	is required by law (42 USC 1395 e since the beginning of the co		Ture to report can res	ult in all interim	U of FORM CMS-2552-10 FORM APPROVED OMB NO. 0938-0050 EXPIRES 05-31-2019
HOSPITAL AND AND SETTLEME	HOSPITAL HEALTH CARE COMPLEX CONT SUMMARY		Provider CCN: 15-0035	From 01/01/2016 To 12/31/2016	
PART I - COS	T REPORT STATUS				
provider use only	<ol> <li>[ X ] Electronically filed</li> <li>[ ] Manually submitted co</li> <li>[ 0 ] If this is an amended</li> <li>4. [ F ] Medicare Utilization.</li> </ol>	cost report st report report enter the number	of times the provider	Date: 5/30/20	17 Time: 10:22 am ost report
Contractor use only	(1) As Submitted (2) Settled without Audit	6. Date Received: 7. Contractor No. 8. [ N ] Initial Report fo 9. [ N ] Final Report for	or this Provider CCN 12	.NPR Date: .Contractor's Vendo .[ 0 ]If line 5, co number of tim	or Code: 4 Dlumn 1 is 4: Enter nes reopened ≈ 0-9.
PART II - CE	RTIFICATION ATION OR FALSIFICATION OF ANY I	NEORMATION CONTAINED IN I	HYS COST REPORT MAY RE	PINTSHARI E RY CRTI	MINAL CIVIL AND
ADMINISTRATION PROVIDED OR	VE ACTION, FINE AND/OR IMPRISON: PROCURED THROUGH THE PAYMENT DI VE ACTION, FINES AND/OR IMPRISON	MENT UNDER FEDERAL LAW. RECTLY OR INDIRECTLY OF A	FURTHERMORE, IF SERVICE	ES IDENTIFIED IN T	HIS REPORT WERE
	CERTIFICATION BY OFFICER OF	R ADMINISTRATOR OF PROVID	ER(S)		
elec Expe endi comp exce	REBY CERTIFY that I have read t tronically filed or manually su nses prepared by PORTER MEMORIA ng 12/31/2016 and to the best o lete and prepared from the book pt as noted. I further certify th care services, and that the	<pre>bmitted cost report and t L HOSPITAL ( 15-0035 ) fc f my knowledge and belief s and records of the prov that I am familiar with</pre>	the Balance Sheet and Sor the cost reporting p f, this report and state rider in accordance wit the laws and regulation	statement of Revenu period beginning 01 tement are true, co th applicable instr ons regalding the p	e and /01/2016 and rrect, uctions, rovision of

Encryption Information
ECR: Date: 5/30/2017 Time: 10:22 am
SUajDnmTDBOMdDY6LYiybia. 4QYle0
vaH00003025RwjTB.9adMOM.Hh57QA
nWfgOCru.5OCRKeV
PI: Date: 5/30/2017 Time: 10:22 am
ySwc1ddwcempBioB2RwUNO:1FXUKU0
wZeCP0380RQgrN5CtvStDaHbm6bOrw

laws and regulations.

klDI00s6KtObGtex

Subprovider - IPF

Subprovider - IRF

Swing bed - SNF

Swing bed - NF

Hospital

1.00

2.00

3.00

5.00

6.00

PART III - SETTLEMENT SUMMARY

officer or Administrator of Provider(s)
Senior Vice President, Revenue Management

5/30/17

Date

Title XVIII Title XIX Title V Part A HIT 5.00 1.00 2.00 3.00 4.00 231,828 -78,664 619,622 0 1.00 0 0 0 2.00 -15,005 0 0 3.00 0 0 0 5.00 0 0 6.00 216,823 -78,664 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.

HOSPI 1	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provi der CCN: 15-0035 PF			Worksheet S-2 Part I Date/Time Prepa 5/30/2017 10:19		
	1.00		2. 00		3. 00			4. 00	5/30/20	117 10:	19 am
	Hospital and Hospital Health Care Co	mnlex Address	2.00		3.00			4.00			
1.00	Street: 85 EAST US HIGHWAY 6	PO Bo:	х.								1. 00
2. 00	Ci ty: VALPARAI SO	State		Zip Code	e: 46383	Count	y: PORTER				2. 00
		Component		CCN	CBSA	Provi der	ť .	Payme	nt Syst	em (P,	
				Number	Number	Type	Certi fi ed		0, or		
						"		V	XVIII	XIX	
		1.00		2.00	3. 00	4.00	5. 00	6. 00	7. 00	8.00	
	Hospital and Hospital-Based Componer	t Identificati	on:	·							
3.00	Hospi tal	PORTER MEMORIA	۱L	150035	23844	1	07/01/1966	N	Р	0	3.00
		HOSPI TAL									
4.00	Subprovi der - IPF										4.00
5.00	Subprovider - IRF	PORTER REHAB U	JNI T	15T035	23844	5	01/01/2009	N	P	0	5. 00
6.00	Subprovider - (Other)										6. 00
7. 00	Swing Beds - SNF										7. 00
8. 00	Swi ng Beds - NF										8. 00
9.00	Hospi tal -Based SNF										9. 00
10.00	Hospi tal -Based NF										10.00
11. 00	Hospi tal -Based OLTC										11. 00
12.00	· •										12.00
13.00											13.00
	Hospi tal -Based Hospi ce										14.00
15. 00	Hospital -Based Health Clinic - RHC										15.00
	•										16.00
17. 00	Hospital -Based (CMHC) I										17. 00
18.00	Renal Dialysis										18. 00
19.00	Other										19. 00
							From:		To		
20. 00	Cost Reporting Period (mm/dd/yyyy)						1.00		2. C		20. 00
							4	010	12/31/	2010	21. 00
21.00	Inpatient PPS Information						4				21.00
22. 00	Does this facility qualify and is it	currently rec	oiving paym	onte for	di enron	ortionato	Y		N		22. 00
22.00	share hospital adjustment, in accord						'		IV		22.00
	for yes or "N" for no. Is this facil						_				
	amendment hospital?) In column 2, en				2. 100(0)	(2) (110111					
22. 01	Did this hospital receive interim un				s cost re	eporti na	N		N		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)		o o								
22. 02	Is this a newly merged hospital that	requires fina	l uncompensa	ated car	e paymen	ts to be	N		N		22. 02
	determined at cost report settlement						5				
	or "N" for no, for the portion of th		9 1								
	in column 2, "Y" for yes or "N" for	no, for the po	rtion of the	e cost r	eporting	peri od o	n				
	or after October 1.										
22. 03							t N		N		22. 03
	of the OMB standards for delineating										
	in column 1, "Y" for yes or "N" for										
	prior to October 1. Enter in column						€				
	cost reporting period occurring on composital contain at least 100 but no										
	42 CFR 412.105)? Enter in column 3,				ili accord	uance witi	'				
23. 00	Which method is used to determine Me				hal ow?	In column		3	N		23. 00
23.00	1, enter 1 if date of admission, 2 i	,						3	14		23.00
	method of identifying the days in th										
	used in the prior cost reporting per						. [				
			In-State			ut-of		ledi cai	d 01	ther	
			Medi cai d			State		HMO day		i cai d	
			pai d day	s eligi	ble Me	di cai d 📗 🛭	Medi cai d		d	ays	
				unpa	ai d pai	d days e	eligible				
				day	/S		unpai d				
			1.00	2. 0	00	3. 00	4. 00	5. 00	6	. 00	
24. 00	If this provider is an IPPS hospital	, enter the	1, 70	)5	418	14	91	7,	322	181	24. 00
	in-state Medicaid paid days in colum	n 1, in-state									
	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		in								
0= -	column 5, and other Medicaid days in					_	_				
25. 00	· ·			0	9	0	0		117		25. 00
	Medicaid paid days in column 1, the										
	Medicaid eligible unpaid days in col		+-								
	out-of-state Medicaid days in column Medicaid eligible unpaid days in col										
	HMO paid and eligible but unpaid day		۵								
	para and originic but unpuru udy	S 711 COLUMN J.	1	1	1	ı	1		1	ı	

ealth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE			L HOSPITAL Provider CC		eri od:	u of Form CMS-2 Worksheet S-2	
					rom 01/01/2016 o 12/31/2016		
		Y/N	IME	Direct GME	I ME	Direct GME	
1.06 Enter the amount of ACA §5: used for cap relief and/or care or general surgery. (	FTEs that are nonprimary	1.00	2. 00 0. 00	3. 00	4.00	5.00	61. 0
pare or general surgery.	see Thisti deti ons)	Pro	gram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1. 00	2. 00	3.00	4.00	
1. 10 Of the FTEs in line 61.05, specialty, if any, and the for each new program. (see column 1, the program name program code, enter in colunweighted count and enter FTE unweighted count.	number of FTE residents instructions) Enter in , enter in column 2, the umn 3, the IME FTE in column 4, direct GME				0.00		61. 1
1. 20 Of the FTEs in line 61.05, program specialty, if any, residents for each expande instructions) Enter in coluenter in column 2, the program to the IME FTE unweighted 4, direct GME FTE unweighted	and the number of FTE d program. (see umn 1, the program name, gram code, enter in column count and enter in column				0.00	0.00	61. 2
						1.00	
ACA Provisions Affecting t 2.00 Enter the number of FTE re					ind for which	0.00	42.0
your hospital received HRS, 2.01 Enter the number of FTE re	A PCRE funding (see instru sidents that rotated from	ctions) a Teachir	ng Health Cent	er (THC) into			62. C
during in this cost report Teaching Hospitals that CL 3.00 Has your facility trained	aim Residents in Nonprovid	er Setti	ngs		period? Enter	N	63. 0
"Y" for yes or "N" for no	in column 1. If yes, compl	ete lines	s 64-67. (see	instructions) Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
				Nonprovi der Si te	Hospi tal	2))	
Section 5504 of the ACA Ba	se Vear ETE Residents in M	lonnrovi d	er SettingsT	1.00	2.00	3.00	
period that begins on or a 4.00 Enter in column 1, if line in the base year period, the resident FTEs attributable settings. Enter in column resident FTEs that trained of (column 1 divided by (colum	fter July 1, 2009 and befo 63 is yes, or your facili he number of unweighted no to rotations occurring in 2 the number of unweighte in your hospital. Enter i	re June : ty traind n-primary all nonp d non-pri n column	30, 2010. ed residents y care provider mary care 3 the ratio	0.00			64.0
[0. (00. a.m.) . a. 1. a.a. 2) (0	Program Name		gram Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	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 is yes, or your facility trained residents in the by year period, the program nassociated with primary care program in which you traineresidents. Enter in column the program code, enter in column 3, the number of unweighted primary care FTI residents attributable to	ase ame re ed 2,			0. 00	0.00	0. 000000	. 55. O

Health Financial Systems PORTER MEMORIAL HOSI	PLTAL		Li	n Lie	u of Form	CMS-2552-
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Pro	ovider CO		eriod: om 01/01/ o 12/31/		Workshee Part I Date/Tim	ne Prepared
			V		XI X	
95.00 If line 94 is "Y", enter the reduction percentage in the applicable 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N			1. 00 0. 00 N		2. 00 0. 00 N	
applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the applicable Rural Providers	e column	า.	0. 00		0.00	97.
105.00 Does this hospital qualify as a critical access hospital (CAH)? 106.00 of this facility qualifies as a CAH, has it elected the all-inclus	sive met	nod of payment	N N			105. 106.
for outpatient services? (see instructions)  107.00  f this facility qualifies as a CAH, is it eligible for cost reimble training programs? Enter "Y" for yes or "N" for no in column 1. (so yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 ar reimbursed. If yes complete Wkst. D-2, Pt. II.	see inst	ructions) If	N			107.
108.00 Is this a rural hospital qualifying for an exception to the CRNA 1 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N			108.
	si cal . 00	Occupational 2.00	Speec 3.00		Respi ra 4.00	
109.00 olf 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.						109.
					1.00	
110.00 Did this hospital participate in the Rural Community Hospital Demo		on project (410	A Demo)fo	r	N	110.
, , , , , , , , , , , , , , , , , , , ,				1 00	2.00	2.00
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" is yes, enter the method used (A, B, or E only) in column 2. If considering a either "93" percent for short term hospital or "98" percent for psychiatric, rehabilitation and long term hospitals providers) based on the provider of	olumn 2 i long te	is "E", enter i rm care (includ	n column es	N		0 115.
Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for years.	es or "N	' for no.		N		116.
117.00 is this facility legally-required to carry malpractice insurance? no. 118.00 is the malpractice insurance a claims-made or occurrence policy?		,		N 1		117.
claim-made. Enter 2 if the policy is occurrence.					1	
		Premi ums	Losse	5	Insura	rice
		1. 00	2. 00		3.00	
118.01 List amounts of malpractice premiums and paid losses:		740, 179	76	1, 368		0 118.
110.00			1. 00		2.00	
118.02 Are mal practice premiums and paid losses reported in a cost center Administrative and General? If yes, submit supporting schedule li and amounts contained therein.			N			118.
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harml §3121 and applicable amendments? (see instructions) Enter in colum "N" for no. Is this a rural hospital with < 100 beds that qualified Hold Harmless provision in ACA §3121 and applicable amendments? (see the column 2, "Y" for yes or "N" for no.	nn 1, "Y' es for tl	' for yes or ne Outpatient	N		N	[119.     120.
121.00 Did this facility incur and report costs for high cost implantable patients? Enter "Y" for yes or "N" for no.	e devi ces	s charged to	Υ			121.
122.00 Does the cost report contain state health or similar taxes? Enter for no in column 1. If column 1 is "Y", enter in column 2 the Work where these taxes are included.			N			122.
Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" for yes	and "N"	for no. If	N			125.
yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, enter the in column 1 and termination date, if applicable, in column 2.	ne certi	fication date				126.
127.00 If this is a Medicare certified heart transplant center, enter the in column 1 and termination date, if applicable, in column 2.  128.00 If this is a Medicare certified liver transplant center, enter the						127. l
in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter the						129.
column 1 and termination date, if applicable, in column 2.  130.00 If this is a Medicare certified pancreas transplant center, enter date in column 1 and termination date, if applicable, in column 2.		ti fi cati on				130.
131.00 If this is a Medicare certified intestinal transplant center, enter date in column 1 and termination date, if applicable, in column 2.  132.00 If this is a Medicare certified islet transplant center, enter the	er the c					131.
in column 1 and termination date, if applicable, in column 2.	Certiii	cation uate				132.

Health Financial Systems	PORTER MEMORI		N 15 0025	D		u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENIIFICATION DATA	Provi der CC	LN: 15-0035		: 1/01/2016 2/31/2016	Worksheet S- Part I Date/Time Pr 5/30/2017 10	epared:
					1. 00	2.00	
33.00 If this is a Medicare certified of in column 1 and termination date,			cation date		1. 00	2.00	133. 00
34.00 If this is an organ procurement or and termination date, if applicable All Providers		he OPO number i	n column 1				134. 00
40.00 Are there any related organization chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	'N" for no in column 1. If	yes, and home	office cost	s	Υ	449008	140. 00
1.00 If this facility is part of a chai	2. (		142 +		3. 00	-6 +1	
home office and enter the home off				name and	u address	or the	
41.00 Name: CHS/COMMUNITY HEALTH SYSTEM INC	SE	SCONSIN PHYSIC ERVICES	IAN Contrac	tor's Nu	ımber: 5228	0	141. 0
42.00 Street: 4000 MERIDIAN BLVD 43.00 City: FRANKLIN	PO Box: State: TM	N.	Zip Cod	۵٠	3706	.7	142. 0 143. 0
43. 00 CITY. TRANKLIN	State.	V	Zi p cou	С.	3700		143.0
						1.00	1
44.00 Are provider based physicians' cos	sts included in Worksheet	A'?				Y	144. 0
					1. 00	2. 00	
45.00 If costs for renal services are clinpatient services only? Enter "Y" no, does the dialysis facility incomperiod? Enter "Y" for yes or "N"	' for yes or "N" for no in clude Medicare utilization	column 1. If o	column 1 is		Y		145. 0
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	column 1. (See CMS Pub.			f	N		146. C
						1. 00	
47.00 Was there a change in the statisti						N	147. 0
48.00 Was there a change in the order of 49.00 Was there a change to the simplifi				r no		N N	148. 0 149. 0
47. 00 Mas there a change to the simplifit	ed cost frinaring metriod: E	Part A	Part B		itle V	Title XIX	147.0
		1.00	2.00		3. 00	4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or '							
55. 00 Hospi tal		N	N		N	N	155. 0
56.00 Subprovider - IPF		N	N		N	N	156. 0
57. 00 Subprovi der  -   I RF 58. 00 SUBPROVI DER		N	N		N	N	157. C
59. 00 S0BPROVI DER 59. 00 SNF		N	N		N	N	159. 0
60.00 HOME HEALTH AGENCY		N	N N		N	N N	160. 0
61.00 CMHC			N		N	N	161.0
Mul +i compu-						1.00	
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has on	e or more campu	uses in diff	erent CE	BSAs?	N	165. 0
	Name	County		ip Code	CBSA	FTE/Campus	
66.00  f  ine 165 is yes, for each	0	1. 00	2. 00	3. 00	4. 00	5. 00	00144 0
campus enter the name in column O, county in column 1, state in						0. 0	00 166. 0
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							
						1.00	
Health Information Technology (HI				ent Act			<b>.</b>
67.00 s this provider a meaningful user 68.00 f this provider is a CAH (line 10 reasonable cost incurred for the F	05 is "Y") and is a meanin	gful user (line		), enter	the	Y	167. C 0168. C
68.01  f this provider is a CAH and is reception under §413.70(a)(6)(ii)?	not a meaningful user, doe	s this provider			dshi p		168. 0
69.00 If this provider is a meaningful utransition factor. (see instruction	user (line 167 is "Y") and				enter the	0. 2	25 169. 0

Health Financial Systems	PORTER MEMORIAL	HOSPI TAL	In Lie	In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provider CCN: 15-0035	Peri od:	Worksheet S-2	)		
			From 01/01/2016				
			To 12/31/2016				
				5/30/2017 10:	<u> 19 am </u>		
	Begi nni ng	Endi ng					
			1. 00	2.00			
170.00 Enter in columns 1 and 2 the EHR begi period respectively (mm/dd/yyyy)	04/01/2016	06/29/2016	170. 00				
			1. 00	2.00			
171.00 If line 167 is "Y", does this provide	er have any days for indiv	/iduals enrolled in	N	(	171. 00		
section 1876 Medicare cost plans repo							
"Y" for yes and "N" for no in column	1. If column 1 is yes, er	nter the number of section	on				
1876 Medicare days in column 2. (see	instructions)						

OSPI T	Financial Systems PORTER MEMORIA AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0035	Peri od:	u of Form CMS Worksheet S-	
				From 01/01/2016 To 12/31/2016	Part II Date/Time Pr 5/30/2017 10	
		<u>'</u>		Y/N	Date	
		6 11 110		1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	for all NO re	sponses. Ente	er all dates in t	ne	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in co			N		1. (
	reporting period: IT yes, enter the date of the change in ec	7 41111 2. (300	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
. 00	Has the provider terminated participation in the Medicare Pryes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.		N			2.
. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	fices, drug er or its the board	Y			3. (
	Teratronships: (see Thatractrons)		Y/N	Type	Date	
			1.00	2.00	3. 00	
. 00	Financial Data and Reports  Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" for		N			4.0
	or "R" for Reviewed. Submit complete copy or enter date avaicolumn 3. (see instructions) If no, see instructions.	lable in				
. 00	Are the cost report total expenses and total revenues differ those on the filed financial statements? If yes, submit reco		N			5.
	those on the fired financial Statements: 11 yes, Submit Feet	merration.		Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities					
	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?		ie provider is		Y	6.
. 00	Are costs claimed for Allied Health Programs? If "Y" see ins Were nursing school and/or allied health programs approved a cost reporting period? If yes, see instructions.		I during the	Y N		7. ( 8. (
. 00	Are costs claimed for Interns and Residents in an approved g		al education	N		9. (
0. 00	program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated or cost reporting period? If yes, see instructions.		he current	N		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 App	proved	N	V//N	11.
					Y/N 1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.			ost reporting	Y N	12.
4. 00	If line 12 is yes, were patient deductibles and/or co-paymer Bed Complement	nts waived? If	yes, see ins	structi ons.	N	14.
5. 00	Did total beds available change from the prior cost reporting	<del></del>			Y	15.
		Y/N	t A Date	Y/N Par	Date	
		1. 00	2.00	3. 00	4. 00	
b. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Υ	04/17/2017		04/17/2017	16.
	date of the PS&R Report used in columns 2 and 4 .(see instructions)					
7. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions)	N		N		17.
8. 00	in columns 2 and 4. (see instructions)  If line 16 or 17 is yes, were adjustments made to PS&R  Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18.
	cost report? If yes, see instructions.					

Heal th	Financial Systems PORTER MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-	-2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0035	Peri od: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Pre 5/30/2017 10:	epared:		
		Descri	ipti on	Y/N	Y/N			
			)	1. 00	3. 00			
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00		
		Y/N	Date 2.00	Y/N 3. 00	Date			
21. 00	Was the cost report prepared only using the provider's	1. 00 N	2.00	3. 00 N	4. 00	21. 00		
	records? If yes, see instructions.							
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	PT CHILDRENS H	OSPI TALS)					
22. 00	Have assets been relifed for Medicare purposes? If yes, see	instructions			N	22. 00		
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		als made dur	ing the cost	N	23. 00		
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during	this cost re	porting period?	N	24. 00		
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	'If yes, see	N	25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	ne cost reporti	ng period? I	f yes, see	N	26. 00		
27. 00	Has the provider's capitalization policy changed during the copy.	cost reportin	g period? If	yes, submit	N	27. 00		
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit en	ntered into dur	ing the cost	reporti ng	N	28. 00		
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		bt Service R	eserve Fund)	N	29. 00		
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu	uctions Irity with new	debt? If yes	, see	N	30. 00		
31. 00	instructions. Has debt been recalled before scheduled maturity without is instructions.	suance of new	debt? If yes	, see	N	31. 00		
32. 00	<u>Purchased Services</u> Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		d through co	ntractual	Υ	32. 00		
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		g to competi	tive bidding? If	Υ	33. 00		
	Provi der-Based Physi ci ans							
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with	provi der-ba	sed physi ci ans?	Υ	34. 00		
35. 00	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		its with the	provi der-based	Υ	35. 00		
				Y/N	Date			
				1. 00	2. 00			
04 00	Home Office Costs					1 0, 05		
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	repared by the	home office?	Y		36. 00 37. 00		
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off			N	12/31/2015	38. 00		
39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions.			i, N		39. 00		
40. 00	see instructions.  If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00		
	1.00 2							
	Cost Report Preparer Contact Information							
41. 00	held by the cost report preparer in columns 1, 2, and 3,	VI CTORI A		ROMANKO		41.00		
42. 00	respectively. Enter the employer/company name of the cost report preparer.	COMMUNITY HEAL	TH SYSTEMS			42. 00		
43. 00		615-925-4333		VI CTORI A_ROMANI	KO@CHS. NET	43. 00		

Heal th	Financial Systems	PORTER MEMORIA	L HOSPITAL		In Li	eu of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	STI ONNAI RE	Provi der C	CN: 15-0035	Period: From 01/01/201 To 12/31/201	Worksheet S-2 6 Part II 6 Date/Time Pre 5/30/2017 10:	pared:
			3.	00			
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the title, held by the cost report preparer in columns 1 respectively.		REVENUE MANAGE	R			41. 00
42. 00	Enter the employer/company name of the cost repreparer.	report					42. 00
43. 00	Enter the telephone number and email address report preparer in columns 1 and 2, respective						43. 00

| Peri od: | Worksheet S-3 | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: 
 Heal th Financial
 Systems
 PORTER

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

				T	o 12/31/2016	Date/Time Pre	
						5/30/2017 10: I/P Days / 0/P	19 alli
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	Component	Line Number	No. of beas	Avai I abl e	CAIT HOURS	TI LIE V	
		1.00	2.00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	19:			0.00	1. 00
	8 exclude Swing Bed, Observation Bed and	00.00		, , , , , ,	0.00	· ·	
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7.00	Total Adults and Peds. (exclude observation		19:	2 70, 272	0.00	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31. 00	32	2 11, 712	0.00	0	8. 00
8.01	NEONATAL INTENSIVE CARE UNIT	31. 01	1.	4 5, 124	0.00	0	8. 01
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43. 00				0	13. 00
14. 00	Total (see instructions)		238	87, 108	0.00	0	14.00
15. 00	CAH visits					0	15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF	41. 00	1.	4 5, 124		0	
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE	20.00					24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	00.00				0	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	
27. 00	Total (sum of lines 14-26)		25:	4		0	27. 00
28. 00	Observation Bed Days					0	28. 00 29. 00
29. 00	Ambulance Trips						30.00
30.00	Employee discount days (see instruction) Employee discount days - IRF						
31.00							31.00
32.00	Labor & delivery days (see instructions)		(	0			32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33. 00	LTCH non-covered days						33. 00
55.50	2. 3 33 voi ou days			1	1		1 55.55

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3
From 01/01/2016	Part
To 12/31/2016	Date/Time Prepared:
5/30/2017	10: 19 am

						5/30/2017 10:	19 am
		I/P Days	o/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	23, 301	981	46, 541			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	6, 251	7, 489				2.00
3. 00	HMO IPF Subprovider	0, 231	7, 409				3.00
4. 00	HMO IRF Subprovider	o	117				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	o o		C			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	Ĭ	o	C			6. 00
7. 00	Total Adults and Peds. (exclude observation	23, 301	981	46, 541			7. 00
	beds) (see instructions)	,					
8.00	INTENSIVE CARE UNIT	3, 650	579	6, 917			8. 00
8.01	NEONATAL INTENSIVE CARE UNIT	0	0	2, 388			8. 01
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY		1, 001	1, 001			13. 00
14.00	Total (see instructions)	26, 951	2, 561	56, 847	0.00	1, 494. 78	1
15. 00	CAH visits	U	0	C			15. 00
16. 00 17. 00	SUBPROVIDER - I PF	1 710		2 407	0.00	13. 41	16.00
18. 00	SUBPROVI DER - I RF SUBPROVI DER	1, 719	9	2, 607	0.00	13.41	17. 00 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)	o	o	C			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0.00		
27. 00	Total (sum of lines 14-26)				0.00	1, 508. 19	
28. 00	Observation Bed Days	_	0	4, 018			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			O			30.00
31.00	Employee discount days - IRF		101	C			31.00
32. 00	Labor & delivery days (see instructions)	0	181	544			32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)			U			32. 01
33 00	LTCH non-covered days	o	ŀ				33. 00
33. 00	121011 Horr covered days	١	ı		l .	I	1 55.00

| Period: | Worksheet S-3 | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: 
 Heal th Financial
 Systems
 PORTER

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

				To	12/31/2016	Date/Time Pre 5/30/2017 10:	
		Full Time		Di scha	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	4, 976	1, 538	12, 366	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)			_	_		
2.00	HMO and other (see instructions)			0	0		2. 00
3.00	HMO I PF Subprovi der				0		3. 00
4.00	HMO I RF Subprovi der				O		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
0.00	beds) (see instructions)						0.00
8.00	INTENSIVE CARE UNIT						8. 00
8. 01	NEONATAL INTENSIVE CARE UNIT						8. 01
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	0.00	0	4 07/	1 500	10.0//	13.00
14.00	Total (see instructions)	0. 00	0	4, 976	1, 538	12, 366	14.00
15. 00	CAH visits			•			15. 00
16. 00 17. 00	SUBPROVI DER - I PF   SUBPROVI DER - I RF	0. 00	0	142	15	210	16. 00 17. 00
18. 00	SUBPROVI DER	0.00	U	142	13	210	18.00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
21.00	HOME HEALTH AGENCY						21.00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPICE						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	0.00					28. 00
29. 00	Ambulance Trips						29.00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see Fristraction)						31. 00
32. 00	Labor & delivery days (see instructions)						32.00
32. 00	Total ancillary labor & delivery room						32. 00
32.01	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days						33. 00
55.50	1=:::::::::::::::::::::::::::::::::::::	ı J		1	J		30.00

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

					10	12/31/2016	Date/lime Pre 5/30/2017 10:	
		Worksheet A Line Number		Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)		Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							-
1.00	Total salaries (see	200. 00	90, 107, 045	0	90, 107, 045	3, 137, 032. 00	28. 72	1.00
2.00	instructions) Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2.00
3. 00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3. 00
4.00	Physician-Part A - Administrative		257, 076	0	257, 076	1, 664. 00	154. 49	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0	0	0	0. 00 0. 00		
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0. 00	0. 00	6. 00
7. 00	services Interns & residents (in an	21. 00	0	0	0	0. 00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved programs)		0	0	0	0.00	0. 00	7. 01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 1, 014, 325	0 351, 313	0 1, 365, 638	0. 00 39, 984. 00		
	instructions) OTHER WAGES & RELATED COSTS							-
11. 00	Contract Labor: Direct Patient Care		2, 697, 519	0	2, 697, 519	27, 545. 00	97. 93	11. 00
12. 00	Contract labor: Top level management and other management and administrative		0	0	0	0.00	0. 00	12.00
13. 00	services Contract Labor: Physician-Part A - Administrative		678, 303	0	678, 303	6, 797. 00	99. 79	13. 00
14. 00	Home office and/or related orgainzation salaries and wage-related costs		0	О	О	0.00	0. 00	14. 00
14. 01 14. 02	Home office salaries Related organization salaries		8, 349, 858 0	0	8, 349, 858 0	243, 341. 00 0. 00		14. 01 14. 02
15. 00	Home office: Physician Part A - Administrative		0	Ō	0	0. 00		
16. 00	Home office and Contract Physicians Part A - Teaching WAGE-RELATED COSTS		0	0	0	0.00	0. 00	16. 00
17. 00	Wage-related costs (core) (see instructions)		24, 414, 158	0	24, 414, 158			17. 00
18. 00	Wage-related costs (other) (see instructions)		0		0			18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		343, 558 0	0	343, 558 0			19. 00 20. 00
21. 00	Non-physician anesthetist Part		0	0	0			21. 00
22. 00	Physician Part A - Administrative		23, 379	0	23, 379			22. 00
22. 01	Physician Part A - Teaching		0		0			22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		0	·	0			23. 00 24. 00
25. 00	Interns & residents (in an approved program)		0	0	0			25. 00
25. 50 25. 51	Home office wage-related Related orgainzation		0	0	0			25. 50 25. 51
25. 52	wage-related Home office: Physician Part A		0	0	О			25. 52
25. 53	- Administrative - wage-related Home office & Contract		0	0				25. 53
20.00	Physicians Part A - Teaching - wage-related OVERHEAD COSTS - DIRECT SALARIE							25.53
26. 00	Employee Benefits Department	4. 00	321, 550	0	321, 550	8, 556. 00		26. 00
27. 00	Administrative & General	5. 00	8, 350, 826	-598, 584	7, 752, 242	320, 096. 00	24. 22	27. 00

							5/30/2017 10:	19 am_
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2. 00	3.00	4.00	5. 00	6. 00	
28. 00	Administrative & General under		980, 894	. 0	980, 894	42, 837. 00	22. 90	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	C	0	C	0.00	0. 00	29. 00
30.00	Operation of Plant	7. 00	1, 642, 527	0	1, 642, 527	58, 426. 00	28. 11	30. 00
31.00	Laundry & Linen Service	8. 00	128, 279	0	128, 279	8, 945. 00	14. 34	31.00
32.00	Housekeepi ng	9. 00	1, 931, 238	0	1, 931, 238	163, 714. 00	11. 80	32.00
33.00	Housekeeping under contract		370, 906	0	370, 906	6, 148. 00	60. 33	33. 00
	(see instructions)							
34.00	Di etary	10. 00	2, 020, 940	-1, 141, 703	879, 237	61, 466. 00	14. 30	34.00
35.00	Di etary under contract (see		440, 471	0	440, 471	11, 544. 00	38. 16	35. 00
	instructions)							
36. 00	Cafeteri a	11. 00	C	1, 141, 703	1, 141, 703	79, 815. 00	14. 30	36. 00
37.00	Maintenance of Personnel	12. 00	C	0	C	0.00	0.00	37. 00
38. 00	Nursing Administration	13. 00	3, 549, 721	247, 271	3, 796, 992	95, 368. 00	39. 81	38. 00
39. 00	Central Services and Supply	14. 00	972, 188	0	972, 188	64, 017. 00	15. 19	39. 00
40.00	Pharmacy	15. 00	2, 704, 036	0	2, 704, 036	58, 235. 00	46. 43	40.00
41.00	Medical Records & Medical	16. 00	973, 294	. 0	973, 294	44, 223. 00	22. 01	41.00
	Records Library							
42.00	Social Service	17. 00	C	0	0	0.00	0.00	42.00
43.00	Other General Service	18. 00	C	0	0	0.00	0.00	43.00

					''	0 12/31/2010	5/30/2017 10:	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	$(col.2 \pm col.$	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		91, 899, 316	0	91, 899, 316	3, 197, 561. 00	28. 74	1. 00
	instructions)							
2.00	Excluded area salaries (see		1, 014, 325	351, 313	1, 365, 638	39, 984. 00	34. 15	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		90, 884, 991	-351, 313	90, 533, 678	3, 157, 577. 00	28. 67	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		11, 725, 680	0	11, 725, 680	277, 683. 00	42. 23	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		24, 437, 537	0	24, 437, 537	0.00	26. 99	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		127, 048, 208	-351, 313	126, 696, 895	3, 435, 260. 00	36. 88	6. 00
7.00	Total overhead cost (see		24, 386, 870	-351, 313	24, 035, 557	1, 023, 390. 00	23. 49	7. 00
	instructions)							

Health Financial Systems	PORTER MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS		From 01/01/2016	Worksheet S-3 Part IV Date/Time Prepared

PART IV - WAGE RELATED COSTS   1.00		To 12/31/2016	Date/Time Pre 5/30/2017 10:	
PART IV - WAGE RELATED COSTS			1'	
PART I V - WAGE RELATED COSTS   Part A - Core   List   RETIREMENT COST   401K Employer Contributions   1,558,208   1.00   2.00   Tax Sheltered Annui ty (TSA) Employer Contribution   0.2.00   2.00   Tax Sheltered Annui ty (TSA) Employer Contribution   0.2.00   3.00   Nonquali fied Defined Benefit Plan Cost (see instructions)   0.3.00   4.00   0.01   fied Defined Benefit Plan Cost (see instructions)   0.4.00   0			Reported	
Part A - Core List   RETIREMENT COST			1. 00	
RETIREMENT COST				
1.00				
2.00		RETI REMENT COST		
3.00   Nonqualified Defined Benefit Plan Cost (see instructions)   0   3.00   0.00	1.00		1, 558, 208	
A. 00	2.00		0	
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)   401K/TSA Pl an Administration fees   0   5.00   6.00   Legal/Accounting/Management fees-Pension Pl an   0   6.00   Employee Managed Care Program Administration fees   0   7.00   Employee Managed Care Program Administration fees   0   8.01   Employee Managed Care Program Administrator   0   8.01   Employee Managed Care Program Administration   0   9.00   Employee Managed Care Program Administration   0   9.00   Employee Managed Care Program Administration   0   9.00   Employee Managed Care Program Administration   0   8.01   Employee Managed Care Program Administr			0	
5.00	4.00		0	4. 00
Column   C				
The color of the				
HEALTH AND INSURANCE COST			_	
Heal th Insurance (Purchased or Self Funded)   13,873,168   8.00   8.01   Heal th Insurance (Self Funded without a Third Party Administrator)   0.8.02   8.03   Heal th Insurance (Purchased)   0.8.02   8.03   Heal th Insurance (Purchased)   0.8.03   0.00   Prescription Drug Plan   0.9.00   0.00	7.00		0	7. 00
Heal th Insurance (Self Funded without a Third Party Administrator)   8. 01				
Heal th Insurance (Self Funded with a Third Party Administrator)   0   8.02     8.03   Heal th Insurance (Purchased)   0   8.03     9.00   Prescription Drug Plan   0   9.00     10.00   Dental, Hearing and Vision Plan   332,817     10.00   11.00   Life Insurance (If employee is owner or beneficiary)   63,476     11.00   Accident Insurance (If employee is owner or beneficiary)   16.7   12.00     12.00   Accident Insurance (If employee is owner or beneficiary)   289,428     13.00   14.00   Long-Term Care Insurance (If employee is owner or beneficiary)   0   14.00     15.00   Workers' Compensation Insurance   1,964,004     15.00   Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.   0   16.00     17.00   Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.   0   16.00     16.00   Non cumulative portion   1,203,282   18.00     17.00   Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.   0   16.00     18.00   Medicare Taxes - Employers Portion Only   1,203,282   18.00     19.00   Unemployment Insurance   0   19.00     20.00   State or Federal Unemployment Taxes   188,909     20.00   OTHER   20.00     21.00   Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see   0   21.00   10.00   22.00   23.00   10.00   24.781,096   24.00   24.781,096   24.00   24.00   24.781,096   24.00   24.00   24.00   24.00   24.781,096   24.00	8.00		13, 873, 168	
8.03   Heal th Insurance (Purchased)   0   8.03   9.00   Prescription Drug Plan   0   9.00   10.00   Dental, Hearing and Vision Plan   332,817   10.00   11.00   Life Insurance (If employee is owner or beneficiary)   63,476   11.00   12.00   Accident Insurance (If employee is owner or beneficiary)   167   12.00   12.00   Accident Insurance (If employee is owner or beneficiary)   289,428   13.00   14.00   Long-Term Care Insurance (If employee is owner or beneficiary)   289,428   13.00   15.00   Workers' Compensation Insurance (If employee is owner or beneficiary)   1,964,004   15.00   16.00   Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.   16.00   Non cumulative portion)   16.00   Non cumulative portion   17.00   16.00   16.00   Non cumulative portion   17.00   16.00   Non cumulative portion	8. 01		0	
9.00         Prescription Drug Plan         0         9.00           10.00         Dental, Hearing and Vision Plan         332,817         10.00           11.00         Life Insurance (If employee is owner or beneficiary)         63,476         11.00           12.00         Accident Insurance (If employee is owner or beneficiary)         289,428         13.00           14.00         Disability Insurance (If employee is owner or beneficiary)         289,428         13.00           15.00         Workers' Compensation Insurance         1,964,004         15.00           16.00         Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.         0         16.00           17.00         Recirca Employers Portion Only         5,145,066         17.00           18.00         Medicare Taxes - Employers Portion Only         1,203,282         18.00           19.00         State or Federal Unemployment Taxes         0         19.00           20.00         Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see         0         21.00           22.00         Day Care Cost and Allowances         0         22.00           23.00         Tuit to ne Reimbursement         24,781,096         24.00           Part B - Other than Core Related Cost			0	
10.00   Dental, Hearing and Vision Plan   332, 817   10.00     11.00   Life Insurance (If employee is owner or beneficiary)   63, 476   11.00     12.00   Accident Insurance (If employee is owner or beneficiary)   167   12.00     13.00   Disability Insurance (If employee is owner or beneficiary)   289, 428   13.00     14.00   Long-Term Care Insurance (If employee is owner or beneficiary)   0   14.00     15.00   Workers' Compensation Insurance   1,964,004   15.00     16.00   Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.   0     Non cumulative portion   15.00     17.00   FI CA-Employers Portion Only   5,145,066   17.00     18.00   Medicare Taxes - Employers Portion Only   1,203,282   18.00     19.00   Unemployment Insurance   0   19.00     20.00   State or Federal Unemployment Taxes   188,909     OTHER   21.00   Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see   0   21.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.	8. 03		0	
11.00			_	
12.00	10.00		332, 817	10.00
13. 00 Disability Insurance (If employee is owner or beneficiary)  14. 00 Long-Term Care Insurance (If employee is owner or beneficiary)  15. 00 'Workers' Compensation Insurance  16. 00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)  17. 00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)  17. 00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)  18. 00 Non cumulative portion Only  19. 00 Unemployers Portion Only  19. 00 Unemployment Insurance  20. 00 State or Federal Unemployment Taxes  21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22. 00 Day Care Cost and Allowances  23. 00 Tuition Reimbursement  162, 571 23. 00  24, 781, 096 Part B - Other than Core Related Cost			63, 476	11. 00
14.00 Long-Term Care Insurance (If employee is owner or beneficiary)  15.00 'Workers' Compensation Insurance Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)  TAXES  17.00 FICA-Employers Portion Only Medicare Taxes - Employers Portion Only Unemployment Insurance State or Federal Unemployment Taxes  17.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see Instructions))  22.00 Day Care Cost and Allowances Tuition Reimbursement Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	12. 00			
15.00 'Workers' Compensation Insurance				
16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.  Non cumulative portion)  TAXES  17.00 FI CA-Employers Portion Only  Medicare Taxes - Employers Portion Only  Unemployment Insurance  State or Federal Unemployment Taxes  188,909  OTHER  21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  Day Care Cost and Allowances  Tuition Reimbursement  Total Wage Related cost (Sum of Lines 1 -23)  Part B - Other than Core Related Cost				
Non cumulative portion   TAXES   To Care Taxes - Employers Portion Only   To Care Taxes - Employers   To Care Taxes - To Care			1, 964, 004	
TAXES	16. 00		0	16. 00
17. 00				
18.00       Medicare Taxes - Employers Portion Only       1, 203, 282       18.00         19.00       Unemployment Insurance       0 19.00         20.00       State or Federal Unemployment Taxes       188,909       20.00         OTHER         21.00       Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))       0 21.00         22.00       Day Care Cost and Allowances       0 22.00         23.00       Tuit ion Reimbursement       162,571       23.00         24.00       Total Wage Related cost (Sum of Lines 1 -23)       24,781,096       24.00         Part B - Other than Core Related Cost				
19.00   Unemployment Insurance   0   19.00   20.00   State or Federal Unemployment Taxes   188,909   20.00   OTHER				
20.00 State or Federal Unemployment Taxes  THER  21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  Day Care Cost and Allowances  Tuition Reimbursement  162,571 23.00  Total Wage Related cost (Sum of Lines 1 -23)  Part B - Other than Core Related Cost				
OTHER  21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22.00 Day Care Cost and Allowances  33.00 Tuition Reimbursement  24.00 Total Wage Related cost (Sum of Lines 1 -23)  Part B - Other than Core Related Cost				
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22.00 Day Care Cost and Allowances Tuition Reimbursement Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost  21.00 22.00 23.00 24.00 24.00	20. 00		188, 909	20. 00
instructions))  22.00 Day Care Cost and Allowances  Tuition Reimbursement  24.00 Part B - Other than Core Related Cost  instructions))  22.00 22.00  23.00 162,571 23.00  24.781,096 24.00				
22. 00       Day Care Cost and Allowances       0       22. 00         23. 00       Tuition Reimbursement       162, 571       23. 00         24. 00       Total Wage Related cost (Sum of lines 1 -23)       24, 781, 096         Part B - Other than Core Related Cost       24, 781, 096       24, 781, 096	21. 00		0	21. 00
23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 -23) 24.00 Part B - Other than Core Related Cost 23.00 24.781,096				
24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 24,781,096 24.00			_	
Part B - Other than Core Related Cost				
	24. 00		24, 781, 096	24. 00
25.00   OTHER WAGE RELATED COSTS (SPECIFY)   0   25.00				
	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		eriod: rom 01/01/2016 o 12/31/2016	Worksheet S-3 Part V Date/Time Prep 5/30/2017 10:	pared:
Cost Center Description		Contract Labor 1,00	Benefit Cost 2.00	
PART V - Contract Labor and Benefit Cost		1. 00	2.00	

			3/30/2017 10.	19 alli
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	2, 697, 519	24, 781, 096	1.00
2.00	Hospi tal	2, 697, 519	24, 781, 096	2.00
3.00	Subprovi der - IPF			3.00
4.00	Subprovi der - I RF	0	0	4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF			8.00
9.00	Hospi tal -Based NF			9.00
10.00	Hospi tal -Based OLTC			10.00
11.00	Hospi tal -Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	0ther	0	0	18. 00

Heal th	Financial Systems	PORTER MEMORIAL	ΗΛΟΣΡΙ ΤΔΙ		In lie	u of Form CMS-2	2552_10		
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA Provider CCN: 15-0035 Period: Worksheet									
1103111	AE GROOM ENSATED AND THUTGENT CARE DATA		Trovider e	ON. 15 0055	From 01/01/2016	WOLKSHEET 2 IV	O		
					To 12/31/2016	Date/Time Pre	pared:		
						5/30/2017 10:	19 am		
						1. 00			
	Uncompensated and indigent care cost comput								
1.00	Cost to charge ratio (Worksheet C, Part I I	ine 202 column 3 d	ivided by li	ne 202 colum	n 8)	0. 130253	1. 00		
	Medicaid (see instructions for each line)								
2.00	Net revenue from Medicaid					22, 606, 657	2. 00		
3.00	Did you receive DSH or supplemental payment					Y	3. 00		
4.00	If line 3 is "yes", does line 2 include all			from Medicai	d?	Υ	4. 00		
5.00	If line 4 is "no", then enter DSH or supple	emental payments fro	om Medicaid			0	5. 00		
6.00	Medicaid charges					215, 532, 846	6. 00		
7.00	Medicaid cost (line 1 times line 6)					28, 073, 800	7. 00		
8.00	Difference between net revenue and costs for	or Medicaid program	(line 7 min	us sum of li	nes 2 and 5; if	5, 467, 143	8. 00		
	< zero then enter zero)								
	Children's Health Insurance Program (CHIP)	(see instructions t	for each lin	e)					
9. 00	Net revenue from stand-alone CHIP					731	9. 00		
10. 00	Stand-alone CHIP charges					10, 240			
11. 00	Stand-alone CHIP cost (line 1 times line 10					1, 334	l		
12. 00	Difference between net revenue and costs for	or stand-alone CHIP	(line 11 mi	nus line 9;	if < zero then	603	12. 00		
	enter zero)								
	Other state or local government indigent ca					_			
13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)				0	13. 00				
14. 00	Charges for patients covered under state or	local indigent ca	re program (	Not included	in lines 6 or	0	14. 00		
45.00	10)	(1) 4 11 11	4.4				45.00		
15. 00	State or local indigent care program cost (			<i>(</i> 1.1	45 ' ''	0	15.00		
16. 00	Difference between net revenue and costs for	or state or Local II	ndigent care	program (II	ne 15 minus line	0	16. 00		
	13; if < zero then enter zero) Uncompensated care (see instructions for ea	oh Lino)							
17 00	Private grants, donations, or endowment inc		funding char	ity caro		0	17. 00		
18.00	Government grants, appropriations or transf					0	18.00		
19. 00	Total unreimbursed cost for Medicaid , CHIF				c (cum of lines	5, 467, 746			
19.00	8, 12 and 16)	and State and rock	ai indigent	care program	s (Suiii Oi TTTIES	3, 467, 746	19.00		
	0, 12 and 10)			Uni nsured	Insured	Total (col. 1			
				patients	pati ents	+ col . 2)			
				1.00	2. 00	3. 00			
20. 00	Charity care charges for the entire facilit	ty (see instruction	5)	3, 322, 4			20. 00		
21. 00	Cost of patients approved for charity care			432, 7			l .		
22. 00	Partial payment by patients approved for ch		20)	5, 2	•		22. 00		
	Cost of charity care (line 21 minus line 22			427.5	•				
20.00	joset of sharrey sare (This 21 million This 22	-/		12770	0.1 1007,07	001,020	20.00		
						1. 00			
24. 00	Does the amount in line 20 column 2 include	charges for patie	nt davs bevo	nd a Length	of stav limit	N	24. 00		
	imposed on patients covered by Medicaid or			3					
25.00	If line 24 is "yes," charges for patient of			ogram's Leng	th of stay limit	0	25. 00		
26.00	Total bad debt expense for the entire hospi	,		0 0	•	23, 931, 325	26. 00		
27. 00	Medicare bad debts for the entire hospital		,			496, 000	1		
28. 00	Non-Medicare and non-reimbursable Medicare			ıs line 27)		23, 435, 325			
29. 00	Cost of non-Medicare and non-reimbursable M				e 28)	3, 052, 521			
30. 00	Cost of uncompensated care (line 23 column				,	3, 637, 044	•		
	Total unreimbursed and uncompensated care of	'	line 30)			9, 104, 790	l .		
		, , , , , , , , , , , , , , , , , , , ,	/						

	Financial Systems	PORTER MEMORIA				u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	OF EXPENSES	Provi der CO		Period: From 01/01/2016	Worksheet A	
				Τ	o 12/31/2016	Date/Time Pre 5/30/2017 10:	
	Cost Center Description	Sal ari es	Other		Reclassificati	Recl assi fi ed	
				+ col . 2)	ons (See A-6)	Trial Balance (col. 3 +-	
						col. 4)	
	CENEDAL CEDIU CE COCT CENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS-BLDG & FIXT		4, 611, 498	4, 611, 498	1, 629, 253	6, 240, 751	1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		12, 607, 893			15, 123, 489	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	321, 550	518, 788			16, 779, 743	
5.00	00500 ADMINISTRATIVE & GENERAL	8, 350, 826	68, 512, 249	76, 863, 075		57, 089, 353	
7.00	00700 OPERATION OF PLANT	1, 642, 527	6, 998, 596				
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	128, 279 1, 931, 238	1, 262, 414 1, 462, 319			1, 390, 693 3, 393, 557	
10. 00	01000 DI ETARY	2, 020, 940	1, 098, 636	3, 119, 576			
11. 00	01100 CAFETERI A	0	0	0, 111, 21		1, 758, 227	
13. 00	01300 NURSING ADMINISTRATION	3, 549, 721	988, 698				
14.00	01400 CENTRAL SERVICES & SUPPLY	972, 188	26, 973, 335			1, 564, 326	
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	2, 704, 036	18, 371, 473			3, 145, 545	
23. 00	02300 ALLI ED HEALTH	973, 294 0	2, 064, 783 0	3, 038, 077		3, 038, 077 44, 698	1
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			, 11, 070	11,070	20.00
30.00	03000 ADULTS & PEDIATRICS	16, 696, 856	4, 021, 869				
31. 00	03100 I NTENSI VE CARE UNI T	5, 739, 777	3, 280, 580				
31. 01	03101 NEONATAL INTENSIVE CARE UNIT	1, 812, 633	528, 301	2, 340, 934		2, 340, 934	
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	961, 252	342, 536 70, 089				
43.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	70,007	70,003	7 373,003	443, 132	43.00
50.00	05000 OPERATI NG ROOM	6, 675, 162	6, 050, 496	12, 725, 658	3, 111, 908	15, 837, 566	50.00
51. 00	05100 RECOVERY ROOM	2, 305, 864	376, 683			0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 661, 529	408, 393			2, 448, 044	1
53. 00 54. 00	05300 ANESTHESI OLOGY	0 5, 155, 538	2, 064, 833			2, 064, 833	
54. 00	05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND	474, 026	1, 775, 942 99, 092	6, 931, 480 573, 118		10, 149, 374 0	1
56. 00	05600 RADI OI SOTOPE	432, 640	893, 052			Ö	1
57. 00	05700 CT SCAN	607, 640	251, 195	858, 835		0	57. 00
58. 00	05800 MRI	242, 153	219, 296				
60.00	06000 LABORATORY	5, 510, 583	6, 840, 215				
65. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 790, 610	507, 864			2, 146, 603	
66. 00 67. 00	06700 OCCUPATI ONAL THERAPY	1, 620, 097 583, 189	163, 329 44, 521	1, 783, 42 <i>6</i> 627, 710		1, 786, 993 618, 435	
68. 00	06800 SPEECH PATHOLOGY	360, 632	25, 050			385, 682	
69. 00	06900 ELECTROCARDI OLOGY	4, 771, 968	2, 676, 183				
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	2, 341, 475	2, 341, 475	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	23, 255, 069		
73.00	07300 DRUGS CHARGED TO PATIENTS	110, 675	367, 824			18, 120, 860	
74. 00 76. 00	07400 RENAL DI ALYSI S 03950 ANCI LLARY	0	545, 915 0	545, 915 (		545, 915 0	1
	03610 SLEEP LAB	331, 849	52, 466				76. 00
	03951 WOUND CARE	711, 615	808, 266				1
	OUTPATIENT SERVICE COST CENTERS						
90.00		0 002 005	0	12 501 125	0	0	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	8, 903, 085	3, 678, 050	12, 581, 135	-147, 653	12, 433, 482	91. 00 92. 00
92.00	SPECIAL PURPOSE COST CENTERS						92.00
118.00		90, 053, 972	181, 562, 722	271, 616, 694	-978, 737	270, 637, 957	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1 070	1 070	-		190.00
	19200   PHYSI CI ANS' PRI VATE OFFI CES   19201   OTHER NONREI MBURSABLE	0	1, 079 0	1, 079			192. 00 192. 01
	07950 NONREI MBURSABLE		0				194. 00
194.01	07951 MARKETI NG		0		978, 737	978, 737	194. 01
	07952 SENIOR CIRCLE	53, 073	26, 672				194. 02
	07953 OTHER NONREIMB COST C - REGENCY LTA	0	0	(			194. 03
194. 0 <sup>2</sup> 200. 00	O7954   VACANT UNFINISHED AREA   TOTAL (SUM OF LINES 118-199)	90, 107, 045	0 181, 590, 473	271, 697, 518	-		194. 04
200.00	)	70, 107, 045	101, 370, 4/3	2/1,09/,016	رار ال	2/1,07/,010	<sub>1</sub> 200.00

 Health Financial
 Systems
 PORTER MED

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0035

| Period: | Worksheet A | From 01/01/2016 | To 12/31/2016 | Date/Time Prepared: 5/30/2017 10: 19 am

				5/30/2017 10:	19 am
	Cost Center Description	Adjustments	Net Expenses		
	·	(See A-8)	For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FLXT	229, 228	6, 469, 979		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-2, 614, 920	12, 508, 569		2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-5, 421	16, 774, 322		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-11, 820, 925	45, 268, 428		5. 00
7.00	00700 OPERATION OF PLANT	0	8, 625, 428		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	1, 390, 693		8. 00
9.00	00900 HOUSEKEEPI NG	0	3, 393, 557		9. 00
10.00	01000 DI ETARY	0	1, 354, 029		10.00
11. 00		-132, 018	1, 626, 209		11. 00
13. 00	01300 NURSING ADMINISTRATION	-12, 289	4, 775, 744		13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	1, 564, 326		14. 00
15. 00		0	3, 145, 545		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-7, 213	3, 030, 864		16. 00
23.00	02300 ALLI ED HEALTH	0	44, 698		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00	l i	-406, 262	1		30. 00
31. 00		-1, 607, 104	7, 391, 020		31. 00
31. 01	03101 NEONATAL INTENSIVE CARE UNIT	-275, 400			31. 01
41. 00		0		1	41. 00
43.00		0	443, 152		43. 00
	ANCILLARY SERVICE COST CENTERS	T			
50. 00	l i	-810, 936	1		50. 00
51. 00	l i	0			51.00
52. 00		0	2, 448, 044		52. 00
53. 00		-1, 859, 316	l		53. 00
54. 00	l i	-85, 656	1	•	54. 00
54. 01	05401 ULTRASOUND	0	0		54. 01
56. 00		0	1		56. 00
57. 00		0	1		57. 00
58. 00		0			58. 00
60.00		0	11, 900, 645		60.00
65. 00		0	2, 146, 603		65. 00
66. 00		0	1, 786, 993		66. 00
67. 00		0	618, 435		67. 00
68. 00	l l	0	385, 682		68. 00
69. 00	l l	-411, 150			69. 00
71. 00	l l	0			71.00
72. 00		0			72. 00
73. 00		-2, 515			73. 00
74. 00		0	545, 915		74.00
76. 00		0	0	1	76. 00
76. 01	1 1	0	ł		76. 01
76. 03		0	1, 519, 881		76. 03
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	0	0	1	90.00
90.00		-	1		91.00
91.00	1 1	-1, 504, 522	10, 928, 960		91.00
92.00	SPECIAL PURPOSE COST CENTERS				92.00
118. 0		-21, 326, 419	249, 311, 538	, I	118. 00
110. U	NONREI MBURSABLE COST CENTERS	-21, 320, 419	247, 311, 338	<u>'</u>	1110.00
100 0	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
	019200 PHYSICIANS' PRIVATE OFFICES				190.00
	1 19201 OTHER NONREI MBURSABLE		l		192. 00
	007950 NONREI MBURSABLE			•	194. 00
	1 07951 MARKETI NG	0	978, 737		194. 00
	2 07952 SENI OR CI RCLE		79, 745		194. 01
	3 07953 OTHER NONREIMB COST C - REGENCY LTA		79,743		194. 02
	4 07954 VACANT UNFINISHED AREA	0	0		194. 03
200. 0		-21, 326, 419	1		200. 00
_55.0	1.0 (00 3. 2.1120 110 177)	2.,020,717	1 200,071,077	1	,

					10 1	/2017 10: 19 am
	Cost Center	Increases Line #	Salary	Other		
	2.00	3.00	4. 00	5. 00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	<u>15, 939, 405</u> 15, 939, 405		1.00
	B - OXYGEN COSTS		<u> </u>	13, 737, 403		
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	49, 213		1. 00
2. 00	PATI ENT CENTRAL SERVI CES & SUPPLY	14. 00	0	206		2. 00
2.00	0			49, 419		
1. 00	C - RENTAL AND LEASE EXPENSES CAP REL COSTS-BLDG & FLXT	1.00	o	1 707		1.00
2.00	CAP REL COSTS-BLDG & FIXT	2. 00	0	1, 787 2, 389, 442		2.00
3. 00	NURSING ADMINISTRATION	13. 00	o	2, 343		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6. 00 7. 00		0. 00 0. 00	0	0		6. 00 7. 00
8. 00		0.00	o	0		8.00
9. 00		0.00	O	0		9. 00
10.00		0.00	0	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	o	0		15. 00
16.00		0.00	О	0		16. 00
17.00		0.00	0	0		17. 00
18. 00 19. 00		0. 00 0. 00	0	0		18. 00 19. 00
19.00			#	2, 393, 572		17.00
	D - OTHER CAPITAL COSTS			, , , , , ,		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	169, 576		1. 00
2.00	CAP REL COSTS MARIE FOLLO	1. 00 2. 00	0	1, 457, 890		2.00
3.00	CAP REL COSTS-MVBLE EQUIP			12 <u>6, 1</u> 54 1, 753, 620		3. 00
	E - MARKETING DEPARTMENT			.,		
1.00	MARKETING	194. 01	351, 313	627, 424		1. 00
	F - CHIEF NURSING OFFICER COST	F	351, 313	627, 424		
1.00	NURSING ADMINISTRATION	13. 00	247, 271	0		1.00
	0		247, 271	<u>0</u>		
	G - MEDICAL SUPPLIES		-1			
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	2, 292, 262		1.00
2.00	IMPL. DEV. CHARGED TO	72.00	o	23, 255, 069		2. 00
	PATI ENTS					
3.00	OPERATING ROOM	5000	•	<u>839, 200</u>		3. 00
	H - COST OF DRUGS/IV SOLUTIONS		0	26, 386, 531		
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	17, 648, 101		1. 00
	0		0	17, 648, 101		
1 00	I - LABOR AND DELIVERY COSTS	20.00	al	0.744		4 00
1. 00 2. 00	ADULTS & PEDIATRICS NURSERY	30. 00 43. 00	0 371, 317	9, 741 1, 746		1. 00 2. 00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	390, 111	0		3. 00
			761, 428	11, 487		
	K - RECOVERY ROOM					
1. 00	OPERATI NG ROOM	50.00	2, 305, 864 2, 305, 864	37 <u>6, 6</u> 83 376, 683		1.00
	L - OTHER RADIOLOGY COST		2, 305, 864	370,083		
1.00	RADI OLOGY-DI AGNOSTI C	54.00	1, 756, 459	1, 462, 635		1. 00
2.00		0.00	0	0		2. 00
3.00		0.00	O	0		3. 00
4. 00		0.00	00_ 1, 756, 459	0000		4. 00
	M - DIETARY COSTS TO CAFETERIA	1	1, 700, 409	1, 402, 033		
1.00	CAFETERI A	1100	1, 141, 703	616, 524		1. 00
	0		1, 141, 703	616, 524		
1 00	N - REHAB THERAPY COSTS	44,00	6	2 502		1.00
1. 00	PHYSICAL THERAPY  O	6600	0	<u>3, 583</u> 3, 583		1.00
	O - SLEEP LAB COSTS TO EKG		<u> </u>	3, 303		
1.00	ELECTROCARDI OLOGY	69.00	331, 849	<u>48, 7</u> 59		1. 00
	10		331, 849	48, 759		

		11101 00303			,	1
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3.00	4. 00	5. 00		
	P - PARAMEDICAL EDUCATION					
1.00	ALLIED HEALTH	23. 00	0	44, 698		
	0		0	44, 698	<u> </u>	
500.00	Grand Total: Increases		6, 895, 887	67, 362, 441		50

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0035 Peri od: Worksheet A-6 From 01/01/2016 To 12/31/2016 Date/Time Prepared:

						o 12/31/2016 Date. 5/30.	/11me Prepared: /2017 10:19 am_
		Decreases					
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	A - EMPLOYEE BENEFITS	7.00	8.00	9.00	10.00		
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0	15, 939, 405	0		1. 00
	0			15, 939, 405			
	B - OXYGEN COSTS						
1.00	RESPIRATORY THERAPY	65.00	0	49, 419			1.00
2. 00		0.00	0	49, 419	<u> </u>		2. 00
	C - RENTAL AND LEASE EXPENSES		U U	49, 419	/		
1.00	ADMINISTRATIVE & GENERAL	5.00	O	854, 689	10		1.00
2. 00	OPERATION OF PLANT	7. 00	o	15, 695			2. 00
3.00	DI ETARY	10.00	0	7, 320	o		3. 00
4.00	SLEEP LAB	76. 01	0	3, 707	0		4. 00
5.00	CENTRAL SERVICES & SUPPLY	14. 00	0	8, 567			5. 00
6.00	PHARMACY	15.00	0	281, 863			6.00
7. 00 8. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	0	66, 282			7. 00 8. 00
9. 00	SUBPROVI DER - I RF	41.00	0	22, 233 2, 308			9.00
10. 00	OPERATING ROOM	50.00	0	409, 839			10.00
11. 00	LABORATORY	60.00	o	450, 153			11. 00
12.00	RESPI RATORY THERAPY	65.00	0	102, 452	0		12. 00
13.00	ELECTROCARDI OLOGY	69. 00	0	48, 776			13. 00
14. 00	DRUGS CHARGED TO PATIENTS	73. 00	0	5, 740			14. 00
15. 00	EMERGENCY	91.00	0	102, 955			15. 00
16.00	PHYSICAL THERAPY	66.00	0	16			16.00
17. 00 18. 00	DELIVERY ROOM & LABOR ROOM OCCUPATIONAL THERAPY	52. 00 67. 00	0	502 9, 275			17. 00 18. 00
19. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 200			19.00
17.00	0			2, 393, 572			17.00
	D - OTHER CAPITAL COSTS	•		, , , , , ,	'		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 753, 620			1. 00
2.00		0. 00	0	C			2. 00
3. 00		0.00		0	12		3. 00
	E - MARKETING DEPARTMENT		0	1, 753, 620	)		
1. 00	ADMINISTRATIVE & GENERAL	5. 00	351, 313	627, 424	0		1.00
1.00	0		351, 313	627, 424			1.00
	F - CHIEF NURSING OFFICER COST	Γ		,	1		
1.00	ADMINISTRATIVE & GENERAL	5.00	247, 271		0 0		1. 00
	0		247, 271	C			
4 00	G - MEDICAL SUPPLIES	44.00		0/ 070 00/			1 00
1. 00 2. 00	CENTRAL SERVICES & SUPPLY ELECTROCARDIOLOGY	14. 00 69. 00	0	26, 372, 836 13, 695			1.00
3. 00	LEECTROCARDI OLOGI	0.00	0	13, 093			3. 00
5.00			- — — <del> </del>				3.00
	H - COST OF DRUGS/IV SOLUTIONS	5	-1				
1.00	PHARMACY	15. 00	0	17, 648, 101	0		1.00
	0		0	17, 648, 101			
	I - LABOR AND DELIVERY COSTS	22.22	7/4 400				
1.00	ADULTS & PEDIATRICS	30.00	761, 428	11 407	0		1.00
2. 00 3. 00	DELIVERY ROOM & LABOR ROOM	52. 00 0. 00	0	11, 487	0 0		2. 00 3. 00
3.00				<sub>11, 487</sub>			3.00
	K - RECOVERY ROOM		701, 120	11, 107			
1.00	RECOVERY ROOM	51.00	2, 305, 864	376, 683	0		1. 00
	0		2, 305, 864	376, 683	3		
	L - OTHER RADIOLOGY COST						
1.00	ULTRASOUND	54. 01	474, 026	99, 092			1.00
2. 00 3. 00	RADI OI SOTOPE CT SCAN	56. 00 57. 00	432, 640 607, 640	893, 052 251, 195			2. 00 3. 00
4. 00	MRI	58. 00	242, 153	219, 296			4. 00
4.00	0		1, 756, 459	1, 462, 635			4.00
	M - DIETARY COSTS TO CAFETERIA	4	.,,	.,,			
1.00	DI ETARY	10.00	1, 141, 703	616, 524	0		1. 00
	0		1, 141, 703	616, 524	l I		
	N - REHAB THERAPY COSTS						
1. 00	SUBPROVI DER - I RF	41.00	•	3,583			1.00
	O CLEED LAR COSTS TO EKC		U]	3, 583	3		
1. 00	O - SLEEP LAB COSTS TO EKG SLEEP LAB	76. 01	331, 849	48, 759	0		1. 00
1.00	0 +		331, 849	4 <u>8, 7</u> 59			1.00
	P - PARAMEDICAL EDUCATION		22.70.7	.5, .6,			
1.00	EMERGENCY	91.00	0	44, 698			1. 00
	0		0	44, 698			
500.00	Grand Total: Decreases		6, 895, 887	67, 362, 441			500. 00

					o 12/31/2016	Date/Time Pre	pared:
						5/30/2017 10:	19 am
			5 . 1	Acqui si ti ons			
		Begi nni ng	Purchases	Donation	Total	Di sposal s and	
		Bal ances	2.00	2.00	4.00	Retirements	
	DADT I ANALYCIC OF CHANCEC IN CADITAL ACCE	1.00	2. 00	3. 00	4. 00	5. 00	
1 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		ما		1 0	0	1 00
1.00	Land	2, 949, 373	2 400	U	2 400	F 221	1.00
2.00	Land Improvements	3, 506, 109	3, 498	U	3, 498	5, 321	2.00
3.00	Buildings and Fixtures	165, 888, 425	800, 471	Ü	800, 471	0	3. 00
4.00	Building Improvements	4, 597, 413	802, 833	Ü	802, 833	·	4. 00
5.00	Fi xed Equi pment	6, 602, 865	144, 133		144, 133	·	5. 00
6.00	Movable Equipment	66, 452, 306	6, 077, 180	O	6, 077, 180		6. 00
7.00	HIT designated Assets	17, 960, 812	0	C	0	41, 065	7. 00
8.00	Subtotal (sum of lines 1-7)	267, 957, 303	7, 828, 115	C	7, 828, 115	1, 628, 282	8. 00
9.00	Reconciling Items	0	0	C	0	0	9. 00
10. 00	Total (line 8 minus line 9)	267, 957, 303	7, 828, 115	C	7, 828, 115	1, 628, 282	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	2, 949, 373	0				1. 00
2.00	Land Improvements	3, 504, 286	0				2. 00
3.00	Buildings and Fixtures	166, 688, 896	0				3. 00
4.00	Building Improvements	5, 359, 943	0				4. 00
5.00	Fi xed Equipment	6, 725, 338	0				5. 00
6.00	Movable Equipment	71, 009, 553	0				6.00
7.00	00 HIT designated Assets		0				7. 00
8.00	.00 Subtotal (sum of lines 1-7)		0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	274, 157, 136	o				10. 00

Heal th	Health Financial Systems PORTER MEMORIAL HOSPITAL In Lieu of Form CMS-25:						
RECONC	RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der CO	CN: 15-0035	Peri od: From 01/01/2016	Worksheet A-7 Part II	
					To 12/31/2016	Date/Time Pre	pared:
						5/30/2017 10:	19 am
			SU	JMMARY OF CAP	PI TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	instructions)	
		9. 00	10.00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	4, 611, 498	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	12, 431, 625	164, 737		0 0	11, 531	2. 00
3.00	Total (sum of lines 1-2)	17, 043, 123	164, 737		0 0	11, 531	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	4, 611, 498		·		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	12, 607, 893				2.00
3.00	Total (sum of lines 1-2)	0	17, 219, 391				3. 00

Heal th	n Financial Systems	PORTER MEMORI	AL HOSPITAL		In Lieu of Form CMS-2552		
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider Co		Period: From 01/01/2016 To 12/31/2016		pared:
		COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio (col. 1 - col 2)	instructions)		
		1.00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FLXT	178, 502, 499		178, 502, 49			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	95, 654, 638 274, 157, 137		95, 654, 63		0	2.00
3.00	3.00 Total (sum of lines 1-2)			274, 157, 13			3. 00
		ALLOCATION OF OTHER CAPITAL			SUMMARY 0		
	Cost Center Description		Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
		6.00	7. 00	8. 00	9. 00	10.00	
4 00	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS			4 404 000	4 707	4 00
1.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	0	0		0 4, 131, 892		1.00
2.00		0	0		0 9, 816, 705		2.00
3.00	Total (sum of lines 1-2)	0	0	<u>l</u> JMMARY OF CAPI	0 13, 948, 597	2, 555, 966	3. 00
			50	JIMIMARY OF CAPT			
	Cost Center Description		Insurance (see			Total (2) (sum	
			instructions)	instructions)	Capi tal -Relate		
					d Costs (see	through 14)	
		11 00	12.00	12.00	instructions)	1F 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	11.00	12.00	13.00	14. 00	15. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	708, 834	169, 576	1, 457, 89	0 0	6, 469, 979	1. 00
2. 00	CAP REL COSTS-MVBLE EQUIP	700,034					2. 00
3.00	Total (sum of lines 1-2)	708, 834					3. 00
0.00	1.0.0. (00 01 111100 1 2)	, , , , , , , ,	275,750	1, 107, 42	.,	10, 770, 040	0.00

Provider CCN: 15-0035 Peri od: Worksheet A-8 From 01/01/2016 To 12/31/2016 Date/Time Prepared:

					To 12/31/2016	Date/Time Prep 5/30/2017 10:	
				Expense Classification o			17 dili
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1. 00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FLXT	1.00		1. 00
	COSTS-BLDG & FLXT (chapter 2)						
2. 00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	o	3. 00
	(chapter 2)						
4. 00	Trade, quantity, and time		0		0.00	0	4. 00
5. 00	di scounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
	expenses (chapter 8)						
6. 00	Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay	A	-113, 524	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
	stations excluded) (chapter						
8. 00	21) Television and radio service	A	01 404	CAD DEL COSTS MADLE FOLLID	2. 00	9	8. 00
6.00	(chapter 21)	A	-01,000	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9. 00	Parking Lot (chapter 21)		0		0.00	0	9. 00
10.00	Provi der-based physician	A-8-2	-6, 960, 323			0	10. 00
11. 00	adjustment Sale of scrap, waste, etc.	В	-23	RADI OLOGY-DI AGNOSTI C	54.00	0	11. 00
	(chapter 23)						
12.00	Related organization	A-8-1	-4, 868, 934			0	12. 00
13. 00	transactions (chapter 10) Laundry and Linen service		0		0.00	0	13. 00
14. 00	Cafeteria-employees and guests	В	-132, 018	CAFETERI A	11. 00		14. 00
15. 00	Rental of quarters to employee		0		0.00	0	15. 00
16. 00	and others Sale of medical and surgical		0		0.00	0	16. 00
10.00	supplies to other than		O		0.00	Ĭ	10.00
	patients	_				_	
17. 00	Sale of drugs to other than patients	В	-2, 515	DRUGS CHARGED TO PATIENTS	73. 00	0	17. 00
18. 00	Sale of medical records and	В	-7, 213	MEDICAL RECORDS & LIBRARY	16. 00	О	18. 00
40.00	abstracts		0		0.00		40.00
19. 00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19. 00
20. 00	Vending machines		0		0.00	О	20. 00
21. 00	Income from imposition of		0		0.00	О	21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to						
23 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
23.00	therapy costs in excess of	A-0-3	0	INCOLUMN TITERALI	03.00		23.00
	limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	limitation (chapter 14)						
25. 00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL	A	-628, 826	CAP REL COSTS-BLDG & FIXT	1.00	9	26. 00
	COSTS-BLDG & FLXT						
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-3, 093, 663	CAP REL COSTS-MVBLE EQUIP	2. 00	9	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0		0.00		29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
21 00	instructions)	1 400	^	SDEECH DATHOLOGY	40.00		21 00
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0.00	0	32. 00
33. 00	Depreciation and Interest TRAINING REVENUE	В	-12 289	NURSING ADMINISTRATION	13. 00	0	33. 00
	MISC. NON PATIENT REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00		33. 01
		<u> </u>				<u> </u>	

				To	12/31/2016	Date/Time Pre 5/30/2017 10:	
	·			Expense Classification on	Worksheet A	07 007 2017 10.	I Z GIII
				To/From Which the Amount is			
					,		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2. 00	3. 00	4. 00	5. 00	
33. 02	NON-ALLOWABLE LEGAL FEES	A	-94, 361	ADMINISTRATIVE & GENERAL	5. 00	0	33. 02
33. 03	PATIENT PHONES WAGE COSTS	A	-19, 965	ADMINISTRATIVE & GENERAL	5.00	0	33. 03
33. 04	PATIENT PHONES BENEFITS COSTS	A	-5, 421	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 04
33. 05	PATIENT TV DEPRECIATION	A	-87, 421	CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 05
33.06	MARKETI NG	A	-979, 944	ADMINISTRATIVE & GENERAL	5.00	0	33. 06
33. 07	PHYSICIAN RECRUITING	A	-148, 335	ADMINISTRATIVE & GENERAL	5. 00	0	33. 07
33. 08	LOBBYING EXPENSE IN	A	-8, 482	ADMINISTRATIVE & GENERAL	5. 00	0	33. 08
	ASSOCIATION DUES						
33. 09	CHARI TABLE CONTRIBUTIONS	A	-121, 094	ADMINISTRATIVE & GENERAL	5. 00	0	33. 09
33. 10	COUNTRY CLUB DUES	A	-24, 285	ADMINISTRATIVE & GENERAL	5.00	0	33. 10
33. 11	MINORITY INTEREST	A	-3, 789, 948	ADMINISTRATIVE & GENERAL	5.00	0	33. 11
33. 12	PATIENT PHONE DEPRECIATION	A	-295	CAP REL COSTS-MVBLE EQUIP	2.00	9	33. 12
33. 14	PENALTI ES	A	-125	ADMINISTRATIVE & GENERAL	5. 00	0	33. 14
33. 15			0		0.00	0	33. 15
50.00	TOTAL (sum of lines 1 thru 49)		-21, 326, 419				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.

<sup>(2)</sup> Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 15-0035 Period: From 01/01/2016 To 12/31/2016 Date/Time Prepared: From 01/01/2017 10-20

					5/30/2017 10:	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1. 00	CAP REL COSTS-BLDG & FIXT	DIRECT ALLOCATION - CAPITAL	708, 834	0	1.00
2.00	5. 00	ADMINISTRATIVE & GENERAL	PASI OPERATING COSTS	1, 538, 749	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS-BLDG & FI	103, 480	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	45, 740	0	4.00
4.01	2. 00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	631, 861	0	4. 01
4.02	5. 00	ADMINISTRATIVE & GENERAL	NON-CAPITAL HOME OFFICE COST	7, 605, 688	0	4. 02
4.03	5. 00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	1, 501, 547	3, 173, 100	4. 03
4.04	5. 00	ADMINISTRATIVE & GENERAL	CIG LEASED EQUIPMENT	126, 322	176, 268	4.04
4.05	5. 00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	0	7, 354, 364	4. 05
4.06	5. 00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	2, 835, 368	4.06
4.07	5. 00	ADMINISTRATIVE & GENERAL	401K FEES	0	11, 162	4. 07
4.08	5. 00	ADMINISTRATIVE & GENERAL	AUDIT FEES	0	104, 824	4. 08
4. 14	5. 00	ADMINISTRATIVE & GENERAL	PPSI FEES	0	29, 300	4. 14
4. 15			CORPORATE OVERHEAD ALLOCATIO	0	2, 448, 482	
4. 17			PASI COLLECTION FEES	0	1, 586, 463	4. 17
4. 18			PASI LIEN UNIT COLLECTION FE	0	280, 797	4. 18
4. 21		ADMINISTRATIVE & GENERAL	SHARED SERVICE CENTER ALLOCA	852, 689	0	4. 21
4. 22		CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS-MOVEABLE	16, 284	0	4. 22
5.00	TOTALS (sum of lines 1-4).			13, 131, 194	18, 000, 128	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

			Related Organization(s) and/or Home Office		
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	В	0. 00 CHS   100	00	6.00
7.00		0.00	00	7. 00
8.00		0.00	00	8.00
9.00		0.00	00	9. 00
10.00		0.00	00	10.00
100.00	G. Other (financial or			100.00
	non-financial) specify:			

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

4.04 -49, 946 10 4.05 -7, 354, 364 11 4 05 4.06 -2, 835, 368 0 4.06 4.07 -11, 162 0 4.07 0 4.08 -104, 824 4.08 0 -29 300 4 14 4 14 4.15 -2, 448, 482 4.15 4.17 -1, 586, 463 0 4. 17 -280, 797 0 4.18 4.18 0 4.21 852, 689 4 21 4. 22 16, 284 4. 22 5.00 -4, 868, 934 5.00 The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as

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

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

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

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

6.00	HOME OFFICE		6. 00							
7.00			7. 00							
8.00			8. 00							
9.00			9. 00							
10.00			10.00							
8. 00 9. 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 organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Peri od: Worksheet A-8-2 From 01/01/2016 To 12/31/2016 Date/Time Prepared:

							5/30/2017 10:	19 am
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				•	'		Hours	
	1. 00	2.00	3.00	4. 00	5. 00	6. 00	7. 00	
1. 00	30.00	ADULTS & PEDIATRICS	406, 262	406, 262	0	159, 800	0	1. 00
2.00	31.00	INTENSIVE CARE UNIT	1, 607, 104	1, 607, 104	0	159, 800	0	
3.00	31. 01	NEONATAL INTENSIVE CARE UNIT	275, 400	275, 400	0	159, 800	0	3. 00
4.00	50.00	OPERATING ROOM	810, 936	810, 936	0	159, 800	0	4. 00
5. 00		ANESTHESI OLOGY	1, 859, 316	1, 859, 316		167, 500		5. 00
6. 00		RADI OLOGY-DI AGNOSTI C	85, 633			217, 600		6. 00
7. 00		ELECTROCARDI OLOGY	411, 150	411, 150		130, 900		
8. 00		EMERGENCY	1, 558, 301	1, 445, 113				
9. 00	0.00	4	0	0	0	0	0	9. 00
10. 00	0.00		l o	0	0	0	l o	10. 00
200.00	0.00		7, 014, 102	6, 900, 914	113, 188	Ĭ	_	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
	MKSt. A LITTO #	I denti fi er		Unadjusted RCE		Component	of Malpractice	
		1 40.1111101		Li mi t	Continuing	Share of col.	Insurance	
				2 2	Educati on	12	111041 41100	
	1. 00	2.00	8. 00	9. 00	12. 00	13. 00	14.00	
1. 00		ADULTS & PEDIATRICS	0	0				1. 00
2.00	•	INTENSIVE CARE UNIT	0	0	0	0	0	
3.00	31. 01	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	3. 00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4. 00
5. 00		ANESTHESI OLOGY	0	0	0	0	0	
6. 00		RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	6. 00
7. 00		ELECTROCARDI OLOGY	0	0	0		l o	
8. 00		EMERGENCY	53, 779	2, 689	0	0	0	8. 00
9. 00	0.00		0.00	0	0		l ő	9. 00
10. 00	0.00		0	0	0		l o	
200.00	0.00		53, 779	2, 689	0	0	l o	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	Ŭ	200.00
		I denti fi er	Component	Li mi t	Di sal I owance	riaj ao timorre		
		1 40.1111101	Share of col.	21 0	Di dai i dilando			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00	30.00	ADULTS & PEDIATRICS	0	0	0	406, 262		1. 00
2.00	31, 00	INTENSIVE CARE UNIT	0	0	0		1	2. 00
3. 00		NEONATAL INTENSIVE CARE UNIT	0	0	0	275, 400		3. 00
4. 00		OPERATING ROOM	0	0	0	810, 936		4. 00
5. 00		ANESTHESI OLOGY	0	0	0	1, 859, 316		5. 00
6. 00		RADI OLOGY-DI AGNOSTI C	l o	0	0	85, 633		6. 00
7. 00		ELECTROCARDI OLOGY	l o	0	0	411, 150		7. 00
8. 00		EMERGENCY	0	53, 779	59, 409			8. 00
9. 00	0.00		1	55, 779 O	0	1, 304, 322	i e	9. 00
10. 00	0.00			0	0			10.00
200.00	0.00		0	53, 779	59, 409	6, 960, 323		200.00
200.00	I	I	1	33, 117	37, 407	1 0,700,323	T	200.00

Health Financial Systems PORTER MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0035 Peri od: Worksheet B From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 5/30/2017 10:19 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 6, 469, 979 1 00 00100 CAP REL COSTS-BLDG & FLXT 6, 469, 979 2.00 00200 CAP REL COSTS-MVBLE EQUIP 12, 508, 569 12, 508, 569 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 16, 774, 322 20, 489 41,688 16, 836, 499 4.00 00500 ADMINISTRATIVE & GENERAL 1, 453, 693 47, 580, 773 5 00 45, 268, 428 282, 947 575, 705 5 00 7.00 00700 OPERATION OF PLANT 8, 625, 428 1, 268, 069 2, 580, 101 308,005 12, 781, 603 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 1, 390, 693 7, 341 14, 938 24, 055 1, 437, 027 8.00 9.00 00900 HOUSEKEEPI NG 3, 393, 557 49, 186 100, 078 362, 144 3, 904, 965 9.00 1, 973, 339 01000 DI ETARY 164, 874 10.00 1, 354, 029 149, 748 304, 688 10 00 11.00 01100 CAFETERI A 1, 626, 209 214, 091 1, 840, 300 11.00 01300 NURSING ADMINISTRATION 4, 775, 744 72, 900 148, 329 712, 008 5, 708, 981 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 1, 564, 326 104, 040 211, 688 182, 304 2, 062, 358 14.00 14.00 507, 058 01500 PHARMACY 116, 125 15.00 15.00 3, 145, 545 57,073 3, 825, 801 16.00 01600 MEDICAL RECORDS & LIBRARY 3, 030, 864 19, 659 40,000 182, 511 3, 273, 034 16.00 02300 ALLI ED HEALTH 23.00 44,698 44, 698 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 19, 494, 494 858, 939 1, 747, 662 2, 988, 208 25, 089, 303 30.00 03100 INTENSIVE CARE UNIT 7, 391, 020 149, 663 304, 517 1, 076, 317 8, 921, 517 31.00 31.00 31.01 03101 NEONATAL INTENSIVE CARE UNIT 2,065,534 57, 856 117, 719 339, 903 2, 581, 012 31.01 04100 SUBPROVIDER - IRF 1, 297, 897 101, 813 207. 157 180, 253 1, 787, 120 41.00 41.00 04300 NURSERY 43.00 443, 152 18, 346 37, 328 69, 629 568, 455 43.00 ANCILLARY SERVICE COST CENTERS 1, 023, 691 50.00 05000 OPERATING ROOM 15, 026, 630 503, 122 1, 684, 113 18, 237, 556 50.00 51.00 05100 RECOVERY ROOM 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 2, 448, 044 100, 139 203, 751 384, 721 3, 136, 655 52.00 05300 ANESTHESI OLOGY 205, 517 17, 672 53.00 8, 685 231, 874 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 10, 063, 718 362, 774 738, 127 1, 296, 131 12, 460, 750 54.00 54.01 05401 ULTRASOUND 0 C C 0 Ω 54.01 05600 RADI OI SOTOPE 56.00 0 0 0 56.00 57.00 05700 CT SCAN 0 Ω 0 0 0 57.00 05800 MRI 58.00 Ω Λ 58.00 60.00 06000 LABORATORY 11, 900, 645 135, 956 276, 626 1, 033, 339 13, 346, 566 60.00 06500 RESPIRATORY THERAPY 2, 146, 603 24, 467 49, 781 335, 773 2, 556, 624 65.00 65.00 06600 PHYSI CAL THERAPY 1, 786, 993 282, 829 303, 799 2, 512, 625 66.00 139,004 66.00 06700 OCCUPATIONAL THERAPY 727, 794 67.00 618, 435 109, 359 67.00 C Ω 68.00 06800 SPEECH PATHOLOGY 385, 682 0 67,625 453, 307 68.00 40 00 04000 ELECTROCARRIOLOGY 7 255 120 221 242 470 EO1 057 043 0 012 044

69. 00  06900  ELECTROCARDI OLOGY	7, 355, 138	231, 242	470, 501	957, 063	9, 013, 944   69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 341, 475	O	0	O	2, 341, 475 71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	23, 255, 069	0	0	0	23, 255, 069 72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	18, 118, 345	0	0	20, 754	18, 139, 099 73. 00
74. 00   07400   RENAL DI ALYSI S	545, 915	5, 053	10, 281	0	561, 249 74. 00
76. 00   03950   ANCI LLARY	0	o	0	o	0 76.00
76. 01   03610   SLEEP LAB	0	o	0	o	0 76.01
76. 03   03951   WOUND CARE	1, 519, 881	79, 919	162, 610	133, 441	1, 895, 851 76. 03
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0	0	0	0	0 90.00
91. 00 09100 EMERGENCY	10, 928, 960	351, 055	714, 283	1, 669, 498	13, 663, 796 91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART					0 92.00
SPECIAL PURPOSE COST CENTERS					
118.00 SUBTOTALS (SUM OF LINES 1-117)	249, 311, 538	5, 159, 485	10, 497, 875	16, 760, 669	245, 914, 520 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7, 395	15, 047	0	22, 442 190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	1, 079	978, 484	1, 990, 897	0	2, 970, 460 192. 00
192. 01 19201 OTHER NONREI MBURSABLE	0	0	0	0	0 192. 01
194. 00 07950 NONREI MBURSABLE	0	0	0	0	0 194. 00
194. 01 07951 MARKETI NG	978, 737	2, 335	4, 750	65, 878	1, 051, 700 194. 01
194. 02 07952 SENI OR CIRCLE	79, 745	0	0	9, 952	89, 697 194. 02
194.03 07953 OTHER NONREIMB COST C - REGENCY LTA	0	115, 874	0	0	115, 874 194. 03
194. 04 07954 VACANT UNFINISHED AREA	0	206, 406	0	0	206, 406 194. 04
200.00 Cross Foot Adjustments					0 200. 00
201.00 Negative Cost Centers		0	0	0	0 201. 00
202.00 TOTAL (sum lines 118-201)	250, 371, 099	6, 469, 979	12, 508, 569	16, 836, 499	250, 371, 099 202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2016 | Part I | To 12/31/2016 | Date/Time Prepared: | 5/30/2017 10: 19 am

COST CONTON DESCRIPTION   CONTON DESCRIPTION DESCRIPTION   CONTON DESCRIPTION DESCRIP							5/30/2017 10:	19 am
SEMERAL SERVICE COST CENTERS		Cost Center Description				HOUSEKEEPI NG	DI ETARY	
ERIERAL SERVICE COST CENTERS 1.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00								
1.00		OFNEDAL CEDIU OF COCT OFNITEDO	5. 00	7. 00	8.00	9. 00	10.00	
2.00	1 00							1 00
4. 00   0.000   DEPAIT ON OF PLANT   2.908, 948   15.780, 551   7.00   0.0500   DEPAIT ON OF PLANT   2.908, 948   15.780, 551   7.00   0.0500   DEPAIT ON OF PLANT   2.908, 948   15.780, 551   7.00   0.000   DEPAIT ON OF PLANT   2.908, 948   15.780, 551   7.00   0.000   DEPAIT ON OF PLANT   2.908, 948   15.780, 551   7.00   0.0000   0.000   0.000   0.000   0.0000   0.000   0.0000   0.0000   0.0000   0.0000   0.0000								
5.00								
7.00   0.0700   OPENATION OF PLANT   2, 998, 948   15, 780, 551   3, 798, 888   0, 00   0.0800   CALMENT & LINEN SERVICE   337, 170   24, 697   1, 798, 888   0, 00   0.0900   OUTSEKEEPING   916, 222   106, 426   0   0   0   0   0   0   0   0   0			47 500 770					
8. 00   00900   LANINDRY & LINEN SERVICE   337, 170   24, 601   1, 798, 888   4, 966, 613   0, 00   0000   DICTARY   463, 0005   503, 638   0   161, 009   3, 101, 071   10, 00   110, 00				45 700 554				
9.00   0.9900   MUSEKEREN ING								
10.00   01000   DI ETARY								
11.00 0 1000 (ARESTRIA MURSINA SAMINISTRATION 1.339, 498 245, 181 0 78, 427 0 113, 00 1300 (1400 (ENTRAL SERVICES & SUPPLY 483, 891 349, 912 0 111, 920 0 14.00 16.00 16.00 0 1600 (PRINANCY 767, 952 66, 119 0 0 10 0 0 22.00 16.00 0 1600 (PRINANCY 767, 952 66, 119 0 0 0 0 0 22.00 16.00 0 1600 (PRINANCY 767, 952 66, 119 0 0 0 0 0 22.00 16.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							l	1
13.00   01300   MURSI NG ADMINISTRATION   1,339, 498   245, 181   0   78, 421   0   13.00   14.00   14.00   01400   CENTRAL SERVICE ICES & SUPPLY   897, 648   191, 951   4,774   61,336   0   15.00   15.00   15.00   10.00				503, 638	0	161, 089		
14.00   01400   CENTRAL SERVICES & SUPPLY				0	0	0	l .	
15.00   01500   PHARMACY   897, 648   191, 951   4, 974   61, 396   0   15.00   02300   ALLIED   HEALTH   10, 487   10, 487   0   0   0   0   0   0   0   0   0							•	
16.00   01600   MEDICAL RECORDS & LIBRARY   76, 7952   66, 119   0   21, 148   0   16, 00   23, 00   18000   MLIED HEACH   10, 487   0   0   0   23, 00   18000   MLIED HEACH   10, 487   0   0   0   23, 00   18000   MUITS & PEDIDITRIC S   18000								
23. 00							l	
INPAIL ENT ROUTINE SERVICE COST CENTERS   1,000   1,			1	66, 119	0	21, 148	<b>l</b>	1
30.00	23. 00		10, 487	0	0	0	0	23. 00
31.00   03100   INTENSIVE CARE UNIT   2,093, 256   503, 254   160, 299   160, 998   170, 046   31.00   31.00   31.01   03101								
13.1 0	30.00	03000 ADULTS & PEDI ATRI CS	5, 886, 778	2, 888, 815	718, 415	923, 990	1, 728, 734	30.00
41.00   04100   SUBPROVI DER - I RF   419, 312   342, 422   69, 768   109, 524   99, 450   41.00	31.00	03100 INTENSIVE CARE UNIT	2, 093, 256	503, 354	160, 299	160, 998	170, 046	31. 00
A3. 00   04300   NURSERY   COST CENTERS   133, 377   61, 702   8, 888   19, 735   0   43, 00	31. 01	03101 NEONATAL INTENSIVE CARE UNIT	605, 583	194, 585	10, 786	62, 238	11, 450	31. 01
ANCIL LARY SERVICE COST CENTERS   1,692, 120   221, 272   541, 226   4,481   50,00   51,00   0,00   0,00   0,00   0,00   0,00   51,00   0,00   0,00   0,00   0,00   51,00   0,00   0,00   0,00   0,00   0,00   51,00   0,	41.00	04100 SUBPROVI DER - I RF	419, 312	342, 422	69, 768	109, 524	99, 450	41.00
50.00	43.00		133, 377	61, 702	8, 858	19, 735	0	43. 00
51 00   OSTOO   RECOVERY ROOM & LABOR ROOM   735, 953   336, 792   45, 826   107, 723   21, 438   52. 00   52. 00   OSZOO   OELIVERY ROOM & LABOR ROOM   735, 953   336, 792   45, 826   107, 723   21, 438   52. 00   53. 00   OSZOO   OSZO		ANCILLARY SERVICE COST CENTERS						
S2 00   05200   05200   05200   05200   05200   05200   05300   05400   05400   05400   05400   05400   05400   05400   05400   05400   05400   0550	50.00	05000 OPERATING ROOM	4, 279, 078	1, 692, 120	221, 272	541, 226	4, 481	50.00
53.00   05300   ANESTHESI OLOGY   54, 405   29, 211   0   9, 343   0   53.0	51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
54. 00   05400   RADI OLOGY-DIAGNOSTIC   2,923,666   1,220,095   173,788   390,248   749   54. 00     54. 01   05401   ILTRASQUIND   0 0 0 0 0 0 0 0 0 0 0 54. 01     56. 00   05600   RADI OLSTOPE   0 0 0 0 0 0 0 0 0 0 0 55. 00     57. 00   05700   CT SCAN   0 0 0 0 0 0 0 0 0 0 0 0 58. 00     58. 00   05800   MR   0 0 0 0 0 0 0 0 0 0 0 0 58. 00     58. 00   05800   MR   0 0 0 0 0 0 0 0 0 0 0 0 0 58. 00     58. 00   05800   MR   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	52.00		735, 953	336, 792	45, 826	107, 723	21, 438	52. 00
54. 00   05400   RADI OLOGY-DIAGNOSTIC   2,923,666   1,220,095   173,788   390,248   749   54. 00     54. 01   05401   ILTRASQUIND   0 0 0 0 0 0 0 0 0 0 0 54. 01     56. 00   05600   RADI OLSTOPE   0 0 0 0 0 0 0 0 0 0 0 55. 00     57. 00   05700   CT SCAN   0 0 0 0 0 0 0 0 0 0 0 0 58. 00     58. 00   05800   MR   0 0 0 0 0 0 0 0 0 0 0 0 58. 00     58. 00   05800   MR   0 0 0 0 0 0 0 0 0 0 0 0 0 58. 00     58. 00   05800   MR   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	53.00	05300 ANESTHESI OLOGY	54, 405	29, 211	0	9, 343	0	53.00
54-01   05401   UTRASQUIND	54.00		2, 923, 666				749	54.00
56.00   05000   Common   Com			1	0	0	0	l e	
57.00   05900   CT SCAN   0   0   0   0   0   0   0   0   0			0	0	0	0	•	
58. 00   0500   MRI			0	0		0		
60.00   06000   LABORATORY   3,131,505   457,252   95   146,252   0 60,00   065.00   06500   RESPIRATORY THERAPY   589,537   467,505   7,028   149,532   0 66.00   06000   PHYSI CAL THERAPY   589,537   467,505   7,028   149,532   0 66.00   067.00   06700   05000   0700   05000   0700   0700   0700   0700   0700   05000   0700			o o	0	j o	0		
65.00   06500   RESPIRATORY THERAPY   599, 861   82, 287   0   26, 319   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   170, 762   0   0   0   0   0   0   0   0   0			3 131 505	457 252	1	146 252		
66.00   06600   PHYSICAL THERAPY   589,537   467,505   7,028   149,532   0 66,00   67.00   06700   0CCUPATI ONAL THERAPY   170,762   0 0 0 0 0 0 0 0 67.00   06800   06800   SPEECH PATHOLOGY   106,359   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						•		
67. 00   06700   OCCUPATI (DNAL THERAPY   170, 762   0   0   0   0   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   106, 359   0   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   2, 114, 942   777, 720   68, 434   248, 754   24, 446   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   549, 380   0   0   0   0   0   0   71. 00   72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   5, 456, 337   0   0   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   4, 255, 977   0   0   0   0   0   0   0   74. 00   07400   RENAL DI ALYSI S   131, 686   16, 995   0   5, 436   0   74. 00   76. 00   03950   ANCI LLARY   0   0   0   0   0   0   0   0   76. 01   03951   MOUND CARE   444, 824   268, 788   8, 611   85, 972   0   76. 01   03951   MOUND CARE   444, 824   268, 788   8, 611   85, 972   0   79. 00   09000   CLLINIC   0   0   0   0   0   0   0   79. 00   09000   CLLINIC   0   0   0   0   0   0   79. 00   09000   OSERNATI ON BEDS (NON-DI STI NCT PART   SPECI AL PURPOSE COST CENTERS   79. 00   19000   OSERNATI ON BEDS (NON-DI STI NCT PART   SPECI AL PURPOSE COST CENTERS   79. 00   19000   OSERNATI ON BEDS (NON-DI STI NCT PART   SPECI AL PURPOSE COST CENTERS   79. 00   19000   OSERNATI ON BEDS (NON-DI STI NCT PART   SPECI AL PURPOSE COST CENTERS   79. 00   19000   OSERNATI ON BEDS (NON-DI STI NCT PART   SPECI AL PURPOSE COST CENTERS   79. 00   19000   OSERNATI ON BEDS (NON-DI STI NCT PART   SPECI AL PURPOSE COST CENTERS   79. 00   19000   OSERNATI ON BEDS (NON-DI STI NCT PART   SPECI AL PURPOSE COST CENTERS   79. 00   19000   OSERNATI ON BEDS (NON-DI STI NCT PART   SPECI AL PURPOSE COST CENTERS   79. 00   19000   OSERNATI ON BEDS (NON-DI STI NCT PART   SPECI AL PURPOSE COST CENTERS   79. 00   19000   OSERNATI ON BEDS (NON-DI STI NCT PART   SPECI AL PURPOSE COST CENTERS   79. 00   19000   OSERNATI ON BEDS (NON-DI STI NCT PART   SPECI AL PURPOSE COST CENTERS   79. 00   19000   OSERNATI ON BEDS (NON-DI STI NCT PART   SPECI AL PURPOSE COST CENTERS   SPECI AL PURPOSE COST CENTERS								1
68. 00 06800 SPEECH PATHOLOGY				467, 303	7,020	149, 332	l	
69. 00   06900   ELECTROCARDI OLOGY   2, 114, 942   777, 720   68, 434   248, 754   24, 446   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   549, 380   0   0   0   0   0   0   72. 00   71. 00   07200   MEDI CAL SUPPLIES CHARGED TO PATIENTS   5, 456, 337   0   0   0   0   0   0   0   72. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   74. 00				0		0		
71. 00				777 700	0	040.754	•	
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   5, 456, 337   0   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   4, 255, 977   0   0   0   0   0   0   74. 00   07400   RENAL DI ALYSI S   131, 686   16, 995   0   5, 436   0   74. 00   76. 01   03950   ANCI LLARY   0   0   0   0   0   0   0   76. 01   03610   SLEEP LAB   0   0   0   0   0   0   0   76. 03   03951   WOUND CARE   444, 824   268, 788   8, 611   85, 972   0   76. 03   03951   WOUND CARE   444, 824   268, 788   8, 611   85, 972   0   76. 03   09700   CLI NI C   0   0   0   0   0   0   0   77. 00   09000   CLI NI C   0   0   0   0   0   0   78. 00   09000   CLI NI C   0   0   0   0   0   79. 00   09000   CLI NI C   0   0   0   0   0   79. 00   09000   CLI NI C   0   0   0   0   79. 00   09000   CLI NI C   0   0   0   0   79. 00   09000   CLI NI C   0   0   0   0   79. 00   09000   CLI NI C   0   0   0   0   79. 00   09000   CLI NI C   0   0   0   0   79. 00   09000   CLI NI C   0   0   0   0   79. 00   09000   CLI NI C   0   0   0   0   79. 00   09000   CLI NI C   0   0   0   79. 00   09000   CLI NI C   0   0   0   79. 00   09000   CLI NI C   0   0   0   79. 00   09000   CLI NI C   0   0   0   79. 00   09000   CLI NI C   0   0   0   79. 00   09000   CLI NI C   0   0   0   79. 00   09000   CLI NI C   0   0   0   79. 00   09000   CLI NI C   0   0   0   79. 00   09000   CLI NI C   0   0   0   79. 00   09000   CLI NI C   0   0   79. 00   09000   CLI NI C   0   0   0   79. 00   09000   CLI NI C   0   0   0   79. 00   09000   CLI NI C   0   0   79. 00   09000   CLI NI C   0   0   0   79. 00   09000   CLI NI C   0   0   0   79. 00   09000   CLI NI C   0   0   0   79. 00   09000   CLI NI C   0   0   79. 00   09000   0				///, /20	68, 434	248, 754		
73. 00   07300   DRUGS CHARGED TO PATIENTS				0	0	0		
74. 00 07400 RENAL DIALYSIS 131,686 16,995 0 5,436 0 74. 00 76. 00 03950 ANCI LLARY 0 0 0 0 0 0 0 76. 00 76. 01 03610 SLEEP LAB 0 0 0 0 0 0 0 0 76. 01 76. 03 03951 WOUND CARE 444,824 268,788 8,611 85,972 0 76. 03  OUTPATIENT SERVICE COST CENTERS  90. 00 09000 CLI NI C 0 0 0 0 0 0 0 0 0 0 0 0 91. 00 09100 EMERGENCY 3,205,936 1,180,682 300,734 377,642 69,678 91. 00  92. 00 SUBTOTALS (SUM OF LI NES 1-117) 46,535,125 12,067,243 1,798,888 3,798,906 2,130,472 118. 00  NONNEI MBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 5,266 24,872 0 7,955 0 190. 00  192. 01 19200 PHYSI CI ANS' PRI VATE OFFI CES 696,959 3,290,872 0 1,052,591 410,555 192. 00  194. 00 07950 NONREI MBURSABLE 0 0 7,852 0 2,511 0 192. 01  194. 00 07950 NONREI MBURSABLE 0 0 0 0 0 0 0 0 194. 02  194. 01 07951 MARKETI NG 246,760 0 0 0 0 0 194. 02  194. 03 07953 OTHER NONREI MBURSABLE 2 1,046 0 0 0 0 0 194. 02  194. 03 07953 OTHER NONREI MB COST C - REGENCY LTA 27,188 389,712 0 124,650 560,044 194. 03  194. 04 07954 VACANT UNFI NI SHED AREA 48,429 0 0 0 124,650 560,044 194. 03  201. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	0	0	0		
76. 00 03950   ANCI LLARY			1	0	0	0	1	
76. 01 03610   SLEEP LAB   0   0   0   0   0   0   0   76. 01   76. 03 03951   WOUND CARE   444, 824   268, 788   8, 611   85, 972   0   76. 03   000   O9000   CLINIC   0   0   0   0   0   0   0   0   91. 00   O9100   BMERGENCY   3, 205, 936   1, 180, 682   300, 734   377, 642   69, 678   91. 00   92. 00   O9200   OBSERVATI ON BEDS (NON-DISTINCT PART   92. 00   SPECIAL PURPOSE COST CENTERS   18. 00   NONREI MBURSABLE   COST CENTERS   190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   5, 266   24, 872   0   7, 955   0   190. 00   192. 01   19201   OTHER NONREI MBURSABLE   0   7, 852   0   2, 511   0   192. 01   194. 00   07950   NONREI MBURSABLE   0   0   0   0   0   0   194. 01   07951   MARKETI NG   246, 760   0   0   0   0   194. 02   07952   SENI OR CI RCLE   21, 046   0   0   0   0   194. 03   07953   OTHER NONREI MB COST C - REGENCY LTA   27, 188   389, 712   0   124, 650   560, 044   194. 03   194. 04   07954   VACANT UNFI NI SHED AREA   48, 429   0   0   0   0   0   201. 00   Negati ve Cost Centers   0   0   0   0   0   0   201. 00   Negati ve Cost Centers   0   0   0   0   0   0   201. 00   Negati ve Cost Centers   0   0   0   0   0   201. 00   Negati ve Cost Centers   0   0   0   0   0   201. 00   Negati ve Cost Centers   0   0   0   0   0   201. 00   Negati ve Cost Centers   0   0   0   0   0   201. 00   Negati ve Cost Centers   0   0   0   0   0   201. 00   Negati ve Cost Centers   0   0   0   0   0   201. 00   Negati ve Cost Centers   0   0   0   0   0   201. 00   Negati ve Cost Centers   0   0   0   0   201. 00   Negati ve Cost Centers   0   0   0   0   0   201. 00   Negati ve Cost Centers   0   0   0   0   0   201. 00   Negati ve Cost Centers   0   0   0   0   0   201. 00   Negati ve Cost Centers   0   0   0   0   0   201. 00   Negati ve Cost Centers   0   0   0   0   201. 00   Negati ve Cost Centers   0   0   0   0   0   201. 00   Negati ve Cost Centers   0   0   0   0   0   201. 00   Negati ve Cost Centers   0   0   0   0   0   201. 00   Negati ve Cost Centers   0   0   0   0   0   202. 00			131, 686	16, 995	0	5, 436	l e	
76. 03			0	0	0	0	0	
90. 00   09000   CLI NI C   0   0   0   0   0   0   0   0   0			0	0	0	0	0	
90. 00	76. 03	03951 WOUND CARE	444, 824	268, 788	8, 611	85, 972	0	76. 03
91. 00		OUTPATIENT SERVICE COST CENTERS						
92. 00   9200   OBSERVATI ON BEDS (NON-DI STI NCT PART   SPECI AL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LI NES 1-117)   46, 535, 125   12, 067, 243   1, 798, 888   3, 798, 906   2, 130, 472   118. 00	90.00		0	0	0	0		
SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1-117)   46,535,125   12,067,243   1,798,888   3,798,906   2,130,472   118.00	91.00		3, 205, 936	1, 180, 682	300, 734	377, 642	69, 678	91.00
SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1-117)   46,535,125   12,067,243   1,798,888   3,798,906   2,130,472   118.00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
NONRE   MBURSABLE COST CENTERS   190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   5, 266   24, 872   0   7, 955   0   190. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   696, 959   3, 290, 872   0   1, 052, 591   410, 555   192. 00   192. 01   192. 01   192. 01   192. 01   192. 01   193. 00   0   0   0   0   0   194. 00   194. 00   194. 00   194. 00   194. 00   194. 01   194. 01   194. 01   194. 01   194. 01   194. 01   194. 02   194. 03   07953   OTHER NONREI MB COST C - REGENCY LTA   21, 046   0   0   0   194. 02   194. 02   194. 03   07953   OTHER NONREI MB COST C - REGENCY LTA   27, 188   389, 712   0   124, 650   560, 044   194. 03   194. 04   07954   VACANT UNFI NI SHED AREA   48, 429   0   0   0   0   194. 04   194. 04   194. 05								
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 5, 266 24, 872 0 7, 955 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 696, 959 3, 290, 872 0 1, 052, 591 410, 555 192. 00 192. 01 19201 OTHER NONREI MBURSABLE 0 7, 852 0 2, 511 0 192. 01 194. 00 07950 NONREI MBURSABLE 0 0 0 0 0 0 194. 00 194. 00 194. 01 07951 MARKETI NG 246, 760 0 0 0 0 0 194. 01 194. 01 194. 02 07952 SENI OR CI RCLE 21, 046 0 0 0 0 0 194. 02 194. 03 07953 OTHER NONREI MB COST C - REGENCY LTA 27, 188 389, 712 0 124, 650 560, 044 194. 02 194. 04 07954 VACANT UNFI NI SHED AREA 48, 429 0 0 0 0 194. 04 07954 Cross Foot Adjustments 0 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	118.00	SUBTOTALS (SUM OF LINES 1-117)	46, 535, 125	12, 067, 243	1, 798, 888	3, 798, 906	2, 130, 472	118. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 696, 959 3, 290, 872 0 1, 052, 591 410, 555 192. 00 192. 01 19201 OTHER NONREI MBURSABLE 0 7, 852 0 2, 511 0 192. 01 194. 00 07950 NONREI MBURSABLE 0 0 0 0 0 0 194. 00 194. 01 07951 MARKETI NG 246, 760 0 0 0 0 0 194. 01 194. 01 194. 02 07952 SENI OR CI RCLE 21, 046 0 0 0 0 0 0 194. 02 194. 03 07953 OTHER NONREI MB COST C - REGENCY LTA 27, 188 389, 712 0 124, 650 560, 044 194. 02 194. 04 07954 VACANT UNFI NI SHED AREA 48, 429 0 0 0 0 194. 04 020. 00 Negati ve Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		NONREI MBURSABLE COST CENTERS						
192. 01 19201 OTHER NONREIMBURSABLE 0 7, 852 0 2, 511 0 192. 01 194. 00 194. 00 07950 NONREIMBURSABLE 0 0 0 0 0 0 194. 00 194. 00 194. 01 07951 MARKETI NG 246, 760 0 0 0 0 194. 01 194. 01 194. 02 07952 SENI OR CI RCLE 21, 046 0 0 0 0 0 194. 02 194. 03 07953 OTHER NONREIMB COST C - REGENCY LTA 27, 188 389, 712 0 124, 650 560, 044 194. 03 194. 04 07954 VACANT UNFI NI SHED AREA 48, 429 0 0 0 0 194. 04 200. 00 0 Negati ve Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5, 266	24, 872	2 0	7, 955	0	190. 00
192. 01 19201 OTHER NONREIMBURSABLE 0 7, 852 0 2, 511 0 192. 01 194. 00 194. 00 07950 NONREIMBURSABLE 0 0 0 0 0 0 194. 00 194. 01 07951 MARKETI NG 246, 760 0 0 0 0 194. 01 194. 01 194. 02 07952 SINIOR CIRCLE 21, 046 0 0 0 0 194. 02 194. 03 07953 OTHER NONREIMB COST C - REGENCY LTA 27, 188 389, 712 0 124, 650 560, 044 194. 03 194. 04 07954 VACANT UNFINI SHED AREA 48, 429 0 0 0 0 194. 04 200. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			696, 959	3, 290, 872	2	1, 052, 591	410, 555	192. 00
194. 00 07950 NONREIMBURSABLE 0 0 0 0 0 194. 00 194. 01 07951 MARKETI NG 246, 760 0 0 0 0 194. 01 194. 02 07952 SENI OR CIRCLE 21, 046 0 0 0 0 194. 02 194. 03 07953 OTHER NONREIMB COST C - REGENCY LTA 27, 188 389, 712 194. 04 07954 VACANT UNFINI SHED AREA 48, 429 0 0 124, 650 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	192. 0°	1 19201 OTHER NONREIMBURSABLE	0			2, 511		
194. 01 07951 MARKETING 246, 760 0 0 0 0 194. 01 194. 01 194. 02 07952 SENI OR CIRCLE 21, 046 0 0 0 0 194. 02 194. 03 07953 OTHER NONREIMB COST C - REGENCY LTA 27, 188 389, 712 0 124, 650 560, 044 194. 03 194. 04 07954 VACANT UNFINI SHED AREA 48, 429 0 0 0 194. 04 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0			0	0	194. 00
194. 02 07952 SENI OR CIRCLE 21, 046 0 0 0 194. 02 194. 03 07953 OTHER NONREIMB COST C - REGENCY LTA 27, 188 389, 712 0 124, 650 560, 044 194. 03 194. 04 07954 VACANT UNFI NI SHED AREA 48, 429 0 0 0 194. 04 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				_	· -	n	•	
194. 03 07953 OTHER NONREIMB COST C - REGENCY LTA 27, 188 389, 712 0 124, 650 560, 044 194. 03 194. 04 07954 VACANT UNFINISHED AREA 48, 429 0 0 0 194. 04 200. 00 Cross Foot Adjustments 0 Negative Cost Centers 0 0 0 0 0 0 0 201. 00					· -	n		
194. 04 07954 VACANT UNFINISHED AREA     48, 429     0     0     0     0 194. 04       200. 00 201. 00     Cross Foot Adjustments     200. 00     0     0     0     0     0     0     0	194 0	07953 OTHER NONRELMB COST C - REGENCY LTA			_	124 650		
200.00       Cross Foot Adjustments       200.00         201.00       Negative Cost Centers       0       0       0       0       0       0       201.00						124, 030 N	555, 544 n	194 04
201.00   Negative Cost Centers   0   0   0   0   201.00			40, 427		1	U	i	
				_		0	^	
202.00    101ML (Suiii 111165 110-201)   41,300,113  13,180,331  1,198,888  4,980,013  3,101,0/1 202.00			_		1 700 000	4 004 413		
	202.00	DI TOTAL (SUIII TITIES TTO-ZUT)	47,000,773	10,700,001	1, /90, 000	4, 700, 013	3, 101, 0/1	J2U2. UU

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2016	Part
To 12/31/2016	Date/Time Prepared:
5/30/2017	10: 19 am

				12/31/2010	5/30/2017 10:	
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
	11. 00	13.00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00   00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
8.00   00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00   01000 DI ETARY						10. 00
11. 00   01100   CAFETERI A	2, 272, 090					11. 00
13.00 O1300 NURSING ADMINISTRATION	88, 950	7, 461, 031				13. 00
14.00  01400   CENTRAL SERVI CES & SUPPLY	59, 714	0	3, 067, 795			14. 00
15. 00   01500   PHARMACY	54, 320		0	5, 375, 301		15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	41, 245	0	0	0	4, 169, 498	16. 00
23. 00   02300   ALLI ED   HEALTH	0	0	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	1					
30. 00   03000   ADULTS & PEDI ATRI CS	533, 737			0	322, 232	30. 00
31. 00   03100   INTENSIVE CARE UNIT	161, 894		0	0	78, 389	31.00
31. 01   03101   NEONATAL INTENSIVE CARE UNIT	44, 737			0	43, 366	31. 01
41. 00   04100   SUBPROVI DER -   RF	26, 016		0	0	15, 345	41.00
43. 00   04300   NURSERY	10, 903	46, 580	0	0	6, 143	43. 00
ANCILLARY SERVICE COST CENTERS	0/4 000	4 407 704		ما	700 000	F0 00
50. 00   05000   OPERATING ROOM	264, 832		0	0	799, 980	50.00
51. 00 05100 RECOVERY ROOM	0		0	0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	60, 257	257, 370	0	U	33, 942	52.00
53. 00   05300   ANESTHESI OLOGY	104 254	047.000	0	U O	39, 296	53.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C 54. 01   05401   ULTRASOUND	194, 254	867, 082	0	U O	553, 780 0	54. 00 54. 01
56. 00   05600   RADI 0I SOTOPE	0		0	0	0	56.00
57. 00   05700 CT   SCAN			0	0	0	57.00
58. 00   05800   MRI	0	0	0	0	0	58.00
60. 00   06000   LABORATORY	213, 208	0	214, 019	0	457, 902	60.00
65. 00   06500   RESPIRATORY THERAPY	56, 901		214, 017	0	87, 252	65. 00
66. 00   06600   PHYSI CAL THERAPY	44, 543		0	0	42, 051	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	15, 346		0	Ö	20, 605	67. 00
68. 00 06800 SPEECH PATHOLOGY	7, 624		0	ol	7, 341	1
69. 00 06900 ELECTROCARDI OLOGY	149, 517	640, 253	0	ol	332, 038	69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0 10, 200	257, 319	ol	101, 575	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	-	2, 596, 457	ol	395, 667	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 785	o	0	5, 375, 301	386, 427	73. 00
74.00 07400 RENAL DIALYSIS	0	o	o	o	7, 200	74.00
76. 00 03950 ANCI LLARY	0	О	0	o	0	76. 00
76. 01   03610   SLEEP LAB	0	0	О	o	0	76. 01
76. 03 03951 WOUND CARE	20, 079	0	0	0	21, 299	76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0		0	0	0	90. 00
91. 00   09100   EMERGENCY	210, 957	1, 116, 856	0	0	417, 668	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	2, 260, 819	7, 461, 031	3, 067, 795	5, 375, 301	4, 169, 498	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			0		190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0			0		192.00
192. 01 19201 OTHER NONREI MBURSABLE	0	0	_	0		192. 01
194. 00 07950 NONREI MBURSABLE	0	0	0	0		194. 00
194. 01 07951 MARKETI NG	9, 312		0	0		194. 01
194. 02 07952 SENI OR CI RCLE	1, 959		0	0		194. 02
194. 03 07953 OTHER NONREIMB COST C - REGENCY LTA	0		0	0		194. 03
194. 04 07954 VACANT UNFINISHED AREA	0	ا		٥	0	194. 04
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers			_		Ō	200. 00 201. 00
202.00   TOTAL (sum lines 118-201)	2, 272, 090	7, 461, 031	3, 067, 795	5, 375, 301		
202.00    101AL (30111 111103 110-201)	2,212,090	1,401,031	3,007,795	5, 575, 501	4, 107, 490	1202. UU

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0035 Peri od: Worksheet B From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 5/30/2017 10:19 am Cost Center Description ALLIED HEALTH Subtotal Intern & Total Residents Cost & Post Stepdown Adjustments 23.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 16 00 23.00 02300 ALLIED HEALTH 55, 185 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 40, 091, 044 30.00 0 40 091 044 0 0 31.00 03100 INTENSIVE CARE UNIT 0 12, 969, 785 12, 969, 785 31.00 03101 NEONATAL INTENSIVE CARE UNIT 0 3, 781, 145 0 3, 781, 145 31.01 31.01 04100 SUBPROVIDER - IRF 41.00 0 2, 989, 542 0 2, 989, 542 41.00 04300 NURSERY 0 0 43.00 855, 753 855, 753 43 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 27, 167, 179 50.00 27, 167, 179 0 51.00 05100 RECOVERY ROOM 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 4, 735, 956 4, 735, 956 0 52 00 52 00 53.00 05300 ANESTHESI OLOGY 364, 129 0 364, 129 53.00 05400 RADI OLOGY-DI AGNOSTI C 000000000000000 18, 784, 412 0 18, 784, 412 54.00 54.00 05401 ULTRASOUND 0 54.01 0 54.01 05600 RADI OI SOTOPE 0 56.00 Ω 0 56.00 0 57.00 05700 CT SCAN 0 0 57.00 05800 MRI 0 58.00 0 58.00 17, 966, 799 0 17, 966, 799 60.00 06000 LABORATORY 60.00 06500 RESPIRATORY THERAPY 0 3, 409, 244 65.00 3, 409, 244 65 00 06600 PHYSI CAL THERAPY 3, 812, 821 3, 812, 821 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 934, 507 934, 507 67.00 06800 SPEECH PATHOLOGY 574, 631 0 574, 631 68.00 68.00 06900 ELECTROCARDI OLOGY 69.00 13, 370, 048 13, 370, 048 69.00 3, 249, 749 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 3, 249, 749 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 31, 703, 530 31, 703, 530 72.00 72.00 0 28, 158, 589 73.00 07300 DRUGS CHARGED TO PATIENTS 28, 158, 589 73.00 0 74.00 07400 RENAL DIALYSIS 722, 566 0 722, 566 74.00 76.00 03950 ANCI LLARY 0 76.00 0 03610 SLEEP LAB 0 76.01 0 76.01 03951 WOUND CARE 0 76.03 2, 745, 424 2, 745, 424 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 09100 EMERGENCY 20, 599, 134 55. 185 20, 599, 134 0 91.00 91 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 55, 185 238, 985, 987 0 238, 985, 987 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 60, 535 0 60, 535 190 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 8, 421, 437 0 8, 421, 437 192.00 0 192. 01 19201 OTHER NONREI MBURSABLE 0 10, 363 192. 01 10, 363 194. 00 07950 NONREI MBURSABLE 0 194.00 0 194. 01 07951 MARKETI NG 1, 307, 772 1, 307, 772 194. 01 194. 02 07952 SENI OR CIRCLE 0 0 0 112, 702 112, 702 194.02 194. 03 07953 OTHER NONREIMB COST C - REGENCY LTA 0 1, 217, 468 1, 217, 468 194 03 194. 04 07954 VACANT UNFINISHED AREA 0 254, 835 254, 835 194.04 200.00 Cross Foot Adjustments 0 0 200.00 C 0 201.00 Negative Cost Centers 201.00 TOTAL (sum lines 118-201) 55.185 250, 371, 099 250, 371, 099 202.00 202. 00

| Peri od: | Worksheet B | From 01/01/2016 | Part | I | To 12/31/2016 | Date/Time Prepared: | To 12/31/2016 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0035

					То	12/31/2016	Date/Time Prep 5/30/2017 10:	
				CAPI TAL REL	LATED COSTS		3/30/2017 10.	17 alli
	C	ost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
			Assigned New				BENEFI TS	
			Capi tal				DEPARTMENT	
			Related Costs 0	1 00	2.00	2.4	4.00	
	CENEDAL	. SERVICE COST CENTERS	0	1. 00	2.00	2A	4. 00	
1.00		AP REL COSTS-BLDG & FLXT						1. 00
2. 00		AP REL COSTS-MVBLE EQUIP						2. 00
4.00		MPLOYEE BENEFITS DEPARTMENT	o	20, 489	41, 688	62, 177	62, 177	4. 00
5.00	00500 AI	DMINISTRATIVE & GENERAL	o	282, 947	575, 705	858, 652	5, 372	5. 00
7.00	00700 0	PERATION OF PLANT	0	1, 268, 069	2, 580, 101	3, 848, 170	1, 138	7. 00
8.00		AUNDRY & LINEN SERVICE	0	7, 341	14, 938	22, 279	89	8. 00
9. 00	1 1	OUSEKEEPI NG	0	49, 186		149, 264	1, 338	9. 00
10.00	01000 D		0	149, 748		454, 436	609	10.00
11. 00 13. 00	1 1	AFETERIA URSING ADMINISTRATION	U O	72, 900	0 148, 329	0 221, 229	791	11. 00 13. 00
14. 00		ENTRAL SERVICES & SUPPLY	0	104, 040		315, 728	2, 631 674	14. 00
15. 00	01500 PI		o	57, 073		173, 198	1, 874	
16. 00		EDICAL RECORDS & LIBRARY	ol	19, 659		59, 659	674	16. 00
23. 00		LLIED HEALTH	o	0		0	0	23. 00
	I NPATI E	NT ROUTINE SERVICE COST CENTERS						
30.00		DULTS & PEDIATRICS	0	858, 939		2, 606, 601	11, 000	30. 00
31. 00		NTENSIVE CARE UNIT	0	149, 663		454, 180	3, 978	31. 00
31. 01		EONATAL INTENSIVE CARE UNIT	0	57, 856		175, 575	1, 256	
41. 00 43. 00	04100 SI	UBPROVI DER - I RF	0	101, 813		308, 970	666 257	41. 00 43. 00
43.00		RY SERVICE COST CENTERS	U	18, 346	37, 328	55, 674	237	43.00
50. 00		PERATING ROOM	ol	503, 122	1, 023, 691	1, 526, 813	6, 224	50. 00
51. 00		ECOVERY ROOM	O	0	0	0	0	51. 00
52.00	05200 D	ELIVERY ROOM & LABOR ROOM	O	100, 139	203, 751	303, 890	1, 422	52.00
53.00		NESTHESI OLOGY	0	8, 685		26, 357	0	53.00
54. 00		ADI OLOGY-DI AGNOSTI C	0	362, 774		1, 100, 901	4, 790	
54. 01		LTRASOUND	0	0	0	0	0	54. 01
56. 00		ADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00 58. 00	05700 C		0	0	0	0	0	57. 00 58. 00
60.00		ABORATORY	Ö	135, 956	276, 626	412, 582	3, 819	60.00
65. 00		ESPI RATORY THERAPY	o	24, 467		74, 248	1, 241	
66.00		HYSI CAL THERAPY	0	139, 004		421, 833	1, 123	66. 00
67. 00	06700 0	CCUPATI ONAL THERAPY	0	0	0	0	404	67. 00
68. 00		PEECH PATHOLOGY	0	0	0	0	250	68. 00
69. 00	1 1	LECTROCARDI OLOGY	0	231, 242		701, 743	3, 537	69. 00
71. 00		EDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72. 00 73. 00		MPL. DEV. CHARGED TO PATIENTS RUGS CHARGED TO PATIENTS	0	0	0	0	0 77	72. 00 73. 00
74. 00		ENAL DIALYSIS	0	5, 053	10, 281	15, 334	0	74. 00
76.00		NCI LLARY	ol	0,000	10, 201	0	0	76.00
76. 01		LEEP LAB	0	0	0	O	0	76. 01
76. 03	03951 W	OUND CARE	0	79, 919	162, 610	242, 529	493	76. 03
		ENT SERVICE COST CENTERS						
	09000 C		0	0	0	0	0	
91.00		MERGENCY BSERVATION BEDS (NON-DISTINCT PART	0	351, 055	714, 283	1, 065, 338	6, 170	
92. 00	SDECT VI	. PURPOSE COST CENTERS				υĮ		92. 00
118.00		UBTOTALS (SUM OF LINES 1-117)	ol	5, 159, 485	10, 497, 875	15, 657, 360	61, 897	118 00
110.00		BURSABLE COST CENTERS	<u> </u>	0, 107, 100	10, 177, 070	10, 007, 000	01, 077	110.00
190.00		IFT, FLOWER, COFFEE SHOP & CANTEEN	0	7, 395		22, 442	0	190. 00
		HYSICIANS' PRIVATE OFFICES	o	978, 484	1, 990, 897	2, 969, 381	0	192. 00
		THER NONREIMBURSABLE	0	0	0	0		192. 01
		ONREI MBURSABLE	0	0	0	0		194. 00
		ARKETI NG	0	2, 335	4, 750	7, 085		194. 01
		ENIOR CIRCLE THER NONREIMB COST C - REGENCY LTA	0	0 115, 874		0 115, 874		194. 02 194. 03
		ACANT UNFINISHED AREA	0	206, 406		206, 406		194. 03 194. 04
200.00		ross Foot Adjustments	٩	200, 400		200, 400 N		200. 00
201.00		egative Cost Centers		0	О	o		201. 00
202.00		OTAL (sum lines 118-201)	О	6, 469, 979	12, 508, 569	18, 978, 548	62, 177	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0035

Peri od: Worksheet B From 01/01/2016 Part II To 12/31/2016 Date/Time Prepared:

5/30/2017 10:19 am Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 864, 024 5 00 5 00 7.00 00700 OPERATION OF PLANT 54, 462 3, 903, 770 7.00 34, 599 00800 LAUNDRY & LINEN SERVICE 8.00 6, 123 6, 108 8.00 9.00 00900 HOUSEKEEPI NG 16, 639 40, 923 208, 164 9.00 0 01000 DI ETARY 0 594, 767 10.00 10.00 8.408 124, 589 6,725 01100 CAFETERI A 7,842 0 0 11.00 11.00 13 00 01300 NURSING ADMINISTRATION 24, 326 60, 653 0 3, 274 0 13.00 01400 CENTRAL SERVICES & SUPPLY 8,788 14.00 0 14 00 86, 561 4.672 0 15.00 01500 PHARMACY 16, 302 47, 484 96 2, 563 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 13, 946 16, 356 0 883 0 16.00 02300 ALLIED HEALTH 23.00 190 23.00 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 106, 842 714, 631 13, 818 38, 572 331, 560 30.00 03100 INTENSIVE CARE UNIT 38, 015 31.00 124, 519 3,083 6,721 32, 614 31.00 10, 998 2, 196 03101 NEONATAL INTENSIVE CARE UNIT 2, 598 48, 136 207 31.01 31.01 04100 SUBPROVIDER - IRF 41.00 7.615 84, 708 1, 342 4, 572 19,074 41.00 04300 NURSERY 43.00 2,422 15, 264 170 824 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 859 50.00 77, 710 418, 594 4, 256 22, 593 50.00 05100 RECOVERY ROOM 51.00 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 13, 365 83, 315 881 4, 497 4, 112 52.00 05300 ANESTHESI OLOGY 988 7, 226 390 53.00 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 53,095 301, 825 3, 343 16, 291 144 54.00 54.01 05401 ULTRASOUND 0 0 54.01 0 05600 RADI OI SOTOPE 56.00 0 0 0 0 56.00 05700 CT SCAN 0 0 57.00 57.00 0 0 0 05800 MRI 58.00 0 0 0 0 58.00 60.00 06000 LABORATORY 56,870 113, 114 2 6, 105 0 60.00 06500 RESPIRATORY THERAPY 65.00 10,894 20, 356 C 1,099 0 65.00 66 00 06600 PHYSI CAL THERAPY 10.706 115, 651 135 6, 242 66 00 0 06700 OCCUPATIONAL THERAPY 67.00 3, 101 0 0 67.00 06800 SPEECH PATHOLOGY 1,932 0 68.00 68.00 C 69.00 06900 ELECTROCARDI OLOGY 38.408 192.391 10.384 4.689 69.00 1, 316 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 9.977 71.00 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 99,090 C 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 77, 291 0 0 0 73.00 74 00 07400 RENAL DIALYSIS 2, 391 0 227 74 00 4 204 0 76.00 03950 ANCI LLARY C 0 0 0 76.00 0 03610 SLEEP LAB 0 76.01 76.01 C 0 76.03 03951 WOUND CARE 66, 492 3, 589 0 76.03 8,078 166 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 0 91.00 09100 EMERGENCY 58, 221 292, 075 5, 784 15, 765 13, 364 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 845, 035 2, 985, 175 34, 599 158, 586 408, 612 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 190. 00 6. 153 96 332 78, 742 192. 00 12.657 814, 093 0 43.938 192. 01 19201 OTHER NONREI MBURSABLE 1, 942 0 105 0 192.01 194. 00 07950 NONREI MBURSABLE O C 0 0 0 194.00 194. 01 07951 MARKETI NG 4, 481 0 0 194, 01 C 0 0 0 194. 02 194. 02 07952 SENI OR CIRCLE 382 194. 03 07953 OTHER NONREIMB COST C - REGENCY LTA 494 0 107, 413 194. 03 96, 407 5, 203 194. 04 07954 VACANT UNFINISHED AREA 879 0 0 194. 04 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 201.00 202.00 TOTAL (sum lines 118-201) 864, 024 3, 903, 770 34, 599 208, 164 594, 767 202. 00 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0035 

			То	12/31/2016	Date/Time Pre 5/30/2017 10:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	7 4111
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11 00	12.00	SUPPLY	15.00	LI BRARY	
GENERAL SERVICE COST CENTERS	11. 00	13.00	14. 00	15. 00	16. 00	
1. 00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00   00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
8.00   00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00   01000   DI ETARY						10. 00
11. 00   01100   CAFETERI A	8, 633	040 454				11.00
13. 00   01300   NURSI NG   ADMI NI STRATI ON	338	312, 451	41/ /50			13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	227	14 204	416, 650	255 027		14.00
15. 00   01500   PHARMACY 16. 00   01600   MEDI CAL RECORDS & LI BRARY	206 157	14, 204 0	0	255, 927 0	91, 675	15. 00 16. 00
23. 00   02300   ALLI ED   HEALTH	157		0	o	91, 073	23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		<u> Ч</u>	0	<u> </u>		25.00
30. 00 03000 ADULTS & PEDIATRICS	2, 030	83, 733	0	0	7, 091	30. 00
31.00 03100 INTENSIVE CARE UNIT	615	30, 151	0	0	1, 725	31. 00
31.01 03101 NEONATAL INTENSIVE CARE UNIT	170	9, 522	0	0	954	31. 01
41. 00   04100   SUBPROVI DER -   RF	99	5, 049	0	0	338	41. 00
43. 00 04300 NURSERY	41	1, 951	0	0	135	43. 00
ANCILLARY SERVICE COST CENTERS	1 00/			ما		
50. 00   05000   OPERATI NG ROOM	1, 006	47, 177	0	0	17, 524	50.00
51. 00 05100 RECOVERY ROOM	0 229	10 777	0	0	0	51.00
52.00   05200   DELI VERY ROOM & LABOR ROOM   53.00   05300   ANESTHESI OLOGY	229	10, 777	0	0	747 865	52. 00 53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	738	36, 309	0	0	12, 187	54.00
54. 01   05401   ULTRASOUND	0	0	Ö	0	12, 107	54. 01
56. 00   05600   RADI OI SOTOPE	0	o	O	o	0	56. 00
57. 00   05700 CT SCAN	0	O	0	0	0	57. 00
58. 00   05800   MRI	0	o	0	0	0	58. 00
60. 00   06000   LABORATORY	810	0	29, 066	0	10, 077	60. 00
65. 00 06500 RESPI RATORY THERAPY	216	0	0	0	1, 920	1
66. 00   06600   PHYSI CAL THERAPY	169	0	0	0	925	66. 00
67. 00   06700   OCCUPATI ONAL THERAPY	58	0	0	0	453	67.00
68. 00 06800 SPEECH PATHOLOGY	29	2/ 010	0	O O	162	68. 00
69. 00   06900   ELECTROCARDI OLOGY 71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT	568	26, 810 0	34, 947	0	7, 307 2, 235	69. 00 71. 00
72. 00 07100 IMPL. DEV. CHARGED TO PATIENTS	0		352, 637	0	2, 233 8, 707	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	7	Ö	0	255, 927	8, 504	73.00
74.00 07400 RENAL DIALYSIS	0	o	0	0	158	
76. 00 03950 ANCI LLARY	0	o	0	0	0	76. 00
76. 01   03610   SLEEP LAB	0	o	0	0	0	76. 01
76. 03 03951 WOUND CARE	76	0	0	0	469	76. 03
OUTPATIENT SERVICE COST CENTERS				-1		
90. 00   09000   CLI NI C	0		0	0	0	
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATI ON   BEDS   (NON-DI STINCT   PART	802	46, 768	U	o	9, 192	91. 00 92. 00
SPECIAL PURPOSE COST CENTERS						92.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	8, 591	312, 451	416, 650	255, 927	91 675	118. 00
NONREI MBURSABLE COST CENTERS	0, 371	312, 431	410,000	233, 721	71,073	1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	O	0	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	o	0	0		192. 00
192.01 19201 OTHER NONREIMBURSABLE	0	O	0	0	0	192. 01
194. 00 07950 NONREI MBURSABLE	0	0	0	0	0	194. 00
194. 01 07951 MARKETI NG	35	0	0	0		194. 01
194. 02 07952 SENI OR CI RCLE	7	이	0	0		194. 02
194. 03 07953 OTHER NONREIMB COST C - REGENCY LTA	0	0	0	0		194. 03
194. 04 07954 VACANT UNFI NI SHED AREA	0		0	이	0	194. 04
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	^		0		0	200. 00 201. 00
202.00   TOTAL (sum lines 118-201)	8, 633	312, 451	416, 650	255, 927		201.00
202.00    101AL (30III 111163 110-201)	0, 033	1 312,431	+10,030	233, 721	71,073	1202.00

near the Fillancial Systems	PURIER WEWURIA				u or Form CMS-	2332-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co	CN: 15-0035 Per Fro To	ri od: om 01/01/2016 12/31/2016	Worksheet B Part II Date/Time Pre 5/30/2017 10:	
Cost Center Description	ALLI ED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	23. 00	24.00	25. 00	26. 00		
GENERAL SERVICE COST CENTERS						
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 ADMINISTRATIVE & GENERAL 7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 01000 DIETARY 11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION 14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY 23. 00 02300 ALLIED HEALTH	190					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
30. 00   03000   ADULTS & PEDI ATRI CS		3, 915, 878	0	3, 915, 878		30. 00
31. 00 03100   INTENSIVE CARE UNIT		695, 601		695, 601		31.00
31. 01   03101   NEONATAL   NTENSI VE CARE UNI T		251, 612 432, 433		251, 612		31. 01
41. 00   04100   SUBPROVI DER - I RF 43. 00   04300   NURSERY		432, 433 76, 738		432, 433 76, 738		41. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS		70, 730	, O	70, 730		43.00
50. 00 05000 OPERATING ROOM		2, 122, 756	0	2, 122, 756		50.00
51.00 05100 RECOVERY ROOM		0	0	o		51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM		423, 235		423, 235		52. 00
53. 00   05300   ANESTHESI OLOGY		35, 826		35, 826		53. 00
54. 00   05400  RADI OLOGY-DI AGNOSTI C 54. 01   05401  ULTRASOUND		1, 529, 623	0	1, 529, 623		54. 00 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	o o	o		58. 00
60. 00   06000   LABORATORY		632, 445	0	632, 445		60.00
65. 00 06500 RESPIRATORY THERAPY		109, 974		109, 974		65. 00
66. 00   06600   PHYSI CAL THERAPY		556, 784		556, 784		66.00
67. 00 06700 OCCUPATI ONAL THERAPY		4, 016		4, 016		67.00
68. 00   06800   SPEECH PATHOLOGY 69. 00   06900   ELECTROCARDI OLOGY		2, 373 987, 153		2, 373 987, 153		68. 00 69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		47, 159		47, 159		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		460, 434		460, 434		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		341, 806	0	341, 806		73. 00
74. 00   07400   RENAL DI ALYSI S		22, 314		22, 314		74. 00
76. 00   03950   ANCI LLARY		0	1	0		76.00
76. 01   03610  SLEEP LAB 76. 03   03951  WOUND CARE		321, 892	0	321, 892		76. 01 76. 03
OUTPATIENT SERVICE COST CENTERS		321, 072		321, 072		70.03
90. 00 09000 CLI NI C		0	0	0		90.00
91. 00   09100   EMERGENCY		1, 513, 479		1, 513, 479		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART			0			92. 00
SPECIAL PURPOSE COST CENTERS		14 402 521		14 402 E21		110 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)  NONREI MBURSABLE COST CENTERS	0	14, 483, 531	0	14, 483, 531		118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		29, 023	0	29, 023		190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES		3, 918, 811		3, 918, 811		192. 00
192. 01 19201 OTHER NONREI MBURSABLE		2, 047	0	2, 047		192. 01
194. 00 07950 NONREI MBURSABLE		0	0	0		194. 00
194. 01 07951 MARKETI NG		11, 844		11, 844		194. 01
194. 02 07952 SENIOR CIRCLE 194. 03 07953 OTHER NONREIMB COST C - REGENCY LTA		426 325, 391		426 325, 391		194. 02 194. 03
194.03 07933 0THER NONKETIMB COST C - REGENCT LTA		207, 285		207, 285		194. 03
200.00 Cross Foot Adjustments	190	190		190		200.00
201.00 Negative Cost Centers	0	0	0	o		201. 00
202.00 TOTAL (sum lines 118-201)	190	18, 978, 548	0	18, 978, 548		202. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0035 Peri od: Worksheet B-1 From 01/01/2016 12/31/2016 Date/Time Prepared: 5/30/2017 10:19 am CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE (SQUARE FEET) (DOLLAR VALUE) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5. 00 4.00 5A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 842 513 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 800, 546 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 89, 785, 495 4.00 2,668 2,668 00500 ADMINISTRATIVE & GENERAL 7, 752, 242 5 00 36, 845 -47, 580, 773 202 790 326 5 00 36 845 7.00 00700 OPERATION OF PLANT 165, 126 165, 126 1, 642, 527 12, 781, 603 7.00 1, 437, 027 8.00 00800 LAUNDRY & LINEN SERVICE 956 956 128, 279 8.00 00900 HOUSEKEEPI NG 6, 405 6, 405 1, 931, 238 0 3, 904, 965 9.00 9.00 1, 973, 339 01000 DI ETARY 0 10.00 879, 237 10 00 19,500 19, 500 11.00 01100 CAFETERI A 1, 141, 703 0 1, 840, 300 11.00 01300 NURSING ADMINISTRATION 9, 493 9, 493 3, 796, 992 5, 708, 981 13.00 0 13.00 01400 CENTRAL SERVICES & SUPPLY 13, 548 13, 548 972, 188 2, 062, 358 14.00 14.00 7, 432 3, 825, 801 15.00 01500 PHARMACY 7.432 2, 704, 036 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 2,560 2, 560 973, 294 0 3, 273, 034 16.00 02300 ALLIED HEALTH 23.00 44, 698 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 111,850 111, 850 15, 935, 428 0 25, 089, 303 30.00 19, 489 03100 INTENSIVE CARE UNIT 19, 489 5, 739, 777 0 8, 921, 517 31.00 31.00 31.01 03101 NEONATAL INTENSIVE CARE UNIT 7,534 7, 534 1, 812, 633 0 2, 581, 012 31.01 04100 SUBPROVI DER - I RF 0 13, 258 13, 258 961, 252 1, 787, 120 41.00 41.00 04300 NURSERY 43.00 2, 389 2, 389 371, 317 568, 455 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 65, 516 65, 516 8, 981, 026 18, 237, 556 50.00 05100 RECOVERY ROOM 0 51.00 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 13,040 13,040 2, 051, 640 0 3, 136, 655 52.00 05300 ANESTHESI OLOGY 0 53.00 1, 131 1, 131 231, 874 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 47.240 47.240 6, 911, 997 12, 460, 750 54.00 54.01 05401 ULTRASOUND 0 C 54.01 0 05600 RADI OI SOTOPE 56.00 0 0 0 0 0 0 0 0 56.00 57.00 05700 CT SCAN 0 0 57.00 05800 MRI 58 00 58 00 60.00 06000 LABORATORY 17, 704 17, 704 5, 510, 583 13, 346, 566 60.00 06500 RESPIRATORY THERAPY 1, 790, 610 2, 556, 624 65.00 3, 186 3, 186 65.00 06600 PHYSI CAL THERAPY 1, 620, 097 2, 512, 625 66.00 18, 101 18, 101 66.00 06700 OCCUPATIONAL THERAPY 727, 794 67.00 583, 189 67.00 68.00 06800 SPEECH PATHOLOGY 360, 632 453, 307 68.00 69.00 06900 ELECTROCARDI OLOGY 30, 112 30, 112 5, 103, 817 0 0 0 9, 013, 944 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71 00 0 C 2, 341, 475 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 C  $\cap$ 23, 255, 069 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 110, 675 18, 139, 099 73.00 0 74.00 07400 RENAL DIALYSIS 658 561, 249 74.00 658 0 03950 ANCLLLARY 76 00 76 00 0 0 0 76.01 03610 SLEEP LAB  $\cap$ 0 0 76.01 03951 WOUND CARE 1, 895, 851 76.03 76.03 10.407 10, 407 711, 615 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0 0 90 00 91.00 09100 EMERGENCY 45, 714 45, 714 8, 903, 085 13, 663, 796 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 671, 862 89, 381, 109 -47, 580, 773 198, 333, 747 118. 00 118.00 671, 862 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 963 963 C 22, 442 190. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 2, 970, 460 192. 00 0 0 127, 417 127, 417 192. 01 19201 OTHER NONREI MBURSABLE 0 0 0 192. 01 194. 00 07950 NONREI MBURSABLE 0 0 0 194.00 0 194. 01 07951 MARKETI NG 351, 313 1, 051, 700 194. 01 304 304 89, 697 194. 02 194. 02 07952 SENI OR CIRCLE C 53.073 194. 03 07953 OTHER NONREIMB COST C - REGENCY LTA 15,089 115, 874 194. 03 C C 194. 04 07954 VACANT UNFINISHED AREA 26,878 0 206, 406 194. 04 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 47, 580, 773 202. 00 6, 469, 979 12, 508, 569 16, 836, 499 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 7. 679382 15.625047 0.187519 0. 234630 203. 00 Cost to be allocated (per Wkst. B, 864, 024 204, 00 204.00 62, 177 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000693 0.004261 205.00 II)

COST A	LLOCATION - STATISTICAL BASIS		Provider Co		Peri od:	Worksheet B-1	
					rom 01/01/2016 o 12/31/2016	Date/Time Pre 5/30/2017 10:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	19 alli
		PLANT (SOUADE FEET)	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	(FTE'S)	
		(SQUARE FEET)	(POUNDS OF LAUNDR)				
		7. 00	8.00	9. 00	10.00	11. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT						1 00
2. 00	00200 CAP REL COSTS-BLDG & FTXT						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL	/10.00/					5.00
7. 00 8. 00	OO7OO  OPERATION OF PLANT   OO8OO  LAUNDRY & LINEN SERVICE	610, 996 956	l .				7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	6, 405		603, 635	5		9. 00
10.00	01000 DI ETARY	19, 500	0	19, 500		447 447	10.00
11. 00 13. 00	01100   CAFETERI A   01300   NURSI NG   ADMI NI STRATI ON	9, 493	0	9, 493	) 3	117, 117 4, 585	1
	01400 CENTRAL SERVICES & SUPPLY	13, 548		13, 548			14. 00
15. 00	01500 PHARMACY	7, 432				2, 800	1
16.00	01600   MEDICAL RECORDS & LIBRARY   02300   ALLIED HEALTH	2, 560		2, 560 0		2, 126 0	1
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		0		را ال	0	23.00
30.00	03000 ADULTS & PEDIATRICS	111, 850				27, 512	
31.00	03100 I NTENSI VE CARE UNI T	19, 489				8, 345	
31. 01 41. 00	03101   NEONATAL   INTENSIVE CARE UNIT   04100   SUBPROVIDER -   IRF	7, 534 13, 258				2, 306 1, 341	•
43. 00	04300 NURSERY	2, 389				562	•
	ANCILLARY SERVICE COST CENTERS						
50. 00 51. 00	05000   OPERATI NG ROOM   05100   RECOVERY ROOM	65, 516		65, 516		13, 651 0	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	13, 040	_	-	1	3, 106	1
53.00	05300 ANESTHESI OLOGY	1, 131	0	1, 131		0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	47, 240	208, 968	47, 240	62	10, 013	1
54. 01 56. 00	05401   ULTRASOUND   05600   RADI OI SOTOPE	0	0			0	
57. 00	05700 CT SCAN	Ö	Ö		ol ol	0	1
58. 00	05800 MRI	0	0	C	o	0	
60.00	06000 LABORATORY	17, 704	l .	1		10, 990	1
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	3, 186 18, 101	l .	3, 18 <i>6</i> 18, 101		2, 933 2, 296	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0, 431	10, 10	o o	791	1
68. 00	06800 SPEECH PATHOLOGY	0	0	C	o	393	1
69. 00	06900 ELECTROCARDI OLOGY	30, 112	82, 287	30, 112		7, 707 0	1
71. 00 72. 00	07100   MEDICAL SUPPLIES CHARGED TO PATIENT   07200   IMPL. DEV. CHARGED TO PATIENTS		0			0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	Ö	d	o	92	1
74.00	07400 RENAL DIALYSIS	658	0	658	0	0	
76. 00 76. 01	03950 ANCI LLARY 03610 SLEEP LAB	0	0	(		0	
	03951 WOUND CARE	10, 407	10, 354	10, 407			76. 03
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C 09100 EMERGENCY	0 45, 714	0 361, 612	( 45, 714	0 1 5, 769	0 10, 874	90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	45, 714	301, 012	45, 714	5, 709	10, 874	92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	· · · · · · · · · · · · · · · · · · ·	467, 223	2, 163, 042	459, 862	176, 393	116, 536	118. 00
190 00	NONREIMBURSABLE COST CENTERS   19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	963	0	963	s ol	0	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	127, 417		127, 417			192. 00
	19201 OTHER NONREI MBURSABLE	304	0	304			192. 01
	07950  NONREI MBURSABLE  07951  MARKETI NG	0	0		1		194. 00 194. 01
	07952 SENI OR CI RCLE		0				194. 01
194. 03	07953 OTHER NONREIMB COST C - REGENCY LTA	15, 089	0	15, 089	46, 369	0	194. 03
	07954 VACANT UNFI NI SHED AREA	0	0	C	0	0	194. 04
200. 00 201. 00	, ,						200. 00 201. 00
202.00		15, 780, 551	1, 798, 888	4, 986, 613	3, 101, 071	2, 272, 090	
	Part I)	05.0075	0.0047:=	0.0405=	40.0770		
203. 00 204. 00		25. 827585 3, 903, 770				19. 400172 8. 633	203. 00
204.00	Part II)	3, 753, 770	34, 377	200, 104	374, 707	0, 033	254.00
205.00		6. 389191	0. 015996	0. 344851	2. 316486	0. 073713	205. 00
	11)	I	I	I			I

	Financial Systems	PORTER MEMORIA				u of Form CMS-2	2552-10
COST A	NLLOCATION - STATISTICAL BASIS		Provider CC	Fi	eriod: com 01/01/2016	Worksheet B-1	
				To	12/31/2016	Date/Time Pre 5/30/2017 10:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	ALLI ED HEALTH	
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	(ASSI GNED	
		(NURSING WA	SUPPLY (COSTED	REQUI S. )	LI BRARY (GROSS	TIME)	
		GES)	REQUIS.)		CHARGES)		
		13.00	14. 00	15. 00	16. 00	23. 00	
1 00	GENERAL SERVI CE COST CENTERS						1 1 00
1. 00 2. 00	OO100   CAP REL COSTS-BLDG & FIXT   OO200   CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A						11.00
13.00	01300 NURSING ADMINISTRATION	59, 476, 007					13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	27, 809, 785				14.00
15. 00 16. 00	01500   PHARMACY   01600   MEDICAL RECORDS & LIBRARY	2, 704, 036	0	18, 347, 639	1 024 705 400		15.00
23. 00	02300 ALLI ED HEALTH	0	0	0	1, 834, 785, 600	100	16. 00 23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS			<u> </u>	<u> </u>	100	20.00
30.00	03000 ADULTS & PEDIATRICS	15, 935, 427	0	0	141, 827, 517	0	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	5, 739, 777	0	0	34, 502, 369	0	31.00
31. 01 41. 00	03101   NEONATAL INTENSIVE CARE UNIT   04100   SUBPROVIDER - IRF	1, 812, 633	0	0	19, 087, 125 6, 753, 755	0	31. 01 41. 00
43. 00	04300 NURSERY	961, 252 371, 317	0	0	2, 703, 787	0	43.00
10.00	ANCI LLARY SERVI CE COST CENTERS	07.170.77	<u> </u>		2,,00,,01		10.00
50.00	05000 OPERATING ROOM	8, 981, 026	0	0	351, 722, 888	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52. 00 53. 00	05200   DELIVERY ROOM & LABOR ROOM   05300   ANESTHESI OLOGY	2, 051, 640	0	0	14, 939, 230 17, 295, 644	0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	6, 911, 997	0	0	243, 741, 329	0	54.00
54. 01	05401 ULTRASOUND	0	Ō	Ō	0	0	54. 01
56. 00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00 60. 00	05800   MRI	0	1, 940, 088	0	201, 541, 214	0	58. 00 60. 00
65. 00	06500 RESPIRATORY THERAPY		1, 940, 000	0	38, 403, 163	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0	0	0	18, 508, 149	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	9, 069, 281	0	67. 00
68. 00	06800   SPEECH PATHOLOGY   06900   ELECTROCARDI OLOGY	0 F 102 017	0	0	3, 231, 203	0	68.00
69. 00 71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5, 103, 817	2, 332, 605	0	146, 143, 379 44, 707, 386	0	69. 00 71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	o	23, 537, 092	ő	174, 149, 214	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	18, 347, 639	170, 082, 197	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	0	3, 169, 215	0	74. 00
	03950 ANCI LLARY	0	0	_	0	0	76.00
76. 01 76. 03	03610   SLEEP LAB   03951   WOUND CARE	0	0	0	9, 374, 649	0	76. 01 76. 03
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>		7, 07 1, 017		70.00
	09000 CLI NI C	0	0	0	0	0	90. 00
91.00	09100 EMERGENCY	8, 903, 085	0	0	183, 832, 906	100	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92. 00
118.00		59, 476, 007	27, 809, 785	18, 347, 639	1, 834, 785, 600	100	118. 00
	NONREI MBURSABLE COST CENTERS			, ,			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 00 192. 01
	19201 OTHER NONREIMBURSABLE  07950 NONREIMBURSABLE	0	0	0	0		194. 00
	07951 MARKETI NG	0	ő	o o	ő		194. 01
194. 02	07952 SENI OR CIRCLE	0	0	0	0		194. 02
	07953 OTHER NONREIMB COST C - REGENCY LTA	0	0	0	0		194. 03
194. 04 200. 00	O7954 VACANT UNFINISHED AREA   Cross Foot Adjustments	O	O	O	O	0	194. 04 200. 00
201.00							201.00
202.00		7, 461, 031	3, 067, 795	5, 375, 301	4, 169, 498	55, 185	202. 00
00-	Part I)						
203. 00 204. 00		1 1	0. 110314 416, 650		0. 002272 91 675	551. 850000	203. 00 204. 00
∠U4. UU	Part II)	312, 451	416, 650	255, 927	91, 675	190	204.00
205.00		0. 005253	0. 014982	0. 013949	0. 000050	1. 900000	205. 00
			l		l		l

Health Financial Systems	PORTER MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0035	Peri od: Worksheet C
		From 01/01/2016   Part I

					0 12/31/2016	Date/Time Pre 5/30/2017 10:	pared: 19 am
			Title	: XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDI ATRI CS	40, 091, 044		40, 091, 044			
31. 00	03100 INTENSIVE CARE UNIT	12, 969, 785		12, 969, 785		12, 969, 785	
31. 01	03101 NEONATAL INTENSIVE CARE UNIT	3, 781, 145		3, 781, 145		3, 781, 145	
	04100 SUBPROVI DER - I RF	2, 989, 542		2, 989, 542		2, 989, 542	
43.00	04300 NURSERY	855, 753		855, 753	0	855, 753	43. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	27, 167, 179		27, 167, 179	0	27, 167, 179	
51. 00	05100 RECOVERY ROOM	0		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4, 735, 956		4, 735, 956	0	4, 735, 956	52. 00
53.00	05300 ANESTHESI OLOGY	364, 129		364, 129	0	364, 129	
54.00	05400 RADI OLOGY-DI AGNOSTI C	18, 784, 412		18, 784, 412	0	18, 784, 412	54.00
54. 01	05401 ULTRASOUND	0		0	0	0	54. 01
56.00	05600 RADI OI SOTOPE	0		0	0	0	56. 00
57.00	05700  CT SCAN	0		0	0	0	57.00
58.00	05800  MRI	0		0	0	0	58. 00
60.00	06000 LABORATORY	17, 966, 799		17, 966, 799	0	17, 966, 799	60.00
65.00	06500 RESPI RATORY THERAPY	3, 409, 244	0	3, 409, 244	0	3, 409, 244	65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 812, 821	0	3, 812, 821	0	3, 812, 821	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	934, 507	0	934, 507	0	934, 507	67.00
68. 00	06800 SPEECH PATHOLOGY	574, 631	0	574, 631	0	574, 631	68. 00
69.00	06900 ELECTROCARDI OLOGY	13, 370, 048		13, 370, 048	0	13, 370, 048	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 249, 749		3, 249, 749	0	3, 249, 749	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	31, 703, 530		31, 703, 530	0	31, 703, 530	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	28, 158, 589		28, 158, 589	0	28, 158, 589	73. 00
74.00	07400 RENAL DIALYSIS	722, 566		722, 566	0	722, 566	74. 00
76.00	03950 ANCI LLARY	0			0	0	76. 00
76. 01	03610 SLEEP LAB	0		l o	0	0	76. 01
	03951 WOUND CARE	2, 745, 424		2, 745, 424	0	2, 745, 424	76. 03
	OUTPATIENT SERVICE COST CENTERS	<u>'                                    </u>			<u> </u>		
90.00	09000 CLI NI C	0		0	0	0	90.00
91.00	09100 EMERGENCY	20, 599, 134		20, 599, 134	59, 409	20, 658, 543	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 186, 113		3, 186, 113		3, 186, 113	
200.00		242, 172, 100					
201.00		3, 186, 113		3, 186, 113		3, 186, 113	
202.00		238, 985, 987					
			'				•

				From 01/01/2016 To 12/31/2016	Part I Date/Time Pre 5/30/2017 10:	pared: 19 am
		Title	· XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	Cost or Other	TEFRA	
		·	+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00  03000 ADULTS & PEDIATRICS	130, 834, 685		130, 834, 68	5		30. 00
31.00  03100   INTENSIVE CARE UNIT	34, 502, 369		34, 502, 36	9		31.00
31.01  03101 NEONATAL INTENSIVE CARE UNIT	19, 087, 125		19, 087, 12			31. 01
41. 00   04100   SUBPROVI DER - I RF	6, 753, 755		6, 753, 75	5		41.00
43. 00 04300 NURSERY	2, 703, 787		2, 703, 78	7		43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	160, 731, 323	190, 991, 565	351, 722, 88	8 0. 077240	0.000000	50. 00
51.00   05100   RECOVERY ROOM	0	0	)	0. 000000	0.000000	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	14, 250, 083	689, 147	14, 939, 23	0. 317015	0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	8, 221, 907	9, 073, 737	17, 295, 64	4 0. 021053	0.000000	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	51, 470, 284	192, 271, 045	243, 741, 32	9 0. 077067	0.000000	54.00
54. 01   05401   ULTRASOUND	0	0	)	0. 000000	0.000000	54. 01
56. 00   05600   RADI 0I SOTOPE	0	0	)	0. 000000	0.000000	56.00
57. 00   05700   CT   SCAN	0	0	)	0. 000000	0.000000	57.00
58. 00   05800   MRI	0	0	)	0. 000000	0.000000	58. 00
60. 00   06000   LABORATORY	78, 224, 489	123, 316, 725	201, 541, 21	4 0. 089147	0.000000	60.00
65. 00 06500 RESPIRATORY THERAPY	35, 567, 369	2, 835, 794	38, 403, 16	3 0. 088775	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	12, 948, 323	5, 559, 826	18, 508, 14	9 0. 206008	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	8, 113, 301	955, 980	9, 069, 28	1 0. 103041	0.000000	67.00
68. 00 06800 SPEECH PATHOLOGY	2, 357, 796	873, 407	3, 231, 20	3 0. 177838	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	52, 412, 461	93, 730, 918	146, 143, 37	9 0. 091486	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	25, 295, 513	19, 411, 873	44, 707, 38	6 0. 072689	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	110, 591, 908	63, 557, 306	174, 149, 21	4 0. 182048	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	61, 108, 917	108, 973, 280	170, 082, 19	7 0. 165559	0.000000	73. 00
74. 00   07400   RENAL DI ALYSI S	3, 086, 235	82, 980	3, 169, 21	5 0. 227995	0.000000	74. 00
76. 00 03950 ANCI LLARY	0	0		0. 000000	0.000000	76. 00
76. 01 03610 SLEEP LAB	o	0	)	0. 000000	0.000000	76. 01
76. 03 03951 WOUND CARE	429, 294	8, 945, 355	9, 374, 64	9 0. 292856	0.000000	76. 03
OUTPATIENT SERVICE COST CENTERS	<u> </u>					ĺ
90. 00 09000 CLI NI C	0	0		0. 000000	0.000000	90.00
91. 00 09100 EMERGENCY	54, 099, 352	129, 733, 554	183, 832, 90	6 0. 112054	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 748, 722	7, 244, 110	10, 992, 83	2 0. 289836	0.000000	92.00
200.00 Subtotal (see instructions)	876, 538, 998	958, 246, 602				200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	876, 538, 998	958, 246, 602	1, 834, 785, 60	o		202. 00

Health Financial Systems	PORTER MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10	
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0035	Peri od: Worksheet C From 01/01/2016 Part I To 12/31/2016 Date/Time Prepared: 5/30/2017 10:19 am	

				10 12,01,2010	5/30/2017 10: 19 am
			Title XVIII	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
	·	Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS				30.00
31. 00	03100 INTENSIVE CARE UNIT				31.00
31. 01	03101 NEONATAL INTENSIVE CARE UNIT				31. 01
41. 00	04100 SUBPROVI DER - I RF				41.00
43.00	04300 NURSERY				43. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 077240			50.00
51. 00	05100 RECOVERY ROOM	0. 000000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 317015			52. 00
	05300 ANESTHESI OLOGY	0. 021053			53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 077067			54. 00
54. 01	05401 ULTRASOUND	0. 000000			54. 01
56. 00	05600 RADI 0I SOTOPE	0. 000000			56. 00
57. 00	05700 CT SCAN	0. 000000			57. 00
58. 00	05800 MRI	0. 000000			58. 00
60.00	06000 LABORATORY	0. 089147			60.00
65. 00	06500 RESPI RATORY THERAPY	0. 088775			65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 206008			66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 103041			67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 177838			68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 091486			69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 072689			71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 182048			72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 165559			73. 00
74. 00	07400 RENAL DIALYSIS	0. 227995			74. 00
	03950 ANCI LLARY	0. 000000			76. 00
	03610 SLEEP LAB	0. 000000			76. 01
	03951 WOUND CARE	0. 292856			76. 03
	OUTPATIENT SERVICE COST CENTERS	,			
	09000 CLI NI C	0. 000000			90. 00
	09100 EMERGENCY	0. 112377			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 289836			92.00
200.00					200. 00
201.00	,				201. 00
202.00					202. 00
	1	1 1			1

Health Financial Systems	PORTER MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0035	Period: Worksheet C
		From 01/01/2016   Part I
		T- 10 /01 /001/   D-+- /T! D

				From 01/01/2016 Fo 12/31/2016	Part I Date/Time Pre 5/30/2017 10:	pared: 19 am
		Ti tl	e XIX	Hospi tal	Cost	
		·		Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	40, 091, 044		40, 091, 044	1 0	40, 091, 044	30.00
31.00 03100 INTENSIVE CARE UNIT	12, 969, 785		12, 969, 78	5 0	12, 969, 785	31.00
31.01 03101 NEONATAL INTENSIVE CARE UNIT	3, 781, 145		3, 781, 14!	5 0	3, 781, 145	31. 01
41. 00   04100   SUBPROVI DER - I RF	2, 989, 542	ł	2, 989, 542		2, 989, 542	41.00
43. 00   04300 NURSERY	855, 753		855, 753		855, 753	43.00
ANCILLARY SERVICE COST CENTERS				-1		
50. 00 05000 OPERATI NG ROOM	27, 167, 179		27, 167, 179	9 0	27, 167, 179	50.00
51. 00   05100   RECOVERY ROOM	0		' ' (	1	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	4, 735, 956		4, 735, 956		4, 735, 956	52. 00
53. 00   05300   ANESTHESI OLOGY	364, 129		364, 129		364, 129	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	18, 784, 412		18, 784, 412		18, 784, 412	54.00
54. 01   05401   ULTRASOUND	10, 701, 112		10, 701, 112		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	17, 966, 799		17, 966, 79		17, 966, 799	60.00
65. 00   06500   RESPI RATORY   THERAPY	3, 409, 244	l			3, 409, 244	65. 00
	1 ' '	0			3, 812, 821	•
	3, 812, 821	0	0,0.2,02			66.00
	934, 507	0	934, 50		934, 507	67.00
68. 00   06800   SPEECH PATHOLOGY	574, 631	0	574, 63		574, 631	
69. 00 06900 ELECTROCARDI OLOGY	13, 370, 048	l .	13, 370, 048		13, 370, 048	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 249, 749		3, 249, 749		3, 249, 749	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	31, 703, 530		31, 703, 530		31, 703, 530	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	28, 158, 589		28, 158, 589		28, 158, 589	73. 00
74. 00   07400   RENAL DI ALYSI S	722, 566		722, 566	6 0	722, 566	74. 00
76. 00  03950  ANCI LLARY	0			0	0	76. 00
76. 01  03610  SLEEP LAB	0			0	0	76. 01
76. 03 03951 WOUND CARE	2, 745, 424		2, 745, 424	1 0	2, 745, 424	76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000   CLI NI C	0	l .		0	0	90. 00
91. 00   09100   EMERGENCY	20, 599, 134		20, 599, 134		20, 658, 543	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 186, 113		3, 186, 113		3, 186, 113	
200.00 Subtotal (see instructions)	242, 172, 100	0	242, 172, 100	59, 409	242, 231, 509	200. 00
201.00 Less Observation Beds	3, 186, 113		3, 186, 113	3	3, 186, 113	201. 00
202.00 Total (see instructions)	238, 985, 987	0	238, 985, 98	59, 409	239, 045, 396	202. 00

			T	0 12/31/2016	Date/Time Pre 5/30/2017 10:	
		Ti tl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6.00	7. 00	8. 00	9. 00	10. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	130, 834, 685		130, 834, 685			30. 00
31. 00 03100 I NTENSI VE CARE UNI T	34, 502, 369		34, 502, 369			31.00
31. 01   03101   NEONATAL   INTENSIVE CARE UNIT	19, 087, 125		19, 087, 125			31. 01
41. 00   04100   SUBPROVI DER -   RF	6, 753, 755		6, 753, 755			41.00
43. 00 04300 NURSERY	2, 703, 787		2, 703, 787			43. 00
ANCILLARY SERVICE COST CENTERS	1.0 701 000	100 001 5/5	054 700 000	0.077040		
50. 00   05000   OPERATI NG ROOM	160, 731, 323	190, 991, 565	351, 722, 888		0. 000000	50.00
51. 00   05100   RECOVERY   ROOM	0	0	0	0. 000000	0. 000000	ł
52. 00 05200 DELIVERY ROOM & LABOR ROOM	14, 250, 083	689, 147	14, 939, 230	0. 317015	0. 000000	52. 00
53. 00   05300   ANESTHESI OLOGY	8, 221, 907	9, 073, 737		0. 021053	0. 000000	
54. 00   05400   RADI OLOGY - DI AGNOSTI C	51, 470, 284	192, 271, 045	243, 741, 329	0. 077067	0. 000000	
54. 01   05401   ULTRASOUND	0	0	0	0. 000000	0. 000000	54. 01
56. 00   05600   RADI OI SOTOPE	0	0	0	0. 000000	0. 000000	56. 00
57. 00   05700   CT   SCAN	0	0	0	0. 000000	0. 000000	
58. 00   05800   MRI	0	0	0	0.000000	0. 000000	58. 00
60. 00   06000   LABORATORY	78, 224, 489	123, 316, 725		0. 089147	0. 000000	60.00
65. 00 06500 RESPIRATORY THERAPY	35, 567, 369	2, 835, 794		0. 088775	0. 000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	12, 948, 323	5, 559, 826		0. 206008	0. 000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	8, 113, 301	955, 980		0. 103041	0.000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	2, 357, 796	873, 407			0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	52, 412, 461	93, 730, 918		0. 091486	0. 000000	69. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	25, 295, 513	19, 411, 873		0. 072689	0. 000000	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	110, 591, 908	63, 557, 306		0. 182048	0.000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	61, 108, 917	108, 973, 280		0. 165559	0.000000	73.00
74. 00 07400 RENAL DIALYSIS	3, 086, 235	82, 980	3, 169, 215	0. 227995	0.000000	74.00
76. 00 03950 ANCI LLARY	0	0	0	0. 000000	0. 000000	l
76. 01 03610 SLEEP LAB	0	0	0	0. 000000	0. 000000	76. 01
76. 03 03951 WOUND CARE	429, 294	8, 945, 355	9, 374, 649	0. 292856	0. 000000	76. 03
OUTPATIENT SERVICE COST CENTERS				0.000000	0.00000	00.00
90. 00   09000   CLI NI C	0	120 722 554	·	0.000000	0.000000	90.00
91. 00 09100 EMERGENCY	54, 099, 352	129, 733, 554		0. 112054	0.000000	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 748, 722	7, 244, 110		0. 289836	0. 000000	
200.00 Subtotal (see instructions)	876, 538, 998	958, 246, 602	1, 834, 785, 600			200.00
201.00 Less Observation Beds 202.00 Total (see instructions)	07/ 520 000	050 044 400	1 004 705 (00			201. 00 202. 00
zuz. uu   Tutai (See Histructions)	876, 538, 998	908, 240, 602	1, 834, 785, 600	l		J2U2. UU

Health Financial Systems	PORTER MEMORIAL HOSPITAL	In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0035	From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/30/2017 10:19 am

Cost Center Description				10 12/31/2010	5/30/2017 10: 19 am
RRILO   11.00   11.00   12.00   13.00   33.00   03.0			Title XIX	Hospi tal	
INPATI ENT ROUTINE SERVICE COST CENTERS   30,00   330.00   30000   ADULTS & PEDI ATRI CS   30,00   31.00   031001   INTENSI VE CARE UNI T   31,01   41.00   04100   SUBPROVIDER - IRF   41,00   43.00   04300   NURSERY C COST CENTERS   43,00   ANCILLARY SERVICE COST CENTERS   43,00   ANCILLARY SERVICE COST CENTERS   50,00   50.00   50500   OFFEATI NG ROOM   5,00   51.00   05100   RECOVERY ROOM   0,00000   51,00   52.00   05200   DELI VERY ROOM   0,00000   52,00   53.00   05300   ANESTHESI OLOGY   0,00000   53,00   54.00   05400   RADI OLOGY-DI AGNOSTI C   0,00000   54,00   55.00   05500   RADI OLOGY-DI AGNOSTI C   0,00000   54,00   56.00   05600   RADI OLOGY-DI AGNOSTI C   0,00000   54,00   57.00   05700   CT SCAN   0,00000   55,00   58.00   05800   NRI   0,00000   57,00   58.00   05800   NRI   0,00000   57,00   58.00   05800   NRI   0,00000   65,00   66.00   06600   HOSI CAL THERAPY   0,00000   65,00   66.00   06600   PHYSI CAL THERAPY   0,00000   65,00   67.00   06700   OCCUPATI ONAL THERAPY   0,00000   66,00   66.00   06600   PHYSI CAL THERAPY   0,00000   66,00   66.00   06600   PHYSI CAL THERAPY   0,00000   67,00   67.00   0700   OCCUPATI ONAL THERAPY   0,00000   71,00   67.00   0700   OCCUPATI ONAL THERAPY   0,00000   72,00   73.00   07300   DRUGS CHARGED TO PATI ENTS   0,00000   72,00   74.00   07400   OCCUPATI ONAL THERAPY   0,00000   72,00   75.00   07500   OCCUPATI ONAL THERAPY   0,00000   74,00   76.01   07400   OCCUPATI ONAL THERAPY   0,00000   72,00   77.00   07500   OCCUPATI ONAL THERAPY   0,00000   72,00   77.00   07500   OCCUPATI ONAL THERAPY   0,00000   73,00   77.00   07500   OCCUPATI ONAL THERAPY   0,00000   74,00   77.00   07500   OCCUPATI ONAL THERAPY   0,00000   74,00   77.00   07500   OCCUPATI ONAL THERAPY   0,	Cost Center Description	PPS Inpatient		· · · · · · · · · · · · · · · · · · ·	
INPATIENT ROUTINE SERVICE COST CENTERS   30, 00   340, 00   340,		Ratio			
30.00		11. 00			
31.00   03100   INTENSIVE CARE UNIT   31.00   03101   INTENSIVE CARE UNIT   31.01   41.00   04100   SUBPROVI DER - I RF   41.00   43.00   04300   NUBSERY   41.00   43.00   04300   NUBSERY   43.00   043000   043000   043000   043000   043000   043000   043000   043000   043000   043000   043000   043000   043000   0430000   0430000   0430000   04300000   04300000   0	INPATIENT ROUTINE SERVICE COST CENTERS				
31. 01   03101   NEONATAL INTENSIVE CARE UNIT	30. 00   03000   ADULTS & PEDI ATRI CS				30.00
41. 00	31.00 03100 INTENSIVE CARE UNIT				31.00
43.00	31.01 03101 NEONATAL INTENSIVE CARE UNIT				31. 01
ANCILLARY SERVICE COST CENTERS	41. 00   04100   SUBPROVI DER - I RF				41.00
50. 00   05000   OPERATI NG ROOM   0.000000   51.00   051.00   051.00   051.00   051.00   051.00   051.00   052.00   052.00   DELI VERY ROOM & LABOR ROOM   0.000000   52.00   052.00   DELI VERY ROOM & LABOR ROOM   0.000000   53.00   053.00   ANESTHESI OLOGY   0.000000   53.00   053.00   ANESTHESI OLOGY   0.000000   54.00   054.00   RADI OLOGY-DI AGNOSTI C   0.000000   54.00   054.01   ULTRASOUND   0.000000   54.00   054.01   ULTRASOUND   0.000000   55.00   055.00   055.00   057.00	43. 00 04300 NURSERY				43. 00
51, 00   05100   RECOVERY ROOM   0.0000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.00000000	ANCILLARY SERVICE COST CENTERS				
52. 00       05200       DELI VERY ROOM & LABOR ROOM       0.000000       52. 00         53. 00       05300       ANESTHESI OLGY       0.000000       53. 00         54. 00       05400       RADI LOGY-DI AGNOSTI C       0.000000       54. 01         56. 00       05600       RADI OLGY-DI AGNOSTI C       0.000000       54. 01         56. 00       05600       RADI OLSTOPE       0.000000       55. 00         57. 00       05700       CT SCAN       0.000000       57. 00         58. 00       05800       MRI       0.000000       58. 00         60. 00       06500       RESPI RATORY THERAPY       0.000000       60. 00         65. 00       06600       PHYSI CAL THERAPY       0.000000       66. 00         66. 00       06600       PHYSI CAL THERAPY       0.000000       67. 00         68. 00       06800       SPECH PATHOLOGY       0.000000       67. 00         69. 00       06900       ELECTROCARDI OLOGY       0.000000       67. 00         71. 00       07100       MEDICAL SUPPLIES CHARGED TO PATI ENTS       0.000000       72. 00         73. 00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       73. 00         76. 01	50.00   05000   OPERATING ROOM	0. 000000			50.00
53. 00     05300 ANESTHESI OLOGY     0.000000     53. 00       54. 01     05401 DLTRASOUND     0.000000     54. 01       56. 00     05600 RADI OL SOTOPE     0.000000     56. 00       57. 00     05700 CT SCAN     0.000000     57. 00       58. 00     05800 MRI     0.000000     58. 00       60. 00     06000 LABORATORY     0.000000     65. 00       65. 00     06500 RESPI RATORY THERAPY     0.000000     65. 00       66. 00     06600 PHSI CAL THERAPY     0.000000     65. 00       67. 00     06700 OCCUPATI ONAL THERAPY     0.000000     68. 00       68. 00     06800 SPECCH PATHOLOGY     0.000000     68. 00       71. 00     07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT     0.000000     68. 00       72. 00     07200 I IMPL. DEV. CHARGED TO PATI ENTS     0.000000     72. 00       73. 00     07300 D RUGS CHARGED TO PATI ENTS     0.000000     73. 00       76. 01     03401 ALLARY     0.000000     76. 01       76. 01     03510 SLEEP LAB     0.000000     76. 01       76. 01     03970 MILLARY     0.000000     76. 01       76. 01     03970 MILLARY     0.000000     76. 01       76. 01     03970 MILLARY     0.000000     76. 01       76. 01     <					
54. 00       05400   RADI OLOGY-DI AGNOSTI C       0.000000       54. 00         54. 01       05401   ULTRASOUND       0.000000       54. 01         56. 00       05600   RADI OLOGY-DI E       0.000000       56. 00         57. 00       05700   CT SCAN       0.000000       57. 00         58. 00       05800   MRI       0.000000       58. 00         60. 00       06000   LABORATORY       0.000000       65. 00         65. 00       06500   RESPI RATORY THERAPY       0.000000       65. 00         66. 00       06600   PHYSI CAL THERAPY       0.000000       66. 00         67. 00       06700   OCCUPATI ONAL THERAPY       0.000000       68. 00         69. 00       06900   ELECTROCARDI OLOGY       0.000000       68. 00         69. 00       06900   ELECTROCARDI OLOGY       0.000000       69. 00         71. 00       07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.000000       72. 00         73. 00       07300   DRUGS CHARGED TO PATI ENTS       0.000000       72. 00         74. 00       07400   RENAL DI ALYSI S       0.000000       74. 00         76. 01       03450   ANCI LLARY       0.000000       76. 01         76. 03       03951   WOUND CARE       0.00000       76. 03 <td>52.00   05200   DELIVERY ROOM &amp; LABOR ROOM</td> <td>0. 000000</td> <td></td> <td></td> <td>52. 00</td>	52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
54. 01       05401 ULTRASOUND       0.000000       54. 01         56. 00       05600 RADI OI SOTOPE       0.000000       56. 00         57. 00       05700 CT SCAN       0.000000       57. 00         60. 00       05800 MRI       0.000000       68. 00         60. 00       06600 LABORATORY       0.000000       60. 00         66. 00       06600 RESPI RATORY THERAPY       0.000000       65. 00         67. 00       06600 PYSI CAL THERAPY       0.000000       67. 00         68. 00       06800 SPECH PATHOLOGY       0.000000       67. 00         69. 00       06900 ELECTROCARDI OLOGY       0.000000       68. 00         69. 00       06900 ELECTROCARDI OLOGY       0.000000       68. 00         71. 00       07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.000000       71. 00         72. 00       07200 I MPL. DEV. CHARGED TO PATI ENTS       0.000000       72. 00         73. 00       07300 DRUGS CHARGED TO PATI ENTS       0.000000       73. 00         76. 01       03410 SLEEP LAB       0.000000       74. 00         76. 01       03451 WOUND CARE       0.000000       76. 01         76. 03       09900 CLI LIN C       0.000000       0.000000         91. 00	53. 00   05300   ANESTHESI OLOGY	0. 000000			53.00
56. 00       05600 RADI OI SOTOPE       0.000000       56. 00         57. 00       05700 CT SCAN       0.000000       57. 00         58. 00       05800 MRI       0.000000       58. 00         60. 00       06000 LABORATORY       0.000000       60. 00         65. 00       06500 RESPI RATORY THERAPY       0.000000       65. 00         66. 00       06600 PHYSI CAL THERAPY       0.000000       66. 00         67. 00       06700 OCCUPATI ONAL THERAPY       0.000000       67. 00         68. 00       06800 PHYSI CAL SUPPLIES CHARGED TO PATIENT       0.000000       68. 00         69. 00       06900 ELECTROCARDI OLOGY       0.000000       69. 00         71. 00       07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS       0.000000       71. 00         72. 00       07200 IMPL. DEV. CHARGED TO PATIENTS       0.000000       71. 00         73. 00       07300 DRUGS CHARGED TO PATIENTS       0.000000       72. 00         74. 00       07400 RENAL DI ALYSI S       0.000000       74. 00         76. 01       039551 WOUND CARE       0.000000       76. 01         76. 03       03951 WOUND CARE       0.000000       76. 03         09000 ELINI C       0.000000       91. 00         91. 00 <td>54. 00   05400   RADI OLOGY-DI AGNOSTI C</td> <td>0. 000000</td> <td></td> <td></td> <td>54.00</td>	54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
57. 00       05700 CT SCAN       0.000000       57. 00         58. 00       05800 MRI       0.000000       58. 00         60. 00       06000 LABORATORY       0.000000       60. 00         65. 00       06500 RESPI RATORY THERAPY       0.000000       65. 00         66. 00       06600 PHYSI CAL THERAPY       0.000000       66. 00         67. 00       06700 OCUPATI ONAL THERAPY       0.000000       67. 00         68. 00       06800 SPEECH PATHOLOGY       0.000000       68. 00         69. 00       06900 ELECTROCARDI OLOGY       0.000000       69. 00         71. 00       07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0.000000       71. 00         72. 00       07200 I MPL. DEV. CHARGED TO PATI ENTS       0.000000       72. 00         73. 00       07300 DRUGS CHARGED TO PATI ENTS       0.000000       72. 00         74. 00       07400 RENAL DI ALYSIS       0.000000       74. 00         76. 01       03950 ANCI LLARY       0.000000       76. 01         76. 03       03951 WUND CARE       0.00000       76. 01         00 09000 CLI NI C       0.000000       90. 00         91. 00       09000 CLI NI C       0.000000       91. 00         92. 00       09200 OBSERV	54. 01   05401   ULTRASOUND	0. 000000			54. 01
58.00   05800   MRI	56. 00   05600   RADI OI SOTOPE	0. 000000			56.00
60. 00	57. 00   05700   CT   SCAN	0. 000000			57.00
65. 00	58. 00   05800   MRI	0. 000000			58.00
66. 00	60. 00   06000   LABORATORY	0. 000000			60.00
67. 00   06700   0CCUPATI ONAL THERAPY   0.000000   67. 00   68. 00   06800   SPEECH PATHOLOGY   0.000000   68. 00   06900   ELECTROCARDI OLOGY   0.000000   69. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0.000000   71. 00   72. 00   73. 00   7300   DRUGS CHARGED TO PATI ENTS   0.000000   73. 00   74. 00   7400   RENAL DI ALYSI S   0.000000   74. 00   74. 00   74. 00   7400   SLEEP LAB   0.000000   76. 01   03610   SLEEP LAB   0.000000   76. 01   03951   WOUND CARE   0.000000   76. 03   0017PATI ENT SERVICE COST CENTERS   0.000000   76. 03   0017PATI ENT SERVICE COST CENTERS   0.000000   76. 03   0017PATI ENT SERVICE COST CENTERS   0.000000   091. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART   0.000000   0201. 00   Subtotal (see instructions)   Less Observation Beds   201. 00   201. 00	65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
68. 00	66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
69. 00	67. 00 06700 OCCUPATIONAL THERAPY	0. 000000			67. 00
71. 00	68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0.000000   73. 00   73. 00   73. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   75. 00   75. 00   75. 00   75. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 01   76. 01   76. 03   76. 01   76. 03   76. 01   76. 03   76. 00   76. 01   76. 03   76. 00   76. 01   76. 03   76. 01   76. 03   76. 01   76. 03   76. 01   76. 03   76. 01   76. 03   76. 01   76. 03   76. 01   76. 03   76. 01   76. 03   76. 01   76. 03   76. 0	69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS   0.000000   74. 00   74. 00   74. 00   74. 00   76. 00   03950   ANCI LLARY   0.000000   76. 01   03610   SLEEP LAB   0.000000   76. 01   03951   WOUND CARE   0.000000   76. 03   000000   000000   000000   000000   000000	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71. 00
74. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
76. 00 03950 ANCI LLARY 0.000000 76. 01 03610 SLEEP LAB 0.000000 76. 01 03951 WOUND CARE 0.000000 76. 03 03951 WOUND CARE 0.000000 76. 03 03951 WOUND CARE 0.000000 76. 03 03951 WOUND CARE 0.000000 90.00 09100 EMERGENCY 0.000000 91. 00 09100 EMERGENCY 0.000000 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 92. 00 Uses observation Beds 0.000000 0201. 00 Less Observation Beds 0.000000 0.000000 0.000000 0201. 00 000000 0201. 00 000000 0.000000 0.000000 0.000000 0.000000	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
76. 01 03610 SLEEP LAB 0. 000000 76. 03 03951 WOUND CARE 0. 0000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 0000000 76. 03 0000000 76. 03 0000000 76. 03 0000000 76. 03 0000000 76. 03 0000000 76. 03 0000000 76. 03 0000000 76. 03 0000000 76. 03 0000000 76. 03 0000000000000000000000000000000000	74.00 07400 RENAL DIALYSIS	0. 000000			74. 00
76. 03 03951 WOUND CARE 0.000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 0000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 000000 76. 03 0000000 76. 03 0000000 76. 03 0000000 76. 03 0000000 76. 03 0000000 76. 03 0000000 76. 03 0000000 76. 03 0000000 76. 03 00000000 76. 03 0000000 76. 03 0000000 76. 03 0000000 76. 03 0000000000000000000000000000000000	76. 00   03950   ANCI LLARY	0. 000000			76. 00
OUTPATIENT SERVICE COST CENTERS   90.00   09000   CLINIC   90.00   91.00   91.00   92.00   09200   0BSERVATION BEDS (NON-DISTINCT PART   0.000000   92.00   Subtotal (see instructions)   200.00   201.00   Less Observation Beds   201.00	76. 01   03610   SLEEP LAB	0. 000000			76. 01
90. 00   9000   CLINIC   90. 00   91. 00   91. 00   92. 00   92. 00   92. 00   Subtotal (see instructions)   Less Observation Beds   0. 000000   90. 000000   91. 00   92. 00   92. 00   92. 00   92. 00   92. 00   93. 00	76. 03   03951   WOUND CARE	0. 000000			76. 03
91.00   09100   EMERGENCY   0.000000   92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART   200.000   201.00   Less Observation Beds   0.000000   201.00   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000	OUTPATIENT SERVICE COST CENTERS				
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   0.000000   200. 00   Subtotal (see instructions)   Less Observation Beds   92.00   201. 00	90. 00 09000 CLI NI C	0. 000000			90.00
200.00       Subtotal (see instructions)       200.00         201.00       Less Observation Beds       201.00	91. 00  09100 EMERGENCY	0. 000000			91.00
201.00 Less Observation Beds 201.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
	200.00 Subtotal (see instructions)				200. 00
202.00 Total (see instructions) 202.00	201.00 Less Observation Beds				201. 00
	202.00 Total (see instructions)				202. 00

	Financial Systems	PORTER MEMORI	AL_HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 01/01/2016 To 12/31/2016		pared: 19 am
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
		Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
		(from Wkst. B,		Related Cost			
		Part II, col.		(col. 1 - col.			
		26)		2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDI ATRI CS	3, 915, 878		3, 915, 87			30. 00
31.00	INTENSIVE CARE UNIT	695, 601		695, 60	1 6, 917	100. 56	
31. 01	NEONATAL INTENSIVE CARE UNIT	251, 612		251, 61:	2, 388	105. 37	31. 01
41.00	SUBPROVI DER - I RF	432, 433	0	432, 43	2, 607	165. 87	41. 00
43.00	NURSERY	76, 738		76, 73	1, 001	76. 66	43.00
200.00	Total (lines 30-199)	5, 372, 262		5, 372, 26	2 63, 472		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 & PEDI ATRI CS	23, 301		•			30. 00
31.00	INTENSIVE CARE UNIT	3, 650	367, 044				31. 00
31. 01	NEONATAL INTENSIVE CARE UNIT	0	0	1			31. 01
	SUBPROVIDER - IRF	1, 719	285, 131				41. 00
43.00	NURSERY	0	0	)			43. 00
200.00	Total (lines 30-199)	28, 670	2, 456, 837	1			200. 00

Health Financial Systems		PORTER MEMORIAL	HOSPI TAL		In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT	ANCILLARY SERVICE CAPITAL	_ COSTS	Provi der CCN:	15-0035	Peri od: From 01/01/2016	Worksheet D

Hear th	Financiai Systems	PORTER MEMORI	AL HUSPITAL		In Lie	u of form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der Co	CN: 15-0035	Peri od:	Worksheet D	
					From 01/01/2016	Part II	
					To 12/31/2016	Date/Time Pre	
						5/30/2017 10:	<u> 19 am</u>
				XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,			. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS			,			
50.00	05000  OPERATI NG ROOM	2, 122, 756	351, 722, 888			418, 691	50.00
51.00	05100 RECOVERY ROOM	0	0	0. 00000	00	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	423, 235	14, 939, 230	0. 02833	36, 662	1, 039	52.00
53.00	05300 ANESTHESI OLOGY	35, 826	17, 295, 644	0.0020	71 2, 841, 664	5, 885	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 529, 623	243, 741, 329	0.0062	76 26, 061, 814	163, 564	54.00
54. 01	05401 ULTRASOUND	0	0	0. 00000		0	54. 01
56.00	05600 RADI OI SOTOPE	0	0	0. 00000	00 0	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	632, 445	201, 541, 214			116, 612	60.00
65. 00	06500 RESPIRATORY THERAPY	109, 974				58, 735	
66. 00	06600 PHYSI CAL THERAPY	556, 784					
67. 00	06700 OCCUPATI ONAL THERAPY	4, 016					
68. 00	06800 SPEECH PATHOLOGY	2, 373					
	06900 ELECTROCARDI OLOGY	987, 153					
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	47, 159					
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	460, 434					
		•					
73.00	07300 DRUGS CHARGED TO PATIENTS	341, 806				55, 687	
	07400 RENAL DIALYSIS	22, 314	3, 169, 215				
	03950 ANCI LLARY	0	0	0.00000		0	76. 00
	03610 SLEEP LAB	0	0	0. 00000		0	76. 01
76. 03	03951 WOUND CARE	321, 892	9, 374, 649	0. 03433	36 215, 015	7, 383	76. 03
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	ľ	0.0000			
	09100 EMERGENCY	1, 513, 479					
	09200 OBSERVATION BEDS (NON-DISTINCT PART	311, 204					
200.00	Total (lines 50-199)	9, 422, 473	1, 640, 903, 879		307, 319, 302	1, 577, 447	200. 00

Health Financial Systems	PORTER MEMORI	AI H	OSPI TAI		In lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA				CN: 15-0035	Peri od:	Worksheet D	
					From 01/01/2016		
					To 12/31/2016	Date/Time Pre 5/30/2017 10:	pared: 19 am
			Titl∈	xVIII	Hospi tal	PPS	.,
Cost Center Description	Nursing School	Al l i	ed Health		Swi ng-Bed	Total Costs	
			Cost	Medi cal	Adjustment	(sum of cols.	
				Education Cos		1 through 3,	
						minus col. 4)	
	1.00		2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	_			1	_	-	
30. 00   03000   ADULTS & PEDI ATRI CS	0	)	0	1	0	0	
31. 00   03100   INTENSI VE CARE UNI T	0		Ü		0	0	31.00
31. 01   03101   NEONATAL   INTENSIVE CARE UNIT	0		Ü	1	0	0	31. 01
41. 00   04100   SUBPROVI DER -   RF	0		Ü		0	0	41.00
43. 00 04300 NURSERY	0		Ü		0	0	10.00
200. 00   Total (lines 30-199)	T-+-1 D-+:+	D	D: (I	1	U	U	200. 00
Cost Center Description	Total Patient Days		⊬ col. 6)	Inpatient Program Days	Inpatient Program		
	Days	5 -	- COI. 6)	Program bays	Pass-Through		
					Cost (col. 7 x		
					col . 8)		
	6, 00		7. 00	8, 00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDIATRICS	50, 559		0.00	23, 30	01 0		30. 00
31.00 03100 INTENSIVE CARE UNIT	6, 917	·	0.00	3, 65	50 0		31. 00
31.01 03101 NEONATAL INTENSIVE CARE UNIT	2, 388	3	0.00		0		31. 01
41. 00   04100   SUBPROVI DER - I RF	2,607	·	0.00	1, 7	19 0		41. 00
43. 00   04300   NURSERY	1, 001		0.00	)	0		43.00
200.00 Total (lines 30-199)	63, 472	2		28, 6	70 0		200. 00

Heal th Financial	Systems	F	PORTER MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF	I NPATI ENT/OUTPATI ENT	ANCI LLARY SERVI	CE OTHER PASS	Provider CCN: 15-0035	Peri od:	Worksheet D

From 01/01/2016 Part IV
To 12/31/2016 Pate/Time Prepared: 5/30/2017 10: 19 am THROUGH COSTS

						373072017 10.	17 aiii
				XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician No	ursing School	Allied Health		Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	(	0	0	50. 00
51.00	05100 RECOVERY ROOM	0	0	(	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	(	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(	0	0	54.00
54. 01	05401 ULTRASOUND	0	0	C	0	0	54. 01
56.00	05600 RADI OI SOTOPE	0	0	C	0	0	56. 00
57.00	05700 CT SCAN	0	0	C	0	0	57. 00
58.00	05800 MRI	0	0	C	0	0	58. 00
60.00	06000 LABORATORY	0	0	C	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0	C	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	C	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	C	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	(	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0	0	74. 00
76.00	03950 ANCI LLARY	0	0	(	0	0	76. 00
76. 01	03610 SLEEP LAB	0	0		0	0	76. 01
76. 03	03951 WOUND CARE	0	0		0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>		<u> </u>			
90.00	09000 CLI NI C	0	0	C	0	0	90.00
91.00	09100 EMERGENCY	o	0	55, 185	0	55, 185	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	o	0		0	0	1
200.00			0	55, 185	Ō	55, 185	
		-1	-,		-1	,	

Health Financial Systems	PORTER MEMORIAL	_ HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT A	NCILLARY SERVICE OTHER PASS	Provi der CC		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2016	Part IV	
			-	To 12/31/2016	Date/Time Pre	oared:
					5/30/2017 10:	19 am_
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Total To	otal Charges	Ratio of Cost	Outpati ent	Inpati ent	
	Outpati ent (f	from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of P	Part I, col.	(col. 5 ÷ col.	to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		

	5
Cost Center Description   Total   Total Charges   Ratio of Cost   Outpatient   Inpatien	
Outpatient (from Wkst. C, to Charges Ratio of Cost   Program	
Cost (sum of   Part I, col.   (col. 5 ÷ col.   to Charges   Charges	
col. 2, 3 and   8)   7)  (col. 6 ÷ col.	
4) 7)	
6.00 7.00 8.00 9.00 10.00	
ANCI LLARY SERVI CE COST CENTERS	
50. 00   05000   OPERATI NG ROOM   0   351, 722, 888   0. 000000   0. 000000   69, 377,	62 50.00
51. 00   05100   RECOVERY ROOM   0   0, 000000   0, 000000	0 51.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM   0   14,939,230   0.000000   0.000000   36,	52.00
53. 00   05300   ANESTHESI OLOGY   0   17, 295, 644   0. 000000   0. 000000   2, 841,	53.00
54. 00   05400   RADI 0LOGY - DI AGNOSTI C   0   243, 741, 329   0. 000000   0. 000000   26, 061,	314 54.00
54. 01   05401   ULTRASOUND   0   0. 000000   0. 000000	0 54.01
56. 00   05600   RADI 0I SOTOPE   0   0   0   0   000000   0   0   0	0 56.00
57. 00   05700   CT SCAN   0   0   0.000000   0.000000	0 57.00
58. 00   05800   MRI   0   0   0. 000000   0. 000000	0 58.00
60. 00 06000 LABORATORY 0 201, 541, 214 0. 000000 0. 000000 37, 161,	85 60.00
65. 00   06500   RESPI RATORY THERAPY   0   38, 403, 163   0.000000   0.000000   20, 508,	
66. 00   06600   PHYSI CAL THERAPY   0   18, 508, 149   0. 000000   0. 000000   5, 937,	•
67. 00 06700 OCCUPATI ONAL THERAPY 0 9, 069, 281 0. 000000 0. 000000 3, 482,	
68. 00   06800  SPEECH PATHOLOGY   0   3, 231, 203   0.000000   0.000000   1, 226,	•
69. 00   06900  ELECTROCARDI OLOGY	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 44,707,386 0.000000 0.000000 11,534,	•
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   174, 149, 214   0. 000000   0. 000000   49, 040,	•
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   170, 082, 197   0.000000   0.000000   27, 704,	
74. 00   07400   RENAL DI ALYSI S   0   3, 169, 215   0. 000000   0. 000000   1, 921,	
74. 00   07400   RENAL BIALTSIS   0   0, 000000   0, 000000   1, 921, 76. 00   03950   ANCI LLARY   0   0, 000000   0, 000000	0 76.00
76. 01   03610  SLEEP LAB	0 76.00
76. 03   03951   WOUND CARE 0   9, 374, 649   0. 000000   0. 000000   215,	•
00 05951   WOUND CARE   0 9, 374, 849   0: 000000   0: 000000   215, 000000   0: 000000   0: 000000   0: 000000   0: 000000   0: 000000   0: 000000   0: 000000   0: 000000   0: 000000   0: 00000000	76.03
90. 00   09000  CLINI C   0   0. 000000   0. 000000	0 90.00
	•
200.00   Total (lines 50-199)   55,185   1,640,903,879   307,319,	302 200. 00

Health Financial Systems	PORTER MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0035	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2016	Part IV

				То	12/31/2016	Date/Time Pr   5/30/2017 10	
		Title	xVIII		Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent				
	Program	Program	Program				
	Pass-Through	Charges	Pass-Through				
	Costs (col. 8		Costs (col.	9			
	x col. 10)		x col. 12)				
	11. 00	12. 00	13. 00				
ANCI LLARY SERVI CE COST CENTERS							
50. 00   05000   OPERATI NG ROOM	0	58, 292, 614		0			50.00
51.00   05100   RECOVERY ROOM	0	0		0			51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	559	l .	0			52. 00
53. 00   05300   ANESTHESI OLOGY	0	2, 045, 155	1	0			53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	59, 438, 404		0			54. 00
54. 01   05401   ULTRASOUND	0	0	1	0			54. 01
56. 00   05600   RADI 01 SOTOPE	0	0	1	0			56. 00
57.00  05700   CT   SCAN	0	0	1	0			57. 00
58. 00   05800   MRI	0	0	)	0			58. 00
60. 00   06000   LABORATORY	0	13, 328, 384		0			60. 00
65. 00 06500 RESPIRATORY THERAPY	0	852, 010	)	0			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	162, 438		0			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	)	0			67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	1	0			68. 00
69. 00 06900 ELECTROCARDI OLOGY	O	37, 865, 442		0			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	O	6, 037, 090	1	0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	O	26, 223, 311		0			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	O	34, 695, 748	1	0			73. 00
74.00 07400 RENAL DIALYSIS	O	77, 544		0			74. 00
76. 00 03950 ANCI LLARY	0	0	)	0			76. 00
76. 01   03610   SLEEP LAB	0	0	)	0			76. 01
76. 03 03951 WOUND CARE	0	3, 417, 222		0			76. 03
OUTPATIENT SERVICE COST CENTERS	<u>'</u>	· · · · · ·	'				
90. 00 09000 CLI NI C	0	0		0			90. 00
91. 00 09100 EMERGENCY	7, 681	24, 708, 690	7, 41	13			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2, 296, 951		0			92. 00
200.00 Total (lines 50-199)	7, 681	269, 441, 562	1	13			200. 00

From 01/01/2016 Part V Date/Time Prepared: 12/31/2016 5/30/2017 10:19 am Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.077240 58, 292, 614 4, 502, 522 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52 00 0.317015 559 177 52 00 05300 ANESTHESI OLOGY 0 0 53.00 0.021053 2, 045, 155 43,057 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.077067 59, 438, 404 4, 580, 739 54.00 54. 01 05401 ULTRASOUND 0.000000 0 0 54.01 C Ω 05600 RADI OI SOTOPE 0 56.00 0.000000 C 0 56.00 57.00 05700 CT SCAN 0.000000 0 0 57.00 05800 MRI 58.00 0.000000 0 0 0 58.00 13, 328, 384 06000 LABORATORY 1, 188, 185 0.089147 29, 622 60 00 60 00 65.00 06500 RESPIRATORY THERAPY 0.088775 852,010 0 75, 637 65.00 66.00 06600 PHYSI CAL THERAPY 0. 206008 162, 438 0 0 33, 464 66.00 0 06700 OCCUPATIONAL THERAPY 67.00 0.103041 0 67.00 0 0 06800 SPEECH PATHOLOGY 68 00 0.177838 0 68 00 69.00 06900 ELECTROCARDI OLOGY 0.091486 37, 865, 442 0 0 3, 464, 158 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.072689 6, 037, 090 438, 830 71.00 71.00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 182048 26, 223, 311 0 0 4, 773, 901 72.00 07300 DRUGS CHARGED TO PATIENTS 0 423, 507 73.00 0.165559 34, 695, 748 5, 744, 193 73.00 74.00 07400 RENAL DIALYSIS 0. 227995 77, 544 17, 680 74.00 03950 ANCI LLARY 0.000000 0 0 76.00 76.00 0 03610 SLEEP LAB 0 76.01 0.000000 0 76.01 0 03951 WOUND CARE 0. 292856 3, 417, 222 0 1,000,754 76.03 76.03 OUTPATIENT SERVICE COST CENTERS 0. 000000 90.00 09000 CLI NI C 90.00 91.00 09100 EMERGENCY 0. 112054 24, 708, 690 78 91.00 0 2, 768, 708 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0.289836 2, 296, 951 Ω 0 665, 739 92.00 200.00 Subtotal (see instructions) 269, 441, 562 29, 700 423, 507 29, 297, 744 200.00 201.00 Less PBP Clinic Lab. Services-Program 201.00

269, 441, 562

29, 700

423, 507

29, 297, 744 202. 00

Only Charges

202.00

Net Charges (line 200 +/- line 201)

Health Financial Systems	PORTER MEMORI	AL HOSPITAL		In Lieu	u of Form CMS-2	552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider CO	CN: 15-0035	From 01/01/2016	Worksheet D Part V Date/Time Prep 5/30/2017 10:1	pared:
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost Rei mbursed Servi ces	Cost Reimbursed Services Not				

		Title	XVIII	Hospi tal	PPS	
	Co	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	C	1 "				50.00
51.00   05100   RECOVERY ROOM	C	0			II	51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	C	0				52.00
53. 00   05300   ANESTHESI OLOGY	C	0				53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	C	0			II	54.00
54. 01   05401   ULTRASOUND	C	0			5	54. 01
56. 00   05600   RADI 0I SOTOPE	C	0			5	56. 00
57. 00  05700 CT SCAN	C	0			5	57. 00
58. 00   05800   MRI	C	0			5	58. 00
60. 00   06000   LABORATORY	2, 641	0			6	60.00
65. 00 06500 RESPIRATORY THERAPY	C	0			6	65.00
66. 00   06600 PHYSI CAL THERAPY	C	o			1 6	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	C	o			1 6	67. 00
68. 00 06800 SPEECH PATHOLOGY	C	o			1 6	68. 00
69. 00 06900 ELECTROCARDI OLOGY	C	o			1 6	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	ol			1 7	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	o			1 7	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	C	70, 115			1 7	73. 00
74. 00 07400 RENAL DI ALYSI S	C	o			1 7	74. 00
76. 00 03950 ANCI LLARY	C	o			1 7	76. 00
76. 01 03610 SLEEP LAB	C	o			1 7	76. 01
76. 03   03951   WOUND CARE	C	o			1 7	76. 03
OUTPATIENT SERVICE COST CENTERS	•					
90. 00 09000 CLI NI C	C	0			9	90.00
91. 00 09100 EMERGENCY	9	ol			•	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		ol			9	92.00
200.00 Subtotal (see instructions)	2, 650	70, 115			20	00.00
201.00 Less PBP Clinic Lab. Services-Program						01. 00
Only Charges					[-]	
202.00 Net Charges (line 200 +/- line 201)	2, 650	70, 115			20	02. 00
1 1 2 2 3 3 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	, , , , , , , , , , , , , , , , , , , ,	1	1		,	

Health Financial Systems	PORTER MEMORI				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAP	TAL COSTS	Provi der C		Peri od:	Worksheet D	
		Component		From 01/01/2016 To 12/31/2016		narod:
		Component	CCN. 13-1033	10 12/31/2010	5/30/2017 10:	19 am
		Title	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 + col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATING ROOM	2, 122, 756				l .	
51.00   05100   RECOVERY ROOM	0	_			0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	423, 235				0	52. 00
53. 00   05300   ANESTHESI OLOGY	35, 826				l .	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 529, 623	243, 741, 329			1, 056	54.00
54. 01   05401   ULTRASOUND	0	0	0.00000		0	54. 01
56. 00   05600   RADI 01 SOTOPE	0	0	0.00000		0	56. 00
57. 00   05700   CT   SCAN	0	0	0.00000	0 0	0	57. 00
58. 00   05800   MRI	0	0	0.00000	0 0	0	58. 00
60. 00   06000   LABORATORY	632, 445			642, 192	2, 015	60.00
65. 00 06500 RESPIRATORY THERAPY	109, 974	38, 403, 163	0. 00286	684	2	65. 00
66. 00 06600 PHYSI CAL THERAPY	556, 784	18, 508, 149	0. 03008	1, 590, 284	47, 841	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	4, 016	9, 069, 281	0.00044	1, 558, 434	690	67. 00
68.00 06800 SPEECH PATHOLOGY	2, 373	3, 231, 203	0.00073	345, 690	254	68. 00
69. 00 06900 ELECTROCARDI OLOGY	987, 153	146, 143, 379	0. 00675	54, 620	369	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	47, 159	44, 707, 386	0. 00105	17, 396	18	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	460, 434	174, 149, 214	0. 00264	4, 474	12	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	341, 806	170, 082, 197	0. 00201	0 527, 277	1, 060	73. 00
74.00 07400 RENAL DIALYSIS	22, 314	3, 169, 215	0. 00704	1 83, 226	586	74. 00
76. 00   03950   ANCI LLARY	0	0	0.00000	0 0	0	76. 00
76. 01 03610 SLEEP LAB	0	0	0.00000	0 0	0	76. 01
76. 03   03951   WOUND CARE	321, 892	9, 374, 649	0. 03433	66 0	0	76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0.00000	0 0	0	90. 00
91. 00 09100 EMERGENCY	1, 513, 479	183, 832, 906	0.00823	9, 436	78	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	10, 992, 832	0. 00000	0 0	0	92. 00
200.00 Total (lines 50-199)	9, 111, 269	1, 640, 903, 879		5, 032, 190	54, 161	200. 00

leel the Financial Customs	PORTER MEMORIAI	LIOCOLTAI		المانا	w of Form CMC	2552 10
Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE		Provider C	CN: 15_0035	Peri od:	eu of Form CMS- Worksheet D	2552-10
THROUGH COSTS	INVICE OTHER TASS	Trovider C	CN. 13-0033	From 01/01/2016	Part IV	
		Component	CCN: 15-T035	To 12/31/2016		pared:
		T: +1 a	e XVIII	Subprovi der -	5/30/2017 10: PPS	19 am
		11 (16	XVIII	I RF	PPS	
Cost Center Description	Non Physician Nu	ursing School	Allied Heal		Total Cost	
	Anesthetist	_		Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	0	)	0	0	
51.00   05100   RECOVERY ROOM	0	0	)	0	0	011 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0		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	0	)	0 0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0	)	0 0	0	65.00
66. 00   06600   PHYSI CAL THERAPY	0	0		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	0	)	0 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	)	0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	)	0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	)	0 0	0	73. 00
74.00   07400   RENAL DIALYSIS	0	0	)	0	0	74. 00
76. 00   03950   ANCI LLARY	0	0	)	0	0	76. 00
76. 01   03610   SLEEP LAB	0	0	)	0	0	76. 01
76.03   03951   WOUND CARE	0	0		0 0	0	76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	C		0 0	0	90.00
91. 00 09100 EMERGENCY	0	0	55, 1	85 0	55, 185	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0	92. 00
200.00 Total (lines 50-199)			55, 1		55, 185	

Health Financial Systems	PORTER MEMORI				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS		Component		From 01/01/2016 To 12/31/2016	Part IV	narodi
		Component	CCN. 13-1033	10 12/31/2010	Date/Time Pre 5/30/2017 10:	pareu. 19 am
		Title	xVIII	Subprovi der -	PPS	17 dill
				IRF		
Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	Inpati ent	
	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges	
	col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6. 00	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0				•	
51.00   05100   RECOVERY ROOM	0		0.0000		0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	, , ====			0	52. 00
53. 00   05300   ANESTHESI OLOGY	0	, = ,			769	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	243, 741, 329			168, 203	
54. 01   05401   ULTRASOUND	0	0	0. 00000		0	54. 01
56. 00   05600   RADI 0I SOTOPE	0	0	0. 00000		0	56. 00
57. 00   05700   CT   SCAN	0	0	0. 00000		0	57. 00
58. 00   05800   MRI	0	0	0. 00000		0	58. 00
60. 00   06000   LABORATORY	0				642, 192	60.00
65. 00 06500 RESPI RATORY THERAPY	0	,,			684	65. 00
66. 00 06600 PHYSI CAL THERAPY	0				1, 590, 284	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	.,,			1, 558, 434	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	-,,			345, 690	
69. 00 06900 ELECTROCARDI OLOGY	0				54, 620	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				17, 396	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0					
73.00 07300 DRUGS CHARGED TO PATIENTS	0	,,	1			73. 00
74. 00   07400   RENAL DI ALYSI S	0	3, 169, 215			83, 226	74. 00
76. 00   03950   ANCI LLARY	0	0			0	76. 00
76. 01   03610   SLEEP LAB	0		0. 00000			
76. 03 03951 WOUND CARE	0	9, 374, 649	0.00000	0. 000000	0	76. 03
OUTPATIENT SERVICE COST CENTERS	_	_				
90. 00   09000   CLI NI C	0					
91. 00   09100   EMERGENCY	55, 185					91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		1	0. 000000	0	, 2. 00
200.00   Total (lines 50-199)	55, 185	1, 640, 903, 879	'	I	5, 032, 190	J200. 00

ealth Financial Systems	PORTER MEMORIA				u of Form CMS-	-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der C	CN: 15-0035	Peri od:	Worksheet D Part IV	
THROUGH COSTS		Component	CCN: 15-T035	From 01/01/2016 To 12/31/2016		enared:
		·			5/30/2017 10:	19 am
		Titl∈	XVIII	Subprovi der -	PPS	
	1		I	I RF		
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.			
	x col . 10)	10.00	x col . 12)			
ANOLILARY OFFICE OF SERVICE	11.00	12. 00	13. 00			
ANCI LLARY SERVI CE COST CENTERS						
0. 00   05000   OPERATI NG   ROOM	0	0	1	0		50.00
1.00 05100 RECOVERY ROOM	0	0	9	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	)	0		52.00
3. 00   05300   ANESTHESI OLOGY	0	0	)	0		53.00
4. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	)	0		54.00
4. 01   05401   ULTRASOUND	0	0	)	0		54. 01
66. 00   05600   RADI 01 SOTOPE	0	0	)	0		56. 00
7. 00  05700   CT   SCAN	0	0	)	0		57.00
8. 00   05800   MRI	0	0	)	0		58.00
0. 00   06000   LABORATORY	0	0		0		60.00
5. 00 06500 RESPIRATORY THERAPY	O	0		0		65.00
6. 00 06600 PHYSI CAL THERAPY	o	0	ol .	0		66.00
7. 00 06700 OCCUPATI ONAL THERAPY	o	0	ol .	0		67.00
8. 00 06800 SPEECH PATHOLOGY	o	0	ol .	0		68.00
9. 00 06900 ELECTROCARDI OLOGY	0	0		0		69.00
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0		71. 00
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0		72. 00
3. 00 07300 DRUGS CHARGED TO PATIENTS		0		0		73. 00
4. 00 07400 RENAL DIALYSIS		0		0		74.00
6. 00 03950 ANCI LLARY		0		o l		76.00
6. 01   03610   SLEEP LAB	0	0		0		76. 01
6. 03   03951   WOUND CARE		0		0		76. 03
OUTPATIENT SERVICE COST CENTERS	1 0		′1	<u> </u>		1 70.03
0. 00   09000   CLINI C	0	0		0		90.00
1. 00   09100   EMERGENCY	- 1	0		0		91.00
	3		1			91.00
22. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	-	0	1	0		
(100.00   Total (lines 50-199)	3	0	7	0		200.00

From 01/01/2016 Part V 12/31/2016 Date/Time Prepared: 5/30/2017 10:19 am Title XIX Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) 3.00 (see inst.) 1. 00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.077240 15, 783, 066 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0. 317015 0 0 142, 357 52 00 0 05300 ANESTHESI OLOGY 0 53.00 0.021053 0 940, 132 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.077067 23, 216, 248 0 54.00 54. 01 05401 ULTRASOUND 0.000000 0 0 54.01 O 0 05600 RADI OI SOTOPE 0 0 56.00 0.000000 0 0 56.00 57.00 05700 CT SCAN 0.000000 0 0 57.00 05800 MRI 0.000000 0 58.00 0 0 58.00 0 06000 LABORATORY 0.089147 14, 002, 057 0 60 00 60 00 0 65.00 06500 RESPIRATORY THERAPY 0.088775 532, 285 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 206008 479, 555 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.103041 150, 618 67.00 0 06800 SPEECH PATHOLOGY 291, 489 68.00 0 0.177838 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.091486 0 0 7, 611, 606 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.072689 1, 344, 650 71.00 71.00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 182048 0 0 4, 535, 320 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 8, 817, 330 73.00 0.165559 0 73.00 74.00 07400 RENAL DIALYSIS 0. 227995 0 74.00 03950 ANCI LLARY 0.000000 0 0 76.00 76.00 0 0 03610 SLEEP LAB 0 76.01 0.000000 0 0 76.01 03951 WOUND CARE 0. 292856 1, 113, 974 76.03 76.03 0 Ω OUTPATIENT SERVICE COST CENTERS 0. 000000 90.00 90.00 09000 CLI NI C 0 0 91.00 91.00 09100 EMERGENCY 0. 112054 0 33, 895, 448 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 0.289836 0 1, 120, 379 0 200.00 Subtotal (see instructions) 113, 976, 514 0 200. 00

0

0

113, 976, 514

201. 00

0 202. 00

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 +/- line 201)

Only Charges

Health Financial Systems	PORTER ME	MORI AL	HOSPI TAL		In Lieu	u of Form CMS-2	552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE CO	OST	Provider C	CN: 15-0035	From 01/01/2016	Worksheet D Part V Date/Time Prep 5/30/2017 10:1	
			Ti tl	e XIX	Hospi tal	Cost	
		Costs					
Cost Center Description	Cost		Cost	1			

					To 12/31/2016	Date/Time Pre 5/30/2017 10:	pared: 19 am
			Ti tl	e XIX	Hospi tal	Cost	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	1, 219, 084	1			50.00
	05100 RECOVERY ROOM	0	C	1			51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	45, 129				52. 00
	05300 ANESTHESI OLOGY	0	19, 793	1			53. 00
	05400  RADI OLOGY-DI AGNOSTI C	0	1, 789, 207	'			54. 00
	05401 ULTRASOUND	0	C	)			54. 01
	05600 RADI 0I SOTOPE	0	C	)			56. 00
	05700  CT SCAN	0	C	)			57. 00
58.00	05800  MRI	0	C	)			58. 00
60.00	06000 LABORATORY	0	1, 248, 241				60.00
65.00	06500 RESPI RATORY THERAPY	0	47, 254				65. 00
66.00	06600 PHYSI CAL THERAPY	0	98, 792	2			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	15, 520				67. 00
68.00	06800 SPEECH PATHOLOGY	0	51, 838	8			68. 00
69.00	06900 ELECTROCARDI OLOGY	0	696, 355	5			69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	97, 741				71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	825, 646				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1, 459, 788	s			73. 00
74.00	07400 RENAL DIALYSIS	0	C				74. 00
76.00	03950 ANCI LLARY	0	C				76. 00
76. 01	03610 SLEEP LAB	0	C				76. 01
76.03	03951 WOUND CARE	0	326, 234				76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	C				90. 00
91.00	09100 EMERGENCY	0	3, 798, 121				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	324, 726				92.00
200.00	Subtotal (see instructions)	0	12, 063, 469				200.00
201.00		0					201.00
	Only Charges						
202. 00	Net Charges (line 200 +/- line 201)	0	12, 063, 469				202. 00

Health Financial Systems	PORTER MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0035	Peri od: From 01/01/2016	Worksheet D-1	
			Date/Time Pre 5/30/2017 10:	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				

		Title XVIII	Hospi tal	5/30/2017 10: PPS	19 am_		
	Cost Center Description	IT LITE AVITE	поѕрі таі	PPS			
				1. 00			
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS						
1. 00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		50, 559	1.00		
2.00	Inpatient days (including private room days, excluding swing-			50, 559	2. 00		
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	vate room days,	0	3. 00		
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation by	ed days)		46, 541	4. 00		
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost						
	reporting period						
6. 00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	om days) after December :	31 of the cost	0	6. 00		
7. 00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00		
	reporting period						
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	m days) after December 3	l of the cost	0	8. 00		
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	23, 301	9. 00		
	newborn days)	0					
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		oom days)	0	10. 00		
11. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII on		oom davs) after	0	11. 00		
	December 31 of the cost reporting period (if calendar year, en	nter O on this line)	,				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	X only (including private	e room days)	0	12. 00		
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	X only (including private	e room days)	0	13. 00		
.0.00	after December 31 of the cost reporting period (if calendar ye			· ·	10.00		
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14.00		
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00		
10.00	SWING BED ADJUSTMENT						
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0. 00	17. 00		
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00		
10.00	reporting period	0.00	10.00				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00		
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0.00	20. 00		
20.00	reporting period	3 ditei becember 31 di ti	10 0031	0.00	20.00		
21. 00	Total general inpatient routine service cost (see instructions			40, 091, 044	1		
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)	er 31 of the cost report	ng period (line	0	22. 00		
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00		
	x line 18)			_			
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	r 31 of the cost reportion	ng period (line	0	24. 00		
25. 00	Swing-bed cost applicable to NF type services after December :	31 of the cost reporting	period (line 8	0	25. 00		
27.00	x line 20)			0	27.00		
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 40, 091, 044	26. 00 27. 00		
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TITIE 21 IIITIGS TITIE 20)		10, 071, 011	27.00		
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	•		
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00		
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000			
32.00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	32. 00		
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1: 00) (		0.00	1		
34. 00 35. 00	Average per diem private room charge differential (line 32 mil Average per diem private room cost differential (line 34 x li		(ions)	0. 00 0. 00	1		
36. 00	Private room cost differential adjustment (line 3 x line 35)			0.00	36. 00		
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	40, 091, 044	37. 00		
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY						
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			-		
38. 00	Adjusted general inpatient routine service cost per diem (see			792. 96	38. 00		
39.00	Program general inpatient routine service cost (line 9 x line	•		18, 476, 761	39. 00		
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	,		0 18, 476, 761	40. 00 41. 00		
<del>-</del> 1.00	Trotal Trogram gonoral Impatrent routine service cost (IIIIe 37		ı	10, 470, 701	1 -1.00		

Heal th Financial Systems PORTER MEMORIAL HOSPITAL		of Form CMS-2	2552-10					
COMPUTATION OF INPATIENT OPERATING COST Provider CCN	l: 15-0035   Peri od: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prep 5/30/2017 10:						
Cost Center Description Total Total		PPS Program Cost						
Inpatient Cost Inpatient Days D	col . 2)	(col. 3 x col. 4)						
1.00 2.00 42.00 NURSERY (title V & XIX only) 0 0	3. 00 4. 00 0. 00 0	5. 00 0	42. 00					
Intensive Care Type Inpatient Hospital Units 43.00 INTENSIVE CARE UNIT 12,969,785 6,917	1, 875. 06 3, 650	6, 843, 969	43. 00					
43. 01 NEONATAL INTENSIVE CARE UNIT 3, 781, 145 2, 388	1, 583. 39	0	43. 01					
44.00 CORONARY CARE UNIT 45.00 BURN INTENSIVE CARE UNIT			44. 00 45. 00					
46.00 SURGICAL INTENSIVE CARE UNIT 47.00 OTHER SPECIAL CARE (SPECIFY)			46. 00 47. 00					
Cost Center Description			47.00					
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		1. 00 34, 691, 346	48. 00					
49.00 Total Program inpatient costs (sum of lines 41 through 48) (see instructions PASS THROUGH COST ADJUSTMENTS	5)	60, 012, 076	49. 00					
50.00 Pass through costs applicable to Program inpatient routine services (from \	Wkst. D, sum of Parts I and	2, 171, 706	50. 00					
51.00 Pass through costs applicable to Program inpatient ancillary services (from and IV)	m Wkst. D, sum of Parts II	1, 585, 128	51. 00					
52.00 Total Program excludable cost (sum of lines 50 and 51) 53.00 Total Program inpatient operating cost excluding capital related, non-physic	cian anesthetist, and	3, 756, 834 56, 255, 242	52. 00 53. 00					
medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION								
54.00 Program discharges 55.00 Target amount per discharge		0 0. 00	54. 00 55. 00					
56.00 Target amount (line 54 x line 55)		0.00	56.00					
57.00 Difference between adjusted inpatient operating cost and target amount (line 58.00 Bonus payment (see instructions)	ne 56 minus line 53)	0	57. 00 58. 00					
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, upo	0.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the							
market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the ma	rket basket	0. 00	60. 00					
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lessel which operating costs (line 53) are less than expected costs (lines 54 x 60	0	61. 00						
amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions)	0	62. 00						
63.00 Allowable Inpatient cost plus incentive payment (see instructions)		0	63. 00					
PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the o	cost reporting period (See	0	64. 00					
instructions)(title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost	st reporting period (See	0	65. 00					
instructions)(title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)	)(title XVIII only) For	0	66. 00					
CAH (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of		0						
(line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the costs after 31 of the co		0	68. 00					
(line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 6		0	69. 00					
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID OF 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost	NLY		70. 00					
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)			71.00					
72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line	e 35)		72. 00 73. 00					
74.00 Total Program general inpatient routine service costs (line 72 + line 73)			74. 00					
75.00   Capital-related cost allocated to inpatient routine service costs (from World 26, line 45) 76.00   Per diem capital-related costs (line 75 ÷ line 2)	rksheet B, Part II, column		75. 00 76. 00					
77.00 Program capital-related costs (line 9 x line 76)			77. 00					
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records)	)		78. 00 79. 00					
80.00 Total Program routine service costs for comparison to the cost limitation			80.00					
81.00   Inpatient routine service cost per diem limitation 82.00   Inpatient routine service cost limitation (line 9 x line 81)			81. 00 82. 00					
83.00 Reasonable inpatient routine service costs (see instructions)			83.00					
84.00   Program inpatient ancillary services (see instructions) 85.00   Utilization review - physician compensation (see instructions)			84. 00 85. 00					
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST			86. 00					
87.00 Total observation bed days (see instructions)		4, 018	87. 00					
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 89.00 Observation bed cost (line 87 x line 88) (see instructions)		792. 96 3, 186, 113						
	ı	, -,						

Health Financial Systems	PORTER MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od: From 01/01/2016	Worksheet D-1	
				To 12/31/2016	Date/Time Prep 5/30/2017 10:	pared: 19 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	3, 915, 878	40, 091, 044	0. 09767	5 3, 186, 113	311, 204	90.00
91.00 Nursing School cost	0	40, 091, 044	0.00000	0 3, 186, 113	0	91.00
92.00 Allied health cost	0	40, 091, 044	0.00000	0 3, 186, 113	0	92.00
93.00 All other Medical Education	0	40, 091, 044	0.00000	0 3, 186, 113	0	93.00

Health Financial Systems	PORTER MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0035		Worksheet D-1
	Component CCN: 15-T035	From 01/01/2016 To 12/31/2016	
	Title XVIII	Subprovider -	PPS

DALL T. ALL PROVIDER COMPONENTS    DALL T. ALL PROVIDER COMPONENTS			litle XVIII	Subprovider -	PPS	
INSPITE HEALTH LIVES		Cost Center Description		-	1.00	
REATLENT DAYS		PART I - ALL PROVIDER COMPONENTS			1.00	
1.00   Injection days (including private room days, excluding saing-bed and neshborn days)   2,007   2,00   3,00   Private room days (seculating saing-bed and observation bed days)   1.7 you have only private room days (seculating saing-bed and observation bed days)   1.7 you have only private room days   2,607   4,00   5.00						
Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this I line.  4.00 Seni-private room days (excluding swing-bed and observation bed days).  5.00 Iotal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (I calendar year, enter 0 on this line).  7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (I calendar year, enter 0 on this line).  7.01 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (I calendar year, enter 0 on this line).  7.01 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (I calendar year, enter 0 on this line).  7.02 Swing-bed SNF type Inpatient days applicable to the Itle XVIII only (Including private room days).  7.03 Swing-bed SNF type Inpatient days applicable to the Itle XVIII only (Including private room days) after become 31 of the cost reporting period (I calendar year, enter 0 on this line).  7.03 Swing-bed SNF type Inpatient days applicable to title XVIII only (Including private room days) after become 31 of the cost reporting period (I calendar year, enter 0 on this line).  7.04 Swing-bed SNF type inpatient days applicable to title XVIII only (Including private room days) after become 31 of the cost reporting period (I calendar year, enter 0 on this line).  7.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (Including private room days).  7.00 Iotal and swing-bed SNF type inpatient days applicable to titles V or XIX only (Including private room days).  7.01 Iotal swing-bed SNF type inpatient days applicable to titles V or XIX only (Including private room days).  7.02 Swing-bed SNF type Inpatient days applicable to titles V or XIX only (Including private room days).  7.03 Swing-bed SNF type Inpatient days applicable to titles V or XIX only						
d. On complete this I ine.         4. 0           5.00 Senior private room days (sextuding swing-bed and observation bed days) through December 31 of the cost         2, 607           5.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost         0. 0           7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost         0. 0           7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost         0. 7. 0           7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost         0. 7. 0           8.00 Total sing-bed NF type inpatient days (including private room days) after December 31 of the cost         0. 0           9.00 Total sing-bed NF type inpatient days applicable to the Program (excluding swing-bed and nector days)         0. 0           10.00 Saring-bed SNF type inpatient days applicable to the Program (excluding private room days) after         0. 10. 0           10.00 Saring-bed SNF type inpatient days applicable to thitle XVIII only (including private room days) after         0. 10. 0           10.00 Saring-bed SNF type inpatient days applicable to thitle XVIII only (including private room days) after         0. 10. 0           10.00 Saring-bed SNF type inpatient days applicable to thitle XVIII only (including private room days)         0. 12. 0           11.00 Saring-bed SNF type inpatient days applicable to thitle XVIII only (including private room days)						
Seel pri vate room days   (excluding swing-bed and observation bed days)   1	3.00		ys). If you have only pr	rivate room days,	0	3.00
101a1 swing_bed SNF Type Inpatient days (Including private room days) after December 31 of the cost of 101al swing_bed SNF type inpatient days (Including private room days) after December 31 of the cost reporting period (If calendar year, enter 0 on this I line)	4.00		ed days)		2, 607	4. 00
1.00   10fall swing-bed SNF type Inpatient days (Including private room days) after December 31 of the cost   0				er 31 of the cost		
reporting period (if calendar year, enter 0 on this line)  1.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 0 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 0 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 1 0 8.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and 1,719 9.00 Exercised days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  10.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  11.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  12.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  13.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  14.00 Medicarly inaccessary private room days applicable to services through December 31 of the cost  15.00 Number of the SWIND SWF services applicable to services after December 31 of the cost  16.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  17.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  18.00 Swing-bed cost applicable to SNF type services intrough December 31 of the cost reporting period (line 6 S X I Ine 12)  18.00 Swing-bed cost applicable to SNF type services		1 1 3 1 1 1 1				
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Proporting period   Proporting period   Proporting period   Proporting period (If calendar year, enter 0 on this line)   Proporting period (If calendar year, enter 0 on this line)   Proporting period (If calendar year, enter 0 on this line)   Proporting period (If calendar year, enter 0 on this line)   Proporting period (If calendar year, enter 0 on this line)   Proporting period (If calendar year, enter 0 on this line)   Proporting period (If calendar year, enter 0 on this line)   Proporting period (If calendar year, enter 0 on this line)   Proporting period (If calendar year, enter 0 on this line)   Proporting period (If calendar year, enter 0 on this line)   Proporting period (If calendar year, enter 0 on this line)   Proporting Proporting Period (If calendar year, enter 0 on this line)   Proporting Period (If calendar year, enter 0 on this line)   Proporting Period (If calendar year, enter 0 on this line)   Proporting Period (If calendar year, enter 0 on this line)   Proporting Period (If calendar year, enter 0 on this line)   Proporting Period (If calendar year, enter 0 on this line)   Proporting Period (If calendar year, enter 0 on this line)   Proporting Period (If calendar year, enter 0 on this line)   Proporting Period (If calendar year, enter 0 on this line)   Proporting Period (If the Cost period Proporting Period (If the Proporting Proportin	7 00		m days) through December	31 of the cost	0	7 00
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newborn days   0   10.00   Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)   10.00   10.00   Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after   11.00   12.00   12.00   13.00   14.00   14.00   15.00   14.00   15.00   14.00   15.00   1	0.00		a the Drogram (eveluding	owing bod and	1 710	0.00
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December 31 of the cost reporting period (if calendar year, enter 0 on this line)   0   12.00					_	
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through December 31 of the cost reporting period  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Nedicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Nedicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19.00 Nedicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19.00 Nedicad rate for swing-bed SNF services applicable to services after December 31 of the cost  19.00 Nedical dar for swing-bed SNF services applicable to services after December 31 of the cost  19.00 Nedical dar for swing-bed SNF services applicable to services after December 31 of the cost  19.00 Nedical dar for swing-bed NF services applicable to services after December 31 of the cost  19.00 Nedical dar for swing-bed NF services applicable to services after December 31 of the cost  19.00 Nedical dar for swing-bed NF services applicable to services after December 31 of the cost  19.00 Nedical dar for swing-bed NF services applicable to services after December 31 of the cost  19.00 Nedical dar for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x line 17)  29.00 Nedical dar for swing-bed to services after December 31 of the cost reporting period (line 6 x line 18)  29.00 Nedical dar for swing-bed services applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  29.00 Nedical dar for swing-bed services after December 31 of the cost reporting period (line 6 x line 18)  29.00 Nedical for swing-bed service services after December 31 of the cost reporting period (line 6 x line 18)  29.00 Nedical for swing-bed service service services after December 31 of the cost repo	12. 00			e room days)	0	12. 00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   14.00   decidally necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   15.00   16.00   1		through December 31 of the cost reporting period	3 .			
14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   0   15.00   0   0   0   0   0   0   0   0   0	13. 00				0	13. 00
15.00   Total nursery days (title V or XIX only)	14 00				0	14 00
16. 00   Nursery days (title V or XIX only)			am (exer during smriig bed	days)	-	
17. 00   Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost   0.00   17. 00   18. 00   18. 00   Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost   0.00   18. 00   19. 00	16.00	Nursery days (title V or XIX only)			0	16. 00
reporting period  Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (1.0.00 led) (2.0.00 led) (2.0.0	47.00			6.11	0.00	47.00
18. 00   Medicare	17.00		es through December 31 c	or the cost	0.00	17.00
19.00   Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period   20.00   Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period   2.000   20.00   2.000   2.	18. 00		es after December 31 of	the cost	0.00	18. 00
reporting period  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  1.00 Total general inpatient routine service cost (see instructions)  2.989,542 21.00  20.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 18)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Opinitate room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  30.00 Average private room per diem charge (line 30 + line 4)  30.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  30.00 Average per diem private room charge differential (line 32 minus line 33)  30.00 Private room cost differential adjustment (line 32 minus line 33)  30.00 Average per diem private room cost differential (line 32 minus line 33)  30.00 Private room cost differential adjustment (line 32 minus line 33)  30.00 Private room cost differential adjustment (line 32 minus line 33)  30.00 Private room cost differential adjustment (line 32 minus line 35)  30.00 Average per diem private room cost differential (line 34 x li	40.00					40.00
Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period   2,989,542   21.00   20.00	19.00		s through December 31 of	tne cost	0.00	19.00
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22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average semi-private room per diem charge (line 30 + line 4) 31.00 Average per diem private room cost differential (line 32 x line 31) 32.00 Average per diem private room cost differential (line 32 x line 31) 33.00 Average per diem private room cost differential (line 32 x line 31) 34.00 Private room cost differential adjustment (line 3 x line 35) 35.00 Average per diem private room cost differential (line 32 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the			`		0 000 540	
5 x line 17)  Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00  Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0 24.00 7 x line 19)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 X line 20)  26.00 Total swing-bed cost (see instructions)  Coeneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  December 31 of the cost reporting period (line 8 0 24.00 X line 20)  Coeneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  December 31 of the cost reporting period (line 8 0 24.00 X line 20)  Private ROOM DIFFERENTIAL ADJUSTMENT  29.00 Private room charges (excluding swing-bed charges)  December 31 of the cost reporting period (line 8 0 24.00 X line 20)  Coeneral inpatient routine service cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  December 31 of the cost reporting period (line 8 0 24.00 X line 20)  Coeneral inpatient routine service cost (line 21 minus line 26)  Private room charges (excluding swing-bed charges)  Coeneral inpatient routine service cost period (line 21 minus line 28)  Coeneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 2 2, 989, 542 27.00 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Coeneral inpatient routine service cost per diem (see instructions)  Coeneral inpatient routine service cost per diem (see instructions)  Coeneral inpatient routine service cost per diem (see instructions)  Coeneral inpatient routine service cost per di				ing period (line		
x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20)  26.00 Total swing-bed cost (see instructions)	22.00		or or the cost report	ing perrod (ine	O	22.00
24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25. 00 x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 29 ÷ line 3) 34. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35. 00 Average per diem private room cost differential (line 3 x line 31) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 989, 542) 37. 00 Average per diem private room cost differential (line 3 x line 31) 38. 00 Average per diem private room cost differential (line 3 x line 35) 39. 00 Average semi-private room cost differential (line 3 x line 35) 39. 00 Average semi-private room cost differential (line 3 x line 35) 39. 00 Average semi-private room cost differential (line 3 x line 35) 39. 00 Average semi-private room cost differential (line 3 x line 35) 39. 00 Average semi-private room cost differential (line 3 x line 35) 39. 00 Average semi-private room cost differential (line 3 x line 35) 39. 00 Average semi-private room cost differential (line 3 x line 35) 39. 00 Average semi-private room cost differential (line 3 x line 35) 39. 00 Average semi-private room cost differential (line 3 x line 35) 39. 00 Average semi-private room cost differential (line 3 x line 35) 39. 00 Average semi-private room cost differential (line 3 x line 35) 39. 00 Average semi-private room cost differential (line 3 x line 35) 3	23. 00		31 of the cost reportin	g period (line 6	0	23. 00
7 x line 19)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	24.00	1	r 21 of the cost reporti	ng poriod (line	0	24.00
25. 00	24.00	31.	31 of the cost reporti	ng perrou (Trie	U	24.00
26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 2, 989, 542  RIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00  29.00 Pri vate room charges (excluding swing-bed charges) 0 29.00  30.00 Semi-pri vate room charges (excluding swing-bed charges) 0 30.00  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.0000000  32.00 Average pri vate room per diem charge (line 29 ÷ line 3) 0.00  33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 0.00  34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 0.00  35.00 Average per diem private room cost differential (line 34 x line 31) 0.00  36.00 Private room cost differential adjustment (line 3 x line 35) 0 36.00  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 989, 542) 37.00  27 minus line 36) PART II - HOSPITAL AND SUBPROVI DERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 1, 971, 246 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	25. 00		31 of the cost reporting	period (line 8	0	25. 00
27.00   Coneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   2, 989, 542   27.00     PRIVATE ROOM DIFFERENTIAL ADJUSTMENT   28.00     Coneral inpatient routine service charges (excluding swing-bed and observation bed charges)   0   28.00     Private room charges (excluding swing-bed charges)   0   29.00     30.00   Semi-private room charges (excluding swing-bed charges)   0   29.00     31.00   General inpatient routine service cost/charge ratio (line 27 ± line 28)   0.000000     31.00   Average private room per diem charge (line 29 ± line 3)   0.00     32.00   Average semi-private room per diem charge (line 30 ± line 4)   0.00     33.00   Average per diem private room charge differential (line 32 minus line 33) (see instructions)   0.00   34.00     35.00   Average per diem private room cost differential (line 34 x line 31)   0.00   35.00     36.00   Private room cost differential adjustment (line 3 x line 35)   0   36.00     Coneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)   0.00     PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS   1,146.74     38.00   Program general inpatient routine service cost (line 9 x line 38)   1,971,246   39.00     Program general inpatient routine service cost (line 9 x line 38)   1,971,246   39.00     40.00   Medically necessary private room cost applicable to the Program (line 14 x line 35)   0   40.00	27.00	1			0	27.00
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30.00 Average private room per diem charge (line 29 ÷ line 3)  30.00 Average semi-private room per diem charge (line 30 ÷ line 4)  30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 989, 542 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00 28.00 29.00 29.00 29.00 29.00 29.00 20.00 20.00 20.00 20.00 20.00 31.00 32.00			(line 21 minus line 26)		-	
29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 Semi-private room per diem charge (line 27 ÷ line 28)  31. 00 Average private room per diem charge (line 29 ÷ line 30 + line 30 + line 31)  32. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  32. 00 Average per diem private room cost differential (line 34 x line 31)  33. 00 Average per diem private room cost differential (line 3 x line 35)  34. 00 Private room cost differential adjustment (line 3 x line 35)  35. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 989, 542)  37. 00 Program INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost (line 9 x line 38)  38. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  39. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	27.00		(1110 21 11110 11110 20)		2/ 707/ 012	27.00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 989, 542) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 30.00			d and observation bed ch	arges)		
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  32.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  32.00 Average per diem private room cost differential (line 34 x line 31)  33.00 Average per diem private room cost differential (line 34 x line 31)  34.00 Average per diem private room cost differential (line 34 x line 31)  35.00 Private room cost differential adjustment (line 3 x line 35)  36.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 989, 542)  37.00 PART II - HOSPITAL AND SUBPROVI DERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost (line 9 x line 38)  38.00 Average per diem private room cost applicable to the Program (line 14 x line 35)  0.00 00000000000000000000000000000000						
32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 989, 542) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 Average per diem charge (line 30 ÷ line 3) 0.00 Jac. 00 0.00			- line 28)		-	
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 989, 542)  37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 33.00  0.00 34.00  36.00 35.00  36.00 36.00  37.00 27 minus line 36) PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 40.00		,	. 11116 23)			
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 989, 542)  Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Average per diem private room cost differential (line 2, 989, 542)  37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  37.00 Program general inpatient routine service cost (line 9 x line 38)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  38.00 Average per diem private room cost differential (line 2, 989, 542)  37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  38.00 Average per diem private room cost differential (line 2, 989, 542)  39.00 Average per diem private room cost differential (line 2, 989, 542)  37.00 Average per diem private room cost differential (line 2, 989, 542)  37.00 Average per diem private room cost differential (line 2, 989, 542)  37.00 Average per diem private room cost differential (line 2, 989, 542)  37.00 Average per diem private room cost differential (line 2, 989, 542)  37.00 Average per diem private room cost differential (line 2, 989, 542)  37.00 Average per diem private room cost differential (line 2, 989, 542)  37.00 Average per diem private room cost differential (line 2, 989, 542)  37.00 Average per diem private room cost differential (line 2, 989, 542)  37.00 Average per diem private room cost differential (line 2, 989, 542)  37.00 Average per diem private room cost differential (line 3 x line 31)  38.00 Average per diem private room cost differential (line 3 x line 31)  38.00 Average per diem private room cost differential (line 3 x line 31)  38.0	33.00				0.00	33. 00
36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 989, 542)  37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  37.00 Program general inpatient routine service cost (line 9 x line 38)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				tions)		
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 989, 542 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37. 00  2, 989, 542  37. 00  37. 00  37. 00  37. 00  37. 00  40. 00			le 31)			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,146.74 38.00 Program general inpatient routine service cost (line 9 x line 38) 1,971,246 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		1	and private room cost di	fferential (line	-	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,146.74 38.00 Program general inpatient routine service cost (line 9 x line 38)  1,971,246 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		27 minus line 36)				
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,146.74 38.00 Program general inpatient routine service cost (line 9 x line 38)  1,971,246 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00			ICTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,971,246 39.00 40.00	38. 00				1, 146, 74	38. 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
41.00   Iotal Program general inpatient routine service cost (line 39 + line 40)   1,971,246   41.00		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			-	
	41.00	liotal Program general inpatient routine service cost (line 39	+ IIne 40)	I	1, 971, 246	41.00

	Financial Systems	PORTER MEMORI				eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST				Period: From 01/01/2016	Worksheet D-1	
			Component	CCN: 15-T035	To 12/31/2016	Date/Time Pre 5/30/2017 10:	
			Ti tl e	e XVIII	Subprovi der -	PPS	17 4111
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
	cost center bescription	Inpatient Cost				(col. 3 x col.	
	I	1. 00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0.0	0 0	0	42. 00
43.00	INTENSIVE CARE UNIT	0	C	0.0	0 0	0	43.00
43. 01	NEONATAL INTENSIVE CARE UNIT	0	С	0.0	0 0	0	43. 01
44. 00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description						
48. 00	Program inpatient ancillary service cost (Wks	st D=3 col 3	Line 200)			1. 00 736, 644	48. 00
49. 00	Total Program inpatient costs (sum of lines 4			ons)		2, 707, 890	•
	PASS THROUGH COST ADJUSTMENTS			,			
50. 00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sum	of Parts I and	285, 131	50. 00
51. 00	Pass through costs applicable to Program inpaland IV)	atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	54, 164	51.00
52. 00	Total Program excludable cost (sum of lines 5	50 and 51)				339, 295	52. 00
53. 00	Total Program inpatient operating cost exclud	ding capital re	lated, non-phy	sician anesth	etist, and	2, 368, 595	
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00	Program discharges					0	54. 00
55.00	Target amount per discharge					0.00	1
56. 00	Target amount (line 54 x line 55)				>	0	56. 00
57. 00 58. 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period	endi na 1996. u	updated and co	mpounded by the		
	market basket						
60. 00 61. 00	51.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by					0.00	60. 00 61. 00
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	the target		
62. 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			Ö	•
	PROGRAM INPATIENT ROUTINE SWING BED COST					_	
64. 00	Medicare swing-bed SNF inpatient routine costinstructions)(title XVIII only)	ts through Dece	mber 31 of the	e cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the d	cost reporting	period (See	0	65. 00
instructions)(title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For					0	66. 00	
CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period					0	67. 00	
40.00	(line 12 x line 19)	-				0	40.00
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)			•	tring perrou		
69. 00	Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70.00	Skilled nursing facility/other nursing facili	ty/ICF/IID rou	tine service d	cost (line 37)			70. 00
71. 00 72. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line 7		ine 70 ÷ line	2)			71. 00 72. 00
72.00	Medically necessary private room cost applica		ı(line 14 x li	ne 35)			72.00
74. 00	Total Program general inpatient routine servi		•				74. 00
75. 00	Capital-related cost allocated to inpatient r	routine service	costs (from V	Vorksheet B, P	art II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lir	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
	Inpatient routine service cost (line 74 minus			1->			78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa	,		*.	ıs line 70)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limit			. (	, , ,		81. 00
82. 00	Inpatient routine service cost limitation (li	ne 9 x line 81	* .				82. 00
83.00	Reasonable inpatient routine service costs (s		s)				83.00
84. 00 85. 00	Program inpatient ancillary services (see ins Utilization review - physician compensation (		ins)				84. 00 85. 00
	Total Program inpatient operating costs (sum						86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST					
87. 00 88. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per d		line 2)			0.00	
	Observation bed cost (line 87 x line 88) (see	•					89. 00

		552-10
COMPUTATION OF INPATIENT OPERATING COST Provider CCN: 15-0035 Period:	Worksheet D-1	
Component CCN: 15-T035 From 01/0° To 12/3°	1/2016 1/2016   Date/Time Prep   5/30/2017 10:1	
Title XVIII Subprovi	der - PPS	
IRF		
Cost Center Description   Cost   Routine Cost   column 1 ÷   Tota	I Observation	
(from line 21) column 2   Observa	tion Bed Pass	
Bed Cost	(from Through Cost	
line	39) (col. 3 x col.	
	4) (see	
	instructions)	
1.00 2.00 3.00 4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
90. 00 Capi tal -rel ated cost 432, 433 2, 989, 542 0. 144649	0 0	90.00
91.00 Nursing School cost 0 2, 989, 542 0.000000	0 0	91.00
92.00   Allied health cost   0   2,989,542   0.000000	0 0	92.00
93.00 All other Medical Education 0 2,989,542 0.000000	0 0	93.00

	R MEMORIAL HOSPITAL			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC		Peri od:	Worksheet D-3	
			From 01/01/2016 To 12/31/2016	Date/Time Pre	nared:
			10 12/31/2010	5/30/2017 10:	
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	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
30. 00   03000   ADULTS & PEDI ATRI CS			65, 015, 604		30. 00
31.00 03100 INTENSIVE CARE UNIT			18, 169, 073		31.00
31.01  03101 NEONATAL INTENSIVE CARE UNIT			0		31. 01
41. 00   04100   SUBPROVI DER - I RF			0		41.00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS					
50. 00   05000   OPERATI NG ROOM		0. 07724		5, 358, 692	
51.00   05100   RECOVERY ROOM		0.00000		0	
52.00   05200   DELIVERY ROOM & LABOR ROOM		0. 31701		11, 622	
53. 00   05300   ANESTHESI OLOGY		0. 02105		59, 826	
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 07706		2, 008, 506	
54. 01   05401   ULTRASOUND		0.00000		0	
56. 00   05600   RADI 0I SOTOPE		0.00000		0	
57. 00   05700   CT   SCAN		0.00000		0	
58. 00   05800   MRI		0.00000		0	
60. 00   06000   LABORATORY		0. 08914		3, 312, 808	
65. 00 06500 RESPI RATORY THERAPY		0. 08877		1, 820, 599	
66. 00 06600 PHYSI CAL THERAPY		0. 20600		1, 223, 072	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 10304			
68. 00   06800   SPEECH PATHOLOGY		0. 17783		218, 087	
69. 00   06900   ELECTROCARDI OLOGY		0. 09148		2, 103, 874	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 07268			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 18204			
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 16555		4, 586, 781	
74. 00   07400   RENAL DI ALYSI S		0. 22799		438, 005	
76. 00   03950   ANCI LLARY		0.00000		0	
76. 01   03610   SLEEP LAB		0.00000		0	
76. 03 03951 WOUND CARE		0. 29285	6 215, 015	62, 968	76. 03
OUTPAȚI ENT SERVI CE COST CENTERS					1
	l	0 00000	ω 0	Λ .	

25, 604, 175 1, 670, 950 307, 319, 302

307, 319, 302

2, 877, 320 91. 00 484, 301 92. 00

34, 691, 346 200. 00

90. 00 91. 00

201. 00 202. 00

0. 000000 0. 112377

0. 289836

90.00

201. 00 202. 00

09000 CLI NI C

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART Total (sum of lines 50-94 and 96-98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net Charges (line 200 minus line 201)

91. 00 09100 EMERGENCY

	Financial Systems PORTER MEMOR ENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0035	Peri od:	wof Form CMS-2 Worksheet D-3	
				From 01/01/2016		
		Component	CCN: 15-T035	To 12/31/2016	Date/Time Pre 5/30/2017 10:	
		Ti tl e	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	9	Program Costs	
				Charges	(col. 1 x col.	
			4 00	0.00	2)	
	LNDATIENT DOUTING CEDVICE COCT CENTERS		1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1		I	
	03000 ADULTS & PEDIATRICS			0	1	30.00
	03100   INTENSIVE CARE UNIT			0		31.00
	03101 NEONATAL INTENSIVE CARE UNIT			4 455 105		31. 01
	04100 SUBPROVI DER - I RF			4, 455, 105		41.00
	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43. 00
	05000 OPERATING ROOM		0.0772	40 29, 505	2, 279	50.00
	05100 RECOVERY ROOM		1		'	
	05200 DELIVERY ROOM & LABOR ROOM		0. 0000 0. 3170		0	
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY		1		1	
	05300   ANESTHESTOLOGY 05400   RADI OLOGY-DI AGNOSTI C		0. 0210 0. 0770		16 12, 963	
	05400  RADI OLOGY -DI AGNOSTI C 05401  ULTRASOUND		0.0770		12, 903	
	05600 RADI OI SOTOPE		0.0000		0	
	05700 CT SCAN		0.0000		0	
	05/00 CT 3CAN		0.0000		0	
	06000 LABORATORY		0.0891		-	
	06500 RESPI RATORY THERAPY		0. 0897		61	
	06600 PHYSI CAL THERAPY		0. 2060			
	06700 OCCUPATI ONAL THERAPY		0. 1030		160, 583	
	06800 SPEECH PATHOLOGY		0. 1778		1	
	06900 ELECTROCARDI OLOGY		0. 0914		1	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 0726			
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1820		814	
	07300 DRUGS CHARGED TO PATIENTS		0. 1655		87, 295	
	07400 RENAL DI ALYSI S		0. 2279			
	03950 ANCI LLARY		0.0000		0	
	03610 SLEEP LAB		0.0000		Ō	
	03951 WOUND CARE		0. 2928		Ō	
	OUTPATIENT SERVICE COST CENTERS			<u>'</u>	•	
90. 00	09000 CLI NI C		0.0000	00 0	0	90.00
91. 00	09100 EMERGENCY		0. 1123	77 9, 436	1, 060	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 2898	36 0	0	92. 00
200.00	Total (sum of lines 50-94 and 96-98)			5, 032, 190	736, 644	200.00
201.00	Less PBP Clinic Laboratory Services-Program only char	ges (line 61)		0		201. 00
202.00	Net Charges (line 200 minus line 201)		1	5, 032, 190	l .	202. 00

Health Financial Systems PORTER MEMO	ORIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
			From 01/01/2016	5 . (7) 5	
			To 12/31/2016	Date/Time Pre 5/30/2017 10:	pared: 10 am
	Ti tl	e XIX	Hospi tal	Cost	17 (1111
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		1	
30. 00   03000   ADULTS & PEDI ATRI CS			5, 228, 691		30. 00
31. 00 03100 INTENSIVE CARE UNIT			4, 805, 716		31. 00
31. 01   03101   NEONATAL   INTENSIVE CARE UNIT			9, 028, 374		31. 01
41. 00   04100   SUBPROVI DER -   RF			367, 087		41. 00
43. 00   04300   NURSERY			856, 315		43. 00
ANCI LLARY SERVI CE COST CENTERS  50, 00 05000 OPERATI NG ROOM		0.07704	0 40 700 004	4 050 000	F0 00
		0.07724		1, 058, 900	1
51. 00   05100   RECOVERY ROOM 52. 00   05200   DELIVERY ROOM & LABOR ROOM		0. 00000 0. 31701		1 207 242	51. 00 52. 00
53. 00   05200   DELT VERY ROOM & LABOR ROOM   53. 00   05300   ANESTHESI OLOGY		0. 31701		1, 207, 363 19, 826	52.00
54. 00   05400  ANESTHESTOLOGY 54. 00   05400  RADI OLOGY-DI AGNOSTI C		0.02105			
54. 00   05400   RADI 0LOGI - DI AGNOSTI C		0.00000		0 507, 955	54. 00
56. 00   05600   RADI OI SOTOPE		0.00000			56.00
57. 00   05700   CT   SCAN		0.00000		0	57. 00
58. 00   05700  CT   36AN		0.00000		0	58.00
60. 00   06000 LABORATORY		0. 08914			
65. 00   06500   RESPIRATORY THERAPY		0. 08877			
66. 00 06600 PHYSI CAL THERAPY		0. 20600		214, 658	
67. 00 06700 OCCUPATIONAL THERAPY		0. 10304			67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 17783	•		
69. 00 06900 ELECTROCARDI OLOGY		0. 09148	•		69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 07268			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 18204		754, 081	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 16555			ı
74. 00   07400   RENAL DI ALYSI S		0. 22799			74. 00
76. 00 03950 ANCI LLARY		0.00000		0	76. 00
76. 01 03610 SLEEP LAB		0.00000		0	76. 01
76. 03 03951 WOUND CARE		0. 29285	6 132, 444	38, 787	76. 03
OUTDATIENT SERVICE COST CENTERS			·		

0. 000000 0. 112054

0. 289836

6, 961, 349

68, 897, 396

68, 897, 396

488, 986

90.00

91. 00

92.00

201. 00 202. 00

780, 047

141, 726

8, 209, 928 200. 00

OUTPATIENT SERVICE COST CENTERS
09000 CLINIC

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (sum of lines 50-94 and 96-98)

Net Charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

90.00

200.00

201.00

202.00

91. 00 09100 EMERGENCY

Health Financial Systems	PORTER MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0035	Peri od: From 01/01/2016 To 12/31/2016 Worksheet E Part A Date/Ti me Prepared: 5/30/2017 10: 19 am

		Title XVIII	Hospi tal	5/30/2017 10: <sup>3</sup> PPS	19 am_
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1. 00	
1.00	DRG Amounts Other than Outlier Payments			0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring instructions)	prior to October 1 (s	see	32, 974, 065	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring instructions)	on or after October 1	(see	11, 371, 016	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for a	discharges occurring p	orior to October	0	1. 03
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for (	discharges occurring o	on or after	0	1. 04
2.00	October 1 (see instructions) Outlier payments for discharges. (see instructions)			2, 374, 722	2. 00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructions	s)		0	2. 01 2. 02
3.00	Managed Care Simulated Payments	2)		0	3. 00
4. 00	Bed days available divided by number of days in the cost reportional rect Medical Education Adjustment	ng period (see instruc	ctions)	227. 02	4. 00
5. 00	FTE count for allopathic and osteopathic programs for the most roor before 12/31/1996. (see instructions)	ecent cost reporting p	period ending on	0. 00	5. 00
6. 00	FTE count for allopathic and osteopathic programs which meet the for new programs in accordance with 42 CFR 413.79(e)	criteria for an add-d	on to the cap	0. 00	6. 00
7.00	MMA Section 422 reduction amount to the IME cap as specified under	er 42 CFR §412.105(f)	(1) (i v) (B) (1)	0.00	7. 00
7. 01	ACA Section 5503 reduction amount to the IME cap as specified und If the cost report straddles July 1, 2011 then see instructions.	der 42 CFR §412.105(f)	(1) (i v) (B) (2)	0. 00	7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c) 1998), and 67 FR 50069 (August 1, 2002).		, I	0. 00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If			0. 00	8. 01
8. 02	the cost report straddles July 1, 2011, see instructions.  The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital		0.00	8. 02	
9. 00	under section 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines	(8, 8,01 and 8,02) (s	see	0. 00	9. 00
10. 00	instructions)   FTE count for allopathic and osteopathic programs in the current year from your records		0. 00	10. 00	
11. 00 12. 00	FTE count for residents in dental and podiatric programs.  Current year allowable FTE (see instructions)				11. 00 12. 00
13. 00	Total allowable FTE count for the prior year.			0.00	13. 00
14. 00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	ended on or after Sept	cember 30, 1997,	0.00	14. 00
15. 00	Sum of lines 12 through 14 divided by 3.			0. 00	15. 00
16. 00	Adjustment for residents in initial years of the program				16. 00
17. 00	Adjustment for residents displaced by program or hospital closure	Э			17. 00
18. 00 19. 00	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4).			0.00	18. 00 19. 00
20. 00	Prior year resident to bed ratio (see instructions)			0.000000	
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	21. 00
22. 00	IME payment adjustment (see instructions)			0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)			0	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for Section Number of additional allopathic and osteopathic IME FTE resident		ec. 412.105	0.00	23. 00
04.00	(f)(1)(iv)(C).			0.00	04.00
24. 00	IME FTE Resident Count Over Cap (see instructions)	or of line 22 or line	24 (500	0.00	
25. 00	If the amount on line 24 is greater than -O-, then enter the low instructions)	er of time 23 of time	24 (See	0. 00	25. 00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27. 00
28.00	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29. 00	Total IME payment ( sum of lines 22 and 28)			0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			0	29. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A patie	ent days (see instruct	i ons)	2. 71	30. 00
31.00	Percentage of Medicaid patient days (see instructions)			17. 83	
32. 00	Sum of lines 30 and 31			20. 54	
33.00	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)			6. 16 682, 915	
54.00	prisproportionate share aujustilient (See Thatructions)		I	002, 710	34.00

	Financial Systems PORTER MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0035	Peri od: From 01/01/2016	u of Form CMS-2 Worksheet E Part A Date/Time Pre	
	To 12/31/2016				pared: 19 am
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1 1.00	0n/After 10/1 2.00	
	Uncompensated Care Adjustment		1.00	2.00	
35.00	Total uncompensated care amount (see instructions)			5, 977, 483, 147	•
35. 01 35. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, en (see instructions)	ter zero on this line)	0. 000238466 1, 527, 648	0. 000257603 1, 539, 818	
35. 03 36. 00	Pro rata share of the hospital uncompensated care payment amount of the hospital uncompensated care (sum of columns 1 and 2 on line 35.0	03)	1, 143, 649 1, 531, 768		35. 03 36. 00
40.00	Additional payment for high percentage of ESRD beneficiary di				40.00
40. 00 41. 00	Total Medicare discharges on Worksheet S-3, Part I excluding 652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6	g .	0		40. 00
41. 00	instructions)  Total ESRD Medicare covered and paid discharges excluding MS-	•			41. 00
42. 00	an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not quali		0.00		42.00
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68 instructions)				43. 00
44. 00	Ratio of average length of stay to one week (line 43 divided days)	by line 41 divided by 7	0. 000000		44. 00
45. 00 46. 00	Average weekly cost for dialysis treatments (see instructions	,	0.00		45. 00 46. 00
47. 00	Total additional payment (line 45 times line 44 times line 47 Subtotal (see instructions)	1.01)	48, 934, 486		47.00
48. 00					48. 00
				Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instructions	s)		48, 934, 486	49. 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I am			3, 871, 783	1
51. 00 52. 00	Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii			0	51. 00 52. 00
53. 00	Nursing and Allied Health Managed Care payment	, , , , , , , , , , , , , , , , ,		16, 530	1
54.00	Special add-on payments for new technologies			8, 693	
54. 01 55. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line o	69)		0	54. 01 55. 00
56. 00	Cost of physicians' services in a teaching hospital (see inti			0	56.00
57. 00	Routine service other pass through costs (from Wkst. D, Pt.		hrough 35).	0	57. 00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		7, 681	58.00
59. 00 60. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments			52, 839, 173 23, 728	1
61. 00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		52, 815, 445	
62.00	Deductibles billed to program beneficiaries			4, 536, 168	
63.00	Coinsurance billed to program beneficiaries			321, 391	1
64. 00 65. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			265, 243 172, 408	1
66. 00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		155, 114	66.00
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			48, 130, 294	67. 00
68.00	Credits received from manufacturers for replaced devices for			0	68. 00
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	.(For SCH see instruction	s)	0	69. 00
70. 00 70. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT			0	70. 00 70. 50
70. 30	SCH or MDH volume decrease adjustment			0	70. 30
70. 89	Pioneer ACO demonstration payment adjustment amount (see ins	tructions)		0	70. 89
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70. 90
70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	70. 91
70. 92 70. 93	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)			0 -7, 367	70. 92 70. 93
	HRR adjustment amount (see instructions)			-251, 223	
70. 94					

Heal th	Financial Systems PORTER MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CC		Peri od: From 01/01/2016 To 12/31/2016	Worksheet E Part A	pared:
		Title	XVIII	Hospi tal	PPS	
			FFY	(yyyy)	Amount	
				0	1. 00	
	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)			0	0	70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or af			0	0	70. 97
70. 98	Low Volume Payment-3	ŕ			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)			47, 871, 704	71. 00
71. 01	Sequestration adjustment (see instructions)	•			957, 434	
	Interim payments				46, 682, 442	72. 00
73.00	Tentative settlement (for contractor use only)				0	73. 00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72	, and 73)			231, 828	74. 00
75.00	Protested amounts (nonallowable cost report items) in accordan	nce with			2, 620, 395	75. 00
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
	Operating outlier amount from Wkst. E, Pt. A, line 2 (see ins	tructions)			0	
	Capital outlier from Wkst. L, Pt. I, line 2				0	
92.00	Operating outlier reconciliation adjustment amount (see instr				0	92. 00
	Capital outlier reconciliation adjustment amount (see instruc				0	93. 00
	The rate used to calculate the time value of money (see instru	uctions)			0. 00	
	Time value of money for operating expenses (see instructions)				0	
96. 00	Time value of money for capital related expenses (see instruc	tions)		1	0	96. 00
				Prior to 10/1		
				1. 00	2. 00	
	HSP Bonus Payment Amount				0	100 00
	HSP bonus amount (see instructions)			0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment			0.000000000	0.000000000	101 00
	HVBP adjustment factor (see instructions)	- >		0.000000000		
	HVBP adjustment amount for HSP bonus payment (see instruction: HRR Adjustment for HSP Bonus Payment	5)		0	0	102. 00
	HRR adjustment factor (see instructions)			0.0000	0.0000	103 00
	HRR adjustment amount for HSP bonus payment (see instructions	)		0.0000		103.00
104.00	This and astiment amount for his bonus payment (see this tructions	,		١	0	1104.00

Health Financial Systems	PORTER MEMORIAL HOSE	PITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pro	ovider CCN: 15-0035	From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/30/2017 10:19 am
		Ti +Lo VVIII	Hospi tal	DDC

PART BWID CAL_AND_CTHER_HEATH_SERVICES   1.00			10	12/31/2016	5/30/2017 10:	parea: 10 am
Deat B			Title XVIII - F	losni tal		17 alli
PART B - INDICAL AND OTHER HEALTH SERVICES   1.00   Ned cal and other services (see instructions)   27,765   1.00   Ned cal and other services (see instructions)   27,765   1.00   Ned cal and other services (see instructions)   27,765   1.00   Ned cal and other services (see instructions)   27,765   1.00   Ned cal and other services (see instructions)   27,765   1.00   Ned cal and other services (see instructions)   27,765   1.00   Ned cal and other services (see instructions)   27,93,886   0.00   Ned cal and other services (see instructions)   27,93,886   0.00   Ned cal and other services (see instructions)   27,00   Ned cal and other services (see instructions)   28,00   Ned cal and other services (see instructions)   27,00   Ned cal and other services (see instructions)   28,00   Ned cal and other services (see instructions)   28,00   Ned cal and other services (see instructions)   28,00   Ned cal and other services (see instructions)   10,00   Ned cal and other			THE XVIII	lospi tui	113	
PART B - INDICAL AND OTHER HEALTH SERVICES   1.00   Ned cal and other services (see instructions)   27,765   1.00   Ned cal and other services (see instructions)   27,765   1.00   Ned cal and other services (see instructions)   27,765   1.00   Ned cal and other services (see instructions)   27,765   1.00   Ned cal and other services (see instructions)   27,765   1.00   Ned cal and other services (see instructions)   27,765   1.00   Ned cal and other services (see instructions)   27,93,886   0.00   Ned cal and other services (see instructions)   27,93,886   0.00   Ned cal and other services (see instructions)   27,00   Ned cal and other services (see instructions)   28,00   Ned cal and other services (see instructions)   27,00   Ned cal and other services (see instructions)   28,00   Ned cal and other services (see instructions)   28,00   Ned cal and other services (see instructions)   28,00   Ned cal and other services (see instructions)   10,00   Ned cal and other					1. 00	
Medical and other services (see instructions)		PART B - MEDICAL AND OTHER HEALTH SERVICES				
PS payments	1.00	Medical and other services (see instructions)			72, 765	1.00
0.00   Outslief payment (see instructions)   0.000   5.00	2.00	Medical and other services reimbursed under OPPS (see instruct	ti ons)		29, 290, 331	2. 00
Enter the hospital specific payment to cost ratio (see instructions)	3.00	PPS payments			29, 704, 190	3. 00
Line 2 times line 5	4.00	Outlier payment (see instructions)			258, 368	4. 00
7.00         Sum of Time 3 plus line 4 divided by line 6         0.00         7.00           8.00         Transitional corridor payment (see instructions)         0.80           9.00         Ancillary service other pass through costs from tRist. D, Pt. IV, col. 13, line 200         7.133           9.00         Organization acquisitions         7.2763           11.00         Total cost (sum of Time 1 and 10) (see instructions)         7.2763           12.00         Ancillary service charges         433,207 12.00           14.00         Intelligency of the charges (sum of Times 12 and 13)         453,207 12.00           14.00         Intelligency charges         453,207 14.00           Customary charges         453,207 14.00           Customary charges         453,207 14.00           Customary charges         453,207 14.00           Customary charges (sum of Lines 12 and 13)         15.00           15.00         Aggregate amount actually collected from patients Hable for payment for services on a chargebasis         0           15.00         Aggregate amount actually collected from patients Hable for payment for services on a chargebasis         0           17.00         Satio of Line 15 to Line 16 (not to exceed 1.000000)         453,207 18.00           18.00         Lacustomary charges (see Instructions)         0	5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	5. 00
8.00   Anounts tional corridor payment (see instructions)   0. 8.00	6.00	Line 2 times line 5			0	6.00
9.00	7.00	Sum of line 3 plus line 4 divided by line 6			0.00	7. 00
10.00   Organ acquisitions   72,765   11.00   Total cost (sum of lines 1 and 10) (see Instructions)   72,765   11.00   CoMPUTATION OF LESSER OF COST OR CHARGES	8.00	Transitional corridor payment (see instructions)			0	8. 00
1.00   Total cost (sum of lines 1 and 10) (see instructions)   72,765   1.00	9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		7, 413	9. 00
COMPUTATION OF LESSER OF COST OR CHARGES   Reasonable charges   Reasonable charges   Charges   Reasonable charges   Charges   Charges   Reasonable charges	10.00	Organ acqui si ti ons			0	10.00
Reasonable charges   453,207   12.00   20.00	11.00	Total cost (sum of lines 1 and 10) (see instructions)			72, 765	11. 00
12.00   Ancil lary service charges   453, 207   12.00   13.00   Total reasonable charges (cym of lines 12 and 13)   0.10   13.00   0.10   0		COMPUTATION OF LESSER OF COST OR CHARGES				
13.00   Organ acquisition charges (from West. D-4, Pt. III, col. 4, line 69)		Reasonabl e charges				
14. 00   Total reasonable charges (sum of lines 12 and 13)					453, 207	1
Customary charges			ne 69)			ł
15.00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   16.00	14. 00				453, 207	14. 00
16.00   Amounts that would have been realized from patients   iable for payment for services on a chargebasis   nature						
had such payment been made in accordance with 42 CFR \$413.13(e)						
17.00   Ratio of line 15 to line 16 (not to exceed 1.000000)   17.00   18.00   17.00   19.00	16.00	·	. ,	nargebasis	1	16.00
18. 00   Total customery charges (see instructions)	17 00		e)		0.000000	17.00
19. 00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see   380, 442   9, 00   instructions)   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20, 00   20, 20, 20   20, 20, 20						
Instructions			vifling 10 avacada lina 11	\ (000		1
20. 00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20. 00	19.00		y IT TITLE TO exceeds TITLE IT	) (See	300, 442	19.00
Instructions	20 00		v if line 11 eveneds line 18	) (500	1	20 00
21.00   Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)   0.20.00   22.00   23.00   20.	20.00		y 11 Title 11 exceeds Title 10,	, (300	ĺ	20.00
22.00   Interns and residents (see instructions)   0.20.00   23.00   23.00   23.00   23.00   25.00   7.00   7.00   29.969,971   24.00   29.969,971   24.00   29.969,971   24.00   29.969,971   24.00   29.969,971   24.00   29.969,971   24.00   29.969,971   24.00   25.00	21. 00		e instructions)		72, 765	21.00
23.00   Cost of physicians' services in a teaching hospital (see instructions)   29,969,971   24.00   COMPUTATION OF REIMBURSEMENT SETTLEMENT   25.00   Deductible sand Coinsurance (for CAH, see instructions)   5,674,382   26.00   27.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   24,368,354   27.00   Extructions   28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   28.00   29.00   2		, ,	,			1
Total prospective payment (sum of lines 3, 4, 8 and 9)   29,969,971   24,00			ructions)			•
COMPUTATION OF RELIMBURSEMENT SETTLEMENT   Deductibles and coinsurance (for CAH, see instructions)   0   25. 00   25. 00   Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)   5, 674, 382   26. 00   27. 00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   10   10   10   10   10   10   10   1			,		29, 969, 971	ł
26.00   Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)   5, 674, 382   26.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   13, 24, 368, 354   27.00   27.00   28.00   29.00						
27.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see linstructions)   24, 368, 354   27.00	25.00	Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
Instructions   Direct graduate medical education payments (from Wkst. E-4, line 50)   0   28	26.00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions)		5, 674, 382	26. 00
28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   ESRD direct medical education costs (from Wkst. E-4, line 36)   29.00   29.00   29.00   29.00   20.00	27. 00		olus the sum of lines 22 and 2	23] (see	24, 368, 354	27. 00
29.00   ESRD direct medical education costs (from Wkst. E-4, line 36)   29.00   30.0			50)			
30.00   Subtotal (sum of lines 27 through 29)   24,368,354   30.00   31.00   Primary payer payments   17,808   31.00   24,350,546   32.00			ne 50)		-	
31.00   Primary payer payments   17,808   31.00   32.00   Subtotal (Line 30 minus Line 31)   24,350,546   32.00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Allowable bad debts (see instructions)   493,729   34.00   Allowable bad debts (see instructions)   320,924   35.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   328,009   37.00   Subtotal (see instructions)   24,671,470   37.00   Subtotal (see instructions)   38.00   39.00   OTHER ADJUSTIMENTS (SEE INSTRUCTIONS) (SPECIFY)   0 39.98   39.99   Partial or full credits received from manufacturers for replaced devices (see instructions)   0 39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0 39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0 39.99   40.00   Subtotal (see instructions)   24,671,470   40.00   41.00   Interim payments   24,256,705   41.00   42.00   Tentative settlement (for contractors use only)   24.20   40.01   43.00   Balance due provider/program (see instructions)   0 39.00   43.00   Allowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   5115.2   510					1	ı
32.00   Subtotal (line 30 minus line 31)   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. 1-5, line 11)   0   33.00   Composite rate ESRD (from Wkst. 1-5, line 11)   0   33.00   Composite rate ESRD (from Wkst. 1-5, line 11)   0   33.00   Composite rate ESRD (from Wkst. 1-5, line 11)   0   33.00   Composite rate ESRD (from Wkst. 1-5, line 11)   0   34.00   Allowable bad debts (see instructions)   320, 924   35.00   Adjusted reimbursable bad debts (see instructions)   320, 924   35.00   Adjusted reimbursable bad debts (see instructions)   398, 813   36.00   398, 813   36.00   MSP-LCC reconciliation amount from PS&R   0   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   MSP-LCC reconciliation amount from PS&R   0   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   0   39.50   99.80   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.98   80.00   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.99   99.80		,				•
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00						ı
33.00   Composite rate ESRD (from Wkst. I-5, line 11)	32.00		SEC)		24, 350, 546	32.00
34.00       Allowable bad debts (see instructions)       493, 729       34.00         35.00       Adjusted reimbursable bad debts (see instructions)       320, 924       35.00         36.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       398, 313       36.00         37.00       Subtotal (see instructions)       24, 671, 470       37.00         38.00       MSP-LCC reconciliation amount from PS&R       0       38.00         39.00       THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       39.00         39.50       Pioneer ACO demonstration payment adjustment (see instructions)       0       39.50         39.98       RECOVERY OF ACCELLERATED DEPRECIATION       0       39.96         39.99       RECOVERY OF ACCELLERATED DEPRECIATION       0       39.99         40.00       Subtotal (see instructions)       24,671,470       40.00         40.01       Interim payments       24,671,470       40.00         42.00       Tentative settlement (for contractors use only)       24,256,705       41.00         43.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515.2       0       44.00         70.00       Diginal outlier amount (see instructions)       0       90.00         90	33 00		,E3)		0	33 00
35.00		1 .				
36.00 Allowable bad debts for dual eligible beneficiaries (see instructions)  37.00 Subtotal (see instructions)  38.00 MSP-LCC reconciliation amount from PS&R  39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  39.50 Pioneer ACO demonstration payment adjustment (see instructions)  39.98 Partial or full credits received from manufacturers for replaced devices (see instructions)  39.98 RECOVERY OF ACCELERATED DEPRECIATION  39.99 QUO Subtotal (see instructions)  39.99 ACCELERATED DEPRECIATION  39.99 ACCELERATED DEPRECIATION  39.99 Caption adjustment (see instructions)  39.99 Caption adjustment (see instructions)  40.01 Sequestration adjustment (see instructions)  40.01 Interim payments  40.02 Tentative settlement (for contractors use only)  42.00 Tentative settlement (for contractors use only)  43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, Si15.2  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  0 90.00 The rate used to calculate the Time Value of Money  1 Time Value of Money (see instructions)  0 93.00  1 Time Value of Money (see instructions)  24, 671, 470 37.00 38.00 38.00 38.00 39.90 39.90 39.90 39.90 39.98 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION  0 39.90 39.99 39.99 40.01 40.00 41.00 42.00 42.00 42.00 43.00 44.00 45.00 46.00 47.00 47.00 48.00 49.00 49.00 49.00 49.00 49.00 49.00						•
37. 00 Subtotal (see instructions)  38. 00 MSP-LCC reconciliation amount from PS&R  39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  39. 50 Pioneer ACO demonstration payment adjustment (see instructions)  39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions)  39. 99 RECOVERY OF ACCELERATED DEPRECIATION  40. 00 Subtotal (see instructions)  50 39. 99  40. 00 Subtotal (see instructions)  40. 01 Sequestration adjustment (see instructions)  40. 01 Interim payments  40. 01 Interim payments  40. 01 Tentative settlement (for contractors use only)  43. 00 Bal ance due provider/program (see instructions)  44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2  70 BE COMPLETED BY CONTRACTOR  90. 00 Other actual actu		, , , , , , , , , , , , , , , , , , , ,	ructions)			•
MSP-LCC reconciliation amount from PS&R   0   38.00     39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00     39.50   Pioneer ACO demonstration payment adjustment (see instructions)   0   39.50     39.98   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99     40.00   Subtotal (see instructions)   24,671,470     40.00   Subtotal (see instructions)   24,671,470     40.01   Interim payments   24,256,705     41.00   Interim payments   24,256,705     42.00   Tentative settlement (for contractors use only)   42.00     43.00   Balance due provider/program (see instructions)   -78,664     44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0     5115.2   TO BE COMPLETED BY CONTRACTOR   0   90.00     90.00   Outlier amount (see instructions)   0   91.00     91.00   Outlier reconciliation adjustment amount (see instructions)   0   92.00     93.00   Time Value of Money (see instructions)   0   93.00     93.00   Time Value of Money (see instructions)   0   93.00     93.00   93.00   0   93.00     94.00   94.00   94.00     95.00   95.00   95.00   95.00     95.00   95.00   95.00     96.00   96.00   96.00     96.00   96.00   96.00     97.00   97.00   97.00     97.00   97.00   97.00     97.00   97.00   97.00     97.00   97.00   97.00     97.00   97.00   97.00     97.00   97.00   97.00     97.00   97.00   97.00     97.00			uetrons)			1
39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 01 Interim payments 41. 00 Interim payments 42, 671, 470 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115. 2 50 BE COMPLETED BY CONTRACTOR 90. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 93. 00 Outlier reconciliation adjustment amount (see instructions) 94. 00 Outlier reconciliation adjustment amount (see instructions) 95. 00 Outlier reconciliation adjustment amount (see instructions) 96. 00 Outlier reconciliation adjustment amount (see instructions) 97. 00 Outlier reconciliation adjustment amount (see instructions) 98. 00 Outlier reconciliation adjustment amount (see instructions) 99. 00 Outlier reconciliation adjustment amount (see instructions)						1
39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.99 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515.2  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.99 94.00 Og 39.99 94.00 Og 39.90 95.00 Og 39.99 96.00 Og 39.99 97.00 Og 39.00						1
39.98 Partial or full credits received from manufacturers for replaced devices (see instructions)  39.98 RECOVERY OF ACCELERATED DEPRECIATION  39.99 40.00 Subtotal (see instructions)  24,671,470 40.00 40.01 Interim payments  10.00 Tentative settlement (for contractors use only)  42.00 Balance due provider/program (see instructions)  43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, possible of the contractors of t		, , , , ,	5)			
39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   40.00   Subtotal (see instructions)   24,671,470   40.00   40.01   40.01   40.00		, , , , , , , , , , , , , , , , , , , ,	•	)		
40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Value of Money (see instructions) 95.00 Value of Money (see instructions) 96.00 Value of Money (see instructions) 97.00 Value of Money (see instructions)		·	( )		0	•
40.01 Sequestration adjustment (see instructions) 41.00 Interim payments 42.4, 256, 705 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  \$\frac{5}{15}\$.2 \tag{10}\$ Diginal outlier amount (see instructions)  90.00 Outlier reconciliation adjustment amount (see instructions)  10 90.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					-	•
41.00 Interim payments  42.00 Tentative settlement (for contractors use only)  43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  5115.2  TO BE COMPLETED BY CONTRACTOR  Original outlier amount (see instructions)  0 Utilier reconciliation adjustment amount (see instructions)  79.00 The rate used to calculate the Time Value of Money  1 Time Value of Money (see instructions)  1 O 93.00  93.00		· · · · · · · · · · · · · · · · · · ·				1
42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)						1
43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  0 Utilier reconciliation adjustment amount (see instructions)  72.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  0 93.00						1
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{5}{115.2}\$ \text{TO BE COMPLETED BY CONTRACTOR}\$  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 Outlier reconciliation adjustment amount (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  93.00 Outlier reconciliation adjustment amount (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  95.00 Outlier reconciliation adjustment amount (see instructions)  97.00 Outlier reconciliation adjustment amount (see instructions)  98.00 Outlier reconciliation adjustment amount (see instructions)  99.00 Outlier reconciliation adjustment amount (see instructions)		,		-78, 664	1	
TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)			nce with CMS Pub. 15-2, chapte	er 1,		1
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 90.00 91.00 92.00 93.00		§115. 2	•			
91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  0 91.00  92.00  93.00						
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00		, ,				•
93.00 Time Value of Money (see instructions) 0 93.00						
						1
94.00   Iotal (sum of lines 91 and 93)   0   94.00						1
	94.00	liotal (Sum of lines 91 and 93)		I	0	94.00

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

					5/30/2017 10: 1	19 am
		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1, 00	2, 00	3. 00	4.00	
1.00	Total interim payments paid to provider		46, 593, 042	2	24, 140, 705	1. 00
2.00	Interim payments payable on individual bills, either		(		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
0.04	Program to Provider	07/44/004/	00.40	07/44/004/	447,000	0.04
3. 01	ADJUSTMENTS TO PROVIDER	07/11/2016	89, 400		116, 000	3. 01
3. 02			(		0	3. 02
3. 03			(		0	3. 03
3.04			(		0	3. 04
3. 05	Dravi dan ta Dragnam			)	U	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		(	1	0	3. 50
3. 51	ADJUSTIMENTS TO PROGRAM					3. 50
3. 52						3. 51
3. 53					0	3. 53
3. 54					0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		89, 400		116, 000	3. 99
0. 77	3. 50-3. 98)		07, 100	1	110,000	0. , ,
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		46, 682, 442	2	24, 256, 705	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	T		J		
5. 01	TENTATI VE TO PROVI DER		(		0	5. 01
5. 02			(		0	5. 02 5. 03
5. 03	Dravidar to Dragram			<u>/ </u>	U	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM				0	5. 50
5. 51	TENTATIVE TO TROUBLAND		(			5. 50
5. 52						5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				0	5. 99
5. , ,	5. 50-5. 98)		`			5. 77
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		231, 828	3	0	6. 01
6.02	SETTLEMENT TO PROGRAM		. (		78, 664	6. 02
7.00	Total Medicare program liability (see instructions)		46, 914, 270		24, 178, 041	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2. 00	
8.00	Name of Contractor	I		1	1	8. 00

Component CCN: 15-T035

Title XVIII

		Title	XVIII	Subprovi der - I RF	PPS	
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		2, 535, 705 (		0	1. 00 2. 00
3. 00	services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					1
3. 01	ADJUSTMENTS TO PROVIDER		(		0	3. 01
3. 02			d		Ō	
3. 03			d		0	
3.04			d	)	0	3. 04
3.05			C	)	0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		C		0	
3. 51			C		0	
3. 52			C		0	3. 52
3.53			(		0	
3.54	Cultural ( 1 i 2 01 2 40i 1 i		(		0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		C	,	0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 535, 705		0	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		2, 333, 700		· ·	4.00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					1
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		(		0	5. 01
5. 02 5. 03					0	
5.05	Provider to Program			/	0	3.03
5. 50	TENTATI VE TO PROGRAM		(		0	5. 50
5. 51					Ö	
5. 52			d	)	0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		C	)	0	
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		(	)	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		15, 005		0	
7. 00	Total Medicare program liability (see instructions)		2, 520, 700	Contractor	NPR Date	7. 00
				Number	(Mo/Day/Yr)	
	Tu.	(	)	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

Heal th	Financial Systems PORTER I	MEMORIAL HOSPITAL	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 01/01/2016		aanad.
			To 12/31/2016	Date/Time Prep 5/30/2017 10:	
		Title XVIII	Hospi tal	PPS	.,
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST RE	PORTS			
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CAL				
1.00	Total hospital discharges as defined in AARA §4102 fr		14	12, 366 26, 951	1. 00
	2.00   Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2. 00
3.00   Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of li			55, 846	4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 lin			1, 834, 785, 600	5. 00
6.00	Total hospital charity care charges from Wkst. S-10,			4, 564, 920	
7. 00	CAH only - The reasonable cost incurred for the purch	ase of certified HIT technology	Wkst. S-2, Pt. I	0	7. 00
	line 168				
8. 00	Calculation of the HIT incentive payment (see instruc	tions)		632, 267	8. 00
9.00	Sequestration adjustment amount (see instructions)			12, 645	9. 00
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)				619, 622	10. 00
	I NPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	Initial/interim HIT payment adjustment (see instructi	ons)		0	30. 00
	Other Adjustment (specify)			0	31. 00
32. 00	Balance due provider (line 8 (or line 10) minus line	30 and line 31) (see instruction	s)	619, 622	32. 00

Health Financial Systems	PORTER MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0035	Period: From 01/01/2016	Worksheet E-3
	Component CCN: 15-T035		Date/Time Prepared: 5/30/2017 10:19 am
	Title XVIII	Subprovi der -	PPS
		LDE	

		II the Aviii	I RF	PP3	
		1	1		
				1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			2, 572, 378	
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0131	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			49, 132	3. 00
4.00	Outlier Payments			27, 978	
5.00	Unweighted intern and resident FTE count in the most recent count to November 15, 2004 (see instructions)	ost reporting period e	nding on or prior	0. 00	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE coun	t for residents that we	re displaced by	0. 00	5. 01
0.0.	program or hospital closure, that would not be counted withou			0.00	0.0.
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)				
6.00	New Teaching program adjustment. (see instructions)			0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth	period of a "new	0.00	7.00
	teaching program" (see instructions)				
8.00	Current year's unweighted I&R FTE count for residents within	the new program growth	period of a "new	0. 00	8. 00
	teaching program" (see instructions)				
9.00	Intern and resident count for IRF PPS medical education adjus	tment (see instructions	)	0. 00	9. 00
10. 00	Average Daily Census (see instructions)			7. 122951	
11. 00	Teaching Adjustment Factor (see instructions)			0. 000000	
12. 00	Teaching Adjustment (see instructions)			0	12. 00
13. 00	Total PPS Payment (see instructions)			2, 649, 488	
14. 00	Nursing and Allied Health Managed Care payments (see instruct	i on)		0	14. 00
15.00	Organ acquisition (DO NOT USE THIS LINE)				15. 00
16.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
17. 00	Subtotal (see instructions)			2, 649, 488	
18.00	Primary payer payments			31, 100	
19.00	Subtotal (line 17 less line 18).			2, 618, 388	
20. 00 21. 00	Deductibles			7, 700	
21.00	Subtotal (line 19 minus line 20) Coinsurance			2, 610, 688 41, 216	
23. 00	Subtotal (line 21 minus line 22)			2, 569, 472	
24. 00	Allowable bad debts (exclude bad debts for professional servi-	cas) (saa instructions)		4, 104	
25. 00	Adjusted reimbursable bad debts (see instructions)	ces) (see mistructions)		2, 668	
26. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		2,000	26. 00
27. 00	Subtotal (sum of lines 23 and 25)	r de trons)		2, 572, 140	
28. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 49)		2, 3, 2, 110	28. 00
29. 00	Other pass through costs (see instructions)			3	29. 00
30. 00	Outlier payments reconciliation			ō	
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			ol	31. 00
31. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	31. 50
31. 99	Recovery of Accelerated Depreciation			o	31. 99
32.00	Total amount payable to the provider (see instructions)			2, 572, 143	32.00
32. 01	Sequestration adjustment (see instructions)			51, 443	32. 01
33.00	Interim payments			2, 535, 705	33.00
34.00	Tentative settlement (for contractor use only)			0	34.00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 33,	and 34)		-15, 005	35.00
36.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	5, 916	36.00
	§115. 2				
	TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			27, 978	
51. 00	Outlier reconciliation adjustment amount (see instructions)			0	51.00
	The rate used to calculate the Time Value of Money			0.00	
53.00	Time Value of Money (see instructions)			υĮ	53. 00

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

Provi der CCN: 15-0035

Peri od: Worksheet G
From 01/01/2016
To 12/31/2016 Date/Ti me Prepared: 5/30/2017 10: 19 am

——————————————————————————————————————					5/30/2017 10:	19 am
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	I	1.00	2.00	3. 00	4.00	
1. 00	CURRENT ASSETS Cash on hand in banks	-1, 031, 597	' 0	0	0	1.00
2.00	Temporary investments	-1,031,347		_		
3.00	Notes recei vabl e		o o	_		3. 00
4.00	Accounts recei vable	52, 597, 739	0	0	0	4. 00
5.00	Other recei vabl e	0	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-7, 985, 915		0	0	
7.00	Inventory	8, 710, 281		0	0	
8. 00 9. 00	Prepaid expenses Other current assets	1, 337, 259 571, 973		0	0	
10.00	Due from other funds	371, 973		_	0	10.00
11. 00	Total current assets (sum of lines 1-10)	54, 199, 740				11.00
	FIXED ASSETS	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		-		
12.00	Land	11, 615, 241	0	0	0	12. 00
13. 00	Land improvements	4, 917, 686	1	_		13. 00
14. 00	Accumulated depreciation	-2, 203, 493	1	_		14. 00
15.00	Buildings	191, 903, 322	1	0		15.00
16. 00 17. 00	Accumul ated depreciation Leasehold improvements	-24, 130, 718 5, 442, 020		0	0	16. 00 17. 00
18. 00	Accumul ated depreciation	-1, 492, 636		_	0	18.00
19. 00	Fi xed equipment	6, 748, 728	1	_	ő	19.00
20. 00	Accumulated depreciation	-3, 417, 120		_	ō	20.00
21.00	Automobiles and trucks	372, 137	0	0	0	21. 00
22. 00	Accumulated depreciation	-320, 099		0	0	22. 00
23. 00	Major movable equipment	57, 655, 000	1	0	0	23. 00
24. 00	Accumulated depreciation	-39, 020, 534		_	0	24. 00
25. 00 26. 00	Mi nor equipment depreciable	20, 851, 075		_	0	25. 00
26.00	Accumulated depreciation HIT designated Assets	-13, 115, 915	0	0	0	26. 00 27. 00
28. 00	Accumulated depreciation			0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e		o o	_		29. 00
30.00	Total fixed assets (sum of lines 12-29)	215, 804, 694	0	0	0	30.00
	OTHER ASSETS					
31. 00	Investments	0	0	_	-	
32.00	Deposits on Leases	0	0	_		32.00
33.00	Due from owners/officers	10.051.071	0	_	0	33. 00
34. 00 35. 00	Other assets Total other assets (sum of lines 31-34)	12, 851, 271 12, 851, 271		_	0	34. 00 35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	282, 855, 705	1	_		36.00
00.00	CURRENT LIABILITIES	202/000//00	,			00.00
37.00	Accounts payable	10, 108, 937	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	7, 955, 682	1	0	_	38. 00
39. 00	Payroll taxes payable	819, 004		0	0	
40.00	Notes and Loans payable (short term)	38, 335	0	0	0	1
41. 00 42. 00	Deferred income Accelerated payments		) U	0	0	41. 00 42. 00
42.00	Due to other funds	-86, 192, 098	0	0	0	
44. 00	Other current liabilities	3, 154, 336	•	0	Ö	
45. 00	Total current liabilities (sum of lines 37 thru 44)	-64, 115, 804	1	_		1
	LONG TERM LIABILITIES		•			
46. 00	Mortgage payable	0	0	_	_	
47. 00	Notes payable	47, 221		_	_	
48. 00	Unsecured Loans	14 (74 75)	0	_		1
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	14, 674, 752 14, 721, 973		_	_	49. 00 50. 00
51. 00	Total liabilities (sum of lines 45 and 50)	-49, 393, 831				51.00
01.00	CAPI TAL ACCOUNTS	17/070/001				0 00
52.00	General fund balance	332, 249, 536				52. 00
53.00	Specific purpose fund		0			53. 00
54.00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant		1		0 0	57.00
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion		1			58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	332, 249, 536	0	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	282, 855, 705		Ö	Ö	
	59)		1			

Provider CCN: 15-0035

					10 12/31/2016	5/30/2017 10:	
	·	General	Fund	Speci al	Purpose Fund	Endowment Fund	7 (4111
		1.00	2.00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period		290, 219, 682		(		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		42, 009, 452				2. 00
3.00	Total (sum of line 1 and line 2)		332, 229, 134		(		3. 00
4.00	ADJ TO R/E	20, 402			0	0	4. 00
5.00		0			0	0	5. 00
6.00		0			0	0	6. 00
7.00		0			0	0	7. 00
8.00		0			0	0	8. 00
9.00		0			0	0	9. 00
10.00	Total additions (sum of line 4-9)		20, 402				10.00
11.00	Subtotal (line 3 plus line 10)		332, 249, 536				11. 00
12.00	Deductions (debit adjustments) (specify)	0			0	0	12.00
13.00		o			О	0	13. 00
14.00		o			О	0	14. 00
15.00		o			О	0	15. 00
16.00		o			О	0	16. 00
17.00		o			0	0	17. 00
18.00	Total deductions (sum of lines 12-17)		0			ol .	18. 00
19.00	Fund balance at end of period per balance		332, 249, 536			ol .	19. 00
	sheet (line 11 minus line 18)						
		Endowment Fund	PI ant	Fund			
		6.00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)	_					2. 00
3.00	Total (sum of line 1 and line 2)	0			0		3. 00
4.00	ADJ TO R/E		0				4. 00
5.00			0				5. 00
6.00			0				6. 00
7. 00			0				7. 00
8. 00			0				8. 00
9.00		_	0				9. 00
10. 00	Total additions (sum of line 4-9)	0			0		10. 00
11. 00	Subtotal (line 3 plus line 10)	0			0		11. 00
12. 00	Deductions (debit adjustments) (specify)		0				12. 00
13. 00			0				13. 00
14. 00			0				14. 00
15. 00			0				15. 00
16. 00			0				16. 00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 12-17)	0			0		18. 00
19. 00	Fund balance at end of period per balance	0			0		19. 00
	sheet (line 11 minus line 18)	1		ı	1		1
		1 1		l			l

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

		T	12/31/2016	Date/Time Prep 5/30/2017 10:	
	Cost Center Description	Inpatient	Outpati ent	Total	17 (111
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	·			
	General Inpatient Routine Services				
1.00	Hospi tal	133, 538, 472		133, 538, 472	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF	6, 753, 755		6, 753, 755	3.00
4.00	SUBPROVI DER				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)	140, 292, 227		140, 292, 227	10.00
	Intensive Care Type Inpatient Hospital Services	•			
11.00	INTENSIVE CARE UNIT	34, 502, 369		34, 502, 369	11.00
11. 01	NEONATAL INTENSIVE CARE UNIT	19, 087, 125		19, 087, 125	11. 01
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines	s 53, 589, 494		53, 589, 494	16.00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	193, 881, 721		193, 881, 721	17.00
18.00	Ancillary services	624, 809, 203	821, 268, 938	1, 446, 078, 141	18.00
19.00	Outpati ent servi ces	57, 848, 074	136, 977, 664	194, 825, 738	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22. 00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )				25.00
26.00	HOSPI CE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27) (transfer column 3 to WI	kst. 876, 538, 998	958, 246, 602	1, 834, 785, 600	28.00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		271, 697, 518		29. 00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37. 00	DEDUCT (SPECIFY)	0			37.00
38. 00		0			38.00
39. 00		0			39. 00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tra	ansfer	271, 697, 518		43.00
	to Wkst. G-3, line 4)				

Heal th Financial Systems   PORTER MEMORIAL HOSP TAL   In Lieu of Form CMS-2552-10		51	DODTED MEMORY ALL IN	0001741		6.5. 040.6	
Total patient revenues (from Wkst. 6-2, Part I, column 3, line 28)   1,834,785,600   1,00				· ·			2552-10
1.00	JIATEM	ENT OF REVENUES AND EXPENSES		Tovi del Gail. 13 0000	From 01/01/2016	Date/Time Pre	
Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)   1,834,785,600   1.00							
2.00   Less contractual allowances and discounts on patients' accounts   1,522,961,408   2.00   3.00   Net patient revenues (line 1 minus line 2)   311,824,192   3.00   311,82							
3.00							
4.00   Less total operating expenses (from Wkst. G-2, Part II, Line 43)   271,697,518   4.00   Net income from service to patients (line 3 minus line 4)   5.00   Net income from service to patients (line 3 minus line 4)   5.00   Net income from service to patients (line 3 minus line 4)   5.00   Net income from service to patients (line 3 minus line 4)   5.00   Net income from service to patients (line 3 minus line 4)   5.00   Net income from investments   5.00   0.00   New Prince from telephone and other miscellaneous communication services   5.00   0.00			patients' accounts				
Net income from service to patients (line 3 minus line 4)				_			
OTHER INCOME         Contributions, donations, bequests, etc         6.00           7.00         Income from investments         0         7.00           8.00         Revenues from telephone and other miscellaneous communication services         0         8.00           9.00         Revenue from television and radio service         0         9.00           10.00         Purchase discounts         0         10.00           11.00         Rebates and refunds of expenses         0         11.00           12.00         Parking lot receipts         0         12.00           13.00         Revenue from laundry and linen service         0         13.00           14.00         Revenue from laundry and linen service         0         13.00           15.00         Revenue from laundry and linen service         0         14.00           15.00         Revenue from laundry and linen service         0         14.00           15.00         Revenue from laundry and linen service         0         14.00           15.00         Revenue from meals sold to employees and guests         0         14.00           15.00         Revenue from sale of medical and surgical supplies to other than patients         0         15.00           16.00         Revenue from sale of medical records an				)			
6.00         Contributions, donations, bequests, etc         0         6.00           7.00         Income from Investments         0         7.00           8.00         Revenues from telephone and other miscellaneous communication services         0         8.00           9.00         Revenue from television and radio service         0         9.00           10.00         Purchase discounts         0         10.00           11.00         Rebates and refunds of expenses         0         11.00           12.00         Parking lot receipts         0         12.00           13.00         Revenue from laundry and linen service         0         13.00           14.00         Revenue from laundry and linen service         0         13.00           15.00         Revenue from laundry and linen service         0         13.00           16.00         Revenue from meals sold to employees and guests         0         14.00           15.00         Revenue from meals sold to employees and guests         0         15.00           16.00         Revenue from sale of medical and surgical supplies to other than patients         0         16.00           17.00         Revenue from sale of medical nectords and abstracts         0         17.00           18.00         Revenu	5. 00		ninus line 4)			40, 126, 674	5. 00
7. 00       Income from investments       0       7. 00         8. 00       Revenues from tel ephone and other miscel laneous communication services       0       8. 00         9. 00       Revenue from tel evision and radio service       0       9. 00         10. 00       Purchase discounts       0       10. 00         11. 00       Rebates and refunds of expenses       0       11. 00         12. 00       Parking lot recel pts       0       12. 00         13. 00       Revenue from laundry and linen service       0       13. 00         14. 00       Revenue from meals sold to employees and guests       0       14. 00         15. 00       Revenue from sale of medical and surgical supplies to other than patients       0       15. 00         16. 00       Revenue from sale of drugs to other than patients       0       17. 00         18. 00       Revenue from sale of medical records and abstracts       0       18. 00         19. 00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19. 00         20. 00       Revenue from gifts, flowers, coffee shops, and canteen       0       20. 00         21. 00       Rental of vending machines       0       21. 00         22. 00       Rental of hospital space       0       22. 0							
8.00       Revenues from telephone and other miscellaneous communication services       0       8.00         9.00       Revenue from television and radio service       0       9.00         10.00       Purchase discounts       0       10.00         11.00       Rebates and refunds of expenses       0       11.00         12.00       Parking lot receipts       0       12.00         13.00       Revenue from laundry and linen service       0       12.00         14.00       Revenue from meals sold to employees and guests       0       14.00         15.00       Revenue from meals sold to employees and guests       0       14.00         16.00       Revenue from medical and surgical supplies to other than patients       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       17.00         18.00       Revenue from sale of medical records and abstracts       0       17.00         18.00       Revenue from sale of medical records and abstracts       0       17.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of hospital space		· · · · · · · · · · · · · · · · · · ·					
9.00       Revenue from television and radio service       0       9.00         10.00       Purchase discounts       0       10.00         11.00       Rebates and refunds of expenses       0       11.00         12.00       Parking lot receipts       0       12.00         13.00       Revenue from laundry and linen service       0       13.00         14.00       Revenue from meal's sold to employees and guests       0       14.00         15.00       Revenue from rental of living quarters       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       15.00         17.00       Revenue from sale of medical records and abstracts       0       17.00         18.00       Revenue from sale of medical records and abstracts       0       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       1, 882, 778       24.00         25.00							
10.00   Purchase discounts		•	ous communication s	ervi ces		-	
11. 00       Rebates and refunds of expenses       0       11. 00         12. 00       Parking lot receipts       0       12. 00         13. 00       Revenue from laundry and linen service       0       13. 00         14. 00       Revenue from meals sold to employees and guests       0       14. 00         15. 00       Revenue from meal sold to employees and guests       0       14. 00         15. 00       Revenue from sale of medical and surgical supplies to other than patients       0       15. 00         16. 00       Revenue from sale of medical records and abstracts       0       17. 00         19. 00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       18. 00         19. 00       Revenue from gifts, flowers, coffee shops, and canteen       0       20. 00         21. 00       Revenue from gifts, flowers, coffee shops, and canteen       0       20. 00         21. 00       Rental of vending machines       0       21. 00         22. 00       Rental of vending machines       0       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 00       MISC INCOME       1, 882, 778       24. 00         25. 00       Total other income (sum of lines 6-24)       1, 882, 778       25. 00						-	
12.00   Parking lot receipts   0   12.00     13.00   Revenue from laundry and linen service   0   13.00     14.00   Revenue from meals sold to employees and guests   0   14.00     15.00   Revenue from rental of living quarters   0   15.00     16.00   Revenue from sale of medical and surgical supplies to other than patients   0   16.00     17.00   Revenue from sale of drugs to other than patients   0   17.00     18.00   Revenue from sale of medical records and abstracts   0   18.00     19.00   Tuition (fees, sale of textbooks, uniforms, etc.)   0   19.00     20.00   Revenue from gifts, flowers, coffee shops, and canteen   0   20.00     21.00   Rental of vending machines   0   21.00     22.00   Rental of hospital space   0   22.00     23.00   Governmental appropriations   0   23.00     24.00   MISC INCOME   1,882,778   24.00     25.00   Total other income (sum of lines 6-24)   1,882,778   24.00     25.00   Total (line 5 plus line 25)   27.00     28.00   Total other expenses (sum of line 27 and subscripts)   0   28.00     28.00   Total other expenses (sum of line 27 and subscripts)   0   28.00						-	
13.00       Revenue from laundry and linen service       0       13.00         14.00       Revenue from meals sold to employees and guests       0       14.00         15.00       Revenue from rental of living quarters       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       15.00         17.00       Revenue from sale of drugs to other than patients       0       17.00         18.00       Revenue from sale of medical records and abstracts       0       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       0       23.00         24.00       MISC INCOME       1,882,778       24.00         25.00       Total other income (sum of lines 6-24)       1,882,778       25.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
14.00       Revenue from meals sold to employees and guests       0       14.00         15.00       Revenue from rental of living quarters       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of drugs to other than patients       0       17.00         18.00       Revenue from sale of medical records and abstracts       0       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       0       23.00         24.00       MISC INCOME       1,882,778       24.00         25.00       Total other income (sum of lines 6-24)       1,882,778       25.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00						~ I	
15.00       Revenue from rental of living quarters       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of drugs to other than patients       0       17.00         18.00       Revenue from sale of medical records and abstracts       0       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       0       23.00         24.00       MISC INCOME       1,882,778       24.00         25.00       Total other income (sum of lines 6-24)       1,882,778       25.00         26.00       Total (line 5 plus line 25)       42,009,452       26.00         27.00       OTHER EXPENSES (SPECI FY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00		,					
16. 00       Revenue from sale of medical and surgical supplies to other than patients       0       16. 00         17. 00       Revenue from sale of drugs to other than patients       0       17. 00         18. 00       Revenue from sale of medical records and abstracts       0       18. 00         19. 00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19. 00         20. 00       Revenue from gifts, flowers, coffee shops, and canteen       0       20. 00         21. 00       Rental of vending machines       0       21. 00         22. 00       Rental of hospital space       0       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 00       MI SC I NCOME       1, 882, 778       24. 00         25. 00       Total other income (sum of lines 6-24)       1, 882, 778       25. 00         26. 00       Total (line 5 plus line 25)       42, 009, 452       26. 00         27. 00       OTHER EXPENSES (SPECI FY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00		1 7	sts			-	
17. 00       Revenue from sale of drugs to other than patients       0       17. 00         18. 00       Revenue from sale of medical records and abstracts       0       18. 00         19. 00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19. 00         20. 00       Revenue from gifts, flowers, coffee shops, and canteen       0       20. 00         21. 00       Rental of vending machines       0       21. 00         22. 00       Rental of hospital space       0       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 00       MISC INCOME       1, 882, 778       25. 00         25. 00       Total other income (sum of lines 6-24)       1, 882, 778       25. 00         26. 00       Total (line 5 plus line 25)       42, 009, 452       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00						-	
18.00       Revenue from sale of medical records and abstracts       0       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       0       23.00         24.00       MI SC I NCOME       1, 882, 778       24.00         25.00       Total other income (sum of lines 6-24)       1, 882, 778       25.00         26.00       Total (line 5 plus line 25)       42,009, 452       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00				n patients		- 1	
19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       0       23.00         24.00       MI SC I NCOME       1,882,778       24.00         25.00       Total other income (sum of lines 6-24)       1,882,778       25.00         26.00       Total (line 5 plus line 25)       42,009,452       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00							
20. 00       Revenue from gifts, flowers, coffee shops, and canteen       0       20. 00         21. 00       Rental of vending machines       0       21. 00         22. 00       Rental of hospital space       0       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 00       MI SC INCOME       1, 882, 778       24. 00         25. 00       Total other income (sum of lines 6-24)       1, 882, 778       24. 00         26. 00       Total (line 5 plus line 25)       42, 009, 452       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00							
21. 00       Rental of vending machines       0       21. 00         22. 00       Rental of hospital space       0       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 00       MI SC I NCOME       1, 882, 778       24. 00         25. 00       Total other income (sum of lines 6-24)       1, 882, 778       24. 00         26. 00       Total (line 5 plus line 25)       42, 009, 452       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00							
22. 00       Rental of hospital space       0       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 00       MI SC I NCOME       1, 882, 778       24. 00         25. 00       Total other income (sum of lines 6-24)       1, 882, 778       25. 00         26. 00       Total (line 5 plus line 25)       42, 009, 452       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00			nd canteen				
23. 00       Governmental appropriations       0       23. 00         24. 00       MI SC I NCOME       1, 882, 778       24. 00         25. 00       Total other income (sum of lines 6-24)       1, 882, 778       25. 00         26. 00       Total (line 5 plus line 25)       42, 009, 452       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00							
24. 00       MI SC I NCOME       1,882,778       24.00         25. 00       Total other income (sum of lines 6-24)       1,882,778       25.00         26. 00       Total (line 5 plus line 25)       42,009,452       26.00         27. 00       OTHER EXPENSES (SPECIFY)       0       27.00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28.00						~	
25. 00       Total other income (sum of lines 6-24)       1,882,778       25. 00         26. 00       Total (line 5 plus line 25)       42,009,452       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00						- 1	
26. 00       Total (line 5 plus line 25)       42, 009, 452       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00							
27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00							
28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00						42, 009, 452	
						-	
29.00   Net income (or loss) for the period (line 26 minus line 28) 42,009,452   29.00						٠	
	29. 00	Net income (or loss) for the period (line 26	minus line 28)			42, 009, 452	29. 00

	Financial Systems PORTER MEMORI		In Lie	u of Form CMS-2	2552-10
CALCUI	LATION OF CAPITAL PAYMENT	Provider CCN: 15-0035	Peri od: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Pre 5/30/2017 10:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			3, 553, 639	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			167, 114	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments			154.07	2. 01
3. 00 4. 00	Total inpatient days divided by number of days in the cost Number of interns & residents (see instructions)	reporting period (see inst	ructions)	154. 07 0. 00	3. 00 4. 00
5. 00	Indirect medical education percentage (see instructions)			0.00	5.00
6. 00	Indirect medical education adjustment (multiply line 5 by t	the sum of lines 1 and 1.01	. columns 1 and	0.00	6. 00
	1.01) (see instructions)				
7. 00	Percentage of SSI recipient patient days to Medicare Part A	A patient days (Worksheet E	, part A line	2. 71	7. 00
	30) (see instructions)				
8.00	Percentage of Medicaid patient days to total days (see inst	tructions)		17. 83	8.00
9. 00 10. 00	Sum of lines 7 and 8 Allowable disproportionate share percentage (see instruction	anc)		20. 54 4. 25	9. 00 10. 00
11. 00		JIIS)		151, 030	
12. 00				3, 871, 783	
				57 57 77 75 5	
	T			1. 00	
1. 00	PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions)			0	l 1. 00
2. 00	Program inpatient ancillary capital cost (see instructions)			0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	<b>,</b>		0	3.00
4. 00	Capital cost payment factor (see instructions)			0	4. 00
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
1. 00	Program inpatient capital costs (see instructions)			0	1.00
2.00	Program inpatient capital costs for extraordinary circumsta	ances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	3.00
	Applicable exception percentage (see instructions)			0.00	4. 00 5. 00
	Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see	instructions)		0. 00	6.00
5.00	The contrage day as the first of extraoral har y criticalistances (see		(lino 6)	0.00	7.00
5. 00 6. 00	Adjustment to capital minimum payment level for extraordina	arv circumstances (line 2)			
5. 00 6. 00 7. 00	Adjustment to capital minimum payment level for extraordina Capital minimum payment level (line 5 plus line 7)	ary circumstances (line 2 >	( Title 0)	0	8.00
5. 00 6. 00 7. 00 8. 00	Adjustment to capital minimum payment level for extraordina Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app		Title 0)		
5. 00 6. 00 7. 00 8. 00 9. 00	Capital minimum payment level (line 5 plus line 7)	ol i cabl e)	ŕ	0	9. 00
5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app	olicable) o capital payments (line 8	less line 9)	0	8. 00 9. 00 10. 00 11. 00
5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital	olicable) o capital payments (line 8 capital payment (from pri payments (line 10 plus lir	less line 9) or year ne 11)	0 0 0 0	9. 00 10. 00 11. 00
5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, ent	olicable) o capital payments (line 8 capital payment (from pri payments (line 10 plus line ter the amount on this line	less line 9) or year ne 11)	0 0 0 0	9. 00 10. 00 11. 00 12. 00 13. 00
5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app. Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, ent Carryover of accumulated capital minimum payment level over	olicable) o capital payments (line 8 capital payment (from pri payments (line 10 plus line ter the amount on this line	less line 9) or year ne 11)	0 0 0 0	9. 00 10. 00 11. 00 12. 00 13. 00
5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app. Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, ent Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	olicable) o capital payments (line 8 capital payment (from pri payments (line 10 plus lir ter the amount on this line capital payment for the f	less line 9) or year ne 11)	0 0 0 0	9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app. Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, ent Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see i	plicable) coapital payments (line 8 capital payment (from pri payments (line 10 plus line ter the amount on this line capital payment for the f	less line 9) or year ne 11)	0 0 0 0	9. 00 10. 00 11. 00 12. 00 13. 00