Heal th Financi	al Systems	WHITLEY MEMORIAL F	IOSPI TAL	In Lie	u of Form CMS-2552-10
•	required by Law (42 USC 1395 since the beginning of the co	3.	•		FORM APPROVED OMB NO. 0938-0050
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX C SUMMARY	OST REPORT CERTIFICATION	Provi der CCN: 15010	01 Period: From 01/01/2015 To 12/31/2015	
PART I - COST	REPORT STATUS			·	·
Provi der use only	1. [X] Electronically filed 2. [] Manually submitted co			Date: 5/20/20	16 Time: 2:30 pm
j	3. [0] If this is an amended 4. [F] Medicare Utilization.	d report enter the number of Enter "F" for full or "L"	f times the provide for low.	r resubmitted this c	ost report
Contractor use only	5. [1]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened		this Provider CCN 1		

PART II - CERTIFICATION

(5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WHITLEY MEMORIAL HOSPITAL (150101) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned))					
		Offi cer	or	Admi ni strator	of	Provi der(s)
	Title					
	IIIIe					
	Date					

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	39, 686	46, 919	14, 086	0	1. 00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - I RF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
200.00	Total	0	39, 686	46, 919	14, 086	0	200. 00

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

Health Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150101 Peri od: Worksheet S-2 From 01/01/2015 Part I 12/31/2015 Date/Time Prepared: 5/19/2016 5:11 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 1260 E STATE ROAD 205 PO Box: 1.00 State: IN Zip Code: 46725-9492 County: WHITLEY 2.00 City: COLUMBIA CITY 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)

/ XVIII XIX Туре Certi fi ed Number Number 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 WHITLEY MEMORIAL 150101 23060 07/01/1966 N 3.00 HOSPI TAI Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital-Based Health Clinic - RHC 15 00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 1. 00 2.00 20.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2015 12/31/2015 Type of Control (see instructions) 21.00 21.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for disproportionate γ N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Υ Υ 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν N 22 03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23 00 3 N 23 00

				0 1 6	0 1 6		0.11	
		In-State	In-State	Out-of	Out-of	Medi cai d	0ther	
		Medicaid	Medi cai d	State	State	HMO days	Medicaid	
		paid days	eligible	Medi cai d	Medi cai d		days	
			unpai d	paid days	eligible			
			days	,	unpai d			
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
24. 00	If this provider is an IPPS hospital, enter the	260	545	0	0	787	0	24. 00
	in-state Medicaid paid days in column 1, in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid paid days in column 3,							
	out-of-state Medicaid eligible unpaid days in column							
	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							
	If this provider is an IRF, enter the in-state		0	_	^	_	1	25. 00
	Medicaid paid days in column 1, the in-state	٥	0		U			25.00
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid days in column 3, out-of-state							
	Medicaid eligible unpaid days in column 4, Medicaid							
	HMO paid and eligible but unpaid days in column 5.							

1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

Health Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150101 Peri od: Worksheet S-2 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/19/2016 5:11 pm Program Name Program Code Unweighted IME Unwei ghted Direct ĞME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62 01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter Ν 63.00 for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) Unwei ahted Ratio (col. 1/ Unwei ahted **FTES** FTEs in (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1. 00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.000000 64.00 0.00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Unwei ghted Program Name Program Code Unwei ghted Ratio (col. 3/ FTĔs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to

rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

In Lieu of Form CMS-2552-10 Health Financial Systems WHITLEY MEMORIAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150101 Peri od: Worksheet S-2 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/19/2016 5:11 pm Unwei ghted Unwei ghted Ratio (col. (col. 1 + col FTEs FTEs in 2)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 66.00 0.00 0.000000 66.00 Enter in column 1 the number of unweighted non-primary care resident 0.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Code Ratio (col. 3/ Program Name Unwei ghted Unwei ahted FTEs FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 3. 00 2 00 4.00 5 00 67.00 Enter in column 1, the program 0.00 0.00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4. the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. 70.00 70.00 Ν If line 70 yes. Column 1: Did the facility have an approved GME teaching program in the most 71.00 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF Ν 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N 81.00 Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. N 85.00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 \$413.40(f)(i)(i)? Enter "Y" for yes and "N" for no.
Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" Ν 87.00 for yes or "N" for no. ٧/ XIX 1.00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for Ν 90.00 yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in Ν Ν 91.00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 92.00 92.00 N Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 93 00 N N 93 00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the N 94.00 Ν applicable column.

99.00 FF In 94 S 'Y' enter the reduction percentage in the applicable colum. 99.00 FF In 94 S 'Y' enter the reduction percentage in the applicable colum. 99.00 FF In 94 S 'Y' enter the reduction percentage in the applicable colum. 90.00 0.00	Health Financial Systems WHITLEY MEMORIAL HOSPI					of Form		
55.00 Filips 4 is "Y", white the restabilish percentage in the applicable column 0.00 20.00 55.00	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Pro	ovider C	Fr	om 01/01/2	015 F 015 E	Part I Date/Tim	e Prej	pared:
99.00 1 1 10 10 1 10 10 10						XI X		1 pm
97.00 Filing by is "", where the reduction percentage in the applicable column. 0.00 0.00 97.00 97.00 Filing by is "", where the reduction percentage in the applicable column. 0.00 0.00 97.00 97.00 Filing by is "", where the reduction percentage in the applicable column. 0.00 0.00 97.00 97.00 Filing by is described by applicable column. 0.00				(0. 00	2. 00		
105. 00 Diese this hospital quality as a critical access hospital (CAN)? 106. 001 This Facility qualities as a CAN, has it elected the All-inclusive method or payment produpationt services? (see instructions) eligible for cost reinbursement for LAR training progress? Fince is as a CAN, has it elected the All-inclusive method or payment produced by the All-inclusive method or the All-inc	applicable column.				0. 00	N	0. 00	
Torr outpatt ent services? (See Instructions) 107.00 (If this facility qualifies as a CM+ or year of "N" for no in culum 1: (see Instructions) If reinburged in Section 108.00 (If Section 942):135(c). Inter "Y" for year of "N" for no in culum 1: (see Instructions) If reinburged if year complete West. 9-2; P+1. II. PL., cot. 25 and the program is cost of the program				N				105. 00
107, 00 f. this Facility qualifies as a CAH. Is it eligible for cost reinflucrament for ISR 107, 00		ve metho	od of payment					106. 00
108.00 is this a rural hospital qualifying for an exception to the CRWA fee schedule? See 42 N 108.00 in CFL Section §412.113(c). Inter "Y" for yes or "N" for no. Physical Occupational Speech Respiratory 109.00 in the provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 109.00 if this hospital qualifies as a CAN or a cost provider, and the provider and the provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 110.00 in this hospital particlipate in the Bural Community Hospital Demonstration project (410A Demo) for N 110.00 in current cost resorting period? Enter "Y" for yes or "N" for no. In column 1. If column 1 N 10.00 is yes, an earth the method used (A. B. or E only) in column 2. If column 2 is "E", enter in column 1 N 10.00 is yes, an earth the method used (A. B. or E only) in column 2. If column 2 is "E", enter in column 1 N 115.00 is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 N 10.00 is yes, enter the method used (A. B. or E only) in column 2. If column 2 is "E", enter in column 1 N 10.00 is yes, enter the method used (A. B. or E only) in column 2. If column 2 is "E", enter in column 1 N 115.00 is this facility classified as a referral center? Enter "Y" for yes or "N" for no. In Column 1 N 115.00 is this facility classified as a referral center? Enter "Y" for yes or "N" for no. N 1116.00 is this facility classified as a referral center? Enter "Y" for yes or "N" for no. In Column 1 N 1117.00 is this facility classified as a referral center? Enter "Y" for yes or "N" for no. N 1116.00 in Column 1 N 1117.00 is this facility classified as a referral center? Enter "Y" for yes or "N" for no. In Column 1 N 1117.00 in this facility classified as a referral center of the column 2 N 1117.00 in this facility classified as a referral center? Enter "Y" for yes or "N" for no. In Column 2 N 1117.00 in this col	107.00 If this facility qualifies as a CAH, is it eligible for cost reimbur training programs? Enter "Y" for yes or "N" for no in column 1. (see yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and	e instru	uctions) If					107. 00
Physical Occupational Speech Respiratory 109 001 ft this hospital qualifies as a CAH or a cost provider, and 100 2,00 3,00 4,50 109 00	108.00 Is this a rural hospital qualifying for an exception to the CRNA fee	e schedu	ul e? See 42	N				108. 00
109.00 This hospital qualifies as a CAH or a cost provider, are herrary services provided by outside supplier? Enter "Y" For yes or "N" For no for each therapy. 100.00 Afthis hospital participate in the Rural Community Hospital Demonstration project (410A Demo) For N 110.00	Physi							
the current cost reporting period? Enter "Y" for yes or "N" for no. 10.00 It is nospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no. 10.00 It is an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 N	109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"		2.00	3.00		4.00		109. 00
Miscellaneous Cost Reporting Information 115.00 Is this an all-line lusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 N 0 115.00 1.00 2.00 3.00 1.00 1.5 yes, enter the method used (A, B, or E only) in column 2. If column 2 is "t", enter in column 3 ei ther "93" percent for short term hospital or "93" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS 116.00 117.00 117.00 118.						1. 00		
Miscel Janeous Cost Reporting Information		strati oı	n project (410	A Demo)for		N		110. 00
Miscel Janeous Cost Reporting Information					1. 00	2, 00	3. 00	
is yes, enter the method used (A, B, or E only) in column 2 is "E", enter in column 3 ei ther "93" percent for short term hospital or "93" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, \$2208.1.		r no in	column 1 lf					115 00
116.00 is this facility classified as a referral center? Enter "Y" for yes or "N" for no. N 116.00 117.00 117.00 118.00	is yes, enter the method used (A, B, or E only) in column 2. If colu 3 either "93" percent for short term hospital or "98" percent for lo psychiatric, rehabilitation and long term hospitals providers) based	umn 2 is ong terr	s "E", enter i m care (includ	n column es	14		J	113.00
118. 00 is the mal practice insurance a claims-made or occurrence policy? Enter 1 if the policy is 1 118. 00 is the mal practice insurance a claims-made or occurrence. Premiums 1. 00 2. 00 3. 00 118. 01 List amounts of mal practice premiums and paid losses: 85,939 215, 374 16, 358 118. 01 118. 02 Are mal practice premiums and paid losses: 85,939 215, 374 16, 358 118. 01 118. 02 Are mal practice premiums and paid losses: 85,939 215, 374 16, 358 118. 01 170 2. 00 170 170 170 170 170 170 170	116.00 Is this facility classified as a referral center? Enter "Y" for yes				N			116. 00
claim-made. Enter 2 if the policy is occurrence. Premiums Losses Insurance		nter "Y'	" for yes or "	N" for	Υ			117. 00
118. 01 List amounts of mal practice premiums and paid losses: 119. 00 List amounts of mal practice premiums and paid losses: 119. 00 List amounts of mal practice premiums and paid losses: 119. 00 List amounts of mal practice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 119. 00 D NOT USE THIS LINE 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA S3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA S3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 121. 00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no. 125. 00 Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 126. 00 If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 129. 00 If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 130. 00 If this is a Medicare certified plant cransplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 131. 00 If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 132. 00 If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 133. 00 If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applic		ter 1 i	f the policy i	S	1			118. 00
118.02 List amounts of malpractice premiums and paid losses: 118.02 Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 119.00 Do Not USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA S3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA S3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA S3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. If papitable amendments? (see instructions) 121.00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no. If ransplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified papicable, in column 2. 130.00 If this is a Medicare certified incustinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified incustinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare certified incustinal transplant center,			Premi ums	Losses		Insurar	nce	
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ealth Financial Systems		MORIAL HOSPITAL	0011 450404	15		u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENIIFICATION DATA	Provi der (CCN: 150101	From O	: 1/01/2015 2/31/2015	Worksheet S- Part I Date/Time Pr 5/19/2016 5:	epared
					1. 00	2.00	-
All Providers					1. 00	2.00	
40.00 Are there any related organization chapter 10? Enter "Y" for yes or "N are claimed, enter in column 2 the	" for no in column 1.	If yes, and home	office cos		Y	15H032	140. 0
1.00		2.00	1 110 11		3.00	6.11	
If this facility is part of a chain home office and enter the home offi				name and	address	or the	
11.00 Name: PARKVIEW HEALTH SYSTEM, INC.		e: WISCONSIN PHYSICI		ctor's Nu	mber: 0810)1	141.
12.00Street: 10501 CORPORATE DRIVE	PO Box:	SERVI CE PO BOX 5600					142.
3. 00 Ci ty: FORT WAYNE	State:	I N	Zi p Co	de:	4689	5-5600	143.
						1.00	_
4.00 Are provider based physicians' cost	s included in Workshe	eet A?				1. 00 Y	144.
5.00 f costs for renal services are cla	imed on Wkst A line	21 are the costs	for		1. 00 N	2. 00	145.
inpatient services only? Enter "Y" no, does the dialysis facility incl	for yes or "N" for no ude Medicare utilizat	o in column 1. If c	olumn 1 is		IN		145.
period? Enter "Y" for yes or "N" f 16.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/dd	changed from the precolumn 1. (See CMS Pu			lf	N		146.
						1 00	4
7.00 Was there a change in the statistic	al basis? Enter "Y" f	for ves or "N" for	no.			1. 00 N	147.
8.00 Was there a change in the order of	allocation? Enter "Y"	' for yes or "N" fo	or no.			N	148.
9.00 Was there a change to the simplifie	d cost finding method	d? Enter "Y" for ye Part A	s or "N" f Part B		itle V	N Title XIX	149.
		1.00	2.00	<u>'</u>	3.00	4.00	1
Does this facility contain a provid or charges? Enter "Y" for yes or "N							
5.00 Hospi tal		N	N		N	N	155.
6.00 Subprovider - IPF 7.00 Subprovider - IRF		N N	N N		N N	N N	156. 157.
8. 00 SUBPROVI DER		IN IN	IV		IV	14	158.
9. 00 SNF		N	N		N	N	159.
O.OO HOME HEALTH AGENCY 1.OO CMHC		N	N N		N N	N N	160. 161.
1. CO Omito							101.
Mul ti campus						1.00	
5.00 Is this hospital part of a Multicam Enter "Y" for yes or "N" for no.	pus hospital that has	s one or more campu	ses in dif	ferent CE	BSAs?	N	165.
	Name 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4. 00	FTE/Campus 5.00	-
6.00 If line 165 is yes, for each	U I	1.00	2.00	3.00	4.00		0 166.
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							
Ser dimit o (See Fristi dell'Olis)					1		
Health Information Technology (HIT)	incentive in the Ame	erican Recovery and	d Reinvestm	ent Act		1.00	
7.00 s this provider a meaningful user 8.00 f this provider is a CAH (line 105	under §1886(n)? Ente is "Y") and is a mea	er "Y" for yes or " aningful user (line	N" for no.		the	Y	167. 0168.
reasonable cost incurred for the HI 8.01 If this provider is a CAH and is no	t a meaningful user,	does this provider			lshi p		168.
exception under §413.70(a)(6)(ii)? 9.00 If this provider is a meaningful us transition factor. (see instruction	er (line 167 is "Y")	"N" for no. (see i and is not a CAH (nstruction line 105 i	s) s "N"), e	enter the	0. 2	5169.
				Ве	gi nni ng	Endi ng	
70.00 Enter in columns 1 and 2 the EHR be	dinning date and endi	ng date for the re	norti na	10.	1. 00 /01/2014	2.00 09/30/2015	170.
period respectively (mm/dd/yyyy)	J G GG C GIIG CIIGI	data for the re	: · · · · · · · · · · · · ·	10/	J., 2017	3., 33, 2013	' ' '

Health Financial Systems	WHITLEY MEMORIAL H	HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provi der CCN: 150101	From 01/01/2015		
			To 12/31/2015	Date/Time Pre 5/19/2016 5:1	
				37 177 2010 3. 1	ı piii
				1.00	
171.00 If line 167 is "Y", does this provi	der have any days for indivi	duals enrolled in sect	i on 1876	N	171. 00
Medicare cost plans reported on Wks	t. S-3, Pt. I, line 2, col.	6? Enter "Y" for yes a	nd "N" for no.		
(see instructions)		J			

Heal th	Financial Systems	WHITLEY MEMORIAL H	IOSPI TAL		In Lie	eu of Form CMS-	-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE			F	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II	2
					Y/N	5/19/2016 5: Date	11 pm
					1. 00	2.00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	oonses. Enter N for	all NO re	esponses. Enter	all dates in	the	
1. 00	Provider Organization and Operation Has the provider changed ownership immediatel	v prior to the bea	inning of	the cost	N		1.00
	reporting period? If yes, enter the date of t						
				Y/N	Date	V/I 3. 00	
2. 00	Has the provider terminated participation in	the Medicare Progr	am? If	1.00 N	2. 00	3.00	2.00
	yes, enter in column 2 the date of termination						
3. 00	voluntary or "I" for involuntary. Is the provider involved in business transact contracts, with individuals or entities (e.g.	, chain home offic	es, drug	Y			3. 00
	or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or frelationships? (see instructions)	, or members of th	e board				
	relationships? (see Thistructions)			Y/N	Type	Date	
				1.00	2. 00	3. 00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prepared Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or	Audited, "C" for C	ompiled,	Y	A		4. 00
	column 3. (see instructions) If no, see instr		16 111				
5.00	Are the cost report total expenses and total			N			5. 00
	those on the filed financial statements? If y	yes, subilli t reconci	rration.		Y/N 1.00	Legal Oper. 2.00	
6. 00	Approved Educational Activities Column 1: Are costs claimed for nursing scho	ool 2 Column 2: If	voc ic +k	ao providor is	N		6.00
6.00	the legal operator of the program?	JOI ? COLUMN 2. II	yes, is ti	le provider is	IN		0.00
7.00	Are costs claimed for Allied Health Programs?				N		7. 00
8. 00	Were nursing school and/or allied health prog cost reporting period? If yes, see instruction		or renewed	d during the	N		8. 00
9. 00	Are costs claimed for Interns and Residents i		uate medio	cal education	N		9. 00
	program in the current cost report? If yes, s						
10. 00	Was an approved Intern and Resident GME progr cost reporting period? If yes, see instruction		newed in 1	the current	N		10.00
11. 00	Are GME cost directly assigned to cost center		in an App	oroved	N		11.00
	Teaching Program on Worksheet A? If yes, see	instructions.				Y/N	
						1.00	
	Bad Debts						
12. 00 13. 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad deb period? If yes, submit copy.	ot collection polic	y change o	during this cos		Y N	12.00
14. 00	If line 12 is yes, were patient deductibles a	and/or co-payments	waived? I1	fyes, see inst	ructi ons.	N	14.00
15. 00	Bed Complement Did total beds available change from the price	or cost reporting p	eriod? If	ves. see instr	ructions.	Y	15. 00
	,	3		Pai	rt A	Part B	
		Descriptio 0	n	Y/N 1.00	2. 00	Y/N 3.00	
	PS&R Data	U		1.00	2.00	3.00	
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see			N		N	16. 00
17. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records			Y	04/30/2016	Y	17. 00
18. 00	for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments			Y		Y	18. 00
	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 cost report? If yes, see instructions.						
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	19. 00
20. 00	Instructions. 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

Health Financial Systems		WHITLEY MEMORIAL H	OSPI TAL		In Lie	u of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMI	ENT QUE				Peri od: From 01/01/2015	Worksheet S-2	
				Pa	art A	Part B	
		Descriptio	n	Y/N	Date	Y/N	
		0		1.00	2. 00	3. 00	
21.00 Was the cost report prepared only usin provider's records? If yes, see instructions.	ng the			N		N	21. 00
					•		
						4 00	

21.00	was the cost report prepared only using the		l IN		IN	21.00
	provider's records? If yes, see					
	instructions.					
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPI	TALS ONLY (EXCEPT CHILDRENS H	OSPLTALS)	•		
	Capital Related Cost	(
22. 00		es? If was see instructions				22. 00
23. 00	Have changes occurred in the Medicare deprec		als made durin	a the cost		23. 00
23.00	reporting period? If yes, see instructions.	ration expense due to apprais	ars made durin	g the cost		25.00
24. 00	Were new leases and/or amendments to existing	a leases entered into during	this cost ropo	rting poriod?		24. 00
24.00	If yes, see instructions	g reases entered filto during	tili s cost Tepo	iting perious		24.00
25 00		ad into during the cost reson	+i na nani ad2 I	£		25.00
25. 00	Have there been new capitalized leases enter	ed into during the cost repor	ting period? i	i yes, see		25. 00
27 00	instructions.		: 16			2/ 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acq	urrea durring the cost reporti	ng period? II	yes, see		26. 00
07.00	instructions.		. 10 1 6			07.00
27. 00	Has the provider's capitalization policy cha	ngea auring the cost reportin	g perioa? it y	es, submit		27. 00
	copy.					
	Interest Expense					
28. 00		rs of credit entered into dur	ing the cost r	eporting		28. 00
	period? If yes, see instructions.					
29. 00	Did the provider have a funded depreciation		bt Service Res	erve Fund)		29. 00
	treated as a funded depreciation account? If					
30. 00	Has existing debt been replaced prior to its	scheduled maturity with new	debt? If yes,	see		30. 00
	instructions.					
31. 00	Has debt been recalled before scheduled matu	rity without issuance of new	debt? If yes,	see		31. 00
	i nstructi ons.					
	Purchased Services					
32.00			d through cont	ractual		32. 00
	arrangements with suppliers of services? If					
33.00	J	Sec. 2135.2 applied pertainin	g to competiti	ve bidding? If		33. 00
	no, see instructions.					
	Provi der-Based Physi ci ans					
34.00		ity under an arrangement with	provi der-base	d physi ci ans?	Υ	34.00
	If yes, see instructions.					
35.00	If line 34 is yes, were there new agreements	or amended existing agreemen	ts with the pr	ovi der-based		35. 00
	physicians during the cost reporting period?	If yes, see instructions.				
				Y/N	Date	
				1. 00	2. 00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost r	eport?		Υ		36. 00
	If line 36 is yes, has a home office cost st		home office?	Υ		37. 00
·	If yes, see instructions.					
38. 00	1 3 .	of the home office different	from that of	N		38. 00
	the provider? If yes, enter in column 2 the					
20.00	LE Line 24 in the manifold and and a			N.		20.00

			1.00	2.00	
	Home Office Costs				
36.00	Were home office costs claimed on the cost report?		Υ		36. 00
37.00	If line 36 is yes, has a home office cost statement been prepared by	the home office?	Υ		37. 00
	If yes, see instructions.				
38. 00	If line 36 is yes , was the fiscal year end of the home office diffe		N		38. 00
	the provider? If yes, enter in column 2 the fiscal year end of the h				
39. 00	If line 36 is yes, did the provider render services to other chain c	omponents? If yes,	N		39. 00
	see instructions.				
40.00	If line 36 is yes, did the provider render services to the home offi	ce? If yes, see	N		40. 00
	instructions.				
		1. 00	2.	00	
	Cost Report Preparer Contact Information				1
41.00	Enter the first name, last name and the title/position		NI CKESON		41.00
	held by the cost report preparer in columns 1, 2, and 3,				
	respecti vel y.				
42.00	Enter the employer/company name of the cost report PARKVIEW	HEALTH SYSTEM, INC.			42. 00
	preparer.				
43.00	Enter the telephone number and email address of the cost (260) 373	-8406	ERI C. NI CKESON@	PARKVIEW.COM	43. 00
	report preparer in columns 1 and 2, respectively.				

				To 12/31/2015	
		Part B			
		Date			
		4. 00			
	PS&R Data				
16. 00	Was the cost report prepared using the PS&R				16. 00
	Report only? If either column 1 or 3 is yes,				
	enter the paid-through date of the PS&R				
	Report used in columns 2 and 4 (see				
17. 00	instructions) Was the cost report prepared using the PS&R	04/30/2015			17. 00
17.00	Report for totals and the provider's records	04/30/2013			17.00
	for allocation? If either column 1 or 3 is				
	yes, enter the paid-through date in columns				
	2 and 4. (see instructions)				
18.00	If line 16 or 17 is yes, were adjustments				18. 00
	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 cost report? If yes, see instructions.				
19. 00	If line 16 or 17 is yes, were adjustments				19. 00
	made to PS&R Report data for corrections of				
	other PS&R Report information? If yes, see instructions.				
20. 00					20.00
20.00	made to PS&R Report data for Other? Describe				20.00
	the other adjustments:				
21. 00	Was the cost report prepared only using the				21. 00
	provider's records? If yes, see				
	i nstructi ons.				
			3. 00		
	Cost Report Preparer Contact Information	, ,,,	DI DECTOR DEL MINISCEMENT		11.00
41.00	Enter the first name, last name and the title held by the cost report preparer in columns 1		DI RECTOR, REIMBURSEMENT		41. 00
	respectively.	, Z, aliu s,			
42 00	Enter the employer/company name of the cost r	enort			42. 00
12. 00	preparer.	00011			12.00
43.00	Enter the telephone number and email address	of the cost			43. 00
	report preparer in columns 1 and 2, respective				

					'	0 12/31/2013	5/19/2016 5: 1	
							I/P Days / O/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1.00	2	2. 00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		30				1. 00
	8 exclude Swing Bed, Observation Bed and				·			
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7.00	Total Adults and Peds. (exclude observation			30	10, 950	0.00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT							8. 00
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43. 00					0	13. 00
14.00	Total (see instructions)			30	10, 950	0.00	0	14.00
15.00	CAH visits						0	15. 00
16.00	SUBPROVIDER - IPF							16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18.00	SUBPROVI DER							18. 00
19.00	SKILLED NURSING FACILITY	44. 00		o)	0	19. 00
20.00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY		İ					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)		İ					23. 00
24.00	HOSPI CE		İ					24. 00
24. 10	HOSPICE (non-distinct part)	30. 00	İ					24. 10
25.00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER							26. 25
27. 00	Total (sum of lines 14-26)			30				27. 00
28. 00	Observation Bed Days						o	28. 00
29. 00	Ambul ance Trips							29. 00
30. 00	Employee discount days (see instruction)							30. 00
31. 00	Employee discount days - IRF							31. 00
32. 00	Labor & delivery days (see instructions)			o	C			32. 00
32. 01	Total ancillary labor & delivery room			Ĭ]			32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33. 00
	•				•	•		

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: | 5/19/2016 5:11 pm

						5/19/2016 5:1	1 pm
		I/P Days	s / O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	1, 098	148	3, 940			1. 00
2.00	HMO and other (see instructions)	981	1, 249				2.00
3.00	HMO I PF Subprovi der	ol	0				3.00
4.00	HMO IRF Subprovider	ol	o				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	o	o	C			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		o	C			6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 098	148	3, 940			7. 00
8. 00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY		104	937			13. 00
14. 00	Total (see instructions)	1, 098	252	4, 877	0.00	204. 60	14. 00
15. 00	CAH visits	0	0	C			15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	0	0	C	0.00	0.00	1
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)	0	0	45			24. 10
25. 00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)				0.00	204. 60	27. 00
28. 00	Observation Bed Days		167	881			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			284			30. 00
31.00	Employee discount days - IRF			C			31.00
32.00	Labor & delivery days (see instructions)	o	91	147			32. 00
32. 01	Total ancillary labor & delivery room			C			32. 01
33. 00	outpatient days (see instructions)	0					33. 00

 Heal th Fi nancial
 Systems
 WHITLEY

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part I | To 12/31/2015 | Date/Time Prepared:

					10) 12/31/2015	5/19/2016 5:1	
			Full Time		Di sch	arges	07 177 2010 0. 1	ı pııı
			Equi val ents			3		
		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	363	57	1, 467	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	2. 00	HMO and other (see instructions)			320	483		2. 00
	3. 00	HMO IPF Subprovider				0		3.00
4	1. 00	HMO IRF Subprovider				0		4.00
í	5. 00	Hospital Adults & Peds. Swing Bed SNF						5. 00
(5. 00	Hospital Adults & Peds. Swing Bed NF						6.00
-	7. 00	Total Adults and Peds. (exclude observation						7.00
		beds) (see instructions)						
	3. 00	INTENSIVE CARE UNIT						8. 00
(9. 00	CORONARY CARE UNIT						9. 00
•	10.00	BURN INTENSIVE CARE UNIT						10.00
•	11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
•	12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
	13.00	NURSERY						13.00
•	14.00	Total (see instructions)	0. 00	0	363	57	1, 467	14.00
•	15. 00	CAH visits						15.00
•	16.00	SUBPROVI DER - I PF						16.00
•	17. 00	SUBPROVI DER - I RF						17.00
•	18. 00	SUBPROVI DER						18.00
•	19. 00	SKILLED NURSING FACILITY	0. 00					19.00
2	20. 00	NURSING FACILITY						20.00
2	21. 00	OTHER LONG TERM CARE						21.00
2	22. 00	HOME HEALTH AGENCY						22.00
2	23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
2	24. 00	HOSPI CE						24.00
2	24. 10	HOSPICE (non-distinct part)						24. 10
2	25. 00	CMHC - CMHC						25.00
2	26. 00	RURAL HEALTH CLINIC						26.00
2	26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
2	27. 00	Total (sum of lines 14-26)	0. 00					27.00
2	28. 00	Observation Bed Days						28.00
2	29. 00	Ambul ance Tri ps						29.00
;	30. 00	Employee discount days (see instruction)						30.00
;	31. 00	Employee discount days - IRF						31.00
;	32. 00	Labor & delivery days (see instructions)						32.00
;	32. 01	Total ancillary labor & delivery room						32. 01
		outpatient days (see instructions)						
;	33. 00	LTCH non-covered days						33.00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared:

No. Contract A Direct						Т	o 12/31/2015	Date/Time Pre 5/19/2016 5:1	
PART II - MARE DATA 1.00								Average Hourly	
Mart 11 - MOE DATA			Line Number	Reported					
Mart 1 Water Mark SAMANES SAME S					,			COI. 3)	
SAMPLES		DADE LA WAGE DATA	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
Total salaries (see 200,000 20,184,362 -3,502,775 16,681,587 550,588,00 30,30 1,00									1
2.00 Non-physic clan anestherit st Part 0 0 0 0 0.00 0.00 0.00 0.00 0.00 0.0	1.00		200. 00	20, 184, 362	-3, 502, 775	16, 681, 587	550, 508. 00	30. 30	1.00
3.00 Non-Physician anesthetist Pert	2 00	1		0			0.00	0.00	2 00
4.00 Physician Part A — Abin is strative with a strative strategy of the personnel strative with a strategy of the personnel strategy of the personn	2.00			0			0.00	0.00	2.00
4.00 Physician-Part A	3.00			0	0	C	0. 00	0. 00	3. 00
Admin I strative Admin I strative Physicians - Part B 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4 00	12		79 403	0	79 403	457 00	173 75	4 00
Physician-Part B		Admi ni strati ve		, , , , , , ,		, , , , , ,			
Mon-physician-Part B 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	0	O			
approved program				0	0	o c		1	
Contracted interns and residents (in an approved programs)	7.00		21. 00	0	0	C	0.00	0. 00	7. 00
Residents (in an approved programs)	7 01			0	0	0	0.00	0.00	7 01
None of Fine personnel	7.01	residents (in an approved		0			0.00	0.00	7.01
9.00 SIVE 44.00 0 0 0 0 0 0 0 0 0	9 00			1 126 012		1 126 012	124 026 00	25 52	0 00
Instructions OTHER WAGES & RELATED COSTS			44. 00	4, 430, 013	Ö				
OTHER WAGES & RELATED COSTS	10. 00			1, 407, 497	80, 358	1, 487, 855	68, 356. 00	21. 77	10.00
11.00 Contract labor: Direct Patient Care Care 0 0 0 0 0 0 0 0 0									1
12.00 Contract labor: Top level	11. 00	Contract Labor: Direct Patient		0	0	C	0.00	0. 00	11. 00
management and other management management and other management management and other management manag	12 00	1		0	,		0.00	0.00	12 00
Services	12.00			O	٥		0.00	0.00	12.00
13. 00 Contract Labor: Physician-Part		1 9							
A - Administrative	13. 00	•		0	0	C	0.00	0. 00	13.00
wage-related costs		A - Administrative							
15.00 Home office: Physician Part A 0 0 0 0 0 0 0 0 0	14. 00			4, 436, 813	0	4, 436, 813	124, 926. 00	35. 52	14.00
Home office and Contract	15. 00	Home office: Physician Part A		0	0	C	0.00	0. 00	15. 00
Physicians Part A - Teaching	16 00			0	0		0.00	0.00	16 00
17. 00 Wage-related costs (core) (see instructions) 18. 00 Wage-related costs (other) (see instructions) 18. 00 0 0 0 0 0 0 18. 00	10.00	Physicians Part A - Teaching					0.00	0.00] 10.00
Instructions Name	17 00			4 002 727	1 0	4 000 727		I	17 00
See instructions Excluded areas 573,109 0 573,109 19.00 20.00 Non-physician anesthetist Part 0 0 0 0 0 0 21.00 Non-physician anesthetist Part 0 0 0 0 0 0 21.00 22.00	17.00			4, 002, 737		4, 002, 737			17.00
19. 00 Excl uded areas	18. 00			0	0	C			18. 00
20.00 Non-physician anesthetist Part A Non-physician anesthetist Part B Non-physician anesthetist Part B O O O O O O O O O	19. 00	1 ` /		573. 109	0	573. 109			19.00
22.00 Physician Part A -		1		0	0	C			1
22.00 Physician Part A -	21 00	A Non-physician anesthetist Part		0	0				21 00
Administrative	21.00	В		O					21.00
22. 01 Physician Part A - Teaching 0 0 0 0 23. 00 24. 00 24. 00 25. 00 Interns & residents (in an approved program) 00 0 0 0 0 0 0 0 0	22. 00			0	0	C			22. 00
24. 00 25. 00 Interns & residents (in an approved program)	22. 01	•		0	О	c			22. 01
25.00 Interns & residents (in an approved program) 0				-	1	1			
Approved program OVERHEAD COSTS - DIRECT SALARIES				-		1			
26. 00 Empl oyee Benefits Department		approved program)							
27. 00 Administrative & General 5. 00 8, 578, 957 -3, 434, 231 5, 144, 726 143, 904. 00 35. 75 27. 00 28. 00 Administrative & General under contract (see inst.) 0 0 0 0 0.00 0.00 28. 00 29. 00 Maintenance & Repairs 6. 00 0 0 0 0 0.00 0.00 29. 00 30. 00 Operation of Plant 7. 00 279, 471 34, 811 314, 282 13, 599. 00 23. 11 30. 00 31. 00 Laundry & Linen Service 8. 00 0 0 0 0.00 0.00 0.00 0.00 31. 00 32. 00 Housekeeping 9. 00 254, 015 31, 732 285, 747 21, 331. 00 13. 40 32. 00 34. 00 Di etary 10. 00 330, 841 -198, 656 132, 185 6, 174. 00 21. 41 34. 00 35. 00 Di etary under contract (see instructions) 0 0 0 0 0.00 0 0.00	26 00			1 434 934	-1 250 500	184 434	6 135 00	30.06	26 00
Contract (see inst.) Contract (see inst.) Contract (see inst.) Contract (see inst.) Contract (see inst.) Contract (see inst.) Contract (see inst.) Contract (see inst.) Contract (see inst.) Contract (see inst.) Contract (see inst.) Contract (see inst.) Contract (see inst.) Contract (see inst.) Contract (see instructions) Contract (se	27. 00	Administrative & General						35. 75	27. 00
29. 00 Maintenance & Repairs 6. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28. 00			0	0	C	0.00	0. 00	28. 00
31. 00 Laundry & Linen Service	29. 00		6. 00	0	0	C	0.00	0.00	29. 00
32. 00 Housekeeping				279, 471	34, 811	314, 282			
33. 00 Housekeeping under contract (see instructions) 34. 00 Dietary 35. 00 Dietary under contract (see instructions) 36. 00 Cafeteria 37. 00 Maintenance of Personnel 38. 00 Nursing Administration 39. 00 Central Services and Supply 30. 00 O O O O O O O O O O O O O O O O O				254 O15	0 31 732	285 747			1
34.00 Di etary under contract (see instructions) 36.00 Cafeteria 36.00 Maintenance of Personnel 38.00 Nursi ng Administrati on 39.00 Central Services and Supply 10.00 330,841 -198,656 132,185 6,174.00 21.41 34.00 0 0 0 0 0 0 0 0.00 35.00 2232,207 232,207 17,989.00 12.91 36.00 0 0 0 0 0 0 0.00 37.00 38.00 136,334 4,226 140,560 3,923.00 35.83 38.00		Housekeeping under contract	7. 50	254, 513	0	255, 747			
35. 00 Di etary under contract (see i nstructions) 36. 00 Cafeteria 11. 00 0 232, 207 232, 207 17, 989. 00 12. 91 36. 00 37. 00 Maintenance of Personnel 12. 00 0 0 0 0 0 0 0. 00 37. 00 38. 00 Nursi ng Administrati on 13. 00 136, 334 4, 226 140, 560 3, 923. 00 39. 00 Central Services and Supply 14. 00 0 0 0 0 0 0. 00 39. 00	24 00	1 '	10.00	220 041	100 454	122 105	4 174 00	21 41	24 00
instructions) 36.00 Cafeteria 11.00 0 232,207 232,207 17,989.00 12.91 36.00 37.00 Maintenance of Personnel 12.00 0 0 0 0 0.00 37.00 38.00 Nursing Administration 13.00 136,334 4,226 140,560 3,923.00 35.83 38.00 39.00 Central Services and Supply 14.00 0 0 0 0 0 0.00 39.00			10.00	330, 641	- 196, 030	132, 163			
37. 00 Maintenance of Personnel 12. 00 0 0 0 0. 00 0. 00 37. 00 38. 00 Nursing Administration 13. 00 136, 334 4, 226 140, 560 3, 923. 00 35. 83 38. 00 39. 00 Central Services and Supply 14. 00 0 0 0 0. 00 0. 00 0. 00 39. 00		instructions)		_					
38.00 Nursing Administration 13.00 136,334 4,226 140,560 3,923.00 35.83 38.00 39.00 Central Services and Supply 14.00 0 0 0 0 0 0 0 0 0				0	232, 207	232, 207			
	38. 00			136, 334	4, 226	140, 560			38. 00
40. 00 Friat macy 10. 00 494, 770 61, 807 556, 577 11, 552. 00 48. 18 40. 00				404 770	(1 007	C			1
	40.00	Frial IIIaCy	15.00	494, 770	l οι, 80 <i>7</i>	J 556, 5//	11, 552. 00	48. I8 	40.00

Heal th	n Financial Systems		WHITLEY MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
HOSPITAL WAGE INDEX INFORMATION				Provi der	CCN: 150101	Peri od:	Worksheet S-3		
						From 01/01/2015			
						To 12/31/2015			
							5/19/2016 5: 1	1 pm	
		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		
41.00	Medical Records & Medical	16. 00	(0 0		0.00	0. 00	41. 00	
	Records Library								
42.00	Soci al Servi ce	17. 00	(0 0		0.00	0. 00	42.00	
43.00	Other General Service	18. 00	(0 (c		0.00	0. 00	43. 00	

							5/19/2016 5: 1	1 pm	
		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		
	PART III - HOSPITAL WAGE INDEX SUMMARY								
1.00	Net salaries (see		15, 747, 549	-3, 502, 775	12, 244, 774	425, 582. 00	28. 77	1.00	
	instructions)								
2.00	Excluded area salaries (see		1, 407, 497	80, 358	1, 487, 855	68, 356. 00	21. 77	2.00	
	instructions)								
3.00	Subtotal salaries (line 1		14, 340, 052	-3, 583, 133	10, 756, 919	357, 226. 00	30. 11	3.00	
	minus line 2)								
4.00	Subtotal other wages & related		4, 436, 813	0	4, 436, 813	124, 926. 00	35. 52	4.00	
	costs (see inst.)								
5.00	Subtotal wage-related costs		4, 882, 737	0	4, 882, 737	0.00	45. 39	5.00	
	(see inst.)								
6.00	Total (sum of lines 3 thru 5)		23, 659, 602	-3, 583, 133	20, 076, 469	482, 152. 00	41. 64	6.00	
7.00	Total overhead cost (see		11, 509, 322	-4, 518, 604	6, 990, 718	224, 607. 00	31. 12	7.00	
	instructions)								
	•				•	•			

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS		Peri od: Worksheet S-3 From 01/01/2015 Part IV To 12/31/2015 Date/Time Prepared:

PART IV - WAGE RELATED COSTS 1.00		To 12/31/2015	Date/Time Pre 5/19/2016 5:1	
PART IV - WAGE RELATED COSTS				
PART IV - WAGE RELATED COSTS Part A - Core List				
Part A - Core List RETIREMENT COST				
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00		Part A - Core List		
2.00		RETI REMENT COST		
3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 335,593 3.00 4.00 Qualified Defined Benefit Plan Cost (see instructions) 4.00 PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 5.00 4.00 ADMINISTRATIVE COSTS (Paid to External Organization) 5.00 4.00 ADMINISTRATIVE COSTS (Paid to External Organization) 5.00 4.00 ADMINISTRATIVE COSTS (Paid to External Organization) 6.00 4.00 Employee Managed Care Program Administration Fees 5.5, 842 7.00 4.00 Employee Managed Care Program Administration Fees 5.5, 842 7.00 4.00 Healt In Insurance (Purchased or Self Funded) 7.00	1.00	401K Employer Contributions	0	1.00
3.00 Nonqual if ied Defined Benefit Plan Cost (see instructions) 335,593 3.00 4.00 Qual if ied Defined Benefit Plan Cost (see instructions) 4.00 PLAN ADMINI STRATIVE COSTS (Paid to External Organization) 5.00 4.00 401K/TSA Plan Administration fees 0 6.00 4.00 Legal /Accounting/Management Fees-Pension Plan 0 6.00 4.00 Employee Managed Care Program Administration Fees 7.00 4.00 Health Insurance (Purchased or Self Funded) 7.00 4.00 Prescription Drug Plan 7.00 7.00 5.00 Dental, Hearing and Vision Plan 7.00 7.00 5.00 Accident Insurance (if employee is owner or beneficiary) 7.00 5.00 Accident Insurance (if employee is owner or beneficiary) 7.00 5.00 Accident Insurance (if employee is owner or beneficiary) 7.00 6.00 Comparation Insurance (if employee is owner or beneficiary) 7.00 6.00 Comparation Insurance (if employee is owner or beneficiary) 7.00 6.00 Comparation Insurance (if employee is owner or beneficiary) 7.00 6.00 Comparation Insurance (if employee is owner or beneficiary) 7.00 6.00 Comparation Insurance (if employee is owner or beneficiary) 7.00 7.00 Comparation Insurance (if employee is owner or beneficiary) 7.00 7.00 Comparation Insurance (if employee is owner or beneficiary) 7.00 7.00 Comparation Insurance (if employee is owner or beneficiary) 7.00 7.00 Comparation Insurance (if employee is owner or beneficiary) 7.00 7.00 Comparation Insurance (if employee is owner or beneficiary) 7.00 7.00 Comparation Insurance (if employee is owner or beneficiary) 7.00 7.00 Comparation Insurance (if employee is owner or beneficiary) 7.00 7.00 Comparation Insurance (if employee is owner or beneficiary) 7.00 7.00 Comparation Insurance (if employee is owner or beneficiary) 7.00 7.00 Comparation Insurance (if employee is owner or beneficiary) 7.00 7.00 Comparation Insurance (if employee is owner or be	2.00	Tax Sheltered Annuity (TSA) Employer Contribution	347, 171	2.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)	3.00			3. 00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA Plan Administration fees 0 6.00 6.00 Legal /Accounting/Management Fees-Pension Plan 0 6.00 6.00 Employee Managed Care Program Administration Fees 7.00 Prescription Drug Plan 0 9.00 7.00 7.00 7.00 Prescription Drug Plan 0 9.00 7.00	4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
Legal / Accounting / Management Fees-Pension Plan 55,842 7.00		PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
Table	5.00	401K/TSA Plan Administration fees	0	5. 00
HEALTH AND INSURANCE COST	6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
8. 00 Heal th Insurance (Purchased or Self Funded) 3, 175, 087 9. 00 9. 00 10. 00	7.00	Employee Managed Care Program Administration Fees	55, 842	7. 00
9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan 0 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 27,608 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 69,042 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 30,582 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion) 1,333,142 17.00 18.00 19.00 18.00 19.00 Unemployment Insurance 0 19.00 19.00 19.00 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00		HEALTH AND INSURANCE COST		
Prescription Drug Plan	8.00	Health Insurance (Purchased or Self Funded)	3, 175, 087	8. 00
11.00 Life Insurance (If employee is owner or beneficiary) 27,608 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 69,042 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 0 14.00 15.00 Workers' Compensation Insurance 30,582 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion) 7AXES 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 1	9.00	Prescription Drug Plan		
12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 69,042 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 30,582 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 17.00 Non cumulative portion 1.333,142 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 0 19.00 20.00 OTHER 2.00 2.000 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 49,813 21.00 19.00 Lines 2.00 22.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 31,967 23.00 24.00 Part B - Other than Core Related Cost 20.00 25.00 Contact 20.00 20.00 26.00 26.00 26.00 27.00 27.00 27.00 28.00 28.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29	10.00	Dental, Hearing and Vision Plan	0	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. 16.00 Non cumul ative portion) TAXES 17.00 FICA-Employers Portion Only 18.00 Medicare Taxes - Employers 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 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	11.00	Life Insurance (If employee is owner or beneficiary)	27, 608	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 49, 813 instructions)) Day Care Cost and Allowances Tuition Reimbursement Taxes 17.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
15.00 'Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only 18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 17.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 49, 813 instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 24.00 Part B - Other than Core Related Cost	13.00	Disability Insurance (If employee is owner or beneficiary)	69, 042	13.00
Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FI CA-Empl oyers Portion Only 18. 00 Medicare Taxes - Employers 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 Tuition Reimbursement 10. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 Part B - Other than Core Related Cost	14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
Non cumulative portion) TAXES 17. 00 FI CA-Empl oyers Portion Only 18. 00 Medicare Taxes - Employers 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 49, 813 instructions)) 22. 00 Day Care Cost and Allowances 23. 00 Tuition Reimbursement 24. 00 Part B - Other than Core Related Cost	15.00	'Workers' Compensation Insurance	30, 582	15. 00
TAXES 17.00 FI CA-Employers Portion Only 1,333,142 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 0 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 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 0 22.00 23.00 Tuition Reimbursement 31,967 23.00 24.00 Part B - Other than Core Related Cost 24.00 Part B - Other than Core Related Cost 24.00 24.00 Part B - Other than Core Related Cost 24.00 24.00 Part B - Other than Core Related Cost 25.00 24.00	16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
17. 00 FI CA-Employers Portion Only 1, 333, 142 17. 00 18. 00 19. 00 1		Non cumulative portion)		
18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 0 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 49,813 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 31,967 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 5,455,847 24.00		·		
19.00 Unempl oyment Insurance 19.00 20.00 State or Federal Unempl oyment Taxes 0 20.00 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 0 22.00 Tuition Reimbursement 31,967 23.00 Total Wage Related cost (Sum of Lines 1 -23) 5,455,847 24.00 Part B - Other than Core Related Cost 23.00 Total Wage Related Cost 24.00 Control of the Cost 25.00 2	17. 00	FICA-Employers Portion Only	1, 333, 142	17. 00
20.00 State or Federal Unemployment Taxes 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 10 22.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	18.00	Medicare Taxes - Employers Portion Only	0	18. 00
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 31,967 23.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost 21.00 22.00 22.00 23.00 5,455,847 24.00			0	19. 00
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		0	20. 00
instructions)) Day Care Cost and Allowances Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 1 instructions) 22.00 22.00 23.00 24.00 24.00				
22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuition Reimbursement 31, 967 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 -23) 5, 455, 847 24. 00 Part B - Other than Core Related Cost 22. 00 24. 00	21. 00		49, 813	21. 00
23.00 Tuition Reimbursement 31,967 23.00 24.00 Total Wage Related cost (Sum of lines 1 -23) 5,455,847 24.00 Part B - Other than Core Related Cost				
24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 24.00			_	
Part B - Other than Core Related Cost				
	24. 00	, , ,	5, 455, 847	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	WHITLEY MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		From 01/01/2015	Worksheet S-3 Part V Date/Time Prep 5/19/2016 5:1	pared:
Cost Center Description		Contract Labor	Benefit Cost	
		1. 00	2. 00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identific	cation:			

	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	0	0	1. 00
2.00	Hospi tal	0	0	2.00
3.00	Subprovi der - I PF			3. 00
4.00	Subprovi der - I RF			4.00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swi ng Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF	0	0	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			17. 00
18. 00	Other	0	0	18. 00

Heal th	Financial Systems WHITLEY MEMORIAL HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
	· · · · · · · · · · · · · · · · · · ·		CCN: 150101	Peri od:	Worksheet S-10	
				From 01/01/2015 To 12/31/2015	Date/Time Pre 5/19/2016 5:1	
					1. 00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by lir	ne 202 columi	า 8)	0. 252447	1. 00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				2, 326, 720	2. 00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Υ	3. 00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental p		from Medicaio	<u></u>	N	4. 00
5.00	If line 4 is "no", then enter DSH or supplemental payments from N	Medi cai d			694, 125	5. 00
6.00	Medi cai d charges				22, 916, 437	6. 00
7.00	Medicaid cost (line 1 times line 6)		5, 785, 186			
8. 00	Difference between net revenue and costs for Medicaid program (li < zero then enter zero)	ne 7 minu	us sum of lin	nes 2 and 5; if	2, 764, 341	8. 00
	State Children's Health Insurance Program (SCHIP) (see instruction	ons for ea	ach line)			
9.00	Net revenue from stand-alone SCHIP		,		5, 252	9. 00
10.00	Stand-al one SCHIP charges				23, 731	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)				5, 991	11. 00
12.00	Difference between net revenue and costs for stand-alone SCHIP (I	ine 11 mi	nus line 9;	if < zero then	739	12.00
	enter zero)					
	Other state or local government indigent care program (see instru					
13. 00	Net revenue from state or local indigent care program (Not include	,	0			
14. 00	Charges for patients covered under state or local indigent care process.	orogram (1	Not included	in lines 6 or	0	14. 00
15.00	State or local indigent care program cost (line 1 times line 14)				0	15. 00
16.00	,					
	13; if < zero then enter zero)					
	Uncompensated care (see instructions for each line)					
17. 00	Private grants, donations, or endowment income restricted to fund	9	,		0	
18. 00	Government grants, appropriations or transfers for support of hos				0	18. 00
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and local 8, 12 and 16)	i ndi gent	care program	ns (sum of lines	2, 765, 080	19. 00
	10, 12 4.14 10,		Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
			1. 00	2. 00	3. 00	
20. 00	Total initial obligation of patients approved for charity care (a		1, 654, 9	7, 705, 471	9, 360, 444	20. 00
04 00	charges excluding non-reimbursable cost centers) for the entire f		447.7	4 045 000	0.040.044	04 00
21. 00	Cost of initial obligation of patients approved for charity care	(line i	417, 7	1, 945, 223	2, 363, 016	21. 00
22. 00	times line 20) Partial payment by patients approved for charity care	+	3, 5	= 4	3, 554	22. 00
	Cost of charity care (line 21 minus line 22)	+	3, 5 414, 2		2, 359, 462	
23.00	cost of charity care (fine 21 millios fine 22)		414, 2	1, 943, 223	2, 339, 402	23.00
					1. 00	
24.00	Does the amount in line 20 column 2 include charges for patient of		nd a Length o	of stay limit	N	24. 00
	imposed on patients covered by Medicaid or other indigent care pr					
25. 00	If line 24 is "yes," charges for patient days beyond an indigent	th of stay limit	0			
26. 00	Total bad debt expense for the entire hospital complex (see instr				6, 163, 775	
27. 00	Medicare bad debts for the entire hospital complex (see instructi	,	>		60, 507	
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (line			00)	6, 103, 268	
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt exper	nse (line	ı tımes line	28)	1, 540, 752	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	20)			3, 900, 214	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line	30)			6, 665, 294	31.00

Heal th	Financial Systems	WHITLEY MEMORIA	L HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der		Peri od:	Worksheet A	
					From 01/01/2015 Fo 12/31/2015	Date/Time Pre	narod:
					10 12/31/2013	5/19/2016 5:1	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Reclassi fi cati	Reclassi fi ed	
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			+ col . 2)	ons (See A-6)		
					, ,	(col. 3 +-	
						col . 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		3, 126, 340	3, 126, 340			
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0	(1, 053, 708		
3.00	00300 OTHER CAP REL COSTS	1 101 001	0		0	0	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 434, 934	3, 869, 007				
5.00	00500 ADMINISTRATIVE & GENERAL	8, 578, 957	7, 462, 792	1	-285, 470		
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	279, 471	995, 898	1	-63, 760	0 1, 211, 609	
8. 00	00800 LAUNDRY & LINEN SERVICE	2/7, 4/1	160, 178			160, 178	1
9. 00	00900 HOUSEKEEPI NG	254, 015	118, 688				1
10. 00	01000 DI ETARY	330, 841	215, 315				1
11. 00	01100 CAFETERI A	0	0.070.0	1	386, 969		1
12. 00	01200 MAINTENANCE OF PERSONNEL	ol	0		0	0	12. 00
13.00	01300 NURSING ADMINISTRATION	136, 334	1, 596	137, 930	4, 226	142, 156	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	O	0		0	0	14. 00
15.00	01500 PHARMACY	494, 770	2, 446, 677	2, 941, 44	-1, 459, 570	1, 481, 877	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0	0	16. 00
17. 00	01700 SOCI AL SERVI CE	0	0)	0	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0) (0	0	19. 00
	02000 NURSI NG SCHOOL	0	0		0	0	20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	(0	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0) (0	0	23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.5(0.774	045 004	0.077.000	- // / / 07	0.010.1/0	
30.00	03000 ADULTS & PEDI ATRI CS	2, 562, 771	315, 034	1			1
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	0	1	213, 102		1
44.00	ANCI LLARY SERVICE COST CENTERS	l U	0		J U	0	1 44.00
50. 00		902, 483	380, 376	1, 282, 859	111, 235	1, 394, 094	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	65, 303	2, 166				1
53. 00	05300 ANESTHESI OLOGY	0	795, 733				1
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 035, 245	502, 729	1			1
60.00	06000 LABORATORY	O	1, 740, 826				
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0)	0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	432, 672	151, 771	584, 443			65. 00
66.00	06600 PHYSI CAL THERAPY	912, 962	303, 801	1, 216, 76	-698, 206	518, 557	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0) (431, 790		•
68. 00	06800 SPEECH PATHOLOGY	0	0		114, 880		
69. 00	06900 ELECTROCARDI OLOGY	0	2, 259				•
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2	743, 331	743, 333			•
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		200, 189		
73.00		0	0		1, 502, 588		
	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY	0	0			0	76. 97 76. 98
	07699 LI THOTRI PSY		0			0	
70. 77	OUTPATIENT SERVICE COST CENTERS	<u> </u>		1	<u> </u>		70.77
90.00	09000 CLI NI C	84, 916	18, 630	103, 546	18, 386	121, 932	90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0	0		0	0	
91.00		1, 271, 189	202, 759	1, 473, 948	120, 233	1, 594, 181	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		•				92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	1, 355, 953	228, 253	1, 584, 200	46, 362	1, 630, 568	95. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		20, 132, 818	23, 784, 159	43, 916, 97	-377, 980	43, 538, 997	118. 00
	NONREI MBURSABLE COST CENTERS			1			4
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	31, 831				190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	15, 515	372, 061				
	07950 OCCUPATI ONAL HEALTH	0	-112, 880	-112, 880			194.00
	07951		0]	0		194. 01
	207952 OAK POINTE BO7953 FOUNDATION		90, 000	90, 000	242, 142		194. 02
	107953 FOUNDATION 107954 COMMUNITY & VOLUNTEER SERVICES	36, 029	175, 659				
	07955 VACANT SPACE	30, 027 N	173,039	211,000	0 23, 491		194. 04
200.00		20, 184, 362	24, 340, 830	44, 525, 192			
			, ,	, .,	, 9	., ., ., ., ., ., ., ., ., ., ., ., ., .	

Peri od: From 01/01/2015 To 12/31/2015 Date/Time Prepared: 5/19/2016 5:11 pm

			5/19/2016 5: 11	l pm
Cost Center Description		Net Expenses		
		or Allocation		
GENERAL SERVICE COST CENTERS	6.00	7. 00		
1. 00 O0100 CAP REL COSTS-BLDG & FIXT	-2, 096, 580	546, 486		1. 00
2. 00 00200 CAP REL COSTS-BUBB & TTXT	-12, 934	1, 040, 774		2. 00
3. 00 00300 OTHER CAP REL COSTS	12, 734	1,040,774		3. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTM		2, 169, 005		4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	-1, 958, 089	13, 798, 190		5. 00
6. 00 00600 MAI NTENANCE & REPAI RS	1, 730, 007	13, 770, 170		6. 00
7. 00 00700 OPERATION OF PLANT	-97, 447	1, 114, 162		7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	77, 447	160, 178		8. 00
9. 00 00900 HOUSEKEEPI NG		404, 059		9. 00
10. 00 01000 DI ETARY	-20, 801	171, 216		10. 00
11. 00 01100 CAFETERI A	-57, 455	329, 514		11. 00
12. 00 01200 MAI NTENANCE OF PERSONNEL	0	327, 314		12. 00
13. 00 01300 NURSING ADMINISTRATION		142, 156		13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY		142, 130		14. 00
15. 00 01500 PHARMACY	-750, 391	731, 486		15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY		701, 100		16. 00
17. 00 01700 SOCIAL SERVICE	ام	0		17. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	ام	0		19. 00
20. 00 02000 NURSI NG SCHOOL	ام	0		20. 00
21. 00 02100 I &R SERVI CES-SALARY & FRI	NGES APPRV 0	0		21. 00
22. 00 02200 1 &R SERVI CES-OTHER PRGM C		0		22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	0		23. 00
INPATIENT ROUTINE SERVICE COST		<u> </u>		20.00
30. 00 03000 ADULTS & PEDIATRICS	21, 083	2, 234, 251		30.00
43. 00 04300 NURSERY	0	213, 102		43. 00
44.00 04400 SKILLED NURSING FACILITY	0	0		44. 00
ANCI LLARY SERVI CE COST CENTERS		<u> </u>		00
50. 00 05000 OPERATING ROOM	0	1, 394, 094		50.00
52.00 05200 DELIVERY ROOM & LABOR ROO		857, 807		52. 00
53. 00 05300 ANESTHESI OLOGY	-776, 307	19, 426		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	1, 612, 698		54. 00
60. 00 06000 LABORATORY	l ol	1, 740, 433		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPH	ILIACS 0	0		62. 30
65. 00 06500 RESPIRATORY THERAPY	-73, 114	494, 622		65.00
66. 00 06600 PHYSI CAL THERAPY	-284, 834	233, 723		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	431, 790		67. 00
68.00 06800 SPEECH PATHOLOGY	0	114, 880		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 819		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED	TO PATIENT O	542, 363		71. 00
72.00 07200 I MPL. DEV. CHARGED TO PAT		200, 189		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 502, 588		73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	o	0		76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	ol	O		76. 98
76. 99 07699 LI THOTRI PSY	ol	O		76. 99
OUTPATIENT SERVICE COST CENTERS		'		
90. 00 09000 CLI NI C	0	121, 932		90.00
90. 01 09001 INTENSIVE OUT PATIENT PRO	GRAM O	0		90. 01
91. 00 09100 EMERGENCY	-4, 963	1, 589, 218		91.00
92.00 09200 OBSERVATION BEDS (NON-DIS				92.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0	1, 630, 568		95.00
SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			
118.00 SUBTOTALS (SUM OF LINES 1	-117) -7, 996, 268	35, 542, 729		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP	& CANTEEN O	31, 831		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFIC	ES -316, 266	70, 777		192. 00
194. 00 07950 OCCUPATI ONAL HEALTH	0	0		194. 00
194. 01 07951 PAIN CLINIC		O		194. 01
194. 02 07952 OAK POINTE		O		194. 02
194. 03 07953 FOUNDATI ON		332, 142		194. 03
194. 04 07954 COMMUNITY & VOLUNTEER SER	VICES 0	235, 179		194. 04
194. 05 07955 VACANT SPACE		0		194. 05
200. 00 TOTAL (SUM OF LINES 118-1	99) -8, 312, 534	36, 212, 658		200. 00
(22 21. 223 110 1	, , , , , , , , , , , , , , , , , , , ,		'	

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2015 To 12/31/2015 Date/Time Prepared: Provider CCN: 150101

					/2016 5: 11 pm
		Increases			
	Cost Center	Li ne #	Salary	Other	
	2. 00 A - CAFETERI A RECLASS	3. 00	4. 00	5. 00	
1. 00	CAFETERIA RECLASS	11. 00	232, 207	154, 762	1. 00
1.00	0		232, 207	154, 762	1.00
	B - OB RECLASS		202, 201	101, 702	
1.00	NURSERY	43.00	189, 725	20, 909	1. 00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	696, 368	76, 746	2. 00
	0		886, 093	97, 655	
	E - BUILDING AND EQUIP LEASE				
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	474, 864	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	48, 986	2. 00
3.00		0.00	0	0	3. 00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5. 00
6.00		0.00	0	0	6.00
7. 00 8. 00		0. 00 0. 00	0	0	7. 00 8. 00
9. 00		0.00	0	0	9.00
10. 00		0.00	0	0	10.00
12. 00		0.00	0	0	12. 00
13. 00		0.00	0	0	13. 00
14. 00		0.00	ol	Ö	14. 00
15. 00		0.00	O	O	15. 00
16.00		0.00	o	0	16. 00
17.00		0.00	0	0	17. 00
18.00		0.00	0	0	18. 00
	0		0	523, 850	
	G - INSURANCE RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	7, 584	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP		•	<u> </u>	2. 00
	0		0	46, 584	
	H - DEPRECIATION RECLASS	0.00		054 (50	1.00
1. 00	CAP REL COSTS-MVBLE EQUIP		•	954, 652	1. 00
	U		0	954, 652	
1. 00	CAP REL COSTS-MVBLE EQUIP	2.00	0	11, 070	1.00
1.00	n REL COSTS-WVBLE EQUIF			11, 070	1.00
	K - SALARY RECLASS		<u> </u>	11,070	
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0	3, 502, 775	1.00
	0			3, 502, 775	
	L - REHAB THERAPY DEPT RECLAS	S			
1.00	OCCUPATI ONAL THERAPY	67.00	415, 423	21, 913	1. 00
2.00	SPEECH PATHOLOGY	68. 00	107, 825	5, 688	2. 00
	0		523, 248	27, 601	
	M - DRUGS CHARGED TO PATIENT				
1.00	DRUGS CHARGED TO PATIENTS	73.00	•	<u>1, 509, 8</u> 71	1. 00
	0		0	1, 509, 871	
	N - PTO ACCRUAL RECLASS	5 00	20.45/		1.00
1.00	ADMINISTRATIVE & GENERAL	5. 00	98, 156	0	1.00
2.00	OPERATION OF PLANT	7. 00 9. 00	34, 811	0	2.00
3. 00 4. 00	HOUSEKEEPI NG DI ETARY	9. 00 10. 00	31, 732 41, 329	0	3. 00 4. 00
4. 00 5. 00	NURSING ADMINISTRATION	13. 00	41, 329	0	5. 00
6. 00	PHARMACY	15. 00	61, 807	0	6. 00
7. 00	ADULTS & PEDIATRICS	30.00	322, 473	Ö	7. 00
8.00	NURSERY	43.00	2, 468	Ö	8. 00
9. 00	OPERATING ROOM	50.00	112, 739	Ö	9. 00
10.00	DELIVERY ROOM & LABOR ROOM	52.00	17, 224	0	10.00
11.00	RADI OLOGY-DI AGNOSTI C	54.00	129, 017	0	11. 00
12.00	RESPI RATORY THERAPY	65. 00	54, 050	0	12. 00
13.00	PHYSI CAL THERAPY	66. 00	116, 087	0	13. 00
14.00	OCCUPATI ONAL THERAPY	67. 00	5, 268	0	14. 00
15.00	SPEECH PATHOLOGY	68.00	1, 367	0	15. 00
16.00	CLI NI C	90.00	10, 608	0	16.00
17. 00	EMERGENCY	91.00	156, 392	0	17. 00
18.00	AMBULANCE SERVICES	95.00	48, 808	0	18.00
19. 00	PHYSICIANS' PRIVATE OFFICES	192.00	1, 938 1, 250, 500	0	19. 00
	O - CLINIC DIETICIAN RECLASS		1, 230, 300	U	
1. 00	CLINIC DIETICIAN RECLASS	90.00	7, 778	Λ	1. 00
1.00	0		$-\frac{7,778}{7,778}$	<u>0</u>	1.00
	P - CORPORATE DIRECT ALLOC RE	CLASS	,,,,,	<u> </u>	
1.00	FOUNDATI ON	194. 03	26, 993	215, 149	1. 00
2.00	COMMUNITY & VOLUNTEER	194. 04	2, 619	20, 872	2. 00
	SERVI CES				
			•		· · · · · · · · · · · · · · · · · · ·

Heal th Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

RECLASSIFICATIONS Provider CCN: 150101 Period: From 01/01/2015 To 12/31/2015 Date/Time Prepared:

					To 12/31/2015 Date/Time Pr 5/19/2016 5:	epared:
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4. 00	5. 00		
	0		29, 612	236, 021		
	Q - OCCUPATIONAL HEALTH RECLA	SS				
1.00	OCCUPATI ONAL HEALTH	194. 00	0	112, 880		1. 00
2.00		0.00	0	0		2. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		000	0_	0		9. 00
	0		0	112, 880		_
	R - IMPLANTABLE MEDICAL SUPPL					
1.00	IMPL. DEV. CHARGED TO	72. 00	0	200, 189		1. 00
	PATI ENTS					
	0		0	200, 189		
500.00	Grand Total: Increases		2, 929, 438	7, 377, 910		500.00

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 01/01/2015 Date/Time Prepared: 5/19/2016 5:11 pm Provider CCN: 150101

					T	Date/Time Prepared: 5/19/2016 5:11 pm
		Decreases				 37 177 2010 3. 11 piii
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00	
	A - CAFETERI A RECLASS	7.00	8.00	9.00	10.00	
1.00	DI ETARY	10.00	232, 207	154, 762	0	1.00
	0		232, 207	154, 762		
	B - OB RECLASS				_1	
1. 00 2. 00	ADULTS & PEDIATRICS	30.00	886, 093	97, 655	0	1. 00 2. 00
2.00		0.00		<u>0</u> 97, 655		2.00
	E - BUILDING AND EQUIP LEASE		000, 070	77,000		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	54, 122		1.00
2.00	OPERATION OF PLANT	7. 00	0	97, 158		2. 00
3.00	RESPIRATORY THERAPY PHYSICAL THERAPY	65.00	0	69, 834	0	3.00
4. 00 5. 00	ADMINISTRATIVE & GENERAL	66. 00 5. 00	0	253, 749 17, 287	0	4. 00 5. 00
6. 00	OPERATION OF PLANT	7. 00	ő	1, 413	o	6. 00
7.00	HOUSEKEEPI NG	9. 00	О	376	0	7. 00
8.00	DIETARY	10.00	0	721	0	8. 00
9. 00 10. 00	PHARMACY ADULTS & PEDIATRICS	15. 00 30. 00	0	11, 506	0	9. 00 10. 00
10.00	OPERATING ROOM	50. 00	0	3, 362 1, 504	0	12. 00
13. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	2, 403	Ö	13. 00
14.00	RESPI RATORY THERAPY	65. 00	0	923	0	14. 00
15. 00	PHYSI CAL THERAPY	66.00	0	1, 758	0	15. 00
16.00	EMERGENCY	91. 00 95. 00	0	2, 817	0	16.00
17. 00 18. 00	AMBULANCE SERVICES PHYSICIANS' PRIVATE OFFICES	192. 00	0	2, 446 2, 471	0	17. 00 18. 00
10.00	0			523, 850	— — —	10.00
	G - INSURANCE RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	46, 584	12	1. 00
2.00		0.00		0	12	2. 00
	H - DEPRECIATION RECLASS		υĮ	46, 584		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	954, 652	9	1.00
	0			954, 652		
	J - TAXES RECLASS					
1. 00	CAP REL COSTS-BLDG & FIXT	1.00		1 <u>1, 0</u> 70 11, 070		1.00
	K - SALARY RECLASS		O ₁	11,070		
1.00	ADMI NI STRATI VE & GENERAL	5.00	3, 502, 775	0	0	1.00
	0		3, 502, 775	0		
1 00	L - REHAB THERAPY DEPT RECLASS PHYSICAL THERAPY		F22 240	27 (01	0	1 00
1. 00 2. 00	PHYSICAL THERAPY	66. 00 0. 00	523, 248 0	27, 601 0	0	1. 00 2. 00
2.00			523, 248	_{27,601}		2.00
	M - DRUGS CHARGED TO PATIENT F	RECLASS		·		
1.00	PHARMACY	1500		1, 509, 871	0	1. 00
	N - PTO ACCRUAL RECLASS		0	1, 509, 871		
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	1, 250, 500	0	0	1.00
2.00	EMILEGIEE BENEFITIS BELYKKIMENT	0. 00	0	0		2. 00
3.00		0. 00	0	0		3. 00
4.00		0.00	0	0	0	4. 00
5. 00 6. 00		0. 00 0. 00	0	0	0	5. 00 6. 00
7. 00		0.00	0	0		7. 00
8.00		0.00	o	0	0	8. 00
9.00		0.00	0	0	0	9. 00
10.00		0.00	0	0	0	10.00
11. 00 12. 00	1	0. 00 0. 00	0	0	0	11. 00 12. 00
13. 00		0.00	0	0	0	13. 00
14. 00		0. 00	ő	0	0	14. 00
15.00		0. 00	O	0	0	15. 00
16.00		0.00	0	0	0	16.00
17. 00 18. 00	1	0. 00 0. 00	O	0	0	17. 00 18. 00
19. 00		0.00	ol	0	0	19. 00
	0		1, 250, 500			 20
_	O - CLINIC DIETICIAN RECLASS					
1. 00	DI ETARY			$ \frac{0}{0}$	0	1.00
	P - CORPORATE DIRECT ALLOC REC	CLASS	7, 778	0		
1. 00	ADMINISTRATIVE & GENERAL	5. 00	29, 612	236, 021	0	1.00
2.00		0.00	0_	0	0	2. 00
	0		29, 612	236, 021		

Health Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 150101 Period: Worksheet A-6

01 Period: Worksheet A-6 From 01/01/2015 To 12/31/2015 Date/Time Prepared:

						5/19/2016 5:1	11 pm		
		Decreases							
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.				
	6. 00	7. 00	8. 00	9. 00	10. 00				
	Q - OCCUPATIONAL HEALTH RECLASS								
1.00	RADI OLOGY-DI AGNOSTI C	54.00	0	51, 890	0		1. 00		
2.00	LABORATORY	60.00	0	393	0		2. 00		
4.00	PHYSI CAL THERAPY	66.00	0	7, 937	0		4. 00		
5.00	OCCUPATI ONAL THERAPY	67. 00	0	10, 814	0		5. 00		
6.00	ELECTROCARDI OLOGY	69. 00	0	440	0		6. 00		
7.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	781	0		7. 00		
	PATI ENT								
8.00	DRUGS CHARGED TO PATIENTS	73. 00	0	7, 283	0		8. 00		
9.00	EMERGENCY	91. 00	0	33, 342	0		9. 00		
	0 — — — — —		<u> </u>	112, 880					
	R - IMPLANTABLE MEDICAL SUPPL	.I ES					1		
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	200, 189	0		1. 00		
	PATI ENT								
	0		0	200, 189					
500.00	Grand Total: Decreases		6, 432, 213	3, 875, 135			500.00		
	•	•							

				Т	o 12/31/2015	Date/Time Prep 5/19/2016 5:1	
				Acqui si ti ons		07 177 2010 0. 1	, p
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						1
1.00	Land	16, 206	244, 770	[C	244, 770	0	1. 00
2.00	Land Improvements	44, 862	235, 051	[C	235, 051	0	2. 00
3.00	Buildings and Fixtures	1, 119, 257	0	C	0	0	3. 00
4.00	Building Improvements	48, 824	0	C	0	0	4. 00
5.00	Fixed Equipment	591, 413	26, 650		26, 650		5. 00
6.00	Movable Equipment	10, 446, 940	548, 936		548, 936		6. 00
7.00	HIT designated Assets	3, 195, 753	215, 055		215, 055		7. 00
8.00	Subtotal (sum of lines 1-7)	15, 463, 255	1, 270, 462		1, 270, 462		8. 00
9.00	Reconciling Items	3, 195, 753	119, 019	C	119, 019	0	9. 00
10.00	Total (line 8 minus line 9)	12, 267, 502	1, 151, 443	C	1, 151, 443	212, 037	10. 00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	T	6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	260, 976	0				1. 00
2.00	Land Improvements	279, 913	44, 862				2. 00
3.00	Buildings and Fixtures	1, 119, 257	237, 338				3. 00
4.00	Building Improvements	48, 824	42, 430				4. 00
5.00	Fi xed Equipment	618, 063	25, 981				5. 00
6.00	Movable Equipment	10, 783, 839	4, 130, 476				6. 00
7.00	HIT designated Assets	3, 410, 808	0				7. 00
8.00	Subtotal (sum of lines 1-7)	16, 521, 680	4, 481, 087				8. 00
9.00	Reconciling Items	3, 314, 772	0				9. 00
10. 00	Total (line 8 minus line 9)	13, 206, 908	4, 481, 087			l	10.00

Heal th	Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lieu of Form CMS-2552-10		
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150101	Peri od:	Worksheet A-7	
					From 01/01/2015		
					To 12/31/2015	Date/Time Prep 5/19/2016 5:1	
			SI	JMMARY OF CAP	I TAI	37 177 2010 3. 1	ı pili
	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 WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	3, 126, 340	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	3, 126, 340	0		0 0	0	3. 00
		SUMMARY OF	F CAPITAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)	45.00				
	DART II DECONOLILATION OF AMOUNTS FROM WORK	14.00	15. 00	1.0			
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUMI					
1.00	CAP REL COSTS-BLDG & FLXT	0	3, 126, 340				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3. 00	Total (sum of lines 1-2)	0	3, 126, 340	l			3. 00

Health Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2015 To 12/31/2015	Worksheet A-7 Part III Date/Time Prep 5/19/2016 5:1	
	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	instructions)		
			2)			
DART III DECONCILIATION OF CARITAL COCTO C	1. 00	2. 00	3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CO	5, 522, 786		5, 522, 78	6 0. 342672	0	1. 00
2.00 CAP REL COSTS-BLDG & FIXT	10, 998, 895				0	2. 00
3.00 Total (sum of lines 1-2)	16, 521, 681	404, 835			0	3. 00
5. 66 Total (Sain of Tritics 1 2)		TION OF OTHER (SUMMARY 0		0.00
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
	/ 00	d Costs 7.00	through 7) 8.00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	6.00	7.00	8.00	9.00	10.00	
1.00 CAP REL COSTS-BLDG & FIXT	INTERS	0		75, 108	474, 864	1. 00
2. 00 CAP REL COSTS-MVBLE EQUIP	0	0		941, 718	48, 986	2. 00
3.00 Total (sum of lines 1-2)	Ö	Ö		1, 016, 826	523, 850	3. 00
		Sl	JMMARY OF CAPI		,	
0 1 0 1 0 1 1		lı	T = /	011	T (0) (
Cost Center Description	Interest	Insurance (see		Other Capi tal -Rel ate	Total (2) (sum of cols. 9	
		I IISTI UCTI OIIS)	Instructions)	d Costs (see	through 14)	
				instructions)	tili ougii 14)	
	11.00	12.00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C	NTERS					
1.00 CAP REL COSTS-BLDG & FLXT	0	7, 584			546, 486	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	39, 000	·		1, 040, 774	2.00
3.00 Total (sum of lines 1-2)	0	46, 584		0	1, 587, 260	3. 00

				11	0 12/31/2015	Date/lime Prep 5/19/2016 5:1	
				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00	5. 00 0	1. 00
1.00	COSTS-BLDG & FIXT (chapter 2)		0	NEE GOSTO BEBG & TIXI	1.00	Ĭ	1. 00
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	0	3. 00
3.00	(chapter 2)		0		0.00		3.00
4.00	Trade, quantity, and time		0		0.00	0	4. 00
Г 00	di scounts (chapter 8)		0		0.00		F 00
5. 00	Refunds and rebates of expenses (chapter 8)		Ü		0.00	0	5. 00
6.00	Rental of provider space by		0		0.00	o	6. 00
	suppliers (chapter 8)		_			_	
7. 00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7. 00
	21)						
8.00	Television and radio service	A	-289	OPERATION OF PLANT	7. 00	0	8.00
0.00	(chapter 21)		0		0.00		0.00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-11, 742		0.00	0	9. 00 10. 00
10.00	adjustment	A 0 2	11, 742			Ĭ	10.00
11. 00	Sale of scrap, waste, etc.		0		0.00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	2 722 225			0	12. 00
12.00	transactions (chapter 10)	A-0-1	-3, 733, 335			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14. 00	Cafeteria-employees and guests		-23, 664	CAFETERI A	11. 00	1	14. 00
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00
16. 00	Sale of medical and surgical		0		0.00	О	16. 00
	supplies to other than						
17 00	patients Sale of drugs to other than		0		0.00	0	17 00
17. 00	patients		U		0.00	U	17. 00
18. 00	Sale of medical records and		0		0.00	o	18.00
40.00	abstracts		•		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						
22.00	repay Medicare overpayments	4.0.2	0	DECDI DATODY THEDADY	/F 00		22.00
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation						
0/ 00	(chapter 21)		•	OAR REL COCTO RIPO A FLYT	4 00		04 00
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	o	27. 00
	COSTS-MVBLE EQUIP						
28. 00 29. 00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28. 00 29. 00
30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00	1	30.00
	therapy costs in excess of		0		37.00		
20.00	limitation (chapter 14)		=	ADULTO A DESCATOLOS	22.55		20.00
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of						
22.00	limitation (chapter 14)		0		0.00	0	32. 00
32. 00	CAH HIT Adjustment for Depreciation and Interest		Ü		0.00		32. UU
33. 00	MI SCELLANEOUS REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00		33. 00
33. 01	ER ADMINISTRATIVE SERVICES ADJ	Α	2, 135	EMERGENCY	91. 00	0	33. 01

) 12/31/2015	5/19/2016 5:1	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	·	1.00	2. 00	3.00	4. 00	5. 00	
34. 01			0		0.00	0	34. 01
35.00	POSTURE ASSESSMENTS	В	-31, 085	PHYSI CAL THERAPY	66.00	0	35. 00
36.00	TELEMETRY ADJUSTMENT	A	21, 083	ADULTS & PEDIATRICS	30.00	0	36. 00
38.00	NON-PATIENT LAB REV.	В	-3, 280	RESPIRATORY THERAPY	65.00	0	38. 00
39.00	TELEVISION OFFSET	A	-12, 934	CAP REL COSTS-MVBLE EQUIP	2.00	9	39. 00
40.00	ANSWERING SERVICE	A	-1, 897	ADMINISTRATIVE & GENERAL	5. 00	0	40.00
41.00	PHYSICIAN RECRUITING	A	-25, 000	ADMINISTRATIVE & GENERAL	5. 00	0	41.00
42. 00	MEALS ON WHEELS	A	-	DI ETARY	10.00	0	42.00
43. 00	VISITOR MEALS	A		CAFETERI A	11. 00	0	43. 00
44. 00	PHARMACY SALES	A		PHARMACY	15. 00	0	44. 00
45. 00	COMMUNITY HEALTH & VOLUNTEER	A		ADMINISTRATIVE & GENERAL	5. 00	0	45. 00
	SV		,			_	
46.00	SELF INSURANCE	A	-1, 884, 436	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	46. 00
48. 00	LOBBY EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	48. 00
48. 01	INTERUNIT RENT EXPENSE	A		RESPIRATORY THERAPY	65.00	0	48. 01
48. 02	INTERUNIT RENT EXPENSE	A		PHYSI CAL THERAPY	66.00	0	48. 02
48. 03	INTERUNIT RENT EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	48. 03
48. 04	INTERUNIT RENT EXPENSE	A		OPERATION OF PLANT	7. 00	0	48. 04
49. 00			0		0.00	0	49. 00
49. 02	RENT EXPENSE - PHYSICIANS'	A	-316, 266	PHYSICIANS' PRIVATE OFFICES	192.00	0	49. 02
	CLINIC		2.27.222			_	
49. 03			0		0.00	0	49. 03
49. 05			0		0.00	0	49. 05
49. 07	NON-ALLOWABLE ANESTHESIA PROF	A	-771, 663	ANESTHESI OLOGY	53.00	0	49. 07
	SVCS		,				
49. 10	HOSPITALIST / SURGERY ON CALL	A	-216, 944	ADMINISTRATIVE & GENERAL	5. 00	0	49. 10
50. 00			-8, 312, 534				50.00
	(Transfer to Worksheet A,		-,-,-				
	column 6, line 200.)						
							50.0

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

* 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 PARKVI EW HEALTH 100. 00	6. 00
7.00		0.00	7. 00
8.00		0.00	8. 00
9.00		0.00	9. 00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

Worksheet A-8, column 2,

line 12.

- 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.

Heal th	Financial Syste	ems		WHI	TLEY MEMORIAL	HOSPI TAL		In Lie	u of Form CMS	-2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED (ORGANI ZATI C	NS AND HOME	Provi der	CCN: 150101	Peri od: From 01/01/2015	Worksheet A-	8-1
011102								To 12/31/2015	Date/Time Pr 5/19/2016 5:	epared: 11 pm
	Net	Wkst. A-7 Ref.								
	Adjustments									
	(col. 4 minus									
	col. 5)*									
	6. 00	7. 00								
	A. COSTS INCUR	RED AND ADJUST	MENTS REQ	UIRED AS A	RESULT OF TRA	NSACTIONS V	VITH RELATED	ORGANIZATIONS OR	CLAIMED	
	HOME OFFICE CO	STS:								
1.00	-2, 096, 580	ç								1. 00
2.00	-5, 316, 673	(2. 00
3.00	3, 679, 918	l c								3.00
4.00	0									4. 00
5.00	-3, 733, 335									5. 00
* The	amounts on line	es 1-4 (and sul	nscrints a	as annronri	ate) are trans	ferred in	detail to Wor	rksheet 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.

nas not	been posted to worksheet A,	cordinals i and/or 2, the amount arrowable should be indicated in cordinal 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	TED 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.

	HOME OFFICE	6. 00
7.00		7. 00
8.00		8. 00
8. 00 9. 00		9. 00
10.00		10.00
10. 00 100. 00		100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related 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 01/01/2015 | To 12/31/2015 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 150101

								То	12/31/2015	Date/Time Pre 5/19/2016 5:1	
	Wkst. A Line #		Cost	Center/Physician	Total	Professi onal	Provi der		RCE Amount	Physi ci an/Prov	ı pııı
				Identi fi er	Remuneration	Component	Component			ider Component	
						i i	'			Hours	
	1. 00			2. 00	3. 00	4. 00	5. 00		6. 00	7. 00	
1.00	91. 00				26, 051		26, 05	1	171, 400	230	1. 00
2.00	53. 00	DR.	В		24, 000)	24, 00	0	200, 300	201	2.00
3.00	0. 00				0)	1	0	0	0	3. 00
4.00	0. 00				0)		0	0	0	4.00
5.00	0. 00				0)	1	0	0	0	5. 00
6.00	0. 00				0)		0	0	0	6.00
7.00	0. 00				0)		0	0	0	7. 00
8.00	0. 00				0)		0	0	0	8. 00
9.00	0. 00				0)		0	0	0	9. 00
10.00	0. 00				0)		0	0	0	10. 00
200.00			_		50, 051		50, 05	1		431	200. 00
	Wkst. A Line #		Cost	Center/Physician	Unadjusted RCE		Cost of			Physician Cost	
				Identi fi er	Limit		Memberships &			of Mal practice	
						Limit	Continuing	Si	hare of col.	Insurance	
	1. 00			2. 00	8. 00	9. 00	Education 12.00	-	12 13. 00	14. 00	
1.00	91.00	DD	Λ	2.00	18, 953			0	13.00	14.00	1. 00
2.00	53.00				19, 356				0	0	2. 00
3.00	0.00	DIV.	D		17, 330) 700		ol	0	0	3. 00
4. 00	0.00							o	0	0	4. 00
5. 00	0.00							o	0	o O	5. 00
6. 00	0.00							ol o	0	0	6. 00
7. 00	0.00							ol	0	Ő	7. 00
8. 00	0.00							ol	0	Ö	8. 00
9. 00	0. 00							o	0	o o	9. 00
10.00	0.00							o	0	o o	10.00
200.00	5. 5.				38, 309	1, 916		ol	0	o	
	Wkst. A Line #		Cost	Center/Physician	Provi der	Adjusted RCE	RCE		Adjustment		
				Identi fi er	Component	Limit	Di sal I owance		,		
					Share of col.						
					14						
	1. 00			2. 00	15. 00	16. 00	17. 00		18. 00		
1.00	91. 00				0	10,700			7, 098		1. 00
2.00	53. 00	DR.	В		0	19, 356			4, 644		2.00
3.00	0. 00				0)		0	0		3.00
4.00	0. 00				0)		0	0		4. 00
5.00	0. 00				0) (1	0	0		5. 00
6.00	0. 00				0) (0	0		6.00
7. 00	0. 00				0) (0	0		7. 00
8. 00	0. 00				0)		0	0		8. 00
9. 00	0. 00				0)	0	0		9. 00
10. 00	0. 00				0) ()	0	0		10. 00
200.00					0	38, 309	11, 74	2	11, 742		200.00

Provi der CCN: 150101 COST ALLOCATION - GENERAL SERVICE COSTS Peri od: Worksheet B From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/19/2016 5:11 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFLTS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 546, 486 1 00 00100 CAP REL COSTS-BLDG & FLXT 546, 486 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 1,040,774 1, 040, 774 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 2, 169, 005 2, 169, 005 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 13, 798, 190 105, 471 200 867 14, 780, 940 5 00 676, 412 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 1, 114, 162 57, 885 110, 241 41, 321 1, 323, 609 7.00 00800 LAUNDRY & LINEN SERVICE 160, 178 2, 705 5, 151 168, 034 8.00 8.00 00900 HOUSEKEEPI NG 9 00 404.059 2. 261 4.305 37 569 448, 194 9 00 10.00 01000 DI ETARY 171, 216 9, 691 18, 456 17, 379 216, 742 10.00 01100 CAFETERI A 10, 928 11.00 329, 514 20, 813 30, 530 391, 785 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 n 01300 NURSING ADMINISTRATION 13.00 142, 156 659 1 254 18.481 162, 550 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 7,824 14, 902 22, 726 14.00 12, 915 01500 PHARMACY 15.00 731, 486 6, 782 73, 178 824, 361 15.00 01600 MEDICAL RECORDS & LIBRARY 2, 410 7,000 4, 590 16,00 0 0 16,00 17 00 01700 SOCIAL SERVICE 0 0 0 0 17 00 C 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 19.00 19.00 0 20.00 02000 NURSING SCHOOL 0 0 0 0 O 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 21.00 0 0 21.00 0 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 C 0 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 2, 234, 251 262, 844 2, 804, 536 30.00 105.849 201, 592 43.00 04300 NURSERY 213, 102 0 25, 269 238, 371 43.00 04400 SKILLED NURSING FACILITY 44.00 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 394, 094 63, 215 120, 391 133, 479 1, 711, 179 50 00 05200 DELIVERY ROOM & LABOR ROOM 52.00 857, 807 102, 408 960, 215 52.00 53.00 05300 ANESTHESI OLOGY 19, 426 0 19, 426 53.00 05400 RADI OLOGY-DI AGNOSTI C 1, 612, 698 48.449 92, 270 1, 906, 492 54 00 153,075 54 00 60.00 06000 LABORATORY 1, 740, 433 14,806 28, 197 1, 783, 436 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 62.30 06500 RESPIRATORY THERAPY 494, 622 11, 707 22, 295 63, 993 592, 617 65.00 65.00 06600 PHYSI CAL THERAPY 66, 502 66.00 233, 723 39, 741 75, 686 415, 652 66.00 67.00 06700 OCCUPATI ONAL THERAPY 431, 790 0 55, 312 487, 102 67.00 68.00 06800 SPEECH PATHOLOGY 114,880 0 14, 356 129, 236 68.00 06900 ELECTROCARDI OLOGY 0 1, 819 69 00 1 819 Ω 0 69 00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 542, 363 C 0 0 542, 363 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 200, 189 0 0 200, 189 72.00 73.00 0 07300 DRUGS CHARGED TO PATIENTS 1,502,588 0 0 1, 502, 588 73.00 07697 CARDIAC REHABILITATION 76 97 0 76 97 Ω 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 C 0 0 0 76.98 07699 LI THOTRI PSY 76. 99 76.99 0 0 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 121, 932 17.939 34, 165 13, 582 187, 618 90 00 90.01 09001 INTENSIVE OUT PATIENT PROGRAM 90.01 0 1, 879, 456 1, 589, 218 91.00 09100 EMERGENCY 35, 305 67, 238 187, 695 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 1, 630, 568 0 0 184, 695 1, 815, 263 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 35, 542, 729 543, 627 1, 035, 328 2. 158. 080 35, 523, 499 118. 00 118.00 NONREI MBURSABLE COST CENTERS 36, 005 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 31,831 1, 437 2, 737 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 73, 072 192. 00 70.777 2, 295 C 0 194. 00 07950 OCCUPATI ONAL HEALTH 0 0 194, 00 0 Ω 0 194. 01 07951 PAIN CLINIC 0 0 0 0 194. 01 0 194. 02 07952 OAK POINTE 0 0 194. 02 194. 03 07953 FOUNDATI ON 335, 691 194. 03 332, 142 0 3.549 244, 391 194. 04 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 235, 179 1, 422 2.709 5.081 194. 05 07955 VACANT SPACE 0 194. 05 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201, 00 202.00 TOTAL (sum lines 118-201) 36, 212, 658 546, 486 1, 040, 774 2, 169, 005 36, 212, 658 202. 00

						5/19/2016 5:1	
	Cost Center Description	ADMI NI STRATI VE		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		<u>& GENERAL</u> 5. 00	REPAI RS 6. 00	PLANT 7.00	LINEN SERVICE 8.00	9. 00	
	GENERAL SERVICE COST CENTERS	3.00	0.00	7.00	8.00	9.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						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	14, 780, 940	,				5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	0				6. 00
7. 00	00700 OPERATION OF PLANT	912, 861	0	2, 236, 470			7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	115, 889	0	15, 788			8. 00
9.00	00900 HOUSEKEEPI NG	309, 109	0	13, 195		770, 498	9.00
10.00	01000 DI ETARY	149, 482	0	56, 569		19, 745	•
11. 00 12. 00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL	270, 205	0	63, 793 0	0	22, 266 0	•
13. 00	01300 NURSING ADMINISTRATION	112, 107	0	3, 845	0	1, 342	12. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	15, 674	0	45, 674	0	15, 942	14.00
15. 00	01500 PHARMACY	568, 542	0	39, 586	0	13, 817	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	4, 828	Ö	14, 069	o o	4, 911	
17. 00	01700 SOCI AL SERVI CE	0	Ö	0	o O	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20.00	02000 NURSI NG SCHOOL	0	0	0	0	0	20. 00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	4 004 045		/47.005	47.540	045 (/5	1 00 00
30.00	03000 ADULTS & PEDI ATRI CS	1, 934, 215	0	617, 885		215, 665	30.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	164, 399	0	0	17, 516	0	43. 00 44. 00
44.00	ANCI LLARY SERVICE COST CENTERS	0	U	0	U	0	44.00
50. 00	05000 OPERATING ROOM	1, 180, 159	0	369, 007	50, 079	128, 798	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	662, 237	Ö	0		0	52.00
53.00	05300 ANESTHESI OLOGY	13, 398	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 314, 862	0	282, 814	44, 272	98, 713	54.00
60.00	06000 LABORATORY	1, 229, 993	0	86, 426	262	30, 166	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	408, 714	0	68, 337		23, 852	65. 00
66. 00	06600 PHYSI CAL THERAPY	286, 665	0	231, 984		80, 971	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	335, 943	0	0	,	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	89, 131	0	0	2, 673	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	1, 255	0	0	0	0	69.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	374, 055	0	0	0	0	71.00
72.00	07300 DRUGS CHARGED TO PATIENTS	138, 066 1, 036, 299	0	0	0	0	72. 00 73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	1,030,244	0	0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	Ö	0	o O	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	129, 396	0	104, 719	2, 334	36, 551	90.00
	09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0	_	0	90. 01
91. 00	09100 EMERGENCY	1, 296, 216	0	206, 088	66, 891	71, 933	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
05.00	OTHER REIMBURSABLE COST CENTERS	1 251 042	0	0	12 214	0	05.00
95. 00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	1, 251, 943	0	0	13, 214	0	95. 00
118.00		14, 305, 643	0	2, 219, 779	299, 711	764, 672	118 00
110.00	NONREI MBURSABLE COST CENTERS	14, 303, 043	0	2,217,117	2//, ///	704, 072	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	24, 832	0	8, 389	0	2, 928	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	50, 396		. 0	0	0	192. 00
194.00	07950 OCCUPATIONAL HEALTH	0	0	0	0	0	194. 00
194.01	07951 PAIN CLINIC	0	0	0	0	0	194. 01
	07952 OAK POINTE	0	0	0	0	0	194. 02
	07953 FOUNDATI ON	231, 518	0	0	0		194. 03
	07954 COMMUNITY & VOLUNTEER SERVICES	168, 551	0	8, 302	0		194. 04
	07955 VACANT_SPACE	0	0	0	0	0	194. 05
200.00		_	_	_		_	200. 00
201.00		14 700 010	0	0	0 744		201.00
202.00	TOTAL (sum lines 118-201)	14, 780, 940	0	2, 236, 470	299, 711	770, 498	1202. UU

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						10 12/31/2015	5/19/2016 5:1	
		Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL) Dill
		·			PERSONNEL	ADMI NI STRATI ON	SERVICES &	
							SUPPLY	
	T		10. 00	11. 00	12. 00	13. 00	14. 00	
4 00		AL SERVICE COST CENTERS			T			4 00
1.00		CAP REL COSTS BLDG & FIXT						1.00
2.00	1	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 6. 00	1	ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS						5. 00 6. 00
7. 00		OPERATION OF PLANT						7.00
8.00	1	LAUNDRY & LINEN SERVICE						8.00
9. 00		HOUSEKEEPING					1	9. 00
10.00	1	DI ETARY	442, 538					10.00
11. 00	1	CAFETERI A	0	748, 049				11. 00
12.00	1	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	0	8, 526		288, 370		13. 00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	(0	100, 016	14. 00
15.00		PHARMACY	0	24, 681		0	3, 788	15. 00
16. 00		MEDICAL RECORDS & LIBRARY	0	0	(0	0	16. 00
17. 00	1	SOCIAL SERVICE	0	0		0	0	17. 00
19. 00	1	NONPHYSICIAN ANESTHETISTS	0	0	(0	0	19. 00
20. 00		NURSI NG SCHOOL	0	0	(0	0	20. 00
21. 00	1	I &R SERVICES-SALARY & FRINGES APPRV	0	0		0	0	21. 00
22. 00	1	I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	•	0	0	
23. 00		PARAMED ED PRGM-(SPECIFY)	U	0		0	0	23. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	442, 538	129, 237	Ι ,	105, 662	8, 056	30.00
43. 00		NURSERY	442, 538	13, 013		0 103, 002	1, 294	1
44. 00		SKILLED NURSING FACILITY	o	13, 013			0	44. 00
		LARY SERVICE COST CENTERS	31			<u>, </u>		
50.00		OPERATI NG ROOM	0	70, 003		57, 234	52, 766	50. 00
52.00		DELIVERY ROOM & LABOR ROOM	0	52, 054		42, 558	4, 872	1
53.00	05300	ANESTHESI OLOGY	0	0		0	0	53. 00
54.00	05400	RADI OLOGY-DI AGNOSTI C	0	86, 607		0	4, 757	54. 00
60.00	06000	LABORATORY	0	0	(0	0	60.00
62. 30		BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0	62. 30
65. 00	1	RESPI RATORY THERAPY	0	37, 245	1	0	4, 085	1
66. 00	1	PHYSI CAL THERAPY	0	44, 425		0	810	•
67. 00	1	OCCUPATIONAL THERAPY	0	21, 091		0	863	1
68. 00	1	SPEECH PATHOLOGY	0	5, 385	1	0	224	•
69. 00 71. 00	1	ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)		0 0	69. 00 71. 00
71.00	1	IMPL. DEV. CHARGED TO PATIENTS	0	0)			71.00
73. 00		DRUGS CHARGED TO PATTENTS	0	0				73.00
76. 97		CARDI AC REHABI LI TATI ON	0	0		0	ĺ	76. 97
76. 98	1	HYPERBARI C OXYGEN THERAPY	o	0		0	Ö	76. 98
76. 99	1	LI THOTRI PSY	0	0		0	0	76. 99
	OUTPA	TIENT SERVICE COST CENTERS						
90.00		CLI NI C	0	7, 180		0		90. 00
	09001	INTENSIVE OUT PATIENT PROGRAM	0	0	(0	0	90. 01
		EMERGENCY	0	101, 415		82, 916	9, 553	1
92. 00		OBSERVATION BEDS (NON-DISTINCT PART						92. 00
		REI MBURSABLE COST CENTERS			T		5 700	
95. 00		AMBULANCE SERVICES	0	0	(0	5, 782	95. 00
110 00		AL PURPOSE COST CENTERS	442 520	400.043	1 ,	200 270	07.012	110 00
118. 00		SUBTOTALS (SUM OF LINES 1-117) IMBURSABLE COST CENTERS	442, 538	600, 862		288, 370	97, 913	118. 00
100 00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	o	135, 969		0	1 025	190. 00
		PHYSICIANS' PRIVATE OFFICES	0	3, 141				192. 00
	1	OCCUPATIONAL HEALTH	0	3, 141	1			194. 00
		PAIN CLINIC	٥	0				194. 01
		OAK POINTE	ol	0		ol o		194. 02
	1	FOUNDATI ON	0	4, 487		o	l e	194. 03
		COMMUNITY & VOLUNTEER SERVICES	О	3, 590		0		194. 04
		VACANT SPACE	О	0		0	0	194. 05
200.00	1	Cross Foot Adjustments						200. 00
201.00	1	Negative Cost Centers	0	0	1	0		201. 00
202. 00	기	TOTAL (sum lines 118-201)	442, 538	748, 049	1	288, 370	100, 016	J202. 00

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				1	0 12/31/2015	5/19/2016 5:1	
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS	NURSI NG SCHOOL)
		15. 00	16. 00	17. 00	19. 00	20.00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6. 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						11. 00
12.00	01200 MAINTENANCE OF PERSONNEL						12. 00
13.00	01300 NURSING ADMINISTRATION						13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15.00	01500 PHARMACY	1, 474, 775					15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	30, 808	3			16. 00
17.00	01700 SOCIAL SERVICE	0	0	0			17. 00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	,	19. 00
20.00	02000 NURSI NG SCHOOL	O	0	0		0	20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	o	0	o o			21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	O	O	0			22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	o	0	ol o			23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>					
30. 00		16	3, 133	8 0	0	0	30.00
43. 00		O	749		0	0	43.00
44. 00	+ I	o	0	1	0		44.00
	ANCILLARY SERVICE COST CENTERS					_	
50.00		94	518	8 0	0	0	50.00
52. 00	I I	o	0	1	0		52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 216	12, 940		0	Ö	54. 00
60. 00	06000 LABORATORY	0	, , , , ,		_	Ö	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0	62. 30
65. 00	1 1	6	0		0	Ö	65. 00
66. 00	06600 PHYSI CAL THERAPY	421	2, 831	ا م	0	Ö	66. 00
67. 00	1 1	0	1, 004	1	0	Ö	67. 00
68. 00	+ +		388	1	0	Ö	68. 00
69. 00	+ +		300		0	Ö	69.00
71. 00	+ +		0		0	Ö	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0		0	Ö	72.00
73. 00	· · · · · · · · · · · · · · · · · · ·	1, 466, 254	0		0	Ö	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 400, 234	0		0	Ö	76. 97
76. 98	+ +		0		0	Ö	76. 98
76. 99			0		0	Ö	76. 99
70. 77	OUTPATIENT SERVICE COST CENTERS	U) 0	0	0	70. 99
90. 00		31	0	0	0	0	90.00
	09001 INTENSIVE OUT PATIENT PROGRAM		0				1
	09100 EMERGENCY	91	9, 245		_		91.00
		91	9, 240		0	0	91.00
92. 00							92.00
05 00	OTHER REIMBURSABLE COST CENTERS	(() (0	0	0	05 00
95.00	09500 AMBULANCE SERVICES	6, 646	0) 0	0	1 0	95. 00
110 0	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	1 474 775	20.000				110 00
118. 00		1, 474, 775	30, 808	8 0	0		118. 00
100.00	NONREI MBURSABLE COST CENTERS						100 00
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
	0 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	1			192. 00
	07950 OCCUPATIONAL HEALTH	0	Ü	0			194. 00
	1 07951 PAIN CLINIC		0	0	0		194. 01
	2 07952 OAK POI NTE	0	0	0	0		194. 02
	3 O7953 FOUNDATION	0	O	0	0		194. 03
	4 07954 COMMUNITY & VOLUNTEER SERVICES	0	0	0	0		194. 04
	5 07955 VACANT SPACE	0	0) 0	0		194. 05
200.00	1 1				0		200. 00
201.00		0	0	0			201. 00
202. 00	TOTAL (sum lines 118-201)	1, 474, 775	30, 808	8 0	0	0	202. 00

Health Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150101 Peri od: Worksheet B From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/19/2016 5:11 pm INTERNS & RESIDENTS Cost Center Description SERVI CES-SALAR SERVI CES-OTHER PARAMED ED Subtotal Intern & Y & FRINGES PRGM COSTS Residents Cost PRGM **APPRV APPRV** & Post Stepdown Adjustments 21. 00 22.00 23. 00 24. 00 25. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16,00 17 00 01700 SOCIAL SERVICE 17 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 20.00 02000 NURSING SCHOOL 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 21.00 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 C 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 30.00 0 0 0 6, 277, 485 0 0 43.00 04300 NURSERY C 0 435, 342 0 43.00 04400 SKILLED NURSING FACILITY 0 44.00 0 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 3, 619, 837 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 1, 786, 227 52.00 53.00 05300 ANESTHESI OLOGY 000000000000000 0 0 32.824 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54 00 3, 752, 673 0 54 00 0 60.00 06000 LABORATORY 0 3, 130, 283 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0 0 62.30 06500 RESPIRATORY THERAPY 0 0 65.00 1, 136, 526 65.00 06600 PHYSI CAL THERAPY 0 0 66.00 1, 073, 424 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 856, 305 0 67.00 68.00 06800 SPEECH PATHOLOGY 227, 037 68.00 06900 ELECTROCARDI OLOGY 0 0 69 00 3 074 0 69 00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 C 916, 418 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 338, 255 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 4,005,141 0 73.00 07697 CARDIAC REHABILITATION 0 76 97 76 97 0 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 76.98 07699 LI THOTRI PSY 0 0 0 76. 99 76.99 0 0 OUTPATIENT SERVICE COST CENTERS 90 00 90 00 09000 CLI NI C 0 0 0 468.892 0 90.01 09001 INTENSIVE OUT PATIENT PROGRAM 0 0 0 0 90.01 0 91.00 09100 EMERGENCY 0 3, 723, 804 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 3, 092, 848 0 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 118.00 0 0 0 34, 876, 395 0 118.00 NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 209, 948 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 192. 00 0 0 126, 863 194. 00 07950 OCCUPATIONAL HEALTH 0 0 194.00 0 0 194. 01 07951 PAIN CLINIC 00000000 0 0 0 0 194. 01 194. 02 07952 OAK POINTE 0 194. 02 194. 03 07953 FOUNDATI ON 0 0 571, 696 0 194. 03 194.04 07954 COMMUNITY & VOLUNTEER SERVICES 0 0 194. 04 0 427, 756 194. 05 07955 VACANT SPACE 0 194. 05

0

0

0

36, 212, 658

0 200. 00

0 201, 00

0 202. 00

0

0

Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

200.00

201.00

202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150101

				5/19/2016 5: 1	
	Cc	ost Center Description	Total		
			26. 00		
1 00		SERVI CE COST CENTERS			1 00
1.00		AP REL COSTS MARIE FOLLD			1.00
2. 00 4. 00		AP REL COSTS-MVBLE EQUIP MPLOYEE BENEFITS DEPARTMENT			2. 00 4. 00
5. 00	1 1	OMINISTRATIVE & GENERAL			5. 00
6.00	1 1	AINTENANCE & REPAIRS			6. 00
7. 00	1 1	PERATION OF PLANT			7. 00
8.00	1 1	AUNDRY & LINEN SERVICE			8. 00
9.00	1 1	DUSEKEEPI NG			9. 00
10.00	01000 DI	ETARY			10.00
11. 00	01100 CA				11. 00
12. 00	1 1	AINTENANCE OF PERSONNEL			12. 00
13. 00	1 1	JRSING ADMINISTRATION			13. 00
14. 00	1 1	ENTRAL SERVICES & SUPPLY			14. 00
15. 00	01500 PH				15. 00
16.00		EDICAL RECORDS & LIBRARY			16.00
17. 00	1 1	OCIAL SERVICE			17. 00
19. 00 20. 00	1 1	DNPHYSICIAN ANESTHETISTS JRSING SCHOOL			19. 00 20. 00
21. 00	1 1	&R SERVICES-SALARY & FRINGES APPRV			21. 00
22. 00	1 1	RR SERVICES-OTHER PRGM COSTS APPRV			22. 00
23. 00	1 1	ARAMED ED PRGM-(SPECIFY)			23. 00
20.00		NT ROUTINE SERVICE COST CENTERS			20.00
30. 00		DULTS & PEDIATRICS	6, 277, 485		30.00
43.00	04300 NU		435, 342		43.00
44.00		KILLED NURSING FACILITY	0		44. 00
	ANCI LLAF	RY SERVICE COST CENTERS			
50.00		PERATING ROOM	3, 619, 837		50. 00
52.00		ELIVERY ROOM & LABOR ROOM	1, 786, 227		52. 00
53. 00	1 1	NESTHESI OLOGY	32, 824		53. 00
54. 00	1 1	ADI OLOGY - DI AGNOSTI C	3, 752, 673		54. 00
60.00		ABORATORY	3, 130, 283		60.00
62. 30		LOOD CLOTTING FOR HEMOPHILIACS	1 124 524		62. 30
65. 00 66. 00	1 1	ESPI RATORY THERAPY HYSI CAL THERAPY	1, 136, 526 1, 073, 424		65. 00 66. 00
67.00	1 1	CCUPATIONAL THERAPY	856, 305		67. 00
68. 00	1 1	PEECH PATHOLOGY	227, 037		68. 00
69. 00	1 1	LECTROCARDI OLOGY	3, 074		69. 00
71. 00	1 1	EDICAL SUPPLIES CHARGED TO PATIENT	916, 418		71. 00
72. 00	1 1	MPL. DEV. CHARGED TO PATIENTS	338, 255		72. 00
73. 00		RUGS CHARGED TO PATIENTS	4, 005, 141		73. 00
76. 97	07697 CA	ARDIAC REHABILITATION	0		76. 97
76. 98	07698 HY	YPERBARI C OXYGEN THERAPY	0		76. 98
76. 99		THOTRI PSY	0		76. 99
		ENT SERVICE COST CENTERS			
90.00	09000 CL		468, 892		90.00
90. 01		NTENSIVE OUT PATIENT PROGRAM	0 722 004		90. 01
91.00	09100 EM		3, 723, 804		91.00
92. 00		BSERVATION BEDS (NON-DISTINCT PART EIMBURSABLE COST CENTERS			92.00
95. 00		MBULANCE SERVICES	3, 092, 848		95. 00
73.00		PURPOSE COST CENTERS	3, 072, 040		73.00
118.00		JBTOTALS (SUM OF LINES 1-117)	34, 876, 395		118. 00
		BURSABLE COST CENTERS			
190.00		FT, FLOWER, COFFEE SHOP & CANTEEN	209, 948		190. 00
192.00	19200 PH	HYSICIANS' PRIVATE OFFICES	126, 863		192. 00
		CCUPATIONAL HEALTH	0		194. 00
	1 1	AIN CLINIC	0		194. 01
		AK POINTE	0		194. 02
	1 1	OUNDATI ON	571, 696		194. 03
		OMMUNITY & VOLUNTEER SERVICES	427, 756		194. 04
	1 1	ACANT SPACE	0		194. 05
200.00	1 1	ross Foot Adjustments	0		200. 00
201.00		egative Cost Centers	26 212 450		201. 00 202. 00
202.00	אן וע	OTAL (sum lines 118-201)	36, 212, 658		1202. UU

In Lieu of Form CMS-2552-10
Worksheet B
01/2015 Part II
81/2015 Date/Time Prepared:
5/19/2016 5:11 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS WHITLEY MEMORIAL HOSPITAL Provi der CCN: 150101 Peri od: From 01/01/2015 To 12/31/2015 CAPITAL RELATED COSTS

				CAPI TAL REI	LATED COSTS			
		Cost Center Description	Di rectly	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Soot Sonton Boson Pt. S.	Assigned New	5256 a 1171		ous coca.	BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs 0	1.00	2.00	2A	4. 00	
	GENER	AL SERVICE COST CENTERS	0	1.00	2.00	ZA	4.00	
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
2.00		CAP REL COSTS-MVBLE EQUIP						2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4. 00
5.00		ADMINISTRATIVE & GENERAL	4, 098, 077	105, 471	200, 867	4, 404, 415	0	5. 00
6. 00 7. 00		MAINTENANCE & REPAIRS OPERATION OF PLANT	0	57, 885	110, 241	168, 126	0	6. 00 7. 00
8. 00	1	LAUNDRY & LINEN SERVICE	0	2, 705		7, 856	0	8. 00
9. 00	1	HOUSEKEEPI NG	0	2, 261		6, 566	0	9. 00
10.00	1	DI ETARY	0	9, 691		28, 147	0	10.00
11. 00	01100	CAFETERI A	0	10, 928	20, 813	31, 741	0	11. 00
12. 00	1	MAINTENANCE OF PERSONNEL	0	0		0	0	12. 00
13.00		NURSI NG ADMI NI STRATI ON	0	659		1, 913	0	13.00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	0	7, 824 6, 782		22, 726 19, 697	0	14. 00 15. 00
16. 00		MEDICAL RECORDS & LIBRARY	0	2, 410		7, 000	0	16. 00
17. 00		SOCIAL SERVICE	0	0	0	0	0	17. 00
19. 00	1	NONPHYSICIAN ANESTHETISTS	0	0	0	o	0	19. 00
20. 00		NURSING SCHOOL	0	0	0	0	0	20. 00
21. 00		I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0	0	22. 00
23. 00		PARAMED ED PRGM-(SPECIFY) ENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	23. 00
30. 00		ADULTS & PEDIATRICS	0	105, 849	201, 592	307, 441	0	30. 00
43. 00	4	NURSERY	0	0		0	0	43. 00
44.00	1	SKILLED NURSING FACILITY	0	0	0	o	0	44. 00
		LARY SERVICE COST CENTERS						
50.00		OPERATING ROOM	0			183, 606	0	50.00
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	0	0	0	0	0	52. 00 53. 00
54.00		RADI OLOGY-DI AGNOSTI C	0	48, 449	92, 270	140, 719	0	54. 00
60.00		LABORATORY	0	14, 806		43, 003	0	60.00
62. 30	1	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0	62. 30
65.00	06500	RESPI RATORY THERAPY	0	11, 707	22, 295	34, 002	0	65. 00
66. 00	1	PHYSI CAL THERAPY	0	39, 741		115, 427	0	66. 00
67. 00		OCCUPATIONAL THERAPY	0	0	0	0	0	67. 00
68. 00 69. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	0	0	0	0	68. 00 69. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71.00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	Ö	Ö	ő	0	72.00
73.00		DRUGS CHARGED TO PATIENTS	0	0	0	o	0	73. 00
76. 97		CARDIAC REHABILITATION	0	0	0	0	0	76. 97
76. 98	1	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99		LITHOTRIPSY TIENT SERVICE COST CENTERS	0	0	0	0	0	76. 99
90. 00		CLINIC	0	17, 939	34, 165	52, 104	0	90.00
90. 01		INTENSIVE OUT PATIENT PROGRAM	0	17, 737	34, 103	0	0	90. 01
91. 00		EMERGENCY	Ō	35, 305	67, 238	102, 543	0	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92. 00
		REI MBURSABLE COST CENTERS	T					
95. 00		AMBULANCE SERVICES	0	0	0	0	0	95. 00
118. 00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	4, 098, 077	543, 627	1, 035, 328	5, 677, 032	0	118. 00
110.00		IMBURSABLE COST CENTERS	4, 090, 077	343, 027	1, 033, 326	5, 077, 032	U	110.00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1, 437	2, 737	4, 174	0	190. 00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	o		192. 00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	o		194. 00
		PAIN CLINIC	0	0	0	0		194. 01
		OAK POINTE	0	0	0	0		194. 02
		FOUNDATION COMMUNITY & VOLUNTEER SERVICES		1, 422	2, 709	4, 131		194. 03 194. 04
		VACANT SPACE		1,422	2, 709 n	4, 131 N		194. 04
200.00		Cross Foot Adjustments				o		200. 00
201.00		Negative Cost Centers		0	0	o	0	201. 00
202.00)	TOTAL (sum lines 118-201)	4, 098, 077	546, 486	1, 040, 774	5, 685, 337	0	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150101 Peri d

Peri od: Worksheet B From 01/01/2015 Part II To 12/31/2015 Date/Time Prepared:

5/19/2016 5:11 pm Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL **REPAIRS PLANT** LINEN SERVICE 9.00 5.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 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 4, 404, 415 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 272, 014 440, 140 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 34, 532 0 3, 107 45, 495 8.00 101, 271 00900 HOUSEKEEPI NG 9.00 92, 108 0 2, 597 0 9 00 10.00 01000 DI ETARY 44, 542 11, 133 2, 595 10.00 11.00 01100 CAFETERI A 80, 515 12, 554 0 2, 927 11.00 01200 MAINTENANCE OF PERSONNEL Ω 0 12 00 12 00 0 C 0 13.00 01300 NURSING ADMINISTRATION 33, 405 757 176 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 4,670 8, 989 0 2,095 14.00 0 01500 PHARMACY 7, 791 1, 816 15.00 169.414 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 1, 439 0 2.769 645 16.00 17.00 01700 SOCIAL SERVICE 0 0 C 0 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 19 00 0 0 0 19.00 02000 NURSING SCHOOL 20.00 0 0 0 20.00 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 21.00 0 Ω 0 0 21 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 576, 363 0 121, 599 2.511 28.346 30.00 43.00 04300 NURSERY 48, 987 0 C 2,659 43.00 04400 SKILLED NURSING FACILITY 0 44.00 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 351, 663 0 72, 621 7,602 16, 929 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 197, 333 9, 759 52.00 05300 ANESTHESI OLOGY 3.992 0 53.00 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 391, 801 6, 720 12, 974 54.00 0 55, 658 54.00 366, 512 60.00 06000 LABORATORY 0 17,009 40 3, 965 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 0 0 62.30 C 65 00 06500 RESPIRATORY THERAPY 121 788 Ω 13 449 254 3. 135 65 00 06600 PHYSI CAL THERAPY 66.00 85, 420 0 45,655 1, 467 10,643 66.00 06700 OCCUPATIONAL THERAPY 100, 104 67.00 67.00 C 1.564 0 68.00 06800 SPEECH PATHOLOGY 26, 559 0 406 68.00 0 06900 ELECTROCARDI OLOGY 69.00 374 0 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 111, 460 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 41, 141 0 0 0 0 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 308, 795 Ω 0 0 73 00 0 07697 CARDIAC REHABILITATION 76.97 0 0 0 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 76. 98 76.98 0 0 76.99 07699 LI THOTRI PSY 0 0 76.99 0 0 OUTPATIENT SERVICE COST CENTERS 4, 804 90.00 09000 CLI NI C 0 20, 609 90.00 38, 557 354 90.01 09001 INTENSIVE OUT PATIENT PROGRAM 0 0 90.01 09100 EMERGENCY 40, 558 10, 153 9, 455 91.00 91.00 386, 245 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 373, 053 0 0 2,006 95.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 4, 262, 786 0 436, 855 45, 495 100, 505 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 7, 399 1, 651 385 190. 00 0 192.00 15,017 0 C 0 0 194.00 194. 00 07950 OCCUPATIONAL HEALTH 0 Ω 0 0 194. 01 07951 PAIN CLINIC 0 0 0 194. 01 0 0 194. 02 07952 OAK POINTE 0 0 0 194. 02 0 194. 03 07953 FOUNDATION 68.988 0 0 0 0 194, 03 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 50.225 0 1,634 0 381 194. 04 194. 05 07955 VACANT SPACE 0 194. 05 C Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers 0 0 201.00 TOTAL (sum lines 118-201) 4, 404, 415 45, 495 101, 271 202. 00 202.00 440, 140

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150101

Period: Worksheet B From 01/01/2015 Part II To 12/31/2015 Date/Time Prepared:

5/19/2016 5:11 pm Cost Center Description DI ETARY CAFETERI A MAINTENANCE OF NURSI NG CENTRAL ADMI NI STRATI ON SERVICES & **PERSONNEL SUPPLY** 10.00 11.00 12.00 13.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 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 86, 417 10.00 01100 CAFETERI A 11.00 127, 737 11.00 0 01200 MAINTENANCE OF PERSONNEL 12.00 0 12.00 13.00 01300 NURSING ADMINISTRATION 0 1, 456 37, 707 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 38, 480 14.00 01500 PHARMACY 0 1, 457 0 15.00 0 15.00 4, 214 01600 MEDICAL RECORDS & LIBRARY 0 16.00 0 0 16.00 17.00 01700 SOCIAL SERVICE 0 0 0 17.00 0 0 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 19.00 02000 NURSING SCHOOL 0 20.00 20 00 C Ω |02100| I &R SERVICES-SALARY & FRINGES APPRV 21.00 0 0 21.00 02200 | &R SERVICES-OTHER PRGM COSTS APPRV 0 0 0 22.00 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 86, 417 22, 069 0 13, 816 3,099 30.00 43.00 04300 NURSERY 2, 222 0 498 43.00 44.00 04400 SKILLED NURSING FACILITY 0 0 44 00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 11, 954 20, 302 50.00 0 7.484 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 8,889 5, 565 1,875 52.00 05300 ANESTHESI OLOGY 0 53.00 Ω 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 14, 789 0 0 1, 830 54.00 06000 LABORATORY 0 0 60.00 000000000000 0 60.00 0 62 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62 30 0 0 06500 RESPIRATORY THERAPY 65.00 6, 360 1,572 65.00 06600 PHYSI CAL THERAPY 7, 586 0 312 66.00 0 0 0 0 0 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 3,601 0 332 67.00 06800 SPEECH PATHOLOGY 0 68 00 920 68 00 86 0 69.00 06900 ELECTROCARDI OLOGY C 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 Ω 0 73 00 0 76. 97 07697 CARDIAC REHABILITATION 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76. 98 07699 LI THOTRI PSY 76. 99 76.99 0 0 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 1, 226 0 0 409 90.00 90. 01 09001 INTENSIVE OUT PATIENT PROGRAM 0 0 90.01 91.00 09100 EMERGENCY 0 10.842 91.00 0 17, 318 3,675 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS 0 95.00 0 0 0 2, 224 95.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 86, 417 102, 604 0 37, 707 37, 671 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 702 190, 00 23, 218 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 536 0 98 192. 00 194. 00 07950 OCCUPATIONAL HEALTH 0 0 0 0 194.00 C 0 194. 01 07951 PAIN CLINIC 0 0 194. 01 0 Ω 194. 02 07952 OAK POINTE 0 0 0 194, 02 C 0 194. 03 07953 FOUNDATI ON 0 766 0 0 194. 03 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 0 613 0 0 9 194. 04 194. 05 07955 VACANT SPACE 0 0 0 0 194. 05 C Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers 0 0 201.00 38, 480 202. 00 202.00 TOTAL (sum lines 118-201) 86.417 127, 737 0 37, 707

Provi der CCN: 150101

					5/19/2016 5:1	1 pm
Cost Center Description	PHARMACY		SOCIAL SERVICE		NURSING SCHOOL	
		RECORDS &		ANESTHETI STS		
	15. 00	16. 00	17. 00	19. 00	20.00	
GENERAL SERVICE COST CENTERS	15.00	10.00	17.00	19.00	20.00	
1. 00 00100 CAP REL COSTS-BLDG & FLXT						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
6.00 00600 MAINTENANCE & REPAIRS						6. 00
7.00 OO700 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						11.00
12. 00 01200 MAINTENANCE OF PERSONNEL						12. 00
13.00 01300 NURSING ADMINISTRATION						13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00 01500 PHARMACY	204, 389					15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	o	11, 853				16. 00
17. 00 01700 SOCIAL SERVICE	O	0	l c)		17. 00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	C	0)	19. 00
20. 00 02000 NURSI NG SCHOOL	0	0	C)	0	20.00
21.00 02100 1 &R SERVICES-SALARY & FRINGES APPRV	o	0	C)		21. 00
22.00 02200 L&R SERVICES-OTHER PRGM COSTS APPRV	0	0	C)		22. 00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	C)		23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	2	1, 205	C			30. 00
43. 00 04300 NURSERY	0	288	C			43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	C			44. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	13	199	C)		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	C)		52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	C)		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	169	4, 980	C)		54. 00
60. 00 06000 LABORATORY	0	0	C)		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	C)		62. 30
65. 00 06500 RESPIRATORY THERAPY	1	0	0)		65. 00
66. 00 06600 PHYSI CAL THERAPY	58	1, 089)		66. 00
67. 00 06700 0CCUPATI ONAL THERAPY	0	386)		67. 00
68.00 06800 SPEECH PATHOLOGY	0	149	0)		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	C)		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C)		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	203, 208	0	0			73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	C			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	C			76. 98
76. 99 07699 LI THOTRI PSY	0	0	C			76. 99
OUTPATIENT SERVICE COST CENTERS		_	T _	T	T	4
90. 00 09000 CLI NI C	4	0				90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0				90. 01
91. 00 09100 EMERGENCY	13	3, 557	C)		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS	004					
95. 00 09500 AMBULANCE SERVI CES	921	0	C			95. 00
SPECIAL PURPOSE COST CENTERS		44.050				
118. 00 SUBTOTALS (SUM OF LINES 1-117)	204, 389	11, 853	C	0	. 0	118. 00
NONREI MBURSABLE COST CENTERS		_	_			4
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
194. 00 07950 OCCUPATI ONAL HEALTH	0	0	1			194. 00
194. 01 07951 PAIN CLINIC	0	0	C			194. 01
194. 02 07952 OAK POI NTE	이	0	C			194. 02
194. 03 07953 FOUNDATION	이	0	C			194. 03
194. 04 07954 COMMUNITY & VOLUNTEER SERVICES	0	0	C			194. 04
194. 05 07955 VACANT SPACE	0	0	C] _	194. 05
200.00 Cross Foot Adjustments	_	_1	_	0		200.00
201.00 Negative Cost Centers	0	0	C			201.00
202.00 TOTAL (sum lines 118-201)	204, 389	11, 853	[C	0	-{ O	202. 00

Heal th	Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS	_	Provi der		eriod: rom 01/01/2015 o 12/31/2015	Worksheet B Part II Date/Time Pre 5/19/2016 5:1	pared: 1 pm
		INTERNS &	RESI DENTS				
	Cost Center Description	SERVI CES-SALARS Y & FRI NGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		21.00	22. 00	23. 00	24. 00	25. 00	
	GENERAL SERVICE COST CENTERS						
13. 00 14. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY						1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
16. 00 17. 00 19. 00	O1500 PHARMACY O1600 MEDICAL RECORDS & LIBRARY O1700 SOCIAL SERVICE O1900 NONPHYSICIAN ANESTHETISTS O2000 NURSING SCHOOL O2100 I&R SERVICES-SALARY & FRINGES APPRV O2200 I&R SERVICES-OTHER PRGM COSTS APPRV O2300 PARAMED ED PRGM-(SPECIFY)	0	0	0			15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00 23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS			<u> </u>			20.00
30. 00	03000 ADULTS & PEDIATRICS				1, 162, 868	0	30. 00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY				54, 654 0	0	43. 00 44. 00
	ANCILLARY SERVICE COST CENTERS				- 1		
	05000 OPERATING ROOM				672, 373	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM				223, 421	0	
53.00	05300 ANESTHESI OLOGY				3, 992	0	
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY				629, 640 430, 529	0	54. 00 60. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS				430, 329	0	62. 30
65. 00	06500 RESPI RATORY THERAPY				180, 561	0	65. 00
66. 00	06600 PHYSI CAL THERAPY				267, 657	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY				105, 987	0	67. 00
68. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY				28, 120	0	68.00
69. 00 71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT				374 111, 460	0	69. 00 71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS				41, 141	0	ı
	07300 DRUGS CHARGED TO PATIENTS				512, 003	0	1
	07697 CARDI AC REHABI LI TATI ON				0	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY				0	0	
70. 77	OUTPATIENT SERVICE COST CENTERS	1	l		<u> </u>	0	70. 77
90.00	09000 CLI NI C				118, 067	0	90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM				0	0	
91.00	09100 EMERGENCY				584, 359	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS					0	92.00
95. 00	09500 AMBULANCE SERVICES				378, 204	0	95. 00
	SPECIAL PURPOSE COST CENTERS				·		
118. 00		0	0	0	5, 505, 410	0	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				37, 529	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES				15, 651		192.00
	07950 OCCUPATI ONAL HEALTH				O		194. 00
	07951 PAIN CLINIC				0		194. 01
	07952 OAK POLNTE 07953 FOUNDATION				0 69, 754		194. 02 194. 03
	07954 COMMUNITY & VOLUNTEER SERVICES				56, 993		194. 03
	07955 VACANT SPACE				0		194. 05
200.00		0	o	0	o	0	200. 00
201.00	1 1 9	0	0	0	0 E 40E 337		201.00
202. 00	TOTAL (sum lines 118-201)	0	0	0	5, 685, 337	Ü	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150101

			5/19/2016 5	
	Cost Center Description	Total		
		26. 00		
	ENERAL SERVICE COST CENTERS			
1	0100 CAP REL COSTS-BLDG & FLXT			1. 00
1	0200 CAP REL COSTS-MVBLE EQUIP			2. 00
1	0400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
1	0500 ADMINISTRATIVE & GENERAL			5. 00
1	0600 MAINTENANCE & REPAIRS			6. 00
1	0700 OPERATION OF PLANT			7. 00
1	0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING			8. 00 9. 00
- 1	1000 DI ETARY			10.00
- 1	1100 CAFETERI A			11. 00
	1200 MAINTENANCE OF PERSONNEL			12. 00
	1300 NURSI NG ADMINI STRATI ON			13. 00
	1400 CENTRAL SERVI CES & SUPPLY			14. 00
	1500 PHARMACY			15. 00
	1600 MEDICAL RECORDS & LIBRARY			16. 00
	1700 SOCIAL SERVICE			17. 00
19. 00 01	1900 NONPHYSICIAN ANESTHETISTS			19. 00
20. 00 02	2000 NURSING SCHOOL			20. 00
21.00 02	2100 I&R SERVICES-SALARY & FRINGES APPRV			21. 00
22. 00 02	2200 I&R SERVICES-OTHER PRGM COSTS APPRV			22. 00
23. 00 02	2300 PARAMED ED PRGM-(SPECIFY)			23. 00
	NPATIENT ROUTINE SERVICE COST CENTERS			
	3000 ADULTS & PEDIATRICS	1, 162, 868		30. 00
	4300 NURSERY	54, 654		43. 00
	4400 SKILLED NURSING FACILITY	0		44. 00
	NCILLARY SERVICE COST CENTERS	(70.070		
	5000 OPERATING ROOM	672, 373		50.00
	5200 DELIVERY ROOM & LABOR ROOM 5300 ANESTHESIOLOGY	223, 421		52.00
1		3, 992		53.00
1	5400 RADI OLOGY-DI AGNOSTI C 6000 LABORATORY	629, 640		54. 00 60. 00
	6250 BLOOD CLOTTING FOR HEMOPHILIACS	430, 529		62. 30
	6500 RESPIRATORY THERAPY	180, 561		65. 00
- 1	6600 PHYSI CAL THERAPY	267, 657		66. 00
- 1	6700 OCCUPATI ONAL THERAPY	105, 987		67. 00
1	6800 SPEECH PATHOLOGY	28, 120		68. 00
1	6900 ELECTROCARDI OLOGY	374		69. 00
1	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	111, 460		71.00
72. 00 07	7200 IMPL. DEV. CHARGED TO PATIENTS	41, 141		72. 00
73. 00 07	7300 DRUGS CHARGED TO PATIENTS	512, 003		73. 00
76. 97 07	7697 CARDIAC REHABILITATION	0		76. 97
76. 98 07	7698 HYPERBARIC OXYGEN THERAPY	0		76. 98
	7699 LI THOTRI PSY	0		76. 99
	JTPATIENT SERVICE COST CENTERS			
	9000 CLINIC	118, 067		90.00
	9001 INTENSIVE OUT PATIENT PROGRAM	0		90. 01
	9100 EMERGENCY	584, 359		91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART THER REIMBURSABLE COST CENTERS			92.00
	9500 AMBULANCE SERVICES	378, 204		95. 00
	PECIAL PURPOSE COST CENTERS	370, 204		95.00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	5, 505, 410		118. 00
	ONREI MBURSABLE COST CENTERS	3, 303, 410		110.00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	37, 529		190. 00
	9200 PHYSI CLANS' PRI VATE OFFICES	15, 651		192. 00
	7950 OCCUPATIONAL HEALTH	0		194. 00
	7951 PAIN CLINIC	o		194. 01
	7952 OAK POINTE	o		194. 02
	7953 FOUNDATION	69, 754		194. 03
	7954 COMMUNITY & VOLUNTEER SERVICES	56, 993		194. 04
	7955 VACANT SPACE	0		194. 05
200. 00	Cross Foot Adjustments	0		200. 00
201.00	Negative Cost Centers	0		201. 00
202.00	TOTAL (sum lines 118-201)	5, 685, 337		202. 00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS		WHITLEY MEMORI			Peri od:	eu of Form CMS- Worksheet B-1		
						From 01/01/2015 To 12/31/2015		
			CAPITAL REL	LATED COSTS			5/19/2016 5:1	ı pili
		Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci I i ati on	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			1.00	2.00	4. 00	5A	5. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT	109, 514	I				1.00
2. 00 4. 00 5. 00 6. 00	00200 00400 00500 00600	CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	0 21, 136 0	109, 51 21, 13	0 16, 497, 15 6 5, 144, 72 0	6 -14, 780, 940 0 0	0	2. 00 4. 00 5. 00 6. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	00800 00900 01000 01100	OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA MAINTENANCE OF PERSONNEL	11, 600 542 453 1, 942 2, 190	54 45 1, 94	2 3 285, 74 2 132, 18 0 232, 20	0 0 7 0 5 0	1, 323, 609 168, 034 448, 194 216, 742 391, 785	8. 00 9. 00 10. 00 11. 00
13. 00 14. 00 15. 00 16. 00 17. 00	01300 01400 01500 01600 01700	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	132 1, 568 1, 359 483	1, 56 1, 35	2 140, 56 8 9 556, 57 3	0 0 0 0 7 0 0 0	162, 550 22, 726 824, 361 7, 000 0	13. 00 14. 00 15. 00 16. 00 17. 00
19. 00 20. 00 21. 00 22. 00 23. 00	02000 02100 02200 02300	NONPHYSICIAN ANESTHETISTS NURSING SCHOOL I&R SERVICES-SALARY & FRINGES APPRV I&R SERVICES-OTHER PRGM COSTS APPRV PARAMED ED PRGM-(SPECIFY) IENT ROUTINE SERVICE COST CENTERS	0 0 0 0		0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	20. 00 21. 00 22. 00
30. 00 43. 00 44. 00	03000 04300	ADULTS & PEDIATRICS NURSERY SKILLED NURSING FACILITY	21, 212 0 0		0 192, 19		238, 371	43. 00
50. 00 52. 00	ANCI L 05000	LARY SERVICE COST CENTERS OPERATING ROOM DELIVERY ROOM & LABOR ROOM	12, 668			2 0	1, 711, 179	50.00
53. 00 54. 00 60. 00	05400 06000	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C LABORATORY	0 9, 709 2, 967			0 2 0 0	19, 426 1, 906, 492 1, 783, 436	54. 00 60. 00
62. 30 65. 00 66. 00 67. 00 68. 00 69. 00	06500 06600 06700 06800	BLOOD CLOTTING FOR HEMOPHILIACS RESPIRATORY THERAPY PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY ELECTROCARDIOLOGY	0 2, 346 7, 964 0 0		4 505, 80 0 420, 69 0 109, 19	1 0 1 0	0 592, 617 415, 652 487, 102 129, 236 1, 819	65. 00 66. 00 67. 00 68. 00
71. 00 72. 00 73. 00	07100 07200 07300 07697 07698	MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY	0 0 0 0		0 0 0 0 0	2 0 0 0 0 0 0 0 0 0 0 0		71. 00 72. 00 73. 00 76. 97 76. 98
70. 77	OUTPA	TIENT SERVICE COST CENTERS	0					
90. 00 90. 01 91. 00 92. 00	09001 09100 09200	CLINIC INTENSIVE OUT PATIENT PROGRAM EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS	3, 595 0 7, 075		0	0		90. 01
95. 00	09500	AMBULANCE SERVICES AL PURPOSE COST CENTERS	0		0 1, 404, 76	1 0	1, 815, 263	95. 00
118. 00		SUBTOTALS (SUM OF LINES 1-117) IMBURSABLE COST CENTERS	108, 941	108, 94	1 16, 414, 05	9 -14, 780, 940	20, 742, 559	118. 00
192. 00 194. 00	19000 19200 07950	GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES OCCUPATIONAL HEALTH	288 0 0		8 0 17, 45 0	0	73, 072 0	190. 00 192. 00 194. 00
194. 02 194. 03 194. 04 194. 05 200. 00	07952 07953 07954 07955	PAIN CLINIC OAK POINTE FOUNDATION COMMUNITY & VOLUNTEER SERVICES VACANT SPACE Cross Foot Adjustments	0 0 0 285 0	28	0 0 0 26, 99 5 38, 64 0		0 335, 691 244, 391	194. 04 194. 05 200. 00
201. 00		Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	546, 486				14, 780, 940	
203. 00	1	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	4. 990102	9. 50357	0. 13147	0	0. 689676 4, 404, 415	1

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2015	Worksheet B-1		
					Date/Time Pre 5/19/2016 5:1		
	CAPITAL REL	LATED COSTS					
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM COST)		
	1.00	2. 00	4.00	5A	5. 00		
205.00 Unit cost multiplier (Wkst. B, Part			0. 000000)	0. 205509	205. 00	

COST ALLOCATION - STATISTICAL BASIS

Provi der CCN: 150101

Peri od: Worksheet B-1 From 01/01/2015 To 12/31/2015 Date/Ti me Prepared:

5/19/2016 5:11 pm Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY REPAI RS PLANT LINEN SERVICE (SQUARE FEET) (MEALS SERVED) (SQUARE FEET) (SQUARE FEET) (POUNDS OF LAUNDRY) 6.00 7.00 9.00 10.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 000000000000000 7.00 7.00 76, 778 00800 LAUNDRY & LINEN SERVICE 8.00 542 226, 116 8.00 9.00 00900 HOUSEKEEPI NG 453 75. 783 9.00 01000 DI ETARY 1, 942 1, 942 16, 907 10.00 10.00 0 2, 190 01100 CAFETERI A 2, 190 0 11.00 Λ 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 0 0 12.00 13.00 01300 NURSING ADMINISTRATION 132 132 13.00 01400 CENTRAL SERVICES & SUPPLY 0 14.00 14.00 1, 568 1.568 01500 PHARMACY 0 15.00 1, 359 1, 359 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 483 483 16.00 01700 SOCIAL SERVICE 17.00 C 0 0 0 17.00 Ol 01900 NONPHYSICIAN ANESTHETISTS 0 19 00 19 00 Ω 0 20.00 02000 NURSING SCHOOL C 0 0 0 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 21.00 21.00 C 0 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 0 22.00 0 02300 PARAMED ED PRGM-(SPECIFY) O 23 00 23.00 Ω INPATIENT ROUTINE SERVICE COST CENTERS 16, 907 30.00 03000 ADULTS & PEDIATRICS 0 21, 212 12, 480 21, 212 30.00 0 43 00 04300 NURSERY 13, 215 43 00 0 04400 SKILLED NURSING FACILITY 44.00 0 C 0 44.00 0 ANCILLARY SERVICE COST CENTERS 0 50.00 05000 OPERATING ROOM 37, 782 0 50.00 12, 668 12,668 05200 DELIVERY ROOM & LABOR ROOM 52 00 52 00 48.504 0 0 53.00 05300 ANESTHESI OLOGY 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0000000000000 9, 709 33, 401 9, 709 54.00 54.00 60.00 06000 LABORATORY 2, 967 198 2, 967 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 C 0 62 30 65.00 06500 RESPIRATORY THERAPY 2, 346 1, 260 2, 346 0 65.00 06600 PHYSI CAL THERAPY 66.00 7,964 7, 292 7,964 66.00 67.00 06700 OCCUPATIONAL THERAPY C 7, 772 0 67.00 0 06800 SPEECH PATHOLOGY 68.00 C 2.017 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 Ω 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 72.00 0 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 C 0 73.00 76.97 07697 CARDIAC REHABILITATION 0 0 0 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 o 0 76. 98 07699 LI THOTRI PSY 76.99 C 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 3, 595 1, 761 3, 595 0 90.00 90. 01 09001 INTENSIVE OUT PATIENT PROGRAM 0 0 90.01 0 91.00 09100 EMERGENCY 7,075 50, 465 7.075 Ω 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 95.00 0 9, 969 0 0 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 118.00 0 76, 205 226, 116 75, 210 16, 907 118. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 288 288 0 190 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 C 0 194. 00 07950 OCCUPATIONAL HEALTH 0 194.00 0 0 0 0 194. 01 07951 PAIN CLINIC 0 0 0 194.01 0 194. 02 07952 OAK POINTE 0 0 194. 02 C 0 0 194. 03 07953 FOUNDATION 0 0 0 194. 03 0 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 285 0 285 0 194. 04 194.05 07955 VACANT SPACE O 0 194 05 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, 202.00 0 2, 236, 470 299, 711 770, 498 442, 538 202. 00 Part I) Unit cost multiplier (Wkst. B, Part I) 203.00 0.000000 29. 129047 1.325475 10. 167162 26. 174839 203. 00 Cost to be allocated (per Wkst. B, 86, 417 204. 00 204.00 440, 140 45, 495 101, 271 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 5.732632 0.201202 1.336329 5. 111315 205. 00 11)

Cost Center Description	016 5: 1 MACY STED IS.)	1. C 2. C 4. C 5. C 6. C 7. C 8. C 9. C 11. C 12. C 13. C 14. C 15. C 17. C 19. C 20. C 21. C 22. C 23. C
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9. 00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 1,667 12.00 01200 MAI NTENANCE OF PERSONNEL 0 0 0 0 0 1,754,530 13.00 01300 MURSI NG AGMI NI STRATI ON 19 0 786 14.00 01400 CENTRAL SERVI CES & SUPPLY 0 0 0 0 0 1,754,530 15.00 01500 PHARMACY 55 0 0 0 0 66,445 1, 16.00 01600 MEDI CAL RECORDS & LI BRARY 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	9. 0 10. 0 11. 0 12. 0 13. 0 14. 0 15. 0 16. 0 17. 0 19. 0 20. 0 21. 0 22. 0 23. 0 43. 0
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50. 00 05000 OPERATI NG ROOM 156 0 156 925, 637 52. 00 05200 DELI VERY ROOM & LABOR ROOM 116 0 116 85, 471 53. 00 05300 ANESTHESI OLOGY 0 0 0 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 193 0 0 83, 446 60. 00 06000 LABORATORY 0 0 0 0 0 62. 30 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 0 1 4 2 0 0 0 1 1, 1 <	0	
53. 00 05300 ANESTHESI OLOGY 0 </td <td>103</td> <td>50.0</td>	103	50.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C 193 0 0 83,446 60. 00 06000 LABORATORY 0 0 0 0 62. 30 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 83 0 0 71,659 66. 00 06600 PHYSI CAL THERAPY 99 0 0 14,208 67. 00 06700 OCCUPATI ONAL THERAPY 47 0 0 15,144 68. 00 06800 SPEECH PATHOLOGY 12 0 0 3,931 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 73. 00 07690 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0	0	52.0
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67. 00 06700 OCCUPATIONAL THERAPY 47 0 0 15, 144 68. 00 06800 SPEECH PATHOLOGY 12 0 0 3, 931 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 1, 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0	461	65. C
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91. 00 09100 EMERGENCY 226 0 226 167, 583 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	100	91. 0
OTHER REIMBURSABLE COST CENTERS	7 070	1
95. 00 09500 AMBULANCE SERVI CES 0 0 101, 426 SPECI AL PURPOSE COST CENTERS	7, 273	95.0
118.00 SUBTOTALS (SUM OF LINES 1-117) 1, 339 0 786 1, 717, 618 1,	613, 934	118. (
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 303 0 32, 021		 190. (
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 7 0 4, 464		192. 0
194. 00 07950 OCCUPATI ONAL HEALTH 0 0 0 0		194. 0 194. 0
194. 01 07951 PALINI C 0 0 0 0 0 194. 02 07952 OAK POLNTE 0 0 0 0		194. 0
194. 03 07953 FOUNDATI ON 10 0 0 0	0	194. 0
194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 8 0 0 427 194. 05 07955 VACANT SPACE 0 0 0 0	0 0 0	194. 0
200. 00 Cross Foot Adjustments	0 0 0 0	
201.00 Negative Cost Centers	0 0 0 0	194. 0 200. 0
202.00 Cost to be allocated (per Wkst. B, 748,049 0 288,370 100,016 1,	0 0 0 0	194. 0 200. 0 201. 0
203.00 Unit cost multiplier (Wkst. B, Part I) 448.739652 0.000000 366.882952 0.057004 0	0 0 0 0	194. 0 200. 0 201. 0
204.00 Cost to be allocated (per Wkst. B, 127,737 0 37,707 38,480 Part II)	0 0 0 0 0 474, 775	194. 0 200. 0 201. 0 202. 0
205.00 Unit cost multiplier (Wkst. B, Part 76.626875 0.000000 47.973282 0.021932 0	0 0 0 0 0	194. 0 200. 0 201. 0 202. 0
	0 0 0 0 0 474, 775	194. 0 200. 0 201. 0 202. 0 203. 0 204. 0

Health Financial Systems In Lieu of Form CMS-2552-10 WHITLEY MEMORIAL HOSPITAL COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 150101 Peri od: Worksheet B-1 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/19/2016 5:11 pm INTERNS & **RESI DENTS** MEDI CAL SOCIAL SERVICE NONPHYSICIAN NURSING SCHOOL SERVICES-SALAR Cost Center Description Y & FRINGES RECORDS & **ANESTHETISTS** LI BRARY (TIME SPENT) (ASSI GNED **APPRV** (ASSI GNED (TIME SPENT) TIME) TIME) (ASSI GNED TIME) 16.00 17. 00 19.00 20.00 21.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 10,000 16.00 16,00 17 00 01700 SOCIAL SERVICE 17 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 20.00 02000 NURSING SCHOOL 0 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 21.00 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 Ω 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 017 30.00 0 0 0 0 0 43.00 04300 NURSERY 243 C 0 0 43.00 04400 SKILLED NURSING FACILITY 0 0 44.00 0 0 44.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 168 0 0 0 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 52.00 0 52.00 0 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54 00 4, 200 0 54 00 0 60.00 06000 LABORATORY 0 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0 0 0 62.30 06500 RESPIRATORY THERAPY 0 65.00 0 65.00 0 0 06600 PHYSI CAL THERAPY 0 66.00 919 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 326 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 126 06900 ELECTROCARDI OLOGY 0 69 00 0 Ω 0 69 00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 C 0 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 72.00 73.00 0 0 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 07697 CARDIAC REHABILITATION 76 97 0 0 76 97 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 0 76.98 07699 LI THOTRI PSY 0 76. 99 76.99 0 0 0 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0 Ω 0 0 0 90 00 90.01 09001 INTENSIVE OUT PATIENT PROGRAM 0 0 0 0 0 90.01 3,001 0 0 91.00 09100 EMERGENCY 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 0 0 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 10,000 0 0 0 0 118.00 118.00 NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 192.00 0 0 0 0 194.00 194. 00 07950 OCCUPATIONAL HEALTH 0 0 194. 01 07951 PAIN CLINIC 0 0 0 194. 01 194. 02 07952 OAK POINTE 0 0 194. 02 0 0 0 194. 03 07953 FOUNDATI ON 0 0 194. 03 0 194.04 07954 COMMUNITY & VOLUNTEER SERVICES 0 0 C 0 0 194. 04 194. 05 07955 VACANT SPACE 0 194.05 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00

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Part II)

Cost to be allocated (per Wkst. B,

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part I)

202.00

203.00

204 00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL				In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS			Provi der		Peri od:	Worksheet B-1		
					From 01/01/2015 To 12/31/2015			
						I NTERNS & RESI DENTS		
Cost Center Description	MEDICAL RECORDS &	SOCI A	L SERVICE	NONPHYSI CI AN ANESTHETI STS		SERVI CES-SALAR Y & FRI NGES		
	LI BRARY	(TIM	E SPENT)	(ASSI GNED	(ASSI GNED	APPRV		
	(TIME SPENT)			TIME)	TIME)	(ASSI GNED		
						TIME)		
	16. 00	•	17. 00	19. 00	20. 00	21. 00		
205.00 Unit cost multiplier (Wkst. B, Part	1. 185300		0. 000000	0. 00000	0. 000000	0. 000000	205. 00	

Health Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 150101 Peri od: Worksheet B-1 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/19/2016 5:11 pm INTERNS & **RESI DENTS** Cost Center Description SERVI CES-OTHER PARAMED ED PRGM COSTS **PRGM APPRV** (ASSI GNED (ASSI GNED TIME) TIME) 23.00 22.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16, 00 17.00 01700 SOCIAL SERVICE 17 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 20.00 02000 NURSING SCHOOL 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30 00 0 0 43.00 04300 NURSERY 0 0 43.00 04400 SKILLED NURSING FACILITY 0 44.00 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0000000000000000 0 52.00 53.00 05300 ANESTHESI OLOGY 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54 00 54 00 60.00 06000 LABORATORY 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 62.30 06500 RESPIRATORY THERAPY 0 65.00 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 69 00 06900 ELECTROCARDI OLOGY 0 69 00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 73.00 07697 CARDIAC REHABILITATION 76 97 76 97 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 76.98 07699 LI THOTRI PSY 0 76. 99 76.99 0 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0 0 90 00 90.01 09001 INTENSIVE OUT PATIENT PROGRAM 0 0 90.01 0 91.00 09100 EMERGENCY 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 118.00 0 0 118,00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 190.00 0 0 192.00 194. 00 07950 OCCUPATIONAL HEALTH 194. 00 0 0 194. 01 07951 PAIN CLINIC 0 194.01 194. 02 07952 OAK POINTE 0 194.02 0 194. 03 07953 FOUNDATI ON 194.03 0 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 0 194.04 194. 05 07955 VACANT SPACE 0 194.05 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 0 O 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.000000 203.00 204. 00 204.00 Cost to be allocated (per Wkst. B, Part II)

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 150101	Peri od: From 01/01/2015	Worksheet B-1		
				To 12/31/2015	Date/Time Pre 5/19/2016 5:1		
	I NTERNS & RESI DENTS						
Cost Center Description	SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM (ASSI GNED					
	(ASSIGNED TIME)	TI ME)					
	22. 00	23. 00					
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000				205. 00	

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150101	Peri od: Worksheet C From 01/01/2015 Part I To 12/31/2015 Date/Time Prepared:

			'	0 12/31/2015	5/19/2016 5:1	
		Ti tl	e XVIII	Hospi tal	PPS	<u> </u>
				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	6, 277, 485		6, 277, 485		6, 277, 485	
43. 00 04300 NURSERY	435, 342		435, 342	0	435, 342	43.00
44.00 O4400 SKILLED NURSING FACILITY	0		C	0	0	44. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	3, 619, 837		3, 619, 837	0	3, 619, 837	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 786, 227		1, 786, 227	0	1, 786, 227	52. 00
53. 00 05300 ANESTHESI OLOGY	32, 824		32, 824	4, 644	37, 468	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 752, 673		3, 752, 673	0	3, 752, 673	54. 00
60. 00 06000 LABORATORY	3, 130, 283		3, 130, 283	0	3, 130, 283	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		C	0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	1, 136, 526	0	1, 136, 526	0	1, 136, 526	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 073, 424	0	1, 073, 424	0	1, 073, 424	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	856, 305	0	856, 305	0	856, 305	67. 00
68.00 06800 SPEECH PATHOLOGY	227, 037	0	227, 037	o o	227, 037	68. 00
69. 00 06900 ELECTROCARDI OLOGY	3, 074		3, 074	0	3, 074	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	916, 418		916, 418	o o	916, 418	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	338, 255		338, 255	0	338, 255	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 005, 141		4, 005, 141	0	4, 005, 141	73.00
76. 97 07697 CARDIAC REHABILITATION	0		C	o	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0		l	ol	0	76. 98
76. 99 07699 LI THOTRI PSY	0		C	o	0	76. 99
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	468, 892		468, 892	2 0	468, 892	90. 00
90.01 09001 INTENSIVE OUT PATIENT PROGRAM	0		C	ol	0	90. 01
91. 00 09100 EMERGENCY	3, 723, 804		3, 723, 804	7, 098	3, 730, 902	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 147, 159		1, 147, 159		1, 147, 159	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVI CES	3, 092, 848		3, 092, 848	0	3, 092, 848	95. 00
200.00 Subtotal (see instructions)	36, 023, 554	0	36, 023, 554	11, 742	36, 035, 296	200.00
201.00 Less Observation Beds	1, 147, 159		1, 147, 159		1, 147, 159	201.00
202.00 Total (see instructions)	34, 876, 395					
	•	•	•			•

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150101	Peri od: Worksheet C From 01/01/2015 Part I
		To 12/31/2015 Date/Time Prepared:

					0 12/31/2015	5/19/2016 5:1	
			Ti tl	e XVIII	Hospi tal	PPS	т рііі
			Charges	9 /	noop: tui		
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	F			+ col. 7)	Ratio	Inpati ent	
						Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	4, 410, 186		4, 410, 186			30. 00
43.00	04300 NURSERY	1, 159, 192		1, 159, 192	2		43.00
44.00	04400 SKILLED NURSING FACILITY	0		C)		44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	4, 442, 781	14, 635, 296	19, 078, 077		0.000000	
	05200 DELIVERY ROOM & LABOR ROOM	7, 898, 319	273, 234			0.000000	
	05300 ANESTHESI OLOGY	426, 046	1, 787, 134			0. 000000	
	05400 RADI OLOGY-DI AGNOSTI C	3, 356, 107	35, 617, 243			0. 000000	
60.00	06000 LABORATORY	2, 365, 738	11, 163, 090	13, 528, 828		0.000000	
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	C	0. 000000	0.000000	
	06500 RESPI RATORY THERAPY	791, 021	1, 913, 908			0. 000000	
66.00	06600 PHYSI CAL THERAPY	217, 563	2, 529, 660			0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	115, 868	876, 209			0. 000000	
68.00	06800 SPEECH PATHOLOGY	19, 141	297, 705			0. 000000	
	06900 ELECTROCARDI OLOGY	601, 480	1, 831, 762			0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	875, 930	1, 907, 848			0. 000000	
	07200 I MPL. DEV. CHARGED TO PATIENTS	451, 133	604, 564			0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	4, 111, 155	9, 981, 404	14, 092, 559		0. 000000	
	07697 CARDI AC REHABI LI TATI ON	0	0	C	0. 000000	0. 000000	
	07698 HYPERBARI C OXYGEN THERAPY	0	0	C	0. 000000	0. 000000	
76. 99	07699 LI THOTRI PSY	0	0	<u>C</u>	0. 000000	0. 000000	76. 99
	OUTPATIENT SERVICE COST CENTERS	1 400	404.004	10,011			
	09000 CLINIC	1, 190	104, 821	106, 011		0. 000000	
	09001 INTENSIVE OUT PATIENT PROGRAM	0	0			0. 000000	
	09100 EMERGENCY	1, 960, 776	15, 235, 210			0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 119, 895	1, 119, 895	1. 024345	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0	5, 070, 867			0. 000000	
200.00		33, 203, 626	104, 949, 850	138, 153, 476			200.00
201.00		00 000 101	404 040 050	400 450 171			201. 00
202.00	Total (see instructions)	33, 203, 626	104, 949, 850	138, 153, 476)		202. 00

Health Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150101 Period: From 01/01/2015 To 12/31/2015 Part I Date/Time Prepared: 5/19/2016 5:11 pm

					5/19/2016 5: 11 pm
			Title XVIII	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS				30. 00
43.00	04300 NURSERY				43.00
44.00	04400 SKILLED NURSING FACILITY				44.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 189738			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 218591			52. 00
53.00	05300 ANESTHESI OLOGY	0. 016929			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 096288			54.00
60.00	06000 LABORATORY	0. 231379			60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65.00	06500 RESPI RATORY THERAPY	0. 420169			65. 00
66.00	06600 PHYSI CAL THERAPY	0. 390731			66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 863144			67. 00
68.00	06800 SPEECH PATHOLOGY	0. 716553			68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 001263			69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 329199			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 320409			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 284203			73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000			76. 98
76. 99	07699 LI THOTRI PSY	0. 000000			76. 99
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>			
90.00	09000 CLI NI C	4. 423050			90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0. 000000			90. 01
91.00	09100 EMERGENCY	0. 216964			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 024345			92.00
	OTHER REIMBURSABLE COST CENTERS	<u>'</u>			
95.00	09500 AMBULANCE SERVI CES	0. 609925			95. 00
200.00	Subtotal (see instructions)				200. 00
201.00					201. 00
202.00	1				202.00
		1			1

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150101	Peri od: Worksheet C From 01/01/2015 Part I To 12/31/2015 Date/Time Prepared:

			'	0 12/31/2013	5/19/2016 5:1	
		Ti t	le XIX	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						
30. 00 03000 ADULTS & PEDIATRICS	6, 277, 485		6, 277, 485		6, 277, 485	
43. 00 04300 NURSERY	435, 342		435, 342	0	435, 342	
44.00 O4400 SKILLED NURSING FACILITY	0		(0	0	44. 00
ANCILLARY SERVICE COST CENTERS	1					
50. 00 05000 OPERATI NG ROOM	3, 619, 837		3, 619, 837		3, 619, 837	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 786, 227		1, 786, 227		1, 786, 227	52.00
53. 00 05300 ANESTHESI OLOGY	32, 824		32, 824		37, 468	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 752, 673		3, 752, 673		3, 752, 673	
60. 00 06000 LABORATORY	3, 130, 283		3, 130, 283	0	3, 130, 283	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		(, I	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	1, 136, 526		.,,		1, 136, 526	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 073, 424	0	1, 073, 424	0	1, 073, 424	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	856, 305	0	856, 305	0	856, 305	67. 00
68. 00 06800 SPEECH PATHOLOGY	227, 037		227, 037	0	227, 037	68. 00
69. 00 06900 ELECTROCARDI OLOGY	3, 074		3, 074	0	3, 074	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	916, 418		916, 418	0	916, 418	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	338, 255		338, 255	0	338, 255	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 005, 141		4, 005, 141	0	4, 005, 141	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0		C	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0		C	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0		C	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	468, 892		468, 892	2	468, 892	90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0		C	0	0	90. 01
91. 00 09100 EMERGENCY	3, 723, 804		3, 723, 804	7, 098	3, 730, 902	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 147, 159		1, 147, 159		1, 147, 159	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	3, 092, 848		3, 092, 848	0	3, 092, 848	95. 00
200.00 Subtotal (see instructions)	36, 023, 554	0	36, 023, 554	11, 742	36, 035, 296	200.00
201.00 Less Observation Beds	1, 147, 159		1, 147, 159		1, 147, 159	201. 00
202.00 Total (see instructions)	34, 876, 395	0	34, 876, 395	11, 742	34, 888, 137	202. 00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150101	Peri od: Worksheet C
		From 01/01/2015 Part To 12/31/2015 Date/Time Prepared

				To 12/31/2015	Date/Time Pre 5/19/2016 5:1	
		Ti t	le XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6.00	7. 00	8. 00	9. 00	10. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	4, 410, 186		4, 410, 18			30. 00
43. 00 04300 NURSERY	1, 159, 192		1, 159, 19			43. 00
44.00 04400 SKILLED NURSING FACILITY	0			0		44. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	4, 442, 781	14, 635, 296			0. 000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	7, 898, 319	273, 234			0. 000000	52.00
53. 00 05300 ANESTHESI OLOGY	426, 046	1, 787, 134			0. 000000	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 356, 107	35, 617, 243			0. 000000	54. 00
60. 00 06000 LABORATORY	2, 365, 738	11, 163, 090			0. 000000	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0. 000000	0. 000000	62. 30
65. 00 06500 RESPI RATORY THERAPY	791, 021	1, 913, 908			0. 000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	217, 563	2, 529, 660			0. 000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	115, 868	876, 209	· ·		0. 000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	19, 141	297, 705			0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	601, 480	1, 831, 762			0. 000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	875, 930	1, 907, 848			0. 000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	451, 133	604, 564			0. 000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 111, 155	9, 981, 404	14, 092, 55		0. 000000	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0. 000000	0. 000000	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0. 000000	0. 000000	76. 98
76. 99 07699 LI THOTRI PSY	0	0		0. 000000	0. 000000	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	1, 190	104, 821	106, 01		0. 000000	90. 00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0		0. 000000	0. 000000	90. 01
91. 00 09100 EMERGENCY	1, 960, 776	15, 235, 210			0. 000000	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 119, 895	1, 119, 89	5 1. 024345	0. 000000	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	0	5, 070, 867			0. 000000	95. 00
200.00 Subtotal (see instructions)	33, 203, 626	104, 949, 850	138, 153, 47	6		200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	33, 203, 626	104, 949, 850	138, 153, 47	6		202. 00

Heal th Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES
Provider CCN: 150101 Period:
From 01/01/2015 To 12/31/2015 Part I
Date/Time Prepared:
5/19/2016 5:11 pm

				5/19/2016 5:11 pm
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Rati o			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
43. 00 04300 NURSERY				43.00
44.00 04400 SKILLED NURSING FACILITY				44. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 189738			50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 218591			52.00
53. 00 05300 ANESTHESI OLOGY	0. 016929			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 096288			54.00
60. 00 06000 LABORATORY	0. 231379			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 420169			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 390731			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 863144			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 716553			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 001263			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 329199			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 320409			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 284203			73.00
76. 97 07697 CARDIAC REHABILITATION	0. 000000			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			76. 98
76. 99 07699 LI THOTRI PSY	0. 000000			76. 99
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	4. 423050			90.00
90.01 09001 INTENSIVE OUT PATIENT PROGRAM	0. 000000			90. 01
91. 00 09100 EMERGENCY	0. 216964			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 024345			92.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 609925			95. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
	. '			•

Health Financial Systems		WHITL	EY MEMORIAL H	HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE	COST TO CHAP	GE RATIOS N	ET OF	Provi der CCN: 150101	Peri od:	Worksheet C
REDUCTIONS FOR MEDICALD ONLY					From 01/01/2015	Part II

12/31/2015 Date/Time Prepared: To 5/19/2016 5:11 pm Title XIX Hospi tal Operating Cost Capital Cost Operating Cost Cost Center Description Total Cost Capi tal (Wkst. B, Part (Wkst. B, Part Net of Capital Reducti on Reducti on I, col. 26) Cost (col. 1 Amount II col. 26) col. 2) 5. 00 1.00 2.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 3, 619, 837 2, 947, 464 05000 OPERATING ROOM 672, 373 50.00 50.00 0 0 0 0 0 0 0 0 0 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 1, 562, 806 52.00 1, 786, 227 223, 421 0 52.00 53.00 05300 ANESTHESI OLOGY 32,824 3, 992 28, 832 53.00 05400 RADI OLOGY-DI AGNOSTI C 629, 640 54.00 3, 752, 673 3, 123, 033 0 54.00 06000 LABORATORY 60.00 3, 130, 283 430, 529 2, 699, 754 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 Ω 0 62.30 65.00 06500 RESPIRATORY THERAPY 1, 136, 526 180, 561 955, 965 0 65.00 66.00 06600 PHYSI CAL THERAPY 1,073,424 267, 657 805, 767 66.00 06700 OCCUPATIONAL THERAPY 67.00 856, 305 105, 987 750, 318 0 67.00 68.00 06800 SPEECH PATHOLOGY 227,037 28, 120 198, 917 0 68.00 69.00 06900 ELECTROCARDI OLOGY 3,074 374 2, 700 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 916, 418 804, 958 0 71.00 111, 460 07200 IMPL. DEV. CHARGED TO PATIENTS 338, 255 41, 141 297, 114 72.00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 4,005,141 512,003 3, 493, 138 0 73.00 07697 CARDIAC REHABILITATION 76. 97 0 0 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 76 98 0 O 0 07699 LI THOTRI PSY 76. 99 0 0 76. 99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 468, 892 118, 067 350, 825 0 0 90.00 09001 INTENSIVE OUT PATIENT PROGRAM 0 Ω 90.01 90.01 91.00 09100 EMERGENCY 3, 723, 804 584, 359 3, 139, 445 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 212, 504 92.00 92.00 1, 147, 159 934, 655 0 0 OTHER REIMBURSABLE COST CENTERS 95.00 95. 00 09500 AMBULANCE SERVICES 3, 092, 848 378, 204 2, 714, 644 0

29, 310, 727

28, 163, 568

1, 147, 159

4, 500, 392

4, 287, 888

212, 504

24, 810, 335

23, 875, 680

934, 655

0

0

0 200.00

0 201. 00

0 202.00

200.00

201.00

202.00

Subtotal (sum of lines 50 thru 199)

Total (line 200 minus line 201)

Less Observation Beds

Health Financial Systems	WHITLEY MEMORIAL H	OSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST	T TO CHARGE RATIOS NET OF	Provider CCN: 150101	From 01/01/2015	Worksheet C Part II Date/Time Prepared:

						5/19/2016 5:11 pm
				le XIX	Hospi tal	PPS
	Cost Center Description	Cost Net of	Total Charges			
		Capital and	(Worksheet C,			
		Operating Cost		Ratio (col.	6	
		Reduction	8)	/ col. 7)		
		6. 00	7. 00	8. 00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	3, 619, 837	19, 078, 077	1		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 786, 227	8, 171, 553	0. 21859	91	52.00
53.00	05300 ANESTHESI OLOGY	32, 824			31	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 752, 673	38, 973, 350	0. 09628	38	54.00
60.00	06000 LABORATORY	3, 130, 283	13, 528, 828	0. 23137	79	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	00	62. 30
65.00	06500 RESPIRATORY THERAPY	1, 136, 526	2, 704, 929	0. 42016	59	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 073, 424	2, 747, 223	0. 39073	31	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	856, 305	992, 077	0. 86314	14	67. 00
68.00	06800 SPEECH PATHOLOGY	227, 037	316, 846	0. 71655	53	68. 00
69.00	06900 ELECTROCARDI OLOGY	3,074	2, 433, 242	0. 00126	53	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	916, 418	2, 783, 778	0. 32919	99	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	338, 255	1, 055, 697	0. 32040)9	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 005, 141	14, 092, 559	0. 28420	03	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0. 00000	00	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	l o	0. 00000	00	76. 98
76. 99	07699 LI THOTRI PSY	0	l o	0. 00000	00	76. 99
	OUTPATIENT SERVICE COST CENTERS			•		
90.00	09000 CLI NI C	468, 892	106, 011	4. 42305	50	90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0	O	0. 00000	00	90. 01
91.00	09100 EMERGENCY	3, 723, 804	17, 195, 986	0. 21655	51	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 147, 159	1, 119, 895	1. 02434	15	92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVI CES	3, 092, 848	5, 070, 867	0.60992	25	95. 00
200.00	Subtotal (sum of lines 50 thru 199)	29, 310, 727				200. 00
201.00	1 1 ,	1, 147, 159				201. 00
202.00	I I	28, 163, 568	ł			202. 00

Health Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Peri od:	Worksheet D	
				From 01/01/2015 To 12/31/2015		narad.
				10 12/31/2013	5/19/2016 5: 1	
		Ti tl	e 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	Ť		
	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 & PEDIATRICS	1, 162, 868	C	1, 162, 86	8 4, 821	241. 21	30.00
43. 00 NURSERY	54, 654		54, 65	4 937	58. 33	43.00
44.00 SKILLED NURSING FACILITY	0			0	0.00	44. 00
200.00 Total (lines 30-199)	1, 217, 522		1, 217, 52	2 5, 758		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 098	264, 849				30. 00
43. 00 NURSERY	0	C)			43.00
44.00 SKILLED NURSING FACILITY	0	C)			44. 00
200.00 Total (lines 30-199)	1, 098	264, 849				200. 00

Health Financial Systems	WHITLEY MEMORIAL F	IOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLAR	Y SERVICE CAPITAL COSTS	Provider CCN: 150101		Worksheet D Part II Date/Time Prepared: 5/19/2016 5:11 pm

						rom 01/01/2015		
						o 12/31/2015	Date/Time Prep 5/19/2016 5:1	parea:
				Ti +I	e XVIII	Hospi tal	PPS	Ι μιι
	Cost Center Description	Capi tal	Total		Ratio of Cost		Capital Costs	
	cost center bescription			Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,			(col. 1 ÷ col.		col umn 4)	
		Part II, col.	lait	8)	2)	Charges	COT dillit 4)	
		26)		0)	2)			
		1.00		2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00		2.00	0.00	1. 00	0.00	
	05000 OPERATING ROOM	672, 373	1	9, 078, 077	0. 035243	683, 658	24, 094	50.00
	05200 DELIVERY ROOM & LABOR ROOM	223, 421		8, 171, 553	•			52. 00
	05300 ANESTHESI OLOGY	3, 992		2, 213, 180				53.00
1	05400 RADI OLOGY-DI AGNOSTI C	629, 640	1	8, 973, 350				
	06000 LABORATORY	430, 529	1	3, 528, 828				
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	ŀ	0, 020, 020	1		0	62. 30
	06500 RESPI RATORY THERAPY	180, 561		2, 704, 929			19, 179	65.00
	06600 PHYSI CAL THERAPY	267, 657		2, 747, 223				66.00
	06700 OCCUPATI ONAL THERAPY	105, 987		992, 077				67. 00
	06800 SPEECH PATHOLOGY	28, 120		316, 846				68.00
	06900 ELECTROCARDI OLOGY	374		2, 433, 242				69.00
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	111, 460	l .	2, 783, 778				71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	41, 141		1, 055, 697				72.00
	07300 DRUGS CHARGED TO PATIENTS	512, 003	l .	4, 092, 559		· ·		
	07697 CARDI AC REHABI LI TATI ON	0.12,000		0	0. 000000		0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0		0	0. 000000		0	76. 98
1	07699 LI THOTRI PSY	0		0	0. 000000		l o	76. 99
	OUTPATIENT SERVICE COST CENTERS							
	09000 CLI NI C	118, 067		106, 011	1. 113724	346	385	90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0	ı	0	0. 000000	0	ol	90. 01
91.00	09100 EMERGENCY	584, 359	1	7, 195, 986	0. 033982	758, 142	25, 763	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	212, 504		1, 119, 895			0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES							95. 00
200.00	Total (lines 50-199)	4, 122, 188	12	7, 513, 231		5, 674, 520	185, 253	200. 00
							·	-

Health Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552						
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P.	ASS THROUGH COS	TS Provi der		Period: From 01/01/2015 To 12/31/2015		
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0	0	30. 00
43. 00 04300 NURSERY	0	0		0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	ol o		o	0	44.00
200.00 Total (lines 30-199)	0	o o		0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpatient	I npati ent		
· ·	Days	5 ÷ col. 6)	Program Days	Program		
		Í		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 & PEDI ATRI CS	4, 821	0.00	1, 09	8 0		30.00
43. 00 04300 NURSERY	937	0.00		o o		43.00
44.00 04400 SKILLED NURSING FACILITY	0	0.00	•	ol		44.00
200.00 Total (lines 30-199)	5, 758	1	1, 09	8 0		200. 00

Health Financial Systems	WHITLEY MEMORIAL H	OSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150101	Peri od: From 01/01/2015	Worksheet D
THROUGH COSTS				Date/Time Prepared: 5/19/2016 5:11 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	Non Physician Nursi	ng School Allied Healt	h All Other	Total Cost

					5/19/2016 5:1	1 pm	
			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Allied Health	All Other	Total Cost	
		Anestheti st			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						
	05000 OPERATING ROOM	0	0	0	0	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
	06500 RESPI RATORY 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
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0	0	0	90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0	90. 01
91.00	09100 EMERGENCY	0	0	0	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50-199)	0	0	0	0	0	200. 00

Heal th	Financial Systems	WHITLEY MEMOR	IAI HOSPITAI		Inlie	u of Form CMS-2	2552_10
APPORT	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERTHROUGH COSTS				Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV	pared:
			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	Inpati ent	
		Outpati ent	(from Wkst. C,		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 OPERATI NG ROOM	0	19, 078, 077	0.00000	0.000000	683, 658	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	8, 171, 553	0.00000	0.000000	1, 998	52.00
53.00	05300 ANESTHESI OLOGY	0	2, 213, 180	0.00000	0.000000	76, 923	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	38, 973, 350	0.00000	0. 000000	1, 288, 536	54. 00
60.00	06000 LABORATORY	0	13, 528, 828	0.00000	0.000000	733, 226	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	0. 000000	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0	2, 704, 929	0.00000	0.000000	287, 310	65.00
66.00	06600 PHYSI CAL THERAPY	0	2, 747, 223	0.00000	0.000000	102, 775	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	992, 077	0.00000	0.000000	53, 950	67. 00
68.00	06800 SPEECH PATHOLOGY	0	316, 846	0.00000	0.000000	8, 936	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	2, 433, 242	0.00000	0.000000	203, 532	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 783, 778	0.00000	0.000000	187, 592	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 055, 697	0.00000	0.000000	225, 473	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	14, 092, 559	0.00000	0. 000000	1, 062, 123	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	O	0.00000	0. 000000	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000	0. 000000	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0.00000	0. 000000	0	76. 99
	OUTPATIENT SERVICE COST CENTERS	'					
90.00	09000 CLI NI C	0	106, 011	0.00000	0. 000000	346	90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0	· o	0.00000	0. 000000	0	90. 01
91.00	09100 EMERGENCY	0	17, 195, 986	0.00000	0. 000000	758, 142	91.00
02.00	00000 OBCEDVATION DEDC (NON DISTINCT DADT	1	1 110 005	0 00000	0 000000		02.00

0 0 0

0.000000

0.000000

17, 195, 986 1, 119, 895

127, 513, 231

0 92.00 95.00

5, 674, 520 200. 00

92. 00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS | 09500 | AMBULANCE SERVICES | 200. 00 | Total (lines 50-199)

Health Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 150101 From 01/01/2015 To 12/31/2015 Date/Time Prepared:

Title XVIII Hospital PPS	<u> </u>
Cost Center Description Inpatient Outpatient Outpatient	
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	
ANCILLARY SERVICE COST CENTERS	
50. 00 05000 OPERATI NG ROOM 0 1,909,333 0	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM O O O	52. 00
53. 00 05300 ANESTHESI OLOGY 0 219, 114 0	53. 00
54. 00 05400 RADI 0LOGY-DI AGNOSTI C 0 6, 850, 446 0	54. 00
60. 00 06000 LABORATORY 0 177, 206 0	60. 00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0	62. 30
65. 00 06500 RESPI RATORY THERAPY 0 424, 912 0	65. 00
66. 00 06600 PHYSI CAL THERAPY 0 0 0	66. 00
67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0	67. 00
68. 00 06800 SPEECH PATHOLOGY 0 0	68. 00
69. 00 06900 ELECTROCARDI OLOGY 0 471, 021 0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 138,847 0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 64, 552 0	72. 00
73. 00 07300 DRUGS CHARGED TO PATLENTS 0 3,351,225 0	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0	76. 97
76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0	76. 98
76. 99 07699 LI THOTRI PSY 0 0 0	76. 99
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLI NI C 0 61, 069 0	90. 00
90. 01 09001 I NTENSI VE OUT PATI ENT PROGRAM 0 0 0	90. 01
91. 00 09100 EMERGENCY 0 2, 773, 089 0	91.00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 427, 240 0	92. 00
OTHER REIMBURSABLE COST CENTERS	
95. 00 09500 AMBULANCE SERVI CES	95. 00
200. 00 Total (lines 50-199) 0 16, 868, 054 0	200. 00

Health Financial Systems		WHI TLEY	MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES	AND VACCINE	COST	Provi der CCN: 150101	Peri od: From 01/01/2015	Worksheet D
						Date/Time Prepared:

					Fo 12/31/2015	Date/Time Pre 5/19/2016 5:1	
			Ti tl	e XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS			-			
	05000 OPERATING ROOM	0. 189738			0	362, 273	1
	05200 DELIVERY ROOM & LABOR ROOM	0. 218591	0		0	0	
	05300 ANESTHESI OLOGY	0. 014831	219, 114		0	3, 250	1
	05400 RADI OLOGY-DI AGNOSTI C	0. 096288			0	659, 616	1
	06000 LABORATORY	0. 231379		(0	41, 002	
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000		(0	0	02.00
65.00	06500 RESPI RATORY THERAPY	0. 420169	424, 912	(0	178, 535	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 390731	0	(0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 863144	0	(0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 716553	0	(0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 001263	471, 021	(0	595	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 329199	138, 847	(0	45, 708	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 320409	64, 552	(0	20, 683	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 284203	3, 351, 225		0	952, 428	73. 00
76. 97	07697 CARDIAC REHABILITATION	0. 000000	0		0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0	0	76. 98
76. 99	07699 LI THOTRI PSY	0. 000000	0		0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS				*		1
90.00	09000 CLI NI C	4. 423050	61, 069	(0	270, 111	90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0. 000000	0		0	0	90. 01
91.00	09100 EMERGENCY	0. 216551	2, 773, 089		0	600, 515	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 024345	427, 240		0	437, 641	92.00
	OTHER REIMBURSABLE COST CENTERS			•			1
95.00	09500 AMBULANCE SERVICES	0. 609925		(95. 00
200.00	Subtotal (see instructions)		16, 868, 054		0	3, 572, 357	200. 00
201.00	, ,				ol o		201.00
	Only Charges						
202.00			16, 868, 054		o	3, 572, 357	202. 00

Health Financial Systems WHITLEY MEMOR			OSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COS	ST	Provi der	CCN: 150101	From 01/01/2015	Worksheet D Part V Date/Time Pre 5/19/2016 5:1	
			Ti tl	e XVIII	Hospi tal	PPS	
		Costs					
Cost Center Description	Cost Reimbursed	d Rei	Cost				

			T: +1	e XVIII	Hospi tal	PPS	і і рііі
		Cos		l viii	поѕрітаі	PPS	
	Cost Center Description	Cost	Cost	-			
	Cost Center Description	Rei mbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00	-			
ANCI	LLARY SERVICE COST CENTERS	0.00	7.00	l			
	OO OPERATING ROOM						50.00
	DO DELIVERY ROOM & LABOR ROOM	0					52. 00
	DO ANESTHESI OLOGY						53. 00
	DO RADI OLOGY-DI AGNOSTI C						54.00
	DO LABORATORY						60.00
	50 BLOOD CLOTTING FOR HEMOPHILIACS	0					62. 30
	DO RESPIRATORY THERAPY	0					65. 00
	DO PHYSI CAL THERAPY	0					66. 00
	DO OCCUPATIONAL THERAPY	0					67. 00
	DOLSPEECH PATHOLOGY	0					68. 00
	DO ELECTROCARDI OLOGY	0					69.00
	DO MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
	DO IMPL. DEV. CHARGED TO PATIENTS	0	0				71.00
	DOLDRUGS CHARGED TO PATTENTS	0	0				73. 00
	97 CARDIAC REHABILITATION	0					76. 97
	98 HYPERBARIC OXYGEN THERAPY	0	0				76. 98
	99 LI THOTRI PSY	0	0				76. 99
	PATIENT SERVICE COST CENTERS	<u> </u>					1 70. 99
90. 00 0900			0				90.00
	D1 INTENSIVE OUT PATIENT PROGRAM						90. 01
	DO EMERGENCY						91.00
	DO OBSERVATION BEDS (NON-DISTINCT PART	0					92. 00
	ER REIMBURSABLE COST CENTERS	<u> </u>					72.00
	DO AMBULANCE SERVICES						95. 00
200.00	Subtotal (see instructions)		0				200.00
201.00 Less PBP Clinic Lab. Services-Program			١				200.00
201.00	Only Charges						201.00
202. 00	Net Charges (line 200 +/- line 201)	0	О				202. 00
202.00	INCL CHAIGES (TITLE 200 T/ - TITLE 201)	1 4	1 0	1			1202.00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Peri od:	Worksheet D		
				From 01/01/2015		narad.	
				To 12/31/2015	Date/Time Pre 5/19/2016 5:1		
		Ti t	le XIX	Hospi tal	PPS	т рііі	
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 & PEDIATRICS	1, 162, 868	0	1, 162, 86	8 4, 821	241. 21	30. 00	
43. 00 NURSERY	54, 654		54, 65	4 937	58. 33	43.00	
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	44. 00	
200.00 Total (lines 30-199)	1, 217, 522		1, 217, 52	2 5, 758		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					
I NPATI ENT ROUTI NE SERVI CE COST CENTERS							
30.00 ADULTS & PEDIATRICS	148	35, 699)			30.00	
43. 00 NURSERY	104	6, 066				43. 00	
44.00 SKILLED NURSING FACILITY	0	0)			44. 00	
200.00 Total (lines 30-199)	252	41, 765	5			200. 00	

Health Financial Systems	WHITLEY MEMORIAL H	OSPI TAL	In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY	SERVICE CAPITAL COSTS	Provi der CCN: 150101	Peri od:	Worksheet D

From 01/01/2015 | Part II To 12/31/2015 | Date/Time Prepared: 5/19/2016 5:11 pm Title XIX Hospi tal PPS Total Charges Ratio of Cost Capital Costs Cost Center Description Capi tal Inpati ent (column 3 x Related Cost (from Wkst. C, to Charges Program (from Wkst. B, Part I, col. (col. 1 ÷ col column 4) Charges Part II, col. 2) 8) 26) 2.00 3.00 4.00 5.00 1.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 672, 373 19, 078, 077 0.035243 1, 124, 065 39, 615 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 223, 421 8, 171, 553 0.027341 1, 339, 735 36, 630 52.00 05300 ANESTHESI OLOGY 3, 992 2, 213, 180 0.001804 156, 226 282 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 629, 640 38, 973, 350 0.016156 256, 219 54.00 4, 139 54.00 60.00 06000 LABORATORY 430, 529 13, 528, 828 0.031823 457, 325 14, 553 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0.000000 0 62.30 65.00 06500 RESPIRATORY THERAPY 180, 561 2, 704, 929 0.066753 107, 549 7, 179 65.00 06600 PHYSI CAL THERAPY 2, 747, 223 0.097428 7, 965 66 00 267 657 776 66 00 06700 OCCUPATIONAL THERAPY 992, 077 67.00 105, 987 0.106833 3, 972 424 67.00 68.00 06800 SPEECH PATHOLOGY 28, 120 316, 846 0.088750 0 68.00 06900 ELECTROCARDI OLOGY 0.000154 69.00 374 2, 433, 242 37, 050 69.00 6 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 2, 783, 778 0.040039 211, 745 8, 478 71 00 111, 460 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 41, 141 1, 055, 697 0.038970 33, 710 1, 314 72.00 07300 DRUGS CHARGED TO PATIENTS 512,003 14, 092, 559 0.036331 704, 631 25, 600 73.00 73.00 07697 CARDIAC REHABILITATION 76 97 0.000000 76 97 0 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 0.000000 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0.000000 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 1. 113724 359 90 00 09000 CLI NI C 118,067 106, 011 322 90.01 09001 INTENSIVE OUT PATIENT PROGRAM 0.000000 0 90.01 09100 EMERGENCY 584, 359 17, 195, 986 0.033982 158, 481 5, 386 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 212, 504 1, 119, 895 0.189754 0 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00 200.00 Total (lines 50-199) 4, 122, 188 127, 513, 231 4, 598, 995 144, 741 200. 00

Health Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Li€	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provi der		Period: From 01/01/2015 To 12/31/2015		
			le XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0	0	30. 00
43. 00 04300 NURSERY	0	0		0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	ol o		o	0	44.00
200.00 Total (lines 30-199)	0	o o		0	0	200. 00
Cost Center Description	Total Patient	Per Diem (col.	Inpatient	I npati ent		
'	Days	5 ÷ col. 6)	Program Days	Program		
		Í		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 & PEDI ATRI CS	4, 821	0.00	14	8 0	,	30.00
43. 00 04300 NURSERY	937		10	4	,	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0.00		o o	,	44.00
200.00 Total (lines 30-199)	5, 758	1	25	2 0	.[200. 00

APPORTI ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 150101 Period: From 01/01/2015 To 12/31/2015 Part IV Date/Time Prepare 5/19/2016 5:11 pm Title XIX Hospital PPS Cost Center Description Non Physician Anesthetist Anesthetist Cost Cost Education Cost Cos	Health Financial	Systems							u of Form CMS-:	2552-10
Cost Center Description Non Physician Nursing School Allied Health All Other Total Cost Anesthetist Medical (sum of col 1		I NPATI ENT/OUTPATI ENT	ANCILLARY SE	RVICE OTHER PASS	S	Provi der		From 01/01/2015	Part IV Date/Time Pre	
Anesthetist Medical (sum of col 1						Ti t	le XIX	Hospi tal	PPS	
Education cost through cont	Cost	Center Description			Nursi	ng School	Allied Healt		(sum of col 1	

		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Allied Health	All Other	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 OPERATI NG ROOM	0	0	0	0	0	00.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	C	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54.00
60. 00 06000 LABORATORY	0	0	C	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	C	0	0	62. 30
65. 00 06500 RESPIRATORY 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	C	0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0	0	C	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	C	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73.00
76. 97 07697 CARDIAC REHABILITATION	0	0	C	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	C	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	C	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	C	0	0	90.00
90.01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0	C	0	0	90. 01
91. 00 09100 EMERGENCY	0	0	C	o	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	C	o	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	0	0	C	0	0	200.00

	Financial Systems	WHITLEY MEMOR				u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	RVICE OTHER PAS	S Provi der		Period: From 01/01/2015	Worksheet D Part IV	
TTIKOOC	11 60313				To 12/31/2015		pared:
			Ti t	le XIX	Hospi tal	PPS	т рііі
	Cost Center Description	Total	Total Charges	Ratio of Cost		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	19, 078, 077				
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	8, 171, 553	•			
53.00	05300 ANESTHESI OLOGY	0	2, 213, 180	•			
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	38, 973, 350				54. 00
60.00	06000 LABORATORY	0	13, 528, 828				60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	0. 000000	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0	2, 704, 929	0.00000			65. 00
66. 00	06600 PHYSI CAL THERAPY	0	2, 747, 223	0.00000	0. 000000	7, 965	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	992, 077	0.00000	0. 000000	3, 972	67. 00
68.00	06800 SPEECH PATHOLOGY	0	316, 846	0.00000	0. 000000	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	2, 433, 242	0.00000	0. 000000	37, 050	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 783, 778	0.00000	0. 000000	211, 745	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 055, 697	0.00000	0. 000000	33, 710	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	14, 092, 559	0.00000	0. 000000	704, 631	73. 00
76. 97	07697 CARDIAC REHABILITATION	0	0	0.00000	0. 000000	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000	0. 000000	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0.00000	0. 000000	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90 00	09000 CLINIC	0	106 011	0.00000	0 000000	322	90 00

0

106, 011

17, 195, 986 1, 119, 895

127, 513, 231

0.000000

0.000000

0.000000

0.000000

0. 000000 0. 000000 0. 000000

0.000000

90.00

90. 01

91.00

92.00 0

95.00

322

4, 598, 995 200. 00

158, 481

09000 CLINIC 09001 INTENSIVE OUT PATIENT PROGRAM

92. 00 | 09200 | 0BSERVATION | BEDS | (NON-DISTINCT PART | OTHER | REIMBURSABLE | COST | CENTERS | 095. 00 | 09500 | AMBULANCE | SERVICES |

Total (lines 50-199)

90.00

90. 01

200.00

91. 00 09100 EMERGENCY

Health Financial Systems	WHITLEY MEMORIAL H	IOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150101	Peri od: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared:

				10	12/31/2015	Date/IIme Pr 5/19/2016 5:	
		Ti t	le XIX		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	(2	0			50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	(2	0			52. 00
53. 00 05300 ANESTHESI OLOGY	0	(2	0			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	(2	0			54.00
60. 00 06000 LABORATORY	0	(2	0			60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	(2	0			62. 30
65. 00 06500 RESPIRATORY THERAPY	0	(2	0			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	()	0			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	(2	0			67. 00
68. 00 06800 SPEECH PATHOLOGY	0	(2	0			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	(2	0			69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	(2	0			71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	(2	0			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	(0			73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	(0			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	(0			76. 98
76. 99 07699 LI THOTRI PSY	<u> </u>		<u>/</u>	U			76. 99
90. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 O9000 CLINIC			\				- 00 00
90. 00 09000 CLINI C 90. 01 09001 INTENSI VE OUT PATI ENT PROGRAM	0	0		0			90. 00 90. 01
91. 00 09100 EMERGENCY	0	(0			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	(0			91.00
OTHER REIMBURSABLE COST CENTERS	U U		ή	U			92.00
95. 00 09500 AMBULANCE SERVICES							95. 00
200.00 Total (lines 50-199)	0	C		0			200.00
200.00 Total (TITIES 30-177)	١		1	٥Į			1200.00

Health Financial Systems		WHI TLEY	MEMORIAL H	IOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES	AND VACCINE	COST	Provi der CCN: 150101	Peri od: From 01/01/2015	Worksheet D Part V

12/31/2015 Date/Time Prepared: 5/19/2016 5:11 pm Title XIX Hospi tal 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. 189738 2, 275, 447 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0. 218591 0 4, 380 52.00 05300 ANESTHESI OLOGY 0 0 259, 929 53 00 0.014831 53 00 0 |05400| RADI OLOGY-DI AGNOSTI C 0 54.00 0.096288 0 4, 999, 582 0 54.00 60.00 06000 LABORATORY 0. 231379 1, 538, 417 0 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0 0 62.30 0 06500 RESPIRATORY THERAPY 0 0 219, 556 65.00 0.420169 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.390731 305, 757 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 0.863144 84, 040 0 67.00 0 06800 SPEECH PATHOLOGY 0 716553 68 00 68 00 166, 630 69.00 06900 ELECTROCARDI OLOGY 0.001263 240, 424 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 329199 353, 118 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.320409 0 65, 978 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 0 73 00 0. 284203 1, 275, 428 0 73.00 76. 97 07697 CARDIAC REHABILITATION 0.000000 0 0 0 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.000000 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0.000000 0 0 76. 99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 4. 423050 0 0 27, 772 0 90.00 09001 INTENSIVE OUT PATIENT PROGRAM 0.000000 0 0 0 90.01 90.01 3, 992, 162 91.00 91.00 09100 EMERGENCY 0.216551 0 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 1.024345 306, 774 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0. 609925 702, 561 95.00 200.00 Subtotal (see instructions) 0 0 200. 00 702, 561 16, 115, 394 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 +/- line 201) 702, 561 0 202.00 16, 115, 394

Health Financial Systems		WHI TLEY	MEMORIAL H	IOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES	AND VACCINE	COST	Provider CCN: 150101		Worksheet D
					From 01/01/2015	Part V

					To 12/31/2015		
			Ti 1	tle XIX	Hospi tal	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost	1			
	·	Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	431, 739	•			50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	957	1			52. 00
	05300 ANESTHESI OLOGY	0	3, 855				53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	481, 400				54. 00
60. 00	06000 LABORATORY	0	355, 957	1			60. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	(62. 30
65. 00	06500 RESPI RATORY THERAPY	0	92, 251	•			65. 00
66. 00	06600 PHYSI CAL THERAPY	0	119, 469	•			66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	72, 539	•			67. 00
	06800 SPEECH PATHOLOGY	0	119, 399				68. 00
	06900 ELECTROCARDI OLOGY	0	304				69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	116, 246	1			71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	21, 140				72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	362, 480				73. 00
	07697 CARDI AC REHABI LI TATI ON	0	(76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	(76. 98
76. 99	07699 LI THOTRI PSY	0	()			76. 99
	OUTPATIENT SERVICE COST CENTERS		T	1			
	09000 CLI NI C	0		1			90. 00
	09001 INTENSIVE OUT PATIENT PROGRAM	0	(1			90. 01
	09100 EMERGENCY	0	864, 507	•			91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	314, 242	2			92. 00
05.63	OTHER REIMBURSABLE COST CENTERS	400 510	1				05.00
	09500 AMBULANCE SERVICES	428, 510					95. 00
200.00	, ,	428, 510	3, 479, 322	<u>2</u>			200. 00
201.00		0					201. 00
202 22	Only Charges	400 540	2 470 000	,			202 00
202.00	Net Charges (line 200 +/- line 201)	428, 510	3, 479, 322	<u>-</u>			202. 00

Health Financial Systems	WHITLEY MEMORIAL HOSPITA	TAL	In Lieu	u of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST	Provi		From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prep	
		Title XVIII	Hospi tal	5/19/2016 5: 11 PPS	l pm
Cost Center Description					

		Title XVIII	Hospi tal	5/19/2016 5: 1 PPS	1 pm
	Cost Center Description	THE AVITE	1103pi tai	113	
	DART I ALL DROW DED COMPONIENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		4, 821	1. 00
2.00	Inpatient days (including private room days, excluding swing-be			4, 821	2. 00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only pr	ivate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed	days)		3, 940	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	0	5. 00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 098	9. 00
7. 00	newborn days)	the rrogram (exertaining	Swifing bed dild	1,070	7.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructi Swing-bed SNF type inpatient days applicable to title XVIII onl		nom dave) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, ent		Join days) arter	U	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
40.00	through December 31 of the cost reporting period				40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar year			0	13. 00
14. 00	Medically necessary private room days applicable to the Program			0	14. 00
15. 00	Total nursery days (title V or XIX only)			0	
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	0.00	17. 00
17.00	reporting period	through becomber of o	1 110 0031	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0.00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
. ,	reporting period	-			
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)			6, 277, 485	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	
	5 x line 17)			_	
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	1 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
05.00	7 x line 19)				05.00
25. 00	Swing-bed cost applicable to NF type services after December 31 x line 20)	or the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		6, 277, 485	27. 00
20.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	and abassustian had ab	2222)	0	20.00
28. 00 29. 00	Private room charges (excluding swing-bed charges)	and observation bed ch	arges)	0	
30. 00	Semi - pri vate room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu	e lino 22)(eoo inetrue	tions)	0. 00 0. 00	
35. 00	Average per diem private room charge differential (fine 32 minu Average per diem private room cost differential (line 34 x line		11 0113)	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 an	d private room cost di	fferential (line	6, 277, 485	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	TMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see i			1, 302. 11	38. 00
39.00	Program general inpatient routine service cost (line 9 x line 3	-		1, 429, 717	
40.00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +	,		0 1, 429, 717	
41.00	Trotal Trogram general Impatrent routine service cost (IIIIe 39 +	11116 40)	ı	1,447,111	41.00

	Financial Systems	WHITLEY MEMORIA				eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi dei	r CCN: 150101	Peri od: From 01/01/2015	Worksheet D-1	
					To 12/31/2015	5/19/2016 5:1	
	Cost Center Description	Total	Ti t Total	le XVIII Average Per	Hospital Program Days	PPS Program Cost	
	cost center bescription	Inpatient Cost I		sDiem (col. 1		(col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0		0 0.			42. 00
40.00	Intensive Care Type Inpatient Hospital Units					I	40.00
43. 00 44. 00							43.00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT						46. 00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
40.00			11 000)			1.00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ons)		1, 241, 160 2, 670, 877	
	PASS THROUGH COST ADJUSTMENTS	y , ,		,			177.00
50. 00	Pass through costs applicable to Program inp	atient routine s	ervices (fro	om Wkst. D, su	m of Parts I and	264, 849	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillary	services (f	rom Wkst. D,	sum of Parts II	185, 253	51.00
F2 00	and IV)	FO F1)				450 400	F2 00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated, non-ph	nvsician anest	hetist, and	450, 102 2, 220, 775	
	medical education costs (line 49 minus line					, , ,	
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55. 00							55. 00
56.00	,			(1: F/ -:	Li F2)	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tar	get amount (Tine 56 minus	11 ne 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period e	ndi ng 1996,	updated and c	ompounded by the		
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report und	ated by the	market hasket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line					0.00	61.00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		(lines 54 x	(60), or 1% o	f the target		
62. 00		instructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instruc	tions)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of th	ne cost report	ing period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decembe	r 31 of the	cost reportin	a period (See	0	65. 00
	instructions) (title XVIII only)			•			
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	THE COSTS (TITHE O	4 prus rine	os)(title xvi	ii diliy). Fdi	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31	of the cost r	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after De	cember 31 of	the cost rep	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (I	ine 67 + lir	ne 68)		0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil				`	I	70.00
71. 00	Adjusted general inpatient routine service c	,		•)		71.00
72.00	Program routine service cost (line 9 x line		/I. 44 I	. 05)			72.00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv		•				73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient				Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		ovi der recor	rds)			78. 00 79. 00
80.00	Total Program routine service costs for comp	arison to the co		,	nus line 79)		80. 00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (83. 00
84.00	Program inpatient ancillary services (see in		۵)				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST	- · g. · • • · ·			T	
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	line 2)			881 1, 302. 11	1
	Observation bed cost (line 87 x line 88) (se		2)			1, 147, 159	

Health Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Prep 5/19/2016 5:1	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	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	1, 162, 868	6, 277, 485	0. 18524	4 1, 147, 159	212, 504	90.00
91.00 Nursing School cost	0	6, 277, 485	0.00000	0 1, 147, 159	0	91.00
92.00 Allied health cost	0	6, 277, 485	0.00000	0 1, 147, 159	0	92.00
93.00 All other Medical Education	0	6, 277, 485	0. 00000	0 1, 147, 159	0	93. 00

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 150101	Peri od: From 01/01/2015	Worksheet D-1	
			To 12/31/2015	Date/Time Pre 5/19/2016 5:1	
		Title XIX	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
1 00 Inpatient days (including private room days	and swing-had days	eveluding newborn)		/ 921	1 1 00

	III e XIX Hospital	PPS	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4, 821	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	4, 821 0	2. 00 3. 00
3.00	do not complete this line.	٥	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3, 940	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	148	9. 00
	newborn days)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	O	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
40.00	through December 31 of the cost reporting period		40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13. 00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	937	15. 00
16. 00	Nursery days (title V or XIX only)	104	16. 00
17 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17 00
17. 00	reporting period	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
	reporting period		
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0. 00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20. 00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	6, 277, 485	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24. 00
25. 00	X Time 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
20.00	x line 20)		20.00
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6, 277, 485	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00		0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)	0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00 0. 00	32. 00 33. 00
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34. 00
35. 00	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
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	6, 277, 485	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 302. 11	
39. 00	Program general inpatient routine service cost (line 9 x line 38)	192, 712	39.00
40. 00 41. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35) Total Program general inpatient routine service cost (line 39 + line 40)	0 192, 712	40.00
41.00	Total Trogram general Impatrent routine service cost (Tille 37 + Tille 40)	174, / 14	J + 1. UU

Heal th	Financial Systems	WHITLEY MEMOR	IAL HOSPITA	AL_		In Lie	eu of Form CMS-2	<u>2552</u> -10
	ATION OF INPATIENT OPERATING COST				CCN: 150101	Peri od: From 01/01/2015	Worksheet D-1	
						To 12/31/2015	Date/Time Pre	
				Ti t	le XIX	Hospi tal	5/19/2016 5: 1 PPS	1 pm
	Cost Center Description	Total	Total		Average Per		Program Cost	
		Inpatient Cost	I npati ent	Days		÷	(col. 3 x col.	
		1.00	2.00		col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	435, 342		937				42. 00
42.00	Intensive Care Type Inpatient Hospital Units		I					1 42 00
43. 00 44. 00	CORONARY CARE UNIT							43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT							45. 00
46. 00	1							46. 00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description							47. 00
							1. 00	
48. 00	Program inpatient ancillary service cost (Wk				,		1, 007, 613	1
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)((see instru	uctio	ins)		1, 248, 644	49. 00
50. 00	Pass through costs applicable to Program inp	atient routine	servi ces ((from	Wkst. D, sum	of Parts I and	41, 765	50.00
E4 00						6.5		
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillar	ry services	s (fr	om Wkst. D, s	sum of Parts II	144, 741	51.00
52. 00	Total Program excludable cost (sum of lines						186, 506	52. 00
53. 00	Total Program inpatient operating cost exclu		elated, nor	n-phy	sician anesth	etist, and	1, 062, 138	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)						
54.00	Program di scharges						0	54.00
	Target amount per discharge						0.00	•
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	araet amour	nt (I	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)	ring cost and te	ir get amour	(1	THE 30 III HUS	11110 33)	ő	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	ending 199	96, u	pdated and co	mpounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost renort ur	ndated by t	the m	arket hasket		0.00	60.00
61.00	If line 53/54 is less than the lower of line					the amount by	0.00	ı
	which operating costs (line 53) are less tha		ts (lines 5	54 x	60), or 1% of	the target		
62. 00	amount (line 56), otherwise enter zero (see instructions) Relief payment (see instructions)							62. 00
	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)				0	63.00
44.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Doos	mbor 21 of	= the	cost roporti	ng pariod (Saa	0	64. 00
64. 00	instructions)(title XVIII only)	ts through bece	elliber 31 Or	the	: Cost Teporti	ng perrou (see		04.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of t	the c	ost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	na costs (lina	64 nlus li	no 6	5)/+i+l_ YVII	Lonly) For	0	66. 00
00.00	CAH (see instructions)	THE COSTS (TITLE	04 prus ri	ne o	o)(title xvii	i only). To		00.00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	n December	31 o	of the cost re	porting period	0	67. 00
68 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after [December 31	l of	the cost reno	orting period	0	68. 00
00.00	(line 13 x line 20)		occomber o	. 01	the cost repe	a tring perrod		00.00
69. 00	Total title V or XIX swing-bed NF inpatient						0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil							70.00
71. 00	Adjusted general inpatient routine service c	-						71.00
72.00	Program routine service cost (line 9 x line		. (: 14		25)			72.00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv							73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient	•		,		art II, column		75. 00
74 00	26, line 45)	no 2)						76. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line							77.00
78. 00	Inpatient routine service cost (line 74 minu	s line 77)						78. 00
79.00	Aggregate charges to beneficiaries for exces					us Line 70)		79.00
80.00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		JUST IIIII Tõ	ation	i (iiile /ŏ Mif	ius IIIIe /9)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81	* .					82. 00
83.00	Reasonable inpatient routine service costs (ns)					83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)					84. 00 85. 00
	Total Program inpatient operating costs (sum							86.00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PASS						001	07.00
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	: line 2)				881 1, 302. 11	1
	Observation bed cost (line 87 x line 88) (se	•					1, 147, 159	

Health Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Prep 5/19/2016 5:1	
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	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	1, 162, 868	6, 277, 485	0. 18524	4 1, 147, 159	212, 504	90.00
91.00 Nursing School cost	0	6, 277, 485	0.00000	0 1, 147, 159	0	91.00
92.00 Allied health cost	0	6, 277, 485	0.00000	0 1, 147, 159	0	92.00
93.00 All other Medical Education	0	6, 277, 485	0. 00000	0 1, 147, 159	0	93. 00

	Financial Systems WHITLEY MEMORIAL ENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 150101	Peri od:	eu of Form CMS-: Worksheet D-3	
				From 01/01/2015		
				To 12/31/2015	Date/Time Pre 5/19/2016 5:1	pared: 1 pm
-		Ti tl	e XVIII	Hospi tal	PPS	- I
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
			1.00	2. 00	2) 3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00	03000 ADULTS & PEDIATRICS			1, 598, 970		30.00
43. 00	04300 NURSERY			1,070,770		43. 00
	ANCI LLARY SERVI CE COST CENTERS			<u> </u>		1
50.00	05000 OPERATI NG ROOM		0. 1897	38 683, 658	129, 716	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 2185	91 1, 998		
53.00	05300 ANESTHESI OLOGY		0. 0169	29 76, 923	1, 302	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 0962	88 1, 288, 536	124, 071	54.00
60.00	06000 LABORATORY		0. 2313		169, 653	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000			
65.00	06500 RESPI RATORY THERAPY		0. 4201			
66.00	06600 PHYSI CAL THERAPY		0. 3907	·		
67. 00	06700 OCCUPATI ONAL THERAPY		0. 8631			
68. 00	06800 SPEECH PATHOLOGY		0. 7165			
69. 00	06900 ELECTROCARDI OLOGY		0. 0012			
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3291			
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 3204	·		
73. 00 76. 97	07300 DRUGS CHARGED TO PATLENTS 07697 CARDLAC REHABLLITATION		0. 2842 0. 0000			
	07698 HYPERBARI C OXYGEN THERAPY		0.0000			
76. 96 76. 99	07699 LI THOTRI PSY		0.0000		_	
70. 77	OUTPATIENT SERVICE COST CENTERS		0.0000	00 0	0	70.77
90. 00	09000 CLINIC		4. 4230	50 346	1, 530	90.00
90. 01	09001 NTENSI VE OUT PATI ENT PROGRAM		0.0000			
91. 00	09100 EMERGENCY		0. 2169		_	
	09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 0243		1	
	OTHER REIMBURSABLE COST CENTERS				,	1
95.00	09500 AMBULANCE SERVI CES					95. 00
200.00				5, 674, 520	1, 241, 160	200.00
201.00		(line 61)		0		201. 00
202.00	Net Charges (line 200 minus line 201)			5, 674, 520		202.00

	INCI ANCILLARY SERVICE COST APPORTIONMENT	_	CCN: 150101	Peri od:	eu of Form CMS-2 Worksheet D-3	
INPAILENI /	ANCILLARY SERVICE CUST APPURTIUNMENT	Provi der	CCN: 150101	From 01/01/2015		
				To 12/31/2015	Date/Time Pre 5/19/2016 5:1	
		Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
			1.00	2, 00	2) 3. 00	
ΙΝΡΔ	TIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	O ADULTS & PEDIATRICS			1, 036, 231		30.00
	0 NURSERY			529, 620		43.00
	LLARY SERVICE COST CENTERS				l .	1
50.00 0500	O OPERATING ROOM		0. 1897	38 1, 124, 065	213, 278	50.00
	O DELIVERY ROOM & LABOR ROOM		0. 2185	91 1, 339, 735	292, 854	52.00
53.00 0530	O ANESTHESI OLOGY		0. 0169	29 156, 226	2, 645	53.00
54.00 0540	O RADI OLOGY-DI AGNOSTI C		0. 0962	88 256, 219	24, 671	54.00
60.00 0600	0 LABORATORY		0. 2313	79 457, 325	105, 815	
	O BLOOD CLOTTING FOR HEMOPHILIACS		0.0000			
	0 RESPI RATORY THERAPY		0. 4201			
	O PHYSI CAL THERAPY		0. 3907			
	O OCCUPATI ONAL THERAPY		0. 8631			
	O SPEECH PATHOLOGY		0. 7165			
	O ELECTROCARDI OLOGY		0. 0012	· ·		
	O MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3291			
	O IMPL. DEV. CHARGED TO PATIENTS		0. 3204			
	O DRUGS CHARGED TO PATIENTS 7 CARDIAC REHABILITATION		0. 2842 0. 0000			
	8 HYPERBARI C OXYGEN THERAPY		0.0000			
	9 LITHOTRIPSY		0.0000		-	
	ATIENT SERVICE COST CENTERS		0.0000	00 0		70. 77
90.00 0900			4. 4230	50 322	1, 424	90.00
	1 INTENSIVE OUT PATIENT PROGRAM		0.0000			•
	O EMERGENCY		0. 2169		34, 385	
	O OBSERVATION BEDS (NON-DISTINCT PART		1. 0243	· ·		
	R REIMBURSABLE COST CENTERS					1
	O AMBULANCE SERVICES					95. 00
200.00	Total (sum of lines 50-94 and 96-98)			4, 598, 995	1, 007, 613	
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)			4, 598, 995		202.00

			Т	o 12/31/2015	Date/Time Pre 5/19/2016 5:1	
		Ti tl	e XVIII	Hospi tal	PPS	, piii
			0	1.00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		0	1.00	2. 00	
1.00	DRG Amounts Other than Outlier Payments			0		1.00
1. 01	DRG amounts other than outlier payments for discharges occurrin	g prior		1, 332, 975		1. 01
1. 02	to October 1 (see instructions) DRG amounts other than outlier payments for discharges occurrin	a on or		590, 507		1. 02
02	after October 1 (see instructions)	9 0 0.		0,0,00,		
1. 03	DRG for federal specific operating payment for Model 4 BPCI for			0		1. 03
1. 04	discharges occurring prior to October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for			0		1. 04
1.01	discharges occurring on or after October 1 (see instructions)					1.01
2.00	Outlier payments for discharges. (see instructions)			2, 150		2. 00
2. 01 2. 02	Outlier reconciliation amount	nc)		0		2. 01 2. 02
3. 00	Outlier payment for discharges for Model 4 BPCI (see instructio Managed Care Simulated Payments	115)		0		3. 00
4. 00	Bed days available divided by number of days in the cost report	i ng		27. 46		4. 00
	period (see instructions)					
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most	recent		0.00		5. 00
5.00	cost reporting period ending on or before 12/31/1996. (see instr			0.00		3.00
6.00	FTE count for allopathic and osteopathic programs which meet th			0.00		6. 00
	criteria for an add-on to the cap for new programs in accordanc CFR 413.79(e)	e with 42				
7. 00	MMA Section 422 reduction amount to the IME cap as specified un	der 42		0.00		7. 00
	CFR §412.105(f)(1)(iv)(B)(1)					
7. 01	ACA Section 5503 reduction amount to the IME cap as specified u			0.00		7. 01
	CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July then see instructions.	1, 2011				
8.00	Adjustment (increase or decrease) to the FTE count for allopath	ic and		0.00		8. 00
	osteopathic programs for affiliated programs in accordance with					
	413.75(b), 413.79(c)(2)(i v), 64 FR 26340 (May 12, 1998), and 67 (August 1, 2002).	FR 50069				
8. 01	The amount of increase if the hospital was awarded FTE cap slot	s under		0.00		8. 01
	section 5503 of the ACA. If the cost report straddles July 1, 2					
0.00	instructions.	o from o		0.00		0.00
8. 02	The amount of increase if the hospital was awarded FTE cap slot closed teaching hospital under section 5506 of ACA. (see instru			0.00		8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines			0.00		9. 00
40.00	and 8,02) (see instructions)			0.00		10.00
10. 00	FTE count for allopathic and osteopathic programs in the curren from your records	t year		0.00		10.00
11. 00	FTE count for residents in dental and podiatric programs.			0.00		11. 00
	Current year allowable FTE (see instructions)			0.00		12. 00
13.00	Total allowable FTE count for the prior year.	andad an		0. 00 0. 00		13. 00 14. 00
14. 00	Total allowable FTE count for the penultimate year if that year or after September 30, 1997, otherwise enter zero.	ended on		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			0.00		16.00
17. 00 18. 00	Adjustment for residents displaced by program or hospital closu Adjusted rolling average FTE count	re		0. 00 0. 00		17. 00 18. 00
	Current year resident to bed ratio (line 18 divided by line 4).			0. 000000		19.00
	Prior year resident to bed ratio (see instructions)			0. 000000		20. 00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000		21. 00
	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)			0		22. 00 22. 01
22.01	Indirect Medical Education Adjustment for the Add-on for Section	n 422 of t	he MMA			22.01
23. 00	Number of additional allopathic and osteopathic IME FTE residen			0.00		23. 00
24.00	slots under 42 Sec. 412.105 (f)(1)(iv)(C).			0.00		24.00
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the lo	wer of		0. 00 0. 00		24. 00 25. 00
23.00	line 23 or line 24 (see instructions)	wci oi		0.00		25.00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000		26. 00
	IME payments adjustment factor. (see instructions)			0. 000000		27. 00 28. 00
28. 00	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)			0		28. 00
29. 00	Total IME payment (sum of lines 22 and 28)			O		29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0		29. 01
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A pat	ient dave		2 22		30 00
30.00	(see instructions)	Tent uays		3. 22		30.00
31. 00	Percentage of Medicaid patient days (see instructions)			29. 99		31. 00
32.00	Sum of lines 30 and 31			33. 21		32.00
	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)			12. 00 57, 704		33. 00 34. 00
5 55	12FF. 1. Share share as as as more (300 Fileti doctions)	ı	I	37,704		, 555

	ATION OF REIMBURSEMENT SETTLEMENT		Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Pre 5/19/2016 5:1	
		Title XVIII	Hospi tal	PPS	ı pııı
			Prior to	On/After	
			October 1	October 1	
		0	1. 00	2. 00	
	Uncompensated Care Adjustment				
35. 00	Total uncompensated care amount (see instructions)		7, 647, 644, 885	6, 406, 145, 534	35.00
35. 01	Factor 3 (see instructions)		0. 000030561	0. 000030771	35. 01
35. 02	Hospital uncompensated care payment (If line 34 is zero,		233, 718		1
00. 02	enter zero on this line) (see instructions)		200, 710	177, 121	00.02
35. 03	Pro rata share of the hospital uncompensated care payment		174, 808	49, 550	35. 03
33. 03	amount (see instructions)		174, 000	47, 550	35.00
36. 00			224 250		2/ 00
36.00	Total uncompensated care (sum of columns 1 and 2 on line		224, 358		36.00
	35.03)	(1)	1 (1)		-
	Additional payment for high percentage of ESRD beneficiary di	scharges (lines 40 throug			-
40. 00	Total Medicare discharges on Worksheet S-3, Part I		0		40.00
	excluding discharges for MS-DRGs 652, 682, 683, 684 and				
	685 (see instructions)				
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652,		0		41.00
	682, 683, 684 an 685. (see instructions)				
41. 01	Total ESRD Medicare covered and paid discharges excluding		0		41.01
	MS-DRGs 652, 682, 683, 684 an 685. (see instructions)				
42. 00	Divide line 41 by line 40 (if less than 10%, you do not		0.00		42.00
	qualify for adjustment)				
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,		n		43.00
	682, 683, 684 an 685. (see instructions)				
44. 00	Ratio of average length of stay to one week (line 43		0. 000000		44.00
00	divided by line 41 divided by 7 days)		3. 000000		' ' . 50
45. 00	Average weekly cost for dialysis treatments (see		0.00		45. 00
45.00			0.00		45.00
44 00	instructions)				1/ 00
46. 00	Total additional payment (line 45 times line 44 times line		0		46. 00
47.00	41.01)		0 007 (04		47.00
47. 00	Subtotal (see instructions)		2, 207, 694		47.00
48. 00	Hospital specific payments (to be completed by SCH and		0		48. 00
	MDH, small rural hospitals only. (see instructions)				
49. 00	Total payment for inpatient operating costs (see		2, 207, 694		49.00
	instructions)				
50. 00	Payment for inpatient program capital (from Wkst. L, Pt. I		155, 504		50.00
	and Pt. II, as applicable)				
51. 00	Exception payment for inpatient program capital (Wkst. L,		0		51.00
	Pt. III, see instructions)				
52. 00	Direct graduate medical education payment (from Wkst. E-4,		0		52.00
	line 49 see instructions).				
53. 00	Nursing and Allied Health Managed Care payment		0		53.00
54. 00	Special add-on payments for new technologies		0		54.00
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,		0		55. 00
	line 69)				
56. 00	Cost of physicians' services in a teaching hospital (see		0		56.00
00.00	intructions)		Ĭ		00.00
57. 00	Routine service other pass through costs (from Wkst. D,		0		57. 00
37.00	Pt. III, column 9, lines 30 through 35).		ď		37.00
E0 00					E0 00
36. 00	Ancillary service other pass through costs from Wkst. D,		0		58.00
FO 00	Pt. IV, col. 11 line 200)		2 2/2 100		F0 00
59. 00	Total (sum of amounts on lines 49 through 58)		2, 363, 198		59.00
60.00	Primary payer payments		0 0 0 0		60.00
61. 00	Total amount payable for program beneficiaries (line 59		2, 363, 198		61.00
	minus line 60)		05		1, -
62. 00	Deductibles billed to program beneficiaries		354, 989		62.00
63. 00	Coinsurance billed to program beneficiaries		976		63.00
64. 00	Allowable bad debts (see instructions)		23, 992		64.00
65. 00	Adjusted reimbursable bad debts (see instructions)		15, 595		65. 00
66. 00	Allowable bad debts for dual eligible beneficiaries (see		10, 472		66.00
	instructions)		·		
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		2, 022, 828		67.00
68. 00	Credits received from manufacturers for replaced devices		. , , s = 0		68. 00
	for applicable to MS-DRGs (see instructions)				
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and		0		69.00
	96). (For SCH see instructions)		i i		
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70. 50	RURAL DEMONSTRATION PROJECT		o		70. 50
70. 30	Pioneer ACO demonstration payment adjustment amount (see		0		70. 89
, 0. 07			١		1 ,0.09
70.00	instructions)				70.00
70. 90	HSP bonus payment HVBP adjustment amount (see		ا		70. 90
70 01	instructions)				70.00
70. 91	HSP bonus payment HRR adjustment amount (see instructions)		0		70. 91
70. 92	Bundled Model 1 discount amount (see instructions)		0		70. 92
	HVBP payment adjustment amount (see instructions)		17, 057		70. 93
70. 93			2 (25)		70. 94
70. 94	HRR adjustment amount (see instructions) Recovery of accelerated depreciation		-3, 625 0		70. 95

	<i>J</i>	EY MEMORIAL			u of Form CMS-	-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT			Peri od: From 01/01/2015 To 12/31/2015	5/19/2016 5:	epared: 11 pm
			Title XVIII	Hospi tal	PPS	
				Prior to	On/After	
				October 1	October 1	
			0	1. 00	2. 00	
70. 96	Low volume adjustment for federal fiscal year (yyy (Enter in column 0 the corresponding federal year period prior to 10/1)	for the	20°			70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy (Enter in column 0 the corresponding federal year) period ending on or after 10/1)	y) for the	20°	16 125, 331		70. 97
70. 98	Low Volume Payment-3			0		70. 98
70. 99	HAC adjustment amount (see instructions)			8, 346		70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/milines 69 & 70)	nus		2, 399, 549		71. 00
	Sequestration adjustment (see instructions)			47, 991		71. 01
72.00	Interim payments			2, 311, 872		72. 00
73.00	Tentative settlement (for contractor use only)			0		73. 00
74. 00	Balance due provider (Program) (line 71 minus lines 72, and 73)	s 71. 01,		39, 686		74. 00
75. 00	Protested amounts (nonallowable cost report items) accordance with CMS Pub. 15-2, chapter 1, §115.2	in		206, 574		75. 00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90. 00	Operating outlier amount from Wkst. E, Pt. A, line instructions)	2 (see		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0		91.00
92. 00	Operating outlier reconciliation adjustment amount instructions)	(see		0		92. 00
93. 00	Capital outlier reconciliation adjustment amount (sinstructions)	see		0		93. 00
94. 00	The rate used to calculate the time value of money instructions)	(see		0.00		94. 00
95. 00	Time value of money for operating expenses (see instructions)			0		95. 00
96.00	Time value of money for capital related expenses (see		o		96.00

Prior to 10/1 0n/After 10/1 1.00 2.00	96.00 Time value of money for capital related expenses (see instructions)	0		96. 00
HSP Bonus Payment Amount 100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 0.0000000000 0.0000000000 0.00000000		Prior to 10/1	On/After 10/1	
100.00 HSP bonus amount (see instructions) 0 0 100.00 HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 0.000000000 0.000000000 101.00 HVBP adjustment amount for HSP bonus payment (see instructions) 0 0 102.00 HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 0.0000 0.0000 103.00		1. 00	2. 00	
HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) 103.00 HRR Adjustment factor (see instructions) 104.00 HRR adjustment factor (see instructions) 105.00 HRR adjustment factor (see instructions) 106.000 0.0000 0.0000 103.00	HSP Bonus Payment Amount			
101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) 103.00 HRR adjustment factor (see instructions) 0.0000000000 0.0000000000 101.00 102.00 103.00 HRR adjustment factor (see instructions) 0.0000000000 0.0000000000 103.00	100.00 HSP bonus amount (see instructions)	0	0	100.00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 0 0 0000 0.0000 103.00	HVBP Adjustment for HSP Bonus Payment			
HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 0.0000 0.0000 0.0000	101.00 HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
103.00 HRR adjustment factor (see instructions) 0.0000 0.0000 103.00	102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
104.00 HRR adjustment amount for HSP bonus payment (see instructions) 0 0 104.00	103.00 HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
	104.00 HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104. 00

Provi der CCN: 150101

						0 12/31/2013	5/19/2016 5:1	
		W/C E Dowt A	Amounto (from		e XVIII	Hospi tal	PPS	
		line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
1.00	DRG amounts other than outlier	1. 00	0	0	C	0	0	1. 00
1. 01	payments DRG amounts other than outlier payments for discharges	1. 01	1, 332, 975	0	1, 332, 975	0	1, 332, 975	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges	1. 02	590, 507	0	C	590, 507	590, 507	1. 02
1. 03	occurring on or after October 1 DRG for Federal specific	1. 03	0	0	ſ	0	0	1. 03
1.03	operating payment for Model 4 BPCI occurring prior to October 1	1.03	o d	0	C		0	1.03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0	C	0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00	2, 150	0	2, 150	0	2, 150	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	C	0	0	2. 01
3. 00	Operating outlier	2. 01	О	0	C	0	0	3. 00
4. 00	reconciliation Managed care simulated payments	3. 00	0	0	C	0	0	4. 00
5. 00	Indirect Medical Education Adju Amount from Worksheet E, Part	ustment 21.00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	0	0. 000000	0.00000	0.00000	0	6. 00
6. 01	instructions) IME payment adjustment for	22. 00	0	0			0	6. 00
0.01	managed care (see instructions)		0	0	C	, o	0	0.01
7. 00	Indirect Medical Education Adju	ustment for the	0.000000	0.000000	ne MMA 0.000000	0. 000000		7. 00
	IME payment adjustment factor (see instructions)		0.000000	0.000000	0.000000	0.00000		
8. 00	IME adjustment (see instructions)	28. 00	0	0	С	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	0	C	0	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	C	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	C	O	0	9. 01
	Di sproporti onate Share Adjustme							
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 1200	0. 1200	0. 1200	0. 1200		10. 00
11. 00	Disproportionate share adjustment (see instructions)	34.00	57, 704	0	39, 989	17, 715	57, 704	11. 00
11. 01	Uncompensated care payments	36. 00	224, 358	0	174, 808	49, 550	224, 358	11. 01
12. 00	Additional payment for high per Total ESRD additional payment	centage of ESF 46.00	RD beneficiary of	di scharges 0	C	O	0	12. 00
13. 00	(see instructions) Subtotal (see instructions)	47. 00	2, 207, 694	0	1, 549, 922		2, 207, 694	
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	48. 00	0	0	(, 547, 722	0	0	14. 00
15. 00	(see instructions) Total payment for inpatient operating costs (see	49. 00	2, 207, 694	0	1, 549, 922	657, 772	2, 207, 694	15. 00
16. 00	instructions) Payment for inpatient program	50. 00	155, 504	0	107, 896	47, 608	155, 504	16. 00
17. 00	capital Special add-on payments for	54. 00	0	0	C	О	0	17. 00
17. 01	new technologies Net organ aquisition cost	55. 00	0	0	С	0	0	17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	C	0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	O	0	C	O	0	18. 00

					Т	o 12/31/2015	Date/Time Pre 5/19/2016 5:1	
				Ti tl	e XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1. 00	2.00	3.00	4. 00	5. 00	
19.00	SUBTOTAL			0	1, 657, 818	705, 380	2, 363, 198	19. 00
		W/S L, line	(Amounts from					
			L)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
20. 00	Capital DRG other than outlier	1. 00	153, 687	0	106, 079	47, 608	153, 687	20. 00
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0	0	0	0	20. 01
	than outlier							
21. 00	Capital DRG outlier payments	2. 00	1, 817	0	1, 817	0	1, 817	21. 00
21. 01	Model 4 BPCI Capital DRG	2. 01	0	0	0	0	0	21. 01
	outlier payments							
22. 00	Indirect medical education	5. 00	0.0000	0.0000	0.0000	0.0000		22. 00
	percentage (see instructions)							
23. 00	Indirect medical education	6. 00	0	0	0	0	0	23. 00
	adjustment (see instructions)							
24. 00	Allowable disproportionate	10. 00	0. 0000	0.0000	0.0000	0.0000		24. 00
	share percentage (see							
	instructions)							
25. 00	Di sproporti onate share	11.00	0	0	0	0	0	25. 00
	adjustment (see instructions)							
26. 00	Total prospective capital	12.00	155, 504	0	107, 896	47, 608	155, 504	26. 00
	payments (see instructions)							
			(Amounts to E,					
		l i ne	Part A)					
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
	Low volume adjustment factor				0. 148571	0. 177679		27. 00
28. 00	Low volume adjustment	70. 96			246, 304		246, 304	28. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)							
29. 00	Low volume adjustment	70. 97				125, 331	125, 331	29. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)							
	Transfer low volume		Y					100. 00
ļ	adjustments to Wkst. E, Pt. A.				l			1

Heal th Financial SystemsWHITLEY MEMORIHOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 In Lieu of Form CMS-2552-10 WHITLEY MEMORIAL HOSPITAL Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/19/2016 5:11 pm Provi der CCN: 150101 Peri od: From 01/01/2015 To 12/31/2015 Hospi tal Peri od on Title XVIII PPS Total (cols. 2 and 3) Wkst. E, Pt. A, line Period to 10/01 Amt. from Wkst. E, Pt. after 10/01

			74, 11110	A)	10,01	41 (61 107 61	ana o)	
			0	1.00	2.00	3. 00	4. 00	
1	. 00	DRG amounts other than outlier payments	1.00					1. 00
1	. 01	DRG amounts other than outlier payments for	1. 01	1, 332, 975	1, 332, 975		1, 332, 975	1. 01
		discharges occurring prior to October 1						
1	. 02	DRG amounts other than outlier payments for	1. 02	590, 507		590, 507	590, 507	1. 02
		discharges occurring on or after October 1		_	_		_	
1	. 03	DRG for Federal specific operating payment	1. 03	0	0		0	1. 03
		for Model 4 BPCI occurring prior to October						
1	. 04	DRG for Federal specific operating payment	1. 04	0		0	0	1. 04
'	. 04	for Model 4 BPCI occurring on or after	1.04	J		U	U	1.04
		October 1						
2	. 00	Outlier payments for discharges (see	2. 00	2, 150	2, 150	0	2, 150	2. 00
		instructions)		_,	_,	_	_,	
2	. 01	Outlier payments for discharges for Model 4	2. 02	O	0	0	0	2. 01
		BPCI						
	. 00	Operating outlier reconciliation	2. 01	0	0	0	0	3. 00
4	. 00	Managed care simulated payments	3. 00	0	0	0	0	4. 00
		Indirect Medical Education Adjustment						
5	. 00	Amount from Worksheet E, Part A, line 21	21. 00	0. 000000	0. 000000	0. 000000		5. 00
,	00	(see instructions)	22.00	0	0	0	0	6. 00
	. 00 . 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see	22. 00 22. 01	0	0	0	0	6. 00
О	. 01	instructions)	22.01	0	U	U	U	6.01
		Indirect Medical Education Adjustment for the	Add-on for Se	ection 422 of t	he MMA			
7	. 00	IME payment adjustment factor (see	27. 00	0. 000000		0. 000000		7. 00
•		instructions)	27.00	0.00000	0.00000	0.00000		7.00
8	. 00	IME adjustment (see instructions)	28. 00	0	0	0	0	8. 00
8	. 01	IME payment adjustment add on for managed	28. 01	0	0	0	0	8. 01
		care (see instructions)						
	. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	9. 00
9	. 01	Total IME payment for managed care (sum of	29. 01	0	0	0	0	9. 01
		lines 6.01 and 8.01)						
1	0 00	Disproportionate Share Adjustment	22.00	0.1200	0.1200	0.1200		10.00
- 1	0. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 1200	0. 1200	0. 1200		10. 00
1	1. 00	Disproportionate share adjustment (see	34.00	57, 704	39, 989	17, 715	57, 704	11. 00
	1. 00	instructions)	34.00	37, 704	37, 707	17, 713	37, 704	11.00
1	1. 01	Uncompensated care payments	36.00	224, 358	174, 808	49, 550	224, 358	11. 01
		Additional payment for high percentage of ESF	D beneficiary	di scharges				
1.	2. 00	Total ESRD additional payment (see	46.00	0	0	0	0	12.00
		instructions)						
	3. 00	Subtotal (see instructions)	47. 00	2, 207, 694	1, 549, 922	657, 772	2, 207, 694	
1.	4. 00	Hospital specific payments (completed by SCH	48. 00	0	0	0	0	14. 00
		and MDH, small rural hospitals only.) (see						
1	5. 00	<pre>instructions) Total payment for inpatient operating costs</pre>	49. 00	2, 207, 694	1, 549, 922	657, 772	2, 207, 694	15. 00
- 1	3.00	(see instructions)	49.00	2, 207, 094	1, 347, 722	037,772	2, 201, 094	13.00
1	6. 00	Payment for inpatient program capital	50.00	155, 504	107, 438	48, 066	155, 504	16. 00
	7. 00	Special add-on payments for new technologies	54.00	0	0	0	0	17. 00
1	7. 01	Net organ aquisition cost	55.00	0	o	0	0	17. 01
1	7. 02	Credits received from manufacturers for	68. 00	0	o	0	0	17. 02
		replaced devices for applicable MS-DRGs						
1	8. 00	Capital outlier reconciliation adjustment	93. 00	0	0	0	0	18. 00
		amount (see instructions)						
1	9. 00	SUBTOTAL			1, 657, 360	705, 838	2, 363, 198	19. 00

Health Financial Systems	WHITLEY MEMORIAL H	IOSPI TAL	In Lie	u of Form CMS-2552-10
HOSPITAL ACQUIRED CONDITION (HAC)	REDUCTION CALCULATION EXHIBIT 5	Provi der CCN: 150101		Worksheet E

From 01/01/2015 Part A Exhibit 5
To 12/31/2015 Date/Time Prepared: 5/19/2016 5:11 pm Titl<u>e XVIII</u> Hospi tal PPS Wkst. L, line (Amt. from L) Wkst. 2.00 3. 00 4.00 n 1 00 20.00 Capital DRG other than outlier 1.00 153, 687 106, 079 47,608 153, 687 20.00 20.01 Model 4 BPCI Capital DRG other than outlier 1.01 20.01 Capital DRG outlier payments 1, 817 1, 359 21.00 2.00 458 1,817 21.00 21.01 Model 4 BPCI Capital DRG outlier payments 2.01 21.01 0 22.00 Indirect medical education percentage (see 5.00 0.0000 0.0000 0.0000 22.00 instructions) 23. 00 23.00 Indirect medical education adjustment (see 6.00 0 instructions) 0.0000 0.0000 24.00 24 00 Allowable disproportionate share percentage 10 00 0 0000 (see instructions) 25.00 Disproportionate share adjustment (see 11.00 0 25.00 instructions) Total prospective capital payments (see 12.00 155, 504 107, 438 48, 066 155, 504 26.00 instructions) Wkst. E, Pt. (Amt. from A, line Wkst. E, Pt. A) 0 1.00 2.00 3.00 4.00 27. 00 27. 00 28.00 Low volume adjustment prior to October 1 70.96 246, 304 246, 304 28.00 246, 304 29.00 Low volume adjustment on or after October 1 70.97 125, 331 125, 331 125, 331 29.00 HVBP payment adjustment (see instructions) 70. 93 17, 057 4, 299 30.00 30.00 12, 758 17,057 HVBP payment adjustment for HSP bonus 30.01 70.90 30.01 payment (see instructions) 70.94 31.00 HRR adjustment (see instructions) -3,625-2,711-914 -3, 625 31.00 31.01 HRR adjustment for HSP bonus payment (see 70. 91 31.01 instructions) (Amt. to Wkst. Pt. A) 0 1.00 2.00 3.00 4.00 32.00 HAC Reduction Program adjustment (see 70.99 8, 346 8, 346 32.00 100.00 Transfer HAC Reduction Program adjustment to Υ 100.00 Wkst. E, Pt. A.

Health Financial Systems	WHITLEY MEMORIAL H	IOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150101		Worksheet E Part B Date/Time Prepared: 5/19/2016 5:11 pm

			To 12/31/2015	Date/Time Pre 5/19/2016 5:1	
		Title XVIII	Hospi tal	PPS	
				4.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		3, 572, 357	2. 00
3.00	PPS payments			2, 759, 003	3. 00
4.00	Outlier payment (see instructions)			2, 971	
5.00	Enter the hospital specific payment to cost ratio (see instruct	ions)		0. 000	
6.00	Line 2 times line 5			0	
7. 00 8. 00	Sum of line 3 plus line 4 divided by line 6			0. 00 0	1
9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV	/ col 13 line 200		0	1
10. 00	Organ acqui si ti ons	, cor. 10, 11116 200		Ö	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			0	1
	COMPUTATION OF LESSER OF COST OR CHARGES]
	Reasonabl e charges				
12.00	Ancillary service charges	(0)		0	
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin Total reasonable charges (sum of lines 12 and 13)	ie 69)		0	
14.00	Customary charges			0	14.00
15. 00	Aggregate amount actually collected from patients liable for pa	yment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for			0	1
	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)			0. 000000	1
	Total customary charges (see instructions)	. : 6 : 10	11) (0	
19. 00	Excess of customary charges over reasonable cost (complete only instructions)	/ IT line 18 exceeds II	ne II) (see	0	19. 00
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20. 00
20.00	instructions)	e execute			20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		0	21. 00
	Interns and residents (see instructions)			0	22. 00
	Cost of physicians' services in a teaching hospital (see instru	ıcti ons)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			2, 761, 974	24. 00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			633, 891	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH. see instructions)		0	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl			2, 128, 083	1
	instructions)				
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	ie 50)		0	
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27 through 29) Primary payer payments			2, 128, 083 4, 181	ı
	Subtotal (line 30 minus line 31)			2, 123, 902	ı
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)		=/ :==/ :==	
	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
	Allowable bad debts (see instructions)			69, 095	
	Adjusted reimbursable bad debts (see instructions)			44, 912	
	Allowable bad debts for dual eligible beneficiaries (see instru Subtotal (see instructions)	ictions)		49, 553 2, 168, 814	
	MSP-LCC reconciliation amount from PS&R			2, 100, 614	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	1
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	1
39. 98	Partial or full credits received from manufacturers for replace	ed devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40. 00	Subtotal (see instructions)			2, 168, 814	1
40. 01	Sequestration adjustment (see instructions)			43, 376	1
41.00	Interim payments Tentative settlement (for contractors use only)			2, 078, 519 0	1
43. 00	Balance due provider/program (see instructions)			46, 919	
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2.	chapter 1,	0	1
	§115. 2		· · ·		
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions)			0	
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0. 00 0	1
	Total (sum of lines 91 and 93)				94. 00

Health Financial Systems WHIT ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 01/01/2015
To 12/31/2015 Part I
Date/Time Prepared: 5/19/2016 5:11 pm Provider CCN: 150101

					5/19/2016 5: 1 ²	1 pm
			e XVIII	Hospi tal	PPS	
		Inpatien	it Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		2, 311, 872		2, 030, 757	1. 00
2.00	Interim payments payable on individual bills, either		0		47, 762	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)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3. 05	Provider to Program		0		0	3. 05
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51	ADSOSTMENTS TO TROOKAWI		0		0	3. 51
3. 52			0		ol	3. 52
3.53			0		o	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 311, 872		2, 078, 519	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03	Describes to Describe		0		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		0		0	5. 50
5. 50	TENTATIVE TO PROGRAM		0			5. 50
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		l ő		l ől	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		39, 686		46, 919	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		2, 351, 558	Contractor	2, 125, 438 NPR Date	7. 00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	•				. '	

Health Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of					2552-10	
CALCUL				Worksheet E-1 Part II		
	To 12/31/2015 Date/Time Prepare					
	5/19/2016 5:11 pl					
		Title XVIII	Hospi tal	PPS		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
1 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	C 2 Dt 11 15 1:	. 14	1, 467	1 00	
1. 00 2. 00					1. 00 2. 00	
3.00					3. 00	
4. 00						
5. 00						
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 li	ne 20		9, 360, 444	6. 00	
7.00	CAH only - The reasonable cost incurred for the purchase of co		Wkst. S-2, Pt. I	0	7. 00	
	line 168					
8.00	Calculation of the HIT incentive payment (see instructions)			292, 000	8.00	
9.00	Sequestration adjustment amount (see instructions)			5, 840	9. 00	
10. 00	Calculation of the HIT incentive payment after sequestration ((see instructions)		286, 160	10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
	Initial/interim HIT payment adjustment (see instructions)			272, 074		
	Other Adjustment (specify)		`	0	31. 00	
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and li	ne 31) (see instruction	is)	14, 086	32. 00	

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

Provi der CCN: 150101 | Peri od: From 01/01/201!

					5/19/2016 5:1	1 pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
			Purpose Fund			
		1.00	2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	367, 132		0	_	1. 00
2.00	Temporary investments	0) 0	0		2. 00
3.00	Notes receivable	0	0	0	0	3. 00
4.00	Accounts receivable	16, 143, 355	0	0	0	4. 00
5.00	Other recei vable	75, 424	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-9, 622, 201	0	0	0	6. 00
7.00	Inventory	214, 164	0	0	0	7. 00
8.00	Prepai d expenses	35, 871	0	0	0	8. 00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0) 0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	7, 213, 745	0	0		11.00
	FIXED ASSETS	.,,,				
12.00	Land	260, 483	0	0	0	12. 00
13. 00	Land improvements	279, 913		0	1	13. 00
14. 00	Accumulated depreciation	-56, 615	1	0		14. 00
15. 00	Buildings	1, 119, 257		0		15. 00
16. 00	Accumulated depreciation	-688, 839	1	0	0	16.00
17. 00	Leasehold improvements	48, 824	1	0	0	17. 00
18. 00	•	-47, 865	1	0	0	18.00
	Accumulated depreciation	1	•	0		
19. 00	Fixed equipment	618, 063	1	0	0	19.00
20.00	Accumulated depreciation	-415, 763	1	0	0	20.00
21. 00	Automobiles and trucks	242, 560		0	0	21.00
22. 00	Accumul ated depreciation	-191, 050		0	0	22. 00
23. 00	Major movable equipment	27, 705, 048		0	0	23. 00
24. 00	Accumulated depreciation	-7, 632, 193	1	0	0	24. 00
25.00	Mi nor equi pment depreci abl e	0) 0	0	0	25. 00
26. 00	Accumulated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	21, 241, 823	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	45, 696, 792	2 0	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	45, 696, 792	2 0	0	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	74, 152, 360	1	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4, 366, 388	8 0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	841, 176	1	0		38. 00
39. 00	Payroll taxes payable	011,170		0	Ö	39. 00
40. 00	Notes and Loans payable (short term)			0	Ö	40.00
41. 00	Deferred income			0	0	41.00
42. 00	Accel erated payments			0	l o	42.00
43. 00	Due to other funds	-332, 189		0	0	43.00
44. 00		1	1	0	0	44.00
	Other current liabilities	4 075 275		0		1
45. 00	Total current liabilities (sum of lines 37 thru 44)	4, 875, 375	0	0	0	45. 00
47.00	LONG TERM LIABILITIES			0	1 0	1 47 00
46. 00	Mortgage payable	0 750 507	0	0	-	46.00
47. 00	Notes payable	9, 750, 507		0	-	47. 00
48. 00	Unsecured Loans	0	0	-		48. 00
49. 00	Other long term liabilities	22, 791, 918		0	-	49. 00
50. 00	Total long term liabilities (sum of lines 46 thru 49	32, 542, 425			-	50.00
51. 00	Total liabilites (sum of lines 45 and 50)	37, 417, 800	0	0	0	51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	36, 734, 560)			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				0	57. 00
58.00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansi on					
59.00	Total fund balances (sum of lines 52 thru 58)	36, 734, 560	0	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	74, 152, 360		0	0	60.00
	59)		1			

Provi der CCN: 150101

					To 12/31/201	5 Date/Time Prep 5/19/2016 5:1	
		General	Fund	Special P	urpose Fund	Endowment Fund	ı pili
				<u> </u>			
4.00	TE 111	1.00	2.00	3. 00	4. 00	5. 00	4 00
1.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		24, 591, 752			0	1. 00 2. 00
2. 00 3. 00	Total (sum of line 1 and line 2)		5, 755, 179 30, 346, 931				3. 00
4. 00	Additions (credit adjustments) (specify)	0	30, 340, 931		0	0	4. 00
5. 00	TRANSFERS	6, 387, 629			0	0	5. 00
6. 00	TRANSI ERS	0,307,027			0		6. 00
7. 00		0			0	0	7. 00
8.00					0	Ö	8. 00
9. 00		l ol			o	Ö	9. 00
10. 00	Total additions (sum of line 4-9)		6, 387, 629			0	10.00
11. 00	Subtotal (line 3 plus line 10)		36, 734, 560			0	11. 00
12.00	Deductions (debit adjustments) (specify)	o			0	0	12.00
13.00		O			0	0	13.00
14.00		0			0	0	14.00
15. 00		0			0	0	15.00
16. 00		0			0	0	16. 00
17. 00		0			0	0	17. 00
18. 00	Total deductions (sum of lines 12-17)		0			0	18. 00
19. 00	Fund balance at end of period per balance		36, 734, 560			0	19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
		Eridomilorre i dild		1 4.14			
		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	Additions (credit adjustments) (specify)		0				4. 00
5.00	TRANSFERS		0				5. 00
6.00			0				6.00
7. 00 8. 00			0				7. 00 8. 00
9. 00			0				9. 00
10. 00	Total additions (sum of line 4-9)	0	U		0		10.00
11. 00	Subtotal (line 3 plus line 10)				0		11.00
12. 00	Deductions (debit adjustments) (specify)		0				12. 00
13. 00			o				13. 00
14. 00			0				14.00
15. 00			0				15. 00
16.00			0				16. 00
			0				17. 00
17. 00	1						
18. 00	Total deductions (sum of lines 12-17)	0			О		18. 00
	Fund balance at end of period per balance	0			0 0		18. 00 19. 00
18. 00		-1					

Health Financial Systems VSTATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 150101

			To 12/31/2015	Date/Time Prep 5/19/2016 5:1	
	Cost Center Description	I npati ent	Outpati ent	Total	ı pili
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>	<u> </u>		
	General Inpatient Routine Services				
1.00	Hospi tal	7, 239, 52	4	7, 239, 524	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF		0	0	5.00
6.00	Swing bed - NF		0	0	6. 00
7.00	SKILLED NURSING FACILITY		0	0	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)	7, 239, 52	4	7, 239, 524	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT				11. 00
12. 00	CORONARY CARE UNIT				12. 00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGI CAL INTENSI VE CARE UNI T				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)			_	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	5	0	0	16. 00
47.00	11-15)			7 000 504	47.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	7, 239, 52		7, 239, 524	17. 00
18.00	Ancillary services	24, 050, 98	5 110, 619, 901	134, 670, 886	18.00
19.00	Outpatient services		0	0	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 23. 00	HOME HEALTH AGENCY AMBULANCE SERVICES			0	22. 00 23. 00
24. 00	CMHC		\mathbb{I}	U	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)	1			25. 00
26. 00	HOSPICE	•			26. 00
27. 00	OTHER (SPECIFY)			0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to We	kst. 31, 290, 50	9 110, 619, 901	141, 910, 410	28. 00
20.00	G-3, line 1)	31, 270, 30	110,019,901	141, 710, 410	20.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		44, 525, 192		29. 00
30. 00	ADD (SPECIFY)		o		30. 00
31. 00	BAD DEBT EXPENSE	6, 228, 77	5		31. 00
32.00			o		32. 00
33.00			o		33. 00
34.00			o		34.00
35.00			o		35. 00
36.00	Total additions (sum of lines 30-35)		6, 228, 775		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	50, 753, 967		43.00
	to Wkst. G-3, line 4)	1			

	Financial Systems WHITLEY MEMORIAL F ENT OF REVENUES AND EXPENSES	Provider CCN: 150101	Peri od:	Worksheet G-3	
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 150101	From 01/01/2015	worksneet G-3	
			To 12/31/2015	Date/Time Prep	
				5/19/2016 5: 17	1 pm
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			141, 910, 410	
2.00	Less contractual allowances and discounts on patients' accounts			85, 346, 265	
3.00	Net patient revenues (line 1 minus line 2)	_		56, 564, 145	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)		50, 753, 967	
5.00	Net income from service to patients (line 3 minus line 4)			5, 810, 178	5. 00
	OTHER I NCOME		,		
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	
8.00	Revenues from telephone and other miscellaneous communication s	ervi ces		0	0.00
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	
11. 00	Rebates and refunds of expenses			0	
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
	Revenue from rental of living quarters			0	15. 00
16. 00	Revenue from sale of medical and surgical supplies to other tha	n 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
	MI SCELLANEOUS REVENUES			266, 359	24.00
25. 00	Total other income (sum of lines 6-24)			266, 359	
	Total (line 5 plus line 25)			6, 076, 537	
	OCCUPATIONAL HEALTH REVENUES			321, 358	
	Total other expenses (sum of line 27 and subscripts)			321, 358	
	Net income (or loss) for the period (line 26 minus line 28)			5, 755, 179	

Heal th	Financial Systems WHITLEY MEMORIAL	HOSPI TAL	In Lie	eu of Form CMS-2	2552-10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 150101	Peri od:	Worksheet L	
			From 01/01/2015 To 12/31/2015		nared:
			10 12/31/2013	5/19/2016 5:1	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			153, 687	1. 00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			1, 817	1
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3. 00 4. 00	Total inpatient days divided by number of days in the cost rep	porting period (see inst	ructions)	11. 98 0. 00	1
5. 00	Number of interns & residents (see instructions) Indirect medical education percentage (see instructions)			0.00	1
6. 00	Indirect medical education percentage (see instructions)	sum of lines 1 and 1 01	columns 1 and	0.00	1
0.00	1.01) (see instructions)	Sam of Fiftes Fana 1. of	, corumns r una		0.00
7.00	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (Worksheet E	, part A line	0.00	7. 00
	30) (see instructions)				
8. 00	Percentage of Medicaid patient days to total days (see instruc	ctions)		0.00	
9.00	Sum of lines 7 and 8			0.00	
10.00	Allowable disproportionate share percentage (see instructions))			10.00
11. 00 12. 00	Disproportionate share adjustment (see instructions) Total prospective capital payments (see instructions)			0 155, 504	11. 00 12. 00
12.00	Total prospective capital payments (see Thistructions)			155, 504	12.00
				1. 00	
1 00	PART II - PAYMENT UNDER REASONABLE COST				1 00
1. 00 2. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions)			0	
3.00	Total inpatient program capital cost (see Histructions)				
4. 00	Capital cost payment factor (see instructions)			Ö	
5. 00	Total inpatient program capital cost (line 3 x line 4)			Ö	1
	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 circumstance	es (see instructions)		ĺ	
3. 00	Net program inpatient capital costs (line 1 minus line 2)	(33 1.131.431.31.3)		Ö	
4.00	Applicable exception percentage (see instructions)			0.00	4. 00
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5. 00
6.00	Percentage adjustment for extraordinary circumstances (see ins			0.00	
7.00	Adjustment to capital minimum payment level for extraordinary	circumstances (line 2 x	line 6)	0	
8.00	Capital minimum payment level (line 5 plus line 7)			0	1
9.00	Current year capital payments (from Part I, line 12, as applic		loog line ()	0 0	1
10. 00 11. 00	Current year comparison of capital minimum payment level to ca Carryover of accumulated capital minimum payment level over ca			0	
11.00	Worksheet L, Part III, Line 14)	apitai payillent (110111 pii	or year		11.00
12.00	Net comparison of capital minimum payment level to capital pay			0	12. 00
13.00	Current year exception payment (if line 12 is positive, enter			0	13. 00
14.00	Carryover of accumulated capital minimum payment level over ca	apital payment for the f	following period	0	14. 00
15. 00	(if line 12 is negative, enter the amount on this line)	tructions)		0	15. 00
16. 00	Current year allowable operating and capital payment (see inst Current year operating and capital costs (see instructions)	ir uc ir ons)		0	
	Current year exception offset amount (see instructions)			0	
00	1			'	,