2 TO BE COMPLETED BY CONTRACTOR				
. 00	Original outlier amount (see instructions)			220, 764	90
00	Outlier reconciliation adjustment amount (see instructions)			0	91
. 00	The rate used to calculate the Time Value of Money			0.00	
. 00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	
. 00				0 Overri des	74
				1.00	
	WORKSHEET OVERRIDE VALUES				1

	Financial Systems PORTER MEMORIAL TION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0035	Peri od:	u of Form CMS-2 Worksheet E	2002		
		Component CCN: 15-T035	From 01/01/2014 To 12/31/2014	Date/Time Pre	par		
		Title XVIII	Subprovider -	12/13/2017 7: PPS	58		
			I RF				
F	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00			
00	Medical and other services (see instructions)			287			
	Medical and other services reimbursed under OPPS (see instruct PPS payments	ctions)		3, 352 1, 050			
	Outlier payment (see instructions)			0	4		
	Enter the hospital specific payment to cost ratio (see instru-	uctions)		0.000			
	Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6			0.00			
00	Transitional corridor payment (see instructions)			0	8		
	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	IV, col. 13, line 200		0			
	Total cost (sum of lines 1 and 10) (see instructions)			287			
C	COMPUTATION OF LESSER OF COST OR CHARGES						
	Reasonable charges Ancillary service charges			1, 520	12		
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, 1	line 69)		0			
	Total reasonable charges (sum of lines 12 and 13)			1, 520	114		
	Aggregate amount actually collected from patients liable for	payment for services on	a charge basi s	0	15		
	Amounts that would have been realized from patients liable for		on a chargebasis	0	16		
	had such payment been made in accordance with 42 CFR §413.13 Ratio of line 15 to line 16 (not to exceed 1.000000)	(e)		0. 000000	1		
00	Total customary charges (see instructions)			1, 520			
	Excess of customary charges over reasonable cost (complete or	nlyifline 18 exceeds l	ine 11) (see	1, 233	19		
	instructions) Excess of reasonable cost over customary charges (complete o	nlyifline 11 exceeds l	ine 18) (see	0	20		
	instructions)	- :		207	0		
	Lesser of cost or charges (line 11 minus line 20) (for CAH so Interns and residents (see instructions)	ee instructions)		287			
	Cost of physicians' services in a teaching hospital (see ins		0				
	Total prospective payment (sum of lines 3, 4, 8 and 9)			1,050	24		
	Deductibles and coinsurance (for CAH, see instructions)			0	25		
	Deductibles and Coinsurance relating to amount on line 24 (fo			210			
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	plus the sum of lines 2	2 and 23] (see	1, 127	27		
00 [Direct graduate medical education payments (from Wkst. E-4,			0	28		
	ESRD direct medical education costs (from Wkst. E-4, line 36))		0	1		
	Subtotal (sum of lines 27 through 29) Primary payer payments			1, 127			
	Subtotal (line 30 minus line 31)			1, 127			
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	I CES)					
	Composite rate ESRD (from Wkst. 1-5, line 11) Allowable bad debts (see instructions)			0	33		
00 /	Adjusted reimbursable bad debts (see instructions)			0	35		
	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		0			
	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			1, 127			
00 0	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39		
	Pioneer ACO demonstration payment adjustment (see instruction Partial or full credits received from manufacturers for repla		ctions)	0			
	RECOVERY OF ACCELERATED DEPRECIATION			0			
00	Subtotal (see instructions)			1, 127			
	Sequestration adjustment (see instructions) Interim payments			23 1, 121			
00	Tentative settlement (for contractors use only)			-17			
00	Balance due provider/program (see instructions)			0	43		
	Protested amounts (nonallowable cost report items) in accorda §115.2	ance with CMS Pub. 15-2,	chapter 1,	0	44		
Т	O BE COMPLETED BY CONTRACTOR			-			
00 0	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0			
	The rate used to calculate the Time Value of Money			0.00			
00 -	0 Time Value of Money (see instructions)						
00	Total (sum of lines 91 and 93)			0 Overri des	94		
				1.00			
M	VORKSHEET OVERRIDE VALUES						

	I Financial Systems PORTER MEMORI SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	CN: 15-0035	Period:	u of Form CMS-2 Worksheet E-1	
				From 01/01/2014 To 12/31/2014	Date/Time Pre	
		Titlo	XVIII	Hospi tal	12/13/2017 7: PPS	58 8
			t Part A		T B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		49, 524, 44		23, 852, 881	1
00	Interim payments payable on individual bills, either			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					3
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
11	Program to Provider ADJUSTMENTS TO PROVIDER			0	0	
D1	ADJUSTMENTS TO PROVIDER			0	0	3
)2				0	0	3
)3)4				0	0	3
)4)5				0	0	3
55	Provider to Program				0	3
50	ADJUSTMENTS TO PROGRAM			0	0	3
50 51				0	0	3
52				0	0	3
53				0	0	3
54				0	0	3
99 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0	0	3
	3. 50-3. 98)			-	-	-
00	Total interim payments (sum of lines 1, 2, and 3.99)		49, 524, 44	0	23, 852, 881	4
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR	T		T		
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)					
01	Program to Provider TENTATIVE TO PROVIDER	07/30/2015	22.74		0	
)2	IENTATIVE TO PROVIDER	0773072015	32, 74	0	0	5
)2)3				0	0	5
0	Provider to Program				0	
	TENTATI VE TO PROGRAM	03/31/2017	10, 67	5 07/30/2015	76, 124	5
50					10, 240	Ę
				0 03/31/2017		
51				0 03/31/2017	0	5
51 52	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		
51 52				0	0	
51 52 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5
51 52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)			0	0 -86, 364	6
51 52 99 00	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER		22, 06	0 8 0	0 -86, 364 0	5 6 6
51 52 99 00 01 02	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		22, 06	0 8 0 0	0 -86, 364 0 0	5 6 6
51 52 99 00 01 02	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER		22, 06	0 8 0 0 8	0 -86, 364 0 23, 766, 517	5 6 6
50 51 52 99 00 01 02 00	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		22, 06	0 8 0 0 8 Contractor	0 -86,364 0 23,766,517 NPR Date	5 6 6
51 52 99 00 01 02	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		22, 06	0 8 0 0 8	0 -86, 364 0 23, 766, 517	5

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component C	CN: 15-0035 CCN: 15-T035	Period: From 01/01/2014 To 12/31/2014	Date/Time Pre	pare
		Title	XVIII	Subprovider -	12/13/2017 7: PPS	58 a
		Inpati en	t Part A	I RF Par	T B	
	-		Amount	mm (dd () y y y y	Amount	
		mm/dd/yyyy 1.00	2.00	mm/dd/yyyy 3.00	4. 00	
00 00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each		3, 255, 2		1, 121	1. 2. 3.
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					-
01	ADJUSTMENTS TO PROVIDER			0	0	3
02 03 04 05				0 0 0	0 0 0	3 3 3 3
	Provider to Program					
50 51 52 53 54 99	ADJUSTMENTS TO PROGRAM Subtotal (sum of lines 3.01-3.49 minus sum of lines			0 0 0 0 0	0 0 0 0 0	3 3 3 3 3 3
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		3, 255, 2	74	1, 121	4
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5
01	TENTATI VE TO PROVI DER			0	0	5
02				0	0	5
)3	Provider to Program			0	0	5
50 51 52	TENTATI VE TO PROGRAM	07/30/2015 03/31/2017	8, 8 1, 5	29 0	17 0 0	5 5 5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		-10, 3	48	-17	5
)0)1)2	Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			0	0	6 6 6
00	Total Medicare program liability (see instructions)		3, 244, 9	26	1, 104	7
		(Contractor Number	NPR Date (Mo/Day/Yr)	
		(J	1.00	2.00	

Heal th	Financial Systems	PORTER MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10		
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0035	Peri od:	Worksheet E-1			
				From 01/01/2014				
				To 12/31/2014	Date/Time Pre 12/13/2017 7:			
			Title XVIII	Hospi tal	PPS			
				nospi tui	110			
					1.00			
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS								
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTI	ON AND CALCULATION						
1.00	Total hospital discharges as defined in AAR	A §4102 from Wkst.	S-3, Pt. I col. 15 line	e 14	12, 988	1.00		
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6	sum of lines 1, 8	-12		28, 514	2.00		
3.00								
4.00	4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12							
5.00	5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200							
6.00	Total hospital charity care charges from Wk	st. S-10, col. 3 l	ine 20		17, 844, 249	6.00		
7.00	CAH only - The reasonable cost incurred for	the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I	0	7.00		
	line 168							
8.00	Calculation of the HIT incentive payment (s				1, 963, 872			
9.00	Sequestration adjustment amount (see instru				39, 277	9.00		
10.00	Calculation of the HIT incentive payment af		(see instructions)		1, 924, 595	10.00		
~~ ~~	INPATIENT HOSPITAL SERVICES UNDER THE IPPS				1 000 540			
30.00	Initial/interim HIT payment adjustment (see	e instructions)			1, 908, 543			
31.00	Other Adjustment (specify)				0	31.00		
32.00	Balance due provider (line 8 (or line 10) m	nus line 30 and l	ine 31) (see instruction	ns)	16, 052	32.00		
					Overri des			
	CONTRACTOR OVERRIDES				1.00			
100 00	Override of HIT payment				0	108.00		
100.00	jovernue of nit payment			I	0	100.00		

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT				2552-1
		Provider CCN: 15-0035	Peri od:	Worksheet E-3	
		Component CCN: 15-T035	From 01/01/2014 To 12/31/2014		pared:
		Title XVIII	Subprovi der -	12/13/2017 7: PPS	58 am
			I RF	PP3	
				1 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
1.00	Net Federal PPS Payment (see instructions)			3, 016, 356	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0131	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions	5)		71, 186	3.0
4.00	Outlier Payments			267, 376	4.0
5.00	Unweighted intern and resident FTE count in the most reto November 15, 2004 (see instructions)	ecent cost reporting period	ending on or prior	0.00	5.0
5. 01	Cap increases for the unweighted intern and resident F			0.00	5.0
	program or hospital closure, that would not be counted CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions		Stillent under 42		
6.00	New Teaching program adjustment. (see instructions)	5)		0.00	6.0
7.00	Current year's unweighted FTE count of I&R excluding F	TEs in the new program growth	period of a "new	0.00	
1.00	teaching program" (see instructions)			0.00	/.0
3. 00	Current year's unweighted I&R FTE count for residents v teaching program" (see instructions)	within the new program growth	period of a "new	0.00	8.0
9.00	Intern and resident count for IRF PPS medical education	n adiustment (see instruction	s)	0.00	9.0
10.00	Average Daily Census (see instructions)		-)	9. 230137	
1.00	Teaching Adjustment Factor (see instructions)			0.000000	
2.00	Teaching Adjustment (see instructions)			0	12.0
3.00	Total PPS Payment (see instructions)			3, 354, 918	
4.00	Nursing and Allied Health Managed Care payments (see in	nstruction)		0	14.0
5.00	Organ acquisition (DO NOT USE THIS LINE)				15.0
6.00	Cost of physicians' services in a teaching hospital (se	ee instructions)		0	16.0
7.00	Subtotal (see instructions)			3, 354, 918	17.0
8.00	Primary payer payments			0	18.0
9.00	Subtotal (line 17 less line 18).			3, 354, 918	19.0
20.00	Deducti bl es			19, 456	20.0
21.00	Subtotal (line 19 minus line 20)			3, 335, 462	21.0
2.00	Coinsurance			24, 320	22.0
3.00	Subtotal (line 21 minus line 22)			3, 311, 142	23.0
4.00	Allowable bad debts (exclude bad debts for professional	services) (see instructions)	11	24.0
5.00	Adjusted reimbursable bad debts (see instructions)			7	25.0
6.00	Allowable bad debts for dual eligible beneficiaries (se	ee instructions)		11	26.0
7.00	Subtotal (sum of lines 23 and 25)			3, 311, 149	27.0
8.00	Direct graduate medical education payments (from Wkst.	E-4, line 49)		0	28.0
9.00	Other pass through costs (see instructions)			0	29.0
0.00	Outlier payments reconciliation			0	30.0
1.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31.0
1.50	Pioneer ACO demonstration payment adjustment (see instr	ructions)		0	31.5
1.99	Recovery of Accelerated Depreciation			0	31.9
2.00	Total amount payable to the provider (see instructions))		3, 311, 149	
2.01	Sequestration adjustment (see instructions)			66, 223	
	Interim payments			3, 255, 274	
4.00	Tentative settlement (for contractor use only)			-10, 348	
35.00	Balance due provider/program (line 32 minus lines 32.0'			0	35.0
36. 00	Protested amounts (nonallowable cost report items) in a §115.2	accordance with CMS Pub. 15-2	, chapter 1,	0	36.0
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount from Wkst. E-3, Pt. III, line 4	4		267, 376	
				0	51.0 52.0

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	F	eriod: rom 01/01/2014 o 12/31/2014	Worksheet G Date/Time Pre 12/13/2017 7:	
		General Fund	Specific Purpose Fund 2.00	Endowment Fund 3.00	Plant Fund 4.00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	-954, 496	0	0	0	1.0
00	Temporary investments	0	0	0	0	2.0
00	Notes receivable	0	0	0	0	3.0
00	Accounts receivable	56, 595, 480	0	0	0	
00	Other receivable	0	0	0	0	
00	Allowances for uncollectible notes and accounts receivable	-10, 147, 858	0	0	0	
00	Inventory	7, 378, 611	0	0	0	
00 00	Prepaid expenses Other current assets	1, 488, 445	0	0	0 0	
	Due from other funds	533, 289 0			0	
	Total current assets (sum of lines 1-10)	54, 893, 471	0		0	
. 00	FIXED ASSETS	01,070,171	<u> </u>	<u> </u>		1
. 00	Land	13, 816, 969	0	0	0	12.
	Land improvements	4, 649, 188	0		0	
	Accumulated depreciation	-1, 600, 180	0	0	0	14.
. 00	Bui I di ngs	187, 048, 545	0	0	0	15
. 00	Accumulated depreciation	-16, 471, 985	0	0	0	16
. 00	Leasehold improvements	3, 214, 613	0	0	0	17
	Accumulated depreciation	-904, 592	0	0	0	18
	Fixed equipment	6, 321, 657	0	0	0	
	Accumulated depreciation	-1, 942, 607	0		0	
	Automobiles and trucks	404, 393	0	0	0	
	Accumulated depreciation	-268, 279	0		0	
	Major movable equipment	54, 040, 239			0	
	Accumulated depreciation	-27, 391, 418	0		0	
	Minor equipment depreciable Accumulated depreciation	20, 607, 889 -10, 311, 778			0	
	HIT designated Assets	-10, 311, 776		0	0	
	Accumulated depreciation	0	0	0	0	
	Mi nor equi pment-nondepreci abl e	0			0	
	Total fixed assets (sum of lines 12-29)	231, 212, 654	0		0	
	OTHER ASSETS					
	Investments	0	0		0	
	Deposits on Leases	0	0		0	
	Due from owners/officers	0	0		0	
	Other assets	10, 927, 948			0	
	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	10, 927, 948 297, 034, 073	0		0	
00	CURRENT LIABILITIES	291,034,013	0	0	0	30
00	Accounts payable	10, 658, 251	0	0	0	37
	Salaries, wages, and fees payable	10, 726, 247	0		0	
	Payroll taxes payable	967, 671	0		0	
	Notes and Loans payable (short term)	0	0	0	0	40
	Deferred income	0	0	0	0	
. 00	Accelerated payments	0				42
. 00	Due to other funds	5, 533, 257	0	0	0	43
	Other current liabilities	1, 237, 314			0	
. 00	Total current liabilities (sum of lines 37 thru 44)	29, 122, 740	0	0	0	45
	LONG TERM LIABILITIES	-				1
	Mortgage payable	0	0		0	
	Notes payable	0	0		0	
	Unsecured Loans Other Long term liabilities	14 007 770	0	0	0	
	Total long term liabilities (sum of lines 46 thru 49)	16, 097, 770 16, 097, 770		0	0	
	Total liabilities (sum of lines 45 and 50)	45, 220, 510			0	
00	CAPITAL ACCOUNTS	43, 220, 310	0	U0	0	1 31
00	General fund balance	251, 813, 563				52
	Specific purpose fund		o			53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			o		55
	Governing body created - endowment fund balance			0		56
00	Plant fund balance - invested in plant				0	
00	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion					
00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	251, 813, 563		0	0	
00		297,034,073		0	0	60

Heal th	Financial Systems	PORTER MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-	2552-10
	IENT OF CHANGES IN FUND BALANCES			Provi der CCN: 15-0035 Peri od: From 01/01/2014 To 12/31/2014		Worksheet G-1	epared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	214, 858, 695 36, 954, 868 251, 813, 563 0 251, 813, 563 0 251, 813, 563				5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
		Endowment Fund	PI ant	Fund			
1.00		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00
8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0			0		8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
17.00 18.00 19.00	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 0		17.00 18.00 19.00

Heal th	Financial Systems PORTER MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	N: 15-0035	Period: From 01/01/2014 To 12/31/2014	Worksheet G-2 Parts I & II	pared:
	Cost Center Description	Ĺ	Inpatient	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					
1 00	General Inpatient Routine Services		115 005 (10	115 005 (40	1 00
1.00 2.00	Hospital SUBPROVIDER - IPF		115, 895, 64	19	115, 895, 649	1.00 2.00
2.00	SUBPROVIDER - IRF		7, 746, 00	18	7, 746, 008	3.00
4.00	SUBPROVIDER		7, 740, 00		7,740,000	4.00
5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	6.00
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		123, 641, 65	57	123, 641, 657	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	I NTENSI VE CARE UNI T		31, 192, 56		31, 192, 560	
11.01	NEONATAL INTENSIVE CARE UNIT		15, 979, 10)/	15, 979, 107	11.01
12.00 13.00	CORONARY CARE UNI T BURN INTENSI VE CARE UNI T					12.00 13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					13.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	47, 171, 66	57	47, 171, 667	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)	170, 813, 32	24	170, 813, 324	17.00
18.00	Ancillary services		528, 463, 55	669, 278, 341		
19.00	Outpatient services		35, 198, 13			
20.00	RURAL HEALTH CLINIC			0 0		20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.00
22.00	HOME HEALTH AGENCY					22.00
23.00 24.00	AMBULANCE SERVICES CMHC					23.00 24.00
24.00	AMBULATORY SURGICAL CENTER (D. P.)					24.00
26.00	HOSPICE					26.00
27.00	OTHER (SPECI FY)			0 0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	734, 475, 01	15 766, 081, 721	1, 500, 556, 736	
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			307, 042, 047		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00 32.00				0		31.00 32.00
32.00				0		32.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)	2) (†******		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4 to Wkst. G-3, line 4)	2) (transter		307, 042, 047		43.00
	10 WASL 0-3, 11110 4)	I		I	I	I

Heal th	Financial Systems P	ORTER MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES			Provider CCN: 15-0035	Peri od:	Worksheet G-3	
				From 01/01/2014 To 12/31/2014	Date/Time Pre	narod
				10 12/31/2014	12/13/2017 7:	58 am
			•			
					1.00 1,500,556,736	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)					1.00
2.00	Less contractual allowances and discounts on p	1, 161, 756, 145	2.00			
3.00	Net patient revenues (line 1 minus line 2)				338, 800, 591	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)				307, 042, 047	4.00
5.00	Net income from service to patients (line 3 mi	nus line 4)			31, 758, 544	5.00
	OTHER I NCOME				-	
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				0	7.00
8.00	Revenues from telephone and other miscellaneou	s communication	services		0	8.00
9.00	Revenue from television and radio service				0	9.00
10.00					0	10.00
11.00 12.00					0	11.00 12.00
12.00	J				0	12.00
	Revenue from meals sold to employees and quest	-			0	13.00
	Revenue from rental of living quarters	5			0	14.00
	Revenue from sale of medical and surgical supp	lies to other t	han nationts		0	16.00
	Revenue from sale of drugs to other than patie				0	17.00
	Revenue from sale of medical records and abstra				0	18.00
	Tuition (fees, sale of textbooks, uniforms, et				0	19.00
	Revenue from gifts, flowers, coffee shops, and				0	20.00
21.00	5 1 1	danteen			0	21.00
22.00	0			0	22.00	
23.00					0	23.00
	MI SC I NCOME				5, 196, 324	
25.00					5, 196, 324	
	Total (line 5 plus line 25)				36, 954, 868	
	OTHER EXPENSES (SPECIFY)				0	27.00
	Total other expenses (sum of line 27 and subsc	ripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 m	inus line 28)			36, 954, 868	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0035	Period: From 01/01/2014 To 12/31/2014	Date/Time Pre				
			lloonital	12/13/2017 7: PPS	<u>58 am</u>			
Ti tl e XVIII Hospi tal								
				1.00				
	PART I - FULLY PROSPECTIVE METHOD							
	CAPITAL FEDERAL AMOUNT							
. 00	Capital DRG other than outlier			3, 577, 583	1.0			
. 01	Model 4 BPCI Capital DRG other than outlier	0	1.0					
. 00	Capital DRG outlier payments	167, 348	2.0					
. 01	Model 4 BPCI Capital DRG outlier payments	0	2.0					
. 00	Total inpatient days divided by number of days in the cost	155.45						
. 00	Number of interns & residents (see instructions) Indirect medical education percentage (see instructions)	0.00 0.00						
. 00 . 00								
	1.01) (see instructions)		0	6.0				
. 00	Percentage of SSI recipient patient days to Medicare Part (30) (see instructions)	2. 71	7.0					
. 00	Percentage of Medicaid patient days to total days (see ins	15.64	8.0					
. 00	Sum of lines 7 and 8		18.35	9.0				
	0 Allowable disproportionate share percentage (see instructions)				10.0			
1.00					11.0			
2.00	Total prospective capital payments (see instructions)			3, 880, 521	12. (
				1.00				
	PART II - PAYMENT UNDER REASONABLE COST			1.00				
. 00	Program inpatient routine capital cost (see instructions)			0	1.0			
. 00	Program inpatient ancillary capital cost (see instructions))		0	2.0			
. 00	Total inpatient program capital cost (line 1 plus line 2)				3.0			
. 00	Capital cost payment factor (see instructions)				4. (
. 00	Total inpatient program capital cost (line 3 x line 4)			0	5.0			
				1.00				
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00				
. 00	Program inpatient capital costs (see instructions)			0	1.0			
00	Program inpatient capital costs for extraordinary circumsta	ances (see instructions)		0	2.0			
00	Net program inpatient capital costs (line 1 minus line 2)			0	3.			
00	Applicable exception percentage (see instructions)			0.00	4.			
00	Capital cost for comparison to payments (line 3 x line 4)			0				
00	Percentage adjustment for extraordinary circumstances (see instructions)			0.00				
00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)			0	7.			
00	Capital minimum payment level (line 5 plus line 7)	nli ochlo)		0				
00	Current year capital payments (from Part I, line 12, as app Current year comparison of capital minimum payment level to		Loss Line ()	0	9. 10.			
00	Carryover of accumulated capital minimum payment level over			0				
			no. 11)	0	12.			
. 00	Worksheet L, Part III, line 14)	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)						
. 00	Net comparison of capital minimum payment level to capital			~	1 1 2			
. 00 . 00 . 00	Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, en	ter the amount on this lin	e)	0	-			
. 00 . 00 . 00	Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, en Carryover of accumulated capital minimum payment level over	ter the amount on this lin	e)	0 0	-			
2.00 3.00 4.00	Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, en Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	ter the amount on this lin r capital payment for the	e)	0	14.			
 00 0	Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, en Carryover of accumulated capital minimum payment level over	ter the amount on this lin r capital payment for the instructions)	e)	-	14. 15.			