

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT
 CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
 PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY 1. ELECTRONICALLY FILED COST REPORT DATE: 05-30-2013 TIME: 16:42
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

CONTRACTOR USE ONLY 5. COST REPORT STATUS 6. DATE RECEIVED: _____ 10. NPR DATE: _____
 1 - AS SUBMITTED 7. CONTRACTOR NO: _____ 11. CONTRACTOR'S VENDOR CODE: _____
 2 - SETTLED WITHOUT AUDIT 8. INITIAL REPORT FOR THIS PROVIDER CCN 12. IF LINE 5, COLUMN 1 IS 4: ENTER
 3 - SETTLED WITH AUDIT 9. FINAL REPORT FOR THIS PROVIDER CCN NUMBER OF TIMES REOPENED - 0-9.
 4 - REOPENED
 5 - AMENDED

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE 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 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 (15-0101) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 01/01/2012 AND ENDING 12/31/2012, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT 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.

(SIGNED) _____
 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

 TITLE

 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5
		PART A 2	PART B 3		
1 HOSPITAL		94,772	-47,909	11,491	1
2 SUBPROVIDER - IPF					2
3 SUBPROVIDER - IRF					3
4 SUBPROVIDER (OTHER)					4
5 SWING BED - SNF					5
6 SWING BED - NF					6
7 SKILLED NURSING FACILITY		38,030			7
8 NURSING FACILITY					8
9 HOME HEALTH AGENCY					9
10 HEALTH CLINIC - RHC					10
11 HEALTH CLINIC - FQHC					11
12 OUTPATIENT REHABILITATION PROVIDER					12
200 TOTAL		132,802	-47,909	11,491	200

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 THIS 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 THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 1260 E STATE ROAD 205
 2 CITY: COLUMBIA CITY

STATE: IN

P.O.BOX:
 ZIP CODE: 46725-9492 COUNTY: WHITLEY

1
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)			3
						V 6	XVIII 7	XIX 8	
3	HOSPITAL	15-0101	23060	1	07/01/1966	N	P	P	3
4	SUBPROVIDER - IPF								4
5	SUBPROVIDER - IRF								5
6	SUBPROVIDER - (OTHER)								6
7	SWING BEDS - SNF								7
8	SWING BEDS - NF								8
9	HOSPITAL-BASED SNF	15-5128	23060		02/01/1993	N	P	N	9
10	HOSPITAL-BASED NF								10
11	HOSPITAL-BASED OLTC								11
12	HOSPITAL-BASED HHA								12
13	SEPARATELY CERTIFIED ASC								13
14	HOSPITAL-BASED HOSPICE								14
15	HOSPITAL-BASED HEALTH CLINIC - RHC								15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC								16
17	HOSPITAL-BASED (CMHC)								17
18	RENAL DIALYSIS								18
19	OTHER								19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 01/01/2012			TO: 12/31/2012				20
21	TYPE OF CONTROL								21

INPATIENT PPS INFORMATION

22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILITY SUBJECT TO 42 CFR §412.06(c)(2)(PICKLE AMENDMENT HOSPITAL)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.							1	2
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.							3	N 23

	IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID UNPAID DAYS 2	OUT-OF STATE MEDICAID PAID DAYS 3	OUT-OF STATE MEDICAID UNPAID DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6			
25									25
26				1					26
27				1					27
35									35
36			BEGINNING:		ENDING:				36
37									37
38			BEGINNING:		ENDING:				38
39								1	2
								Y	Y 39

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

	V 1	XVIII 2	XIX 3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N	45
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	48

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS

	1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N	57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N		58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N		59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N		60

	Y/N	IME AVERAGE	DIRECT GME AVERAGE	
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	N		61

ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)			62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)			62.01

TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS

63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N		63
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SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS

	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTES ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER 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)			64

ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR
 FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME.
 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)

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
1	2	3	4	5

SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS

	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTES ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER 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)			66

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. 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)

PROGRAM NAME 1	PROGRAM CODE 2	UNWEIGHTED FTEs NONPROVIDER SITE 3	UNWEIGHTED FTEs IN HOSPITAL 4	RATIO (COL.1/ (COL.3+COL.4)) 5	
INPATIENT PSYCHIATRIC FACILITY PPS					
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N	70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED 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 AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.				71
INPATIENT REHABILITATION FACILITY PPS					
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N	75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST 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 AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.				76
LONG TERM CARE HOSPITAL PPS					
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N	80
TEFRA PROVIDERS					
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.			N	85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N	86
TITLE V AND XIX INPATIENT SERVICES					
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			V 1 2 N Y	XIX 90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N 91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N 92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N 93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N 94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.				95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N 96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.				97
RURAL PROVIDERS					
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			N	105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.				106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.				107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			N	108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.		PHY- OCCUP- SICAL ATIONAL N	RESPI- RATORY	109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	1		118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 49,809 PAID LOSSES: 20,040 SELF INSURANCE: 91,654			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 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 §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121

TRANSPLANT CENTER INFORMATION

125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S) (MM/DD/YYYY) BELOW.	N		125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			132
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			133
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			134

ALL PROVIDERS

140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	1 Y	2 15H032	140
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IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.

141	NAME: PARKVIEW HEALTH SYSTEM, INC. CONTRACTOR'S NAME: WISCONSIN PHYSICIANS SERVICE CONTRACTOR'S NUMBER: 08101			141
142	STREET: 10501 CORPORATE DRIVE P.O. BOX: PO BOX 56			142
143	CITY: FORT WAYNE STATE: IN ZIP CODE: 46895-5600			143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	N		145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.	N		146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		149

DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13)

	TITLE XVIII		TITLE V	TITLE XIX
	PART A	PART B		
	1	2	3	4
155 HOSPITAL	N	N		N 155
156 SUBPROVIDER - IPF	N	N		156
157 SUBPROVIDER - IRF	N	N		157
158 SUBPROVIDER - (OTHER)	N	N		158
159 SNF	N	N		159
160 HHA	N	N		160
161 CMHC		N		161

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
PERIOD FROM 01/01/2012 TO 12/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
05/30/2013 16:42

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I (CONT)

MULTICAMPUS

165	IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	165			
166	IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.					
	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
	0	1	2	3	4	5

HEALTH INFORMATION TECHNOLOGY (HIT) INCENTIVE IN THE AMERICAN RECOVERY AND REINVESTMENT ACT

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y	167
168	IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS.		168
169	IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.	1.00	169

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.
 ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION					
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	N		1	
		Y/N	DATE	V/I	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N		2	
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	Y		3	
FINANCIAL DATA AND REPORTS					
		Y/N	TYPE	DATE	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	N		4	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5	
APPROVED EDUCATIONAL ACTIVITIES					
		Y/N		Y/N	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N		6	
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7	
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8	
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10	
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11	
				Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y 12	
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N 13	
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N 14	
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			Y 15	
PS&R REPORT DATA					
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
		1	2	3	4
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	18
19	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
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	21

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.
ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

CAPITAL RELATED COST

22	HAVE ASSETS BEEN RELIEFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.	22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	27

INTEREST EXPENSE

28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (DEBT SERVICE RESERVE FUND) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.	29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.	30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.	31

PURCHASED SERVICES

32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.	32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.	33

PROVIDER-BASED PHYSICIANS

34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.	34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	35

HOME OFFICE COSTS

	Y/N	DATE	
	1	2	
36			WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT? 36
37			IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS. 37
38	N		IF LINE 36 IS YES, WAS THE FISCAL YEAR END OF THE HOME OFFICE DIFFERENT FROM THAT OF THE PROVIDER? IF YES, ENTER IN COLUMN 2 THE FISCAL YEAR END OF THE HOME OFFICE. 38
39			IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS. 39
40			IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS. 40

COST REPORT PREPARER CONTACT INFORMATION

41	FIRST NAME: ERIC	LAST NAME: NICKESON	TITLE: DIRECTOR, REIMBURSEM	41
42	EMPLOYER: PARKVIEW HEALTH SYSTEM, INC.			42
43	PHONE NUMBER: 2603738406	E-MAIL ADDRESS: ERIC.NICKESON@PARKVIEW.COM		43

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4 5	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
	1	2	3	4	5	6	
SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	19,751,052	-3,612,091	16,138,961	645,671.00	25.00
2	NON-PHYSICIAN ANESTHETIST PART A						
3	NON-PHYSICIAN ANESTHETIST PART B						
4	PHYSICIAN-PART A ADMINISTRATIVE						
4.01	PHYSICIAN-PART A - TEACHING						4.01
5	PHYSICIAN-PART B						
6	NON-PHYSICIAN-PART B						
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21					
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)						7.01
8	HOME OFFICE PERSONNEL		2,595,909		2,595,909	94,035.00	27.61
9	SNF	44	2,075,662	321,529	2,397,191	135,436.00	17.70
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		1,229,082	146,126	1,375,208	69,857.00	19.69
OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)						
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES						
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE		83,352		83,352	735.00	113.40
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		2,595,909		2,595,909	94,035.00	27.61
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE						
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING						
WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (CORE)		4,111,010		4,111,010		
18	WAGE-RELATED COSTS (OTHER)						
19	EXCLUDED AREAS		1,254,044		1,254,044		
20	NON-PHYSICIAN ANESTHETIST PART A						
21	NON-PHYSICIAN ANESTHETIST PART B						
22	PHYSICIAN PART A - ADMINISTRATIVE						
22.01	PHYSICIAN PART A - TEACHING						22.01
23	PHYSICIAN PART B						
24	WAGE-RELATED COSTS (RHC/FQHC)						
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)						
OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS		1,444,986	-1,444,986			
27	ADMINISTRATIVE & GENERAL		7,472,077	-4,041,257	3,430,820	76,927.00	44.60
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)						
29	MAINTENANCE & REPAIRS						
30	OPERATION OF PLANT		281,488	34,441	315,929	14,280.00	22.12
31	LAUNDRY & LINEN SERVICE						
32	HOUSEKEEPING		173,652	21,247	194,899	18,218.00	10.70
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						
34	DIETARY		323,474	-212,341	111,133	7,759.00	14.32
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)						
36	CAFETERIA			248,697	248,697	17,648.00	14.09
37	MAINTENANCE OF PERSONNEL						
38	NURSING ADMINISTRATION		68,679	8,403	77,082	2,518.00	30.61
39	CENTRAL SERVICES AND SUPPLY			175,384	175,384	11,373.00	15.42
40	PHARMACY		465,287	56,930	522,217	11,186.00	46.68
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY			309,882	309,882	17,064.00	18.16
42	SOCIAL SERVICE						
43	OTHER GENERAL SERVICE						

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	17,155,143	-3,612,091	13,543,052	551,636.00	24.55	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	3,304,744	467,655	3,772,399	205,293.00	18.38	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	13,850,399	-4,079,746	9,770,653	346,343.00	28.21	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	2,679,261		2,679,261	94,770.00	28.27	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	4,111,010		4,111,010		42.08%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	20,640,670	-4,079,746	16,560,924	441,113.00	37.54	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	10,229,643	-4,843,600	5,386,043	176,973.00	30.43	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

	AMOUNT REPORTED	
RETIREMENT COST		
1 401K EMPLOYER CONTRIBUTIONS		1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	317,669	2
3 NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	1,100,568	3
4 QUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	17,133,336	4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)		
5 401K/TSA PLAN ADMINISTRATION FEES		5
6 LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES	43,249	7
HEALTH AND INSURANCE COST		
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	2,536,218	8
9 PRESCRIPTION DRUG PLAN		9
10 DENTAL, HEARING AND VISION PLAN		10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	21,842	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	48,674	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15 WORKERS' COMPENSATION INSURANCE	45,172	15
16 RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)		16
TAXES		
17 FICA-EMPLOYERS PORTION ONLY	1,220,301	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19 UNEMPLOYMENT INSURANCE		19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES		20
OTHER		
21 EXECUTIVE DEFERRED COMPENSATION (OTHER THAN RETIREMENT COST REPORTED ON LINES 1 THROUGH 4 ABOVE) (SEE INSTRUCTIONS)	25,481	21
22 DAY CARE COSTS AND ALLOWANCES		22
23 TUITION REIMBURSEMENT	5,880	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	22,498,390	24
PART B - OTHER THAN CORE RELATED COST		
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
PERIOD FROM 01/01/2012 TO 12/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
05/30/2013 16:42

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

COMPONENT		CONTRACT	BENEFIT
0		LABOR	COST
		1	2
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST		1
2	HOSPITAL		2
3	SUBPROVIDER - IPF		3
4	SUBPROVIDER - IRF		4
5	SUBPROVIDER - (OTHER)		5
6	SWING BEDS - SNF		6
7	SWING BEDS - NF		7
8	HOSPITAL-BASED SNF		8
9	HOSPITAL-BASED NF		9
10	HOSPITAL-BASED OLTC		10
11	HOSPITAL-BASED HHA		11
12	SEPARATELY CERTIFIED ASC		12
13	HOSPITAL-BASED HOSPICE		13
14	HOSPITAL-BASED HEALTH CLINIC - RHC		14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC		15
16	HOSPITAL-BASED (CMHC)		16
17	RENAL DIALYSIS		17
18	OTHER		18

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

		Y/N	DATE
		1	2
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR WAS THERE NO MEDICARE UTILIZATION? ENTER 'Y' FOR YES IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N	1
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	N	2

	GROUP	SNF DAYS	SWING BED SNF DAYS	TOTAL (COLS. 2 + 3)
	1	2	3	4
3	RUX			3
4	RUL			4
5	RVX			5
6	RVL			6
7	RHX			7
8	RHL			8
9	RMX			9
10	RML			10
11	RLX			11
12	RUC	379		379
13	RUB	270		270
14	RUA	449		449
15	RVC	164		164
16	RVB	75		75
17	RVA	147		147
18	RHC	73		73
19	RHB			19
20	RHA	47		47
21	RMC	44		44
22	RMB	29		29
23	RMA	33		33
24	RLB			24
25	RLA			25
26	ES3			26
27	ES2			27
28	ES1			28
29	HE2			29
30	HE1			30
31	HD2			31
32	HD1			32
33	HC2			33
34	HC1			34
35	HB2			35
36	HB1			36
37	LE2			37
38	LE1			38
39	LD2			39
40	LD1			40
41	LC2			41
42	LC1	18		18
43	LB2			43
44	LB1			44
45	CE2			45
46	CE1			46
47	CD2	8		8
48	CD1			48
49	CC2			49
50	CC1			50
51	CB2			51
52	CB1	13		13
53	CA2			53
54	CA1	4		4
55	SE3			55
56	SE2			56
57	SE1			57
58	SSC			58
59	SSB			59
60	SSA			60
61	IB2			61
62	IB1			62
63	IA1			63
64	IA2			64
65	BB2			65
66	BB1			66
67	BA2			67
68	BA1			68

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

		GROUP	SNF	SWING BED	TOTAL
		1	DAYS	SNF DAYS	(COLS.
			2	3	2 + 3)
					4
69	PE2				69
70	PE1				70
71	PD2				71
72	PD1		1		1 72
73	PC2				73
74	PC1		8		8 74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1		2		2 78
199	AAA		1		1 199
200	TOTAL		1,765		1,765 200

		CBSA AT	CBSA ON/AFTER
		BEGINNING	OCT 1 OF THE
		OF COST	COST REPORTING
		REPORTING	PERIOD (IF
		PERIOD	APPLICABLE)
		1	2
201	ENTER IN COLUMN 1 THE SNF CBSA CODE, OR 5 CHARACTER NON-CBSA CODE IF A RURAL FACILITY, IN EFFECT AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER IN COLUMN 2 THE CODE IN EFFECT ON OR AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (IF APPLICABLE).	23060	201

A NOTICE PUBLISHED IN THE FEDERAL REGISTER VOLUME 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. FOR LINES 202 THROUGH 207: ENTER IN COLUMN 1 THE AMOUNT OF THE EXPENSE FOR EACH CATEGORY. ENTER IN COLUMN 2 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 7, COLUMN 3. IN COLUMN 3, ENTER 'Y' OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)

		EXPENSES	PERCENTAGE	ASSOCIATED	
		1	2	WITH	
				DIRECT	
				PATIENT	
				CARE AND	
				RELATED	
				EXPENSES?	
				3	
202	STAFFING	2,342,751	61.06%	Y	202
203	RECRUITMENT				203
204	RETENTION OF EMPLOYEES				204
205	TRAINING	62,299	1.62%	Y	205
206	OTHER (SPECIFY)				206
207	TOTAL SNF REVENUE (WORKSHEET G-2, PART I, LINE 7, COLUMN 3)	3,836,794			207

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 202, COL. 3 DIVIDED BY LINE 202, COL. 8)				0.347914	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				1,183,185	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				N	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID				868,778	5
6	MEDICAID CHARGES				11,414,774	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				3,971,360	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.				1,919,397	8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP				13,463	9
10	STAND-ALONE SCHIP CHARGES				28,494	10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)				9,913	11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.					12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS					18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)				1,919,397	19
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL		
		1	2	3		
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FACILITY	1,660,736	629,241	2,289,977		20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	577,793	218,922	796,715		21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	14,042	13,790	27,832		22
23	COST OF CHARITY CARE	563,751	205,132	768,883		23
24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					N 24
25	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)			4,856,000		26
26	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			41,138		27
27	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			4,814,862		28
28	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			1,675,158		29
29	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			2,444,041		30
30	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			4,363,438		31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL (COL. 1 + COL. 2)	RECLASSIFI- CATIONS	
		1	2	3	4	
GENERAL SERVICE COST CENTERS						
1	00100		3,795,558	3,795,558	-1,114,670	1
2	00200				1,479,051	2
2.01	00201				214,581	2.01
3	00300					3
4	00400	1,444,986	4,303,088	5,748,074	-1,444,986	4
5	00500	7,472,077	2,474,937	9,947,014	-274,836	5
6	00600					6
7	00700	281,488	842,818	1,124,306	-66,638	7
8	00800		151,988	151,988		8
9	00900	173,652	106,887	280,539	20,173	9
10	01000	323,474	174,799	498,273	-334,329	10
11	01100				369,513	11
12	01200					12
13	01300	68,679	172	68,851	8,403	13
14	01400		978	978	-792	14
15	01500	465,287	2,159,334	2,624,621	-1,368,872	15
16	01600					16
17	01700					17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	2,220,970	272,777	2,493,747	-374,543	30
43	04300				186,437	43
44	04400	2,075,662	704,386	2,780,048	448,157	44
ANCILLARY SERVICE COST CENTERS						
50	05000	883,772	361,172	1,244,944	105,821	50
52	05200	28,731	-332	28,399	459,415	52
53	05300		831,451	831,451	-52	53
54	05400	907,430	386,308	1,293,738	56,537	54
60	06000		1,321,915	1,321,915	-1,872	60
62.30	06250					62.30
65	06500	389,141	156,516	545,657	-19,435	65
66	06600	658,141	485,777	1,143,918	-593,971	66
67	06700		173,628	173,628	292,137	67
68	06800		88,054	88,054	80,910	68
69	06900		89,566	89,566	-1,035	69
71	07100		1,023,108	1,023,108	-203,667	71
72	07200				202,452	72
73	07300				1,419,062	73
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
90	09000	81,736	14,540	96,276	13,223	90
91	09100	1,046,744	159,011	1,205,755	85,520	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
95	09500	909,535	222,556	1,132,091	106,549	95
SPECIAL PURPOSE COST CENTERS						
118		19,431,505	20,300,992	39,732,497	-251,757	118
NONREIMBURSABLE COST CENTERS						
190	19000					190
192	19200	13,951	2,734,855	2,748,806	1,707	192
194	07950		-144,571	-144,571	196,582	194
194.01	07951	2,728	560	3,288	334	194.01
194.02	07952	285,073	666,154	951,227	45,910	194.02
194.03	07953		90,000	90,000		194.03
194.04	07954	17,795	82,398	100,193	7,224	194.04
194.05	07955					194.05
200		19,751,052	23,730,388	43,481,440		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
GENERAL SERVICE COST CENTERS					
1	00100	2,680,888	362,347	3,043,235	1
2	00200	1,479,051	1,020,646	2,499,697	2
2.01	00201	214,581		214,581	2.01
3	00300				3
4	00400	4,303,088	-1,198,305	3,104,783	4
5	00500	9,672,178	-2,213,300	7,458,878	5
6	00600				6
7	00700	1,057,668	-316	1,057,352	7
8	00800	151,988		151,988	8
9	00900	300,712		300,712	9
10	01000	163,944	-17,354	146,590	10
11	01100	369,513	-34,176	335,337	11
12	01200				12
13	01300	77,254		77,254	13
14	01400	186	178,239	178,425	14
15	01500	1,255,749	-626,419	629,330	15
16	01600		435,562	435,562	16
17	01700				17
19	01900				19
20	02000				20
21	02100				21
22	02200				22
23	02300				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	2,119,204		2,119,204	30
43	04300	186,437		186,437	43
44	04400	3,228,205	-11,211	3,216,994	44
ANCILLARY SERVICE COST CENTERS					
50	05000	1,350,765		1,350,765	50
52	05200	487,814		487,814	52
53	05300	831,399	-778,298	53,101	53
54	05400	1,350,275	969	1,351,244	54
60	06000	1,320,043		1,320,043	60
62.30	06250				62.30
65	06500	526,222	-1,957	524,265	65
66	06600	549,947	-600	549,347	66
67	06700	465,765		465,765	67
68	06800	168,964		168,964	68
69	06900	88,531		88,531	69
71	07100	819,441		819,441	71
72	07200	202,452		202,452	72
73	07300	1,419,062		1,419,062	73
76.97	07697				76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
90	09000	109,499		109,499	90
91	09100	1,291,275	-12,743	1,278,532	91
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
95	09500	1,238,640		1,238,640	95
SPECIAL PURPOSE COST CENTERS					
118		39,480,740	-2,896,916	36,583,824	118
NONREIMBURSABLE COST CENTERS					
190	19000				190
192	19200	2,750,513	-2,652,053	98,460	192
194	07950	52,011		52,011	194
194.01	07951	3,622		3,622	194.01
194.02	07952	997,137	-325,054	672,083	194.02
194.03	07953	90,000		90,000	194.03
194.04	07954	107,417		107,417	194.04
194.05	07955				194.05
200		43,481,440	-5,874,023	37,607,417	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER
			LINE #			
	1	2	3		4	5
1 CAFETERIA RECLASS	A	CAFETERIA	11		248,697	120,816
500 TOTAL RECLASSIFICATIONS					248,697	120,816
CODE LETTER - A						500
1 OB RECLASS	B	NURSERY	43		153,491	14,166
2		DELIVERY ROOM & LABOR ROOM	52		375,335	34,641
500 TOTAL RECLASSIFICATIONS					528,826	48,807
CODE LETTER - B						500
1 ASSOCIATION DUES RECLASS	C	OAK POINTE	194.02			1,477
500 TOTAL RECLASSIFICATIONS						1,477
CODE LETTER - C						500
1 LTC A&G COST	D	SKILLED NURSING FACILITY	44		98,565	153,345
500 TOTAL RECLASSIFICATIONS					98,565	153,345
CODE LETTER - D						500
1 BUILDING AND EQUIP LEASE	E	CAP REL COSTS-BLDG & FIXT	1			447,475
2		CAP REL COSTS-MVBLE EQUIP	2			79,455
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
500 TOTAL RECLASSIFICATIONS						526,930
CODE LETTER - E						500
1 INSURANCE RECLASS	G	CAP REL COSTS-BLDG & FIXT	1			5,199
2		CAP REL COSTS-MVBLE EQUIP	2			31,894
3		SNF CAPITAL	2.01			13,596
4		OAK POINTE	194.02			13,632
5		CAP REL COSTS-MVBLE EQUIP	2			1,164
6		SNF CAPITAL	2.01			179
7		OAK POINTE	194.02			179
8		ADMINISTRATIVE & GENERAL	5			6,354
500 TOTAL RECLASSIFICATIONS						72,197
CODE LETTER - G						500
1 DEPRECIATION RECLASS	H	CAP REL COSTS-MVBLE EQUIP	2			1,366,008
2		SNF CAPITAL	2.01			200,609
500 TOTAL RECLASSIFICATIONS						1,566,617
CODE LETTER - H						500
1 TAXES RECLASS	J	CAP REL COSTS-MVBLE EQUIP	2			530
2		SNF CAPITAL	2.01			197
500 TOTAL RECLASSIFICATIONS						727
CODE LETTER - J						500
1 SALARY RECLASS	K	ADMINISTRATIVE & GENERAL	5			4,097,357
2		CENTRAL SERVICES & SUPPLY	14		175,384	
3		MEDICAL RECORDS & LIBRARY	16		309,882	
500 TOTAL RECLASSIFICATIONS					485,266	4,097,357
CODE LETTER - K						500

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER	
			LINE #				
1	1	2	3	4	5		
1 REHAB THERAPY DEPT RECLASS	L	OCCUPATIONAL THERAPY	67		269,857	14,810	1
2		SPEECH PATHOLOGY	68		69,961	3,852	2
500 TOTAL RECLASSIFICATIONS					339,818	18,662	500
CODE LETTER - L							
1 DRUGS CHARGED TO PATIENT RECLASS	M	DRUGS CHARGED TO PATIENTS	73			1,424,592	1
500 TOTAL RECLASSIFICATIONS						1,424,592	500
CODE LETTER - M							
1 SALARY BENEFITS RECLASS	N	ADMINISTRATIVE & GENERAL	5		154,665		1
2		OPERATION OF PLANT	7		34,441		2
3		HOUSEKEEPING	9		21,247		3
4		DIETARY	10		39,578		4
5		NURSING ADMINISTRATION	13		8,403		5
6		PHARMACY	15		56,930		6
7		ADULTS & PEDIATRICS	30		207,040		7
8		NURSERY	43		18,780		8
9		SKILLED NURSING FACILITY	44		222,964		9
10		OPERATING ROOM	50		108,133		10
11		DELIVERY ROOM & LABOR ROOM	52		49,439		11
12		RADIOLOGY-DIAGNOSTIC	54		111,027		12
13		RESPIRATORY THERAPY	65		47,613		13
14		PHYSICAL THERAPY	66		48,391		14
15		OCCUPATIONAL THERAPY	67		25,037		15
16		SPEECH PATHOLOGY	68		7,097		16
17		CLINIC	90		10,001		17
18		EMERGENCY	91		128,074		18
19		AMBULANCE SERVICES	95		111,285		19
20		PHYSICIANS' PRIVATE OFFICES	192		1,707		20
21		PAIN CLINIC	194.01		334		21
22		OAK POINTE	194.02		30,622		22
23		COMMUNITY & VOLUNTEER SERVICE	194.04		2,178		23
500 TOTAL RECLASSIFICATIONS					1,444,986		500
CODE LETTER - N							
1 CLINIC DIETICIAN RECLASS	O	CLINIC	90		3,222		1
500 TOTAL RECLASSIFICATIONS					3,222		500
CODE LETTER - O							
1 CORPORATE DIRECT ALLOC RECLASS	P	OCCUPATIONAL HEALTH	194			52,012	1
2		COMMUNITY & VOLUNTEER SERVICE	194.04			5,046	2
500 TOTAL RECLASSIFICATIONS						57,058	500
CODE LETTER - P							
1 OCCUPATIONAL HEALTH RECLASS	Q	OCCUPATIONAL HEALTH	194			144,570	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
500 TOTAL RECLASSIFICATIONS						144,570	500
CODE LETTER - Q							
1 IMPLANTABLE MEDICAL SUPPLIES	R	IMPL. DEV. CHARGED TO PATIENT	72			202,452	1
500 TOTAL RECLASSIFICATIONS						202,452	500
CODE LETTER - R							
GRAND TOTAL (INCREASES)					3,149,380	8,435,607	

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 CAFETERIA RECLASS	A	DIETARY	10	248,697	120,816	1
500 TOTAL RECLASSIFICATIONS				248,697	120,816	500
CODE LETTER - A						
1 OB RECLASS	B	ADULTS & PEDIATRICS	30	528,826	48,807	1
2						2
500 TOTAL RECLASSIFICATIONS				528,826	48,807	500
CODE LETTER - B						
1 ASSOCIATION DUES RECLASS	C	SKILLED NURSING FACILITY	44		1,477	1
500 TOTAL RECLASSIFICATIONS					1,477	500
CODE LETTER - C						
1 LTC A&G COST	D	ADMINISTRATIVE & GENERAL	5	98,565	153,345	1
500 TOTAL RECLASSIFICATIONS				98,565	153,345	500
CODE LETTER - D						
1 BUILDING AND EQUIP LEASE	E	ADMINISTRATIVE & GENERAL	5		51,000	10 1
2		OPERATION OF PLANT	7		91,555	10 2
3		RESPIRATORY THERAPY	65		65,806	3
4		PHYSICAL THERAPY	66		239,114	4
5		ADMINISTRATIVE & GENERAL	5		10,044	5
6		OPERATION OF PLANT	7		9,524	6
7		HOUSEKEEPING	9		1,074	7
8		DIETARY	10		1,172	8
9		CENTRAL SERVICES & SUPPLY	14		792	9
10		PHARMACY	15		1,210	10
11		ADULTS & PEDIATRICS	30		3,950	11
12		SKILLED NURSING FACILITY	44		18,886	12
13		OPERATING ROOM	50		2,312	13
14		ANESTHESIOLOGY	53		52	14
15		RADIOLOGY-DIAGNOSTIC	54		2,215	15
16		RESPIRATORY THERAPY	65		1,200	16
17		PHYSICAL THERAPY	66		20,302	17
18		EMERGENCY	91		1,986	18
19		AMBULANCE SERVICES	95		4,736	19
500 TOTAL RECLASSIFICATIONS					526,930	500
CODE LETTER - E						
1 INSURANCE RECLASS	G	ADMINISTRATIVE & GENERAL	5		64,321	12 1
2		ADMINISTRATIVE & GENERAL	5		1,522	12 2
3		SKILLED NURSING FACILITY	44		6,354	12 3
4						4
5						5
6						6
7						7
8						8
500 TOTAL RECLASSIFICATIONS					72,197	500
CODE LETTER - G						
1 DEPRECIATION RECLASS	H	CAP REL COSTS-BLDG & FIXT	1		1,566,617	9 1
2						9 2
500 TOTAL RECLASSIFICATIONS					1,566,617	500
CODE LETTER - H						
1 TAXES RECLASS	J	CAP REL COSTS-BLDG & FIXT	1		727	13 1
2						13 2
500 TOTAL RECLASSIFICATIONS					727	500
CODE LETTER - J						
1 SALARY RECLASS	K	ADMINISTRATIVE & GENERAL	5	4,097,357		1
2		CENTRAL SERVICES & SUPPLY	14		175,384	2
3		MEDICAL RECORDS & LIBRARY	16		309,882	3
500 TOTAL RECLASSIFICATIONS				4,097,357	485,266	500
CODE LETTER - K						

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 REHAB THERAPY DEPT RECLASS	L	PHYSICAL THERAPY	66	339,818	18,662	1
2						2
500 TOTAL RECLASSIFICATIONS				339,818	18,662	500
CODE LETTER - L						
1 DRUGS CHARGED TO PATIENT RECLASS	M	PHARMACY	15		1,424,592	1
500 TOTAL RECLASSIFICATIONS					1,424,592	500
CODE LETTER - M						
1 SALARY BENEFITS RECLASS	N	EMPLOYEE BENEFITS	4	1,444,986		1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
16						16
17						17
18						18
19						19
20						20
21						21
22						22
23						23
500 TOTAL RECLASSIFICATIONS				1,444,986		500
CODE LETTER - N						
1 CLINIC DIETICIAN RECLASS	O	DIETARY	10	3,222		1
500 TOTAL RECLASSIFICATIONS				3,222		500
CODE LETTER - O						
1 CORPORATE DIRECT ALLOC RECLASS	P	ADMINISTRATIVE & GENERAL	5		57,058	1
2						2
500 TOTAL RECLASSIFICATIONS					57,058	500
CODE LETTER - P						
1 OCCUPATIONAL HEALTH RECLASS	Q	RADIOLOGY-DIAGNOSTIC	54		52,275	1
2		LABORATORY	60		1,872	2
3		RESPIRATORY THERAPY	65		42	3
4		PHYSICAL THERAPY	66		24,466	4
5		OCCUPATIONAL THERAPY	67		17,567	5
6		ELECTROCARDIOLOGY	69		1,035	6
7		MEDICAL SUPPLIES CHRGED TO PA	71		1,215	7
8		DRUGS CHARGED TO PATIENTS	73		5,530	8
9		EMERGENCY	91		40,568	9
500 TOTAL RECLASSIFICATIONS					144,570	500
CODE LETTER - Q						
1 IMPLANTABLE MEDICAL SUPPLIES	R	MEDICAL SUPPLIES CHRGED TO PA	71		202,452	1
500 TOTAL RECLASSIFICATIONS					202,452	500
CODE LETTER - R						
GRAND TOTAL (DECREASES)				6,761,471	4,823,516	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND	105,745					105,745		1
2 LAND IMPROVEMENTS	304,956				25,165	279,791	78,333	2
3 BUILDINGS AND FIXTURES	3,979,847	183		183	25,904	3,954,126	396,250	3
4 BUILDING IMPROVEMENTS	48,069	756		756		48,825	42,430	4
5 FIXED EQUIPMENT	846,514	19,963		19,963	112	866,365	123,377	5
6 MOVABLE EQUIPMENT	14,593,555	984,680		984,680	3,405,256	12,172,979	3,271,849	6
7 HIT DESIGNATED ASSETS		1,753,661		1,753,661		1,753,661		7
8 SUBTOTAL (SUM OF LINES 1-7)	19,878,686	2,759,243		2,759,243	3,456,437	19,181,492	3,912,239	8
9 RECONCILING ITEMS	44,792	1,753,661		1,753,661	33,432	1,765,021		9
10 TOTAL (LINE 7 MINUS LINE 9)	19,833,894	1,005,582		1,005,582	3,423,005	17,416,471	3,912,239	10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

----- SUMMARY OF CAPITAL -----

DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1)	
							(SUM OF COLS. 9-14) 15	
1 CAP REL COSTS-BLDG & FIXT	3,795,013				545		3,795,558	1
2 CAP REL COSTS-MVBLE EQUIP								2
2.01 SNF CAPITAL								2.01
3 TOTAL (SUM OF LINES 1-2)	3,795,013				545		3,795,558	3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

----- COMPUTATION OF RATIOS ----- ALLOCATION OF OTHER CAPITAL -----

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 7	TOTAL
								(SUM OF COLS. 5-7) 8
1 CAP REL COSTS-BLDG & FIXT	1,772,482		1,772,482	0.092406				1
2 CAP REL COSTS-MVBLE EQUIP	12,803,543		12,803,543	0.667494				2
2.01 SNF CAPITAL	4,605,467		4,605,467	0.240100				2.01
3 TOTAL (SUM OF LINES 1-2)	19,181,492		19,181,492	1.000000				3

----- SUMMARY OF CAPITAL -----

DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)	
							(SUM OF COLS. 9-14) 15	
1 CAP REL COSTS-BLDG & FIXT	2,590,743	447,475		5,199	-182		3,043,235	1
2 CAP REL COSTS-MVBLE EQUIP	2,386,654	79,455		33,058	530		2,499,697	2
2.01 SNF CAPITAL	200,609			13,775	197		214,581	2.01
3 TOTAL	5,178,006	526,930		52,032	545		5,757,513	3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)					4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)					7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)	A	-316	OPERATION OF PLANT	7	8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-15,185			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	2,790,475			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-19,336	CAFETERIA	11	14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17 SALE OF DRUGS TO OTHER THAN PATIENTS					17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS					18
19 NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)					19
20 VENDING MACHINES					20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32 CAH HIT ADJ FOR DEPRECIATION AND MISCELLANEOUS REVENUE	B	-3,180	ADMINISTRATIVE & GENERAL	5	32
33					33
34					34
35 POSTURE ASSESSMENTS	B	-600	PHYSICAL THERAPY	66	35
36 SALE OF LTC SUPPLIES	B	-10,544	SKILLED NURSING FACILITY	44	36
37 NON-PATIENT RADIOLOGY REV.	B	969	RADIOLOGY-DIAGNOSTIC	54	37
38 NON-PATIENT LAB REV.	B	-1,957	RESPIRATORY THERAPY	65	38
39 TELEVISION OFFSET	A	-13,827	CAP REL COSTS-MVBLE EQUIP	2	39
40 ANSWERING SERVICE	A	-1,897	ADMINISTRATIVE & GENERAL	5	40
41 PHYSICIAN RECRUITING	A	-25,000	ADMINISTRATIVE & GENERAL	5	41
42 MEALS ON WHEELS	A	-17,354	DIETARY	10	42
43 VISITOR MEALS	A	-14,840	CAFETERIA	11	43
44 PHARMACY SALES	A	-609,907	PHARMACY	15	44
45 COMMUNITY HEALTH & VOLUNTEER SVCS	A	-49,513	ADMINISTRATIVE & GENERAL	5	45
46 SELF INSURANCE	A	-1,937,801	EMPLOYEE BENEFITS	4	46
47 LOBBY EXPENSE	A	-3,592	ADMINISTRATIVE & GENERAL	5	47
48 LOBBY EXPENSE	A	-667	SKILLED NURSING FACILITY	44	48
49 LOBBY EXPENSE	A	-118	OAK POINTE	194.02	49
49.02 RENT EXPENSE - MEDICATION ASSIST P	A	-263,918	PHYSICIANS' PRIVATE OFFICES	192	49.02
49.03 ALLOWABLE ER ADMIN SVCS	A	1,750	EMERGENCY	91	49.03
49.04 RENT EXPENSE - OAK POINTE	A	-324,936	OAK POINTE	194.02	49.04
49.05 INTERUNIT RENT EXPENSE	A	-2,170,476	CAP REL COSTS-BLDG & FIXT	1	49.05
49.06 OPERATING INTEREST EXPENSE	A	-16,512	PHARMACY	15	49.06
49.07 NON-ALLOW - PROF SERVICES	A	-777,621	ANESTHESIOLOGY	53	49.07
49.08 TRANSCRIPTION ADD-BACK	A	15	EMERGENCY	91	49.08
49.09 SUBSIDY ADJUSTMENT	A	-2,388,135	PHYSICIANS' PRIVATE OFFICES	192	49.09
50 TOTAL (SUM OF LINES 1 THRU 49)		-5,874,023			50
TRANSFER TO WKST A, COL. 6, LINE 200)					

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

WORKSHEET A-8-1

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR THE CLAIMING OF HOME OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ- USTMENTS (COL. 4-5)	WKST A-7 REF	
1	2	3	4	5	6	7	
1	1	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	2,532,823		2,532,823	9 1
2	2	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	1,034,473		1,034,473	9 2
3	5	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	4,077,882	6,208,000	-2,130,118	3
4	4	EMPLOYEE BENEFITS	HOME OFFICE ALLOCATION	56,403		56,403	4
4.01	14	CENTRAL SERVICES & SUPPLY	HOME OFFICE ALLOCATION	178,239		178,239	4.01
4.02	4	EMPLOYEE BENEFITS	HOME OFFICE ALLOCATION	99,658		99,658	4.02
4.03	16	MEDICAL RECORDS & LIBRARY	HOME OFFICE ALLOCATION	435,562		435,562	4.03
4.04	4	EMPLOYEE BENEFITS	HOME OFFICE ALLOCATION	583,435		583,435	4.04
4.05	194.02	OAK POINTE	HOME OFFICE ALLOCATION	212,000	212,000		4.05
5		TOTALS (SUM OF LINES 1-4) TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.		9,210,475	6,420,000	2,790,475	5

B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

THE SECRETARY, BY VIRTUE OF 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.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES 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 REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

SYMBOL (1)	NAME	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----			
		PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
6	B		PARKVIEW HEALTH		HOME OFFICE
7					
8					
9					
10					

- (1) USE THE FOLLOWING SYMBOLS TO INDICATE THE 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.
 - G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY:

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
 PERIOD FROM 01/01/2012 TO 12/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 05/30/2013 16:42

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT	
1	2	3	4	5	6	7	8	9	
1	91 EMERGENCY DR A	30,000		30,000	171,400	188	15,492	775	1
2	53 ANESTHESIOLOGY DR B	53,352		53,352	200,300	547	52,675	2,634	2
200	TOTAL	83,352		83,352		735	68,167	3,409	200

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
 PERIOD FROM 01/01/2012 TO 12/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 05/30/2013 16:42

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
LINE NO.		12	13	14	15	16	17	18	
10	11								
1	91 EMERGENCY					15,492	14,508	14,508	1
2	53 ANESTHESIOLOGY					52,675	677	677	2
200	TOTAL					68,167	15,185	15,185	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP	CAP	CAP	CAP RELATE	EMPLOYEE	
	FOR COST					BLDGS &
	ALLOCATION	FIXTURES	EQUIPMENT	SNF		
	(FROM WKST	1	2	2.01	4	
	A, COL.7)					
	0					
GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	3,043,235	3,043,235			1
2	CAP REL COSTS-MVBLE EQUIP	2,499,697		2,499,697		2
2.01	SNF CAPITAL	214,581			214,581	2.01
4	EMPLOYEE BENEFITS	3,104,783				4
5	ADMINISTRATIVE & GENERAL	7,458,878	594,895	488,643		5
6	MAINTENANCE & REPAIRS					6
7	OPERATION OF PLANT	1,057,352	326,494	268,181		7
8	LAUNDRY & LINEN SERVICE	151,988	15,255	12,531		8
9	HOUSEKEEPING	300,712	12,750	10,473		9
10	DIETARY	146,590	54,660	44,897		10
11	CAFETERIA	335,337	61,640	50,631		11
12	MAINTENANCE OF PERSONNEL					12
13	NURSING ADMINISTRATION	77,254	3,715	3,052		13
14	CENTRAL SERVICES & SUPPLY	178,425	44,133	36,251		14
15	PHARMACY	629,330	38,250	31,419		15
16	MEDICAL RECORDS & LIBRARY	435,562	13,595	11,166		16
17	SOCIAL SERVICE					17
19	NONPHYSICIAN ANESTHETISTS					19
20	NURSING SCHOOL					20
21	I&R SRVCES-SALARY & FRINGES APPRVD					21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23	PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	2,119,204	597,033	490,400		30
43	NURSERY	186,437				43
44	SKILLED NURSING FACILITY	3,216,994			205,667	44
ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,350,765	362,859	298,050		50
52	DELIVERY ROOM & LABOR ROOM	487,814				52
53	ANESTHESIOLOGY	53,101				53
54	RADIOLOGY-DIAGNOSTIC	1,351,244	247,235	203,077		54
60	LABORATORY	1,320,043	62,625	51,440		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	RESPIRATORY THERAPY	524,265	66,031	54,237		65
66	PHYSICAL THERAPY	549,347	224,155	184,120	8,914	66
67	OCCUPATIONAL THERAPY	465,765				67
68	SPEECH PATHOLOGY	168,964				68
69	ELECTROCARDIOLOGY	88,531				69
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	819,441				71
72	IMPL. DEV. CHARGED TO PATIENT	202,452				72
73	DRUGS CHARGED TO PATIENTS	1,419,062				73
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	109,499	101,185	83,113		90
91	EMERGENCY	1,278,532	199,133	163,567		91
92	OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	1,238,640				95
SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	36,583,824	3,025,643	2,485,248	214,581	118
NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		9,570	7,860		190
192	PHYSICIANS' PRIVATE OFFICES	98,460				192
194	OCCUPATIONAL HEALTH	52,011				194
194.01	PAIN CLINIC	3,622				194.01
194.02	OAK POINTE	672,083				194.02
194.03	FOUNDATION	90,000				194.03
194.04	COMMUNITY & VOLUNTEER SERVICES	107,417	8,022	6,589		194.04
194.05	VACANT SPACE					194.05
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	TOTAL (SUM OF LINES 118-201)	37,607,417	3,043,235	2,499,697	214,581	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	SUBTOTAL (COLS.0-4) 4A	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 SNF CAPITAL						2.01
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	9,202,433	9,202,433				5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	1,712,805	554,901	2,267,706			7
8 LAUNDRY & LINEN SERVICE	179,774	58,242	16,304	254,320		8
9 HOUSEKEEPING	361,429	117,093	13,627		492,149	9
10 DIETARY	267,527	86,671	58,417		12,848	10
11 CAFETERIA	495,452	160,513	65,877		14,488	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	98,850	32,025	3,971		873	13
14 CENTRAL SERVICES & SUPPLY	292,549	94,778	47,167		10,373	14
15 PHARMACY	799,462	259,003	40,880		8,991	15
16 MEDICAL RECORDS & LIBRARY	519,937	168,445	14,529		3,195	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	3,571,998	1,157,227	638,075	93,301	140,331	30
43 NURSERY	219,578	71,137		2,691		43
44 SKILLED NURSING FACILITY	3,883,828	1,258,266				44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,202,495	713,547	387,802	41,459	85,289	50
52 DELIVERY ROOM & LABOR ROOM	575,058	186,303		1,099		52
53 ANESTHESIOLOGY	53,101	17,203				53
54 RADIOLOGY-DIAGNOSTIC	1,997,485	647,129	264,230	36,329	58,112	54
60 LABORATORY	1,434,108	464,611	66,930	14	14,720	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	728,555	236,031	70,570	1,920	15,520	65
66 PHYSICAL THERAPY	1,037,084	335,986	239,564	6,055	52,687	66
67 OCCUPATIONAL THERAPY	522,496	169,274		5,104		67
68 SPEECH PATHOLOGY	183,788	59,542		1,328		68
69 ELECTROCARDIOLOGY	88,531	28,682				69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	819,441	265,476				71
72 IMPL. DEV. CHARGED TO PATIENT	202,452	65,589				72
73 DRUGS CHARGED TO PATIENTS	1,419,062	459,736				73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	312,065	101,100	108,141	1,509	23,783	90
91 EMERGENCY	1,867,241	604,934	212,822	52,239	46,805	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	1,435,023	464,907		11,272		95
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	36,483,607	8,838,351	2,248,906	254,320	488,015	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,430	5,647	10,227		2,249	190
192 PHYSICIANS' PRIVATE OFFICES	101,472	32,874				192
194 OCCUPATIONAL HEALTH	52,011	16,850				194
194.01 PAIN CLINIC	4,211	1,364				194.01
194.02 OAK POINTE	732,816	237,412				194.02
194.03 FOUNDATION	90,000	29,157				194.03
194.04 COMMUNITY & VOLUNTEER SERVICES	125,870	40,778	8,573		1,885	194.04
194.05 VACANT SPACE						194.05
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	37,607,417	9,202,433	2,267,706	254,320	492,149	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	10	11	13	14	15	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 SNF CAPITAL						2.01
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY	425,463					10
11 CAFETERIA		736,330				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		5,235	140,954			13
14 CENTRAL SERVICES & SUPPLY		23,556		468,423		14
15 PHARMACY		23,119		12,431	1,143,886	15
16 MEDICAL RECORDS & LIBRARY		35,770				16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	425,463	156,600	58,664	23,601	15	30
43 NURSERY		12,650	4,691	2,088	2	43
44 SKILLED NURSING FACILITY				36,192		44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		78,082	29,308	61,187	3,425	50
52 DELIVERY ROOM & LABOR ROOM		32,716	12,254	5,160	4	52
53 ANESTHESIOLOGY				94		53
54 RADIOLOGY-DIAGNOSTIC		78,082		15,525	196	54
60 LABORATORY				18		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		37,078		14,918		65
66 PHYSICAL THERAPY		27,918		2,467	85	66
67 OCCUPATIONAL THERAPY		16,576		2,079	54	67
68 SPEECH PATHOLOGY		4,362		955	15	68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				184,984		71
72 IMPL. DEV. CHARGED TO PATIENT				45,635		72
73 DRUGS CHARGED TO PATIENTS					1,129,691	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC		7,416		2,381		90
91 EMERGENCY		95,967	36,037	23,331	1,458	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES		90,733		27,392	8,941	95
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	425,463	725,860	140,954	460,438	1,143,886	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES		3,054		2,484		192
194 OCCUPATIONAL HEALTH						194
194.01 PAIN CLINIC						194.01
194.02 OAK POINTE				5,461		194.02
194.03 FOUNDATION		4,362				194.03
194.04 COMMUNITY & VOLUNTEER SERVICES		3,054		40		194.04
194.05 VACANT SPACE						194.05
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	425,463	736,330	140,954	468,423	1,143,886	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
2.01 SNF CAPITAL					2.01
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY	741,876				16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	149,488	6,414,763		6,414,763	30
43 NURSERY	16,099	328,936		328,936	43
44 SKILLED NURSING FACILITY		5,178,286		5,178,286	44
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	47,554	3,650,148		3,650,148	50
52 DELIVERY ROOM & LABOR ROOM		812,594		812,594	52
53 ANESTHESIOLOGY		70,398		70,398	53
54 RADIOLOGY-DIAGNOSTIC	154,310	3,251,398		3,251,398	54
60 LABORATORY		1,980,401		1,980,401	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY		1,104,592		1,104,592	65
66 PHYSICAL THERAPY	99,411	1,801,257		1,801,257	66
67 OCCUPATIONAL THERAPY	37,910	753,493		753,493	67
68 SPEECH PATHOLOGY	3,338	253,328		253,328	68
69 ELECTROCARDIOLOGY		117,213		117,213	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		1,269,901		1,269,901	71
72 IMPL. DEV. CHARGED TO PATIENT		313,676		313,676	72
73 DRUGS CHARGED TO PATIENTS		3,008,489		3,008,489	73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC		556,395		556,395	90
91 EMERGENCY	233,766	3,174,600		3,174,600	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES		2,038,268		2,038,268	95
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	741,876	36,078,136		36,078,136	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		35,553		35,553	190
192 PHYSICIANS' PRIVATE OFFICES		139,884		139,884	192
194 OCCUPATIONAL HEALTH		68,861		68,861	194
194.01 PAIN CLINIC		5,575		5,575	194.01
194.02 OAK POINTE		975,689		975,689	194.02
194.03 FOUNDATION		123,519		123,519	194.03
194.04 COMMUNITY & VOLUNTEER SERVICES		180,200		180,200	194.04
194.05 VACANT SPACE					194.05
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	741,876	37,607,417		37,607,417	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION		DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	CAP RELATE COSTS SNF 2.01	SUBTOTAL 2A	
GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
2.01	SNF CAPITAL						2.01
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL		594,895	488,643		1,083,538	5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT		326,494	268,181		594,675	7
8	LAUNDRY & LINEN SERVICE		15,255	12,531		27,786	8
9	HOUSEKEEPING		12,750	10,473		23,223	9
10	DIETARY		54,660	44,897		99,557	10
11	CAFETERIA		61,640	50,631		112,271	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		3,715	3,052		6,767	13
14	CENTRAL SERVICES & SUPPLY		44,133	36,251		80,384	14
15	PHARMACY		38,250	31,419		69,669	15
16	MEDICAL RECORDS & LIBRARY		13,595	11,166		24,761	16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		597,033	490,400		1,087,433	30
43	NURSERY						43
44	SKILLED NURSING FACILITY				205,667	205,667	44
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		362,859	298,050		660,909	50
52	DELIVERY ROOM & LABOR ROOM						52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC		247,235	203,077		450,312	54
60	LABORATORY		62,625	51,440		114,065	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		66,031	54,237		120,268	65
66	PHYSICAL THERAPY		224,155	184,120	8,914	417,189	66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENT						72
73	DRUGS CHARGED TO PATIENTS						73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		101,185	83,113		184,298	90
91	EMERGENCY		199,133	163,567		362,700	91
92	OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES						95
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (SUM OF LINES 1-117)		3,025,643	2,485,248	214,581	5,725,472	118
NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		9,570	7,860		17,430	190
192	PHYSICIANS' PRIVATE OFFICES						192
194	OCCUPATIONAL HEALTH						194
194.01	PAIN CLINIC						194.01
194.02	OAK POINTE						194.02
194.03	FOUNDATION						194.03
194.04	COMMUNITY & VOLUNTEER SERVICES		8,022	6,589		14,611	194.04
194.05	VACANT SPACE						194.05
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)		3,043,235	2,499,697	214,581	5,757,513	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION		ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
2.01	SNF CAPITAL						2.01
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL	1,083,538					5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	65,337	660,012				7
8	LAUNDRY & LINEN SERVICE	6,858	4,745	39,389			8
9	HOUSEKEEPING	13,787	3,966		40,976		9
10	DIETARY	10,205	17,002		1,070	127,834	10
11	CAFETERIA	18,900	19,173		1,206		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	3,771	1,156		73		13
14	CENTRAL SERVICES & SUPPLY	11,160	13,728		864		14
15	PHARMACY	30,496	11,898		749		15
16	MEDICAL RECORDS & LIBRARY	19,834	4,229		266		16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	136,257	185,710	14,450	11,683	127,834	30
43	NURSERY	8,376		417			43
44	SKILLED NURSING FACILITY	148,153					44
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	84,016	112,869	6,421	7,101		50
52	DELIVERY ROOM & LABOR ROOM	21,936		170			52
53	ANESTHESIOLOGY	2,026					53
54	RADIOLOGY-DIAGNOSTIC	76,196	76,904	5,627	4,838		54
60	LABORATORY	54,705	19,480	2	1,226		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	27,791	20,539	297	1,292		65
66	PHYSICAL THERAPY	39,561	69,725	938	4,387		66
67	OCCUPATIONAL THERAPY	19,931		790			67
68	SPEECH PATHOLOGY	7,011		206			68
69	ELECTROCARDIOLOGY	3,377					69
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	31,258					71
72	IMPL. DEV. CHARGED TO PATIENT	7,723					72
73	DRUGS CHARGED TO PATIENTS	54,132					73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	11,904	31,474	234	1,980		90
91	EMERGENCY	71,228	61,942	8,091	3,897		91
92	OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	54,740		1,746			95
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (SUM OF LINES 1-117)	1,040,669	654,540	39,389	40,632	127,834	118
NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	665	2,977		187		190
192	PHYSICIANS' PRIVATE OFFICES	3,871					192
194	OCCUPATIONAL HEALTH	1,984					194
194.01	PAIN CLINIC	161					194.01
194.02	OAK POINTE	27,954					194.02
194.03	FOUNDATION	3,433					194.03
194.04	COMMUNITY & VOLUNTEER SERVICES	4,801	2,495		157		194.04
194.05	VACANT SPACE						194.05
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	1,083,538	660,012	39,389	40,976	127,834	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 SNF CAPITAL						2.01
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	151,550					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,077	12,844				13
14 CENTRAL SERVICES & SUPPLY	4,848		110,984			14
15 PHARMACY	4,758		2,945	120,515		15
16 MEDICAL RECORDS & LIBRARY	7,362				56,452	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	32,232	5,345	5,592	2	11,375	30
43 NURSERY	2,604	427	495		1,225	43
44 SKILLED NURSING FACILITY			8,575			44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	16,071	2,671	14,497	361	3,619	50
52 DELIVERY ROOM & LABOR ROOM	6,734	1,117	1,223			52
53 ANESTHESIOLOGY			22			53
54 RADIOLOGY-DIAGNOSTIC	16,071		3,678	21	11,742	54
60 LABORATORY			4			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	7,631		3,535			65
66 PHYSICAL THERAPY	5,746		584	9	7,565	66
67 OCCUPATIONAL THERAPY	3,412		493	6	2,885	67
68 SPEECH PATHOLOGY	898		226	2	254	68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			43,829			71
72 IMPL. DEV. CHARGED TO PATIENT			10,812			72
73 DRUGS CHARGED TO PATIENTS				119,018		73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	1,526		564			90
91 EMERGENCY	19,752	3,284	5,528	154	17,787	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	18,674		6,490	942		95
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	149,396	12,844	109,092	120,515	56,452	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES	628		589			192
194 OCCUPATIONAL HEALTH						194
194.01 PAIN CLINIC						194.01
194.02 OAK POINTE			1,294			194.02
194.03 FOUNDATION	898					194.03
194.04 COMMUNITY & VOLUNTEER SERVICES	628		9			194.04
194.05 VACANT SPACE						194.05
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	151,550	12,844	110,984	120,515	56,452	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS				
1 CAP REL COSTS-BLDG & FIXT				1
2 CAP REL COSTS-MVBLE EQUIP				2
2.01 SNF CAPITAL				2.01
4 EMPLOYEE BENEFITS				4
5 ADMINISTRATIVE & GENERAL				5
6 MAINTENANCE & REPAIRS				6
7 OPERATION OF PLANT				7
8 LAUNDRY & LINEN SERVICE				8
9 HOUSEKEEPING				9
10 DIETARY				10
11 CAFETERIA				11
12 MAINTENANCE OF PERSONNEL				12
13 NURSING ADMINISTRATION				13
14 CENTRAL SERVICES & SUPPLY				14
15 PHARMACY				15
16 MEDICAL RECORDS & LIBRARY				16
17 SOCIAL SERVICE				17
19 NONPHYSICIAN ANESTHETISTS				19
20 NURSING SCHOOL				20
21 I&R SRVCES-SALARY & FRINGES APPRVD				21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23 PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	1,617,913		1,617,913	30
43 NURSERY	13,544		13,544	43
44 SKILLED NURSING FACILITY	362,395		362,395	44
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	908,535		908,535	50
52 DELIVERY ROOM & LABOR ROOM	31,180		31,180	52
53 ANESTHESIOLOGY	2,048		2,048	53
54 RADIOLOGY-DIAGNOSTIC	645,389		645,389	54
60 LABORATORY	189,482		189,482	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	181,353		181,353	65
66 PHYSICAL THERAPY	545,704		545,704	66
67 OCCUPATIONAL THERAPY	27,517		27,517	67
68 SPEECH PATHOLOGY	8,597		8,597	68
69 ELECTROCARDIOLOGY	3,377		3,377	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	75,087		75,087	71
72 IMPL. DEV. CHARGED TO PATIENT	18,535		18,535	72
73 DRUGS CHARGED TO PATIENTS	173,150		173,150	73
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	231,980		231,980	90
91 EMERGENCY	554,363		554,363	91
92 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES	82,592		82,592	95
SPECIAL PURPOSE COST CENTERS				
118 SUBTOTALS (SUM OF LINES 1-117)	5,672,741		5,672,741	118
NONREIMBURSABLE COST CENTERS				
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,259		21,259	190
192 PHYSICIANS' PRIVATE OFFICES	5,088		5,088	192
194 OCCUPATIONAL HEALTH	1,984		1,984	194
194.01 PAIN CLINIC	161		161	194.01
194.02 OAK POINTE	29,248		29,248	194.02
194.03 FOUNDATION	4,331		4,331	194.03
194.04 COMMUNITY & VOLUNTEER SERVICES	22,701		22,701	194.04
194.05 VACANT SPACE				194.05
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINES 118-201)	5,757,513		5,757,513	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	CAP RELATE COSTS SNF SQUARE FEET	EMPLOYEE BENEFITS GROSS SALARIES	RECON-CILIATION	
	1	2	2.01	4	5A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	108,123					1
2 CAP REL COSTS-MVBLE EQUIP		108,123				2
2.01 SNF CAPITAL			26,287			2.01
4 EMPLOYEE BENEFITS				16,138,961		4
5 ADMINISTRATIVE & GENERAL	21,136	21,136		3,430,820	-9,202,433	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	11,600	11,600		315,929		7
8 LAUNDRY & LINEN SERVICE	542	542				8
9 HOUSEKEEPING	453	453		194,899		9
10 DIETARY	1,942	1,942		111,133		10
11 CAFETERIA	2,190	2,190		248,697		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	132	132		77,082		13
14 CENTRAL SERVICES & SUPPLY	1,568	1,568		175,384		14
15 PHARMACY	1,359	1,359		522,217		15
16 MEDICAL RECORDS & LIBRARY	483	483		309,882		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	21,212	21,212		1,899,184		30
43 NURSERY				172,271		43
44 SKILLED NURSING FACILITY			25,195	2,397,191		44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	12,892	12,892		991,905		50
52 DELIVERY ROOM & LABOR ROOM				453,505		52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	8,784	8,784		1,018,457		54
60 LABORATORY	2,225	2,225				60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	2,346	2,346		436,754		65
66 PHYSICAL THERAPY	7,964	7,964	1,092	366,714		66
67 OCCUPATIONAL THERAPY				294,894		67
68 SPEECH PATHOLOGY				77,058		68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	3,595	3,595		94,959		90
91 EMERGENCY	7,075	7,075		1,174,818		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES				1,020,820		95
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	107,498	107,498	26,287	15,784,573	-9,202,433	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	340	340				190
192 PHYSICIANS' PRIVATE OFFICES				15,658		192
194 OCCUPATIONAL HEALTH						194
194.01 PAIN CLINIC				3,062		194.01
194.02 OAK POINTE				315,695		194.02
194.03 FOUNDATION						194.03
194.04 COMMUNITY & VOLUNTEER SERVICES	285	285		19,973		194.04
194.05 VACANT SPACE						194.05
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	3,043,235	2,499,697	214,581	3,104,783		202
203 UNIT COST MULT-WS B PT I	28.146047	23.119013	8.163008	0.192378		203
204 COST TO BE ALLOC PER B PT II						204
205 UNIT COST MULT-WS B PT II						205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL ACCUM COST 5	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 8	HOUSE- KEEPING SQUARE FEET 9	DIETARY MEALS SERVED 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 SNF CAPITAL						2.01
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	28,404,984					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	1,712,805	75,387				7
8 LAUNDRY & LINEN SERVICE	179,774	542	214,613			8
9 HOUSEKEEPING	361,429	453		74,392		9
10 DIETARY	267,527	1,942		1,942	19,517	10
11 CAFETERIA	495,452	2,190		2,190		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	98,850	132		132		13
14 CENTRAL SERVICES & SUPPLY	292,549	1,568		1,568		14
15 PHARMACY	799,462	1,359		1,359		15
16 MEDICAL RECORDS & LIBRARY	519,937	483		483		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	3,571,998	21,212	78,734	21,212	19,517	30
43 NURSERY	219,578		2,271			43
44 SKILLED NURSING FACILITY	3,883,828					44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,202,495	12,892	34,986	12,892		50
52 DELIVERY ROOM & LABOR ROOM	575,058		927			52
53 ANESTHESIOLOGY	53,101					53
54 RADIOLOGY-DIAGNOSTIC	1,997,485	8,784	30,657	8,784		54
60 LABORATORY	1,434,108	2,225	12	2,225		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	728,555	2,346	1,620	2,346		65
66 PHYSICAL THERAPY	1,037,084	7,964	5,110	7,964		66
67 OCCUPATIONAL THERAPY	522,496		4,307			67
68 SPEECH PATHOLOGY	183,788		1,121			68
69 ELECTROCARDIOLOGY	88,531					69
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	819,441					71
72 IMPL. DEV. CHARGED TO PATIENT	202,452					72
73 DRUGS CHARGED TO PATIENTS	1,419,062					73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	312,065	3,595	1,273	3,595		90
91 EMERGENCY	1,867,241	7,075	44,083	7,075		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	1,435,023		9,512			95
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	27,281,174	74,762	214,613	73,767	19,517	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,430	340		340		190
192 PHYSICIANS' PRIVATE OFFICES	101,472					192
194 OCCUPATIONAL HEALTH	52,011					194
194.01 PAIN CLINIC	4,211					194.01
194.02 OAK POINTE	732,816					194.02
194.03 FOUNDATION	90,000					194.03
194.04 COMMUNITY & VOLUNTEER SERVICES	125,870	285		285		194.04
194.05 VACANT SPACE						194.05
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	9,202,433	2,267,706	254,320	492,149	425,463	202
203 UNIT COST MULT-WS B PT I	0.323972	30.080863	1.185017	6.615617	21.799611	203
204 COST TO BE ALLOC PER B PT II	1,083,538	660,012	39,389	40,976	127,834	204
205 UNIT COST MULT-WS B PT II	0.038146	8.754984	0.183535	0.550812	6.549880	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAFETERIA FTE'S	NURSING ADMINIS- TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY TIME SPENT	
	11	13	14	15	16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 SNF CAPITAL						2.01
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	1,688					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	12	180,305				13
14 CENTRAL SERVICES & SUPPLY	54		2,078,090			14
15 PHARMACY	53		55,148	617,570		15
16 MEDICAL RECORDS & LIBRARY	82				10,000	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	359	75,042	104,701	8	2,015	30
43 NURSERY	29	6,000	9,262	1	217	43
44 SKILLED NURSING FACILITY			160,561			44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	179	37,490	271,447	1,849	641	50
52 DELIVERY ROOM & LABOR ROOM	75	15,675	22,891	2		52
53 ANESTHESIOLOGY			415			53
54 RADIOLOGY-DIAGNOSTIC	179		68,875	106	2,080	54
60 LABORATORY			78			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	85		66,183			65
66 PHYSICAL THERAPY	64		10,944	46	1,340	66
67 OCCUPATIONAL THERAPY	38		9,222	29	511	67
68 SPEECH PATHOLOGY	10		4,238	8	45	68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGED TO PATIENTS			820,656			71
72 IMPL. DEV. CHARGED TO PATIENT			202,452			72
73 DRUGS CHARGED TO PATIENTS				609,907		73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	17		10,565			90
91 EMERGENCY	220	46,098	103,505	787	3,151	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	208		121,520	4,827		95
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	1,664	180,305	2,042,663	617,570	10,000	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES	7		11,021			192
194 OCCUPATIONAL HEALTH						194
194.01 PAIN CLINIC						194.01
194.02 OAK POINTE			24,229			194.02
194.03 FOUNDATION	10					194.03
194.04 COMMUNITY & VOLUNTEER SERVICES	7		177			194.04
194.05 VACANT SPACE						194.05
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	736,330	140,954	468,423	1,143,886	741,876	202
203 UNIT COST MULT-WS B PT I	436.214455	0.781753	0.225410	1.852237	74.187600	203
204 COST TO BE ALLOC PER B PT II	151,550	12,844	110,984	120,515	56,452	204
205 UNIT COST MULT-WS B PT II	89.780806	0.071235	0.053407	0.195144	5.645200	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION

GENERAL SERVICE COST CENTERS		
1	CAP REL COSTS-BLDG & FIXT	1
2	CAP REL COSTS-MVBLE EQUIP	2
2.01	SNF CAPITAL	2.01
4	EMPLOYEE BENEFITS	4
5	ADMINISTRATIVE & GENERAL	5
6	MAINTENANCE & REPAIRS	6
7	OPERATION OF PLANT	7
8	LAUNDRY & LINEN SERVICE	8
9	HOUSEKEEPING	9
10	DIETARY	10
11	CAFETERIA	11
12	MAINTENANCE OF PERSONNEL	12
13	NURSING ADMINISTRATION	13
14	CENTRAL SERVICES & SUPPLY	14
15	PHARMACY	15
16	MEDICAL RECORDS & LIBRARY	16
17	SOCIAL SERVICE	17
19	NONPHYSICIAN ANESTHETISTS	19
20	NURSING SCHOOL	20
21	I&R SRVCES-SALARY & FRINGES APPRVD	21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD	22
23	PARAMED ED PRGM-(SPECIFY)	23
INPATIENT ROUTINE SERV COST CENTERS		
30	ADULTS & PEDIATRICS	30
43	NURSERY	43
44	SKILLED NURSING FACILITY	44
ANCILLARY SERVICE COST CENTERS		
50	OPERATING ROOM	50
52	DELIVERY ROOM & LABOR ROOM	52
53	ANESTHESIOLOGY	53
54	RADIOLOGY-DIAGNOSTIC	54
60	LABORATORY	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65	RESPIRATORY THERAPY	65
66	PHYSICAL THERAPY	66
67	OCCUPATIONAL THERAPY	67
68	SPEECH PATHOLOGY	68
69	ELECTROCARDIOLOGY	69
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	71
72	IMPL. DEV. CHARGED TO PATIENT	72
73	DRUGS CHARGED TO PATIENTS	73
76.97	CARDIAC REHABILITATION	76.97
76.98	HYPERBARIC OXYGEN THERAPY	76.98
76.99	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS		
90	CLINIC	90
91	EMERGENCY	91
92	OBSERVATION BEDS	92
OTHER REIMBURSABLE COST CENTERS		
95	AMBULANCE SERVICES	95
SPECIAL PURPOSE COST CENTERS		
118	SUBTOTALS (SUM OF LINES 1-117)	118
NONREIMBURSABLE COST CENTERS		
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190
192	PHYSICIANS' PRIVATE OFFICES	192
194	OCCUPATIONAL HEALTH	194
194.01	PAIN CLINIC	194.01
194.02	OAK POINTE	194.02
194.03	FOUNDATION	194.03
194.04	COMMUNITY & VOLUNTEER SERVICES	194.04
194.05	VACANT SPACE	194.05
200	CROSS FOOT ADJUSTMENTS	200
201	NEGATIVE COST CENTER	201
202	COST TO BE ALLOC PER B PT I	202
203	UNIT COST MULT-WS B PT I	203
204	COST TO BE ALLOC PER B PT II	204
205	UNIT COST MULT-WS B PT II	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST	THERAPY	TOTAL	RCE	TOTAL	
	(FROM WKST B, PART I, COL 26)	LIMIT ADJUSTMENT	COSTS	DISALLOWANCE	COSTS	
	1	2	3	4	5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	6,414,763		6,414,763		6,414,763	30
43 NURSERY	328,936		328,936		328,936	43
44 SKILLED NURSING FACILITY	5,178,286		5,178,286		5,178,286	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,650,148		3,650,148		3,650,148	50
52 DELIVERY ROOM & LABOR ROOM	812,594		812,594		812,594	52
53 ANESTHESIOLOGY	70,398		70,398	677	71,075	53
54 RADIOLOGY-DIAGNOSTIC	3,251,398		3,251,398		3,251,398	54
60 LABORATORY	1,980,401		1,980,401		1,980,401	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	1,104,592		1,104,592		1,104,592	65
66 PHYSICAL THERAPY	1,801,257		1,801,257		1,801,257	66
67 OCCUPATIONAL THERAPY	753,493		753,493		753,493	67
68 SPEECH PATHOLOGY	253,328		253,328		253,328	68
69 ELECTROCARDIOLOGY	117,213		117,213		117,213	69
71 MEDICAL SUPPLIES CHRGD TO	1,269,901		1,269,901		1,269,901	71
72 IMPL. DEV. CHARGED TO PATIE	313,676		313,676		313,676	72
73 DRUGS CHARGED TO PATIENTS	3,008,489		3,008,489		3,008,489	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	556,395		556,395		556,395	90
91 EMERGENCY	3,174,600		3,174,600	14,508	3,189,108	91
92 OBSERVATION BEDS	1,057,773		1,057,773		1,057,773	92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	2,038,268		2,038,268		2,038,268	95
200 SUBTOTAL (SEE INSTRUCTIONS)	37,135,909		37,135,909	15,185	37,151,094	200
201 LESS OBSERVATION BEDS	1,057,773		1,057,773		1,057,773	201
202 TOTAL (SEE INSTRUCTIONS)	36,078,136		36,078,136		36,093,321	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	6,276,798		6,276,798			30
43 NURSERY	503,560		503,560			43
44 SKILLED NURSING FACILITY	3,839,867		3,839,867			44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,153,437	9,626,402	12,779,839	0.285618	0.285618	0.285618 50
52 DELIVERY ROOM & LABOR ROOM	1,151,825	79,590	1,231,415	0.659886	0.659886	0.659886 52
53 ANESTHESIOLOGY	322,326	1,031,738	1,354,064	0.051990	0.051990	0.052490 53
54 RADIOLOGY-DIAGNOSTIC	2,653,552	25,955,593	28,609,145	0.113649	0.113649	0.113649 54
60 LABORATORY	1,929,420	7,219,097	9,148,517	0.216472	0.216472	0.216472 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	1,066,902	2,888,888	3,955,790	0.279234	0.279234	0.279234 65
66 PHYSICAL THERAPY	549,368	1,760,069	2,309,437	0.779955	0.779955	0.779955 66
67 OCCUPATIONAL THERAPY	420,611	686,190	1,106,801	0.680785	0.680785	0.680785 67
68 SPEECH PATHOLOGY	217,850	162,510	380,360	0.666022	0.666022	0.666022 68
69 ELECTROCARDIOLOGY	308,862	120,159	429,021	0.273210	0.273210	0.273210 69
71 MEDICAL SUPPLIES CHRGD TO	988,029	1,960,617	2,948,646	0.430673	0.430673	0.430673 71
72 IMPL. DEV. CHARGED TO PATIE	875,312	578,155	1,453,467	0.215812	0.215812	0.215812 72
73 DRUGS CHARGED TO PATIENTS	3,542,285	6,410,376	9,952,661	0.302280	0.302280	0.302280 73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	4,207	523,996	528,203	1.053373	1.053373	1.053373 90
91 EMERGENCY	1,672,713	10,041,722	11,714,435	0.270999	0.270999	0.272237 91
92 OBSERVATION BEDS		1,058,035	1,058,035	0.999752	0.999752	0.999752 92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES		4,118,387	4,118,387	0.494919	0.494919	0.494919 95
200 SUBTOTAL (SEE INSTRUCTIONS)	29,476,924	74,221,524	103,698,448			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	29,476,924	74,221,524	103,698,448			202

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
 PERIOD FROM 01/01/2012 TO 12/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 05/30/2013 16:42

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

CHECK [] TITLE V
 APPLICABLE [XX] TITLE XVIII-PT A
 BOXES [] TITLE XIX

COST CENTER DESCRIPTION	CAP-REL COST	REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT (COL.1 MINUS COL.2)	(COL.1 MINUS COL.2)	(COL.3 + COL.4)	PGM DAYS	(COL.5 x COL.6)	
	1	2	3	5	6	7	
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS	1,617,913		1,617,913	286.25	1,627	465,729	30
31 INTENSIVE CARE UNIT							31
32 CORONARY CARE UNIT							32
33 BURN INTENSIVE CARE UNIT							33
34 SURGICAL INTENSIVE CARE UNIT							34
35 OTHER SPECIAL CARE (SPECIFY)							35
40 SUBPROVIDER - IPF							40
41 SUBPROVIDER - IRF							41
42 SUBPROVIDER I							42
43 NURSERY	13,544		13,544	25.55			43
44 SKILLED NURSING FACILITY	362,395		362,395	19.07	1,765	33,659	44
45 NURSING FACILITY							45
200 TOTAL (LINES 30-199)	1,993,852		1,993,852		3,392	499,388	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (15-0101) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX [] IRF

COST CENTER DESCRIPTION	CAP-REL	TOTAL	RATIO OF	INPATIENT	CAPITAL	
	COST	CHARGES	COST TO			
	(FROM WKST	(FROM WKST	CHARGES	PROGRAM	(COL.3 x	
	B, PT. II,	C, PT. I,	(COL.1 +	CHARGES	COL.4)	
	COL. 26)	COL. 8)	COL.2)			
	1	2	3	4	5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	908,535	12,779,839	0.071091	535,222	38,049	50
52 DELIVERY ROOM & LABOR ROOM	31,180	1,231,415	0.025320			52
53 ANESTHESIOLOGY	2,048	1,354,064	0.001512	55,014	83	53
54 RADIOLOGY-DIAGNOSTIC	645,389	28,609,145	0.022559	1,078,302	24,325	54
60 LABORATORY	189,482	9,148,517	0.020712	710,528	14,716	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY	181,353	3,955,790	0.045845	484,107	22,194	65
66 PHYSICAL THERAPY	545,704	2,309,437	0.236293	80,508	19,023	66
67 OCCUPATIONAL THERAPY	27,517	1,106,801	0.024862	27,444	682	67
68 SPEECH PATHOLOGY	8,597	380,360	0.022602	4,404	100	68
69 ELECTROCARDIOLOGY	3,377	429,021	0.007871	153,793	1,211	69
71 MEDICAL SUPPLIES CHRGD TO PA	75,087	2,948,646	0.025465	216,832	5,522	71
72 IMPL. DEV. CHARGED TO PATIENT	18,535	1,453,467	0.012752	232,766	2,968	72
73 DRUGS CHARGED TO PATIENTS	173,150	9,952,661	0.017397	1,108,521	19,285	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	231,980	528,203	0.439187	1,288	566	90
91 EMERGENCY	554,363	11,714,435	0.047323	649,012	30,713	91
92 OBSERVATION BEDS	266,788	1,058,035	0.252154			92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES						95
200 TOTAL (SUM OF LINES 50-199)	3,863,085	88,959,836		5,337,741	179,437	200

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
 PERIOD FROM 01/01/2012 TO 12/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 05/30/2013 16:42

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [XX] TITLE XVIII-PT A
 BOXES [] TITLE XIX

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
 PERIOD FROM 01/01/2012 TO 12/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 05/30/2013 16:42

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [XX] TITLE XVIII-PT A
 BOXES [] TITLE XIX

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	5,652		1,627		30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY	530				43
44 SKILLED NURSING FACILITY	18,999		1,765		44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	25,181		3,392		200

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
 PERIOD FROM 01/01/2012 TO 12/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 05/30/2013 16:42

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-0101) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			MEDICAL EDUCATION COST 4	COST (SUM OF COLS.1-4) 5	COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES						95
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[]	TITLE V	[XX]	HOSPITAL (15-0101)	[]	SUB (OTHER)	[]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[]	IPF	[]	SNF			[]	TEFRA
BOXES	[]	TITLE XIX	[]	IRF	[]	NF				

COST CENTER DESCRIPTION	TOTAL	RATIO OF	O/P RATIO	INPAT PGM	INPAT PGM	O/P PGM	O/P PGM
	CHARGES	COST TO	OF COST TO				
	(FROM WKST	CHARGES	CHARGES	INPAT	COSTS	CHARGES	COSTS
	C, PT. I,	(COL. 5 +	(COL. 6 +	PGM	(COL. 8 x	O/P PGM	(COL. 9 x
	COL. 8)	COL. 7)	COL. 7)	CHARGES	COL. 10)	CHARGES	COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	12,779,839			535,222		1,405,120	50
52 DELIVERY ROOM & LABOR ROOM	1,231,415						52
53 ANESTHESIOLOGY	1,354,064			55,014		146,823	53
54 RADIOLOGY-DIAGNOSTIC	28,609,145			1,078,302		4,739,517	54
60 LABORATORY	9,148,517			710,528		160,033	60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	3,955,790			484,107		644,346	65
66 PHYSICAL THERAPY	2,309,437			80,508			66
67 OCCUPATIONAL THERAPY	1,106,801			27,444			67
68 SPEECH PATHOLOGY	380,360			4,404			68
69 ELECTROCARDIOLOGY	429,021			153,793		48,252	69
71 MEDICAL SUPPLIES CHRGED TO P	2,948,646			216,832		162,748	71
72 IMPL. DEV. CHARGED TO PATIEN	1,453,467			232,766		65,002	72
73 DRUGS CHARGED TO PATIENTS	9,952,661			1,108,521		1,732,173	73
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	528,203			1,288		15,084	90
91 EMERGENCY	11,714,435			649,012		1,730,788	91
92 OBSERVATION BEDS	1,058,035					259,766	92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES							95
200 TOTAL (SUM OF LINES 50-199)	88,959,836			5,337,741		11,109,652	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-0101) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS			
	COST TO CHARGE FROM WKST C, PT I, COL. 9 1	RATIO REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCS NOT SUBJECT TO DED & COINS 7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.285618		1,405,120		401,328			50
52 DELIVERY ROOM & LABOR ROOM	0.659886							52
53 ANESTHESIOLOGY	0.051990	146,823			7,633			53
54 RADIOLOGY-DIAGNOSTIC	0.113649	4,739,517			538,641			54
60 LABORATORY	0.216472	160,033			34,643			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65 RESPIRATORY THERAPY	0.279234	644,346			179,923			65
66 PHYSICAL THERAPY	0.779955							66
67 OCCUPATIONAL THERAPY	0.680785							67
68 SPEECH PATHOLOGY	0.666022							68
69 ELECTROCARDIOLOGY	0.273210	48,252			13,183			69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.430673	162,748			70,091			71
72 IMPL. DEV. CHARGED TO PATIENT	0.215812	65,002			14,028			72
73 DRUGS CHARGED TO PATIENTS	0.302280	1,732,173			523,601			73
76.97 CARDIAC REHABILITATION								76.97
76.98 HYPERBARIC OXYGEN THERAPY								76.98
76.99 LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS								
90 CLINIC	1.053373	15,084			15,889			90
91 EMERGENCY	0.270999	1,730,788			469,042			91
92 OBSERVATION BEDS	0.999752	259,766			259,702			92
OTHER REIMBURSABLE COST CENTERS								
95 AMBULANCE SERVICES	0.494919							95
200 SUBTOTAL (SEE INSTRUCTIONS)		11,109,652			2,527,704			200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)		11,109,652			2,527,704			202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [XX] SNF (15-5128) [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			MEDICAL EDUCATION COST 4	COST (SUM OF COLS.1-4) 5	COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES						95
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[]	TITLE V	[]	HOSPITAL	[]	SUB (OTHER)	[]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[]	IPF	[XX]	SNF (15-5128)	[]		[]	TEFRA
BOXES	[]	TITLE XIX	[]	IRF	[]	NF	[]			
COST CENTER DESCRIPTION	TOTAL	RATIO OF	O/P RATIO	INPAT PGM	INPAT PGM	O/P PGM	O/P PGM			
	CHARGES	COST TO	OF COST TO					PASS-THRU	PASS-THRU	PASS-THRU
	(FROM WKST	CHARGES	CHARGES	CHARGES	COSTS	CHARGES	COSTS			
	C, PT. I,	(COL. 5 +	(COL. 6 +	PGM	(COL. 8 x	(COL. 9 x	(COL. 9 x			
	COL. 8)	COL. 7)	COL. 7)	CHARGES	COL. 10)	COL. 12)	COL. 12)			
	7	8	9	10	11	12	13			
ANCILLARY SERVICE COST CENTERS										
50	OPERATING ROOM	12,779,839					50			
52	DELIVERY ROOM & LABOR ROOM	1,231,415					52			
53	ANESTHESIOLOGY	1,354,064		2,380			53			
54	RADIOLOGY-DIAGNOSTIC	28,609,145					54			
60	LABORATORY	9,148,517		2,633			60			
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30			
65	RESPIRATORY THERAPY	3,955,790					65			
66	PHYSICAL THERAPY	2,309,437		148,625			66			
67	OCCUPATIONAL THERAPY	1,106,801		161,335			67			
68	SPEECH PATHOLOGY	380,360		85,350			68			
69	ELECTROCARDIOLOGY	429,021					69			
71	MEDICAL SUPPLIES CHRGED TO P	2,948,646					71			
72	IMPL. DEV. CHARGED TO PATIEN	1,453,467					72			
73	DRUGS CHARGED TO PATIENTS	9,952,661		114,059			73			
76.97	CARDIAC REHABILITATION						76.97			
76.98	HYPERBARIC OXYGEN THERAPY						76.98			
76.99	LITHOTRIPSY						76.99			
OUTPATIENT SERVICE COST CENTERS										
90	CLINIC	528,203					90			
91	EMERGENCY	11,714,435					91			
92	OBSERVATION BEDS	1,058,035					92			
OTHER REIMBURSABLE COST CENTERS										
95	AMBULANCE SERVICES						95			
200	TOTAL (SUM OF LINES 50-199)	88,959,836		514,382			200			

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [XX] SNF (15-5128) [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCES NOT SUBJECT TO	COST SERVICES	COST SVCES NOT SUBJECT TO	
	CHARGE RATIO FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.285618						50
52 DELIVERY ROOM & LABOR ROOM	0.659886						52
53 ANESTHESIOLOGY	0.051990						53
54 RADIOLOGY-DIAGNOSTIC	0.113649						54
60 LABORATORY	0.216472						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.279234						65
66 PHYSICAL THERAPY	0.779955						66
67 OCCUPATIONAL THERAPY	0.680785						67
68 SPEECH PATHOLOGY	0.666022						68
69 ELECTROCARDIOLOGY	0.273210						69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.430673						71
72 IMPL. DEV. CHARGED TO PATIENT	0.215812						72
73 DRUGS CHARGED TO PATIENTS	0.302280						73
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	1.053373						90
91 EMERGENCY	0.270999						91
92 OBSERVATION BEDS	0.999752						92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES	0.494919						95
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
 PERIOD FROM 01/01/2012 TO 12/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 05/30/2013 16:42

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	CAP-REL COST	REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26) 1	SWING-BED ADJUSTMENT (COL.1 MINUS COL.2) 3	4	(COL.3 + COL.4) 5	6	(COL.5 x COL.6) 7	8
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS	1,617,913	1,617,913	5,652	286.25	201	57,536	30
31 INTENSIVE CARE UNIT							31
32 CORONARY CARE UNIT							32
33 BURN INTENSIVE CARE UNIT							33
34 SURGICAL INTENSIVE CARE UNIT							34
35 OTHER SPECIAL CARE (SPECIFY)							35
40 SUBPROVIDER - IPF							40
41 SUBPROVIDER - IRF							41
42 SUBPROVIDER I							42
43 NURSERY	13,544	13,544	530	25.55	42	1,073	43
44 SKILLED NURSING FACILITY	362,395	362,395	18,999	19.07	10,191	194,342	44
45 NURSING FACILITY							45
200 TOTAL (LINES 30-199)	1,993,852	1,993,852	25,181		10,434	252,951	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [] TITLE XVIII-PT A [XX] TITLE XIX	[XX] HOSPITAL (15-0101) [] IPF [] IRF	[] SUB (OTHER)	[XX] PPS [] TEFRA [] OTHER			
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5		
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	908,535	12,779,839	0.071091	85,713	6,093	50
52	DELIVERY ROOM & LABOR ROOM	31,180	1,231,415	0.025320	45,541	1,153	52
53	ANESTHESIOLOGY	2,048	1,354,064	0.001512	7,862	12	53
54	RADIOLOGY-DIAGNOSTIC	645,389	28,609,145	0.022559	107,178	2,418	54
60	LABORATORY	189,482	9,148,517	0.020712	99,507	2,061	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
65	RESPIRATORY THERAPY	181,353	3,955,790	0.045845	29,555	1,355	65
66	PHYSICAL THERAPY	545,704	2,309,437	0.236293	2,008	474	66
67	OCCUPATIONAL THERAPY	27,517	1,106,801	0.024862	653	16	67
68	SPEECH PATHOLOGY	8,597	380,360	0.022602	367	8	68
69	ELECTROCARDIOLOGY	3,377	429,021	0.007871	18,870	149	69
71	MEDICAL SUPPLIES CHRGED TO PA	75,087	2,948,646	0.025465	21,018	535	71
72	IMPL. DEV. CHARGED TO PATIENT	18,535	1,453,467	0.012752			72
73	DRUGS CHARGED TO PATIENTS	173,150	9,952,661	0.017397	169,476	2,948	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	231,980	528,203	0.439187	684	300	90
91	EMERGENCY	554,363	11,714,435	0.047323	71,105	3,365	91
92	OBSERVATION BEDS	266,788	1,058,035	0.252154			92
OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES						95
200	TOTAL (SUM OF LINES 50-199)	3,863,085	88,959,836		659,537	20,887	200

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
PERIOD FROM 01/01/2012 TO 12/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
05/30/2013 16:42

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK [] TITLE V
APPLICABLE [] TITLE XVIII-PT A
BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
 PERIOD FROM 01/01/2012 TO 12/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 05/30/2013 16:42

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	5,652		201		30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY	530		42		43
44 SKILLED NURSING FACILITY	18,999		10,191		44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	25,181		10,434		200

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
 PERIOD FROM 01/01/2012 TO 12/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 05/30/2013 16:42

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-0101) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] OTHER

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN			MEDICAL	COST	COST
	ANESTHETIST	SCHOOL	HEALTH	EDUCATION	(SUM OF	(SUM OF
	COST			COST	COLS. 1-4)	COLS. 2-4)
	1	2	3	4	5	6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES						95
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-0101) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] OTHER

COST CENTER DESCRIPTION	TOTAL	RATIO OF	O/P RATIO	INPAT PGM	O/P PGM	O/P PGM
	CHARGES	COST TO	OF COST TO			
	(FROM WKST	CHARGES	CHARGES	INPAT	PASS-THRU	PASS-THRU
	C, PT. I,	(COL. 5 +	(COL. 6 +	PGM	(COL. 8 x	(COL. 9 x
	COL. 8)	COL. 7)	COL. 7)	CHARGES	COL. 10)	COL. 12)
	7	8	9	10	11	12
						13
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	12,779,839			85,713		50
52 DELIVERY ROOM & LABOR ROOM	1,231,415			45,541		52
53 ANESTHESIOLOGY	1,354,064			7,862		53
54 RADIOLOGY-DIAGNOSTIC	28,609,145			107,178		54
60 LABORATORY	9,148,517			99,507		60
62.30 BLOOD CLOTTING FOR HEMOPHILI						62.30
65 RESPIRATORY THERAPY	3,955,790			29,555		65
66 PHYSICAL THERAPY	2,309,437			2,008		66
67 OCCUPATIONAL THERAPY	1,106,801			653		67
68 SPEECH PATHOLOGY	380,360			367		68
69 ELECTROCARDIOLOGY	429,021			18,870		69
71 MEDICAL SUPPLIES CHRGED TO P	2,948,646			21,018		71
72 IMPL. DEV. CHARGED TO PATIEN	1,453,467					72
73 DRUGS CHARGED TO PATIENTS	9,952,661			169,476		73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	528,203			684		90
91 EMERGENCY	11,714,435			71,105		91
92 OBSERVATION BEDS	1,058,035					92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	4,118,387					95
200 TOTAL (SUM OF LINES 50-199)	88,959,836			659,537		200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-0101) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES				PROGRAM COSTS		
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCS NOT SUBJECT TO DED & COINS 7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.285618		319,006			91,114		50
52 DELIVERY ROOM & LABOR ROOM	0.659886		2,119			1,398		52
53 ANESTHESIOLOGY	0.051990		36,398			1,892		53
54 RADIOLOGY-DIAGNOSTIC	0.113649		1,196,620			135,995		54
60 LABORATORY	0.216472		314,657			68,114		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65 RESPIRATORY THERAPY	0.279234		85,174			23,783		65
66 PHYSICAL THERAPY	0.779955		56,556			44,111		66
67 OCCUPATIONAL THERAPY	0.680785		36,639			24,943		67
68 SPEECH PATHOLOGY	0.666022		13,210			8,798		68
69 ELECTROCARDIOLOGY	0.273210		50,024			13,667		69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.430673		48,689			20,969		71
72 IMPL. DEV. CHARGED TO PATIENT	0.215812		24,074			5,195		72
73 DRUGS CHARGED TO PATIENTS	0.302280		222,732			67,327		73
76.97 CARDIAC REHABILITATION								76.97
76.98 HYPERBARIC OXYGEN THERAPY								76.98
76.99 LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS								
90 CLINIC	1.053373		3,355			3,534		90
91 EMERGENCY	0.270999		635,573			172,240		91
92 OBSERVATION BEDS	0.999752		52,973			52,960		92
OTHER REIMBURSABLE COST CENTERS								
95 AMBULANCE SERVICES	0.494919		282,777			139,952		95
200 SUBTOTAL (SEE INSTRUCTIONS)			3,380,576			875,992		200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)						875,992		202

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-0101) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	5,652	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	5,652	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,720	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,627	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	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)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	6,414,763	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	6,414,763	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	6,414,763	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-0101) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,134.95 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 1,846,564 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 1,846,564 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
42 NURSERY (TITLES V AND XIX ONLY)					42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					1,350,464 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					3,197,028 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 465,729 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 179,437 51
 52 TOTAL PROGRAM EXCLUDABLE COST 645,166 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 2,551,862 53

TARGET AMOUNT AND LIMIT COMPUTATION
 54 PROGRAM DISCHARGES 54
 55 TARGET AMOUNT PER DISCHARGE 55
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET 59
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 61
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

PROGRAM INPATIENT ROUTINE SWING BED COST
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 66
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 932 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 + LINE 2) 1,134.95 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 1,057,773 89

COMPUTATION OF OBSERVATION BED PASS-THROUGH COST	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) 5
90 CAPITAL-RELATED COST	1,617,913	6,414,763	0.252217	1,057,773	266,788 90
91 NURSING SCHOOL COST					91
92 ALLIED HEALTH COST					92
93 ALL OTHER MEDICAL EDUCATION					93

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [XX] SNF (15-5128) [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	18,999	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	18,999	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	18,999	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,765	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	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)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	5,178,286	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5,178,286	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	5,178,286	37

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
PERIOD FROM 01/01/2012 TO 12/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
05/30/2013 16:42

WORKSHEET D-1
PARTS III & IV

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
APPLICABLE [XX] TITLE XVIII-PT A [] IPF [XX] SNF (15-5128) [] TEFRA
BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

70	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COSTS (LINE 37)	5,178,286	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (LINE 70 ÷ LINE 2)	272.56	71
72	PROGRAM ROUTINE SERVICE COST (LINE 9 x LINE 71)	481,068	72
73	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM (LINE 14 x LINE 35)		73
74	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS (LINE 72 + LINE 73)	481,068	74
75	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS (FROM WKST B, PART II, COL. 26, LINE 45)		75
76	PER DIEM CAPITAL-RELATED COSTS (LINE 75 ÷ LINE 2)		76
77	PROGRAM CAPITAL-RELATED COSTS (LINE 9 x LINE 76)		77
78	INPATIENT ROUTINE SERVICE COST (LINE 74 MINUS LINE 77)		78
79	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS (FROM PROVIDER RECORDS)		79
80	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION (LINE 78 MINUS LINE 79)		80
81	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		81
82	INPATIENT ROUTINE SERVICE COST LIMITATION (LINE 9 x LINE 81)		82
83	REASONABLE INPATIENT ROUTINE SERVICE COSTS (SEE INSTRUCTIONS)	481,068	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (SEE INSTRUCTIONS)	317,772	84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (SEE INSTRUCTIONS)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (SUM OF LINES 83 THROUGH 85)	798,840	86

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-0101) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	5,652	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	5,652	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,720	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	201	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	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)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	530	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	42	16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	6,414,763	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	6,414,763	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	6,414,763	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-0101) [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,134.95 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 228,125 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 228,125 41

	TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (COL. 1 ÷ COL. 2)	PROGRAM DAYS	PROGRAM COST (COL. 3 x COL. 4)
	1	2	3	4	5
42 NURSERY (TITLES V AND XIX ONLY)	328,936	530	620.63	42	26,066 42

INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS
 43 INTENSIVE CARE UNIT 43
 44 CORONARY CARE UNIT 44
 45 BURN INTENSIVE CARE UNIT 45
 46 SURGICAL INTENSIVE CARE UNIT 46
 47 OTHER SPECIAL CARE (SPECIFY) 47
 48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200) 184,689 48
 49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS) 438,880 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 58,609 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 20,887 51
 52 TOTAL PROGRAM EXCLUDABLE COST 79,496 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 359,384 53

TARGET AMOUNT AND LIMIT COMPUTATION
 54 PROGRAM DISCHARGES 54
 55 TARGET AMOUNT PER DISCHARGE 55
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET 59
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 61
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

PROGRAM INPATIENT ROUTINE SWING BED COST
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 66
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 932 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 + LINE 2) 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

	TOTAL OBS. BED COST (FROM LINE 89)	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.)
	1	5
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST		
90 CAPITAL-RELATED COST		90
91 NURSING SCHOOL COST		91
92 ALLIED HEALTH COST		92
93 ALL OTHER MEDICAL EDUCATION		93

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (15-0101) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		2,158,872		30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.285618	535,222	152,869	50
52 DELIVERY ROOM & LABOR ROOM	0.659886			52
53 ANESTHESIOLOGY	0.052490	55,014	2,888	53
54 RADIOLOGY-DIAGNOSTIC	0.113649	1,078,302	122,548	54
60 LABORATORY	0.216472	710,528	153,809	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.279234	484,107	135,179	65
66 PHYSICAL THERAPY	0.779955	80,508	62,793	66
67 OCCUPATIONAL THERAPY	0.680785	27,444	18,683	67
68 SPEECH PATHOLOGY	0.666022	4,404	2,933	68
69 ELECTROCARDIOLOGY	0.273210	153,793	42,018	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.430673	216,832	93,384	71
72 IMPL. DEV. CHARGED TO PATIENT	0.215812	232,766	50,234	72
73 DRUGS CHARGED TO PATIENTS	0.302280	1,108,521	335,084	73
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	1.053373	1,288	1,357	90
91 EMERGENCY	0.272237	649,012	176,685	91
92 OBSERVATION BEDS	0.999752			92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		5,337,741	1,350,464	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		5,337,741		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK	[]	TITLE V	[]	HOSPITAL	[]	SUB (OTHER)	[]	S/B SNF	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[]	IPF	[XX]	SNF (15-5128)	[]	S/B NF	[]	TEFRA
BOXES	[]	TITLE XIX	[]	IRF	[]	NF	[]	ICF/MR	[]	OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.285618			50
52 DELIVERY ROOM & LABOR ROOM	0.659886			52
53 ANESTHESIOLOGY	0.051990	2,380	124	53
54 RADIOLOGY-DIAGNOSTIC	0.113649			54
60 LABORATORY	0.216472	2,633	570	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.279234			65
66 PHYSICAL THERAPY	0.779955	148,625	115,921	66
67 OCCUPATIONAL THERAPY	0.680785	161,335	109,834	67
68 SPEECH PATHOLOGY	0.666022	85,350	56,845	68
69 ELECTROCARDIOLOGY	0.273210			69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.430673			71
72 IMPL. DEV. CHARGED TO PATIENT	0.215812			72
73 DRUGS CHARGED TO PATIENTS	0.302280	114,059	34,478	73
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	1.053373			90
91 EMERGENCY	0.270999			91
92 OBSERVATION BEDS	0.999752			92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		514,382	317,772	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		514,382		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (15-0101) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		243,855		30
43 NURSERY		17,915		43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.285618	85,713	24,481	50
52 DELIVERY ROOM & LABOR ROOM	0.659886	45,541	30,052	52
53 ANESTHESIOLOGY	0.052490	7,862	413	53
54 RADIOLOGY-DIAGNOSTIC	0.113649	107,178	12,181	54
60 LABORATORY	0.216472	99,507	21,540	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.279234	29,555	8,253	65
66 PHYSICAL THERAPY	0.779955	2,008	1,566	66
67 OCCUPATIONAL THERAPY	0.680785	653	445	67
68 SPEECH PATHOLOGY	0.666022	367	244	68
69 ELECTROCARDIOLOGY	0.273210	18,870	5,155	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.430673	21,018	9,052	71
72 IMPL. DEV. CHARGED TO PATIENT	0.215812			72
73 DRUGS CHARGED TO PATIENTS	0.302280	169,476	51,229	73
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	1.053373	684	721	90
91 EMERGENCY	0.272237	71,105	19,357	91
92 OBSERVATION BEDS	0.999752			92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		659,537	184,689	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		659,537		202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A

CHECK [XX] HOSPITAL (15-0101)
 APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	2,364,456	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	13,207	2
2.01	OUTLIER RECONCILIATION AMOUNT		2.01
3	MANAGED CARE SIMULATED PAYMENTS		3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	27.45	4
INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS			
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)		5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)		6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(1)		7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS.		7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)		9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS		10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)		12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR		13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO		14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3		15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT		18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)		19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)		20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)		21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)		22
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON			
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)		29
DISPROPORTIONATE SHARE ADJUSTMENT			
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.0217	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)	0.1918	31
32	SUM OF LINES 30 AND 31	0.2135	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0683	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	161,492	34
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES			
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		41
42	DIVIDE LINE 41 BY LINE 40 (IF LESS THAN 10%, YOU DO NOT QUALIFY FOR ADJUSTMENT)		42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (LINE 43 DIVIDED BY LINE 41 DIVIDED BY 7 DAYS)		44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (SEE INSTRUCTIONS)		45
46	TOTAL ADDITIONAL PAYMENT (LINE 45 TIMES LINE 44 TIMES LINE 41)		46
47	SUBTOTAL (SEE INSTRUCTIONS)	2,539,155	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)		48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	2,539,155	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	199,064	50

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A

CHECK [XX] HOSPITAL (15-0101)
 APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)		52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)		58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	2,738,219	59
60	PRIMARY PAYER PAYMENTS		60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	2,738,219	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	381,558	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	2,718	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	-8,597	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	-6,018	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	-26,137	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	2,347,925	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		70
70.96	LOW VOLUME PAYMENT ADJUSTMENT - 1	347,716	70.96
70.97	LOW VOLUME PAYMENT ADJUSTMENT - 2	108,657	70.97
71	AMOUNT DUE PROVIDER (LINE 67 MINUS LINE 68 PLUS/MINUS LINES 69 AND 70)	2,804,298	71
72	INTERIM PAYMENTS	2,709,526	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	94,772	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	258,427	75
TO BE COMPLETED BY CONTRACTOR			
90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2		90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2		91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (SEE INSTRUCTIONS)		95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (SEE INSTRUCTIONS)		96

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [XX] HOSPITAL (15-0101) [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A

PART B

DESCRIPTION	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT	
	1	2	3	4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		2,709,526		1,544,643	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		29,209	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 .03 .04 .05 .06 .07 .08 .09 .50 .51 .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE		NONE	3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)					
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		2,709,526		1,573,852	4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 .04 .05 .06 .07 .08 .09 PROVIDER .50 TO .51 PROGRAM .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE		NONE	5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO .01 PROVIDER PROVIDER TO .02 PROGRAM	94,772		-47,909	6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		2,804,298		1,525,943	7
8 NAME OF CONTRACTOR: _____		CONTRACTOR NUMBER: _____		NPR DATE: _____	8

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [] HOSPITAL [] SUB (OTHER)
 APPLICABLE [] IPF [XX] SNF (15-5128)
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A

PART B

DESCRIPTION	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		700,573		1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 PROGRAM .03 TO .04 PROVIDER .05 .06 .07 .08 .09 .50 .51 PROVIDER .52 TO .53 PROGRAM .54 .55 .56 .57 .58 .59 .99	NONE		3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)				
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		700,573		4
TO BE COMPLETED BY CONTRACTOR				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 .04 .05 .06 .07 .08 .09 PROVIDER .50 TO .51 PROGRAM .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE		5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)				
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO .01 PROVIDER PROVIDER TO .02 PROGRAM	38,030		6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		738,603		7
8 NAME OF CONTRACTOR: _____		CONTRACTOR NUMBER: _____	NPR DATE: _____	8

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
PERIOD FROM 01/01/2012 TO 12/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
05/30/2013 16:42

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (15-0101) [] CAH
APPLICABLE BOX

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	1,477	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	1,627	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	1,319	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	4,720	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	103,698,448	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	2,289,977	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	1,318,297	8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)	1,306,806	30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)	11,491	32

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
PERIOD FROM 01/01/2012 TO 12/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
05/30/2013 16:42

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART VI

PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES

1	PROSPECTIVE PAYMENT AMOUNT		
2	RESOURCE UTILIZATION GROUP (RUGS) PAYMENT	809,237	1
3	ROUTINE SERVICE OTHER PASS THROUGH COSTS		2
4	ANCILLARY SERVICE OTHER PASS THROUGH COSTS		3
5	SUBTOTAL (SUM OF LINES 1-3)	809,237	4
6	COMPUTATION OF NET COST OF COVERED SERVICES		
7	MEDICAL AND OTHER SERVICES		5
8	DEDUCTIBLES		6
9	COINSURANCE	108,664	7
10	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	38,030	8
11	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	38,030	9
12	ALLOWABLE REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	38,030	10
13	UTILIZATION REVIEW		11
14	SUBTOTAL (SUM OF LINES 4, 5 MINUS 6 & 7 PLUS 10 AND 11) (SEE INSTRUCTIONS)	738,603	12
15	INPATIENT PRIMARY PAYER PAYMENTS		13
16	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		14
17	SUBTOTAL (LINE 12 MINUS 13 ± LINE 14)	738,603	15
18	INTERIM PAYMENTS	700,573	16
19	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		17
20	BALANCE DUE PROVIDER/PROGRAM (LINE 15 MINUS THE SUM OF LINES 16 AND 17)	38,030	18
21	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		19

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK [] TITLE V [XX] HOSPITAL (15-0101) [] SNF [XX] PPS
 APPLICABLE [XX] TITLE XIX [] IPF [] NF [] TEFRA
 BOXES: [] IRF [] ICF/MR [] OTHER
 [] SUB (OTHER)

PART VII - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

	INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1			1
2			2
3		875,992	3
4		875,992	4
5			5
6			6
7		875,992	7
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES			
8			8
9	659,537	3,380,576	9
10			10
11			11
12	659,537	3,380,576	12
CUSTOMARY CHARGES			
13			13
14			14
15	1.000000	1.000000	15
16	659,537	3,380,576	16
17	659,537	2,504,584	17
18			18
19			19
20			20
21		875,992	21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29		875,992	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31		875,992	31
32			32
33			33
34			34
35			35
36		875,992	36
37			37
38		875,992	38
39			39
40		875,992	40
41		875,992	41
42			42
43			43

SECTION 115.2

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	-92,222			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	6,558,660			4
5	OTHER RECEIVABLES	232,320			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7	INVENTORY	146,149			7
8	PREPAID EXPENSES	131,520			8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	6,976,427			11
FIXED ASSETS					
12	LAND	105,745			12
13	LAND IMPROVEMENTS	279,791			13
14	ACCUMULATED DEPRECIATION	-200,958			14
15	BUILDINGS	3,954,126			15
16	ACCUMULATED DEPRECIATION	-3,153,855			16
17	LEASEHOLD IMPROVEMENTS	48,824			17
18	ACCUMULATED AMORTIZATION	-44,029			18
19	FIXED EQUIPMENT	866,365			19
20	ACCUMULATED DEPRECIATION	-497,335			20
21	AUTOMOBILES AND TRUCKS	212,812			21
22	ACCUMULATED DEPRECIATION	-149,179			22
23	MAJOR MOVABLE EQUIPMENT	12,055,566			23
24	ACCUMULATED DEPRECIATION	-6,465,156			24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS				27
28	ACCUMULATED DEPRECIATION				28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	7,012,717			30
OTHER ASSETS					
31	INVESTMENTS	42,205,191			31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	54,891			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	42,260,082			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	56,249,226			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	568,931			37
38	SALARIES, WAGES & FEES PAYABLE	881,062			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)				40
41	DEFERRED INCOME	120,008			41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS				43
44	OTHER CURRENT LIABILITIES	37,852			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	1,607,853			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE	272,168			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	30,143,580			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	30,415,748			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	32,023,601			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	24,225,625			52
53	SPECIFIC PURPOSE FUND BALANCE				53
54	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				56
57	PLANT FUND BALANCE - INVESTED IN PLANT				57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				58
59	TOTAL FUND BALANCES (SUM OF LINES 52-58)	24,225,625			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	56,249,226			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		15,669,590							1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		8,556,035							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		24,225,625							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5									5
6									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)									10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		24,225,625							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 GENERAL FUND BALANCE									13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)									18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		24,225,625							19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	6,595,378		6,595,378	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				6
7 SKILLED NURSING FACILITY	3,836,794		3,836,794	7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	10,432,172		10,432,172	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	10,432,172		10,432,172	18
19 ANCILLARY SERVICES	19,368,480		19,368,480	19
20 OUTPATIENT SERVICES		77,261,671	77,261,671	20
21 RHC				21
22 FQHC				22
23 HOME HEALTH AGENCY				23
25 AMBULANCE				25
26 ASC				26
27 HOSPICE				27
28 OTHER (SPECIFY)				28
TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	29,800,652	77,261,671	107,062,323	

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		43,481,440	29
30 BAD DEBT	4,856,365		30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		4,856,365	36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		48,337,805	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	107,062,323	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	55,517,350	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	51,544,973	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	48,337,805	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	3,207,168	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	2,849,603	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE	504	9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	158,881	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS	853,041	15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	609,908	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	100,102	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (CLINIC RENTAL)	136,177	24
24.01	OTHER (GAIN ON DISPOSAL OF ASSETS)	-61,728	24.01
24.02	OTHER (COUNTY REIMBURSEMENT OF AMBULANCE S)	354,117	24.02
24.03	OTHER (REVENUE FROM SALE OF SCRAP)	208	24.03
24.04	OTHER (MISCELLANEOUS)	2,211,821	24.04
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	7,212,634	25
26	TOTAL (LINE 5 PLUS LINE 25)	10,419,802	26
27	OTHER EXPENSES (UNREALIZED GAIN (LOSS))	1,863,767	27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	1,863,767	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	8,556,035	29

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((15-010) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
 BOXES [] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT			
1	CAPITAL DRG OTHER THAN OUTLIER	193,509	1
2	CAPITAL DRG OUTLIER PAYMENTS	5,555	2
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	13.19	3
4	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)		8
9	SUM OF LINES 7 AND 8		9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)		10
11	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	199,064	12

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (SEE INSTRUCTIONS)		1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (SEE INSTRUCTIONS)		2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (LINE 1 PLUS LINE 2)		3
4	CAPITAL COST PAYMENT FACTOR (SEE INSTRUCTIONS)		4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (LINE 3 TIMES LINE 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (SEE INSTRUCTIONS)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (LINE 1 MINUS LINE 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (SEE INSTRUCTIONS)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (LINE 3 TIMES LINE 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 2 TIMES LINE 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 5 PLUS LINE 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (FROM PART I, LINE 12 AS APPLICABLE)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (LINE 8 LESS LINE 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (FROM PRIOR YEAR WKST L, PART III, LINE 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (LINE 10 PLUS LINE 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (IF LINE 12 IS POSITIVE, ENTER THE AMOUNT ON THIS LINE)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (IF LINE 12 IS NEGATIVE, ENTER THE AMOUNT ON THIS LINE)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (SEE INSTRUCTIONS)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (SEE INSTRUCTIONS)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (SEE INSTRUCTIONS)		17

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((15-010) [XX] PPS
APPLICABLE [] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
BOXES [XX] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT	
1 CAPITAL DRG OTHER THAN OUTLIER	1
2 CAPITAL DRG OUTLIER PAYMENTS	2
3 TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	3
4 NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)	4
5 INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)	5
6 INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)	6
7 PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)	7
8 PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)	8
9 SUM OF LINES 7 AND 8	9
10 ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	10
11 DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)	11
12 TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	12

PART II - PAYMENT UNDER REASONABLE COST

1 PROGRAM INPATIENT ROUTINE CAPITAL COST (SEE INSTRUCTIONS)	1
2 PROGRAM INPATIENT ANCILLARY CAPITAL COST (SEE INSTRUCTIONS)	2
3 TOTAL INPATIENT PROGRAM CAPITAL COST (LINE 1 PLUS LINE 2)	3
4 CAPITAL COST PAYMENT FACTOR (SEE INSTRUCTIONS)	4
5 TOTAL INPATIENT PROGRAM CAPITAL COST (LINE 3 TIMES LINE 4)	5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1 PROGRAM INPATIENT CAPITAL COSTS (SEE INSTRUCTIONS)	1
2 PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)	2
3 NET PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (LINE 1 MINUS LINE 2)	3
4 APPLICABLE EXCEPTION PERCENTAGE (SEE INSTRUCTIONS)	4
5 CAPITAL COST FOR COMPARISON TO PAYMENTS (LINE 3 TIMES LINE 4)	5
6 PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)	6
7 ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 2 TIMES LINE 6)	7
8 CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 5 PLUS LINE 7)	8
9 CURRENT YEAR CAPITAL PAYMENTS (FROM PART I, LINE 12 AS APPLICABLE)	9
10 CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (LINE 8 LESS LINE 9)	10
11 CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (FROM PRIOR YEAR WKST L, PART III, LINE 14)	11
12 NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (LINE 10 PLUS LINE 11)	12
13 CURRENT YEAR EXCEPTION PAYMENT (IF LINE 12 IS POSITIVE, ENTER THE AMOUNT ON THIS LINE)	13
14 CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (IF LINE 12 IS NEGATIVE, ENTER THE AMOUNT ON THIS LINE)	14
15 CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (SEE INSTRUCTIONS)	15
16 CURRENT YEAR OPERATING AND CAPITAL COSTS (SEE INSTRUCTIONS)	16
17 CURRENT YEAR EXCEPTION OFFSET AMOUNT (SEE INSTRUCTIONS)	17

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS 0	SUBTOTAL (COLS.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
2.01 SNF CAPITAL					2.01
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES AP					21
22 I&R SRVCES-OTHER PRGM COSTS AP					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
52 DELIVERY ROOM & LABOR ROOM					52
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIAC					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY					69
71 MEDICAL SUPPLIES CHRGD TO PAT					71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC					90
91 EMERGENCY					91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES					95
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CA					190
192 PHYSICIANS' PRIVATE OFFICES					192
194 OCCUPATIONAL HEALTH					194
194.01 PAIN CLINIC					194.01
194.02 OAK POINTE					194.02
194.03 FOUNDATION					194.03
194.04 COMMUNITY & VOLUNTEER SERVICES					194.04
194.05 VACANT SPACE					194.05
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINE 118 AND LINES 190-201)					202
203 TOTAL STATISTICAL BASIS					203
204 UNIT COST MULTIPLIER					204
204 UNIT COST MULTIPLIER					204

WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3 Part IV, Line 4)

EXHIBIT 3

STEP 1: Determine the 3-Year Averaging Period				
1	Wage index fiscal year ending date	12/31/2010	1	
2	Provider's cost reporting period used for wage index year on Line 1 (FYB in Col 1, FYE in Col 2)	01/01/2010	12/31/2010	2
3	Midpoint of provider's cost reporting period shown on Line 2, adjusted to first of month	07/01/2010		3
4	Date beginning the 3-year averaging period (subtract 18 months from midpoint shown on Line 3)	01/01/2009		4
5	Date ending the 3-year averaging period (add 18 months to midpoint shown on Line 3)	01/01/2012		5
STEP 2 (OPTIONAL): Adjust Averaging Period for a New Plan (SEE INSTRUCTIONS)				
6	Effective date of pension plan			6
7	First day of the provider cost reporting period containing the pension plan effective date			7
8	Starting date of the adjusted averaging period (date on Line 7, adjusted to first of month)			8
If this date occurs after the period shown on line 2, stop here and see instructions.				
STEP 3: Average Pension Contributions During the Averaging Period				
9	Beginning date of averaging period from Line 4 or Line 8, as applicable	01/01/2009		9
10	Ending date of averaging period from Line 5	01/01/2012		10
11	Enter provider contributions made during averaging period on Lines 9 & 10			11
11.01		03/31/2011	8,600,000	11.01
11.02		02/28/2009	5,000,000	11.02
11.03		04/30/2009	2,500,000	11.03
11.04		05/31/2009	10,000,000	11.04
11.05		10/31/2009	5,000,000	11.05
11.06		01/31/2010	5,000,000	11.06
11.07		02/28/2010	5,300,000	11.07
11.08		07/31/2010	5,000,000	11.08
11.09		10/31/2010	5,000,000	11.09
12	Total calendar months included in averaging period (36 unless Step 2 completed)	36		12
13	Total contributions made during averaging period	51,400,000		13
14	Average monthly contribution (Line 13 divided by Line 12)	1,427,778		14
15	Number of months in provider cost reporting period on Line 2	12		15
16	Average pension contributions (Line 14 times Line 15)	17,133,336		16
STEP 4: Total Pension Cost for Wage Index				
17	Annual prefunding installment (SEE INSTRUCTIONS)			17
18	Reportable prefunding installment ((Line 17 times Line 15) divided by 12)			18
19	Total Pension Cost for Wage Index (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)	17,133,336		19

LOW VOLUME ADJUSTMENT CALCULATION SCHEDULE (For Worksheet E Part A, Lines 70.96 and 70.97)

EXHIBIT 4

	Amounts From E Part A (1)	Prior to 10/1/2010 or after 9/30/2013 Pre/Post Entitlement (2)	10/01/2011 through 09/30/2012 (3)	(3.01)	10/01/2012 through 09/30/2013 (4)	(4.01)	(Columns 2 through 4) TOTAL (5)	
1	DRG Amounts Other than Outlier Payments	2,364,456	1,773,342		591,114		2,364,456	1
2	Outlier payments for discharges	13,207	13,207				13,207	2
3	Operating outlier reconciliation							3
4	Managed Care Simulated Payments							4
INDIRECT MEDICAL EDUCATION ADJUSTMENT								
5	Amount from Worksheet E Part A, Line 21							5
6	IME payment adjustment							6
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON FOR MME SECTION 422								
7	Amount from Worksheet E Part A, Line 27							7
8	IME add-on adjustment							8
9	Total IME payment							9
DISPROPORTIONATE SHARE ADJUSTMENT								
10	Allowable disproportionate share percentage	0.0683	0.0683	0.0683	0.0683	0.0683		10
11	Disproportionate share adjustment	161,492	121,119		40,373		161,492	11
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES								
12	Total ESRD additional payment							12
13	Subtotal	2,539,155	1,907,668		631,487		2,539,155	13
14	Hospital specific payments							14
15	Total payment for inpatient operating costs - E Part A Line 49	2,539,155	1,907,668		631,487		2,539,155	15
16	Payment for inpatient program capital	199,064	150,687		48,377		199,064	16
17	Special add-on payments for new technologies							17
18	Capital outlier reconciliation adjustment amount							18
19	SUBTOTAL		2,058,355		679,864		2,738,219	19
CAPITAL PAYMENTS								
20	Capital DRG other than outlier	193,509	145,132		48,377		193,509	20
21	Capital DRG outlier payments	5,555	5,555				5,555	21
22	Indirect medical education percentage							22
23	Indirect medical education adjustment							23
24	Allowable disproportionate share percentage							24
25	Disproportionate share adjustment							25
26	Total prospective capital payments	199,064	150,687		48,377		199,064	26
LOW VOLUME ADJUSTMENT								
27	Low volume adjustment factor		0.168929		0.159821			27
28	Low Volume Adjustment		347,716				347,716	28
29	Low Volume Adjustment				108,657		108,657	29