



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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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. <input checked="" type="checkbox"/> ELECTRONICALLY FILED COST REPORT	DATE: 05/28/2014	TIME: 16:13
	2. <input type="checkbox"/> MANUALLY SUBMITTED COST REPORT		
	3. <input type="checkbox"/> IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT		
	4. <input checked="" type="checkbox"/> MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.		
CONTRACTOR USE ONLY	5. <input type="checkbox"/> 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. <input type="checkbox"/> INITIAL REPORT FOR THIS PROVIDER CCN	12. <input type="checkbox"/> IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.
	3 -SETTLED WITH AUDIT	9. <input type="checkbox"/> FINAL REPORT FOR THIS PROVIDER CCN	
	4 -REOPENED		
	5 -AMENDED		

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE 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 01/01/2013 AND ENDING 12/31/2013, 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 XVIII			HIT	TITLE XIX	
		TITLE V	PART A	PART B			
		1	2	3	4	5	
1	HOSPITAL		108,047	-26,009	-22,399		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		-1,333				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		106,714	-26,009	-22,399		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.



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX ADDRESS:										
1	STREET: 1260 E STATE ROAD 205	P.O. BOX:							1	
2	CITY: COLUMBIA CITY	STATE: IN	ZIP CODE: 46725-9492	COUNTY: WHITLEY					2	
HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:										
							PAYMENT SYSTEM (P, T, O, OR N)			
0	1	2	3	4	5	6	7	8		
COMPONENT	COMPONENT NAME	CCN NUMBER	CBSA NUMBER	PROV- IDER TYPE	DATE CERTIFIED	V	XVIII	XIX		
3	HOSPITAL	WHITLEY MEMORIAL 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	PARKVIEW OAKS	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 / 2013	TO: 12 / 31 / 2013							20
21	TYPE OF CONTROL (see instructions)	2								21
INPATIENT PPS INFORMATION							1	2		
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.						Y	N		22
22.01	DID THIS HOSPITAL RECEIVE INTERIM UNCOMPENSATED CARE PAYMENTS FOR THIS COST REPORTING PERIOD? ENTER IN COLUMN 1, 'Y' FOR YES OR 'N' FOR NO FOR THE PORTION OF THE COST REPORTING PERIOD OCCURRING PRIOR TO OCTOBER 1. ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO FOR THE PORTION OF THE COST REPORTING PERIOD OCCURRING ON OR AFTER OCTOBER 1. (see instructions)						N	N		22.01
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	IN-STATE MEDICAID ELIGIBLE UNPAID DAYS	OUT-OF- STATE MEDICAID PAID DAYS	OUT-OF- STATE MEDICAID ELIGIBLE UNPAID DAYS	MEDICAID HMO DAYS	OTHER MEDICAID DAYS			
		1	2	3	4	5	6			
24	IF THIS PROVIDER IS AN IPPS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	237	182			635			24	
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.								25	
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.			1					26	
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.			1					27	
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.								35	
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:			36	
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.								37	
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:			38	
39	DOES THIS FACILITY QUALIFY FOR THE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW VOLUME HOSPITALS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(ii)? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)(ii)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (see instructions)						1	2	39	
							Y	Y		



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XVIII	XIX	
PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL		1	2	3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	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	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	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48
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	DIRECT GME	
61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.(see instructions)	N			61
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (see instructions)				61.01
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503) of ACA). (see instructions)				61.02
61.03	ENTER THE BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (see instructions)				61.03
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (see instructions)				61.04
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTEs AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (see instructions)				61.06
OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.					
	PROGRAM NAME	PROGRAM CODE	UNWEIGHTED IME FTE COUNT	UNWEIGHTED DIRECT GME FTE COUNT	
	1	2	3	4	
OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.					
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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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS-THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.		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. 3/ col. 3 + col. 4)	
	1	2	3	4	5	
65						65
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS-EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010		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	
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	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4)	
	1	2	3	4	5	
67						67
INPATIENT PSYCHIATRIC FACILITY PPS		1	2	3		
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		1	2	3		
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.				86	



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WORKSHEET S-2
PART I

		V	XIX	
TITLE V AND XIX SERVICES		1	2	
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.	N	Y	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	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		1	2	
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.	N	PHYSICAL OCCUPATIONAL SPEECH RESPIRATORY	109
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'	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:	90,795	PAID LOSSES 35,000	SELF INSURANCE 38,869 118.01
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 HIGH COST 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



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

ALL PROVIDERS			
		1	2
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.	Y	15H032

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

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.					166
	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 IS A MEANINGFUL USER (line 167 is 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. (see instructions)				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. (see instructions)	0.75			169
170	ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD RESPECTIVELY (mm/dd/yyyy)	10/01/2012	09/30/2013		170



WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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HOSPITAL AND HOSPITAL 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	2		
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	
		1	2	3	
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	
		1	2	3	
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	
		1		2	
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
BAD DEBTS				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
		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



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WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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HOSPITAL AND HOSPITAL 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 COSTS			
22	HAVE ASSETS BEEN RELIEVED 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
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	1	2
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
38	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.		
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.		
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
COST REORT PREPARER INFORMATION			
41	FIRST NAME: ERIC	LAST NAME: NICKESON	TITLE: DIRECTOR, REIMBURSEMENT
42	EMPLOYER: PARKVIEW HEALTH SYSTEM, INC.		
43	PHONE NUMBER: 2603738406	E-MAIL ADDRESS: ERIC.NICKESON@PARKVIEW.COM	



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

	WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF- ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1	200	21,345,730		21,345,730	651,579.00	32.76	1
2							2
3							3
4		80,046		80,046	711.00	112.58	4
4.01							4.01
5							5
6							6
7	21						7
7.01							7.01
8		4,139,556		4,139,556	118,097.00	35.05	8
9	44	2,131,105	101,522	2,232,627	129,107.00	17.29	9
10		1,238,148		1,238,148	70,021.00	17.68	10
OTHER WAGES & RELATED COSTS							
11							11
12							12
13							13
14		4,437,511		4,437,511	120,971.00	36.68	14
15							15
16							16
WAGE-RELATED COSTS							
17		4,991,899		4,991,899			17
18							18
19		497,490		497,490			19
20							20
21							21
22		80,046		80,046			22
22.01							22.01
23							23
24							24
25							25
OVERHEAD COSTS - DIRECT SALARIES							
26		1,424,818		1,424,818	62,065.00	22.96	26
27		8,971,055	-101,522	8,869,533	131,506.00	67.45	27
28							28
29							29
30		295,653		295,653	14,681.00	20.14	30
31							31
32		201,134		201,134	19,979.00	10.07	32
33							33
34		316,318	-226,888	89,430	7,017.00	12.74	34
35							35
36			223,349	223,349	17,871.00	12.50	36
37							37
38		109,755		109,755	4,090.00	26.83	38
39							39
40		474,101		474,101	11,893.00	39.86	40
41							41
42							42
43							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)		17,206,174		17,206,174	533,482.00	32.25	1
2	EXCLUDED AREA SALARIES (see instructions)		3,369,253	101,522	3,470,775	199,128.00	17.43	2
3	SUBTOTAL SALARIES (line 1 minus line 2)		13,836,921	-101,522	13,735,399	334,354.00	41.08	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)		4,437,511		4,437,511	120,971.00	36.68	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)		5,071,945		5,071,945		36.93%	5
6	TOTAL (sum of lines 3 through 5)		23,346,377	-101,522	23,244,855	455,325.00	51.05	6
7	TOTAL OVERHEAD COST (see instructions)		11,792,834	-105,061	11,687,773	269,102.00	43.43	7



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3

PART IV - WAGE RELATED COST

PART IV

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS		1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	321,324	2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	1,046,013	3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	25,628,684	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	40,780	7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)	2,686,661	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN		10
11	LIFE INSURANCE (If employee is owner or beneficiary)	24,183	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	51,995	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	95,441	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	1,173,883	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)	26,185	21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT	22,925	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	31,118,074	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25
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WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	Supporting Exhibit for Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD				
1	WAGE INDEX FISCAL YEAR ENDING DATE	09/30/2014		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	7/01/2010		3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)	1/01/2009		4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)	1/01/2012		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	1/01/2009		9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5	1/01/2012		10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	DEPOSIT DATE(S)	CONTRIB-UTION(S)	11
11.01		02/28/2009	5,000,000	11.01
11.02		04/30/2009	2,500,000	11.02
11.03		05/31/2009	10,000,000	11.03
11.04		10/31/2009	5,000,000	11.04
11.05		01/31/2010	5,000,000	11.05
11.06		02/28/2010	5,300,000	11.06
11.07		07/31/2010	5,000,000	11.07
11.08		10/31/2010	5,000,000	11.08
11.09		03/31/2011	8,600,000	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)	8,495,348		17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)	8,495,348		18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)	25,628,684		19



WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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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 LABOR	BENEFIT COST	
	0	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



WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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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 (sum of col. 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	330		330	12
13	RUB	452		452	13
14	RUA	507		507	14
15	RVC	69		69	15
16	RVB	90		90	16
17	RVA	129		129	17
18	RHC	35		35	18
19	RHB	45		45	19
20	RHA	36		36	20
21	RMC	5		5	21
22	RMB	14		14	22
23	RMA	35		35	23
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	30		30	42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1	1		1	48
49	CC2				49
50	CC1	3		3	50
51	CB2				51
52	CB1	5		5	52
53	CA2				53
54	CA1	5		5	54
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
69	PE2				69
70	PE1	1		1	70



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

	GROUP	SNF DAYS	SWING BED SNF DAYS	TOTAL (sum of col. 2 + 3)	
	1	2	3	4	
71	PD2				71
72	PD1		3	3	72
73	PC2				73
74	PC1		4	4	74
75	PB2				75
76	PB1		1	1	76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL	1,800		1,800	200

SNF SERVICES

		CBSA AT BEGINNING OF COST REPORTING PERIOD	CBSA ON/AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (if 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	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 WITH DIRECT PATIENT CARE AND RELATED EXPENSES?	
		1	2	3	
202	STAFFING	2,193,948	57.14%	Y	202
203	RECRUITMENT				203
204	RETENTION OF EMPLOYEES				204
205	TRAINING	38,679	1.01%	Y	205
206	OTHER (SPECIFY)				206
207	TOTAL SNF REVENUE (Worksheet G-2, Part I, line 7, column 3)	3,839,662			207



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)		0.334501	1
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MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID		1,149,081	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		16,197	5
6	MEDICAID CHARGES		12,469,879	6
7	MEDICAID COST (line 1 times line 6)		4,171,187	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.		3,005,909	8

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(see instructions for each line)

9	NET REVENUE FROM STAND-ALONE SCHIP			9
10	STAND-ALONE SCHIP CHARGES			10
11	STAND-ALONE SCHIP COST (line 1 times line 10)			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)		191,297	13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (not included in lines 6 or 10)		1,178,649	14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (line 1 times line 14)		394,259	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.		202,962	16

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

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)		3,208,871	19	
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL (col. 1 + col. 2)	
		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	1,873,263	672,535	2,545,798	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	626,608	224,964	851,572	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	53,637	15,392	69,029	22
23	COST OF CHARITY CARE (line 21 minus line 22)	572,971	209,572	782,543	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?		N	24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (see instructions)			25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)		4,651,584	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)		61,222	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)		4,590,362	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)		1,535,481	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)		2,318,024	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)		5,526,895	31



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	CAP REL COSTS-BLDG & FIXT		3,590,893	3,590,893	-850,270	2,740,623	-2,221,284	519,339	1
2	00200	CAP REL COSTS-MVBLE EQUIP				1,306,243	1,306,243	-13,604	1,292,639	2
2.01	00201	SNF CAPITAL				100,224	100,224		100,224	2.01
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	1,424,818	4,407,952	5,832,770		5,832,770	-1,557,923	4,274,847	4
5	00500	ADMINISTRATIVE & GENERAL	8,971,055	1,413,172	10,384,227	-412,930	9,971,297	2,211,641	12,182,938	5
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	295,653	876,138	1,171,791	-94,797	1,076,994	-266	1,076,728	7
8	00800	LAUNDRY & LINEN SERVICE		163,933	163,933		163,933		163,933	8
9	00900	HOUSEKEEPING	201,134	63,173	264,307	-289	264,018		264,018	9
10	01000	DIETARY	316,318	179,199	495,517	-356,259	139,258	-15,791	123,467	10
11	01100	CAFETERIA				351,311	351,311	-41,424	309,887	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	109,755	205	109,960		109,960		109,960	13
14	01400	CENTRAL SERVICES & SUPPLY								14
15	01500	PHARMACY	474,101	1,770,024	2,244,125	-877,031	1,367,094	-806,244	560,850	15
16	01600	MEDICAL RECORDS & LIBRARY								16
17	01700	SOCIAL SERVICE								17
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL								20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD								21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD								22
23	02300	PARAMED ED PRGM-(SPECIFY)								23
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	2,001,727	257,337	2,259,064	-604,420	1,654,644		1,654,644	30
43	04300	NURSERY				94,112	94,112		94,112	43
44	04400	SKILLED NURSING FACILITY	2,131,105	759,960	2,891,065	241,811	3,132,876	-8,637	3,124,239	44
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	881,720	329,508	1,211,228	-1,546	1,209,682		1,209,682	50
52	05200	DELIVERY ROOM & LABOR ROOM	42,145	342	42,487	503,832	546,319		546,319	52
53	05300	ANESTHESIOLOGY		937,471	937,471	-156	937,315	-889,566	47,749	53
54	05400	RADIOLOGY-DIAGNOSTIC	998,035	456,394	1,454,429	-66,585	1,387,844		1,387,844	54
60	06000	LABORATORY		1,184,859	1,184,859	-898	1,183,961		1,183,961	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY	406,061	144,013	550,074	-70,464	479,610	-2,376	477,234	65
66	06600	PHYSICAL THERAPY	648,106	539,710	1,187,816	-723,648	464,168	-5,454	458,714	66
67	06700	OCCUPATIONAL THERAPY		194,851	194,851	323,624	518,475		518,475	67
68	06800	SPEECH PATHOLOGY		55,410	55,410	91,169	146,579		146,579	68
69	06900	ELECTROCARDIOLOGY		21,147	21,147	-916	20,231		20,231	69
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		770,326	770,326	-170,865	599,461		599,461	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				170,002	170,002		170,002	72
73	07300	DRUGS CHARGED TO PATIENTS				869,940	869,940		869,940	73
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	CLINIC	79,404	14,902	94,306	3,539	97,845		97,845	90
90.01	09001	INTENSIVE OUT PATIENT PROGRAM		78	78		78		78	90.01
91	09100	EMERGENCY	1,126,445	155,034	1,281,479	-37,732	1,243,747	-8,730	1,235,017	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
95	09500	AMBULANCE SERVICES	907,624	195,082	1,102,706	-4,415	1,098,291		1,098,291	95
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	21,015,206	18,481,113	39,496,319	-217,414	39,278,905	-3,359,658	35,919,247	118
		NONREIMBURSABLE COST CENTERS								
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		16,779	16,779		16,779		16,779	190
192	19200	PHYSICIANS' PRIVATE OFFICES	13,595	2,985,682	2,999,277		2,999,277	-2,939,639	59,638	192
194	07950	OCCUPATIONAL HEALTH		-159,752	-159,752	203,080	43,328		43,328	194
194.01	07951	PAIN CLINIC								194.01
194.02	07952	OAK POINTE	293,492	695,176	988,668	10,131	998,799	-318,552	680,247	194.02
194.03	07953	FOUNDATION		90,000	90,000		90,000		90,000	194.03
194.04	07954	COMMUNITY & VOLUNTEER SERVICES	23,437	120,638	144,075	4,203	148,278		148,278	194.04
194.05	07955	VACANT SPACE								194.05
200		TOTAL (sum of lines 118-199)	21,345,730	22,229,636	43,575,366		43,575,366	-6,617,849	36,957,517	200



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION(S)		CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
1		1	2	3	4	5	
1	CAFETERIA RECLASS	A	CAFETERIA	11	223,349	127,962	1
500	TOTAL RECLASSIFICATIONS				223,349	127,962	500
	CODE LETTER - A						
1	OB RECLASS	B	NURSERY	43	85,582	8,530	1
2			DELIVERY ROOM & LABOR ROOM	52	458,168	45,664	2
500	TOTAL RECLASSIFICATIONS				543,750	54,194	500
	CODE LETTER - B						
1	LTC A&G COST	D	SKILLED NURSING FACILITY	44	101,522	157,945	1
500	TOTAL RECLASSIFICATIONS				101,522	157,945	500
	CODE LETTER - D						
1	BUILDING AND EQUIP LEASE	E	CAP REL COSTS-BLDG & FIXT	1		456,425	1
2			CAP REL COSTS-MVBLE EQUIP	2		61,005	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
500	TOTAL RECLASSIFICATIONS					517,430	500
	CODE LETTER - E						
1	INSURANCE RECLASS	G	CAP REL COSTS-BLDG & FIXT	1		3,820	1
2			CAP REL COSTS-MVBLE EQUIP	2		23,627	2
3			SNF CAPITAL	2.01		9,910	3
4			OAK POINTE	194.02		9,943	4
5			CAP REL COSTS-MVBLE EQUIP	2		1,222	5
6			SNF CAPITAL	2.01		188	6
7			OAK POINTE	194.02		188	7
8			ADMINISTRATIVE & GENERAL	5		6,559	8
500	TOTAL RECLASSIFICATIONS					55,457	500
	CODE LETTER - G						
1	DEPRECIATION RECLASS	H	CAP REL COSTS-MVBLE EQUIP	2		1,207,519	1
2			SNF CAPITAL	2.01		90,021	2
500	TOTAL RECLASSIFICATIONS					1,297,540	500
	CODE LETTER - H						
1	TAXES RECLASS	J	CAP REL COSTS-MVBLE EQUIP	2		12,870	1
2			SNF CAPITAL	2.01		105	2
500	TOTAL RECLASSIFICATIONS					12,975	500
	CODE LETTER - J						
1	SALARY RECLASS	K	ADMINISTRATIVE & GENERAL	5	4,502,206		1
500	TOTAL RECLASSIFICATIONS				4,502,206		500
	CODE LETTER - K						
1	REHAB THERAPY DEPT RECLASS	L	OCCUPATIONAL THERAPY	67	330,581	17,733	1
2			SPEECH PATHOLOGY	68	86,528	4,641	2
500	TOTAL RECLASSIFICATIONS				417,109	22,374	500
	CODE LETTER - L						
1	DRUGS CHARGED TO PATIENT RECLASS	M	DRUGS CHARGED TO PATIENTS	73		876,011	1
500	TOTAL RECLASSIFICATIONS					876,011	500
	CODE LETTER - M						
1	CLINIC DIETICIAN RECLASS	O	CLINIC	90	3,539		1
500	TOTAL RECLASSIFICATIONS				3,539		500
	CODE LETTER - O						
1	CORPORATE DIRECT ALLOC RECLASS	P	OCCUPATIONAL HEALTH	194		43,328	1
2			COMMUNITY & VOLUNTEER SERVICE	194.04		4,203	2
500	TOTAL RECLASSIFICATIONS					47,531	500
	CODE LETTER - P						



WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	OCCUPATIONAL HEALTH RECLASS	Q	OCCUPATIONAL HEALTH	194		159,752	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
500	TOTAL RECLASSIFICATIONS					159,752	500
	CODE LETTER - Q						
1	IMPLANTABLE MEDICAL SUPPLIES	R	IMPL. DEV. CHARGED TO PATIENT	72		170,002	1
500	TOTAL RECLASSIFICATIONS					170,002	500
	CODE LETTER - R						
	GRAND TOTAL (INCREASES)				5,791,475	3,499,173	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
 Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.



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WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES							
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.		
		1	6	7	8	9	10		
1	CAFETERIA RECLASS	A	DIETARY	10	223,349	127,962		1	
500	TOTAL RECLASSIFICATIONS				223,349	127,962		500	
	CODE LETTER - A								
1	OB RECLASS	B	ADULTS & PEDIATRICS	30	543,750	54,194		1	
2								2	
500	TOTAL RECLASSIFICATIONS				543,750	54,194		500	
	CODE LETTER - B								
1	LTC A&G COST	D	ADMINISTRATIVE & GENERAL	5	101,522	157,945		1	
500	TOTAL RECLASSIFICATIONS				101,522	157,945		500	
	CODE LETTER - D								
1	BUILDING AND EQUIP LEASE	E	ADMINISTRATIVE & GENERAL	5		52,021	10	1	
2			OPERATION OF PLANT	7		93,386	10	2	
3			RESPIRATORY THERAPY	65		67,122		3	
4			PHYSICAL THERAPY	66		243,896		4	
5			ADMINISTRATIVE & GENERAL	5		11,572		5	
6			OPERATION OF PLANT	7		1,411		6	
7			HOUSEKEEPING	9		289		7	
8			DIETARY	10		1,409		8	
9			PHARMACY	15		1,020		9	
10			ADULTS & PEDIATRICS	30		6,476		10	
11			SKILLED NURSING FACILITY	44		11,097		11	
12			OPERATING ROOM	50		1,546		12	
13			RADIOLOGY-DIAGNOSTIC	54		2,159		13	
14			RESPIRATORY THERAPY	65		3,153		14	
15			PHYSICAL THERAPY	66		14,937		15	
16			EMERGENCY	91		1,521		16	
17			AMBULANCE SERVICES	95		4,415		17	
500	TOTAL RECLASSIFICATIONS					517,430		500	
	CODE LETTER - E								
1	INSURANCE RECLASS	G	ADMINISTRATIVE & GENERAL	5		47,300	12	1	
2			ADMINISTRATIVE & GENERAL	5		1,598	12	2	
3			SKILLED NURSING FACILITY	44		6,559	12	3	
4								4	
5							12	5	
6							12	6	
7								7	
8								8	
500	TOTAL RECLASSIFICATIONS					55,457		500	
	CODE LETTER - G								
1	DEPRECIATION RECLASS	H	CAP REL COSTS-BLDG & FIXT	1		1,297,540	9	1	
2							9	2	
500	TOTAL RECLASSIFICATIONS					1,297,540		500	
	CODE LETTER - H								
1	TAXES RECLASS	J	CAP REL COSTS-BLDG & FIXT	1		12,975	13	1	
2							13	2	
500	TOTAL RECLASSIFICATIONS					12,975		500	
	CODE LETTER - J								
1	SALARY RECLASS	K	ADMINISTRATIVE & GENERAL	5	4,502,206			1	
500	TOTAL RECLASSIFICATIONS				4,502,206			500	
	CODE LETTER - K								
1	REHAB THERAPY DEPT RECLASS	L	PHYSICAL THERAPY	66	417,109	22,374		1	
2								2	
500	TOTAL RECLASSIFICATIONS				417,109	22,374		500	
	CODE LETTER - L								
1	DRUGS CHARGED TO PATIENT RECLASS	M	PHARMACY	15		876,011		1	
500	TOTAL RECLASSIFICATIONS					876,011		500	
	CODE LETTER - M								
1	CLINIC DIETICIAN RECLASS	O	DIETARY	10	3,539			1	
500	TOTAL RECLASSIFICATIONS				3,539			500	
	CODE LETTER - O								
1	CORPORATE DIRECT ALLOC RECLASS	P	ADMINISTRATIVE & GENERAL	5		47,531		1	
2								2	
500	TOTAL RECLASSIFICATIONS					47,531		500	
	CODE LETTER - P								



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WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				WKST A-7 REF.	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9	10	
1	OCCUPATIONAL HEALTH RECLASS	Q	RADIOLOGY-DIAGNOSTIC	54		64,426		1
2			LABORATORY	60		898		2
3			RESPIRATORY THERAPY	65		189		3
4			PHYSICAL THERAPY	66		25,332		4
5			OCCUPATIONAL THERAPY	67		24,690		5
6			ELECTROCARDIOLOGY	69		916		6
7			MEDICAL SUPPLIES CHARGED TO P	71		863		7
8			DRUGS CHARGED TO PATIENTS	73		6,071		8
9			EMERGENCY	91		36,211		9
10			ANESTHESIOLOGY	53		156		10
500	TOTAL RECLASSIFICATIONS					159,752		500
	CODE LETTER - Q							
1	IMPLANTABLE MEDICAL SUPPLIES	R	MEDICAL SUPPLIES CHARGED TO P	71		170,002		1
500	TOTAL RECLASSIFICATIONS					170,002		500
	CODE LETTER - R							
	GRAND TOTAL (DECREASES)					5,791,475	3,499,173	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS			DISPOSALS AND RETIRE- MENTS	ENDING BALANCE	FULLY DEPREC- IATED ASSETS	
			PURCHASES	DONATION	TOTAL				
		1	2	3	4	5	6	7	
1	LAND	105,745				13,128	92,617		1
2	LAND IMPROVEMENTS	279,791					279,791	104,200	2
3	BUILDINGS AND FIXTURES	3,954,126	7,025		7,025		3,961,151	2,596,961	3
4	BUILDING IMPROVEMENTS	48,824					48,824	42,430	4
5	FIXED EQUIPMENT	866,365	16,990		16,990	10,848	872,507	156,365	5
6	MOVABLE EQUIPMENT	12,201,679	176,427		176,427	34,149	12,343,957	4,889,492	6
7	HIT DESIGNATED ASSETS	1,753,661	1,052,284		1,052,284		2,805,945		7
8	SUBTOTAL (sum of lines 1-7)	19,210,191	1,252,726		1,252,726	58,125	20,404,792	7,789,448	8
9	RECONCILING ITEMS	1,634,008	-300		-300	-117,011	1,750,719		9
10	TOTAL (line 7 minus line 9)	17,576,183	1,253,026		1,253,026	175,136	18,654,073	7,789,448	10

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

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(1) (Sum of cols. 9 through 14)	
		DEPREC- IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL- RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	3,590,522				371		3,590,893	1	
2	CAP REL COSTS-MVBLE EQUIP								2	
2.01	SNF CAPITAL								2.01	
3	TOTAL (sum of lines 1-2)	3,590,522				371		3,590,893	3	

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

* All line numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		GROSS ASSETS	CAPITAL- IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL- RELATED COSTS	TOTAL (sum of cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI	3,277,767		3,277,767	0.160637					1
2	CAP REL COSTS-MVBLE EQU	12,524,715		12,524,715	0.613813					2
2.01	SNF CAPITAL	4,602,310		4,602,310	0.225550					2.01
3	TOTAL (sum of lines 1-2)	20,404,792		20,404,792	1.000000					3

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(2) (sum of cols. 9 through 14)	
		DEPREC- IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL- RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	71,698	456,425		3,820	-12,604		519,339	1	
2	CAP REL COSTS-MVBLE EQUIP	1,193,915	61,005		24,849	12,870		1,292,639	2	
2.01	SNF CAPITAL	90,021			10,098	105		100,224	2.01	
3	TOTAL (sum of lines 1-2)	1,355,634	517,430		38,767	371		1,912,202	3	

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			WKST A-7 REF.
				COST CENTER	LINE#		
		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	-266	OPERATION OF PLANT	7		8
9	PARKING LOT (chapter 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-14,607				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	-2,439,211				12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-15,159	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 OVERPAYMENTS						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						32
33	MISCELLANEOUS REVENUE	B	-9,148	ADMINISTRATIVE & GENERAL	5		33
34							34
34.01	CAFE - EMP. & GUESTS	B	-1,217	CAFETERIA	11		34.01
35	POSTURE ASSESSMENTS	B	-5,454	PHYSICAL THERAPY	66		35
36	SALE OF LTC SUPPLIES	B	-8,637	SKILLED NURSING FACILITY	44		36
37							37
38	NON-PATIENT LAB REV.	B	-2,376	RESPIRATORY THERAPY	65		38
39	TELEVISION OFFSET	A	-13,604	CAP REL COSTS-MVBLE EQUIP	2	9	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	-15,791	DIETARY	10		42
43	VISITOR MEALS	A	-25,048	CAFETERIA	11		43
44	PHARMACY SALES	A	-791,328	PHARMACY	15		44
45	COMMUNITY HEALTH & VOLUNTEER SVCS	A	-42,129	ADMINISTRATIVE & GENERAL	5		45
46	SELF INSURANCE	A	-1,557,923	EMPLOYEE BENEFITS DEPARTMENT	4		46
47							47
48	LOBBY EXPENSE	A	-3,738	ADMINISTRATIVE & GENERAL	5		48
49							49
49.02	RENT EXPENSE - MEDICATION ASSIST P	A	-303,985	PHYSICIANS' PRIVATE OFFICES	192		49.02
49.03	ALLOWABLE ER ADMIN SVCS	A	-318,552	OAK POINTE	194.02		49.03
49.05	INTERUNIT RENT EXPENSE	A	-14,916	PHARMACY	15	9	49.05
49.07	NON-ALLOW - PROF SERVICES	A	-883,689	ANESTHESIOLOGY	53		49.07
49.10	HOSPITALIST / SURGERY ON CALL	A	-124,174	ADMINISTRATIVE & GENERAL	5		49.10
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-6,617,849				50

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

(2) Basis for adjustment (see instructions)

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

B. Amount Received - if cost cannot be determined



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	

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

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



WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
--	---------------------------------------	--	---

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 CLAIMED HOME OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUSTMENTS (col. 4 minus col. 5)*	WKST. A-7 REF.		
1	2	3	4	5	6	7		
1	1	CAP REL COSTS-BLDG & FIXT	INTERCOMPANY RENT		2,221,284	-2,221,284	9	1
2	192	PHYSICIANS' PRIVATE OFFICES	REMOVE PPG SUBSIDY		2,635,654	-2,635,654		2
3	5	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	10,115,727	7,698,000	2,417,727		3
4								4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12			10,115,727	12,554,938	-2,439,211		5

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

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

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

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

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



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
--	---------------------------------------	--	---

PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFESS- IONAL COMPON- ENT	PROVIDER COMPON- ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON- ENT HOURS	UNADJ- USTED RCE LIMIT	5 PERCENT OF UNADJ- USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	91	EMERGENCY DR A	26,694		26,694	171,400	218	17,964	898	1
2	53	ANESTHESIOLOGY DR B	53,352		53,352	200,300	493	47,475	2,374	2
200		TOTAL	80,046		80,046		711	65,439	3,272	200



WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
--	---------------------------------------	--	---

PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER- SHIPS & CONTIN- UING EDUCATION	PROVIDER COMPON- ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT- ICE INSURANCE	PROVIDER COMPON- ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW- ANCE	ADJUST- MENT	
	10	11	12	13	14	15	16	17	18	
1	91	EMERGENCY DR A					17,964	8,730	8,730	1
2	53	ANESTHESIOLOGY DR B					47,475	5,877	5,877	2
200		TOTAL					65,439	14,607	14,607	200



WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
--	---------------------------------------	--	---

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)						57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)						59
60	OVERTIME ALLOWANCE (from column 5, line 56)						60
61	EQUIPMENT COST (see instructions)						61
62	SUPPLIES (see instructions)						62
63	TOTAL ALLOWANCE (sum of lines 57-62)						63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)						64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)						65



WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: [] OCCUPATIONAL [XX] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)						57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)						59
60	OVERTIME ALLOWANCE (from column 5, line 56)						60
61	EQUIPMENT COST (see instructions)						61
62	SUPPLIES (see instructions)						62
63	TOTAL ALLOWANCE (sum of lines 57-62)						63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)						64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)						65



WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: [] OCCUPATIONAL [] PHYSICAL [XX] RESPIRATORY [] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)						57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)						59
60	OVERTIME ALLOWANCE (from column 5, line 56)						60
61	EQUIPMENT COST (see instructions)						61
62	SUPPLIES (see instructions)						62
63	TOTAL ALLOWANCE (sum of lines 57-62)						63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)						64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)						65



WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: [] OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [XX] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)						57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)						59
60	OVERTIME ALLOWANCE (from column 5, line 56)						60
61	EQUIPMENT COST (see instructions)						61
62	SUPPLIES (see instructions)						62
63	TOTAL ALLOWANCE (sum of lines 57-62)						63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)						64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)						65



WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	CAP RELATE COSTS SNF	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	
		0	1	2	2.01	4	4A	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	519,339	519,339					1
2	CAP REL COSTS-MVBLE EQUIP	1,292,639		1,292,639				2
2.01	SNF CAPITAL	100,224			100,224			2.01
4	EMPLOYEE BENEFITS DEPARTMENT	4,274,847				4,274,847		4
5	ADMINISTRATIVE & GENERAL	12,182,938	101,006	251,402		1,903,320	14,438,666	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	1,076,728	55,010	136,920		63,444	1,332,102	7
8	LAUNDRY & LINEN SERVICE	163,933	1,797	4,473			170,203	8
9	HOUSEKEEPING	264,018	2,148	5,347		43,162	314,675	9
10	DIETARY	123,467	9,209	22,922		19,191	174,789	10
11	CAFETERIA	309,887	10,385	25,849		47,929	394,050	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	109,960	626	1,558		23,552	135,696	13
14	CENTRAL SERVICES & SUPPLY		7,436	18,508			25,944	14
15	PHARMACY	560,850	6,445	16,041		101,738	685,074	15
16	MEDICAL RECORDS & LIBRARY		2,290	5,701			7,991	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,654,644	100,592	250,374		312,869	2,318,479	30
43	NURSERY	94,112				18,365	112,477	43
44	SKILLED NURSING FACILITY	3,124,239			96,061	479,102	3,699,402	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,209,682	61,137	152,170		189,209	1,612,198	50
52	DELIVERY ROOM & LABOR ROOM	546,319				107,363	653,682	52
53	ANESTHESIOLOGY	47,749					47,749	53
54	RADIOLOGY-DIAGNOSTIC	1,387,844	46,042	114,599		214,169	1,762,654	54
60	LABORATORY	1,183,961	12,761	31,763			1,228,485	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	477,234	11,125	27,691		87,137	603,187	65
66	PHYSICAL THERAPY	458,714	37,767	94,002	4,163	49,570	644,216	66
67	OCCUPATIONAL THERAPY	518,475				70,940	589,415	67
68	SPEECH PATHOLOGY	146,579				18,568	165,147	68
69	ELECTROCARDIOLOGY	20,231					20,231	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	599,461					599,461	71
72	IMPL. DEV. CHARGED TO PATIENTS	170,002					170,002	72
73	DRUGS CHARGED TO PATIENTS	869,940					869,940	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	97,845	17,048	42,433		17,799	175,125	90
90.01	INTENSIVE OUT PATIENT PROGRAM	78					78	90.01
91	EMERGENCY	1,235,017	33,551	83,509		241,725	1,593,802	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	1,098,291				194,768	1,293,059	95
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	35,919,247	516,375	1,285,262	100,224	4,203,920	35,837,979	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,779	1,612	4,013			22,404	190
192	PHYSICIANS' PRIVATE OFFICES	59,638				2,917	62,555	192
194	OCCUPATIONAL HEALTH	43,328					43,328	194
194.01	PAIN CLINIC							194.01
194.02	OAK POINTE	680,247				62,981	743,228	194.02
194.03	FOUNDATION	90,000					90,000	194.03
194.04	COMMUNITY & VOLUNTEER SERVICES	148,278	1,352	3,364		5,029	158,023	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)	36,957,517	519,339	1,292,639	100,224	4,274,847	36,957,517	202



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	ADMINIS- TRATIVE & GENERAL	OPERATION OF PLANT FIXTURES	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING SNF	DIETARY BENEFITS DEPARTMENT	CAFETERIA SUBTOTAL (cols.0-4)	
		5	7	8	9	10	11	
	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 DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL	14,438,666						5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	854,118	2,186,220					7
8	LAUNDRY & LINEN SERVICE	109,131	10,815	290,149				8
9	HOUSEKEEPING	201,764	12,926		529,365			9
10	DIETARY	112,071	55,415		13,565	355,840		10
11	CAFETERIA	252,657	62,492		15,298		724,497	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	87,006	3,767		922		11,555	13
14	CENTRAL SERVICES & SUPPLY	16,635	44,743		10,953			14
15	PHARMACY	439,256	38,779		9,493		32,932	15
16	MEDICAL RECORDS & LIBRARY	5,124	13,782		3,374			16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,486,565	605,288	95,336	148,172	355,840	174,480	30
43	NURSERY	72,118		4,704			8,666	43
44	SKILLED NURSING FACILITY	2,371,993						44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,033,711	367,875	48,209	90,054		92,440	50
52	DELIVERY ROOM & LABOR ROOM	419,128		879			50,264	52
53	ANESTHESIOLOGY	30,616						53
54	RADIOLOGY-DIAGNOSTIC	1,130,180	277,048	41,425	67,820		109,195	54
60	LABORATORY	787,681	76,788	352	18,797			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	386,752	66,943	2,207	16,387		49,109	65
66	PHYSICAL THERAPY	413,059	227,254	5,286	55,631		31,776	66
67	OCCUPATIONAL THERAPY	377,922		7,567			24,843	67
68	SPEECH PATHOLOGY	105,889		1,986			7,511	68
69	ELECTROCARDIOLOGY	12,972						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	384,363						71
72	IMPL. DEV. CHARGED TO PATIENTS	109,002						72
73	DRUGS CHARGED TO PATIENTS	557,789						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	112,287	102,584	1,495	25,112		8,666	90
90.01	INTENSIVE OUT PATIENT PROGRAM	50						90.01
91	EMERGENCY	1,021,916	201,886	67,352	49,421		123,060	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	829,085		13,351				95
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	13,720,840	2,168,385	290,149	524,999	355,840	724,497	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,365	9,702		2,375			190
192	PHYSICIANS' PRIVATE OFFICES	40,109						192
194	OCCUPATIONAL HEALTH	27,781						194
194.01	PAIN CLINIC							194.01
194.02	OAK POINTE	476,544						194.02
194.03	FOUNDATION	57,706						194.03
194.04	COMMUNITY & VOLUNTEER SERVICES	101,321	8,133		1,991			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)	14,438,666	2,186,220	290,149	529,365	355,840	724,497	202



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NURSING ADMINISTRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY & LINEN SERVICE 15	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	
	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 DEPARTMENT							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	238,946						13
14	CENTRAL SERVICES & SUPPLY		98,275					14
15	PHARMACY		1,790	1,207,324				15
16	MEDICAL RECORDS & LIBRARY				30,271			16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	94,701	5,855	19	2,210	5,286,945		30
43	NURSERY		302	4	403	198,674		43
44	SKILLED NURSING FACILITY		7,597			6,078,992		44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	50,172	13,487		397	3,308,543		50
52	DELIVERY ROOM & LABOR ROOM	27,281	1,699	11		1,152,944		52
53	ANESTHESIOLOGY		1			78,366		53
54	RADIOLOGY-DIAGNOSTIC		3,704	1,771	10,564	3,404,361		54
60	LABORATORY					2,112,103		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		3,533			1,128,118		65
66	PHYSICAL THERAPY		452	117	6,935	1,384,726		66
67	OCCUPATIONAL THERAPY		648	75	3,006	1,003,476		67
68	SPEECH PATHOLOGY		169	22	360	281,084		68
69	ELECTROCARDIOLOGY					33,203		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		34,267			1,018,091		71
72	IMPL. DEV. CHARGED TO PATIENTS		9,745			288,749		72
73	DRUGS CHARGED TO PATIENTS			1,194,219		2,621,948		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		626			425,895		90
90.01	INTENSIVE OUT PATIENT PROGRAM					128		90.01
91	EMERGENCY	66,792	5,946	34	6,396	3,136,605		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES		6,578	11,052		2,153,125		95
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	238,946	96,399	1,207,324	30,271	35,096,076		118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					48,846		190
192	PHYSICIANS' PRIVATE OFFICES		393			103,057		192
194	OCCUPATIONAL HEALTH					71,109		194
194.01	PAIN CLINIC							194.01
194.02	OAK POINTE		1,464			1,221,236		194.02
194.03	FOUNDATION					147,706		194.03
194.04	COMMUNITY & VOLUNTEER SERVICES		19			269,487		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)	238,946	98,275	1,207,324	30,271	36,957,517		202



WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	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 DEPARTMENT					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 SERVICES-SALARY & FRINGES APPRVD					21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					22
23	PARAMED ED PRGM-(SPECIFY)					23
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS	5,286,945				30
43	NURSERY	198,674				43
44	SKILLED NURSING FACILITY	6,078,992				44
	ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	3,308,543				50
52	DELIVERY ROOM & LABOR ROOM	1,152,944				52
53	ANESTHESIOLOGY	78,366				53
54	RADIOLOGY-DIAGNOSTIC	3,404,361				54
60	LABORATORY	2,112,103				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	RESPIRATORY THERAPY	1,128,118				65
66	PHYSICAL THERAPY	1,384,726				66
67	OCCUPATIONAL THERAPY	1,003,476				67
68	SPEECH PATHOLOGY	281,084				68
69	ELECTROCARDIOLOGY	33,203				69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,018,091				71
72	IMPL. DEV. CHARGED TO PATIENTS	288,749				72
73	DRUGS CHARGED TO PATIENTS	2,621,948				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	425,895				90
90.01	INTENSIVE OUT PATIENT PROGRAM	128				90.01
91	EMERGENCY	3,136,605				91
92	OBSERVATION BEDS (NON-DISTINCT PART)					92
	OTHER REIMBURSABLE COST CENTERS					
95	AMBULANCE SERVICES	2,153,125				95
	SPECIAL PURPOSE COST CENTERS					
118	SUBTOTALS (sum of lines 1-117)	35,096,076				118
	NONREIMBURSABLE COST CENTERS					
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	48,846				190
192	PHYSICIANS' PRIVATE OFFICES	103,057				192
194	OCCUPATIONAL HEALTH	71,109				194
194.01	PAIN CLINIC					194.01
194.02	OAK POINTE	1,221,236				194.02
194.03	FOUNDATION	147,706				194.03
194.04	COMMUNITY & VOLUNTEER SERVICES	269,487				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)	36,957,517				202



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	CAP RELATE COSTS SNF	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	
		0	1	2	2.01	2A	5	
	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 DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL	3,828,630	101,006	251,402		4,181,038	4,181,038	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		55,010	136,920		191,930	247,329	7
8	LAUNDRY & LINEN SERVICE		1,797	4,473		6,270	31,601	8
9	HOUSEKEEPING		2,148	5,347		7,495	58,425	9
10	DIETARY		9,209	22,922		32,131	32,453	10
11	CAFETERIA		10,385	25,849		36,234	73,162	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		626	1,558		2,184	25,194	13
14	CENTRAL SERVICES & SUPPLY		7,436	18,508		25,944	4,817	14
15	PHARMACY		6,445	16,041		22,486	127,196	15
16	MEDICAL RECORDS & LIBRARY		2,290	5,701		7,991	1,484	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		100,592	250,374		350,966	430,467	30
43	NURSERY						20,883	43
44	SKILLED NURSING FACILITY				96,061	96,061	686,869	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		61,137	152,170		213,307	299,334	50
52	DELIVERY ROOM & LABOR ROOM						121,368	52
53	ANESTHESIOLOGY						8,865	53
54	RADIOLOGY-DIAGNOSTIC		46,042	114,599		160,641	327,268	54
60	LABORATORY		12,761	31,763		44,524	228,090	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		11,125	27,691		38,816	111,993	65
66	PHYSICAL THERAPY		37,767	94,002	4,163	135,932	119,610	66
67	OCCUPATIONAL THERAPY						109,436	67
68	SPEECH PATHOLOGY						30,663	68
69	ELECTROCARDIOLOGY						3,756	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						111,301	71
72	IMPL. DEV. CHARGED TO PATIENTS						31,564	72
73	DRUGS CHARGED TO PATIENTS						161,520	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		17,048	42,433		59,481	32,515	90
90.01	INTENSIVE OUT PATIENT PROGRAM						14	90.01
91	EMERGENCY		33,551	83,509		117,060	295,918	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES						240,080	95
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	3,828,630	516,375	1,285,262	100,224	5,730,491	3,973,175	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		1,612	4,013		5,625	4,160	190
192	PHYSICIANS' PRIVATE OFFICES						11,614	192
194	OCCUPATIONAL HEALTH						8,045	194
194.01	PAIN CLINIC							194.01
194.02	OAK POINTE						137,994	194.02
194.03	FOUNDATION						16,710	194.03
194.04	COMMUNITY & VOLUNTEER SERVICES		1,352	3,364		4,716	29,340	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)	3,828,630	519,339	1,292,639	100,224	5,740,832	4,181,038	202



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT COSTS 7	LAUNDRY & LINEN SERVICE 8	HOUSE-KEEPING EQUIPMENT 9	DIETARY COSTS SNF 10	CAFETERIA SUBTOTAL 11	NURSING ADMINISTRATION 13	
	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 DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	439,259						7
8	LAUNDRY & LINEN SERVICE	2,173	40,044					8
9	HOUSEKEEPING	2,597		68,517				9
10	DIETARY	11,134		1,756	77,474			10
11	CAFETERIA	12,556		1,980		123,932		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	757		119		1,977	30,231	13
14	CENTRAL SERVICES & SUPPLY	8,990		1,418				14
15	PHARMACY	7,792		1,229		5,633		15
16	MEDICAL RECORDS & LIBRARY	2,769		437				16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	121,617	13,158	19,178	77,474	29,846	11,981	30
43	NURSERY		649			1,482		43
44	SKILLED NURSING FACILITY							44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	73,914	6,653	11,656		15,813	6,348	50
52	DELIVERY ROOM & LABOR ROOM		121			8,598	3,452	52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	55,665	5,717	8,778		18,679		54
60	LABORATORY	15,428	49	2,433				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	13,450	305	2,121		8,400		65
66	PHYSICAL THERAPY	45,660	730	7,200		5,436		66
67	OCCUPATIONAL THERAPY		1,044			4,250		67
68	SPEECH PATHOLOGY		274			1,285		68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							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	20,611	206	3,250		1,482		90
90.01	INTENSIVE OUT PATIENT PROGRAM							90.01
91	EMERGENCY	40,563	9,295	6,397		21,051	8,450	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES		1,843					95
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	435,676	40,044	67,952	77,474	123,932	30,231	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,949		307				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	1,634		258				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)	439,259	40,044	68,517	77,474	123,932	30,231	202



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY & LINEN SERVICE	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		14	15	16	24	25	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 DEPARTMENT							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	41,169						14
15	PHARMACY	750	165,086					15
16	MEDICAL RECORDS & LIBRARY			12,681				16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	2,453	3	926	1,058,069		1,058,069	30
43	NURSERY	127	1	169	23,311		23,311	43
44	SKILLED NURSING FACILITY	3,182			786,112		786,112	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	5,650		166	632,841		632,841	50
52	DELIVERY ROOM & LABOR ROOM	712	1		134,252		134,252	52
53	ANESTHESIOLOGY				8,865		8,865	53
54	RADIOLOGY-DIAGNOSTIC	1,552	242	4,426	582,968		582,968	54
60	LABORATORY				290,524		290,524	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	1,480			176,565		176,565	65
66	PHYSICAL THERAPY	190	16	2,905	317,679		317,679	66
67	OCCUPATIONAL THERAPY	271	10	1,259	116,270		116,270	67
68	SPEECH PATHOLOGY	71	3	151	32,447		32,447	68
69	ELECTROCARDIOLOGY				3,756		3,756	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,354			125,655		125,655	71
72	IMPL. DEV. CHARGED TO PATIENTS	4,082			35,646		35,646	72
73	DRUGS CHARGED TO PATIENTS		163,294		324,814		324,814	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	262			117,807		117,807	90
90.01	INTENSIVE OUT PATIENT PROGRAM				14		14	90.01
91	EMERGENCY	2,491	5	2,679	503,909		503,909	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	2,756	1,511		246,190		246,190	95
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	40,383	165,086	12,681	5,517,694		5,517,694	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				12,041		12,041	190
192	PHYSICIANS' PRIVATE OFFICES	165			11,779		11,779	192
194	OCCUPATIONAL HEALTH				8,045		8,045	194
194.01	PAIN CLINIC							194.01
194.02	OAK POINTE	613			138,607		138,607	194.02
194.03	FOUNDATION				16,710		16,710	194.03
194.04	COMMUNITY & VOLUNTEER SERVICES	8			35,956		35,956	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)	41,169	165,086	12,681	5,740,832		5,740,832	202



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	CAP RELATE COSTS SNF SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	
		1	2	2.01	4	5A	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	109,514						1
2	CAP REL COSTS-MVBLE EQUIP		109,514					2
2.01	SNF CAPITAL			26,287				2.01
4	EMPLOYEE BENEFITS DEPARTMENT				19,920,912			4
5	ADMINISTRATIVE & GENERAL	21,299	21,299		8,869,533	-14,438,666	22,518,851	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	11,600	11,600		295,653		1,332,102	7
8	LAUNDRY & LINEN SERVICE	379	379				170,203	8
9	HOUSEKEEPING	453	453		201,134		314,675	9
10	DIETARY	1,942	1,942		89,430		174,789	10
11	CAFETERIA	2,190	2,190		223,349		394,050	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	132	132		109,755		135,696	13
14	CENTRAL SERVICES & SUPPLY	1,568	1,568				25,944	14
15	PHARMACY	1,359	1,359		474,101		685,074	15
16	MEDICAL RECORDS & LIBRARY	483	483				7,991	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	21,212	21,212		1,457,977		2,318,479	30
43	NURSERY				85,582		112,477	43
44	SKILLED NURSING FACILITY			25,195	2,232,627		3,699,402	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	12,892	12,892		881,720		1,612,198	50
52	DELIVERY ROOM & LABOR ROOM				500,313		653,682	52
53	ANESTHESIOLOGY						47,749	53
54	RADIOLOGY-DIAGNOSTIC	9,709	9,709		998,035		1,762,654	54
60	LABORATORY	2,691	2,691				1,228,485	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	2,346	2,346		406,061		603,187	65
66	PHYSICAL THERAPY	7,964	7,964	1,092	230,997		644,216	66
67	OCCUPATIONAL THERAPY				330,581		589,415	67
68	SPEECH PATHOLOGY				86,528		165,147	68
69	ELECTROCARDIOLOGY						20,231	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						599,461	71
72	IMPL. DEV. CHARGED TO PATIENTS						170,002	72
73	DRUGS CHARGED TO PATIENTS						869,940	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		82,943		175,125	90
90.01	INTENSIVE OUT PATIENT PROGRAM						78	90.01
91	EMERGENCY	7,075	7,075		1,126,445		1,593,802	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES				907,624		1,293,059	95
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	108,889	108,889	26,287	19,590,388	-14,438,666	21,399,313	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	340	340				22,404	190
192	PHYSICIANS' PRIVATE OFFICES				13,595		62,555	192
194	OCCUPATIONAL HEALTH						43,328	194
194.01	PAIN CLINIC							194.01
194.02	OAK POINTE				293,492		743,228	194.02
194.03	FOUNDATION						90,000	194.03
194.04	COMMUNITY & VOLUNTEER SERVICES	285	285		23,437		158,023	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	519,339	1,292,639	100,224	4,274,847		14,438,666	202
203	UNIT COST MULT-WS B PT I	4,742,216	11,803,413	3,812,683	0,214,591		0,641,181	203
204	COST TO BE ALLOC PER B PT II						4,181,038	204
205	UNIT COST MULT-WS B PT II						0,185,668	205



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT FIXTURES SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SNF SQUARE FEET	DIETARY BENEFITS DEPARTMENT MEALS SERVED	CAFETERIA RECON-CILIATION FTES	NURSING ADMINIS-TRATION DIRECT NRSING HRS	
		7	8	9	10	11	13	
	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 DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	76,615						7
8	LAUNDRY & LINEN SERVICE	379	197,054					8
9	HOUSEKEEPING	453		75,783				9
10	DIETARY	1,942		1,942	16,472			10
11	CAFETERIA	2,190		2,190		1,254		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	132		132		20	762	13
14	CENTRAL SERVICES & SUPPLY	1,568		1,568				14
15	PHARMACY	1,359		1,359		57		15
16	MEDICAL RECORDS & LIBRARY	483		483				16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	21,212	64,747	21,212	16,472	302	302	30
43	NURSERY		3,195			15		43
44	SKILLED NURSING FACILITY							44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	12,892	32,741	12,892		160	160	50
52	DELIVERY ROOM & LABOR ROOM		597			87	87	52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	9,709	28,134	9,709		189		54
60	LABORATORY	2,691	239	2,691				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	2,346	1,499	2,346		85		65
66	PHYSICAL THERAPY	7,964	3,590	7,964		55		66
67	OCCUPATIONAL THERAPY		5,139			43		67
68	SPEECH PATHOLOGY		1,349			13		68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							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	1,015	3,595		15		90
90.01	INTENSIVE OUT PATIENT PROGRAM							90.01
91	EMERGENCY	7,075	45,742	7,075		213	213	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES		9,067					95
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	75,990	197,054	75,158	16,472	1,254	762	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	340		340				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	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	2,186,220	290,149	529,365	355,840	724,497	238,946	202
203	UNIT COST MULT-WS B PT I	28,535,143	1,472,434	6,985,274	21,602,720	577,748,804	313,577,428	203
204	COST TO BE ALLOC PER B PT II	439,259	40,044	68,517	77,474	123,932	30,231	204
205	UNIT COST MULT-WS B PT II	5,733,329	0,203,213	0,904,121	4,703,375	98,829,346	39,673,228	205



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY & LINEN SERVICE COSTED REQUIS.	MEDICAL RECORDS & LIBRARY TIME SPENT				
	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 DEPARTMENT						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	1,714,427					14
15	PHARMACY	31,235	885,624				15
16	MEDICAL RECORDS & LIBRARY			10,000			16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	102,134	14	730			30
43	NURSERY	5,275	3	133			43
44	SKILLED NURSING FACILITY	132,526					44
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	235,279		131			50
52	DELIVERY ROOM & LABOR ROOM	29,634	8				52
53	ANESTHESIOLOGY	12					53
54	RADIOLOGY-DIAGNOSTIC	64,611	1,299	3,490			54
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	61,630					65
66	PHYSICAL THERAPY	7,892	86	2,291			66
67	OCCUPATIONAL THERAPY	11,296	55	993			67
68	SPEECH PATHOLOGY	2,955	16	119			68
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	597,816					71
72	IMPL. DEV. CHARGED TO PATIENTS	170,002					72
73	DRUGS CHARGED TO PATIENTS		876,011				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	10,915					90
90.01	INTENSIVE OUT PATIENT PROGRAM						90.01
91	EMERGENCY	103,730	25	2,113			91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	114,759	8,107				95
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,681,701	885,624	10,000			118
NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192	PHYSICIANS' PRIVATE OFFICES	6,858					192
194	OCCUPATIONAL HEALTH						194
194.01	PAIN CLINIC						194.01
194.02	OAK POINTE	25,542					194.02
194.03	FOUNDATION						194.03
194.04	COMMUNITY & VOLUNTEER SERVICES	326					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	98,275	1,207,324	30,271			202
203	UNIT COST MULT-WS B PT I	0.057322	1.363247	3.027100			203
204	COST TO BE ALLOC PER B PT II	41,169	165,086	12,681			204
205	UNIT COST MULT-WS B PT II	0.024013	0.186406	1.268100			205



WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	COSTS			
				TOTAL COSTS	RCE DISALLOW- ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	5,286,945		5,286,945		5,286,945	30
43	NURSERY	198,674		198,674		198,674	43
44	SKILLED NURSING FACILITY	6,078,992		6,078,992		6,078,992	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	3,308,543		3,308,543		3,308,543	50
52	DELIVERY ROOM & LABOR ROOM	1,152,944		1,152,944		1,152,944	52
53	ANESTHESIOLOGY	78,366		78,366	5,877	84,243	53
54	RADIOLOGY-DIAGNOSTIC	3,404,361		3,404,361		3,404,361	54
60	LABORATORY	2,112,103		2,112,103		2,112,103	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	1,128,118		1,128,118		1,128,118	65
66	PHYSICAL THERAPY	1,384,726		1,384,726		1,384,726	66
67	OCCUPATIONAL THERAPY	1,003,476		1,003,476		1,003,476	67
68	SPEECH PATHOLOGY	281,084		281,084		281,084	68
69	ELECTROCARDIOLOGY	33,203		33,203		33,203	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,018,091		1,018,091		1,018,091	71
72	IMPL. DEV. CHARGED TO PATIENTS	288,749		288,749		288,749	72
73	DRUGS CHARGED TO PATIENTS	2,621,948		2,621,948		2,621,948	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	425,895		425,895		425,895	90
90.01	INTENSIVE OUT PATIENT PROGRAM	128		128		128	90.01
91	EMERGENCY	3,136,605		3,136,605	8,730	3,145,335	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	878,754		878,754		878,754	92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	2,153,125		2,153,125		2,153,125	95
200	SUBTOTAL (SEE INSTRUCTIONS)	35,974,830		35,974,830	14,607	35,989,437	200
201	LESS OBSERVATION BEDS	878,754		878,754		878,754	201
202	TOTAL (SEE INSTRUCTIONS)	35,096,076		35,096,076		35,110,683	202



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	5,575,408		5,575,408				30
43	NURSERY	351,064		351,064				43
44	SKILLED NURSING FACILITY	3,844,164		3,844,164				44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	2,584,009	10,874,948	13,458,957	0.245825	0.245825	0.245825	50
52	DELIVERY ROOM & LABOR ROOM	1,898,075	82,789	1,980,864	0.582041	0.582041	0.582041	52
53	ANESTHESIOLOGY	239,678	1,165,686	1,405,364	0.055762	0.055762	0.059944	53
54	RADIOLOGY-DIAGNOSTIC	2,318,878	27,664,441	29,983,319	0.113542	0.113542	0.113542	54
60	LABORATORY	1,655,260	7,351,014	9,006,274	0.234515	0.234515	0.234515	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	948,528	2,255,548	3,204,076	0.352088	0.352088	0.352088	65
66	PHYSICAL THERAPY	611,250	1,772,192	2,383,442	0.580977	0.580977	0.580977	66
67	OCCUPATIONAL THERAPY	429,102	807,628	1,236,730	0.811395	0.811395	0.811395	67
68	SPEECH PATHOLOGY	172,831	259,558	432,389	0.650072	0.650072	0.650072	68
69	ELECTROCARDIOLOGY	314,803	528,873	843,676	0.039355	0.039355	0.039355	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	561,829	1,764,515	2,326,344	0.437636	0.437636	0.437636	71
72	IMPL. DEV. CHARGED TO PATIENTS	418,771	533,935	952,706	0.303083	0.303083	0.303083	72
73	DRUGS CHARGED TO PATIENTS	3,062,734	7,216,396	10,279,130	0.255075	0.255075	0.255075	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	3,115	434,582	437,697	0.973036	0.973036	0.973036	90
90.01	INTENSIVE OUT PATIENT PROGRAM		5,790	5,790	0.022107	0.022107	0.022107	90.01
91	EMERGENCY	1,577,643	10,592,216	12,169,859	0.257736	0.257736	0.258453	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		896,789	896,789	0.979889	0.979889	0.979889	92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES		4,146,592	4,146,592	0.519252	0.519252	0.519252	95
200	SUBTOTAL (SEE INSTRUCTIONS)	26,567,142	78,353,492	104,920,634				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	26,567,142	78,353,492	104,920,634				202



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK TITLE V PPS
 APPLICABLE TITLE XVIII, PART A TEFRA
 BOXES: TITLE XIX

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26))	SWING BED ADJUSTMENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
	INPATIENT ROUTINE SERV COST CENTERS	1	2	3	4	5	6	7	
30	ADULTS & PEDIATRICS (General Routine Care)	1,058,069		1,058,069	4,759	222.33	1,183	263,016	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	23,311		23,311	621	37.54			43
44	SKILLED NURSING FACILITY	786,112		786,112	18,817	41.78	1,800	75,204	44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	1,867,492		1,867,492	24,197		2,983	338,220	200

(A) Worksheet A line numbers



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-0101

WORKSHEET D
PART II

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] TEFRA
 BOXES: [] TITLE XIX [] IRF

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
	ANCILLARY SERVICE COST CENTERS	1	2	3	4	5	
50	OPERATING ROOM	632,841	13,458,957	0.047020	359,494	16,903	50
52	DELIVERY ROOM & LABOR ROOM	134,252	1,980,864	0.067774			52
53	ANESTHESIOLOGY	8,865	1,405,364	0.006308	44,196	279	53
54	RADIOLOGY-DIAGNOSTIC	582,968	29,983,319	0.019443	911,258	17,718	54
60	LABORATORY	290,524	9,006,274	0.032258	581,090	18,745	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	176,565	3,204,076	0.055106	284,883	15,699	65
66	PHYSICAL THERAPY	317,679	2,383,442	0.133286	45,666	6,087	66
67	OCCUPATIONAL THERAPY	116,270	1,236,730	0.094014	14,172	1,332	67
68	SPEECH PATHOLOGY	32,447	432,389	0.075041			68
69	ELECTROCARDIOLOGY	3,756	843,676	0.004452	224,965	1,002	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	125,655	2,326,344	0.054014	119,405	6,450	71
72	IMPL. DEV. CHARGED TO PATIENTS	35,646	952,706	0.037416	93,720	3,507	72
73	DRUGS CHARGED TO PATIENTS	324,814	10,279,130	0.031599	821,424	25,956	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	117,807	437,697	0.269152	866	233	90
90.01	INTENSIVE OUT PATIENT PROGRAM	14	5,790	0.002418			90.01
91	EMERGENCY	503,909	12,169,859	0.041406	482,286	19,970	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	175,864	896,789	0.196104			92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
200	TOTAL (sum of lines 50-199)	3,579,876	91,003,406		3,983,425	133,881	200

(A) Worksheet A line numbers



WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK TITLE V PPS
 APPLICABLE TITLE XVIII, PART A TEFRA
 BOXES: TITLE XIX

(A)	COST CENTER DESCRIPTION	NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUSTMENT AMOUNT (see instructions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)
		1	2	3	4	5
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)					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 (lines 30-199)					200

(A) Worksheet A line numbers



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK TITLE V PPS
 APPLICABLE TITLE XVIII, PART A TEFRA
 BOXES: TITLE XIX

(A)	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS	PER DIEM (col. 5 ÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
6		7		8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	4,759		1,183		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	621				43
44	SKILLED NURSING FACILITY	18,817		1,800		44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	24,197		2,983		200

(A) Worksheet A line numbers



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0101

WORKSHEET D
PART IV

CHECK TITLE V HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX IRF NF

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS	NON PHYSICIAN ANESTHETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPATIENT COST (sum of col. 2, 3, and 4)	
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 CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							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
90.01	INTENSIVE OUT PATIENT PROGRAM							90.01
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0101

WORKSHEET D
PART IV

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] SNF [] TEFRA
 BOXES: [] TITLE XIX [] IRF [] NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	13,458,957			359,494		1,849,055	50
52	DELIVERY ROOM & LABOR ROOM	1,980,864						52
53	ANESTHESIOLOGY	1,405,364			44,196		190,157	53
54	RADIOLOGY-DIAGNOSTIC	29,983,319			911,258		5,398,252	54
60	LABORATORY	9,006,274			581,090		192,872	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	3,204,076			284,883		259,171	65
66	PHYSICAL THERAPY	2,383,442			45,666			66
67	OCCUPATIONAL THERAPY	1,236,730			14,172			67
68	SPEECH PATHOLOGY	432,389						68
69	ELECTROCARDIOLOGY	843,676			224,965		389,318	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,326,344			119,405		201,570	71
72	IMPL. DEV. CHARGED TO PATIENTS	952,706			93,720		48,122	72
73	DRUGS CHARGED TO PATIENTS	10,279,130			821,424		1,915,945	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	437,697			866		90,962	90
90.01	INTENSIVE OUT PATIENT PROGRAM	5,790						90.01
91	EMERGENCY	12,169,859			482,286		2,048,852	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	896,789					190,737	92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)	91,003,406			3,983,425		12,775,013	200

(A) Worksheet A line numbers



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-0101

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [XX] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF
 BOXES: [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COST		
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	0.245825	1,849,055			454,544		50
52	DELIVERY ROOM & LABOR ROOM	0.582041						52
53	ANESTHESIOLOGY	0.055762	190,157			10,604		53
54	RADIOLOGY-DIAGNOSTIC	0.113542	5,398,252			612,928		54
60	LABORATORY	0.234515	192,872			45,231		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	0.352088	259,171			91,251		65
66	PHYSICAL THERAPY	0.580977						66
67	OCCUPATIONAL THERAPY	0.811395						67
68	SPEECH PATHOLOGY	0.650072						68
69	ELECTROCARDIOLOGY	0.039355	389,318			15,322		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.437636	201,570			88,214		71
72	IMPL. DEV. CHARGED TO PATIENTS	0.303083	48,122			14,585		72
73	DRUGS CHARGED TO PATIENTS	0.255075	1,915,945			488,710		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	0.973036	90,962			88,509		90
90.01	INTENSIVE OUT PATIENT PROGRAM	0.022107						90.01
91	EMERGENCY	0.257736	2,048,852			528,063		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.979889	190,737			186,901		92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	0.519252						95
200	SUBTOTAL (see instructions)		12,775,013			2,624,862		200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)		12,775,013			2,624,862		202

(A) Worksheet A line numbers



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-5128

WORKSHEET D
PART IV

CHECK TITLE V HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX IRF NF

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS	NON PHYSICIAN ANESTHETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPATIENT COST (sum of col. 2, 3, and 4)	
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 CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							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
90.01	INTENSIVE OUT PATIENT PROGRAM							90.01
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-5128

WORKSHEET D
PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [XX] SNF [] TEFRA
 BOXES: [] TITLE XIX [] IRF [] NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	13,458,957						50
52	DELIVERY ROOM & LABOR ROOM	1,980,864						52
53	ANESTHESIOLOGY	1,405,364						53
54	RADIOLOGY-DIAGNOSTIC	29,983,319				510		54
60	LABORATORY	9,006,274				2,063		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	3,204,076						65
66	PHYSICAL THERAPY	2,383,442				156,450		66
67	OCCUPATIONAL THERAPY	1,236,730				137,660		67
68	SPEECH PATHOLOGY	432,389				59,740		68
69	ELECTROCARDIOLOGY	843,676						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,326,344						71
72	IMPL. DEV. CHARGED TO PATIENTS	952,706						72
73	DRUGS CHARGED TO PATIENTS	10,279,130				55,080		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	437,697						90
90.01	INTENSIVE OUT PATIENT PROGRAM	5,790						90.01
91	EMERGENCY	12,169,859						91
92	OBSERVATION BEDS (NON-DISTINCT PART)	896,789						92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)	91,003,406				411,503		200

(A) Worksheet A line numbers



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-5128

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [XX] TITLE XVIII, PART B [] IPF [XX] SNF [] SWING BED NF
 BOXES: [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST		
			PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	0.245825						50
52	DELIVERY ROOM & LABOR ROOM	0.582041						52
53	ANESTHESIOLOGY	0.055762						53
54	RADIOLOGY-DIAGNOSTIC	0.113542						54
60	LABORATORY	0.234515						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	0.352088						65
66	PHYSICAL THERAPY	0.580977						66
67	OCCUPATIONAL THERAPY	0.811395						67
68	SPEECH PATHOLOGY	0.650072						68
69	ELECTROCARDIOLOGY	0.039355						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.437636						71
72	IMPL. DEV. CHARGED TO PATIENTS	0.303083						72
73	DRUGS CHARGED TO PATIENTS	0.255075						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	0.973036						90
90.01	INTENSIVE OUT PATIENT PROGRAM	0.022107						90.01
91	EMERGENCY	0.257736						91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.979889						92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	0.519252						95
200	SUBTOTAL (see instructions)							200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)							202

(A) Worksheet A line numbers



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK TITLE V PPS
 APPLICABLE TITLE XVIII, PART A TEFRA
 BOXES: TITLE XIX

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26))	SWING BED ADJUSTMENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
	INPATIENT ROUTINE SERV COST CENTERS	1	2	3	4	5	6	7	
30	ADULTS & PEDIATRICS (General Routine Care)	1,058,069		1,058,069	4,759	222.33	162	36,017	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	23,311		23,311	621	37.54	69	2,590	43
44	SKILLED NURSING FACILITY	786,112		786,112	18,817	41.78	9,880	412,786	44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	1,867,492		1,867,492	24,197		10,111	451,393	200

(A) Worksheet A line numbers



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-0101

WORKSHEET D
PART II

CHECK TITLE V HOSPITAL SUB (OTHER) PPS
 APPLICABLE TITLE XVIII, PART A IPF TEFRA
 BOXES: TITLE XIX IRF

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)
		1	2	3	4	5
	ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	632,841	13,458,957	0.047020		50
52	DELIVERY ROOM & LABOR ROOM	134,252	1,980,864	0.067774		52
53	ANESTHESIOLOGY	8,865	1,405,364	0.006308		53
54	RADIOLOGY-DIAGNOSTIC	582,968	29,983,319	0.019443		54
60	LABORATORY	290,524	9,006,274	0.032258		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	RESPIRATORY THERAPY	176,565	3,204,076	0.055106		65
66	PHYSICAL THERAPY	317,679	2,383,442	0.133286		66
67	OCCUPATIONAL THERAPY	116,270	1,236,730	0.094014		67
68	SPEECH PATHOLOGY	32,447	432,389	0.075041		68
69	ELECTROCARDIOLOGY	3,756	843,676	0.004452		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	125,655	2,326,344	0.054014		71
72	IMPL. DEV. CHARGED TO PATIENTS	35,646	952,706	0.037416		72
73	DRUGS CHARGED TO PATIENTS	324,814	10,279,130	0.031599		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	117,807	437,697	0.269152		90
90.01	INTENSIVE OUT PATIENT PROGRAM	14	5,790	0.002418		90.01
91	EMERGENCY	503,909	12,169,859	0.041406		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	175,864	896,789	0.196104		92
	OTHER REIMBURSABLE COST CENTERS					
95	AMBULANCE SERVICES					95
200	TOTAL (sum of lines 50-199)	3,579,876	91,003,406			200

(A) Worksheet A line numbers



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK TITLE V PPS
 APPLICABLE TITLE XVIII, PART A TEFRA
 BOXES: TITLE XIX

(A)	COST CENTER DESCRIPTION	NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUSTMENT AMOUNT (see instructions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)
		1	2	3	4	5
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)					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 (lines 30-199)					200

(A) Worksheet A line numbers



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK TITLE V PPS
 APPLICABLE TITLE XVIII, PART A TEFRA
 BOXES: TITLE XIX

(A)	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS	PER DIEM (col. 5 ÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
6		7		8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	4,759		162		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	621		69		43
44	SKILLED NURSING FACILITY	18,817		9,880		44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	24,197		10,111		200

(A) Worksheet A line numbers



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0101

WORKSHEET D
PART IV

CHECK TITLE V HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX IRF NF

(A)	COST CENTER DESCRIPTION	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 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 CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							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
90.01	INTENSIVE OUT PATIENT PROGRAM							90.01
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0101

WORKSHEET D
PART IV

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII, PART A [] IPF [] SNF [] TEFRA
 BOXES: [XX] TITLE XIX [] IRF [] NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	13,458,957						50
52	DELIVERY ROOM & LABOR ROOM	1,980,864						52
53	ANESTHESIOLOGY	1,405,364						53
54	RADIOLOGY-DIAGNOSTIC	29,983,319						54
60	LABORATORY	9,006,274						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	3,204,076						65
66	PHYSICAL THERAPY	2,383,442						66
67	OCCUPATIONAL THERAPY	1,236,730						67
68	SPEECH PATHOLOGY	432,389						68
69	ELECTROCARDIOLOGY	843,676						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,326,344						71
72	IMPL. DEV. CHARGED TO PATIENTS	952,706						72
73	DRUGS CHARGED TO PATIENTS	10,279,130						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	437,697						90
90.01	INTENSIVE OUT PATIENT PROGRAM	5,790						90.01
91	EMERGENCY	12,169,859						91
92	OBSERVATION BEDS (NON-DISTINCT PART)	896,789						92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)	91,003,406						200

(A) Worksheet A line numbers



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-0101

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF
 BOXES: [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST		
			PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	0.245825						50
52	DELIVERY ROOM & LABOR ROOM	0.582041						52
53	ANESTHESIOLOGY	0.055762						53
54	RADIOLOGY-DIAGNOSTIC	0.113542						54
60	LABORATORY	0.234515						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	0.352088						65
66	PHYSICAL THERAPY	0.580977						66
67	OCCUPATIONAL THERAPY	0.811395						67
68	SPEECH PATHOLOGY	0.650072						68
69	ELECTROCARDIOLOGY	0.039355						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.437636						71
72	IMPL. DEV. CHARGED TO PATIENTS	0.303083						72
73	DRUGS CHARGED TO PATIENTS	0.255075						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	0.973036						90
90.01	INTENSIVE OUT PATIENT PROGRAM	0.022107						90.01
91	EMERGENCY	0.257736						91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.979889						92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	0.519252						95
200	SUBTOTAL (see instructions)							200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)							202

(A) Worksheet A line numbers



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0101

WORKSHEET D-1
PART I

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] SNF [] TEFRA
 BOXES: [] TITLE XIX - I/P [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	4,759	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	4,759	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	3,968	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 (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	1,183	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)	5,286,945	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	5,286,945	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation 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)	5,286,945	37



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WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0101

WORKSHEET D-1
PART II

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] TEFRA
 BOXES: [] TITLE XIX - I/P [] IRF [] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
		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		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					1,110.94	38	
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					1,314,242	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)					1,314,242	41	
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	

							1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					893,626	48	
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					2,207,868	49	

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					263,016	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					133,881	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					396,897	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					1,810,971	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 (line 56 minus line 53)						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 (line 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



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WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0101

WORKSHEET D-1
PARTS III & IV

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX - I/P IRF NF OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					791	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					1,110.94	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					878,754	89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERVATION BED COST (from line 89)	OBSERVATION BED PASS-THROUGH COST col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	CAPITAL-RELATED COST	1,058,069	5,286,945	0.200129	878,754	175,864	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-5128

WORKSHEET D-1
PART I

CHECK [] TITLE V - I/P [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [XX] SNF [] TEFRA
 BOXES: [] TITLE XIX - I/P [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	18,817	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	18,817	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	18,817	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 (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	1,800	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)	6,078,992	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	6,078,992	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation 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)	6,078,992	37



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WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-5128

WORKSHEET D-1
PARTS III & IV

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX - I/P IRF NF OTHER

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

70	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST (line 37)	6,078,992	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (line 70 ÷ line 2)	323.06	71
72	PROGRAM ROUTINE SERVICE COST (line 9 x line 71)	581,508	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)	581,508	74
75	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS (from Worksheet B, Part II, column 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)	581,508	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (see instructions)	256,018	84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (see instructions)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (sum of lines 83 through 85)	837,526	86



WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0101

WORKSHEET D-1
PART I

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII, PART A [] IPF [] SNF [] TEFRA
 BOXES: [XX] TITLE XIX - I/P [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	4,759	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	4,759	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	3,968	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 (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	162	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)	621	15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)	69	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)	5,286,945	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	5,286,945	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation 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)	5,286,945	37



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WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0101

WORKSHEET D-1
PART II

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII, PART A [] IPF [] TEFRA
 BOXES: [XX] TITLE XIX - I/P [] IRF [] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
		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		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					1,110.94	38	
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					179,972	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)					179,972	41	
42	NURSERY (Titles V and XIX only)	198,674	621	319.93	69	22,075	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	

							1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)						48	
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					202,047	49	

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					38,607	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)						51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					38,607	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					163,440	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 (line 56 minus line 53)						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 (line 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



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WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0101

WORKSHEET D-1
PARTS III & IV

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX - I/P IRF NF OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					791	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
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERVATION BED COST (from line 89)	OBSERVATION BED PASS-THROUGH COST col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



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WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-0101

WORKSHEET D-3

CHECK [] TITLE V - O/P [XX] HOSPITAL [] SUB (OTHER) [] SWING BED SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF [] TEFRA
 BOXES: [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR [] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		1,471,605		30
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.245825	359,494	88,373	50
52	DELIVERY ROOM & LABOR ROOM	0.582041			52
53	ANESTHESIOLOGY	0.059944	44,196	2,649	53
54	RADIOLOGY-DIAGNOSTIC	0.113542	911,258	103,466	54
60	LABORATORY	0.234515	581,090	136,274	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.352088	284,883	100,304	65
66	PHYSICAL THERAPY	0.580977	45,666	26,531	66
67	OCCUPATIONAL THERAPY	0.811395	14,172	11,499	67
68	SPEECH PATHOLOGY	0.650072			68
69	ELECTROCARDIOLOGY	0.039355	224,965	8,853	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.437636	119,405	52,256	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.303083	93,720	28,405	72
73	DRUGS CHARGED TO PATIENTS	0.255075	821,424	209,525	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	0.973036	866	843	90
90.01	INTENSIVE OUT PATIENT PROGRAM	0.022107			90.01
91	EMERGENCY	0.258453	482,286	124,648	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.979889			92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
200	TOTAL (sum of lines 50-94, and 96-98)		3,983,425	893,626	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		3,983,425		202

(A) Worksheet A line numbers



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-5128

WORKSHEET D-3

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] SWING BED SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART B [] IPF [XX] SNF [] SWING BED NF [] TEFRA
 BOXES: [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR [] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.245825			50
52	DELIVERY ROOM & LABOR ROOM	0.582041			52
53	ANESTHESIOLOGY	0.055762			53
54	RADIOLOGY-DIAGNOSTIC	0.113542	510	58	54
60	LABORATORY	0.234515	2,063	484	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.352088			65
66	PHYSICAL THERAPY	0.580977	156,450	90,894	66
67	OCCUPATIONAL THERAPY	0.811395	137,660	111,697	67
68	SPEECH PATHOLOGY	0.650072	59,740	38,835	68
69	ELECTROCARDIOLOGY	0.039355			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.437636			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.303083			72
73	DRUGS CHARGED TO PATIENTS	0.255075	55,080	14,050	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	0.973036			90
90.01	INTENSIVE OUT PATIENT PROGRAM	0.022107			90.01
91	EMERGENCY	0.257736			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.979889			92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
200	TOTAL (sum of lines 50-94, and 96-98)		411,503	256,018	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		411,503		202

(A) Worksheet A line numbers



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-0101

WORKSHEET D-3

CHECK [] TITLE V - O/P [XX] HOSPITAL [] SUB (OTHER) [] SWING BED SNF [XX] PPS
 APPLICABLE [] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF [] TEFRA
 BOXES: [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR [] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.245825			50
52	DELIVERY ROOM & LABOR ROOM	0.582041			52
53	ANESTHESIOLOGY	0.059944			53
54	RADIOLOGY-DIAGNOSTIC	0.113542			54
60	LABORATORY	0.234515			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.352088			65
66	PHYSICAL THERAPY	0.580977			66
67	OCCUPATIONAL THERAPY	0.811395			67
68	SPEECH PATHOLOGY	0.650072			68
69	ELECTROCARDIOLOGY	0.039355			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.437636			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.303083			72
73	DRUGS CHARGED TO PATIENTS	0.255075			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	0.973036			90
90.01	INTENSIVE OUT PATIENT PROGRAM	0.022107			90.01
91	EMERGENCY	0.258453			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.979889			92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
200	TOTAL (sum of lines 50-94, and 96-98)				200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)				202

(A) Worksheet A line numbers



WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL
APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS				1
1.01	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING PRIOR TO OCTOBER 1, 2013 (see instructions)	1,363,182			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	319,873			1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4 BPCI (see instructions)				1.03
2	OUTLIER PAYMENTS FOR DISCHARGES (see instructions)	11,261			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS				3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	27.83			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)(iv) 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)	0.0244			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.2208			31
32	SUM OF LINES 30 AND 31	0.2452			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0918			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	132,481			34
			PRIOR TO OCTOBER 1	ON OR AFTER OCTOBER 1	
	UNCOMPENSATED CARE ADJUSTMENT				
35	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)			9,046,380,143	35
35.01	FACTOR 3 (see instructions)			0.000024733	35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)			223,744	35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)			56,396	35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	56,396			36
	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



WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL
APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
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)	1,883,193			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)	1,883,193			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	136,047			50
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)	2,019,240			59
60	PRIMARY PAYER PAYMENTS	1,586			60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	2,017,654			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	302,879			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES				63
64	ALLOWABLE BAD DEBTS (see instructions)	32,242			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	20,957			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	12,081			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	1,735,732			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 ADJUSTMENT FOR FEDERAL FISCAL YEAR (2013)	257,356			70.96
70.97	LOW VOLUME ADJUSTMENT FOR FEDERAL FISCAL YEAR (2014)	56,890			70.97
71	AMOUNT DUE PROVIDER (see instructions)	2,049,978			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	30,955			71.01
72	INTERIM PAYMENTS	1,910,976			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	108,047			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	241,981			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



WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	Supporting Exhibit for Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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LOW VOLUME ADJUSTMENT CALCULATION SCHEDULE (For Worksheet E Part A, Lines 70.96 and 70.97)

EXHIBIT 4

		AMOUNTS FROM E PART A	PRIOR TO 10/1/2010 OR AFTER 3/31/2015 PRE/POST ENTITLEMENT	10/01/2012 through 09/30/2013	3.01	10/01/2013 through 03/31/2014	4.01	(COLUMNS 2 THROUGH 4) TOTAL	
		1	2	3		4		5	
1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS								1
1.01	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES PRIOR TO 10/1/2013	1,363,182		1,363,182				1,363,182	1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES ON/AFTER 10/1/2013	319,873				319,873		319,873	1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4								1.03
2	OUTLIER PAYMENTS FOR DISCHARGES	11,261		11,261				11,261	2
2.01	OUTLIER PAYMENT FOR DISCHARGES FOR MODEL 4 BPCI								2.01
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	0.0918	0.0918	0.0918	0.0918	0.0918	0.0918		10
11	DISPROPORTIONATE SHARE ADJUSTMENT	132,481		125,140		7,341		132,481	11
11.01	UNCOMPENSATED CARE PAYMENTS	56,396				56,396		56,396	11.01
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES								
12	TOTAL ESRD ADDITIONAL PAYMENT								12
13	SUBTOTAL	1,883,193		1,499,583		383,610		1,883,193	13
14	HOSPITAL SPECIFIC PAYMENTS								14
15	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS - E PART A LINE 49	1,883,193		1,499,583		383,610		1,883,193	15
16	PAYMENT FOR INPATIENT PROGRAM CAPITAL	136,047		110,692		25,355		136,047	16
17	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES								17
18	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT								18
19	SUBTOTAL			1,610,275		408,965		2,019,240	19
	CAPITAL PAYMENTS								
20	CAPITAL DRG OTHER THAN OUTLIER	133,400		108,045		25,355		133,400	20
20.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER								20.01
21	CAPITAL DRG OUTLIER PAYMENTS	2,647		2,647				2,647	21
21.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS								21.01
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	136,047		110,692		25,355		136,047	26
	LOW VOLUME ADJUSTMENT								
27	LOW VOLUME ADJUSTMENT FACTOR			0.159821		0.139107			27
28	LOW VOLUME ADJUSTMENT			257,356				257,356	28
29	LOW VOLUME ADJUSTMENT					56,890		56,890	29



WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-0101

WORKSHEET E
PART B

CHECK APPLICABLE BOX: HOSPITAL IPF IRF SUB (OTHER) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)				1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (see instructions)	2,624,862			2
3	PPS PAYMENTS	2,130,341			3
4	OUTLIER PAYMENT (see instructions)	15,672			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES				12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)				18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))				19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions))				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)				21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	2,146,013			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)	533,939			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)				26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	1,612,074			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	1,612,074			30
31	PRIMARY PAYER PAYMENTS	729			31
32	SUBTOTAL (line 30 minus line 31)	1,611,345			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)	61,946			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	40,265			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	35,478			36
37	SUBTOTAL (see instructions)	1,651,610			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	1,651,610			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	24,939			40.01
41	INTERIM PAYMENTS	1,652,680			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	-26,009			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY				92
93	TIME VALUE OF MONEY (see instructions)				93
94	TOTAL (sum of lines 91 and 93)				94



WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-5128

WORKSHEET E
PART B

CHECK APPLICABLE BOX: HOSPITAL IPF IRF SUB (OTHER) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)				1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (see instructions)				2
3	PPS PAYMENTS				3
4	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES				12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)				18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))				19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions))				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)				21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)				26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)				27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)				30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)				34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)				35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				36
37	SUBTOTAL (see instructions)				37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)				40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)				40.01
41	INTERIM PAYMENTS				41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)				43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY				92
93	TIME VALUE OF MONEY (see instructions)				93
94	TOTAL (sum of lines 91 and 93)				94



WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-0101

WORKSHEET E-1
PART I

CHECK HOSPITAL SUB (OTHER)
 APPLICABLE IPF SNF
 BOXES: IRF SWING BED SNF

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,910,976		1,652,680	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					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. (1)					
		.01				3.01
		.02				3.02
	PROGRAM	.03				3.03
	TO	.04				3.04
	PROVIDER	.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51				3.51
	PROVIDER	.52				3.52
	TO	.53				3.53
	PROGRAM	.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99				3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,910,976		1,652,680	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. (1)					
		.01				5.01
		.02				5.02
	PROGRAM	.03				5.03
	TO	.04				5.04
	PROVIDER	.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
	PROVIDER	.52				5.52
	TO	.53				5.53
	PROGRAM	.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)	.01	139,002			6.01
		.02			-1,070	6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)		2,049,978		1,651,610	7
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.



WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-5128

WORKSHEET E-1
PART I

CHECK HOSPITAL SUB (OTHER)
 APPLICABLE IPF SNF
 BOXES: IRF SWING BED SNF

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		644,624		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				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. (1)				
		.01			3.01
		.02			3.02
		PROGRAM .03			3.03
		TO .04			3.04
		PROVIDER .05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			3.50
		.51			3.51
		PROVIDER .52			3.52
		TO .53			3.53
		PROGRAM .54			3.54
		.55			3.55
		.56			3.56
		.57			3.57
		.58			3.58
		.59			3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99			3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		644,624		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. (1)				
		.01			5.01
		.02			5.02
		PROGRAM .03			5.03
		TO .04			5.04
		PROVIDER .05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
		PROVIDER .52			5.52
		TO .53			5.53
		PROGRAM .54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)	.01	8,530		6.01
		.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)		653,154		7
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)	
					8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.



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WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK HOSPITAL 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	1,334	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	1,183	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	1,265	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	3,968	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	104,920,634	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	2,545,798	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)	965,843	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	19,317	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	946,526	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	968,925	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-22,399	32



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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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

PROSPECTIVE PAYMENT AMOUNT (see instructions)			
1	RESOURCE UTILIZATION GROUP (RUGS) PAYMENT	742,842	1
2	ROUTINE SERVICE OTHER PASS THROUGH COSTS		2
3	ANCILLARY SERVICE OTHER PASS THROUGH COSTS		3
4	SUBTOTAL (sum of lines 1-3)	742,842	4
COMPUTATION OF NET COST OF COVERED SERVICES			
5	DO NOT USE THIS LINE		5
6	DEDUCTIBLES		6
7	COINSURANCE	89,688	7
8	ALLOWABLE BAD DEBTS (see instructions)		8
9	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)		9
10	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)		10
11	UTILIZATION REVIEW		11
12	SUBTOTAL (sum of lines 4 and 5 minus 6 & 7 plus 10 and 11) (see instructions)	653,154	12
13	INPATIENT PRIMARY PAYER PAYMENTS		13
14	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		14
15	SUBTOTAL (line 12 minus 13 ± line 14)	653,154	15
15.01	SEQUESTRATION ADJUSTMENT (see instructions)	9,863	15.01
16	INTERIM PAYMENTS	644,624	16
17	TENTATIVE SETTLEMENT (for contractor use only)		17
18	BALANCE DUE PROVIDER/PROGRAM (line 15 minus 15.01, 16 and 17)	-1,333	18
19	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		19



WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-0101

WORKSHEET E-3
PART VII

CHECK TITLE V HOSPITAL NF PPS
 APPLICABLE TITLE XIX SUB (OTHER) ICF/MR TEFRA
 BOXES: SNF OTHER

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES			1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)			4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES			9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			14
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)	1	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)			16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)			17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)			18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (sum of lines 22 through 26)			27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (from line 18)			30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)			31
32	DEDUCTIBLES			32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)			38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)			40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)			42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43



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WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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BALANCE SHEET

WORKSHEET G

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

	ASSETS (Omit Cents)	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
CURRENT ASSETS						
1	CASH ON HAND AND IN BANKS	-371				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	-4,053,522				4
5	OTHER RECEIVABLES	10,938,034				5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE					6
7	INVENTORY	208,872				7
8	PREPAID EXPENSES	17,254				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	7,110,267				11
FIXED ASSETS						
12	LAND	92,617				12
13	LAND IMPROVEMENTS	279,791				13
14	ACCUMULATED DEPRECIATION	-211,125				14
15	BUILDINGS	3,961,151				15
16	ACCUMULATED DEPRECIATION	-3,244,644				16
17	LEASEHOLD IMPROVEMENTS	48,824				17
18	ACCUMULATED AMORTIZATION	-45,307				18
19	FIXED EQUIPMENT	872,507				19
20	ACCUMULATED DEPRECIATION	-535,730				20
21	AUTOMOBILES AND TRUCKS	343,825				21
22	ACCUMULATED DEPRECIATION	-217,639				22
23	MAJOR MOVABLE EQUIPMENT	12,003,075				23
24	ACCUMULATED DEPRECIATION	-7,617,703				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)	5,729,642				30
OTHER ASSETS						
31	INVESTMENTS	46,034,903				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	6,753				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	46,041,656				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	58,881,565				36
LIABILITIES AND FUND BALANCES						
	(Omit Cents)	1	2	3	4	
CURRENT LIABILITIES						
37	ACCOUNTS PAYABLE	632,283				37
38	SALARIES, WAGES & FEES PAYABLE	865,513				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)					40
41	DEFERRED INCOME	89,476				41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	-903,911				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	683,361				45
LONG TERM LIABILITIES						
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE	191,740				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	34,182,522				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	34,374,262				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	35,057,623				51
CAPITAL ACCOUNTS						
52	GENERAL FUND BALANCE	23,823,942				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					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)	23,823,942				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	58,881,565				60



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WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		24,225,625			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		6,859,723			2
3	TOTAL (sum of line 1 and line 2)		31,085,348			3
4	ADDITIONS (credit adjustments)	-7,261,407				4
5	TO BALANCE	1				5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)		-7,261,406			10
11	SUBTOTAL (line 3 plus line 10)		23,823,942			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)		23,823,942			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD					1
2	NET INCOME (loss) (from Worksheet G-3, line 29)					2
3	TOTAL (sum of line 1 and line 2)					3
4	ADDITIONS (credit adjustments)					4
5	TO BALANCE					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)					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)					19



WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	5,672,680		5,672,680	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY	3,839,662		3,839,662	7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	9,512,342		9,512,342	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT				11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)				16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	9,512,342		9,512,342	17
18	ANCILLARY SERVICES	16,993,258		16,993,258	18
19	OUTPATIENT SERVICES		81,167,916	81,167,916	19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	26,505,600	81,167,916	107,673,516	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		43,575,366	29
30	BAD DEBT			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)			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 Worksheet G-3, line 4)		43,575,366	43



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WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	107,673,516	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	64,653,009	2
3	NET PATIENT REVENUES (line 1 minus line 2)	43,020,507	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	43,575,366	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-554,859	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	1,491,326	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		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	145,631	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS	861,597	15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	791,925	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	27,971	20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	107,353	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (CLINIC RENTAL)	152,731	24
24.01	OTHER (GAIN ON DISPOSAL OF ASSETS)	21,511	24.01
24.02	OTHER (COUNTY REIMBURSEMENT OF AMBULANCE S)	310,000	24.02
24.03	OTHER (REVENUE FROM SALE OF SCRAP)		24.03
24.04	OTHER (MISCELLANEOUS)	1,172,483	24.04
25	TOTAL OTHER INCOME (sum of lines 6-24)	5,082,528	25
26	TOTAL (line 5 plus line 25)	4,527,669	26
27	OTHER EXPENSES (UNREALIZED GAIN (LOSS))	-2,332,054	27
28	TOTAL OTHER EXPENSES (sum of line 27 and subscripts)	-2,332,054	28
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	6,859,723	29



WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 15-0101

WORKSHEET L

CHECK TITLE V HOSPITAL PPS
 APPLICABLE TITLE XVIII, PART A SUB (OTHER) COST METHOD
 BOXES: TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	133,400	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	2,647	2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	11.13	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (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 the sum of lines 1 and 1.01)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	136,047	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 (line 1 minus line 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (see instructions)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (line 3 x line 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (line 2 x line 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL (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 (from prior year Worksheet 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



COMPU-MAX

WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 15-0101

WORKSHEET L

CHECK TITLE V HOSPITAL PPS
 APPLICABLE TITLE XVIII, PART A SUB (OTHER) COST METHOD
 BOXES: TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER		1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS		2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
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 (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (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 the sum of lines 1 and 1.01)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 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 (line 1 minus line 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (see instructions)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (line 3 x line 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (line 2 x line 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL (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 (from prior year Worksheet 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



WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 16:13 Version: 2014.03
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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		0	2A	24	25	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 DEPARTMENT						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 SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-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 CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						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
90.01	INTENSIVE OUT PATIENT PROGRAM						90.01
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT PART)						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	TOTAL (sum of lines 118-201)						202