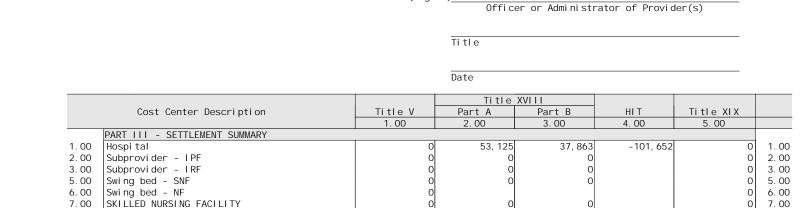
Health Financial Systems	WHIILEY MEMORIAL F	HOSPITAL	In Lieu	of Form CMS-2552-10
This report is required by law (42 USC 13	95g; 42 CFR 413.20(b)). Failu	ure to report can resu	lt in all interim	FORM APPROVED
payments made since the beginning of the	cost reporting period being o	deemed overpayments (4	2 USC 1395g).	OMB NO. 0938-0050
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX AND SETTLEMENT SUMMARY	COST REPORT CERTIFICATION	Provider CCN: 150101		Worksheet S Parts I-III Date/Time Prepared: 5/21/2015 2:33 pm
PART I – COST REPORT STATUS				
Provider 1. [X] Electronically file			Date: 5/21/201	5 Time: 2:33 pm
use only 2. [] Manually submitted	cost report			
	ed report enter the number o n. Enter "F" for full or "L"		resubmitted this co	st report
Contractor use only 5. [1]Cost Report Status (1) As Submitted (2) Settled without Audi (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. t 8. [N] Initial Report for 9. [N] Final Report for t	this Provider CCN 12.		r Code: 4 lumn 1 is 4: Enter es reopened = 0-9.
PART II - CERTIFICATION				
MISREPRESENTATION OR FALSIFICATION OF ANY ADMINISTRATIVE ACTION, FINE AND/OR IMPRIS PROVIDED OR PROCURED THROUGH THE PAYMENT ADMINISTRATIVE ACTION, FINES AND/OR IMPRI	ONMENT UNDER FEDERAL LAW. FUDIRECTLY OF A H	JRTHERMORE, IF SERVICE	S IDENTIFIED IN TH	IS REPORT WERE
CERTIFICATION BY OFFICER	OR ADMINISTRATOR OF PROVIDER	R(S)		

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WHITLEY MEMORIAL HOSPITAL (150101) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed)



200.00 Total 53, 125 0 37,863 -101,652 0 200. 00 The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

5111	AL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DATA	A F	Provider (CCN: 150101	Period: From 01/01	/2014	Workshe Part I	et S-2	2
						To 12/31		Date/Ti		
	1.00	2.0	0	3.00			4.00	5/21/20	<u>)15 2:2</u>	
	Hospital and Hospital Health Care Co									
00	Street: 1260 E STATE ROAD 205	PO Box:		0 1 4/7	05 0400					1.0
00	City: COLUMBIA CITY	State: IN Component Nam				nty: WHITLEY er Date	Payme	ent Syst	em (P	2.0
			Numb			Certified		, 0, or		
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00	Hospital and Hospital-Based Componer Hospital	WHITLEY MEMORIAL	1501	01 230	60 1	07/01/1966	N	Р	Р	3.0
00		HOSPITAL	1301	230				1	'	5. (
00	Subprovider - IPF									4.0
00	Subprovider - IRF									5.0
00 00	Subprovider - (Other) Swing Beds - SNF									7.
00	Swing Beds - NF									8.
00	Hospital-Based SNF	PARKVI EW OAKS	1551	28 230	60	02/01/1993	N	P	N	9.
. 00	Hospital-Based NF									10.
. 00 . 00	Hospi tal -Based OLTC Hospi tal -Based HHA									11.
. 00	Separately Certified ASC									13.
. 00	Hospi tal -Based Hospi ce									14.0
. 00	Hospital - Based Health Clinic - RHC									15.
00	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I									16. 17.
00	Renal Dialysis									18.
00	Other									19.
						From 1.00		To 2. (-
00	Cost Reporting Period (mm/dd/yyyy)					01/01/2		12/31/		20.
00	Type of Control (see instructions)						2			21.
	Inpatient PPS Information			<u> </u>						
00	Does this facility qualify and is it share hospital adjustment, in accord							N		22.
	for yes or "N" for no. Is this facil									
	amendment hospital?) In column 2, en	ter "Y" for yes or	"N" for no							
01	Did this hospital receive interim un					Y		Y		22.
	period? Enter in column 1, "Y" for y reporting period occurring prior to									
	for no for the portion of the cost r									
	(see instructions)									
02	Is this a newly merged hospital that determined at cost report settlement							N		22.
	or "N" for no, for the portion of th									
	in column 2, "Y" for yes or "N" for									
00	or after October 1.									0.00
03	Did this hospital receive a geograph of the OMB standards for delineating							N		22.
	in column 1, "Y" for yes or "N" for									
	prior to October 1. Enter in column					he				
	cost reporting period occurring on c hospital contain at least 100 but no					th				
	42 CFR 412.105)? Enter in column 3,				con dance wi					
. 00	Which method is used to determine Me	dicaid days on line	es 24 and/o			n	3	N		23.
	1, enter 1 if date of admission, 2 i method of identifying the days in th	f census days, or 3	3 if date o	f dischar	ge. Is the	d				
	used in the prior cost reporting per									
		1	n-State I	n-State	Out-of	Out-of !	ledi ca		ther	
				Medicaid	State Medicaid		-MO da	J	li cai d	
		þ	aid days e	eligible unpaid	paid days	Medicaid eligible			lays	
				days		unpai d				
			1.00	2.00	3.00	4.00	5.00		. 00	
00	If this provider is an IPPS hospital in-state Medicaid paid days in colum		333	69	0	4		918	87	24.
	Medicaid eligible unpaid days in col									
	out-of-state Medicaid paid days in c	olumn 3,								
	out-of-state Medicaid eligible unpai	d days in column								
	4, Medicaid HMO paid and eligible bu									
		COLUMNI D.		0	о	0		0		25.
00	column 5, and other Medicaid days in If this provider is an IRF, enter th	e in-state	0	0	01					
00	column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in column 1, the	in-state	0	0	0			-		
00	column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in column 1, the Medicaid eligible unpaid days in col	in-state umn 2,	0	0	0					
00	column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in column 1, the	in-state umn 2, 3, out-of-state	0	0	0					

Cost réporting period. Intér "1" for urban er 2" for "urban. 1 2 Cost réporting period. Intér in column 1, "1: for urban er 2" for "urban. 1 2 Cost réporting period. Intér in column 1, "1: for urban er 2" for "urban. 1 2 So Dif this is a sole community hespital (SO), enter the nubber of periods SOH status in orbital in the cost reporting period. 100 2.00 30.00 Enter applicable beginning and coming delos of SOH status. Subscript Line 36 for number of periods NH status. 0 37. 31.00 This is a Wei common thespital (MO), enter the nubber of periods NH status. 0 37. 31.00 This is a Wei common thespital (MO), enter the nubber of periods NH status. 0 37. 31.00 This is a Wei common thespital (MO), enter the nubber of periods NH status. 0 2.00 31.00 This is a Wei common the status. NN VN VN 32.00 Deschie facility geal (f) for the ingeliner hospital payeent agigstent for la volume 1. YO VN VN 32.00 Deschie facility geal (f) for the ingeliner hospital payeent agigstent for its wolume 1. YO VN VN 30.00 Es the facility geal (f) for the ingeliner hospital payeent in disporter its wolum 1. YO VN NN 30.00 Es this facility geal (f) for the ingeliner hospital payeent	Heal th	Financial Systems	WHI TLEY	MEMORI	AL HOSPITAL		1	n Lie	u of For	m CMS-2	2552-10
Col Display Status at the baginning of the status of the sage status at the baginning of the satus of the paper of the tree with the sature of the paper of the tree status	HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICA	TION DAT	ΓΑ	Provi der	F	rom 01/01/		Part I Date/Ti	me Pre	pared:
26.00 Enter your standard geographic classification (not wage) status at the beginning of the construction period. Prof. "In for urban or "2" for rundus at the mod of the construction of the geographic classification (not wage) status at the beginning of the construction of the geographic classification (not wage) status and of the construction (not wage) status at the beginning of the construction (not wage) status at the beginning of the construction (not wage) status at the beginning of the community hospital (SGU), enter the number of periods SGU status in the cost regording period. In the cost regording period. With status subscript line 36 for number of the cost regording period. SGU status subscript line 36 for number of the cost regording period. SGU status subscript line 36 for number of the cost regording period. SGU status subscript line 36 for number of the cost regording period. SGU status subscript line 36 for number of the cost regording period. SGU status subscript line 36 for number of the cost regording period. SGU status subscript line 36 for number of the cost regording period. SGU status subscript line 36 for number of the cost regording period. SGU status subscript line 36 for number of the cost regording period. SGU status subscript line 36 for number of the cost regording period. SGU status subscript line 36 for number of the cost regording period. SGU status subscript line 36 for number of the cost regording period. SGU status subscript line 36 for number of the cost regording period. SGU status subscript line 36 for number of the cost regording period. SGU status subscript line 36 for number of the cost regording period. SGU status subscript line 36 for number of the cost regording period. SGU status subscript line 36 for number of the cost regording period. SGU status subscript line 36 for number of the cost regording period. SGU status subscript line 36 for number of the cost regording period. SGU status subscripe the cost regording period. SGU							-			0	
27.00 Filter your stindard geographic classification (not wege) status at the end of the cest in applicable. 1 27.00 27.00 Filter your stindard geographic plane. For urban or "2" for urban orban or "2" for urban orban or "2" for urban or "2" for urban or "2	26.00					ginning of the	1.00	1	2.0		26.00
35.00 IPC this is a sole community hospital (3CH), enter the number of particles SPI status in 0 35. 10.00 Term applicable beginning, and enting dates of SUI status. Subscript Line is for number of particles MDI status. 100 100 10.01 Term applicable beginning, and enting dates of SUI status. Subscript Line is for number of particles MDI status. 0 100 10.02 Term applicable beginning, and enting dates of MDI status. Subscript Line is for number of particles MDI status. 0 37. 10.00 Term applicable beginning, and enting dates of MDI status. Subscript Line is for number of particles MDI status. 0 37. 10.00 Term applicable beginning, and enting dates of MDI status. Subscript Line is for number of particles MDI status. 0 0 10.00 Term applicable beginning, and enting dates of MDI status. Subscript Line is for number of particles MDI status. 0 0 10.00 Term applicable beginning, in a first status particle payment adjustment for low volume 1 'Y' for yes or 'W' for no. N N 10.00 Term and non-in column 1. 'F' for discorper prior to Status in accordance with A 2 CH 32. N N N 10.00 Term and non-in column 1. 'F' discorper prior to Status in accordance in N N N N 10.00 Term and non-in column 1. 'F' discorper prior to Status in approved in training residents in approved GME payment? Circum stance as N N<	27.00	Enter your standard geographic classification reporting period. Enter in column 1, "1" for u	(not wag urban or	ge) sta "2" fo	atus at the end or rural. If a			1			27. 00
Description The applicable beginning and ending dates of SOI status. Subscript Time 36 for number of periods in excess of one and enter subsequent dates. The interval of the applicable beginning and ending dates of SOI status. Subscript Time 36 for number of periods in excess of one and enter subsequent dates. The applicable beginning and ending dates of XOI status. Subscript Time 38 for number of periods in excess of one and enter subsequent dates. YR YR YR SOI Sol		If this is a sole community hospital (SCH), er				CH status in					35.00
36.00 Enter applicable beginning and ending dates of SOI status. Subscript line 36 for number of periods UNDI status. 0 36.00 For this is a Well care dependent hospital (WD), enter the number of periods UNDI status. 0 37.00 17 this is a Well care dependent hospital (WD), enter the number of periods UNDI status. 0 37.00 17.00 20.00 20.01								0		5	
37.00 In fifts is a Modi care dependent hospital (MDM), enter the number of periods MDM status of periods in texcess of moments of periods in excess of moments and periods in excess of me and write subsequent datas. 38.00 Enter applicable beginning and ending dates of NDM status. Subscript line 38 for number of the main subsequent datas. 39.00 100 20.00 100 100 20.00 100 100 20.00 100 100 100 20.00 100 100 20.00 100 100 20.00 100 100 20.00 100 100 20.00 100 100 20.00 100 100 20.00 100 100 20.00<	36.00				Subscript line	36 for number	1.00		2.0		36.00
of periods in excess of one and enter subsequent dates. V/II V/II V/II 30.00 boas this facility qualify for the inputient hospital payment adjustment for low volume hospitals in accordance with 42 CPR \$412.01(b) (2)(1)? Enter in column 1.1" for yss Y Y 39. 30.00 boas this facility qualify for the inputient hospital payment adjustment for low volume hospital subject to the IAC program reduction adjustment? Enter "Y for yes or "N" for non in column 2. Tor discharges prior to October 1. Enter "Y" for yes or "N" for non in column 2. Tor discharges prior to October 1. Enter "Y" for yes or "N" for non in column 2. Tor discharges on or after October 1. (see instructions) N N 40. 40.00 Is this facility qualify and receive October 1. (see instructions) V XVIII XIX 40. 40.00 Is this facility qualify and receive October 1. (see instructions) V XVIII XIX 40. 40.00 Is this a facility obtaing the Contor of the State In accordance N N N 40. 40.01 Is this a new hospital under 42 CFR \$412.300 PPS capital There "Y for yes or "N" for no. N N N 40. 50.00 Is this a new hospital under 42 CFR \$412.300 PPS capital There "Y for yes or "N" for no. N N 40.		If this is a Medicare dependent hospital (MDH)			umber of period	ds MDH status		0			37.00
Y/k Y/k Y/k Y/k Y/k Y/k Y/k Y/k Y/k Y S7	38.00				Subscript line	38 for number					38.00
39.00 Does this facility quality for the inpatient hospital payment adjustment for low volume Y Y 39.00 Does this facility quality for the inpatient hospital payment adjustment? Firther 'Y' for yeas or 'N' for no. See instructions) N N 40.00 40.00 Is this hospital subject to the M&C program reduction adjustment? Enter 'Y' for yeas or 'N' for no in column 1, for discharges prior to becteer i. Enter 'Y' for yeas or 'N' for no in column 1, for discharges prior to becteer i. Enter 'Y' for yeas or 'N' for 0.2 (200 3:00 N N 40.00 Prospective Payment System (PFS)-Capital Prospective Payment System (PFS)-Capital N N N N N 45.00 N N N N N N 46.00 No in column 2, 'Y' for yeas N N N N 47.40 No in column 2, 'Y' for yeas N N N N 47.40 No in column 2, 'Y' for yeas N N N N N 47.40 No in column 2, 'Y' for yeas N N N N N 47.40 No in column 2, 'Y' for yeas N N N N N </td <td></td> <td>of periods in excess of one and enter subseque</td> <td>ent date:</td> <td>5.</td> <td></td> <td></td> <td>Y/N</td> <td></td> <td>Y/</td> <td>N</td> <td></td>		of periods in excess of one and enter subseque	ent date:	5.			Y/N		Y/	N	
Inopin tais in accordance with 42 CFR §12.101(b)(2)(11) ² Enter in column 1 *Y* for yes N 40 0.01 St His social status in accordance with 42 See instructions) N N 40 0.01 St His social status in accordance with 42 See instructions) N N 40 0.01 St His social status in a status in accordance with 42 See instructions) N N 40 1.00 Dolum 2, for discharges on a fate October 1. Enter *Y for yes or *X* for into in accurdance with 42 V XVIII 1 XIX 1.00 2.00 3.00 45.00 Does this racility eligible for additional payment for disproprionate share in accordance in accordance with 42 N N N A 46.00 45.00 Is this an inhospital under 42 CFR §412.300 PS capital? Enter *Y for yes or *W for no. N N N 47.43 47.01 Is this a nonspital under 42 CFR §412.300 PS capital? Enter *Y for yes or *W for no. N	39.00	Does this facility qualify for the inpatient h	nosni tal	navmer	at adjustment :	For low volume					39.00
"N" for no lincolum", 1, for discharges prior to October 1. Enter "Y" for yes or "N" for in colum 2. Tor discharges on after October 1. (see instructions) V XVIII XIX 1.00 2.00 3.00 Prospective Payment System (PPS)-Capital 1.00 2.00 3.00 0.00 Des this facility qualify and receive Capital payment for disproportionate share in accordance point to 42 CFR Section \$412.340(f)? If yes, complete Wkst, L, Pt. II and Wkst, L-1, Pt. I through the thit to 42 CFR Section \$412.340(f)? If yes, complete Wkst, L, Pt. III and Wkst, L-1, Pt. I through the thit to 42 CFR Section \$412.340(f)? If yes, complete Wkst, L, Pt. III and Wkst, L-1, Pt. I through the thit to 42 CFR Section \$412.340(f)? If yes, complete Wkst, L, Pt. III and Wkst, L-1, Pt. I through the thit to 42 CFR Section \$412.340(f)? If yes, complete Wkst, L, Pt. III and Wkst, L-1, Pt. I through the through Hospital? N		hospitals in accordance with 42 CFR §412.101(b or "N" for no. Does the facility meet the mile CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" f	o)(2)(ii) eage requ for yes o)? Ente uiremer or "N"	er in column 1 nts in accorda for no. (see i	"Y" for yes nce with 42 instructions)					
Image: Prospective Payment System (PPS)-Capital 45.00 Does this facility quality and receive Capital payment for disproportionate share in accordance with 42 CFR Section 5412.320 (F) fees, complete Wkst. L. Pt. III and Wkst. L-1, Pt. I through Pt. III. N	40.00	"N" for no in column 1, for discharges prior t	to Octob	er 1. E	Enter "Y" for y		N		N		40. 00
Prospective Payment System (PFS)-Capital 6:00 Does this Facility quality and receive capital payment for disproportionate share in accordance N <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>_</td> <td></td> <td></td>									_		
with 42 CFR Section \$412.3207 (see instructions) N S								1.00) 2.00	3.00	
pursuant to 42 GFR §412.348(f)? If yes, complete Wkst L, Pt. II II and Wkst. L-1, Pt. I through Pt. III. 47.00 Is this a new hospital under 42 GFR §412.300 PPS capital? Enter "Y for yes or "N" for no. N N N N 47. 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N N N N 47. 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N N N N 47. 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N N N N 47. 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N N N N 47. 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N N N N 47. 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no loum 1. If column 1 is "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E4. If column 2 is "N", complete Wkst. D-2, Pt I. I. N 46.00 Are you claiming nursing school and/or allied heal th costs for a program that meets the provider-operated criteria under \$413.85? Enter "Y" for yes or "N" for no. (see instructions) 41.00 2.00 4.00 5.00 41.00 2.00 4.00 5.00 41.00 2.00 4.00 5.00 41.00 2.00 4.00 5.00 41.00 2.00 4.00 5.00 41.00 2.00 4.00 5.00 41.00 2.00 4.00 5.00 41.00 2.00 4.00 5.00 41.00 2.00 4.00 5.00 41.00 2.00 4.00 5.00 41.00 2.00 4.00 5.00 41.00 2.00 4.00 5.00 41.00 2.00 4.00 5.00 41.00 5.00 41.00 2.00 4.00 5.00 41.00 5.00 41.00 5.00 41.00 5.00 41.00 5.00 41.00 5.00 41.00 5.00 41.00 5.00 41.00 5.00 41.00 5.00 41.00 5.00 41.00 5.00 41.00 5.00 41.00 5.00 41.00 5.00 41.00 5.00 41.00 5.00 41.00 41.00 5.00 41.00 5.00 41.00 5.00 41.00 5.00 41.00 5.00 41.00 5.00 41.00 5.00 41.00 5.00 41.00 5.00 41.00 41.00 5.0		with 42 CFR Section §412.320? (see instruction	ns)								45.00 46.00
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N Status		pursuant to 42 CFR §412.348(f)? If yes, comple Pt. III.	ete Wkst	. L, P1	t. III and Wks [.]	t. L-1, Pt. I	through				
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes N 56.00 60 If line 56 is yes, is this the first cost reporting period during which residents in approved N 57.00 60 If line 56 is yes, is this the first cost reporting period during which residents in approved N S7.00 61 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 1. If column 2 is "N", complete Wist. D. 57.00 S8.00 If line 56 is yes, did this facility? experiment for physiclans' services as defined in CMS Pub. 15-1, § 21487 If yes, complete Wist. D-2, Pt. I. N S8.00 59.00 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 59.00 61.00 Did your hospital receive FTE slots under ACA so a complete Wist. D-2, Pt. I. N N 60.00 61.01 Did your hospital receive FTE slots under ACA so a program that meets the ending and submitted before March 23, 2010. (see instructions) N 0.00 0.00 0.00 0.00 61.00 61.02 Enter the average number of unweighted primary care ending and submitted before March 23, 2010. (see N		Is the facility electing full federal capital						1			47.00 48.00
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved N GWE programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 2 is "," 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 "," complete Worksheet E-4. If column 2 is "," complete Wst. D, Parts III & IV and D-2, Pt. 11, if applicable. 58. 58.00 If line 56 is yes, did this facility; elect cost reimbursement for physicians' services as defined in CMS photo 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 59. 61.00 Did your hospital receive FTE slots under ACA set in 5032 from yes or "N" for no in column 1. (see instructions) N 0.00 0.00 61.00 Did your hospital receive FTE slots under ACA set in surgery FTEs, and the during which is used for determining and submitted before March 23, 2010. (see instructions) 0.00 0.00 0.00 0.00 61. 61.02 Enter the base line FTE count for primary care FTE sadded under section 5503 of ACA). (see instructions) N 0.00 0.00 0.00 61. 61.02 Enter the as anger year total unweighted primary care on doring and years of the sus of th	56.00	Is this a hospital involved in training reside	ents in a	approve	ed GME programs	s? Enter "Y"	for yes	N			56.00
"N", "complete Wkst. D, Parts III & IV and D-2, Pt. II., if applicable. N 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, § 2148? If yes, complete Wkst. D-5. N N 59.00 59.00 Are costs claimed on line 100 Of Worksheet A? If yes, complete Wkst. D-2, Pt. I. N N 59.00 60.00 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 50.00 61.00 Did your hospital receive FTE slots under ACA section 503? Enter "Y" for yes or "N" for no in column 1. (see instructions) N 0.00 0.00 0.00 0.00 61.00 61.00 Did your hospital receive FTE slots under ACA section 503? Enter "Y" for yes or "N" for no in column 1. (see instructions) N 0.00 0.00 0.00 61.00 61.00 Enter the average number of unweighted primary care instructions) 0.00 0.00 0.00 0.00 0.00 61.10 61.02 Enter the current year total unweighted primary care instructions) 0.00 0.00 0.00 61.11 61.02 Enter the basel line FTE count for primary care and/or general surgery FTEs, and primary care/or surgery aligantic and/or osteopathic FTEs in the current year's		If line 56 is yes, is this the first cost repo GME programs trained at this facility? Enter is "Y" did residents start training in the fir	"Y" for st montl	yes or h of th	⁻ "N" for no in his cost report	n column 1. lf ting period?	column 1 Enter "Y"	N			57.00
59.00 Are costs claimed on line 100 of Worksheet A7 if yes, complete Wkst. D-2, Pt. I. N 59.00 60.00 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 60.00 61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) V/N IME Direct GME Direct GME 61.00 Did your hospital' receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) N 0.00 0.00 0.00 61.00 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) N 0.00 0.00 61. 61.02 Enter the current year total unweighted primary care and primary care FTEs added under section 5503 of ACA). (see instructions) 0.00 0.00 0.00 61. 61.03 Enter the base line FTE count for primary care for determining compliance with the 75% test. (see instructions). 0.00 0.00 0.00 61. 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current year's sprimary care and/or general surgery FTE counts ((ine du/or fTEs that are nonpr		"N", complete Wkst. D, Parts III & IV and D-2, If line 56 is yes, did this facility elect cos	Pt. II st reimb	, if ap ursemer	oplicable. nt for physicia			N			58.00
provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions) Direct GME IME Direct GME Direct GME 61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) N 0.00 0.00 0.00 61.00 61.01 Enter the average number of unweighted primary care ending and submitted before March 23, 2010. (see instructions) 0.00 0.00 0.00 61. 61.02 Enter the current year total unweighted primary care fTE count (excluding 0B/GW, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 0.00 0.00 61. 61.04 Enter the number of unweighted primary care instructions) 0.00 0.00 61. 61.05 Enter the base line FTE count for primary care instructions) 0.00 0.00 0.00 61. 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 0.00 0.00 61. 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 FTEs counts (line 61.04 minus line 61.03). (see instructions) 0.00						Pt. I.		N			59.00
Y/NIMEDirect GMEIMEDirect GMEDirect GME61.00Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)N0.000.000.0061.01Enter the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)N0.000.000.0061.61.02Enter the current year total unweighted primary care (received under section 5503 of ACA). (see instructions)0.000.000.0061.61.03Enter 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)0.000.000.0061.61.04Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs in the current cost reporting period, (see instructions).0.000.0061.61.05Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs toat are nonprimary and/or general surgery FTEs that are nonprimary and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs that are nonprimary and/or general surgery FTEs that are nonprimary and/or general surgery FTEs that are nonprimary0.000.0061.								N			60. 00
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 0.00 0.00 61.01 61.01 Enter the average number of unweighted primary care ending and submitted before March 23, 2010. (see instructions) 0.00 0.00 61. 61.02 Enter the current year total unweighted primary care instructions) 0.00 0.00 61. 61.03 Enter the current year total unweighted primary care instructions) 0.00 0.00 61. 61.03 Enter the base line FTE count (excluding 08/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 0.00 0.00 61. 61.04 Enter the number of unweighted primary care/or and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions). 0.00 0.00 61. 61.05 Enter the difference between the baseline primary care/or and/or general surgery FTEs counts (line 61.04 minus line 61.03). (see instructions). 0.00 0.00 61. 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary 0.00 0.00 61.		provider-operated criteria under §413.85? Ent	Lerr					I	Direct	GME	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 0.00 0.00 61.01 61.01 Enter the average number of unweighted primary care ending and submitted before March 23, 2010. (see instructions) 0.00 0.00 61. 61.02 Enter the current year total unweighted primary care instructions) 0.00 0.00 61. 61.03 Enter the current year total unweighted primary care instructions) 0.00 0.00 61. 61.03 Enter the base line FTE count (excluding 08/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 0.00 0.00 61. 61.04 Enter the number of unweighted primary care/or and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions). 0.00 0.00 61. 61.05 Enter the difference between the baseline primary care/or and/or general surgery FTEs counts (line 61.04 minus line 61.03). (see instructions). 0.00 0.00 61. 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary 0.00 0.00 61.				1 00	2 00	3.00	1.00		5 (0	
61.01Enter 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)0.000.0061.61.02Enter the current year total unweighted primary care FTE count (excluding 0B/GVN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)0.000.0061.61.03Enter 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)0.000.0061.61.04Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).0.000.0061.61.05Enter the difference between the baseline primary and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)0.000.0061.61.06Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary0.000.0061.		section 5503? Enter "Y" for yes or "N" for no	in		2.00	0.00	1.00		0.0		61.00
61.02Enter the current year total unweighted primary care FTE count (excluding 0B/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)0.000.0061.61.03Enter 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)0.000.0061.61.04Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).0.000.0061.61.05Enter 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)0.000.0061.61.06Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary0.000.0061.	61.01	Enter the average number of unweighted primary FTEs from the hospital's 3 most recent cost re	eports		0.00	0.0	o				61.01
ACA). (see instructions)61.03Enter 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)61.04Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).61.0561.05Enter 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)61.0661.06Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary0.000.000.000.000.000.0061.06		Enter the current year total unweighted primar			0.00	0.0	o				61. 02
determining compliance with the 75% test. (see instructions)determining compliance with the 75% test. (see instructions).determining compliance with test of 0.00determining compliance with test of 0.00<		ACA). (see instructions)			0.00	0.0	d				61. 03
 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 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) 61.06 Enter the amount of ACA §5503 award that is being 0.00 0.00 0.00 0.00 61. used for cap relief and/or FTEs that are nonprimary 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.		determining compliance with the 75% test. (see instructions)	Э								
61.05Enter 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)0.000.0061.61.06Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary0.000.0061.	61.04	surgery allopathic and/or osteopathic FTEs in	the		0.00	0.0	o				61.04
61.06Enter the amount of ACA §5503 award that is being0.000.0061.used for cap relief and/or FTEs that are nonprimary0.000.0061.		Enter the difference between the baseline prim and/or general surgery FTEs and the current ye primary care and/or general surgery FTE counts	mary ear's		0.00	0.0	o				61.05
	61.06	Enter the amount of ACA §5503 award that is be used for cap relief and/or FTEs that are nonpr			0.00	0.0	c				61.06

IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DA	TA Provi d		eriod: rom 01/01/2014	Worksheet S-2 Part I	
			T		5/21/2015 2:2	
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	1
 of the FTEs in line 61.05, specify early if any, and the number of for each new program. (see instruction column 1, the program name, enter in program code, enter in column 3, the unweighted count and enter in column FTE unweighted count. of the FTEs in line 61.05, specify early program special ty, if any, and the numeris for each expanded program. instructions) Enter in column 1, the enter in column 2, the program code, 3, the IME FTE unweighted count. 	FTE residents ons) Enter in column 2, the IME FTE 4, direct GME ach expanded umber of FTE (see program name, enter in column			0.00		61. 1
ACA Provisions Affecting the Health I	Posourcos and S-	Nicoe Administration			1.00	
2.00 Enter the number of FTE residents that				od for which	0.00	62.00
your hospital received HRSA PCRE fund	ding (see instruc	tions)				
52.01 Enter the number of FTE residents that during in this cost reporting period	of HRSA THC prog	ıram. (see instruct		your hospital	0.00	62.01
Teaching Hospitals that Claim Resider 3.00 Has your facility trained residents i "Y" for yes or "N" for no in column	n nonprovider se	ettings during this		period? Enter	N	63.00
			Unwei ghted		Ratio (col. 1/	
			FTEs Nonprovider Site	FTEs in Hospital	(col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTI			sThis base year	is your cost r	eporti ng	
period that begins on or after July Enter in column 1, if line 63 is yes, in the base year period, the number of resident FTEs attributable to rotation settings. Enter in column 2 the numm resident FTEs that trained in your ho of (column 1 divided by (column 1 + of)	or your facilit of unweighted non ons occurring in oer of unweighted ospital. Enter in column 2)). (see	y trained resident p-primary care all nonprovider non-primary care column 3 the rati instructions)	0			
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te		Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
55.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to 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			0. 00) 0.00	0. 000000	03.00

Heal th	Financial Systems	WHI TLEY	MEMORIAL H	OSPI TAL		I	n Lie	u of For	m CMS-2	2552-10
	AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ATA	Provi der	CCN: 150101	Period: From 01/01 To 12/31		Workshe Part I Date/Ti 5/21/20	me Pre	oared:
					Unweighted FTEs Nonprovider Site 1.00	Unwei gh FTEs Hospi t	in tal	Ratio (c (col. 1 2)) 3.0	:ol. 1/ + col.)	-
	Section 5504 of the ACA Current		n Nonprovide	er Setting						
66.00	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar occurring in all nonpr unweighted non-primar al. Enter in column 3 column 2)). (see ins	rovider sett ry care resi 3 the ratio <u>structions)</u>	i ngs. dent of	0.1		0.00		000000	66.00
		Program Name	Program	n Code	Unwei ghted FTEs Nonprovi der Si te	Unwei gł FTEs Hospi t	in	Ratio (c (col. 3 4))	+ col.	
		1.00	2. (00	3.00	4.00)	5.0		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0. (20	0.00	0.	000000	67.00
							1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility P			- : + +		han an ai ai ai a an O	N			70.00
	Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, ente reporting period covers the begi or subsequent academic years of instructions) For cost reporting peporting period covers the begi teaching program in existence, e Inpatient Rehabilitation Facilit	le facility have an ap- lefore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) r 1, 2, or 3, in colu- nning of the fourth y the new teaching prog- periods beginning or nning of the sixth or enter 6 in column 3.	pproved GME 204? Enter ility train)(D)? Enter umn 3. (see year, enter gram in exis n or after (r any subsec	teaching p "Y" for ye residents "Y" for ye instruction 4 in colur tence, en october 1, juent acade	program in th es or "N" for in a new tea es or "N" for ons) If this nn 3, or if t ter 5. (see 2012, if thi	e most no. (see ching no. cost he fifth s cost	N		0	70.00
75.00	Is this facility an Inpatient Re	habilitation Facility	y (IRF), or	does it co	ontain an IRF		N			75.00
76.00	subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente 1, 2, or 3, in column 3. (see in of the fourth year, enter 4 in c teaching program in existence, e on or after October 1, 2012, if any subsequent academic year of instructions)	the facility have an appling on or before Nove train residents in a er "Y" for yes or "N" (structions) If this of (solumn 3, or if the fi (nter 5. (see instruct) this cost reporting p	ember 15, 20 new teachir for no. Col cost reporti ifth or subs tions) For c period cover	004? Enter ig program umn 3: If ng period sequent aca cost report	"Y" for yes in accordanc column 2 is covers the b ademic years ting periods nning of the	or "N" for e with 42 Y, enter eginning of the new beginning sixth or			0	76.00
								1.0	0	
	Long Term Care Hospital PPS									
	Is this a long term care hospita Is this a LTCH co-located within "Y" for yes and "N" for no. TEFRA Providers					g period? E	inter	N		80. 00 81. 00
	Is this a new hospital under 42 Did this facility establish a ne \$413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider	(excluded un				no.	N		85. 00 86. 00

Health Financial Systems WHITLEY MEMORI	AL HOSPITAL		In	Lieu	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der				Worksheet S- Part I Date/Time Pr 5/21/2015 2:	epared:
			V 1.00		XI X 2.00	_
Title V and XIX Services			1.00		2.00	
90.00 Does this facility have title V and/or XIX inpatient hospita yes or "N" for no in the applicable column.			N		Y	90.00
91.00 Is this hospital reimbursed for title V and/or XIX through full or in part? Enter "Y" for yes or "N" for no in the app	licable column		N		N	91.00
 92.00 Are title XIX NF patients occupying title XVIII SNF beds (duinstructions) Enter "Y" for yes or "N" for no in the application of the	able column.		N		N	92.00
"Y" for yes or "N" for no in the applicable column. 94.00 [Does tille V or XIX reduce capital cost? Enter "Y" for yes,			N		N	94.00
applicable column. 95.00 [If line 94 is "Y", enter the reduction percentage in the ap				0. 00		95.00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			N		Ν	96.00
97.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers	plicable colum	n.		0.00	0.0	97.00
105.00 Does this hospital qualify as a Critical Access Hospital (CA 106.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)		hod of payment	N			105. 00 106. 00
107.00 Column 1: If this facility qualifies as a CAH, is it eligit for I &R training programs? Enter "Y" for yes or "N" for m						107.00
instructions) If yes, the GME elimination would not be on W the program would be cost reimbursed. If yes complete Wkst.	kst. B, Pt. I, D-2, Pt. II. (col. 25 and Column 2: If				
this facility is a CAH, do I&Rs in an approved medical educa CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or	ation program "N" for no in (train in the column 2. (see				
instructions) 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dul e? See 42	N			108.00
CIR Section 3412. H3(c). Litter i for yes of in for ho.	Physi cal 1.00	Occupational 2.00	Speech 3.00	١	Respi ratory 4.00	_
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		2.00	0.00		1.00	109.00
roi yes or in torno tor each therapy.					1.00	-
110.00 Did this hospital participate in the Rural Community Hospit: the current cost reporting period? Enter "Y" for yes or "N"		on project (410	A Demo)for		N	110.00
			-	1.00	2.00 3.00)
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of is yes, enter the method used (A, B, or E only) in column 2 3 either "93" percent for short term hospital or "98" percent	. If column 2	is "E", enter i	n col umn	N	0	115. 00
psychiatric, rehabilitation and long term hospitals provider Pub.15-1, §2208.1.	rs) based on t	he definition i				11/ 00
116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insur- no.			N" for	N Y		116.00 117.00
118.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1	if the policy i	s	1		118.00
		Premi ums	Losses	6	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1.00 59,066	2.00	3, 812	3.00 18,29	95 118. 01
			1.00		2.00	_
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheme			N		2.00	118.02
and amounts contained therein. 119.00D0 NOT USE THIS LINE						119.00
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified the Hold Harmless provision in ACA \$3121 and applicable amendment	n column 1, "Y ualifies for t	" for yes or he Outpatient	N		Ν	120.00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.		ŗ	Y			121.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	or yes and "N"	for no. If	N			125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en	-					126.00
in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified heart transplant center, en	ter the certif	ication date				127.00
in column 1 and termination date, if applicable, in column 2	۷.		I			

SPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der		Peri od:	Worksheet S-	-2
				From 01/01/2014 To 12/31/2014	Date/Time Pr	
					5/21/2015 2:	26 pm
				1.00	2.00	_
8.00 If this is a Medicare certified li			cation date			128. (
in column 1 and termination date, 9.00 f this is a Medicare certified lu			ation date in			129.0
column 1 and termination date, if				•		127.0
0.00 If this is a Medicare certified pa			ification			130. (
date in column 1 and termination d 1.00 f this is a Medicare certified in			erti fi cati on			131. (
date in column 1 and termination d	late, if applicable, in co	olumn 2.				
2.00 f this is a Medicare certified is in column 1 and termination date,	slet transplant center, er if applicable, in column	nter the certifi 2	cation date			132.
3.00 If this is a Medicare certified ot			cation date			133.
in column 1 and termination date,			n column 1			124 /
4.00 If this is an organ procurement or and termination date, if applicabl		the UPU number i	n column I			134.0
ALL Providers					1	
0.00 Are there any related organization				Y	15H032	140. (
chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the						
1.00	2.	00		3.00		
If this facility is part of a chai home office and enter the home off				ame and address	of the	
1. 00Name: PARKVIEW HEALTH SYSTEM, INC				or's Number: 0810)1	141.0
		ERVI CE				
2.00 Street: 10501 CORPORATE DRIVE 3.00 City: FORT WAYNE	PO Box: P State: I	0 BOX 5600 N	Zip Code:	4689	95-5600	142.
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Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifin. no. Does this facility contain a provior or charges? Enter "Y" for yes or " 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC	Toolumn 1. (See CMS Pub. column 2. cal basis? Enter "Y" for Fallocation? Enter "Y" for ed cost finding method? E der that qualifies for an N" for no for each component impus hospital that has or Name 0 0 0 0 0 0 0 0 0 0 0 0 0	15-2, § 4020) I yes or "N" for or yes or "N" for Enter "Y" for yes Part A 1.00 n exemption from nent for Part A N N N N N N N N N N N N N	f yes, enter no. or no. ss or "N" for <u>Part B</u> 2.00 n the applica and Part B. N N N N N N N N Sess in differ <u>State Zij</u> 2.00 (State Zij) 2.00	N N N N N N N See 42 CFR §413 N N N N N N N N N N N N N N N N N N N	Ti tl e XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N	147. 1 148. 1 149. 1 155. 1 156. 1 157. 1 158. 1 157. 1 160. 1 161. 1 160. 1 161. 1 165. 1 165. 1 165. 1 165. 1 165. 1

Health Financial Systems	WHITLEY MEMORIAL H	OSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIF	ICATION DATA	Provider CCN: 150101	Period: From 01/01/2014	Worksheet S-2	2
				Date/Time Pre	pared:
				5/21/2015 2:2	6 pm
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	date and ending date	for the reporting	10/01/2013	09/30/2014	170.00
				1.00	
171.00 If line 167 is "Y", does this provider have				N	171.00
Medicare cost plans reported on Wkst. S-3, (see instructions)	Pt. I, line 2, col. 6	5? Enter "Y" for yes ar	nd "N" for no.		

SPITAL	. AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE P	rovi der	CCN: 150101	Period: From 01/01/2014 To 12/31/2014	Date/Time Pr	epare
					Y/N	5/21/2015 2: Date	<u>26 pm</u>
					1.00	2.00	
mm CO	eneral Instruction: Enter Y for all YES resp m/dd/yyyy format. DMPLETED BY ALL HOSPITALS	oonses. Enter N for al	l NO re	sponses. Ente	er all dates in	the	_
0 Ha	rovider Organization and Operation as the provider changed ownership immediatel	ly prior to the bogin	ing of	the cost	N		1.
	eporting period? If yes, enter the date of t	the change in column 2	2. (see	instructions)			1.
I				Y/N	Date	V/I	
				1.00	2.00	3.00	-
	as the provider terminated participation in es, enter in column 2 the date of terminatic			N			2.
	oluntary or "I" for involuntary.	on and the containing,	101				
0 Is co or of	s the provider involved in business transact ontracts, with individuals or entities (e.g. r medical supply companies) that are related fficers, medical staff, management personnel f directors through ownership, control, or f elationships? (see instructions)	., chain home offices, d to the provider or i l, or members of the b	drug ts poard	Y			3
				Y/N	Туре	Date	
				1.00	2.00	3.00	
	nancial Data and Reports olumn 1: Were the financial statements prep	parad by a Costified !	Public	Y	A	1	4.
Ac or	ccountant? Column 2: If yes, enter "A" for r "R" for Reviewed. Submit complete copy or olumn 3. (see instructions) If no, see instr	Audited, "C" for Comp enter date available	oiled,	ř	A		4
	re the cost report total expenses and total		om	N			5.
tł	hose on the filed financial statements? If y	yes, submit reconcilia	ntion.				
					Y/N 1.00	Legal Oper.	_
Δn	oproved Educational Activities				1.00	2.00	-
	olumn 1: Are costs claimed for nursing scho	ool? Column 2: If yes	s, is th	e provider is	s N		6
tł	he legal operator of the program?	5					
	re costs claimed for Allied Health Programs?				N		7
	ere nursing school and/or allied health prog ost reporting period? If yes, see instructio		renewed	i during the	Ν		8
	re costs claimed for Intern-Resident program		ent cos	t report? If	Ν		9
ye	es, see instructions.			·			
	as an Intern-Resident program been initiated	d or renewed in the cu	irrent c	ost reporting) N		10.
	eriod? If yes, see instructions. re GME cost directly assigned to cost center	rs other than I & R in	n an App	roved	Ν		11.
	eaching Program on Worksheet A? If yes, see						
						Y/N	
Ba	ad Debts					1.00	-
	s the provider seeking reimbursement for bac	d debts? If ves, see i	nstruct	i ons.		Y	12
	fline 12 is yes, did the provider's bad deb				ost reporting	N	13
	eriod? If yes, submit copy.						
	fline 12 is yes, were patient deductibles a	and/or co-payments wai	ved? If	yes, see ins	structions.	N	14
	ed Complement id total beds available change from the pric	or cost reporting peri	od? If	ves see inst	ructions	Y	15
00 10.	ra total bodo avallabro chango rrom the pric		041 11	r'	art A	Part B	
		Description		Y/N	Date	Y/N	
DC		0		1.00	2.00	3.00	_
	S&R Data as the cost report prepared using the PS&R			N		N	16
Re er	eport only? If either column 1 or 3 is yes, nter the paid-through date of the PS&R eport used in columns 2 and 4 . (see			N N			10.
	nstructions)				04/20/2015		17
Re fo	as the cost report prepared using the PS&R eport for totals and the provider's records or allocation? If either column 1 or 3 is es, enter the paid-through date in columns			Y	04/30/2015	Y	17
DO If ma	and 4. (see instructions) f line 16 or 17 is yes, were adjustments ade to PS&R Report data for additional laims that have been billed but are not			Y		Y	18
ir th DOII	ncluded on the PS&R Report used to file his cost report? If yes, see instructions. fline 16 or 17 is yes, were adjustments ade to PS&R Report data for corrections of			N		N	19
ot ir 00 If	ther PS&R Report information? If yes, see nstructions. f line 16 or 17 is yes, were adjustments			N		N	20
lms	ade to PS&R Report data for Other? Describe he other adjustments:						

Heal th	Financial Systems	WHITLEY MEMOR	LAL HOSPITAL		In Lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE			r CCN: 150101	Peri od:	Worksheet S-2	
					rom 01/01/2014	Part II	
					To 12/31/2014	Date/Time Pre 5/21/2015 2:2	epared:
				Pa	rt A	Part B	26 pili
		Docori	iption	Y/N	Date	Y/N	
			0	1.00	2.00	3.00	
21.00	Was the east report propaged only using the		0	1.00	2.00	S.00	21.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N		IN	21.00
						1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	TALS ONLY (EXCE	EPT CHILDRENS	HOSPI TALS)			
	Capital Related Cost	0.1.6				1	
	Have assets been relifed for Medicare purpose						22.00
23.00	Have changes occurred in the Medicare depreci	ation expense	due to appra	isais made durir	ig the cost		23.00
24.00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing	a Loacos ontoro	od into durin	a this cost rong	rting poriod?		24.00
24.00	If yes, see instructions	y reases entere		y this cost rept	n tring periou?		24.00
25.00	Have there been new capitalized leases entered instructions.	ed into during	the cost rep	orting period? I	f yes, see		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acqu	uired during th	he cost renor	ting period? If	Ves see		26.00
20.00	instructions.	arred darring ti		ting period. II	J03, 300		20.00
27.00	Has the provider's capitalization policy char	nged during the	e cost report	ing period? If y	ves, submit		27.00
	copy.						-
00.00	Interest Expense						
28.00	Were new Loans, mortgage agreements or letter	rs of credit er	nterea into a	uring the cost r	eporting		28.00
29.00	period? If yes, see instructions. Did the provider have a funded depreciation a	account and/or	bond funds (Naht Sarvica Pag	erve Fund)		29.00
27.00	treated as a funded depreciation account? If			Debt Jervice Kes	serve runu)		29.00
30.00	Has existing debt been replaced prior to its			w debt? If ves	See		30.00
	instructions.						
31.00	Has debt been recalled before scheduled matur	rity without is	ssuance of ne	w debt? If yes,	see		31.00
	instructions.	-		-			
	Purchased Services						
32.00	Have changes or new agreements occurred in pa			hed through cont	ractual		32.00
	arrangements with suppliers of services? If						
33.00	If line 32 is yes, were the requirements of 9 no, see instructions.	sec. 2135.2 app	piled pertain	ing to competiti	ve blading? Ir		33.00
	Provi der-Based Physi ci ans						-
3/ 00	Are services furnished at the provider facili	ty under an ar	rrangement wi	th provider_base	d physicians?	Y	34.00
54.00	If yes, see instructions.		rangement wi	til provider-base		1	54.00
35.00	If line 34 is yes, were there new agreements	or amended exi	istina aareem	ents with the pr	ovi der-based		35.00
	physicians during the cost reporting period?		0 0				
					Y/N	Date	
					1.00	2.00	
	Home Office Costs						
36.00	Were home office costs claimed on the cost re	eport?			Y		36.00
37.00	If line 36 is yes, has a home office cost sta	atement been pr	repared by th	e home office?	Y		37.00
	If yes, see instructions.						
38.00	If line 36 is yes, was the fiscal year end of the provider? If year enter in column 2 the				N		38.00
30 00	the provider? If yes, enter in column 2 the 1 If line 36 is yes, did the provider render se				N		39.00
57.00	see instructions.			onents: 11 yes,	IN		39.00
40.00	If line 36 is yes, did the provider render se	ervices to the	home office?	lf yes, see	Ν		40.00
	instructions.			-			
				1.00	2.	00	
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title		ERIC		NI CKESON		41.00
	held by the cost report preparer in columns ?	i, 2, and 3,					
12 00	respectively. Enter the employer/company name of the cost r	conort					12 00
42.00	preparer.	eport	FAREVIEW HEA	LTH SYSTEM, INC.			42.00
43.00	Enter the telephone number and email address	of the cost	(260) 373-84	06	ERI C. NI CKESON@	PARKVI EW. COM	43.00
	report preparer in columns 1 and 2, respectiv						
	· · · · ·	-					

ealth Financial Systems		Y MEMORIAL H				u of Form CMS-	
OSPITAL AND HOSPITAL HEALTH CARE REIMBURS	EMENT QUESTIONNA	I RE	Provider (CCN: 150101	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Pre 5/21/2015 2:2	epared
		t B					
		ote 00					
PS&R Data	Ţ.	00			· · · · ·		
6.00 Was the cost report prepared using	the PS&R						16.0
Report only? If either column 1 or							
enter the paid-through date of the							
Report used in columns 2 and 4 . (se	e						
instructions)		10045					1.7
7.00 Was the cost report prepared using Report for totals and the provider'		0/2015					17.0
for allocation? If either column 1							
yes, enter the paid-through date in							
2 and 4. (see instructions)	COLUMITS						
8.00 If line 16 or 17 is yes, were adjus	tments						18.
made to PS&R Report data for additi							
claims that have been billed but ar							
included on the PS&R Report used to	file						
this cost report? If yes, see instr	uctions.						
9.00 fline 16 or 17 is yes, were adjus							19.
made to PS&R Report data for correc							
other PS&R Report information? If y	es, see						
instructions.							
0.00 If line 16 or 17 is yes, were adjus							20.
made to PS&R Report data for Other? the other adjustments:	Describe						
1.00 Was the cost report prepared only u	sing the						21.0
provider's records? If yes, see	sing the						21.
instructions.							
			3.0	0			
Cost Report Preparer Contact Inform							
1.00 Enter the first name, last name and			CTOR, REIMB	URSEMENT			41.
held by the cost report preparer in	columns 1, 2, a	nd 3,					
respectively. 2.00 Enter the employer/company name of	the east report						42.
2.00 Enter the employer/company name of preparer.	the cost report						42.
3.00 Enter the telephone number and emai	l address of the	cost					43.
report preparer in columns 1 and 2,		CUSI					43.

	Financial Systems	WHITLEY MEMORI			CON. 1E0101	De		u of Form CM		
HUSPI I	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA		Provi der	CCN: 150101		eriod: com 01/01/2014 o 12/31/2014	Worksheet S Part I Date/Time P 5/21/2015 2	rep	pared: 5 pm
								I/P Days / O Visits / Tri		
	Component	Worksheet A Line Number	No.	of Beds	Bed Days Avai I abl e		CAH Hours	Title V		
		1.00		2.00	3.00		4.00	5.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)	30. 00		30	10, 9	50	0.00		0	1.00
2.00 3.00 4.00	HMO IPF Subprovider HMO IFF Subprovider									2.00 3.00 4.00
5.00	Hospital Adults & Peds. Swing Bed SNF								o	5.00
6.00	Hospital Adults & Peds. Swing Bed NF								Ő	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)			30	10, 9	50	0.00		0	7.00
8.00	INTENSIVE CARE UNIT									8.00
9.00	CORONARY CARE UNIT									9.00
10.00	BURN INTENSIVE CARE UNIT									10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T									11.00
12.00 13.00	OTHER SPECIAL CARE (SPECIFY) NURSERY	43.00							0	12.00 13.00
14.00	Total (see instructions)	43.00		30	10, 9	50	0.00		0	13.00
14.00	CAH visits			50	10, 9	50	0.00		0	14.00
16.00	SUBPROVIDER - IPF								Ŭ	16.00
17.00	SUBPROVI DER – I RF									17.00
18.00	SUBPROVI DER									18.00
19.00	SKILLED NURSING FACILITY	44.00		75	27, 3	88			o	19.00
20.00	NURSING FACILITY									20.00
21.00	OTHER LONG TERM CARE									21.00
22.00	HOME HEALTH AGENCY									22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)									23.00
24.00	HOSPI CE									24.00
24.10	HOSPICE (non-distinct part)	30. 00								24.10
25.00	CMHC - CMHC									25.00
26.00	RURAL HEALTH CLINIC									26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER									26. 25
27.00	Total (sum of lines 14-26)			105						27.00
28.00	Observation Bed Days								0	28.00
29.00	Ambul ance Trips									29.00
30.00	Employee discount days (see instruction)									30.00
31.00	Employee discount days - IRF			~		~				31.00
32.00 32.01	Labor & delivery days (see instructions) Total ancillary labor & delivery room			0		0				32.00 32.01
JZ. UI	outpatient days (see instructions)									JZ. UI
	LTCH non-covered days									33.00

HOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der		Period: From 01/01/2014 Fo 12/31/2014	Worksheet S-3 Part I Date/Time Pre 5/21/2015 2:2	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time E		
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1, 177	223	3, 99			1.00
2.00	HMO and other (see instructions)	950	991				2.00
3.00	HMO I PF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	(D		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0		C		6.00
7.00 8.00	Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT	1, 177	223	3, 99			7.00 8.00
5.00 9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		110	85	4		12.00
14.00	Total (see instructions)	1, 177	333		-	257.50	
15.00	CAH visits	1, 1, 7	0	т, 0-1 (0.00	207.00	15.00
16.00	SUBPROVIDER - IPF	0	0				16.00
17.00	SUBPROVI DER – I RF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	1, 499	8, 539	18, 11	5 0.00	69.54	
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)	0	0	(C		24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	327.04	
28.00	Observation Bed Days		144	81	3		28.00
29.00	Ambul ance Trips	6, 551					29.00
30.00	Employee discount days (see instruction)			8			30.00
31.00	Employee discount days - IRF				D		31.00
32.00	Labor & delivery days (see instructions)	0	87	-			32.00
32.01	Total ancillary labor & delivery room			(C		32.01
	outpatient days (see instructions)				1		1

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provi der	CCN: 150101	Period: From 01/01/2014 To 12/31/2014		
		Full Time Equivalents		Dis	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	3	51 257	1, 385	1.00
2.00 3.00 4.00 5.00 6.00 7.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation			2	85 0		2.00 3.00 4.00 5.00 6.00 7.00
8.00 9.00 10.00 11.00 12.00 13.00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						8.00 9.00 10.00 11.00 12.00 13.00
14.00 15.00 16.00 17.00 18.00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER	0.00	0	3	51 257	1, 385	14.00 15.00 16.00 17.00 18.00
19.00 20.00 21.00 22.00 23.00 24.00 24.10 25.00 26.00 26.25	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC EEDEPALLY QUALLELED HEALTH CENTED	0.00					19.00 20.00 21.00 22.00 23.00 24.00 24.10 25.00 26.00 26.25
27.00 28.00 29.00 30.00 31.00 32.00 32.01	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days	0. 00					26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01 33. 00

PIT	Financial Systems AL WAGE INDEX INFORMATION			Provi der	F	Period: From 01/01/2014 Fo 12/31/2014		pared:
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Sal ari es (col.2 ± col.		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							
0	Total salaries (see	200.00	22,067,480	-3, 740, 823	18, 326, 657	681, 309. 00	26. 90	1.0
~	instructions)		0		C		0.00	2.0
0	Non-physician anesthetist Part A		0	0		0.00	0.00	2.0
0	Non-physician anesthetist Part		0	0	C	0.00	0.00	3.0
0	B Physician-Part A -		83, 352	0	83, 352	457.00	182. 39	4.0
0	Admini strati ve		03, 332		03, 332	437.00	102.37	4.0
1	Physicians - Part A - Teaching		0	-	C			•
0	Physician-Part B Non-physician-Part B		0			0.00		•
0	Interns & residents (in an	21.00	0			0.00		
	approved program)			_	_			
1	Contracted interns and residents (in an approved programs)		C	0	C	0.00	0.00	7.0
0	Home office personnel		4, 379, 630	0	4, 379, 630	127, 507. 00	34.35	8.0
0	SNF	44.00	2, 156, 587					
00	Excluded area salaries (see instructions)		1, 354, 413	132, 521	1, 486, 934	79, 629. 00	18. 67	10.0
	OTHER WAGES & RELATED COSTS	I		I				
00	Contract Labor: Direct Patient		0	0	C	0.00	0.00	11.0
00	Care Contract Labor: Top Level		0	0	0	0.00	0.00	12.0
00	management and other management and administrative		Ŭ			0.00	0.00	12.0
00	services Contract Labor: Physician-Part		0	0	c	0.00	0.00	13.0
	A – Administrative			_				
00	Home office salaries &		4, 379, 630	0	4, 379, 630	127, 507. 00	34.35	14.0
00	wage-related costs Home office: Physician Part A		O	0	c	0.00	0.00	15.0
	- Administrative							
00	Home office and Contract Physicians Part A - Teaching		0	0	C	0.00	0.00	16.0
	WAGE-RELATED COSTS							
00	Wage-related costs (core) (see		5, 193, 817	0	5, 193, 817	7		17. C
00	instructions) Wage-related costs (other)		0	0				18. C
00	(see instructions)		0					
	Excluded areas		468, 243	-	100,210			19. C
00	Non-physician anesthetist Part ₄		0	0	C)		20.0
00	^ Non-physician anesthetist Part		0	0	C)		21.0
	В		_	_				
00	Physician Part A - Administrative		0	0)		22.0
01	Physician Part A - Teaching		0	0	C			22.0
	Physician Part B		0	0	C)		23.0
00 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	0			24.0 25.0
00	approved program)		0					25.0
	OVERHEAD COSTS - DIRECT SALARIE							
00 00	Employee Benefits Department Administrative & General	4.00 5.00	1, 464, 003 9, 072, 296			0.00 141,247.00		
00	Administrative & General under	5.00	9,072,290	-3, 483, 721 0	5, 566, 575	0.00		
	contract (see inst.)				-			
00	Maintenance & Repairs	6.00	0	0	0	0.00		
00 00	Operation of Plant Laundry & Linen Service	7.00 8.00	288, 318 0	35, 270	323, 588	14, 522. 00 0. 00		
00	Housekeepi ng	9.00	244, 908	29, 959	274, 867			
00	Housekeeping under contract		0	0	C	0.00	0.00	33. C
00	(see instructions) Dietary	10.00	325, 821	- 194, 491	131, 330	7, 196. 00	18. 25	34. C
00	Dietary under contract (see	10.00	525, 621	0	0	0.00		
	instructions)		-	-				
	Cafeteria Maintenance of Decembel	11.00	0	229, 997	229, 997			
00 00	Maintenance of Personnel Nursing Administration	12.00 13.00	0 114, 824	0 14, 046	128, 870	0.00 4,028.00		37.0 38.0
00	Central Services and Supply	14.00	024	0	120, 070	0.00		39.0
	Pharmacy	15.00	485, 816	59, 429	545, 245	12, 304. 00	44. 31	1 10 0

Health Financial Systems		WHITLEY MEMO	RIAL HOSPITA	-		In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi	der CC		eri od:	Worksheet S-3	
						rom 01/01/2014		
					1	o 12/31/2014	Date/Time Pre 5/21/2015 2:20	
	Worksheet A	Amount	Recl assi fi	ati	Adj usted	Paid Hours	Average Hourly	
	Line Number	Reported	on of Sala	i es	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(0	col.2 ± col.	Salaries in	col. 5)	
			Worksheet /	-6)	3)	col. 4		
	1.00	2.00	3.00		4.00	5.00	6.00	
41.00 Medical Records & Medical	16.00		0	0	C	0.00	0.00	41.00
Records Library								
42.00 Social Service	17.00		0	0	C	0.00	0.00	42.00
43.00 Other General Service	18.00		ol	0	C	0.00	0.00	43.00

Heal th	Financial Systems		WHITLEY MEMOR	IAL HOSPITAL		In Lieu of Form CMS-2552-10			
HOSPI TA	AL WAGE INDEX INFORMATION			Provi der		Period: From 01/01/2014 To 12/31/2014			
		Worksheet A		Recl assi fi cati			Average Hourly		
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷		
				(from	(col.2 ± col.		col. 5)		
				Worksheet A-6)	,	col. 4			
		1.00	2.00	3.00	4.00	5.00	6.00		
	PART III - HOSPITAL WAGE INDEX	SUMMARY		•					
	Net salaries (see		17, 687, 850	-3, 740, 823	13, 947, 02	7 553, 802. 00	25. 18	1.00	
	instructions)								
	Excluded area salaries (see instructions)		3, 511, 000	225, 583	3, 736, 58	3 206, 323. 00	18. 11	2.00	
	Subtotal salaries (line 1 minus line 2)		14, 176, 850	-3, 966, 406	10, 210, 44	4 347, 479. 00	29. 38	3.00	
4.00	Subtotal other wages & related costs (see inst.)		4, 379, 630	0	4, 379, 63	0 127, 507. 00	34.35	4.00	
	Subtotal wage-related costs (see inst.)		5, 193, 817	0	5, 193, 81	7 0.00	50. 87	5.00	
6.00	Total (sum of lines 3 thru 5)		23, 750, 297	-3, 966, 406	19, 783, 89	1 474, 986.00	41.65	6.00	
	Total overhead cost (see		11, 995, 986					7.00	
	instructions)		,,						

Heal th	Financial Systems	WHITLEY MEMORIAL F	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
HOSPIT	AL WAGE RELATED COSTS		Provider CC	N: 150101	Period: From 01/01/2014 To 12/31/2014		pared:
						Amount Reported	
						1.00	
	PART IV - WAGE RELATED COSTS						
	Part A - Core List						
	RETIREMENT COST						
1.00	401K Employer Contributions					0	
2.00	Tax Sheltered Annuity (TSA) Employer Contribu					340, 050	
3.00	Nonqualified Defined Benefit Plan Cost (see in					617, 720	
4.00	Qualified Defined Benefit Plan Cost (see inst					0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Or	rgani zati on)					
5.00	401K/TSA Plan Administration fees					0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan					0	6.00
7.00	Employee Managed Care Program Administration I	ees				58, 537	7.00
	HEALTH AND INSURANCE COST						
8.00	Health Insurance (Purchased or Self Funded)					3, 115, 124	
9.00	Prescription Drug Plan					0	
10.00	Dental, Hearing and Vision Plan					0	
11.00	Life Insurance (If employee is owner or benefi					27, 174	
12.00	Accident Insurance (If employee is owner or be					0	
13.00	Disability Insurance (If employee is owner or					57, 218	
14.00	Long-Term Care Insurance (If employee is owned	r or beneficiary)				0	
15.00	'Workers' Compensation Insurance					91, 666	
16.00	Retirement Health Care Cost (Only current year	r, not the extraor	di nary accrua	al require	ed by FASB 106.	0	16.00
	Non cumulative portion)						
	TAXES						
	FICA-Employers Portion Only					1, 289, 663	
18.00	Medicare Taxes - Employers Portion Only					0	
19.00	Unemployment Insurance					0	
20.00	State or Federal Unemployment Taxes					0	20.00
	OTHER					01.000	
21.00	Executive Deferred Compensation (Other Than Reinstructions))	etirement Cost Rep	orted on line	es 1 throu	igh 4 above. (see	31, 000	21.00
22.00	Day Care Cost and Allowances					0	
23.00	Tuition Reimbursement					33, 909	
24.00	Total Wage Related cost (Sum of lines 1 -23)					5, 662, 061	24.00
	Part B - Other than Core Related Cost						
25.00	OTHER WAGE RELATED COSTS (SPECIFY)					0	25.00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 1501		Worksheet S-3	
		From 01/01/2014		norod.
		To 12/31/2014	Date/Time Pre 5/21/2015 2:2	
Cost Center Description		Contract Labor		
· ·		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Ider	iti fi cati on:			
1.00 Total facility's contract labor and benefi	t cost	0	0	1.00
2.00 Hospital		0	0	2.00
3.00 Subprovider - IPF				3.00
4.00 Subprovider - IRF				4.00
5.00 Subprovider - (Other)		0	0	5.00
6.00 Swing Beds - SNF		0	0	6.00
7.00 Swing Beds - NF		0	0	7.00
8.00 Hospital-Based SNF		0	0	8.00
9.00 Hospital-Based NF				9.00
10.00 Hospital-Based OLTC				10.00
11.00 Hospital-Based HHA				11.00
12.00 Separately Certified ASC				12.00
13.00 Hospital-Based Hospice				13.00
14.00 Hospital-Based Health Clinic RHC				14.00
15.00 Hospital-Based Health Clinic FQHC				15.00
16.00 Hospital-Based-CMHC				16.00
17.00 Renal Dialysis				17.00
18.00 Other		0	0	18.00

If the Bry/11 and the bry/11		Financial Systems ECTIVE PAYMENT FOR SNF STATISTICAL DATA	WHITLEY MEMORIA		CCN: 150101	In Li Period:	eu of Form CMS- Worksheet S-7	
Image: 10 bit is facility contains a busy tablesed SWF, sure all patients under managed care or was there no kedlores utill zation? Furth "Y for yas in colum 1 and do not complete the rank of this worksheet. Image: 10 bit is worksheet. <t< th=""><th></th><th></th><th></th><th></th><th></th><th>From 01/01/201</th><th>4</th><th></th></t<>						From 01/01/201	4	
1.00 If this shall try contains a hospital-based SR, were all partients under sanaged care were so there no Mulcaro utilization Phone sin column 1 and do not service and do not servi								
n was. there in Medicane utility attaint in the in '' for yes in column 1 and an on't complete the read of this worksheet. N 200 Distribution of the social the social in 1283 or section 1913 for the the agreement in the agreement. N N 300 Distribution of the social the social in 1 if yes. Inter the agreement. Stir Bays Stir Bays Total (sum of bays) 300 N N N N N 300 N N N N N 300 N N N N N N 300 N							2.00	
Long bits the rest of this worksheet. N 1000000000000000000000000000000000000	1.00	If this facility contains a hospital-base or was there no Medicare utilization? End	ed SNF, were all pati ter "Y" for ves in co	ents under m plumn 1 and c	nanaged care Io not	N		1.00
string bady? Enter "Y" for yes or "N" for no in colum 1. If yes, enter the agreement Total year of both the string bady of the	2 00	complete the rest of this worksheet.				N		2.00
Intervent Group SNP Days Swing Bed SNP Total (sum of our a) 0.0 1.00 2.00 Suing Bed SNP Total (sum of our a) 4.00 1.00 2.00 Suing Bed SNP Suing Bed SNP 4.00 RUL 0 0 0 0 5.00 RVX 0 0 0 0 6.00 RVX 0 0 0 0 6.00 RVX 0 0 0 0 9.00 RVX 0 0 0 0 9.00 RVX 0 0 0 0 9.00 RVX 0 0 0 0 0 11.00 RVX 0 0 0 10 0 10 12.00 RVB 35 0 35 17 0 17 13.00 RVB 0 0 0 0 0 10 13.00 RVB	2.00					N		2.00
Image: state				-	-	Swing Rod SNE	Total (cum of	
3.00 RUX 0 0 4.00 RVX 0 0 5.00 RVX 0 0 5.00 RVX 0 0 5.00 RVX 0 0 6.00 RVX 0 0 8.00 RVX 0 0 9.00 RVX 0 0 10.00 RVX 0 0 10.00 RVX 0 0 12.00 RVX 0 0 12.00 RVX 0 0 12.00 RVX 0 0 12.00 RVX 17.00 70 12.00 RVX 10 0 12.00 RVX 10 0 12.00 RVX 17.00 70 12.00 RVX 17.00 70 12.00 RVX 10 0 12.00 RVX 10 0 12.00 RVX 10 0<				•	SINF Days	Days	col. 2 + 3)	
4.00NUL005.00RVX006.00RVX006.00RVX008.00RVX0010.00RVX0010.00RVX0011.00RVX0011.00RVX0011.00RVX0011.00RVX0011.00RVX0011.00RVX4046811.00RVX4040012.00RVX13315.00RVX13315.00RVX131316.00RVX131317.00RVX131318.00RVX131319.00RVX131320.00RVX131321.00RVX10022.00RVX10023.00RVX10024.00FS10025.00RVX0026.00RV20027.00FS20028.00FS10029.00RV20020.00RV20020.00RV20020.00RV20020.00RV20020.00RV20020.00RV20	3 00				2.00			3.00
6.00FVL008.00BHX008.00BHX0010BLX0011.00BLX0012.00BLX0013.00BLX0014.00BLX0015.00RVG40015.00RVG0015.00RVG0017.00RVG00	4.00			RUL		-	0 0	4.00
7.00 FHX 0 0 0 9.00 RML 0 0 0 9.00 RMX 0 0 0 11 00 RMX 0 0 0 11 00 RMX 0 0 0 11 00 RM 40 46 0 4292 13 00 RIA 468 0 4292 14 00 RIA 468 0 460 15 00 RVG 40 0 460 16 00 RVG 10 10 10 17 00 RVG 0 0 0 0 18 00 RVG 0 <								
9.00NAX00010.00RAL00011.00RLC4.5404.5413.00RUC4.5404.5413.00RUC4.5404.6815.00RVA4.6804.6815.00RVA1001015.00RVA100015.00RVA100015.00RVA100015.00RVA100015.00RVA130016.00RVA130017.00RVA130020.00RVA130021.00RVA70022.00RVA70024.00CRVA0025.00RVA00026.00CC0027.00RVA00028.00CC0029.00HE100029.00HE200039.00HE200039.00HE200039.00HE100039.00HE200039.00HE100039.00HE100039.00HE1000 <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td>						-		
10.00 RML 0 0 0 11.00 RUX 0 0 0 12.00 RUX 0 454 0 454 13.00 RUB 272 0 272 14.00 RUM 466 0 468 16.00 RVM 40 0 40 17.00 RVM 35 0 35 17.00 RVM 179 0 179 19.00 RVM 10 0 0 10.00 RVM 10 0 0 10.00 RVM 10 0 0 10.00 RVM 0 0 0 10.00 RVM 0 0 0 10.00 RVM 7 0 7 12.00 RVM 7 0 0 13.00 RVM 7 0 0 14.00 ES1 0 0 0 13.00 HE1 0 0 0 14.00 LD1 0 0 0 15.00 LE1 0 0 0 14.00 LD1 0 0 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td>						-		
11 00RLX00012 00RUC454045413 00RUC454045414 00RUA466046815 00RVC40003516 00RVC100010017 00RVA3503517 00RVA131010019 00RVA1320020 00RVA130020 00RVA130020 00RVA70020 00RVA70020 00RVA70020 00RVA00020 00RVA00020 00RVA00020 00RVA00020 00RVA00020 00RVA00020 00RVA00020 00RVA00020 00RVA00020 00RVA1000020 00RVA1000020 00RVA1000020 00RVA1000020 00RVA1000020 00RVA1000020 00RVA1000020 00RVA100 <td< td=""><td></td><td></td><td></td><td></td><td></td><td>-</td><td></td><td></td></td<>						-		
13.00 RUB 222 0 222 14.00 RUA 468 0 460 15.00 RVA 179 0 315 17.00 RVA 179 0 179 18.00 RVA 179 0 179 19.00 RVA 13 0 130 19.00 RVB 0 0 0 19.00 RVB 13 0 130 20.00 RVB 0 0 0 21.00 RVB 7 0 7 22.00 RVB 7 0 0 0 23.00 RVB 7 0 0 0 0 24.00 ES3 0						-		
14.00 RUA 466 0 466 15.00 RVG 40 0 406 17.00 RVB 35 0 35 18.00 RVA 179 0 179 19.00 RVC 0 0 0 0 20.00 RVA 179 0 13 21.00 RVA 13 0 13 22.00 RVA 0 0 0 23.00 RVA 7 0 7 24.00 RLB 0 0 0 0 25.00 RLB 0 0 0 0 0 26.00 ES3 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>-</td><td></td></td<>							-	
16 00 RVB 35 0 35 17 00 RVC 0 0 0 18 00 RHC 0 0 0 18 00 RHC 0 0 0 20 00 RHA 13 0 13 20 00 RHA 13 0 10 22 00 RHB 0 0 0 22 00 RHB 0 0 0 23 00 RHB 0 0 0 24 00 RHB 0 0 0 26 00 ES3 0 0 0 28 00 ES1 0 0 0 28 00 HE1 0 0 0 30 0 HE1 0 0 0 31 00 HE2 0 0 0 35 00 HE2 0 0 0 36 00 HE2 0 0 0 36 00 LE2 0 0 0 36 00 LC2	14.00			RUA	40	58	0 468	14.00
17.00 RNA 170 0 179 18.00 RHE 10 0 0 19.00 RHE 10 0 10 20.00 RHE 10 0 10 21.00 RMC 0 0 0 22.00 RMA 7 0 0 0 23.00 RMA 7 0 0 0 24.00 RMA 0 0 0 0 25.00 RLA 0 0 0 0 26.00 ES2 0 0 0 0 0 27.00 ES2 0 0 0 0 0 0 0 20.00 HE12 0								
19.00 RHB 10 0 10 20.00 RHA 13 0 13 21.00 RMC 0 0 0 22.00 RMA 7 0 7 22.00 RMA 7 0 7 23.00 RMA 7 0 7 24.00 RLA 0 0 0 25.00 RLA 0 0 0 26.00 ES2 0 0 0 27.00 ES2 0 0 0 28.00 HE1 0 0 0 29.00 HE2 0 0 0 31.00 HE2 0 0 0 32.00 HE1 0 0 0 33.00 HC2 0 0 0 34.00 HC2 0 0 0 35.00 HB2 0 0 0 36.00 LL2 0 0 0 37.00 LL2 0 0 0 36.00 LD1 8 0 0 37.00 LL2 0 0 0 37.00 <td>17.00</td> <td></td> <td></td> <td>RVA</td> <td></td> <td>79</td> <td>0 179</td> <td>17.00</td>	17.00			RVA		79	0 179	17.00
20.00 RHA 13 0 13 21.00 RMB 0 0 0 22.00 RMB 0 0 0 22.00 RMB 0 0 0 22.00 RLB 0 0 0 24.00 RLB 0 0 0 25.00 RLA 0 0 0 26.00 ES3 0 0 0 27.00 ES2 0 0 0 0 28.00 ES1 0 <						-		
22.00 RMB 0 0 0 23.00 RLB 0 0 0 24.00 RLB 0 0 0 25.00 RLA 0 0 0 26.00 ES3 0 0 0 26.00 ES1 0 0 0 27.00 ES2 0 0 0 27.00 ES1 0 0 0 28.00 HE2 0 0 0 0 29.00 HE1 0 0 0 0 0 20.01 HD2 0	20. 00			RHA		13		20.00
23.00 RMA 7 0 7 24.00 RLB 0 0 0 25.00 RLA 0 0 0 25.00 ES3 0 0 0 27.00 ES2 0 0 0 27.00 ES1 0 0 0 28.00 ES1 0 0 0 29.00 HE1 0 0 0 0 30.00 HE2 0 0 0 0 31.00 HD1 0 0 0 0 0 0 0 33.00 HC1 0						-		
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28.00 E51 0 0 0 30.00 HE2 0 0 0 31.00 HE1 0 0 0 31.00 HD1 0 0 0 31.00 HD2 0 0 0 32.00 HD1 0 0 0 33.00 HC2 0 0 0 35.00 HB2 0 0 0 36.00 HB2 0 0 0 37.00 LE1 0 0 0 38.00 LD2 0 0 0 37.00 LC2 0 0 0 38.00 LD2 0 0 0 41.00 LC2 0 0 0 42.00 LC2 0 0 0 43.00 LC2 0 0 0 44.00 LB2 0 0 0 45.00 CC1 0 0 0 50 C52 <t< td=""><td></td><td></td><td></td><td>ES3</td><td></td><td>-</td><td></td><td></td></t<>				ES3		-		
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31.00 H02 0 0 0 33.00 H01 0 0 0 33.00 HC2 0 0 0 34.00 HC1 0 0 0 36.00 H81 0 0 0 36.00 H81 0 0 0 37.00 LE2 0 0 0 38.00 LC1 0 0 0 38.00 LC1 0 0 0 44.00 LC2 0 0 0 44.00 LC1 0 0 0 45.00 CE2 0 0 0 46.00 CC1 0 0 0 47.00 CC2 0 0 0 47.00 CC2 0 0 0 47.00 CC2 0 0 0 50.00 CC1 5 5 5 51.00 CR1 0 0 0 55.00 SE3				HE2			-	
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37.00 LE2 0 0 0 38.00 LD1 0 0 0 40.00 LD1 8 0 88 41.00 LC2 0 0 0 42.00 LC1 0 0 0 43.00 LB2 0 0 0 44.00 LB1 0 0 0 45.00 CE2 0 0 0 46.00 CE1 0 0 0 47.00 CD2 0 0 0 48.00 CD1 0 0 0 48.00 CD1 0 0 0 49.00 CC1 5 0 5 51.00 CB2 0 0 0 52.00 CA1 0 0 0 54.00 SE3 0 0 0 55.00 SE2 0 0 0 54.00 SSB 0 0 0 55.00 SSB						0		
38.00 LE1 0 0 0 39.00 LD2 0 0 0 30.00 LD2 0 0 0 41.00 LC2 0 0 0 42.00 LC1 0 0 0 42.00 LB2 0 0 0 43.00 LB2 0 0 0 44.00 CE1 0 0 0 44.00 CE1 0 0 0 44.00 CE2 0 0 0 45.00 CE2 0 0 0 46.00 CD1 0 0 0 47.00 CC2 0 0 0 48.00 CD1 0 0 0 50.00 CS1 5 0 5 51.00 CS2 0 0 0 55.00 CA1 0 0 0 56.00 SS2 0 0 0 55.00 SS4						0		
39.00 LD2 0 0 0 40.00 LD1 8 0 8 41.00 LC2 0 0 0 42.00 LC1 0 0 0 43.00 LB2 0 0 0 43.00 LB2 0 0 0 45.00 CE2 0 0 0 45.00 CE2 0 0 0 46.00 CD2 0 0 0 47.00 CD2 0 0 0 48.00 CD1 0 0 0 49.00 CC1 5 0 5 51.00 CC2 0 0 0 52.00 CA2 0 0 0 53.00 CA2 0 0 0 55.00 SSC 0 0 0 55.00 SSS 0 0 0 56.00 SSSA 0 0 0 61.00 SSA						0		
41.00 LC2 0 0 0 42.00 LC1 0 0 0 42.00 LB2 0 0 0 44.00 LB1 0 0 0 44.00 CE1 0 0 0 45.00 CE1 0 0 0 45.00 CE1 0 0 0 47.00 CD2 0 0 0 48.00 CD1 0 0 0 49.00 CC1 5 0 5 51.00 CC2 0 0 0 52.00 CB1 5 0 5 53.00 CA2 0 0 0 54.00 SE3 0 0 0 55.00 SE2 0 0 0 58.00 SSR 0 0 0 58.00 SSA 0 0 0				LD2		-		39.00
42.00 LC1 0 0 0 43.00 LB2 0 0 0 44.00 LB1 0 0 0 45.00 CE2 0 0 0 46.00 CE1 0 0 0 47.00 CD2 0 0 0 48.00 CD1 0 0 0 49.00 CC1 5 0 0 50.00 CC2 0 0 0 51.00 CB2 0 0 0 52.00 CB1 5 0 5 53.00 CA1 0 0 0 55.00 SE3 0 0 0 56.00 SE2 0 0 0 57.00 SC 0 0 0 59.00 SSB 0 0 0 59.00 SSA 0 0 0 59.00 SSB 0 0 0 61.00 IB1								
44.00 LB1 0 0 0 45.00 CE2 0 0 0 46.00 CE1 0 0 0 7.00 CD2 0 0 0 48.00 CD1 0 0 0 49.00 CC2 0 0 0 50.00 CC1 5 0 55 51.00 CB2 0 0 0 52.00 CB2 0 0 0 53.00 CA1 0 0 0 55.00 SE3 0 0 0 55.00 SE3 0 0 0 56.00 SE2 0 0 0 56.00 SSC 0 0 0 58.00 SSS 0 0 0 59.00 SSA 0 0 0 59.00 IB2 0 0 0 64.00 IA2 0 0 0 64.00 BB2	42.00			LC1		-		42.00
45.00 CE2 0 0 0 46.00 CE1 0 0 0 47.00 CD2 0 0 0 48.00 CD1 0 0 0 49.00 CC2 0 0 0 49.00 CC2 0 0 0 50.00 CC1 5 0 5 51.00 CB2 0 0 0 53.00 CA2 0 0 0 54.00 SE3 0 0 0 55.00 SE3 0 0 0 54.00 SE1 0 0 0 55.00 SE2 0 0 0 56.00 SE3 0 0 0 57.00 SSR 0 0 0 58.00 SSA 0 0 0 59.00 SSA 0 0 0 61.00 IB2 0 0 0 63.00 BB2						-		
47.00 CD2 0 0 0 48.00 CD1 0 0 0 49.00 CC2 0 0 0 50.00 CC1 5 0 5 51.00 CB2 0 0 0 52.00 CB1 5 0 5 53.00 CA2 0 0 0 54.00 CA1 0 0 0 55.00 SE3 0 0 0 56.00 SE2 0 0 0 57.00 SE1 0 0 0 58.00 SSC 0 0 0 59.00 SSB 0 0 0 59.00 SSA 0 0 0 61.00 IB2 0 0 0 62.00 IA1 0 0 0 63.00 BB2 0 0 0	45.00			CE2		0		45.00
48.00 CD1 0 0 49.00 CC2 0 0 50.00 CC1 5 0 5 51.00 CB2 0 0 0 52.00 CB1 5 0 5 53.00 CA2 0 0 0 54.00 CA1 0 0 0 55.00 SE3 0 0 0 56.00 SE2 0 0 0 57.00 SE1 0 0 0 58.00 SE2 0 0 0 57.00 SE1 0 0 0 58.00 SSR 0 0 0 59.00 SSB 0 0 0 60.00 SSA 0 0 0 61.00 IB2 0 0 0 63.00 IA1 0 0 0 63.00 BB2 0 0 0								
50.00 CC1 5 0 5 51.00 CB2 0 0 0 52.00 CB1 5 0 5 53.00 CA2 0 0 0 54.00 CA1 0 0 0 55.00 SE3 0 0 0 56.00 SE2 0 0 0 57.00 SE1 0 0 0 57.00 SE1 0 0 0 57.00 SSB 0 0 0 58.00 SSB 0 0 0 59.00 SSB 0 0 0 59.00 SSA 0 0 0 59.00 SSA 0 0 0 61.00 IB2 0 0 0 62.00 IA1 0 0 0 63.00 BB2 0 0 0	48.00			CD1		-	0 0	48.00
51.00 CB2 0 0 0 52.00 CB1 5 0 5 53.00 CA2 0 0 0 54.00 CA1 0 0 0 55.00 SE3 0 0 0 56.00 SE2 0 0 0 57.00 SE1 0 0 0 57.00 SE1 0 0 0 57.00 SSC 0 0 0 58.00 SSS 0 0 0 59.00 SSB 0 0 0 60.00 SSA 0 0 0 61.00 IB2 0 0 0 63.00 IA1 0 0 0 63.00 BB2 0 0 0						-		
53.00 CA2 0 0 0 54.00 CA1 0 0 0 55.00 SE3 0 0 0 56.00 SE2 0 0 0 57.00 SE1 0 0 0 58.00 SSC 0 0 0 59.00 SSB 0 0 0 60.00 SSA 0 0 0 61.00 IB2 0 0 0 63.00 IA1 0 0 0 64.00 BB2 0 0 0	51.00			CB2		0	0 0	51.00
54.00 CA1 0 0 0 55.00 SE3 0 0 0 56.00 SE2 0 0 0 57.00 SE1 0 0 0 58.00 SSC 0 0 0 59.00 SSB 0 0 0 60.00 SSA 0 0 0 60.00 SSA 0 0 0 61.00 IB2 0 0 0 63.00 IA1 0 0 0 63.00 BB2 0 0 0						-		
56.00 SE2 0 0 0 57.00 SE1 0 0 0 58.00 SSC 0 0 0 59.00 SSB 0 0 0 60.00 SSA 0 0 0 61.00 IB2 0 0 0 62.00 IB1 0 0 0 63.00 IA2 0 0 0 64.00 BB2 0 0 0	54.00			CA1		0	0 0	54.00
57.00 SE1 0 0 0 58.00 SSC 0 0 0 59.00 SSB 0 0 0 59.00 SSA 0 0 0 50.00 SSA 0 0 0 50.00 IB2 0 0 0 52.00 IB1 0 0 0 54.00 IA2 0 0 0 54.00 BB2 0 0 0						-		
59.00 SSB 0 0 0 60.00 SSA 0 0 0 61.00 IB2 0 0 0 62.00 IB1 0 0 0 63.00 IA1 0 0 0 65.00 BB2 0 0 0	57.00			SE1		0	0 0	57.00
60.00 SSA 0 0 0 61.00 IB2 0 0 0 62.00 IB1 0 0 0 63.00 IA2 0 0 0 64.00 IA1 0 0 0 65.00 BB2 0 0 0						-	-	
62.00 I B1 0 0 0 63.00 I A2 0 0 0 64.00 I A1 0 0 0 65.00 BB2 0 0 0	60.00			SSA		-	0 0	60.00
63.00 I A2 0 0 64.00 I A1 0 0 65.00 BB2 0 0						-		
64.00 I A1 0<						-		1
	64.00			I A1				64.00
	65.00 66.00			BB2 BB1		-	-	
67.00 BA2 0 0	67.00			BA2		0	0 0	67.00

Health Financial Systems WHITLEY MEM	ORIAL HOSPITAL		Inlie	eu of Form CMS-	2552-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		CCN: 150101	Peri od:	Worksheet S-7	
			From 01/01/2014 To 12/31/2014		
	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1.00	2.00	3.00	4.00	
69.00	PE2	2.00	0 0		69.00
70.00	PE1		0 0	-	
71.00	PD2		0 0	0	71.00
72.00	PD1		0 0	0	72.00
73.00	PC2		0 0	0	
74.00	PC1		0 0	0	74.00
75.00	PB2		0 0	0	75.00
76.00	PB1		0 0	0	76.00
77.00	PA2		0 0	0	77.00
78.00	PA1		3 0	3	
199.00	AAA		0 0		199.00
200. 00 TOTAL		1,4	99 0	1, 499	200.00
			CBSA at	CBSA on/after	
			Beginning of	October 1 of	
			Cost Reporting	the Cost	
			Peri od	Reporting	
				Period (if	
				applicable)	
			1.00	2.00	
SNF SERVICES					
201.00 Enter in column 1 the SNF CBSA code or 5 character non-CE			23060	23060	201.00
in effect at the beginning of the cost reporting period. in effect on or after October 1 of the cost reporting per					
In effect on or after uctober 1 of the cost reporting per	Tod (IT applicat	Expenses	Percentage	Associ ated	
		Expenses	Percentage	with Direct	
				Patient Care	
				and Related	
				Expenses?	
		1.00	2.00	3,00	
A notice published in the Federal Register Volume 68, No.	149 August 4, 2				
payments beginning 10/01/2003. Congress expected this inc					
expenses. For lines 202 through 207: Enter in column 1 th					
column 2 the percentage of total expenses for each catego	ry to total SNF	revenue from	Worksheet G-2, F	Part I,	
line 7, column 3. In column 3, enter "Y" for yes or "N" f	or no if the spe	nding reflec	ts increases asso	oci ated	
with direct patient care and related expenses for each ca	tegory. (see ins			1	
202.00 Staffing		2, 221, 4			202.00
203.00 Recruitment			0 0.00		203.00
204.00 Retention of employees			0 0.00		204.00
205.00 Training		35, 4			205.00
206.00 ROUTINE PATIENT CARE EXPENSES		1, 105, 4		Y	206.00
207.00 Total SNF revenue (Worksheet G-2, Part I, line 7, column	3)	4, 969, 6	89		207.00

Heal th	Financial Systems WHITLEY MEMORIAL HO	SPI TAL		In Lie	eu of Form CMS-2	2552-10
H0SPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 150101	Peri od:	Worksheet S-1	0
				From 01/01/2014 To 12/31/2014	Date/Time Pre	nared
				10 12/31/2014	5/21/2015 2:2	
					1.00	
	Uncompensated and indigent care cost computation				I	
1.00	Cost to charge ratio (Worksheet C, Part line 202 column 3 divid	ded by lir	ne 202 columr	8)	0. 300798	1.00
0.00	Medicaid (see instructions for each line)				4 444 405	0.00
2.00 3.00	Net revenue from Medicaid				1, 441, 425 Y	2.00 3.00
3.00 4.00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is "yes", does line 2 include all DSH or supplemental p	anymonte t	from Madiania	2	N N	4.00
4.00 5.00	If line 4 is "no", then enter DSH or supplemental payments from N		ITOII Meurcard	· · ·	973, 439	
6.00	Medicaid charges	leur car u			15, 029, 919	
7.00	Medicaid cost (line 1 times line 6)				4, 520, 970	
8.00	Difference between net revenue and costs for Medicaid program (li	ine 7 mini	us sum of lir	es 2 and 5 if	2, 106, 106	
0.00	<pre>< zero then enter zero)</pre>				2,100,100	0.00
	State Children's Health Insurance Program (SCHIP) (see instruction	ons for ea	ach line)			
9.00	Net revenue from stand-alone SCHIP		,		6, 229	9.00
10.00	Stand-alone SCHIP charges				50, 751	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)				15, 266	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (I	line 11 mi	inus line 9;	if < zero then	9, 037	12.00
	enter zero)					
	Other state or local government indigent care program (see instru					
13.00	Net revenue from state or local indigent care program (Not includ				255, 087	
14.00	Charges for patients covered under state or local indigent care p	orogram (ľ	Not included	in lines 6 or	1, 810, 953	14.00
15.00	10) State on local indigent core program cost (line 1 times line 14)				E44 701	15.00
	State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indic	nont caro	program (Lir	o 15 minus lino	544, 731 289, 644	
10.00	13; if < zero then enter zero)	Jent care			209,044	10.00
	Uncompensated care (see instructions for each line)				1	
17.00	Private grants, donations, or endowment income restricted to fund	ding chari	ity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hos	spital ope	erations		0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local	i ndi gent	care program	s (sum of lines	2, 404, 787	19.00
	8, 12 and 16)					
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col . 2)	
20,00	Total initial abligation of nationta approved for abority appa (at 6.11	1.00	2.00	3.00	20.00
20.00	Total initial obligation of patients approved for charity care (a charges excluding non-reimbursable cost centers) for the entire t		1, 365, 66	53 756, 867	2, 122, 530	20.00
21.00	Cost of initial obligation of patients approved for charity care		410, 78	227, 664	638, 453	21.00
21.00	times line 20)		110,70	227,001	000, 100	21.00
22.00	Partial payment by patients approved for charity care		2, 17	3, 546	5, 720	22.00
23.00			408, 61			
			· · ·			
					1.00	
24.00	Does the amount in line 20 column 2 include charges for patient of		nd a length c	f stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent care p					
	If line 24 is "yes," charges for patient days beyond an indigen			h of stay limit	0	
26.00	Total bad debt expense for the entire hospital complex (see inst				6, 203, 189	
27.00	Medicare bad debts for the entire hospital complex (see instructi	,			32, 231	
	Non-Medicare and non-reimbursable Medicare bad debt expense (line			20)	6, 170, 958	
	Cost of non-Medicare and non-reimbursable Medicare bad debt exper	nse (line	ι τιmes line	∠8)	1, 856, 212	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	- 20)			2, 488, 945	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line	e 30)			4, 893, 732	3 I. UÜ

Health Financial Systems RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (WHITLEY MEMORIA		CCN: 150101 F	In Lie Period:	u of Form CMS-2 Worksheet A	2552-10
RECERCITIENT ON AND ADJUSTMENTS OF TREAD DALANCE			F	rom 01/01/2014 o 12/31/2014		
Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS	1 1	2 224 542	2 224 54	771 005	2 4/4 /00	1 00
1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP		3, 236, 543	3, 236, 543		2, 464, 608 1, 139, 626	1.00 2.00
2. 01 00201 SNF CAPITAL		0	(203, 758	2.00
3.00 00300 OTHER CAP REL COSTS		0	C	0	0	3.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 464, 003	4, 436, 992	5, 900, 995		4, 436, 992	4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL 6. 00 00600 MAI NTENANCE & REPAI RS	9, 072, 296	5, 081, 149	14, 153, 445	-50, 618 0	14, 102, 827 0	5.00 6.00
7. 00 00700 OPERATION OF PLANT	288, 318	921, 873	1, 210, 191	-	1, 149, 040	7.00
8.00 00800 LAUNDRY & LI NEN SERVI CE	0	162, 222	162, 222		162, 222	8.00
9. 00 00900 HOUSEKEEPI NG	244, 908	84, 213	329, 121		358, 681	9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	325, 821	190, 647	516, 468		188, 660 362, 111	
11. 00 01100 CAFETERIA 12. 00 01200 MAINTENANCE OF PERSONNEL	0	0) 362, 111 0 0	362, 111	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	114, 824	369	115, 193	-	129, 239	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	C	0	0	14.00
15.00 01500 PHARMACY	485, 816	2, 294, 574	2, 780, 390		2, 065, 373	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCIAL SERVICE	0	0			0	16.00 17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20. 00 02000 NURSI NG SCHOOL	0	0	C	0	0	20.00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	C	0	0	21.00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV 23. 00 02300 PARAMED ED PRGM-(SPECI FY)	0	0	(0	22.00 23.00
INPATIENT ROUTINE SERVICE COST CENTERS	0	0	L C	/	0	23.00
30. 00 03000 ADULTS & PEDI ATRI CS	2, 216, 845	273, 892	2, 490, 737	-700, 939	1, 789, 798	30.00
43.00 04300 NURSERY	0	0	C	/		
44. 00 04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	2, 156, 587	968, 006	3, 124, 593	215, 239	3, 339, 832	44.00
50. 00 05000 OPERATING ROOM	873, 719	337, 935	1, 211, 654	105, 656	1, 317, 310	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	55, 956	848	56, 804		821, 298	
53.00 05300 ANESTHESI OLOGY	0	999, 499	999, 499		999, 499	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	992, 698 0	442, 341 1, 468, 559	1, 435, 039 1, 468, 559		1, 457, 648 1, 467, 294	54.00 60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	1, 400, 337	1, 400, 33		1,407,274	62.30
65. 00 06500 RESPI RATORY THERAPY	388, 808	141, 397	530, 205	-22, 111	508, 094	65.00
66.00 06600 PHYSI CAL THERAPY	755, 674	542, 982	1, 298, 656		507, 342	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	184, 608 61, 913	184, 608 61, 913		652, 632 191, 996	
69. 00 06900 ELECTROCARDI OLOGY	0	2, 114	2, 114		1, 453	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	-221	749, 928	749, 707		566, 333	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C			
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 97 07697 CARDIAC REHABILITATION	0	0		760, 570 0	760, 570 0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0			0	
76. 99 07699 LI THOTRI PSY	0	0	C	0	0	76.99
OUTPATIENT SERVICE COST CENTERS	01.000	10.5(0	01.00	4	10/ 1/0	
90. 00 09000 CLINIC 90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	81, 328	10, 569	91, 897	14, 272	106, 169 0	90.00 90.01
91. 00 09100 EMERGENCY	1, 195, 687	180, 689	1, 376, 376	-	1, 466, 753	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1,1,0,00,	100,007	1,0,0,0,0,0	, , , , , , , , , , , , , , , , , , , ,	17 1007 700	92.00
OTHER REIMBURSABLE COST CENTERS	1			· · · · ·		
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	1, 048, 334	221, 254	1, 269, 588	122, 953	1, 392, 541	95.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	21, 761, 401	22, 995, 116	44, 756, 517	-252, 478	44, 504, 039	118.00
NONREI MBURSABLE COST CENTERS					.,	1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13, 718				
192. 00 19200 PHYSICIANS' PRIVATE OFFICES 194. 00 07950 OCCUPATIONAL HEALTH	12, 152	367, 039 -200, 479	379, 191 -200, 479			
194. 00 07950 0CC0PATIONAL HEALTH 194. 01 07951 PALN CLINIC	0	-200, 479	-200, 479	-		194.00
194. 02 07952 OAK POINTE	271, 089	657, 239	928, 328	-	928, 516	194.02
194. 03 07953 FOUNDATI ON	0	90, 000	90, 000		90, 000	
194.04 07954 COMMUNI TY & VOLUNTEER SERVICES 194.05 07955 VACANT SPACE	22, 838	173, 000 0	195, 838 (-	202, 835	194.04 194.05
200.00 TOTAL (SUM OF LINES 118-199)	22, 067, 480	0 24, 095, 633	-	-		
	22,007,700	21,070,000	10, 100, 110		10, 100, 110	

	n Financial Systems SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (WHITLEY MEMOR DF EXPENSES		CCN: 150101	Peri od:	u of Form CMS- Worksheet A	2552-10
					From 01/01/2014 To 12/31/2014	Date/Time Pre 5/21/2015 2:2	
	Cost Center Description	Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00			10/21/2010 2:2	
	GENERAL SERVICE COST CENTERS	0.00	/.00				
1.00	00100 CAP REL COSTS-BLDG & FIXT	-2, 096, 580					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-14, 477					2.00
2.01	00201 SNF CAPITAL	0		1			2.01
3.00	00300 OTHER CAP REL COSTS	-1, 572, 056	-				3.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	-1, 611, 740					4.00
6.00	00600 MAINTENANCE & REPAIRS	-1,011,740) 12,491,007	1			6.00
7.00	00700 OPERATION OF PLANT	-95, 519	-				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0		1			8.00
9.00	00900 HOUSEKEEPI NG	0	358, 681				9.00
10.00		-15, 791		1			10.00
11.00		-43, 468		1			11.00
12.00		0	-				12.00
13.00 14.00		0					13.00
14.00		-717, 638	-				14.00
16.00		, , , , 030					16.00
17.00		0	-				17.00
19.00		0	c c				19.00
20.00		0) C				20.00
21.00		0	-				21.00
22.00		0	-	1			22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	0) C	1			23.00
30.00		14, 758	1, 804, 556				30.00
43.00		0		1			43.00
44.00		-7, 138					44.00
	ANCI LLARY SERVICE COST CENTERS		1				
50.00		0					50.00
52.00		0					52.00
53.00 54.00		-977, 274		1			53.00 54.00
60.00							60.00
62.30		0		1			62.30
65.00		-70, 588	437, 506				65.00
66.00	06600 PHYSI CAL THERAPY	-279, 859	227, 483				66.00
67.00		0					67.00
68.00		0		1			68.00
69.00 71.00		0	.,	1			69.00
72.00		0		1			71.00
73.00							73.00
	07697 CARDI AC REHABI LI TATI ON	0		1			76.97
	07698 HYPERBARI C OXYGEN THERAPY	0					76. 98
76.99	07699 LI THOTRI PSY	0) C				76.99
00.00	OUTPATIENT SERVICE COST CENTERS		10/ 1/0	1			
90.00 90.01	09000 CLINIC 09001 INTENSIVE OUT PATIENT PROGRAM	0		1			90.00 90.01
91.00		-11, 212	-				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	11,212	1, 100, 011				92.00
	OTHER REIMBURSABLE COST CENTERS	•	•				
95.00		0	1, 392, 541				95.00
	SPECIAL PURPOSE COST CENTERS		1				
118.0		-7, 498, 582	37, 005, 457				118.00
100 0	NONREIMBURSABLE COST CENTERS 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13, 718				190.00
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 19200 PHYSICIANS' PRIVATE OFFICES	-310, 065					190.00
	0 07950 OCCUPATIONAL HEALTH	-310,005					192.00
	107951 PAIN CLINIC		0	1			194.01
	2 07952 OAK POI NTE	-277, 640	650, 876	,			194. 02
	3 07953 FOUNDATI ON	0	90, 000				194.03
	4 07954 COMMUNI TY & VOLUNTEER SERVICES	0					194.04
	507955 VACANT SPACE	0	-	1			194.05
200.0	0 TOTAL (SUM OF LINES 118-199)	-8, 086, 287	38, 076, 826	'			200.00

	Financial Systems SIFICATIONS		WHITLEY MEMORIA	AL HOSPITAL Provider (CN: 150101			of Form CMS Worksheet A	
						From 01/0	01/2014 31/2014	Date/Time Pi	repared:
		Increases						5/21/2015 2:	:26 pm
	Cost Center	Line #	Salary	Other					
	2.00 A - CAFETERIA RECLASS	3.00	4.00	5.00					
. 00			229, 997	13 <u>2, 1</u> 14					1.00
	O B - OB RECLASS		229, 997	132, 114					_
. 00	NURSERY	43.00	148, 615	14, 866					1.00
. 00	DELIVERY ROOM & LABOR ROOM	52.00	<u>530, 6</u> 63	<u> </u>					2.00
	O D - LTC A&G COST		679, 278	67, 949					_
. 00	SKILLED NURSING FACILITY	44.00	93, 062	144, 783					1.00
			93, 062	144, 783					
. 00	E - BUILDING AND EQUIP LEASE CAP REL COSTS-BLDG & FIXT	1.00	0	465, 553					1.00
. 00	CAP REL COSTS-MVBLE EQUIP	2.00	0	47, 525					2.00
. 00		0.00	0	0					3.00
. 00 . 00		0.00 0.00	0	0					4.00
. 00		0.00	Ö	0					6.00
. 00		0.00	0	0					7.00
. 00 . 00		0. 00 0. 00	0	0					8.00 9.00
D. 00		0.00	Ö	0					10.00
1.00		0.00	0	0					11.00
2.00 3.00		0.00 0.00	0	0					12.00 13.00
4.00		0.00	0	Ő					14.00
5.00		0.00	0	0					15.00
6.00 7.00		0.00 0.00	0	0					16.00
	0		<u>0</u>	513,078					
. 00	G - INSURANCE RECLASS CAP REL COSTS-BLDG & FIXT	1.00	0	6, 266					1.00
. 00	CAP REL COSTS-BEDG & FIXT	2.00	0	37, 507					2.00
. 00	SNF CAPI TAL	2.01	0	14, 598					3.00
. 00	OAK POINTE	<u> </u>	0	<u>188</u> 58, 559					4.00
	H - DEPRECIATION RECLASS		0	30, 337					-
. 00	CAP REL COSTS-MVBLE EQUI P	2.00	0	1,041,724					1.00
. 00	<u>SNF CAPI TAL</u>		0	<u>189, 055</u> 1, 230, 779					2.00
	J - TAXES RECLASS			1,200,777					
. 00	CAP REL COSTS-MVBLE EQUIP	2.00	0	12, 870					1.00
. 00	<u>SNF</u> <u>CAPI</u> <u>TAL</u>		<u>o</u>	<u>105</u> 12, 975					2.00
	K – SALARY RECLASS								
. 00	ADMI NI STRATI VE & GENERAL		0	3, 741, 044					1.00
	L - REHAB THERAPY DEPT RECLAS	S	0	3,741,044					
. 00	OCCUPATIONAL THERAPY	67.00	425, 909	33, 042					1.00
. 00	SPEECH PATHOLOGY		<u>114, 134</u> 540, 043	<u>8, 8</u> 53 41, 895					2.00
	M - DRUGS CHARGED TO PATIENT	RECLASS							
. 00	DRUGS_CHARGED_TO_PATIENTS		<u>o</u>	<u>773, 2</u> 75 773, 275					1.00
	N - PTO ACCRUAL RECLASS		U	113, 215					_
. 00	ADMI NI STRATI VE & GENERAL	5.00	350, 385	0					1.00
. 00 . 00	OPERATION OF PLANT HOUSEKEEPING	7.00 9.00	35, 270 29, 959	0					2.00 3.00
. 00	DI ETARY	10.00	39, 857	0					4.00
. 00	NURSING ADMINISTRATION	13.00	14, 046	0					5.00
. 00 . 00	PHARMACY ADULTS & PEDIATRICS	15.00 30.00	59, 429 48, 574	0					6.00 7.00
. 00	NURSERY	43.00	48, 374	0					8.00
. 00	OPERATING ROOM	50.00	106, 881	0					9.00
0.00	DELIVERY ROOM & LABOR ROOM	52.00	180, 748	0					10.00
1.00 2.00	RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY	54.00 65.00	121, 435 47, 562	0					11.00
3.00	PHYSI CAL THERAPY	66.00	60, 313	Ö					13.00
4.00		67.00	25, 032	0					14.00
5.00 6.00	SPEECH PATHOLOGY CLINIC	68.00 90.00	7, 096 9, 921	0					15.00 16.00
7.00	EMERGENCY	91.00	146, 267	0					17.00
B. 00 9. 00	AMBULANCE SERVICES	95.00	128, 241	0					18.00
	PHYSICIANS' PRIVATE OFFICES	192.00	1, 486	0					19.00

CLASS	SEFECATIONS			Provi der	CCN: 150101	Peri od:	Worksheet A	-6
						From 01/01/2014 To 12/31/2014	Date/Time P	roparod
						10 12/31/2014	5/21/2015 2:	:26 pm
		Increases						
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
). 00	COMMUNITY & VOLUNTEER	194.04	2, 794	0				20. (
	TOTALS		1, 464, 003	0				
	0 - CLINIC DIETICIAN RECLASS							
00	<u>CLINIC</u>		4, 351	<u>0</u>				1.
	0		4, 351	0				
	P - CORPORATE DI RECT ALLOC RE		-					- · · ·
	OCCUPATIONAL HEALTH	194.00	0	43, 328				1.
00	COMMUNITY & VOLUNTEER	194.04	0	4, 203				2.
	<u>SERVICES</u>	+		47, 531				
	Q - OCCUPATIONAL HEALTH RECLA	22	U	47, 551				-
00	OCCUPATIONAL HEALTH	194.00	0	200, 479				1.
00		0,00	0	200, 177				2.
00		0,00	0	0				3.
00		0.00	0	0				4.
00		0.00	0	0				5.
00		0.00	0	0				6.
00		0.00	0	0				7.
00		0.00	0	0				8.
00		0.00	0	0				9.
	0		0	200, 479				
	R - IMPLANTABLE MEDICAL SUPPL							
00	I MPL. DEV. CHARGED TO PATI ENTS	72.00	0	182, 152				1.
		†		182, 152				
	S - RECLASSIFY NEGATIVE SALAR	Y AMOUNT	· ·					-
	MEDI CAL SUPPLI ES CHARGED TO PATI ENT	71.00	221	0				1.
		+		₀				
00 00	Grand Total: Increases		3, 010, 955	7, 146, 613				500.

	Financial Systems SIFICATIONS		WHITLEY MEMORIA		- CCN: 150101	In Lie Period:	u of Form CMS Worksheet A-	
RECEAS						From 01/01/2014 To 12/31/2014	Date/Time Pr 5/21/2015 2:	epared:
	Cost Center	Decreases Li ne #	Salary	Other	Wkst. A-7 Ref.			
	6. 00	7.00	8.00	9.00	10.00	-		
1 00	A - CAFETERIA RECLASS	10.00	229, 997	100 114	1			1 00
1.00	DI ETARY	<u>10.00</u>	229,997	<u>132, 1</u> 14 132, 114		0		1.00
	B - OB RECLASS					-		
1.00 2.00	ADULTS & PEDIATRICS	30.00 0.00	679, 278 0	67, 949 0		0		1.00
2.00	0	0.00	679, 278	67, 949				2.00
1 00	D - LTC A&G COST	5 00	02.042	144 700	1			1 00
1.00	ADMI NI STRATI VE & GENERAL	5.00	9 <u>3, 0</u> 62 93, 062	<u>144, 783</u> 144, 783		0		1.00
4 9 9	E - BUILDING AND EQUIP LEASE	5 00		50.0/4				
1.00 2.00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5.00 7.00	0	53, 061 95, 253				1.00 2.00
3.00	RESPI RATORY THERAPY	65.00	0	68, 464	. (o		3.00
4.00 5.00	PHYSICAL THERAPY	66.00	0	248, 774		0		4.00
5.00 6.00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5.00 7.00	0	15, 982 1, 168		0		5.00 6.00
7.00	HOUSEKEEPI NG	9.00	0	399) (0		7.00
8.00 9.00	DI ETARY PHARMACY	10. 00 15. 00	0	1, 203 1, 171		0		8.00 9.00
9.00 10.00	ADULTS & PEDIATRICS	30.00	0	2, 286		0		10.00
11.00	SKILLED NURSING FACILITY	44.00	О	10, 631	(0		11.00
12. 00 13. 00	OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C	50.00 54.00	0	1, 225 2, 186		0		12.00 13.00
14.00	RESPIRATORY THERAPY	65.00	0	1, 123		0		14.00
15.00	PHYSICAL THERAPY	66.00	0	2, 181		0		15.00
16. 00 17. 00	EMERGENCY AMBULANCE SERVICES	91.00 95.00	0	2, 683 5, 288		0		16.00 17.00
17.00	0			513, 078				17.00
1.00	G - I NSURANCE RECLASS ADMI NI STRATI VE & GENERAL	5.00	0	46, 584	1:			1.00
2.00	SKILLED NURSING FACILITY	44.00	0	11, 975				2.00
3.00		0.00	0	0				3.00
4.00	<u> </u>	0.00	0	00 58, 559		0		4.00
	H - DEPRECIATION RECLASS	1						
1.00 2.00	CAP REL COSTS-BLDG & FIXT	1.00 0.00	0	1, 230, 779 0		9		1.00 2.00
2.00	0	0.00	0	1, 230, 779		7		2.00
1.00	J - TAXES RECLASS CAP REL COSTS-BLDG & FIXT	1.00	0	12, 975	1:	2		1.00
2.00	CAP REL COSTS-BEDG & FIXT	0.00	0	12, 975				2.00
	0		0	12, 975		1		
1.00	K – SALARY RECLASS ADMI NI STRATI VE & GENERAL	5.00	3, 741, 044	0		0		1.00
1.00	0	T	3, 741, 044	0				1.00
1 00	L - REHAB THERAPY DEPT RECLAS		F 40 042	41 005	1			1 00
1.00 2.00	PHYSI CAL THERAPY	66.00 0.00	540, 043 0	41, 895 0		0		1.00 2.00
	0		540, 043	41, 895		1		
1.00	M - DRUGS CHARGED TO PATIENT PHARMACY	RECLASS 15.00	0	773, 275		0		1.00
1.00	0		<u>0</u>	773, 275		51		1.00
1.00	N - PTO ACCRUAL RECLASS EMPLOYEE BENEFITS DEPARTMENT	4.00	1, 464, 003	0		ol		1.00
2.00	LINFLOTEL BENEFITS DEFARTMENT	0.00	1, 404, 003	0		0		2.00
3.00		0.00	0	0		0		3.00
4.00 5.00		0.00 0.00	0	0		0		4.00 5.00
6.00		0.00	0	0		0		6.00
7.00		0.00	0	0) (0		7.00
8.00 9.00		0.00 0.00	0	0		0		8.00 9.00
10.00		0.00	0	0		0		10.00
11.00		0.00	0	0		0		11.00
12.00 13.00		0.00 0.00	0	0 0		0		12.00 13.00
14.00		0.00	0	0		0		14.00
15.00		0.00	0	0)	0		15.00
16. 00 17. 00		0.00 0.00	0	0		0		16.00 17.00
18.00		0.00	0	0		0		18.00
19.00		0.00	0	0		0		19.00
20.00		0.00	0	0	(0		20.00

	Financial Systems SSIFICATIONS			AL HOSPITAL Provider	- CCN: 150101	Peri od:	Worksheet A-	-6
						From 01/01/2014 To 12/31/2014	Date/Time Pr	repared:
							5/21/2015 2:	26 pm
		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	<u>°.</u>		
	6.00	7.00	8.00	9.00	10.00			
	TOTALS		1, 464, 003	C)			
	0 - CLINIC DIETICIAN RECLASS	i			1			
1.00	DI ETARY		4, 351	0		Q		1.0
	0		4, 351	C)			
	P - CORPORATE DI RECT ALLOC RE					-		
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	47, 531		0		1.0
2.00		0.00	0	0)	0		2.0
	0		0	47, 531				
	Q - OCCUPATIONAL HEALTH RECLA	SS						
1.00	RADI OLOGY-DI AGNOSTI C	54.00	0	96, 640)	0		1.0
2.00	LABORATORY	60.00	0	1, 265	5	0		2.0
3.00	RESPI RATORY THERAPY	65.00	0	86))	0		3.0
4.00	PHYSI CAL THERAPY	66.00	0	18, 734	-	0		4.0
5.00	OCCUPATI ONAL THERAPY	67.00	0	15, 959		0		5.0
5.00	ELECTROCARDI OLOGY	69.00	0	661		0		6.0
7.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	1, 222		0		7.0
	PATI ENT							
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	12, 705		0		8.0
9.00	EMERGENCY	91.00	0	53, 207	r	0		9.0
				200, 479	,	1		
	R - IMPLANTABLE MEDICAL SUPPL	IES						
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	182, 152	2	0		1.0
	PATI ENT		-					
				182, 152	2	1		
	S - RECLASSIFY NEGATIVE SALAR	Y AMOUNT						
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	221		0		1.0
	PATI ENT		ő	221		-		
	TOTALS	+		221	<u> </u>	1		
500 00	Grand Total: Decreases		6, 751, 778	3, 405, 790		-		500.0

Heal th	Financial Systems	WHITLEY MEMORI	AL HOSPITAL			In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150101	Peri		Worksheet A-7	
					To	01/01/2014 12/31/2014		narod
					10	12/ 51/ 2014	5/21/2015 2:2	6 pm
				Acqui si ti on	s			
		Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	92, 617	0		0	0	76, 411	1.00
2.00	Land Improvements	279, 791	0		0	0	234, 929	
3.00	Buildings and Fixtures	3, 961, 151	59, 793		0	59, 793	2, 901, 687	3.00
4.00	Building Improvements	48, 824	0		0	0	0	
5.00	Fixed Equipment	872, 507	0		0	0	281, 093	5.00
6.00	Movable Equipment	12, 343, 957	66, 773		0	66, 773		6.00
7.00	HIT designated Assets	2, 805, 945	389, 808		0	389, 808	0	7.00
8.00	Subtotal (sum of lines 1-7)	20, 404, 792	516, 374		0	516, 374	5, 457, 910	
9.00	Reconciling Items	3, 192, 810	0		0	0	-2, 943	9.00
10.00	Total (line 8 minus line 9)	17, 211, 982	516, 374		0	516, 374	5, 460, 853	10.00
		Endi ng Bal ance	Fully					
		_	Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	16, 206						1.00
2.00	Land Improvements	44, 862	44, 862					2.00
3.00	Buildings and Fixtures	1, 119, 257	38, 112					3.00
4.00	Building Improvements	48, 824	42, 430					4.00
5.00	Fixed Equipment	591, 414	25, 981					5.00
6.00	Movable Equipment	10, 446, 940	3, 978, 726					6.00
7.00	HIT designated Assets	3, 195, 753	0					7.00
8.00	Subtotal (sum of lines 1-7)	15, 463, 256	4, 130, 111					8.00
9.00	Reconciling Items	3, 195, 753	0					9.00
10.00	Total (line 8 minus line 9)	12, 267, 503	4, 130, 111					10.00

Heal th	n Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150101	Period: From 01/01/2014		
					To 12/31/2014	Date/Time Pre 5/21/2015 2:2	
			Sl	JMMARY OF CAP	1 TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			ind 2			
1.00	CAP REL COSTS-BLDG & FIXT	3, 236, 543	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
2.01	SNF CAPITAL	2 224 542	0		0 0	0	2.01
3.00	Total (sum of lines 1-2)	3, 236, 543	I U DF CAPITAL	1	0 0	0	3.00
		SUMMARY	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum	-			
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	<u>(SHEET A, COLUN</u>					
1.00	CAP REL COSTS-BLDG & FIXT	0	3, 236, 543				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	1			2.00
2.01	SNF CAPITAL	0	0				2.01
3.00	Total (sum of lines 1-2)	0	3, 236, 543				3.00

Heal th	n Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		eriod:	Worksheet A-7	
					rom 01/01/2014 o 12/31/2014		hared
						5/21/2015 2:26	<u>5 pm</u>
		COM	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capitalized	Gross Assets	Ratio (see	Insurance	
	cost center bescription	GIUSS ASSELS	Leases	for Ratio	instructions)	Thou ance	
			200000	(col. 1 - col.			
				2)			
	1	1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		-			-	
1.00	CAP REL COSTS-BLDG & FIXT	1, 804, 357		1, 804, 357		0	1.00
2.00 2.01	CAP REL COSTS-MVBLE EQUIP	10, 446, 940 4, 148, 740				0	2. 00 2. 01
2.01	Total (sum of lines 1-2)	4, 148, 740				Ű	2.01
3.00			TION OF OTHER			F CAPITAL	3.00
		, ALLOON	IT ON OF OTHER S			i on i i nie	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel ate				
			d Costs	through 7)			
		6.00	7.00	8.00	9.00	10.00	
1.00	PART III - RECONCILIATION OF CAPITAL COSTS CI CAP REL COSTS-BLDG & FIXT	ENTERS 0			-90, 816	465, 553	1.00
2.00	CAP REL COSTS-BEDG & FIXT	0		0	-90, 818 1, 027, 247	405, 553 47, 525	2.00
2.00	SNF CAPITAL	0			189,055		2.00
3.00	Total (sum of lines 1-2)	0	0	0	1, 125, 486		3.00
		-	SI	JMMARY OF CAPIT			
	Cost Center Description	Interest	Insurance (see			Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
		11.00	12.00	13.00	instructions) 14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		12.00	13.00	14.00	15.00	
1.00	CAP REL COSTS-BLDG & FIXT	0	6, 266	-12, 975	0	368, 028	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0				1, 125, 149	2.00
2.01	SNF CAPITAL	0	14, 598			203, 758	2.01
3.00	Total (sum of lines 1-2)	0	58, 371	0	0	1, 696, 935	3.00

	Financial Systems MENTS TO EXPENSES		WHITLEY MEMOR	Provider CCN: 150101	In Lie Period: From 01/01/2014 To 12/31/2014	Date/Time Pre	pared:
				Expense Classification o		5/21/2015 2: 2	
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00 C	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00 0	1.00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		C	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	COSTS-MVBLE EQUIP (chapter 2) Investment income - SNF		C	SNF CAPI TAL	2.01	0	2. 01
3.00	CAPITAL (chapter 2) Investment income - other		C		0.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time		C		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of		C		0.00		
6.00	expenses (chapter 8) Rental of provider space by		C		0.00		
7.00	suppliers (chapter 8) Telephone services (pay		C		0.00		
7.00	stations excluded) (chapter		C		0.00	0	7.00
8.00	21) Tel evision and radio service	А	-266	OPERATION OF PLANT	7.00	0	8. 00
9.00	(chapter 21) Parking lot (chapter 21)		C		0.00		
	Provider-based physician adjustment	A-8-2	-40, 430			0	
	Sale of scrap, waste, etc. (chapter 23)		C		0.00		
12.00	Related organization transactions (chapter 10)	A-8-1	-3, 350, 717			0	12.00
	Laundry and linen service Cafeteria-employees and guests	В	C - 17, 08C	CAFETERI A	0.00 11.00		
15.00	Rental of quarters to employee and others		C		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		C	5	0.00	0	16. 00
17.00	Sale of drugs to other than patients		C		0.00	0	17.00
18.00	Sale of medical records and abstracts		C		0.00	0	18.00
19.00	Nursing school (tuition, fees,		C		0.00	0	19. 00
	books, etc.) Vending machines		C		0.00		
21.00	Income from imposition of interest, finance or penalty		C		0.00	0	21.00
22.00	charges (chapter 21) Interest expense on Medicare		C		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	C	RESPI RATORY THERAPY	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66.00		24. 00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		C	*** Cost Center Deleted ***	114.00		25. 00
26.00	(chapter 21) Depreciation - CAP REL		C	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		C	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27. 01	COSTS-MVBLE EQUIP Depreciation - SNF CAPITAL			SNF CAPI TAL	2.01	0	
	Non-physician Anesthetist Physicians' assistant		C	NONPHYSICIAN ANESTHETISTS	19.00 0.00		28. 00 29. 00
	Adjustment for occupational therapy costs in excess of	A-8-3	C	OCCUPATI ONAL THERAPY	67.00		30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		C	ADULTS & PEDIATRICS	30.00		30. 99
31.00	instructions) Adjustment for speech	A-8-3	C	SPEECH PATHOLOGY	68.00		31.00
	pathology costs in excess of limitation (chapter 14)						

Heal th Financial Systems ADJUSTMENTS TO EXPENSES		WHITLEY MEMORIA	Provi der CCN: 150101	Period:	u of Form CMS- Worksheet A-8	
ADJUSTMENTS TO EXPENSES			Provider CCN. 150101	From 01/01/2014		
				To 12/31/2014	Date/Time Pre 5/21/2015 2:2	pared:
			Expense Classification of	n Worksheet A		
		T	o/From Which the Amount is	s to be Adjusted		
Cost Center De	escription Basis/Code (2) Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
32.00 CAH HIT Adjustment		0		0.00	C	32.00
Depreciation and In						
33.00 MI SCELLANEOUS REVEN	JE B		DMINISTRATIVE & GENERAL	5.00		
33.01 NON-ALLOWABLE ER	A	-2, 082 EN	MERGENCY	91.00	C	33.01
ADMI NI STRATI VE PMTS						
34. 01 CAFE EMP. & GUES		-1, 340 CA		11.00		
35.00 POSTURE ASSESSMENTS	В		HYSICAL THERAPY	66.00		
36.00 SALE OF LTC SUPPLIES			KILLED NURSING FACILITY	44.00		00.00
38.00 NON-PATIENT LAB REV				65.00		
39.00TELEVI SI ON OFFSET40.00ANSWERI NG SERVI CE	A		AP REL COSTS-MVBLE EQUIP DMINISTRATIVE & GENERAL	2.00 5.00		
40.00 ANSWERING SERVICE 41.00 PHYSICIAN RECRUITING						
41.00 PHYSICIAN RECRUITING 42.00 MEALS ON WHEELS	J A A	-22, 917AL -15, 791DI	DMI NI STRATI VE & GENERAL	5.00 10.00		
43. 00 VI SI TOR MEALS	Â	-25, 048 CA		11.00		
44. 00 PHARMACY SALES	Â	-706, 446 Ph		15.00		
45. 00 COMMUNITY HEALTH & Y			DMI NI STRATI VE & GENERAL	5.00		
SV		50,722/1	Similar Sharrive & General	5.00		
46.00 SELF INSURANCE	А	-1, 572, 056 EN	MPLOYEE BENEFITS DEPARTMEN	JT 4.00	l c	46.00
48.00 LOBBY EXPENSE	А		OMINISTRATIVE & GENERAL	5.00	l c	
48.01 INTERUNIT RENT EXPE	NSE A		ESPI RATORY THERAPY	65.00	c c	48.01
48.02 INTERUNIT RENT EXPEN	NSE A		HYSI CAL THERAPY	66.00	c c	48.02
48.03 INTERUNIT RENT EXPE	NSE A	-53, 061 AE	DMINISTRATIVE & GENERAL	5.00	C C	48.03
48.04 INTERUNIT RENT EXPEN	NSE A	-95, 253 OF	PERATION OF PLANT	7.00	C	48.04
49.00 TELEMETRY MONITORING	G EXPENSE A	14, 758 AE	DULTS & PEDIATRICS	30.00	C	49.00
49. 02 RENT EXPENSE - MEDI ASSI S	CATION A	-310, 065 PH	HYSICIANS' PRIVATE OFFICES	5 192.00	C	49.02
49.03 RENT EXPENSE - OAK	POINTE A	-277, 640 04	AK POINTE	194.02	c c	49.03
49. 05 I NTERUNI T RENT EXPE		-11, 192 PF		15.00		
49. 07 NON-ALLOWABLE ANEST			VESTHESI OLOGY	53.00		
SVCS				20100		
49. 10 HOSPI TALI ST / SURGE	RY ON CALL A	-216, 944 AE	DMINISTRATIVE & GENERAL	5.00	c c	49.10
50.00 TOTAL (sum of lines	1 thru 49)	-8, 086, 287				50.00
(Transfer to Worksho	eet A,					
column 6, line 200.)					

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	WHITLEY MEMOR	REAL HOSPETAL	In Lie	In Lieu of Form CMS-2552-10		
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 150101	Period: From 01/01/2014	Worksheet A-8	-1	
OFFICE	COSTS			To 12/31/2014			
	Line No.	Cost Center	Expense Items	Amount of	Amount		
				Allowable Cost	Included in		
					Wks. A, column		
					5		
	1.00	2.00	3. 00	4.00	5.00		
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANI ZATI ONS OR	CLAI MED		
	HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	INTERCOMPANY RENT	0	2, 096, 580	1.00	
2.00	5.00	ADMINISTRATIVE & GENERAL	REMOVE PPG SUBSIDY	0	3, 671, 864	2.00	
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	10, 115, 727	7, 698, 000	3.00	
4.00	0.00			0	0	4.00	
5.00	TOTALS (sum of lines 1-4).			10, 115, 727	13, 466, 444	5.00	
	Transfer column 6, line 5 to						
	Worksheet A-8, column 2,						
	line 12.						

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

110	been posted to worksheet A,	corumns r anu/or z, the amount			or this part.	
				Related Organization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	
	1.00	2.00	3.00	4.00	5.00	
	B INTERPRIATIONSHIP TO RELAT	TED OPCANIZATION(S) AND/OP HO				

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

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

6.00 B	0. 00 PARKVI EW HEALTH 100. 0	0 6.00
7.00	0.00 0.0	0 7.00
8.00	0.00 0.0	0 8.00
9.00	0.00 0.0	0 9.00
10.00	0.00 0.0	0 10.00
100.00 G. Other (financial or		100.00
non-financial) specify:		

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

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

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

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

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

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

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

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10		
STATEMENT OF COSTS OF SERVICES FROM OFFICE COSTS	RELATED ORGANIZATIONS AND HOME Provider CCN: 150101	Period: Worksheet A-8-1 From 01/01/2014 To 12/31/2014 Date/Time Prepared:		

			5/21/2015 2:2	26 pm
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	-2,096,580	9		1.00
2.00	-3, 671, 864	0		2.00
3.00	2, 417, 727	0		3.00
4.00	0	0		4.00
5.00	-3, 350, 717			5.00

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

1103 1101	been posted to norkaneet A,			
	Related Organization(s)			
	and/or Home Office			
	Type of Business			
	6. 00			
	B. INTERRELATIONSHIP TO RELAT	O ORGANIZATION(S) AND/OR HOME OFFI	CE:	

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

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

6.00	HOME OFFICE	6.00						
7.00		7.00						
8.00		8.00						
9.00		9.00						
10. 00 100. 00		10.00						
100.00		100.00						

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

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

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

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

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

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

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

Heal th	Financial Syste	ems			WHITLEY MEMOR	RIAL H	OSPI TAL		In Lie	eu of Form CMS-	2552-10
PROVI DER BASED PHYSI CI AN ADJUSTMENT					Provi der	CCN: 150101	Period: From 01/01/2014 To 12/31/2014		epared.		
	Wkst. A Line # Cost Center/Physician I dentifier				essi onal ponent	Provider Component	RCE Amount	Physician/Prov ider Component			
	1.00			2.00	3.00	4.00		5.00	6.00	Hours 7.00	
1.00	91.00	DR.	A	2.00	27, 918		0				1.00
2.00	53.00				53, 352		0	53, 35			2.00
3.00	0.00				0		0		0 0		3.00
4.00	0.00	1			0		0		o o	0	4.00
5.00	0.00				0		0		0 0	0	5.00
6.00	0.00				0		0		0 0	0	6.00
7.00	0.00				0		0		0 0	0	7.00
8.00	0.00				0		0		0 0	0	8.00
9.00	0.00				0		0		0 0	0	9.00
10.00	0.00				0		0	01 07	0	0	10.00
200.00	Wkst. A Line #		Coot	Center/Physician	81, 270 Unadj usted RCE	E Des	0 cent of	81,27 Cost of	J Provi der	457 Physician Cost	200.00
	WKSL A LINE #		COSI	I denti fi er				Memberships &		of Malpractice	
				rdentifier			imit	Continuing	Share of col.	Insurance	
						_		Education	12	i nour anoo	
	1.00			2.00	8.00	Ģ	9.00	12.00	13.00	14.00	
1.00	91.00				18, 788		939		0 0	-	1.00
2.00	53.00		В		22, 052		1, 103		0 0	-	2.00
3.00	0.00				0		0		0 0	-	3.00
4.00	0.00				0		0		0 0	°,	4.00
5.00	0.00				0		0		0 0	0	5.00
6.00 7.00	0.00				0		0			0	6.00 7.00
8.00	0.00				0		0			0	7.00 8.00
9.00	0.00				0		0			-	9,00
10.00	0.00				0		0			°,	10.00
200.00					40, 840		2, 042		0 0	-	
	Wkst. A Line #		Cost	Center/Physician	Provi der		sted RCE	RCE	Adjustment		
				ldenti fi er	Component	L	imit	Di sal I owance			
					Share of col.						
	1.00			2.00	14	1	(00	17.00	10.00		
1.00	1.00	DD	٨	2.00	15.00		6.00 18.788	17.00 9,13	18.00 9,130		1.00
2.00	53.00				0		22, 052	9, 13 31, 30			2.00
3.00	0.00	DIX.	D		0		22,032		0 0		3.00
4.00	0.00				0		0				4.00
5.00	0.00	1			0		0		0 0		5.00
6.00	0.00	1			0		0		0 0		6.00
7.00	0.00				0		0		o o		7.00
8.00	0.00				0		0		o o		8.00
9.00	0.00				0		0		0 0		9.00
10.00	0.00				0		0		0 0		10.00
200.00	l	I			0		40, 840	40, 43	0 40, 430		200.00

	ncial Systems ATION - GENERAL SERVICE COSTS	WHITLEY MEMORI		F	Period: From 01/01/2014	u of Form CMS- Worksheet B Part I	
				1	o 12/31/2014	Date/Time Pre 5/21/2015 2:2	
			CAP	ITAL RELATED C	OSTS		
	Cost Center Description	Net Expenses for Cost Allocation	BLDG & FIXT	MVBLE EQUIP	SNF CAPITAL	EMPLOYEE BENEFITS DEPARTMENT	
		(from Wkst A					
		<u>col.7)</u>	1.00	2.00	2.01	4.00	
GENE	RAL SERVICE COST CENTERS	0	1.00	2.00	2.01	1.00	
1.00 0010	O CAP REL COSTS-BLDG & FIXT	368, 028	368, 028				1.00
	O CAP REL COSTS-MVBLE EQUIP	1, 125, 149		1, 125, 149			2.00
	1 SNF CAPITAL 0 EMPLOYEE BENEFITS DEPARTMENT	203, 758 2, 864, 936	0		203, 758 0 0	2, 864, 936	2.01
	0 ADMINISTRATIVE & GENERAL	12, 491, 087	71, 577	218, 827		873, 643	
	O MAI NTENANCE & REPAI RS	0	C	c c		0	6.00
	O OPERATION OF PLANT	1, 053, 521	38, 982			50, 585	
	0 LAUNDRY & LINEN SERVICE 0 HOUSEKEEPING	162, 222 358, 681	1, 274 1, 522			0 42, 969	
	0 DI ETARY	172, 869				20, 530	
	O CAFETERI A	318, 643	7,360			35, 955	
	O MAINTENANCE OF PERSONNEL	0	C		-	0	
	O NURSING ADMINISTRATION O CENTRAL SERVICES & SUPPLY	129, 239	444 5, 269			20, 146 0	
	O PHARMACY	1, 347, 735	4, 567			85, 236	
	0 MEDICAL RECORDS & LIBRARY	0	1, 623			00,200	
	0 SOCI AL SERVI CE	0	C			0	
	O NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	
	0 NURSING SCHOOL 0 I&R SERVICES-SALARY & FRINGES APPRV	0				0	
	0 I &R SERVICES-OTHER PRGM COSTS APPRV	0	C C			0	
23.00 0230	O PARAMED ED PRGM-(SPECIFY)	0	0	0	0 0	0	23.00
	TI ENT ROUTI NE SERVI CE COST CENTERS	4 004 554	74.004	017.000		0.47.055	1 00 00
	0 ADULTS & PEDIATRICS 0 NURSERY	1, 804, 556 212, 188				247, 955 30, 847	
	0 SKILLED NURSING FACILITY	3, 332, 694	0			351, 679	
	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	1, 317, 310				153, 293	
	0 DELIVERY ROOM & LABOR ROOM 0 ANESTHESIOLOGY	821, 298 22, 225				119, 959 0	
	0 RADI OLOGY-DI AGNOSTI C	1, 457, 648			-	174, 168	
	0 LABORATORY	1, 467, 294	9, 043	27, 647		0	
	O BLOOD CLOTTING FOR HEMOPHILIACS	0	0		-	0	
	0 RESPI RATORY THERAPY 0 PHYSI CAL THERAPY	437, 506 227, 483	7, 884 26, 763			68, 216 43, 137	
	0 OCCUPATIONAL THERAPY	652, 632	20,703			70, 494	
	O SPEECH PATHOLOGY	191, 996	C			18, 951	68.00
		1,453		0	0	0	
	O MEDICAL SUPPLIES CHARGED TO PATIENT O IMPL. DEV. CHARGED TO PATIENTS	566, 333 182, 152				0	
	O DRUGS CHARGED TO PATIENTS	760, 570	C) O	0	1
76.97 0769	7 CARDI AC REHABI LI TATI ON	0	0	c c	0 0	0	
	8 HYPERBARI C OXYGEN THERAPY	0	0		, i	0	
	9 LI THOTRI PSY ATI ENT SERVI CE COST CENTERS	0	U	η (0 0	0	76.99
	O CLINIC	106, 169	12, 081	36, 935	j 0	14, 945	90.00
	1 INTENSIVE OUT PATIENT PROGRAM	0	C	C		0	90.01
	O EMERGENCY	1, 455, 541	23, 776	72, 689	0	209, 782	
	0 OBSERVATI ON BEDS (NON-DI STI NCT PART R REI MBURSABLE COST CENTERS		L				92.00
	O AMBULANCE SERVICES	1, 392, 541	C	(0	183, 929	95.00
	I AL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	37,005,457	365, 927	1, 118, 728	3 203, 758	2, 816, 419	118.00
	EIMBURSABLE COST CENTERS O GIFT, FLOWER, COFFEE SHOP & CANTEEN	13, 718	1, 143	3, 493	3 0	0	190. 00
	O PHYSI CI ANS' PRI VATE OFFI CES	70, 612	0	0, 170			192.00
194.000795	O OCCUPATIONAL HEALTH	43, 328	0	c c	0	0	194.00
	1 PAIN CLINIC	0	0	0	0		194.01
	2 OAK POINTE 3 FOUNDATI ON	650, 876 90, 000					194.02 194.03
	4 COMMUNITY & VOLUNTEER SERVICES	202, 835	958	2, 928			194.03
194. 05 0795	5 VACANT SPACE	0	0		0		194.05
200.00	Cross Foot Adjustments		_	-		_	200.00
201.00	Negative Cost Centers	38, 076, 826	0 368, 028	C 1, 125, 149	0 0 203, 758		201.00
202.00	TOTAL (sum lines 118-201)						

Health Fi	nancial Systems	WHITLEY MEMORI	AL HOSPITAL			In Lie	u of Form CMS-2	2552-10
	OCATION - GENERAL SERVICE COSTS			CCN: 150101		riod: om 01/01/2014	Worksheet B Part I	
					То			pared:
	Cost Center Description	Subtotal	ADMI NI STRATI VE		&	OPERATION OF	LAUNDRY &	
		4A	& <u>GENERAL</u> 5.00	REPAI RS 6.00		PLANT 7.00	LINEN SERVICE 8.00	
GE	NERAL SERVICE COST CENTERS		0100	0100		7100	0100	
1.00 00	100 CAP REL COSTS-BLDG & FIXT							1.00
	200 CAP REL COSTS-MVBLE EQUIP							2.00
	0201 SNF CAPITAL							2.01
	0400 EMPLOYEE BENEFITS DEPARTMENT	10 (55 10)	40 /55 404					4.00
	0500 ADMI NI STRATI VE & GENERAL	13, 655, 134	13, 655, 134		~			5.00
	0600 MAINTENANCE & REPAIRS 0700 OPERATION OF PLANT	0	705 704		0	1 0/0 051		6.00
	0800 LAUNDRY & LINEN SERVICE	1, 262, 267 167, 390	705, 784 93, 594		0 0	1, 968, 051 9, 736	270, 720	7.00 8.00
	1900 HOUSEKEEPING	407, 826	228, 032		0	11, 636	270,720	9.00
	000 DI ETARY	219, 877	122, 942		Ő	49, 885	0	10.00
	100 CAFETERI A	384, 458	214, 966		0	56, 256	0	11.00
12.00 01	200 MAINTENANCE OF PERSONNEL	0	0		0	0	0	12.00
13.00 01	300 NURSING ADMINISTRATION	151, 185	84, 534		0	3, 391	0	13.00
	400 CENTRAL SERVICES & SUPPLY	21, 379	11, 954		0	40, 278	0	14.00
	500 PHARMACY	1, 451, 500	811, 592		0	34, 909	0	15.00
	600 MEDI CAL RECORDS & LI BRARY	6, 585	3, 682		0	12, 407	0	16.00
	700 SOCIAL SERVICE	0	0		0	0	0	17.00
	900 NONPHYSI CI AN ANESTHETI STS 2000 NURSI NG SCHOOL	0	0		0	0	0	19.00 20.00
	2100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0	0	0	20.00
	2200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0	0	0	22.00
	2300 PARAMED ED PRGM-(SPECIFY)	0	0		0	0	0	23.00
	IPATIENT ROUTINE SERVICE COST CENTERS							
	3000 ADULTS & PEDIATRICS	2, 341, 728	1, 309, 354		0	544, 884	16, 563	30.00
	300 NURSERY	243,035	135, 891		0	0	16, 607	43.00
	1400 SKI LLED NURSI NG FACI LI TY	3, 879, 667	2, 169, 268		0	0	0	44.00
	000 OPERATING ROOM	1, 646, 380	920, 557		0	331, 164	44, 636	50.00
	5200 DELIVERY ROOM & LABOR ROOM	941, 257	526, 294		0	001,101	59, 296	
	300 ANESTHESI OLOGY	22, 225	12, 427		0	0	0	53.00
	400 RADI OLOGY-DI AGNOSTI C	1, 764, 194	986, 431		0	249, 400	40, 265	54.00
	0000 LABORATORY	1, 503, 984	840, 938		0	69, 125	248	60.00
	250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0	0	62.30
	500 RESPI RATORY THERAPY 5600 PHYSI CAL THERAPY	537, 709 387, 669	300, 655 216, 761		0 0	60, 263 204, 576	2, 038 5, 772	65.00 66.00
	000 OCCUPATI ONAL THERAPY	723, 126	404, 329		0	204, 370	8, 261	67.00
	800 SPEECH PATHOLOGY	210, 947	117, 949		0	0	2, 162	68.00
	900 ELECTROCARDI OLOGY	1, 453	812		0	0	0	69.00
71.00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENT	566, 333	316, 659		0	0	0	71.00
72.00 07	200 IMPL. DEV. CHARGED TO PATIENTS	182, 152	101, 848		0	0	0	72.00
	300 DRUGS CHARGED TO PATIENTS	760, 570	425, 265		0	0	0	73.00
	697 CARDIAC REHABILITATION	0	0		0	0	0	76.97
	7698 HYPERBARI COXYGEN THERAPY 7699 LI THOTRI PSY	0	0		0	0	0	76. 98 76. 99
	ITPATIENT SERVICE COST CENTERS	0	0		0	0	0	70. 77
90.00 09	2000 CLINIC	170, 130	95, 126		0	92, 347	1, 486	90.00
	2001 INTENSIVE OUT PATIENT PROGRAM	0	0		0	0	0	90. 01
	2100 EMERGENCY	1, 761, 788	985, 086		0	181, 739	60, 249	
	2200 OBSERVATION BEDS (NON-DI STINCT PART	0						92.00
	HER REIMBURSABLE COST CENTERS	1, 576, 470	881, 467		0	0	13, 137	95.00
	ECIAL PURPOSE COST CENTERS	1,070,170	001, 107				10, 10,	70.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	36, 948, 418	13, 024, 197		0	1, 951, 996	270, 720	118.00
	NREI MBURSABLE COST CENTERS							
190.0019	2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	18, 354	10, 262		0	8, 734		190.00
	2000 PHYSI CLANS' PRI VATE OFFI CES 2950 OCCUPATI ONAL HEALTH	72, 744 43, 328	40, 674		0 0	0		192. 00 194. 00
	1950 OCCUPATIONAL HEALTH 1951 PAIN CLINIC	43, 328	24, 226		0	0		194.00 194.01
	952 OAK POINTE	693, 254	387, 626		Ő	0		194.02
194.0307	953 FOUNDATI ON	90,000	50, 323		0	0		194.03
	954 COMMUNITY & VOLUNTEER SERVICES	210, 728	117, 826		0	7, 321		194. 04
194.0507	955 VACANT SPACE	0	0		0	0	0	194. 05
200.00	Cross Foot Adjustments	0	-			_	_	200.00
201.00 202.00	Negative Cost Centers TOTAL (sum lines 118-201)	0 38, 076, 826	0 13, 655, 134		0	0 1, 968, 051		201.00
202.00	TOTAL (SUIII TITIES 110-201)	30,070,620	13,000,134	I	V	1, 700, 051	270,720	1202.00

Health Financial Systems	WHITLEY MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS				Period:	Worksheet B	
				From 01/01/2014 To 12/31/2014		pared:
				-	5/21/2015 2:2	6 pm
Cost Center Description	HOUSEKEEPING	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG ADMI NI STRATI ON	
	9.00	10.00	11.00	PERSONNEL 12.00	13.00	
GENERAL SERVICE COST CENTERS	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10100	11100	12100	10100	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
2. 01 00201 SNF CAPITAL						2.01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
6.00 00600 MAINTENANCE & REPAIRS						5.00 6.00
7. 00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG	647, 494					9.00
10. 00 01000 DI ETARY	16, 593	409, 297				10.00
11. 00 01100 CAFETERI A	18, 711	0				11.00
12. 00 01200 MAINTENANCE OF PERSONNEL	0	0		0 0	050 070	12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	1, 128 13, 397	0	9, 83	4 0 0 0	250, 072 0	13.00 14.00
15. 00 01500 PHARMACY	11, 611	0	30, 53	-	0	14.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	4, 127	0		0 0	0	16.00
17. 00 01700 SOCIAL SERVICE	0	0		0 0	0	17.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0)	0 0	0	19.00
20. 00 02000 NURSI NG SCHOOL	0	0		0 0	0	20.00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0 0	0	21.00
22. 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	22.00
23. 00 02300 PARAMED ED PRGM-(SPECI FY)	0	0		0 0	0	23.00
30. 00 03000 ADULTS & PEDIATRICS	181, 237	409, 297	160, 96	4 0	99, 326	30.00
43. 00 04300 NURSERY	01,237	407, 277				43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		0 0	0	44.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	110, 150	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	82, 954 22, 992	0		3 0 0 0	0	54.00 60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	22, 442	0		0 0	0	62.30
65. 00 06500 RESPIRATORY THERAPY	20, 044	0	42, 95	-	0	65.00
66. 00 06600 PHYSI CAL THERAPY	68, 045	0			0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	24, 84	3 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	12, 93	9 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	0	0		0 0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0			0	72.00 73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	
76. 99 07699 LI THOTRI PSY	0	0)	0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	30, 716	0	8, 28		0	90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0		0 0		90.01
91.00 09100 EMERGENCY	60, 449	0	117, 48	8 0	72, 499	
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVICES	0	0		0 0	0	95.00
SPECIAL PURPOSE COST CENTERS			1	0		70.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	642, 154	409, 297	674, 39	1 0	250, 072	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 905	0		0 0		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
194. 00 07950 OCCUPATI ONAL HEALTH	0	0		0 0		194.00
194. 01 07951 PALN CLINIC 194. 02 07952 OAK POINTE	0	0				194. 01 194. 02
194. 03 07953 FOUNDATI ON	0	0				194. 02 194. 03
194. 04 07954 COMMUNITY & VOLUNTEER SERVICES	2, 435	0		0 0		194.03
194. 05 07955 VACANT SPACE	0	0		0 0		194.05
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	647, 494	409, 297	674, 39	1 0	250, 072	202.00

	I Financial Systems ALLOCATION - GENERAL SERVICE COSTS	WHITLEY MEMORIA		CCN: 150101	Period: From 01/01/2014 To 12/31/2014	u of Form CMS- Worksheet B Part I Date/Time Pre 5/21/2015 2:2	pared:
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	ANESTHETI STS	
	GENERAL SERVICE COST CENTERS	14.00	15.00	16.00	17.00	19.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.00 2.00 2.01 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 19.00 20.00 21.00 22.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00201 SNF CAPI TAL 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I & SERVICES-SALARY & FRINGES APPRV 02200 I & SERVICES-OTHER PRGM COSTS APPRV	87, 008 0 3, 739 0 0 0 0 0	2, 340, 149 0 0 0 0 0 0 0 0	30, 54		0 0 0 0	$\begin{array}{c} 2,00\\ 2,01\\ 4,00\\ 5,00\\ 6,00\\ 7,00\\ 8,00\\ 9,00\\ 10,00\\ 11,00\\ 12,00\\ 13,00\\ 14,00\\ 15,00\\ 16,00\\ 17,00\\ 19,00\\ 20,00\\ 21,00\\ \end{array}$
22.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0 0	0	
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
30.00	03000 ADULTS & PEDIATRICS	1, 600	3			0	
43.00		1,604	3 0			0	
44.00	04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	7, 331	0		0 0	0	44.00
50.00	05000 OPERATI NG ROOM	13, 411	154	48	33 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 774	9		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	5	0		0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 158	8	12, 54		0	
60.00 62.30	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	60.00 62.30
65.00	06500 RESPIRATORY THERAPY	3, 531	3		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	392	58	2, 68	31 0	0	
67.00	06700 OCCUPATI ONAL THERAPY	775	115			0	67.00
68.00	06800 SPEECH PATHOLOGY	229	31			0	
69.00 71.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0 30, 049	0		0 0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2, 318, 275		0 0	0	
	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	
	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	0	0		0 0	0	•
70. 77	OUTPATIENT SERVICE COST CENTERS	0	0	1	0 0	0	/0. //
90.00	09000 CLINIC	363	0		0 0	0	90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0	0		0 0	0	
		6, 525	79	9, 46	01 0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95 00	09500 AMBULANCE SERVICES	5, 985	21, 411		0 0	0	95.00
	SPECIAL PURPOSE COST CENTERS	-,	,		-1		
118.00		84, 471	2, 340, 149	30, 54	0 0	0	118.00
	NONREI MBURSABLE COST CENTERS	1		1			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	687	0		0 0		190.00 192.00
	0 19200 PHYSI CLANS' PRI VATE OFFI CES 0 07950 OCCUPATI ONAL HEALTH	144	0		0 0	0	192.00
	07951 PAIN CLINIC	0	0		0 0		194.01
194.02	2 07952 OAK POINTE	1, 638	0		0 0		194. 02
		1	0		0 0		194.03
	4 07954 COMMUNI TY & VOLUNTEER SERVICES 07955 VACANT SPACE	67	0		0 0		194.04 194.05
200.00		0	0		0		200.00
				1	1		
201.00	Negative Cost Centers	O	0 2, 340, 149		0 0	0	201.00

	Financial Systems	WHITLEY MEMORI		CON AFORAL		u of Form CMS-2	2552-1
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	1	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part I Date/Time Prep	pared:
			INTERNS &	RESI DENTS		5/21/2015 2:28	o pm
	Cost Center Description	NURSING SCHOOL	SERVI CES-SALAR Y & FRI NGES	SERVICES-OTHE PRGM COSTS	R PARAMED ED PRGM	Subtotal	
		20.00	APPRV	APPRV	22.00	24.00	
	GENERAL SERVICE COST CENTERS	20.00	21.00	22.00	23.00	24.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 SNF CAPITAL						2.0
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINI STRATI VE & GENERAL						4.0 5.0
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00	00700 OPERATION OF PLANT						7.0
8.00	00800 LAUNDRY & LINEN SERVICE						8.0
9.00	00900 HOUSEKEEPI NG						9.0
10.00 11.00	01000 DI ETARY 01100 CAFETERI A						10. 0 11. 0
12.00	01200 MAINTENANCE OF PERSONNEL						12.0
13.00	01300 NURSING ADMINISTRATION						13.0
14.00	01400 CENTRAL SERVICES & SUPPLY						14.0
	01500 PHARMACY						15.00
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE						16.00 17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000 NURSI NG SCHOOL	0					20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	C				21.0
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0		22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	(/	0 0		23.0
30. 00	03000 ADULTS & PEDIATRICS	0	C		0 0	5, 068, 083	30. 0
43.00	04300 NURSERY	0	C		0 0	409, 314	43.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	0	C)	0 0	6, 056, 266	44.00
50.00	ANCI LLARY SERVICE COST CENTERS	0	C	ป	0 0	3, 198, 335	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	1, 606, 281	52.00
53.00	05300 ANESTHESI OLOGY	0	C		0 0	34, 657	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	3, 238, 326	
60.00	06000 LABORATORY	0	0		0 0	2, 437, 287	60.00
62.30 65.00	06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 06500 RESPI RATORY THERAPY	0			0 0	0 967, 201	62.3 65.0
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	914, 938	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	C		0 0	1, 162, 472	67.00
68.00	06800 SPEECH PATHOLOGY	0	C		0 0	344, 691	68.00
69.00 71.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0			0 0 0 0	2, 265 913, 041	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 0	284, 000	
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	3, 504, 110	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	C		0 0	0	76.9
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	C		0 0	0	76.98
10.99	07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0	(<u>и</u>	0 0	0	76.99
90.00	09000 CLINIC	0	C		0 0	398, 449	90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0	C		0 0	0	90.0
91.00	09100 EMERGENCY	0	C		0 0	3, 255, 363	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	0	C		0 0	2, 498, 470	95.00
/0.00	SPECIAL PURPOSE COST CENTERS				0	2, 170, 170	, , , , , , , , , , , , , , , , , , , ,
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	C		0 0	36, 293, 549	118.00
100 00	NONREI MBURSABLE COST CENTERS		-			40.042	100 0
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0				40, 942 113, 562	
	07950 OCCUPATIONAL HEALTH	0	(Ó	o 0	67, 554	
	07951 PAIN CLINIC	0	C		0 0		194.0
	07952 OAK POINTE	0	C		0 0	1, 082, 518	
	07953 FOUNDATION	0	C		0 0	140, 324	
	07954 COMMUNITY & VOLUNTEER SERVICES	0	C		0	338, 377	194. 0 194. 0
	O7055 VACANT SDACE	∩	r				
194.05	07955 VACANT SPACE Cross Foot Adjustments	0					
	Cross Foot Adjustments	0 0 0				0	200. 00 201. 00

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lieu of Form CMS	S-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150101	Period: Worksheet B	
			From 01/01/2014 Part I To 12/31/2014 Date/Time Pr	
Cost Center Description	Intern &	Total	5/21/2015 2	:26 pm
	Residents Cost			
	& Post Stepdown			
	Adjustments			
GENERAL SERVICE COST CENTERS	25.00	26.00		
1.00 00100 CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP				2.00
2.01 00201 SNF CAPITAL				2.01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL				4.00 5.00
6. 00 00600 MAI NTENANCE & REPAI RS				6.00
7.00 00700 OPERATION OF PLANT				7.00
8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING				8.00 9.00
10. 00 01000 DI ETARY				10.00
11. 00 01100 CAFETERI A				11.00
12. 00 01200 MAI NTENANCE OF PERSONNEL				12.00
13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY				13.00 14.00
15. 00 01500 PHARMACY				15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY				16.00
17.00 01700 SOCIAL SERVICE				17.00
19. 00 01900 NONPHYSICIAN ANESTHETISTS 20. 00 02000 NURSING SCHOOL				19.00 20.00
21. 00 02100 I &R SERVICES-SALARY & FRINGES APPRV				21.00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV				22.00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)				23.00
30. 00 03000 ADULTS & PEDIATRICS	0	5, 068, 083		30.00
43. 00 04300 NURSERY	0	409, 314		43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0	6, 056, 266		44.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	3, 198, 335		50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	1, 606, 281		52.00
53.00 05300 ANESTHESI OLOGY	0	34, 657		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0	3, 238, 326		54.00 60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	2, 437, 287 0		62.30
65. 00 06500 RESPI RATORY THERAPY	0	967, 201		65.00
66. 00 06600 PHYSI CAL THERAPY	0	914, 938		66.00
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	0	1, 162, 472 344, 691		67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	0	2, 265		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	913, 041		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	284,000		72.00
73. 00 07300 DRUGS CHARGED TO PATTENTS 76. 97 07697 CARDIAC REHABILITATION	0	3, 504, 110 0		73.00 76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		76. 98
76. 99 07699 LI THOTRI PSY	0	0		76.99
0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C	0	398, 449		90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0		90.01
91. 00 09100 EMERGENCY	0	3, 255, 363		91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART OTHER REIMBURSABLE COST CENTERS	0			92.00
95. 00 09500 AMBULANCE SERVICES	0	2, 498, 470		95.00
SPECIAL PURPOSE COST CENTERS		_,,		
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	36, 293, 549		118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	40, 942		190.00
192. 00 19000 PHYSICIANS' PRIVATE OFFICES	0	113, 562		190.00
194.0007950 OCCUPATIONAL HEALTH	0	67, 554		194.00
194. 01 07951 PALN CLINIC	0	0		194.01
194. 02 07952 OAK POI NTE 194. 03 07953 FOUNDATI ON	0	1, 082, 518 140, 324		194. 02 194. 03
194. 04 07954 COMMUNITY & VOLUNTEER SERVICES	Ő	338, 377		194.04
194. 05 07955 VACANT SPACE	0	0		194.05
200.00Cross Foot Adjustments201.00Negative Cost Centers	0	0		200. 00 201. 00
202.00 TOTAL (sum lines 118-201)	0	38, 076, 826		201.00

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	WHITLEY MEMORI				u of Form CMS-: Worksheet B Part II	2552-10
			T		Date/Time Pre	
		CAP	I TAL RELATED CC	ISTS	5/21/2015 2:2	
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	SNF CAPITAL	Subtotal	
cost center bescription	Assigned New		WVDEL EQUIT	SNI CALLAL	Subtotal	
	Capital Related Costs					
	0	1.00	2.00	2. 01	2A	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-BLDG & FTXT						2.00
2. 01 00201 SNF CAPI TAL		_			-	2.01
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL	3, 539, 432	71, 577	0 218, 827	0	0 3, 829, 836	4.00 5.00
6. 00 00600 MAI NTENANCE & REPAI RS	0	0	0	0	0	6.00
7.00 00700 0PERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE	0	38, 982		0	158, 161	7.00 8.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	0	1, 274 1, 522		0	5, 168 6, 176	9.00
10. 00 01000 DI ETARY	0	6, 526	19, 952		26, 478	1
11. 00 01100 CAFETERIA 12. 00 01200 MAINTENANCE OF PERSONNEL	0	7,360			29, 860 0	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	444	-	-	1, 800	•
14.00 01400 CENTRAL SERVICES & SUPPLY	0	5, 269			21, 379	•
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	4, 567 1, 623			18, 529 6, 585	•
17.00 01700 SOCIAL SERVICE	0	O	0	0	0	17.00
19. 00 01900 NONPHYSICIAN ANESTHETISTS 20. 00 02000 NURSING SCHOOL	0	0	0	0	0	19.00 20.00
21. 00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	20.00
22.00 02200 I & SERVICES-OTHER PRGM COSTS APPRV	0	0	0	-	0	22.00
23. 00 02300 PARAMED ED PRGM-(SPECIFY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	C	0	0	0	23.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	71, 284			289, 217	30.00
43. 00 04300 NURSERY 44. 00 04400 SKI LLED NURSI NG FACI LI TY	0				0 195, 294	43.00 44.00
ANCI LLARY SERVI CE COST CENTERS		0		173, 274	173, 274	44.00
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	43, 324			175, 777	50.00 52.00
53.00 05300 ANESTHESI OLOGY	0		0	0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	32, 628		0	132, 378	•
60. 00 06000 LABORATORY 62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	9, 043	27,647	0	36, 690 0	60.00 62.30
65. 00 06500 RESPIRATORY THERAPY	0	7, 884	-	0	31, 987	65.00
66. 00 06600 PHYSI CAL THERAPY	0	26, 763		8, 464	117, 049	1
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0		0	0	0	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C	0	0	0	•
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS	0		0	0	0	71.00 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON 76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.97
76. 98 07698 HYPERBARI C 0XYGEN THERAPY 76. 99 07699 LI THOTRI PSY	0		0	0	0	•
OUTPATIENT SERVICE COST CENTERS					10.01/	
90. 00 09000 CLINIC 90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	12, 081	36, 935	0	49, 016 0	•
91.00 09100 EMERGENCY	0	23, 776	72, 689	0	96, 465	•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS					0	92.00
95. 00 09500 AMBULANCE SERVICES	0	C	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS		0/5 007	4 440 700	000 750	5 007 045	
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	3, 539, 432	365, 927	1, 118, 728	203, 758	5, 227, 845	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1, 143	3, 493	0		190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 194. 00 07950 OCCUPATI ONAL HEALTH	0	0	0	0		192.00 194.00
194. 01 07950 OCCUPATIONAL HEALTH 194. 01 07951 PAIN CLINIC	0		0	0		194.00 194.01
194. 02 07952 OAK POI NTE	0	0	0	0	0	194. 02
194. 03 07953 FOUNDATI ON 194. 04 07954 COMMUNI TY & VOLUNTEER SERVI CES	0	0 958	0 2, 928	0		194. 03 194. 04
194. 05 07955 VACANT SPACE	0	958	2, 928	0		194. 04 194. 05
200.00 Cross Foot Adjustments					0	200. 00
201.00Negative Cost Centers202.00TOTAL (sum lines 118-201)	3, 539, 432	0 368, 028	0 1, 125, 149	0 203, 758		201.00
	1 0,007,402	. 555, 520	1 1, 120, 147	200,700	5, 200, 007	1-02.00

Health Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2014 To 12/31/2014		pared: 6 pm
Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMI NI STRATI VE & GENERAL	MAI NTENANCE & REPAI RS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
	4.00	5.00	6.00	7.00	8.00	
1.00 GENERAL SERVICE COST CENTERS						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.01 00201 SNF CAPITAL 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 6.00 00600 MAINTENANCE & REPAIRS 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DIETARY 11.00 01100 CAFETERIA 12.00 01200 MAINTENANCE OF PERSONNEL 13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDICAL RECORDS & LI BRARY		3, 829, 836 0 197, 950 26, 250 63, 956 34, 481 60, 291 0 23, 709 3, 353 227, 626 1, 033		0 356, 111 0 1, 762 0 2, 106 0 9, 027 0 10, 179 0 614 0 7, 288 0 6, 317 0 2, 245	33, 180 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 2.\ 01\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
17. 00 01700 SOCI AL SERVI CE 19. 00 01900 NONPHYSI CI AN ANESTHETI STS 20. 00 02000 NURSI NG SCHOOL 21. 00 02100 I &R SERVI CES-SALARY & FRI NGES APPRV 22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV 23. 00 02300 PARAMED ED PRGM-(SPECI FY) INPATI ENT ROUTI NE SERVI CE COST CENTERS				0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	17.00 19.00 20.00 21.00 22.00 23.00
30. 00 03000 ADULTS & PEDI ATRI CS 43. 00 04300 NURSERY 44. 00 04400 SKI LLED NURSI NG FACI LI TY	0 0 0	38, 113	(D 98, 593 D 0 D 0	2, 030 2, 035 0	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	258, 187		59, 923	5, 471	50.00
52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY <	000000000000000000000000000000000000000	147, 609 3, 485 276, 663 235, 856		0 0 0 0 0 45, 128 0 12, 508	7, 267 0 4, 935 30	52.00 53.00 54.00 60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 65. 00 06500 RESPIRATORY THERAPY 66. 00 06600 PHYSICAL THERAPY 67. 00 06700 OCCUPATIONAL THERAPY 68. 00 06800 SPECH PATHOLOGY		0 84, 324 60, 795 113, 401 33, 081		0 0 0 10,904 0 37,017 0 0 0 0	0 250 707 1, 012 265	66. 00 67. 00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 76. 97 07697 CARDI AC REHABI LI TATI ON		228 88, 813 28, 565 119, 273 0			0 0 0 0	72. 00 73. 00
76. 98 07698 HYPERBARI C 0XYGEN THERAPY 76. 99 07699 LI THOTRI PSY	0			0 0 0 0	0 0	76. 98
0UTPATI ENT_SERVI CE_COST_CENTERS 90. 00 09000 CLI NI C	0	26, 680		0 16, 710	182	90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	-		0 0 0 32, 885	0 7, 386	
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES	0	247, 224	(0 0	1, 610	
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117)	0	3, 652, 877		353, 206	33, 180	118.00
NONRE IMBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 194.00 07950 OCCUPATI ONAL HEALTH 194.01 07951 PAI N CLI NI C 194.02 07952 OAK POI NTE 194.03 07953 FOUNDATI ON 194.04 07954 COMMUNI TY & VOLUNTEER 194.05 07955 VACANT SPACE		2, 878 11, 408		0 1,580 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	190. 00 192. 00 194. 00 194. 01 194. 02 194. 03 194. 03 194. 04 194. 05
200.00Cross Foot Adjustments201.00Negative Cost Centers202.00TOTAL (sum lines 118-201)	0	0 3, 829, 836		0 0 0 356, 111	0 33, 180	200. 00 201. 00 202. 00

Health F	- inancial Systems	WHITLEY MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	I ON OF CAPITAL RELATED COSTS				eriod:	Worksheet B	2002 10
					rom 01/01/2014 o 12/31/2014	Part II Date/Time Pre	pared:
						5/21/2015 2:2	6 pm
	Cost Center Description	HOUSEKEEPING	DI ETARY	CAFETERI A	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI ON	
		9.00	10.00	11.00	12.00	13.00	
	ENERAL SERVICE COST CENTERS						
1	00100 CAP REL COSTS-BLDG & FIXT						1.00 2.00
	00200 CAP REL COSTS-MVBLE EQUIP 00201 SNF CAPITAL						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00500 ADMINISTRATIVE & GENERAL						5.00
	00600 MAINTENANCE & REPAIRS						6.00
	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
	00900 HOUSEKEEPI NG	72, 238					9.00
10.00 0	1000 DI ETARY	1, 851	71, 837				10.00
1	1100 CAFETERIA	2, 088	0				11.00
	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	0 126	0		-	27, 742	12.00 13.00
	1400 CENTRAL SERVICES & SUPPLY	1, 495	0			27,742	14.00
	1500 PHARMACY	1, 295	0		0	0	15.00
	1600 MEDICAL RECORDS & LIBRARY	460	0	-	-	0	16.00
	11700 SOCIAL SERVICE 1900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	17.00
1	1900 NURSING SCHOOL	0	0		0	0	19.00 20.00
1	2100 I & R SERVI CES-SALARY & FRI NGES APPRV	0	0	-	-	0	21.00
22.00 0	2200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
-	2300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
	NPATIENT ROUTINE SERVICE COST CENTERS	20, 220	71, 837	24, 445	0	11, 018	30.00
	4300 NURSERY	20, 220	0			0	43.00
	04400 SKILLED NURSING FACILITY	0	0			0	44.00
	NCI LLARY SERVI CE COST CENTERS					-	
	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	12, 289 0	0			5, 563 3, 118	50.00 52.00
	05300 ANESTHESI OLOGY	0	0			3, 118	52.00
	05400 RADI OLOGY-DI AGNOSTI C	9, 255	0		-	0	54.00
	6000 LABORATORY	2, 565	0		-	0	60.00
	6250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		-	0	62.30
	16500 RESPI RATORY THERAPY 16600 PHYSI CAL THERAPY	2, 236 7, 591	0			0	65.00 66.00
	6700 OCCUPATI ONAL THERAPY	0	0		-	0	67.00
1	06800 SPEECH PATHOLOGY	0	0			0	68.00
	6900 ELECTROCARDI OLOGY	0	0	-	-	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	72.00 73.00
	07697 CARDI AC REHABI LI TATI ON	0	0			0	76.97
	7698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	
	07699 LI THOTRI PSY UTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	76.99
	09000 CLINIC	3, 427	0	1, 258	0	0	90.00
	99001 INTENSIVE OUT PATIENT PROGRAM	0	0			0	90.01
	9100 EMERGENCY	6, 744	0	17, 843	0	8, 043	
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	95.00
	PECIAL PURPOSE COST CENTERS	<u> </u>	0		0	0	/5.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	71, 642	71, 837	102, 418	0	27, 742	118.00
	ONREI MBURSABLE COST CENTERS	0.04					100.00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 9200 PHYSI CLANS' PRI VATE OFFICES	324 0	0				190. 00 192. 00
	7200 PHYSICIANS PRIVATE OFFICES	0	0	0	-		192.00
	07951 PAIN CLINIC	0	0	0	0		194.01
	7952 OAK POINTE	0	0	0	0		194. 02
		0	0	0	0		194.03
	07954 COMMUNITY & VOLUNTEER SERVICES 07955 VACANT SPACE	272	0		0		194. 04 194. 05
200.00	Cross Foot Adjustments		0		0	0	200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	72, 238	71, 837	102, 418	0	27, 742	202.00

Heal th	Financial Systems	WHITLEY MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2014	Worksheet B Part II	
					To 12/31/2014		
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	
		SERVICES & SUPPLY		RECORDS & LI BRARY		ANESTHETI STS	
		14.00	15.00	16.00	17.00	19.00	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
	00200 CAP REL COSTS-BEDG & TTXT						2.00
	00201 SNF CAPI TAL						2.01
	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
1	00600 MAINTENANCE & REPAIRS						6.00
1	00700 OPERATION OF PLANT						7.00
1	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8.00 9.00
	01000 DI ETARY						10.00
1	01100 CAFETERIA						11.00
1	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON						12.00
	01400 CENTRAL SERVICES & SUPPLY	33, 515					14.00
	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	0	258, 404 0	11, 76	3		15.00 16.00
	01700 SOCIAL SERVICE	0	0		0 0		17.00
	01900 NONPHYSICIAN ANESTHETISTS	0	0		0 0	0	
	02000 NURSING SCHOOL 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0				20.00
	02200 I & SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0		22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0 0		23.00
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	616	0	1, 20	5 0		30.00
	04300 NURSERY	618	0	30	3 0		43.00
•	04400 SKILLED NURSING FACILITY	2, 824	0		0 0		44.00
	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	5, 166	17	18	6 0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 224	1		0 0		52.00
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	2 1, 216	0	4, 83	0		53.00 54.00
1	06000 LABORATORY	0	0				60.00
1	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0		62.30
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 360 151	0	1, 03			65.00 66.00
	06700 OCCUPATI ONAL THERAPY	299	13	39			67.00
	06800 SPEECH PATHOLOGY	88	3	16			68.00
1	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0 11, 575	0				69.00 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0		72.00
	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION	0	255, 990		0 0		73.00
	07698 HYPERBARIC OXYGEN THERAPY	0	0				76. 97 76. 98
76. 99	07699 LI THOTRI PSY	0	0		0 0		76. 99
	OUTPATIENT SERVICE COST CENTERS	140	0		0 0		90.00
	09001 INTENSIVE OUT PATIENT PROGRAM	0	0		0 0		90.01
	09100 EMERGENCY	2, 514	9	3, 64	4 0		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
	09500 AMBULANCE SERVICES	2, 305	2, 364		0 0		95.00
	SPECIAL PURPOSE COST CENTERS	22 520	250,404	11, 76		0	110.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	32, 538	258, 404	11, 70	3 0	0	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	265	0		0 0		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 OCCUPATI ONAL HEALTH	55	0		0 0		192. 00 194. 00
	07950 OCCOPATIONAL HEALTH	0	0		0		194.00
194.02	07952 OAK POINTE	631	0		0 0		194. 02
	07953 FOUNDATION 07954 COMMUNITY & VOLUNTEER SERVICES	0 26	0				194. 03 194. 04
	07955 VACANT SPACE	20	0				194.04 194.05
200.00	Cross Foot Adjustments						200. 00
201.00 202.00		0 33, 515	0 258, 404	11, 76	0 3 0		201. 00 202. 00
202.00	1.51/1E (50m 111/05 110 201)	1 55, 515	200, 404	11,70	- -	0	1-02.00

LOCATION OF CAP	Systems PITAL RELATED COSTS	WHITLEY MEMOR			CCN: 150101		eri od:	u of Form CMS- Worksheet B	
						Fi	rom 01/01/2014 p 12/31/2014	Part II Date/Time Pre	par
				INTERNS &	RESI DENTS	-		5/21/2015 2:2	<u>6 pi</u>
Cost	Center Description	NURSING SCHOOL		CES-SALAR FRI NGES	SERVI CES-OTH PRGM COSTS		PARAMED ED PRGM	Subtotal	
				APPRV	APPRV			04.00	
GENERAL SE	RVICE COST CENTERS	20.00	· ·	21.00	22.00		23.00	24.00	
	REL COSTS-BLDG & FIXT								1
	REL COSTS-MVBLE EQUIP								2
01 00201 SNF (2
	DYEE BENEFITS DEPARTMENT								4
1 1	NESTRATIVE & GENERAL FENANCE & REPAERS								5
1 1	ATION OF PLANT								7
	DRY & LINEN SERVICE								8
00 00900 HOUSI	EKEEPING								9
. 00 01000 DI ET/									10
. 00 01100 CAFE									11
	FENANCE OF PERSONNEL NG ADMINISTRATION								12
	RAL SERVICES & SUPPLY								14
00 01500 PHAR									15
	CAL RECORDS & LI BRARY								16
. 00 01700 SOCI /									17
	HYSI CLAN ANESTHETI STS								19
. 00 02000 NURS		0							20
	SERVICES-SALARY & FRINGES APPRV SERVICES-OTHER PRGM COSTS APPRV			C		0			21
	MED ED PRGM-(SPECIFY)					0	о		23
	ROUTI NE SERVI CE COST CENTERS		1		1				1 - 1
. 00 03000 ADUL	FS & PEDIATRICS							886, 413	30
. 00 04300 NURSI								42, 798	
								806, 532	44
. 00 05000 OPER	SERVICE COST CENTERS				1			534, 919	50
	/ERY ROOM & LABOR ROOM							167, 136	
. 00 05300 ANES	THESI OLOGY							3, 487	53
	DLOGY-DI AGNOSTI C							489, 499	
. 00 06000 LABO								287, 649	
	CLOTTING FOR HEMOPHILIACS							127 595	
	RATORY THERAPY CAL THERAPY							137, 585 228, 751	
	PATIONAL THERAPY							118, 892	
	CH PATHOLOGY							35, 569	
	FROCARDI OLOGY							228	
	CAL SUPPLIES CHARGED TO PATIENT							100, 388	
	DEV. CHARGED TO PATIENTS S CHARGED TO PATIENTS							28, 565	
	AC REHABILITATION							375, 263 0	
	RBARI C OXYGEN THERAPY							0	
99 07699 LI TH								0	76
	SERVICE COST CENTERS		-		1			07.01	
. 00 09000 CLIN . 01 09001 INTE	C NSIVE OUT PATIENT PROGRAM							97, 413 0	
. 00 09100 EMER								451, 818	
	RVATION BEDS (NON-DISTINCT PART							101,010	92
	BURSABLE COST CENTERS				1				
	LANCE SERVICES							253, 503	95
	RPOSE COST CENTERS DTALS (SUM OF LINES 1-117)	0		(0	0	5, 046, 408	1110
	SABLE COST CENTERS			L. L.	<u>и</u>	0	U.	5, 040, 400	
	FLOWER, COFFEE SHOP & CANTEEN							9, 683	190
2. 00 19200 PHYS	CLANS' PRIVATE OFFICES							11, 463	
	PATIONAL HEALTH							6, 795	
4. 01 07951 PALN									194
4. 02 07952 0AK I 4. 03 07953 FOUNI								109, 348 14, 114	
	JNI TY & VOLUNTEER SERVICES							38, 556	
4. 05 07955 VACAI									194
	s Foot Adjustments	0		C		0	0	0	200
	tive Cost Centers	0		C		0	0		201
2.00 TOTA	_ (sum lines 118-201)	0		C		0	0	5, 236, 367	1

-	Financial Systems	WHITLEY MEMORIA		001 450103		J of Form CMS-2552-1
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150101	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Prepared: 5/21/2015 2:26 pm
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments 25.00	Total 26.00	-	1	<u>372172013 2, 20 plil</u>
	GENERAL SERVICE COST CENTERS			1		
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 2.\ 01\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\end{array}$	00100CAPRELCOSTS-BLDG & FIXT00200CAPRELCOSTS-MVBLEEQUIP00201SNFCAPITAL00400EMPLOYEE00500ADMI NI STRATI VE & GENERAL00600MAI NTENANCE & REPAIRS00700OPERATION OFPLANT00800LAUNDRY & LI NENSERVICE00900HOUSEKEEPI NG01000DI ETARY01100CAFETERIA01200MAI NTENANCE OF01300NURSI NG ADMI NI STRATI ON01400CENTRAL01500PHARMACY01600MEDI CALNECODIS& LI BRARY01700SOCI AL01900NONPHYSI CI AN ANESTHETI STS02000NURSI NG SCHOOL02100I & SERVI CES-SALARY & FRI NGES02200I & SERVI CES-OTHER02200I & SERVI CES-OTHER02200I & SERVI CES-OTHER02200I & SERVI CES-OTHER					1. 00 2. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 20. 00 21. 00 22. 00
23.00	02300 PARAMED ED PRGM- (SPECI FY)					23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	886, 413			30.00
43.00	04300 NURSERY	0	42, 798			43.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	0	806, 532			44.00
50 00	ANCI LLARY SERVICE COST CENTERS	0	53/ 010			50.00
76. 97 76. 98	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07697 CARDI AC REHABILITATI ON 07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY 0UTPATI ENT SERVICE COST CENTERS 090000 CLI NI C		534, 919 167, 136 3, 487 489, 499 287, 649 0 137, 585 228, 751 118, 892 35, 565 375, 263 0 0 0 0 97, 413			50. 00 52. 00 53. 00 64. 00 62. 30 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 90 76. 90 76. 90 76. 90 90. 00
90.00 90.01		0	97, 413	1		90.0
91.00	09100 EMERGENCY	0	451, 818			91.00
92.00		0				92.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	253, 503			95.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	5, 046, 408			118. 00
100 00	NONREIMBURSABLE COST CENTERS	0	9, 683			190. 00
192.00 194.00 194.01 194.02	19000 GFFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFT CES 07950 OCCUPATI ONAL HEALTH 107951 PALN CLINIC 207952 OAK POINTE 307953 FOUNDATI ON		9, 683 11, 463 6, 795 0 109, 348 14, 114			190. 00 192. 00 194. 00 194. 00 194. 00 194. 00
194.04	07954 COMMUNITY & VOLUNTEER SERVICES	0	38, 556			194. 04
	07955 VACANT SPACE	0	0			194. 0
200.00	5	0	0			200. 00 201. 00
201.00) Negative Cost Centers	0				

	Financial Systems LLOCATION - STATISTICAL BASIS	WHITLEY MEMORI			eriod:	u of Form CMS-: Worksheet B-1	2552-10
				Fi Te	rom 01/01/2014 p 12/31/2014		
		CAPI	ITAL RELATED CO	OSTS			
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	SNF CAPITAL (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconciliation	
		1.00	2.00	2.01	4.00	5A	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	109, 514	[1			1.00
2.00 2.01 4.00 5.00	00200 CAP REL COSTS-MVBLE EQUIP 00201 SNF CAPITAL 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	0 21, 299	109, 514 0 0 21, 299	26, 287 0	18, 326, 657 5, 588, 575	-13, 655, 134	2.00 2.01 4.00 5.00
7.00 8.00 9.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0 11, 600 379 453	0 11, 600 379 453	0	0 323, 588 0 274, 867	0	8.00 9.00
11. 00 12. 00 13. 00	01000 DI ETARY 01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	1, 942 2, 190 0 132 1, 568	1, 942 2, 190 0 132 1, 568	0 0 0	131, 330 229, 997 0 128, 870		10.00 11.00 12.00 13.00 14.00
15. 00 16. 00 17. 00	01500 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	1, 368 1, 359 483 0 0	1, 368 1, 359 483 0	0	545, 245 0 0 0	-	14.00 15.00 16.00 17.00 19.00
21.00 22.00 23.00	02000 NURSI NG SCHOOL 02100 I &R SERVI CES-SALARY & FRI NGES APPRV 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECI FY)	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	20.00 21.00 22.00 23.00
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	21, 212	21, 212	0	1, 586, 141	0	30.00
43.00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	0	0	197, 322 2, 249, 649	0	43.00
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	12, 892	12, 892 0	0	980, 600 767, 367	0	50.00 52.00
54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0 9, 709 2, 691	0 9, 709 2, 691		0 1, 114, 133 0	0	53.00 54.00 60.00
62. 30 65. 00	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY	0 2, 346	0 2, 346	0	0 436, 370	0	62.30 65.00
67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	7,964	7, 964 0	1, 092 0 0	275, 944 450, 941 121, 230	0 0 0	66.00 67.00 68.00
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	0	0	69.00 71.00
73.00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION	0			0 0 0	0 0 0	72.00 73.00 76.97
76.99	07698 HYPERBARI C 0XYGEN THERAPY 07699 LI THOTRI PSY 0UTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	76. 98 76. 99
90.00	09000 CLINIC 09001 INTENSIVE OUT PATIENT PROGRAM	3, 595 0	3, 595 0	0	95, 600 0	0	90. 00 90. 01
92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	7,075	7, 075	0	1, 341, 954	0	91.00 92.00
	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES	0	0	0	1, 176, 575	0	95.00
118.00		108, 889	108, 889	26, 287	18, 016, 298		118.00
190.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES	340	340 0	0	0 13, 638		190. 00 192. 00
194.01	07950 OCCUPATI ONAL HEALTH 07951 PAIN CLINIC 07952 OAK POINTE	0	0	0	0 0	0	194.00 194.01
194.03	07922 OAK POINTE 07953 FOUNDATION 07954 COMMUNITY & VOLUNTEER SERVICES	0 285	0	0	271, 089 0 25, 632	0	194. 02 194. 03 194. 04
200. 00 201. 00	Negative Cost Centers	0	0	0	0		194.05 200.00 201.00
202.00	Part I)	368, 028			2, 864, 936		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	3. 360557	10. 274020	7. 751284	0. 156326	I	203.00

Health Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2014	Worksheet B-1	
				To 12/31/2014		
	CAP	ITAL RELATED CO	OSTS			
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	SNF CAPI TAL (SQUARE FEET		Reconciliation	
	1.00	2.00	2.01	4.00	5A	
204.00 Cost to be allocated (per Wkst. B, Part II)				0		204. 00
205.00 Unit cost multiplier (Wkst. B, Part				0. 000000		205. 00

00 0 00 0 01 0 00 0 00 0 00 0	Cost Center Description GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00201 SNF CAPITAL 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	ADMI NI STRATI VE & GENERAL (ACCUM COST) 5. 00	MAI NTENANCE & REPAI RS (SQUARE FEET) 6.00		rom 01/01/2014 o 12/31/2014 LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY)	Date/Time Prep 5/21/2015 2:26 HOUSEKEEPING (SQUARE FEET)
00 0 00 0 01 0 00 0 00 0 00 0	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00201 SNF CAPITAL 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	& GENERAL (ACCUM COST)	REPAI RS (SQUARE FEET)	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG
00 0 00 0 01 0 00 0 00 0 00 0	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00201 SNF CAPITAL 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	(ACCUM COST)	(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF	(SQUARE FEET)
DO 0 DO 0	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00201 SNF CAPITAL 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL		. ,	. ,		
DO 0 DO 0	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00201 SNF CAPITAL 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	5.00	6.00	7 00		
00 0 00 0 01 0 00 0 00 0 00 0 00 0 00 0 00 0	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00201 SNF CAPITAL 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL			7.00	8.00	9.00
00 (0) 01 (0) 00 (0) 00 (0) 00 (0)	00200 CAP REL COSTS-MVBLE EQUIP 00201 SNF CAPITAL 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL			I.	<u>г</u>	
01 0 00 0 00 0 00 0 00 0 00 0	00201 SNF CAPITAL 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL					
	00500 ADMINI STRATI VE & GENERAL					
0 0	00600 MAINTENANCE & REPAIRS	24, 421, 692	0			
0 0	00700 OPERATION OF PLANT	1, 262, 267	0	76, 615		
1	00800 LAUNDRY & LINEN SERVICE	167, 390		379		
1	00900 HOUSEKEEPI NG	407, 826		453		75, 783
	01000 DI ETARY 01100 CAFETERI A	219, 877 384, 458		1, 942 2, 190		1, 942 2, 190
	01200 MAINTENANCE OF PERSONNEL	0		0		0
	01300 NURSI NG ADMI NI STRATI ON	151, 185		132		132
	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	21, 379 1, 451, 500		1, 568 1, 359		1, 568 1, 359
	01600 MEDICAL RECORDS & LIBRARY	6, 585		483	0	483
	01700 SOCIAL SERVICE	0	0	0	0	0
	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0	0	0	0	0
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0			0	0
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	2, 341, 728	0	21, 212	13, 083	21, 212
	04300 NURSERY	243, 035				0
	04400 SKILLED NURSING FACILITY	3, 879, 667	0	0	0	0
	ANCI LLARY SERVI CE COST CENTERS	1, 646, 380	0	12, 892	35, 258	12, 892
	05200 DELIVERY ROOM & LABOR ROOM	941, 257				12, 872
	05300 ANESTHESI OLOGY	22, 225		0	0	0
	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	1, 764, 194		9, 709		9, 709
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	1, 503, 984		2, 691 0		2, 691 0
	06500 RESPI RATORY THERAPY	537, 709	0	2, 346		2, 346
	06600 PHYSI CAL THERAPY	387,669		7, 964		7, 964
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	723, 126 210, 947		0		0
	06900 ELECTROCARDI OLOGY	1, 453		0	0	0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	566, 333		0	0	0
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	182, 152		0	0	0
	07697 CARDI AC REHABI LI TATI ON	760, 570 0			0	0
98 0	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0
	07699 LI THOTRI PSY	0	0	0	0	0
	DUTPATIENT SERVICE COST CENTERS	170, 130	0	3, 595	1, 174	3, 595
	09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0		0
	09100 EMERGENCY	1, 761, 788	0	7, 075	47, 590	7, 075
	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS				<u> </u>	
	09500 AMBULANCE SERVICES	1, 576, 470	0	0	10, 377	0
S	SPECIAL PURPOSE COST CENTERS					
. 00	SUBTOTALS (SUM OF LINES 1-117)	23, 293, 284	0	75, 990	213, 841	75, 158
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	18, 354	0	340	0	340
. 00 1	19200 PHYSICIANS' PRIVATE OFFICES	72, 744	0	0		0
	07950 OCCUPATIONAL HEALTH	43, 328	0	0	0	0
	07951 PAIN CLINIC 07952 OAK POINTE	0 693, 254			0	0
	07953 FOUNDATI ON	90,000		0	0	0
. 04 0	07954 COMMUNITY & VOLUNTEER SERVICES	210, 728		285	0	285
	07955 VACANT SPACE	0	0	0	0	0
. 00 . 00	Cross Foot Adjustments Negative Cost Centers					
. 00	Cost to be allocated (per Wkst. B,	13, 655, 134	0	1, 968, 051	270, 720	647, 494
	Part I)					
3.00	Unit cost multiplier (Wkst. B, Part I)					8.544053
4.00	Cost to be allocated (per Wkst. B, Part II)	3, 829, 836	0	356, 111	33, 180	72, 238 :
5.00	Unit cost multiplier (Wkst. B, Part	0. 156821	0. 000000	4. 648058	0. 155162	0. 953222

	ancial Systems ATION - STATISTICAL BASIS	WHITLEY MEMORIA		CCN: 150101	Peri od:	u of Form CMS-2 Worksheet B-1	
					From 01/01/2014 To 12/31/2014		
	Cost Center Description	DI ETARY (MEALS SERVED)	(FTES)	MAI NTENANCE C PERSONNEL (NUMBER HOUSED)	OF NURSING ADMINISTRATION (DIRECTNRSING HRS)	SUPPLY	
CENE		10.00	11.00	12.00	13.00	14.00	
I. 00 0010 2. 00 0020 2. 01 0022 3. 00 0040 5. 00 0050 6. 00 0040 5. 00 0050 7. 00 0070 8. 00 0080 9. 00 0090 10. 00 0110 11. 00 0110 12. 00 0120 13. 00 0140 15. 00 0150 16. 00 0140 17. 00 0170 19. 00 0190 21. 00 0210 22. 00 0220 23. 00 0220	Image: Ref Service Cost Centers Image: Ref Service Cost-BLDG & FIXT Image: Ref Service Costs-BLDG & FIXT Image: Ref Service Costs-MVBLE EQUIP Image: Ref Service Costs-MVBLE EQUIP Image: Ref Service Costs-MVBLE EQUIP Image: Ref Vices-Other Preformer Expert Image: Ref Vices-Other Preformer Exper Image:	16, 585 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 303 0 19 0 59 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 783 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 579, 838 0 67, 882 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15.00 16.00 17.00 29.00 21.00 22.00
30.00 0300 43.00 0430 44.00 0440	TI ENT ROUTINE SERVICE COST CENTERS 10 ADULTS & PEDIATRICS 10 NURSERY 10 SKILLED NURSING FACILITY	16, 585 0 0	311 22 0		0 311 0 0 0 0	29, 051 29, 132 133, 120	43.00
50.00 0500 52.00 0522 53.00 0532 54.00 0542 50.00 0620 52.30 0622 55.00 0650 55.00 0650 55.00 0650 56.00 0660 57.00 0670 58.00 0680 59.00 0670 59.00 0670 59.00 0670 69.00 0690 71.00 0710 72.00 0720 73.00 0733 76.97 0769 00459 0769 00459 0769 00459 0459	LLARY SERVICE COST CENTERS DO DERATING ROOM DO DELIVERY ROOM & LABOR ROOM DO ANESTHESIOLOGY DO RADIOLOGY-DIAGNOSTIC LABORATORY DO LABORATORY DO DELOTTING FOR HEMOPHILIACS DO RESPIRATORY THERAPY DO PHYSICAL THERAPY DO OCCUPATIONAL THERAPY DO SPEECH PATHOLOGY DO ELECTROCARDIOLOGY DO MEDICAL SUPPLIES CHARGED TO PATIENTS DO DRUGS CHARGED TO PATIENTS DO DRUGS CHARGED TO PATIENTS DO DRUGS CHARGED TO PATIENTS DO RUGN CHABILITATION 28 HYPERBARIC OXYGEN THERAPY DO LITHOTRIPSY 24 TIENT SERVICE COST CENTERS		157 88 0 192 0 83 56 48 25 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 157 0 88 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0	52.00 53.00 54.00 60.00 62.30 65.00 66.00 68.00 69.00 71.00 72.00 73.00 76.95 76.95
90.01 0900 91.00 0910 92.00 0920	00 CLINIC 11 INTENSIVE OUT PATIENT PROGRAM 100 EMERGENCY 100 OBSERVATION BEDS (NON-DISTINCT PART 11 REIMBURSABLE COST CENTERS	0 0 0	16 0 227		0 0 0 0 0 227	6, 589 0 118, 485	90.00 90.0 91.00 92.00
95.00 0950	00 AMBULANCE SERVI CES	0	0		0 0	108, 669	95.00
18.00	SUBTOTALS (SUM OF LINES 1-117)	16, 585	1, 303		0 783	1, 533, 797	118. 0
90. 00 1900 92. 00 1920 94. 00 0795 94. 01 0795 94. 02 0795 94. 03 0795 94. 03 0795	ELIMBURSABLE COST CENTERS OGIFT, FLOWER, COFFEE SHOP & CANTEEN OPHYSICIANS' PRIVATE OFFICES OCCUPATIONAL HEALTH T PAIN CLINIC OAK POINTE STOUNDATION 4 COMMUNITY & VOLUNTEER SERVICES 5 VACANT SPACE Cross Foot Adjustments Negative Cost Centers	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 29, 733 14 1, 216	192. 00 194. 00 194. 0
202.00 203.00 204.00	Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	409, 297 24. 678746 71, 837	674, 391 517. 567920 102, 418	0. 00000	0 250, 072 00 319. 376756 0 27, 742	87, 008 0. 055074 33, 515	203.00

Health Financial Systems	WHITLEY MEMOR	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2014	Worksheet B-1	
	_			o 12/31/2014	Date/Time Pre 5/21/2015 2:2	
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	
	(MEALS SERVED)	(FTES)	PERSONNEL	ADMI NI STRATI ON	SERVICES &	
			(NUMBER		SUPPLY	
			HOUSED)	(DI RECT NRSI NG	(COSTED	
				HRS)	REQUIS.)	
	10.00	11.00	12.00	13.00	14.00	
205.00 Unit cost multiplier (Wkst. B, Part	4. 331444	78. 601688	0. 000000	35. 430396	0. 021214	205.00
11)			1			

	Financial Systems	WHITLEY MEMORI		001 450404 5		u of Form CMS-2	
CUST AL	LOCATION - STATISTICAL BASIS		Provi der	F	eriod: rom 01/01/2014	Worksheet B-1	
						Date/Time Pre 5/21/2015 2:2	
	Cost Center Description	PHARMACY (COSTED	MEDI CAL RECORDS &	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	NURSING SCHOOL	
		REQUI S.)	LI BRARY	(TIME SPENT)	(ASSI GNED	(ASSI GNED	
		15.00	(TIME SPENT) 16.00	17.00	TI ME) 19.00		
	GENERAL SERVICE COST CENTERS						1.00
1	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
	00201 SNF CAPITAL						2.01
1	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00
6.00	00600 MAI NTENANCE & REPAI RS						6.00
1	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00
9.00	00900 HOUSEKEEPI NG						9.00
1	01000 DI ETARY 01100 CAFETERI A						10.00
1	01200 MAINTENANCE OF PERSONNEL						12.00
	01300 NURSING ADMINISTRATION						13.00 14.00
	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	1, 486, 732					14.00
1	01600 MEDI CAL RECORDS & LI BRARY	0	10, 000				16.00
1	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0 0	0	0		17.00 19.00
20.00	02000 NURSI NG SCHOOL	0	0	0		0	20.00
	02100 I &R SERVICES-SALARY & FRINGES APPRV 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			21.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	2	1, 024	0		0	30.00
43.00	04300 NURSERY	2	258	0		0	43.00
t t	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	0	0		0	44.00
50.00	05000 OPERATING ROOM	98	158	0	0	0	50.00
1	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	6	0	0	0	0	
	05400 RADI OLOGY-DI AGNOSTI C	5	4, 107	0	0	0	54.00
	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	60.00 62.30
	06500 RESPIRATORY THERAPY	2	0	0	0	0	
	06600 PHYSI CAL THERAPY	37	878	0	0	0	
1	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	73 20	335 142	0	0	0	
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 472, 834	0	0	Ō	0	73.00
	07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	
76.99	07699 LI THOTRI PSY	0	0	0	0	0	
	DUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	90.00
	09000 INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0	•
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	50	3, 098	0	0	0	91.00 92.00
	OTHER REIMBURSABLE COST CENTERS						92.00
	09500 AMBULANCE SERVICES	13, 603	0	0	0	0	95.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	1, 486, 732	10, 000	0	0	0	118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN			0			190.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0 0	0	0 0		190.00
194.00	07950 OCCUPATI ONAL HEALTH	0	0	0	0	0	194.00
	07951 PALN CLINIC 07952 OAK POINTE	0	0	0	0		194.01 194.02
194.03	07953 FOUNDATI ON	0	0	0	0	0	194. 03
	07954 COMMUNI TY & VOLUNTEER SERVI CES 07955 VACANT SPACE	0	0	0	0		194.04 194.05
200.00	Cross Foot Adjustments	Ű	0	0	Ű	Ũ	200.00
201.00 202.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	2, 340, 149	30, 540	0	0	0	201.00 202.00
202.00	Part I)				0		
		1. 574022	3. 054000	0.000000	0.000000	0.000000	203.00
203.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B.				0		204 00
	Cost to be allocated (per Wkst. B, Part I) Part II) Unit cost multiplier (Wkst. B, Part	258, 404 0. 173807	11, 763 1. 176300		0 0. 000000		204.00

	ncial Systems TION - STATISTICAL BASIS	WHITLEY MEMORI		CCN: 150101	Period: From 01/01/2014	u of Form CMS-2552 Worksheet B-1
					To 12/31/2014	Date/Time Prepare 5/21/2015 2:26 pm
		INTERNS &	RESI DENTS			
	Cost Center Description	SERVI CES-SALAR	SERVICES-OTHER	PARAMED ED		
	bust benter beschiption	Y & FRI NGES	PRGM COSTS	PRGM		
		APPRV	APPRV	(ASSI GNED		
		(ASSI GNED TI ME)	(ASSIGNED TIME)	TIME)		
		21.00	22.00	23.00	_	
	RAL SERVICE COST CENTERS					
	O CAP REL COSTS-BLDG & FIXT					1
	O CAP REL COSTS-MVBLE EQUIP 1 SNF CAPITAL					2
	O EMPLOYEE BENEFITS DEPARTMENT					4
	0 ADMINISTRATIVE & GENERAL					5
	O MAINTENANCE & REPAIRS					6
	O OPERATION OF PLANT O LAUNDRY & LINEN SERVICE					7
	O HOUSEKEEPI NG					9
	0 DI ETARY					10
						11
	0 MAI NTENANCE OF PERSONNEL 0 NURSI NG ADMI NI STRATI ON					12
	O CENTRAL SERVICES & SUPPLY					14
	0 PHARMACY					15
	O MEDICAL RECORDS & LIBRARY					16
	0 SOCIAL SERVICE 0 NONPHYSICIAN ANESTHETISTS					17 19
	0 NURSI NG SCHOOL					20
	0 I & R SERVICES-SALARY & FRINGES APPRV	0				21
	0 I &R SERVICES-OTHER PRGM COSTS APPRV		0			22
	O PARAMED ED PRGM-(SPECIFY) TIENT ROUTINE SERVICE COST CENTERS				0	23
	O ADULTS & PEDIATRICS	0	0		0	30
	0 NURSERY	0	0		0	43
	O SKILLED NURSING FACILITY	0	0		0	44
	LLARY SERVICE COST CENTERS		0	1	0	
	O DELIVERY ROOM & LABOR ROOM	0	0		0	50 52
	O ANESTHESI OLOGY	0	0		0	53
	0 RADI OLOGY-DI AGNOSTI C	0	0		0	54
	O LABORATORY	0	0		0	60
	0 BLOOD CLOTTING FOR HEMOPHILIACS 0 RESPIRATORY THERAPY	0	0		0	62
	O PHYSI CAL THERAPY	0	0		0	66
	0 OCCUPATI ONAL THERAPY	0	0		0	67
	O SPEECH PATHOLOGY	0	0		0	68
	0 ELECTROCARDI OLOGY 0 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0		0	69
	O I MPL. DEV. CHARGED TO PATIENTS	0	0		0	72
	O DRUGS CHARGED TO PATIENTS	0	0		0	73
	7 CARDI AC REHABI LI TATI ON 8 HYPERBARI C OXYGEN THERAPY	0	0		0	76
	9 LI THOTRI PSY	0	0		0	76
OUTP/	ATIENT SERVICE COST CENTERS					
		0	0		0	90
	1 INTENSIVE OUT PATIENT PROGRAM 0 EMERGENCY	0	0		0	90 91
	O OBSERVATION BEDS (NON-DISTINCT PART	0	0			91
	R REIMBURSABLE COST CENTERS			-		
	O AMBULANCE SERVI CES	0	0		0	95
	AL PURPOSE COST CENTERS				0	110
8.00 NONRE	SUBTOTALS (SUM OF LINES 1-117) EIMBURSABLE COST CENTERS	0	0	1	0	118
	O GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	190
2.00 1920	0 PHYSICIANS' PRIVATE OFFICES	0	0		0	192
	O OCCUPATIONAL HEALTH	0	0		0	194
	1 PAIN CLINIC 2 OAK POINTE	0	0		0	194 194
	3 FOUNDATI ON	0	0		0	194
4.0407954	4 COMMUNITY & VOLUNTEER SERVICES	0	0		0	194
	5 VACANT_SPACE	0	0		0	194
0.00	Cross Foot Adjustments					200
01.00 02.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	0	Λ		0	201 202
	Part I)		0			202
03. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0.00000	no	203

Health Financial Systems	WHITLEY MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 150101	Period:	Worksheet B-1	
				From 01/01/2014 To 12/31/2014	Date/Time Pre 5/21/2015 2:2	
	INTERNS &	RESI DENTS				
Cost Center Description	SERVI CES-SALAR Y & FRI NGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM			
	APPRV (ASSI GNED	APPRV (ASSI GNED	(ASSIGNED TIME)			
	TI ME)	TI ME)	TTWL)			
	21.00	22.00	23.00			
204.00 Cost to be allocated (per Wkst. B, Part II)	0	0		0		204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0.0000	00		205. 00

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	WHITLEY MEMOR		CCN: 150101	Peri od:	u of Form CMS- Worksheet C	2002 .
				From 01/01/2014	Part I	
				To 12/31/2014	Date/Time Pre 5/21/2015 2:2	epared:
		Ti tl	e XVIII	Hospi tal	PPS	o piii
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
•	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	5, 068, 083		5, 068, 0	83 0	5, 068, 083	30.00
43. 00 04300 NURSERY	409, 314		409, 3	14 0	409, 314	43.00
44.00 04400 SKILLED NURSING FACILITY	6, 056, 266		6, 056, 2	66 0	6, 056, 266	44.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM	3, 198, 335		3, 198, 3	35 0	3, 198, 335	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 606, 281		1, 606, 2	81 0	1, 606, 281	52.00
53.00 05300 ANESTHESI OLOGY	34, 657		34, 6	57 31, 300	65, 957	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 238, 326		3, 238, 3	26 0	3, 238, 326	54.00
60. 00 06000 LABORATORY	2, 437, 287		2, 437, 2	87 0	2, 437, 287	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	967, 201	0	967, 2	01 0	967, 201	65.00
66. 00 06600 PHYSI CAL THERAPY	914, 938	0	914, 9	38 0	914, 938	66.00
67.00 06700 OCCUPATI ONAL THERAPY	1, 162, 472	0	1, 162, 4	72 0	1, 162, 472	67.00
68.00 06800 SPEECH PATHOLOGY	344, 691	0	344, 6	91 0	344, 691	68.00
69. 00 06900 ELECTROCARDI OLOGY	2, 265		2, 2	65 0	2, 265	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	913, 041		913, 0	41 0	913, 041	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	284,000		284, 0	00 0	284, 000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 504, 110		3, 504, 1	10 0	3, 504, 110	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0			0 0	0	76.9
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0			0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0			0 0	0	76.9
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	398, 449		398, 4	49 0	398, 449	90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0			0 0	0	
91.00 09100 EMERGENCY	3, 255, 363		3, 255, 3	63 9, 130	3, 264, 493	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	862, 246		862, 2		862, 246	
OTHER REIMBURSABLE COST CENTERS		•				1
95. 00 09500 AMBULANCE SERVICES	2, 498, 470		2, 498, 4	70 0	2, 498, 470	95.00
200.00 Subtotal (see instructions)	37, 155, 795					
201.00 Less Observation Beds	862, 246		862, 2		862, 246	
202.00 Total (see instructions)	36, 293, 549					

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES				Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre 5/21/2015 2:2	epared: 26 pm
			e XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	7 004 000		7 004 00			
30. 00 03000 ADULTS & PEDI ATRI CS	7, 324, 290		7, 324, 29			30.00
43. 00 04300 NURSERY	915, 751		915, 75			43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	2, 800, 856		2, 800, 85	6		44.00
ANCI LLARY SERVI CE COST CENTERS	0.100.504	10.000.011	45 450 00			
50. 00 05000 OPERATING ROOM	3, 180, 584	12, 298, 241			0.00000	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	3, 183, 084	130, 413			0.00000	
53. 00 05300 ANESTHESI OLOGY	288, 722	1, 374, 083			0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 802, 695	30, 911, 258			0.00000	
60. 00 06000 LABORATORY	1, 995, 322	9, 124, 370			0.00000	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0. 000000	0.00000	
65. 00 06500 RESPI RATORY THERAPY	816, 249	1, 693, 636			0.00000	
66. 00 06600 PHYSI CAL THERAPY	700, 696	2,055,762			0.00000	
67. 00 06700 OCCUPATI ONAL THERAPY	516, 706	792, 582			0.00000	
68.00 06800 SPEECH PATHOLOGY	1, 046, 937	279, 515			0.00000	
69.00 06900 ELECTROCARDI OLOGY	446, 810	1, 494, 167			0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	679, 778	1, 565, 101			0.00000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	348, 950	649, 537			0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 640, 723	7, 991, 106	11, 631, 82		0.00000	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0.000000	0.00000	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0.000000	0.00000	
76. 99 07699 LI THOTRI PSY	0	0		0 0.000000	0.00000	76. 99
OUTPATIENT SERVICE COST CENTERS						-
90. 00 09000 CLI NI C	1, 173	80, 593			0.00000	
90. 01 09001 I NTENSI VE OUT PATI ENT PROGRAM	0	0		0 0.000000	0.00000	
91.00 09100 EMERGENCY	1, 665, 757	12, 409, 877			0.00000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	916, 579	916, 57	0. 940722	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS	,,					
95. 00 09500 AMBULANCE SERVI CES	0	4, 535, 528			0.00000	
200.00 Subtotal (see instructions)	32, 355, 083	88, 302, 348	120, 657, 43	1		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	32, 355, 083	88, 302, 348	120, 657, 43			202.00

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150101	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/21/2015 2:26 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient Ratio 11.00			
INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
30. 00 03000 ADULTS & PEDI ATRI CS				30, 00
43. 00 04300 NURSERY				43.00
44. 00 04400 SKILLED NURSING FACILITY				44.00
ANCI LLARY SERVI CE COST CENTERS	<u> </u>			
50. 00 05000 OPERATING ROOM	0. 206626			50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 484769			52.00
53. 00 05300 ANESTHESI OLOGY	0. 039666			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.096053			54.00
60. 00 06000 LABORATORY	0. 219187			60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65. 00 06500 RESPIRATORY THERAPY	0. 385357			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 331925			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 887866			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 259859			68.00
69. 00 06900 ELECTROCARDI OLOGY	0.001167			69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 406722			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 284430			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 301252			73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			76. 98
76. 99 07699 LI THOTRI PSY	0. 000000			76.99
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLINIC	4.873040			90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0. 000000			90.01
91. 00 09100 EMERGENCY	0. 231925			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.940722			92.00
OTHER REIMBURSABLE COST CENTERS				12100
95.00 09500 AMBULANCE SERVICES	0, 550866			95.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00
	1 I			1

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	WHITLEY MEMOR		CCN: 150101	Period:	u of Form CMS- Worksheet C	2552-1
COMPUTATION OF RATIO OF COSTS TO CHARGES		FIOVICEI	CCN. 150101	From 01/01/2014		
				To 12/31/2014	Date/Time Pre	pared:
			le XIX	lleonitel	5/21/2015 2:2 PPS	26 pm
				Hospital Costs	PP5	
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
cost center bescription	(from Wkst. B,	Adj.		Di sal I owance	10121 00313	
	Part I, col.	naj.		Di Sai i Owanee		
	26)					
	1.00	2.00	3.00	4,00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	5, 068, 083		5, 068, 0	83 0	5, 068, 083	30.00
43. 00 04300 NURSERY	409, 314		409, 3	14 0	409, 314	43.00
44.00 04400 SKILLED NURSING FACILITY	6, 056, 266		6, 056, 2	66 0	6, 056, 266	44.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	3, 198, 335		3, 198, 3	35 0	3, 198, 335	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 606, 281		1, 606, 2	81 0	1, 606, 281	52.00
53. 00 05300 ANESTHESI OLOGY	34, 657		34, 6	57 31, 300	65, 957	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	3, 238, 326		3, 238, 3	26 0	3, 238, 326	54.00
60. 00 06000 LABORATORY	2, 437, 287		2, 437, 2	87 0	2, 437, 287	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	967, 201	C	967, 2	01 0	967, 201	65.00
66. 00 06600 PHYSI CAL THERAPY	914, 938	C	914, 9	38 0	914, 938	66.00
67.00 06700 OCCUPATI ONAL THERAPY	1, 162, 472	C	1, 162, 4	72 0	1, 162, 472	67.00
68.00 06800 SPEECH PATHOLOGY	344, 691	C	344, 6	91 0	344, 691	68.00
69. 00 06900 ELECTROCARDI OLOGY	2, 265		2, 2		2, 265	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	913, 041		913, 0	41 0	913, 041	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	284,000		284, 0	00 0	284, 000	
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 504, 110		3, 504, 1	10 0	3, 504, 110	
76. 97 07697 CARDI AC REHABI LI TATI ON	0			0 0	0	76.9
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0			0 0	0	1
76. 99 07699 LI THOTRI PSY	0			0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLINIC	398, 449		398, 4		398, 449	
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0			0 0	0	
91.00 09100 EMERGENCY	3, 255, 363		3, 255, 3			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	862, 246		862, 2	46	862, 246	92.00
OTHER REIMBURSABLE COST CENTERS			0.407.1		0.400.175	
95. 00 09500 AMBULANCE SERVICES	2, 498, 470		2, 498, 4		2/ 1/0/ 1/0	
200.00 Subtotal (see instructions)	37, 155, 795		0,1,100,1			
201.00 Less Observation Beds	862, 246		862, 2		862, 246	
202.00 Total (see instructions)	36, 293, 549	C	36, 293, 5	49 40, 430	36, 333, 979	202. 00

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			CCN: 150101	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre 5/21/2015 2:2	pared: 6 pm
			le XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	7, 324, 290		7, 324, 29			30.00
43. 00 04300 NURSERY	915, 751		915, 75			43.00
44.00 04400 SKILLED NURSING FACILITY	2, 800, 856		2, 800, 85	56		44.00
ANCI LLARY SERVICE COST CENTERS	,		1			
50. 00 05000 OPERATI NG ROOM	3, 180, 584	12, 298, 241			0.00000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 183, 084	130, 413			0.00000	
53. 00 05300 ANESTHESI OLOGY	288, 722	1, 374, 083			0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 802, 695	30, 911, 258			0.00000	
60. 00 06000 LABORATORY	1, 995, 322	9, 124, 370			0.00000	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0.000000	0.00000	
65. 00 06500 RESPI RATORY THERAPY	816, 249	1, 693, 636			0.00000	
66. 00 06600 PHYSI CAL THERAPY	700, 696	2, 055, 762			0.00000	
67.00 06700 OCCUPATI ONAL THERAPY	516, 706	792, 582			0.00000	
68.00 06800 SPEECH PATHOLOGY	1, 046, 937	279, 515			0.00000	
69. 00 06900 ELECTROCARDI OLOGY	446, 810	1, 494, 167			0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	679, 778	1, 565, 101			0.00000	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	348, 950	649, 537	998, 48		0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 640, 723	7, 991, 106	11, 631, 82		0.00000	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0.000000	0.00000	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0.000000	0.00000	76.98
76. 99 07699 LI THOTRI PSY	0	0		0 0.000000	0.00000	76.99
OUTPATIENT SERVICE COST CENTERS			_			
90. 00 09000 CLI NI C	1, 173	80, 593	81, 70	4. 873040	0.00000	90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0		0 0.000000	0.00000	
91.00 09100 EMERGENCY	1, 665, 757	12, 409, 877	14, 075, 63	0. 231276	0.00000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	916, 579	916, 5	0. 940722	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	4, 535, 528	4, 535, 52	0. 550866	0.00000	95.00
200.00 Subtotal (see instructions)	32, 355, 083	88, 302, 348	120, 657, 43	31		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	32, 355, 083	88, 302, 348	120, 657, 43	31		202.00

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lieu	」of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 150101	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/21/2015 2:26 pm
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient Ratio 11.00			
INPATIENT ROUTINE SERVICE COST CENTERS	· · · ·			
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
43.00 04300 NURSERY				43.00
44.00 04400 SKILLED NURSING FACILITY				44.00
ANCI LLARY SERVI CE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 206626			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 484769			52.00
53.00 05300 ANESTHESI OLOGY	0. 039666			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 096053			54.00
60. 00 06000 LABORATORY	0. 219187			60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62.30
65. 00 06500 RESPI RATORY THERAPY	0. 385357			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 331925			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 887866			67.00
68.00 06800 SPEECH PATHOLOGY	0. 259859			68.00
69. 00 06900 ELECTROCARDI OLOGY	0.001167			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 406722			71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 284430			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 301252			73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0.000000			76.98
76. 99 07699 LI THOTRI PSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			
90. 00 09000 CLINIC	4. 873040			90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0.000000			90.01
91.00 09100 EMERGENCY	0. 231925			91.00
92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART	0.940722			92.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 550866			95.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00
	1 I			1

Health Financial Systems	WHITLEY MEMOR	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE R REDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet C Part II Date/Time Pre 5/21/2015 2:2	
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost	Operating Cos	st Capital	Operating Cost	
	(Wkst. B, Part	(Wkst. B, Part	Net of Capita	al Reduction	Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	1					
50.00 05000 OPERATI NG ROOM	3, 198, 335				0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 606, 281				0	52.00
53. 00 05300 ANESTHESI OLOGY	34, 657				0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 238, 326	489, 499	2, 748, 82	27 0	0	54.00
60. 00 06000 LABORATORY	2, 437, 287	287, 649	2, 149, 63	38 0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	967, 201	137, 585	829, 6	16 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	914, 938	228, 751	686, 18	37 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	1, 162, 472	118, 892	1, 043, 58	30 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	344, 691	35, 569	309, 12	22 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	2, 265	228	2, 03	37 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	913, 041	100, 388	8 812, 65	53 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	284,000	28, 565	255, 43	35 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 504, 110	375, 263	3, 128, 84	17 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	398, 449	97, 413	301, 03	36 0	0	90.00
90.01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0		0 0	0	90.01
91.00 09100 EMERGENCY	3, 255, 363	451, 818	2, 803, 54	15 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	862, 246	150, 808	711, 43	38 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	2, 498, 470	253, 503	2, 244, 96	57 0	0	95.00
200.00 Subtotal (sum of lines 50 thru 199)	25, 622, 132	3, 461, 473	22, 160, 65	59 0	0	200.00
201.00 Less Observation Beds	862, 246	150, 808	711, 43	38 0	0	201.00
202.00 Total (line 200 minus line 201)	24, 759, 886	3, 310, 665	21, 449, 22	21 0	0	202.00

Health Financial Systems	WHITLEY MEMOR	AL HOSPITAL		In Lie	u of Form CMS-	-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE R REDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF		CCN: 150101	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part II Date/Time Pro 5/21/2015 2::	
			le XIX	Hospi tal	PPS	
Cost Center Description	Capital and	Total Charges (Worksheet C,	Cost to Charg			
	Operating Cost Reduction	Part I, column 8)	Ratio (col. / col. 7)	6		
	6,00	7.00	8,00	_		
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	3, 198, 335	15, 478, 825	0. 20662	26		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 606, 281			59		52.00
53. 00 05300 ANESTHESI OLOGY	34, 657	1, 662, 805	0. 02084	12		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 238, 326	33, 713, 953	0. 0960	53		54.00
60. 00 06000 LABORATORY	2, 437, 287	11, 119, 692	0. 21918	37		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.0000	00		62.30
65. 00 06500 RESPI RATORY THERAPY	967, 201	2, 509, 885	0. 3853	57		65.00
66. 00 06600 PHYSI CAL THERAPY	914, 938	2, 756, 458	0. 33192	25		66.00
67.00 06700 OCCUPATI ONAL THERAPY	1, 162, 472	1, 309, 288	0. 88786	56		67.00
68.00 06800 SPEECH PATHOLOGY	344, 691	1, 326, 452	0. 2598	59		68.00
69. 00 06900 ELECTROCARDI OLOGY	2, 265	1, 940, 977	0.00116	57		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	913, 041	2, 244, 879	0. 40672	22		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	284,000	998, 487	0. 28443	30		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 504, 110	11, 631, 829				73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0.0000			76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.0000			76.98
76. 99 07699 LI THOTRI PSY	0	0	0.0000	00		76.99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	398, 449					90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0				90.01
91.00 09100 EMERGENCY	3, 255, 363					91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS	862, 246	916, 579	0. 94072	22		92.00
95. 00 09500 AMBULANCE SERVICES	2, 498, 470	4, 535, 528	0. 55080	56		95.00
200.00 Subtotal (sum of lines 50 thru 199)	25, 622, 132					200.00
201.00 Less Observation Beds	862, 246					200.00
202.00 Total (line 200 minus line 201)	24, 759, 886					201.00

ealth Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	WHITLEY MEMORI		CCN: 150101 F	Period:	eu of Form CMS-2	2002-10
PPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	0515	Provi der		Period: From 01/01/2014	Worksheet D Part I	
					Date/Time Pre	.narod.
			'	.0 12/31/2014	5/21/2015 2:20	
		Ti tl	e XVIII	Hospi tal	PPS	<u>o pin</u>
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,	1	Related Cost			
	Part II, col.	((col. 1 - col.		(
	26)	(2)	/	1	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	886, 413	0	886, 413			30.00
43. 00 NURSERY	42, 798	1	42, 798	8 856	50.00	43.00
44.00 SKILLED NURSING FACILITY	806, 532	1	806, 532	2 18, 115	44.52	44.00
200.00 Total (lines 30-199)	1, 735, 743	í'	1, 735, 743	3 23, 779	1'	200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				4
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						4
30. 00 ADULTS & PEDIATRICS	1, 177	216, 992	4		,	30.00
43. 00 NURSERY	0	0	-		,	43.00
44.00 SKILLED NURSING FACILITY	1, 499	66, 735	l l		,	44.00
200.00 Total (lines 30-199)	2,676	283, 727	4		,	200.00

Health Financial Systems	WHITLEY MEMOR	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der	CCN: 150101	Period: From 01/01/2014 To 12/31/2014		
		Ti tl	e XVIII	Hospi tal	PPS	0 pm
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col		column 4)	
	Part II, col.	8)	2)	5	í í	
	26)	í í	Í Í			
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	534, 919	15, 478, 825	0. 03455	68 474, 387	16, 394	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	167, 136	3, 313, 497	0. 05044	1 838	42	52.00
53.00 05300 ANESTHESI OLOGY	3, 487	1, 662, 805	0.00209	45, 449	95	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	489, 499	33, 713, 953	0. 01451	9 1,046,916	15, 200	54.00
60. 00 06000 LABORATORY	287, 649	11, 119, 692	0. 02586	686, 962	17, 770	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.0000	0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	137, 585	2, 509, 885	0. 05481	7 324, 882	17, 809	65.00
66.00 06600 PHYSI CAL THERAPY	228, 751	2, 756, 458	0. 08298	72, 284		
67.00 06700 OCCUPATI ONAL THERAPY	118, 892	1, 309, 288	0. 09080	36, 983	3, 358	67.00
68.00 06800 SPEECH PATHOLOGY	35, 569	1, 326, 452	0. 02681	5 7, 185	193	68.00
69.00 06900 ELECTROCARDI OLOGY	228					
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	100, 388					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	28, 565					1
73.00 07300 DRUGS CHARGED TO PATIENTS	375, 263					1
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0.00000		0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000		0	76.98
76. 99 07699 LI THOTRI PSY	0	0	0.00000		0	76.99
OUTPATIENT SERVICE COST CENTERS		-		-1		
90, 00 09000 CLINIC	97, 413	81, 766	1. 19136	3 472	562	90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0					90.01
91. 00 09100 EMERGENCY	451, 818	14, 075, 634			20, 623	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	150, 808					
OTHER REIMBURSABLE COST CENTERS		/-/-				1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	3, 207, 970	105, 081, 006		4, 874, 027	143, 149	

Health Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	ASS THROUGH COS	TS Provi der		Period:	Worksheet D	
				From 01/01/2014 To 12/31/2014		narod
				10 12/31/2014	5/21/2015 2:2	6 pm
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swing-Bed	Total Costs	
		Cost	Medi cal	Adj ustment	(sum of cols.	
			Education Cos		1 through 3,	
					minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	C) C		0 0	0	30.00
43. 00 04300 NURSERY	C) C		0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	C	C)	0	0	44.00
200.00 Total (lines 30-199)	C	C)	0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.		Inpati ent		
	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDI ATRI CS	4, 808			7 0		30.00
43. 00 04300 NURSERY	856			0 0		43.00
44.00 04400 SKILLED NURSING FACILITY	18, 115					44.00
200.00 Total (lines 30-199)	23, 779		2,67	6 0		200.00

Health Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PAS	S Provi der		Period: From 01/01/2014 To 12/31/2014		pared: 6 pm
		Ti tl	e XVIII	Hospi tal	PPS	•
Cost Center Description	Non Physician Anesthetist	Nursing School	Allied Health	ALL Other Medical	Total Cost (sum of col 1	
	Cost			Educati on Cost	through col.	
	1.00	2.00	3.00	4,00	4) 5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM		0	1	0 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0			0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			0 0	0	54.00
60. 00 06000 LABORATORY				0 0	0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0 0	0	62.30
65. 00 06500 RESPIRATORY THERAPY				0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY				0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY				0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY				0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY				0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT				0 0	0	71.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS				0 0	-	72.00
72.00 07200 TMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS				0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATTENTS 76. 97 07697 CARDIAC REHABILITATION				0 0	0	76.97
				0 0	e e	
76. 98 07698 HYPERBARI C 0XYGEN THERAPY 76. 99 07699 LI THOTRI PSY	0				0	76. 98 76. 99
76. 99 07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0		/	0 0	0	/0.99
90. 00 09000 CLINIC	0	0	7	0 0	0	90.00
90. 00 109000 CEINIC 90. 01 109001 INTENSIVE OUT PATIENT PROGRAM				0 0	0	90.00
91. 00 09100 EMERGENCY				0 0	-	90.01
					0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0			0 0	0	92.00
95. 00 09500 AMBULANCE SERVICES	1	1		1		95.00
200.00 Total (lines 50-199)	0	c		o o	0	200.00
200.00 [10tal (11163 30-199)	1 0	i U	1	0	0	200.00

Health Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provi der		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2014 To 12/31/2014	Part IV	norod.
				To 12/31/2014	Date/Time Pre 5/21/2015 2:2	pareu: 6 pm
	_		e XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	Total	Total Charges		t Outpatient	Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost		
	Cost (sum of		1 ·		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	1	1	1	1	I	
50. 00 05000 OPERATI NG ROOM	0	15, 478, 825				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	3, 313, 497				
53. 00 05300 ANESTHESI OLOGY	0	1, 662, 805				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	33, 713, 953				
60. 00 06000 LABORATORY	0	11, 119, 692				60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000			62.30
65. 00 06500 RESPI RATORY THERAPY	0	2, 509, 885				65.00
66. 00 06600 PHYSI CAL THERAPY	0	2, 756, 458				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	1, 309, 288				67.00
68.00 06800 SPEECH PATHOLOGY	0	1, 326, 452				
69. 00 06900 ELECTROCARDI OLOGY	0	1, 940, 977				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 244, 879				
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	998, 487	0.00000	0.000000	148, 517	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	11, 631, 829	0. 00000	0.000000	1, 006, 276	73.00
76. 97 07697 CARDIAC REHABILITATION	0	0	0. 00000	0.000000	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0. 00000	0.000000	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0. 00000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	81, 766	0. 00000	0.000000	472	90.00
90.01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0. 00000	0.000000	0	90.01
91.00 09100 EMERGENCY	0	14, 075, 634	0. 00000	0.000000	642, 477	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	916, 579	0. 00000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	105, 081, 006			4, 874, 027	200.00
			•		-	•

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 150101 Period: Trom 01/01/2014 To 12/31/2014 Dirksheet D Patr IV Date/Time Prepared: 5/21/2015 2: 26 pm 5/21/2015 2: 26 pm 5/21/2	Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
Andown Social To 12/31/2014 Date/Time Propared: 5/21/2015 Date/Time Propare	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	6 Provi der	CCN: 150101			
Cost Center Description Inpatient Program Pass-Through Costs (col. 8 Outpatient Program Charges Outpatient Program Pass-Through Costs (col. 9 Program Pass-Through Costs (col. 9 Source State	THROUGH COSTS						
Cost Center Description Inpatient Program Pass-Through Costs (col. 9 x col. 10) Outpatient Program Pass-Through Costs (col. 9 x col. 10) Hospital PPS ANCILLARY SERVICE COST CENTERS					10 12/31/2014		
Cost Center Description Inpatient Program Pass-Through Costs (col. 8 x col. 10) Outpatient Program Casts (col. 9 x col. 10) Outpatient Program Pass-Through Costs (col. 9 x col. 10) Outpatient Program Pass-Through Costs (col. 9 x col. 12) ANCILLARY SERVICE COST CENTERS 0 11.00 12.00 13.00 50.00 05200 DELIVERY ROM & LABOR ROOM 0 05300 ANESTHESI OLOGY 0 1,678,567 0 50.00 05300 ANESTHESI OLOGY 0 183,163 0 53.00 54.00 05400 RADIOLOGY-DIARNOSTI C 0 5,883,753 0 64.01 60.00 66.00 65.00 06500 RESPI RATORY THERAPY 0 298,006 0 62.30 65.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 68.00 66.00 67.00 68.00 66.00 71.00 72.00 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 76.97 76.97 76.97 76.97 76.97 76.97 76.97 76.97				e XVIII	Hospi tal		o pili
Program Pass-Through Costs (col. 8 x col. 10) Program (harges Program (harges Program Pass-Through Costs (col. 9 x col. 12) ANCI LLARY SERVICE COST CENTERS	Cost Center Description	Inpatient					
Pass-Through Costs (col. 8 x col. 10) Charges x col. 10) Pass-Through Costs (col. 9 x col. 12) ANCILLARY SERVICE COST CENTERS 11.00 12.00 13.00 50.00 05000 DEPERATING ROOM 0 000 0 1.678,567 0 50.00 05300 AUESTHESI OLOGY 0 183,163 0 51.00 05300 AUESTHESI OLOGY 0 183,163 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 5,883,753 0 60.00 6000 LABORATORY 0 166,401 0 60.00 6000 LABORATORY 0 298,006 0 62.30 65.00 0 COCUPATI ONAL THERAPY 0 298,006 0 66.00 60.00 0 GOROU DEPECH PATHONOGY 0 0 0 67.00 67.00 0 GOROU CLUBRATI ONAL THERAPY 0 298,006 0 68.00 69.00 0 GOROU DEPECH PATHONOGY 0 0 0 69.00 71.00 DEV< CHARGED TO PATI ENTS							
Costs (col. 8 x col. 10) Costs (col. 9 x col. 12) ANCI LLARY SERVICE COST CENTERS 50.00 05200 OPERATI NG ROOM 0 1.00 12.00 13.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 50.00 52.00 53.00 50.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 68.00 66.00 67.00 68.00 68.00 68.00 69.00 71.00 72.00 72.00 72.00 72.00 <td></td> <td></td> <td></td> <td></td> <td>h</td> <td></td> <td></td>					h		
II.00 I2.00 I3.00 ANCI LLARY SERVICE COST CENTERS 50.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 56.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 66.00 67.00 67.00 68.00 69.00			J				
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 0 1, 678, 567 0 50.00 52.00 55.00 50.00 52.00 55.00 50.00 52.00 55.00 50.00 53.00 50.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 54.00 53.00 54.00 53.00 54.00 53.00 54.00 50.00 65.00 65.00 65.00 66.00 62.30 66.00 65.00 66.00 67.00 66.00 67.00 68.00 68.00 68.00 68.00 68.00 68.00 71.00 72.00 69.00 71.00 72.00 73.00		x col. 10)		x col. 12)			
50.00 05000 OPERATING ROM 0 1, 678, 567 0 50.00 52.00 05200 DELIVERY ROM & LABOR ROM 0 0 0 0 53.00 05200 DELIVERY ROM & LABOR ROM 0 0 0 0 52.00 53.00 05200 RESPIRSTOCY 0 183, 163 0 53.00 60.00 LABORATORY 0 166, 401 0 60.00 62.30 06250 BLOD CLOTTING FOR HEMOPHILIACS 0 0 0 65.00 06500 RESPIRATORY THERAPY 0 298, 006 0 66.00 64.00 06700 06700 000 0 0 66.00 67.00 69.00 06700 06700 000 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 76.98 76.98 76.98 76.98 76.98<			12.00				
52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 52.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 54.00 05.00 RADOLOGY-DI AGNOSTI C 0 583.753 0 60.00 60.00 60.00 60.00 62.30 62.30 62.30 62.30 62.30 62.30 62.30 62.00 66.00 60.00 62.30 66.00 60.00 66.00 60.00 66.00 60.00 66.00 67.00 68.00 69.00 67.00 68.00 69.00 67.00 68.00 <td>ANCI LLARY SERVI CE COST CENTERS</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	ANCI LLARY SERVI CE COST CENTERS						
53.00 05300 ANESTHESI OLOGY 0 183, 163 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 5,883, 753 0 54.00 60.00 LABORATORY 0 166,401 0 60.20 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 65.00 06500 RESPI RATORY THERAPY 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 66.00 67.00 06700 0CUPATI ONAL THERAPY 0 0 0 67.00 68.00 06900 FLECTROCARDI OLOGY 0 0 0 68.00 69.00 06900 FLECTROCARDI OLOGY 0 372,500 0 72.00 71.00 71.00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 164,918 73.00 73.00 73.00 7300 DRUGS CHARGED TO PATI ENTS 0 2,831,016 73.00 76.97 76.98 HYBERARL C OXYGEN THERAPY 0 0 0 0 90.	50. 00 05000 OPERATI NG ROOM	0	1, 678, 567		0		50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C 0 5, 883, 753 0 54.00 60.00 06000 LABORATORY 0 166, 401 0 60.00 62.30 06500 RESPI RATORY THERAPY 0 298, 006 0 62.30 65.00 06500 RESPI RATORY THERAPY 0 298, 006 0 66.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 66.00 67.00 0CCUPATI ONAL THERAPY 0 0 0 68.00 68.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 372, 500 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 52, 415 0 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 2, 831, 016 0 73.00 76.97 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 76.97 76.98 07699 LI THOTRI PSY 0 0 <	52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0)	0		52.00
60.00 LABORATORY 0 166, 401 0 60.00 62.30 06250 BLODD CLOTTI NG FOR HEMOPHI LI ACS 0 0 62.30 65.00 06500 RESPI RATORY THERAPY 0 298, 006 0 65.00 66.00 06000 PHYSI CAL THERAPY 0 0 0 66.00 67.00 06700 OCUPATI ONAL THERAPY 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 69.00 ELECTROCARDI OLOGY 0 372,500 0 71.00 71.00 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 164,918 71.00 71.00 72.00 07300 DRUS CHARGED TO PATI ENTS 0 2,831,016 73.00 76.97 76.97 OR697 LI HOTRI PSY 0 0 0 76.97 76.97 OR698 HYPERBARI C OXYGEN THERAPY 0 0 0 76.97 76.99 DTHOT NER REHABI LI TATI ON 0 0 0 0 90.0	53.00 05300 ANESTHESI OLOGY	0	183, 163		0		53.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 62.30 65.00 06500 RESPIRATORY THERAPY 0 298,006 0 65.00 66.00 06600 PHYSICAL THERAPY 0 0 0 66.00 67.00 06700 0CCUPATIONAL THERAPY 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0 372,500 0 69.00 71.00 MDIO ALS SUPPLIES CHARGED TO PATIENT 0 164,918 0 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 2,831,016 0 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 2,831,016 0 76.97 76.97 OR698 HYPERBARI C 0XYGEN THERAPY 0 0 0 76.97 76.99 DTHOT RESPVICE COST CENTERS 90.00 0 0 90.01 90.01 90.00 OPOTOL INTC 0 9,026 0 90.01 9	54.00 05400 RADI OLOGY-DI AGNOSTI C	0	5, 883, 753		0		54.00
65.00 06500 RESPI RATORY THERAPY 0 298,006 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 67.00 68.00 06800 SPECH PATHOLOGY 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 372,500 0 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 164,918 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 2,831,016 0 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 2,831,016 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 76.98 76.99 DT4904 ITHOTR SERVICE COST CENTERS 90.00 90.01 90.01 90.01 90.00 09000 CLI NI C 0 9,026 0 90.01 91.00 090000 ITHOTR SERVICE COST CENTERS	60. 00 06000 LABORATORY	0	166, 401		0		60.00
66.00 06600 PHYSI CAL THERAPY 0 0 0 66.00 67.00 66.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 68.00 67.00 68.00 68.00 68.00 68.00 68.00 68.00 69.00 0 0 0 0 68.00 69.00 69.00 71.00 68.00 69.00 71.00 71.00 71.00 71.00 71.00 71.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 76.97 76.97 76.97 76.98 97.698 HYPERBARI C 0XYGEN THERAPY 0 0 0 76.99 76.99 76.99 76.99 76.99 76.99 76.99 76.99 76.99 90.00 90.00 76.99 76.99 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.01 90.01 90.00 90.01 90.01 90.01	62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0)	0		62.30
67.00 06700 0CCUPATIONAL THERAPY 0 0 0 67.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 69.00 0 0 0 0 0 68.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 71.00 71.00 71.00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 164,918 0 71.00 72.00 72.00 72.00 72.00 72.00 72.00 73.00 73.00 74.97 64.918 0 72.00 73.00 76.97 76.97 76.97 76.97 76.97 76.97 76.97 76.97 76.98 HYPERBARI C OXYGEN THERAPY 0 0 0 76.97 76.98 76.98 76.98 76.98 76.98 76.98 76.98 76.98 76.99 76.99 76.99 76.99 76.99 76.99 76.99 76.99 76.98 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.0	65. 00 06500 RESPI RATORY THERAPY	0	298, 006		0		65.00
68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 372,500 0 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 164,918 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 52,415 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 2,831,016 0 73.00 76.97 7677 CARDI AC REHABI LI TATI ON 0 0 0 76.97 76.98 07699 LI THOTRI PSY 0 0 0 76.98 70.00 09000 CLI NI C 0 0 0 90.00 90.01 09000 CLI NI C 0 0 90.00 90.01 91.00 09000 CLI NI C 0 0 90.01 90.01 92.00 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 197,578 0 91.00 92.00 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 197,578 <td< td=""><td>66. 00 06600 PHYSI CAL THERAPY</td><td>0</td><td>0</td><td>)</td><td>0</td><td></td><td>66.00</td></td<>	66. 00 06600 PHYSI CAL THERAPY	0	0)	0		66.00
69.00 06900 ELECTROCARDI OLOGY 0 372,500 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 164,918 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 52,415 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 2,831,016 0 73.00 76.97 07697 CARDI AC REHABILI TATI ON 0 0 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 76.97 76.99 07699 LI THOTRI PSY 0 0 0 76.99 0UTPATI ENT SERVICE COST CENTERS 0 9,026 0 90.00 90.01 90.00 09000 CLI NI C 0 9,026 0 90.01 91.00 09100 EMERGENCY 0 2,495,201 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 197,578 0 92.00 95.00 09500 AMBULANCE SERVICES 95.00	67.00 06700 OCCUPATI ONAL THERAPY	0	0)	0		67.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 164,918 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 52,415 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 2,831,016 0 73.00 76.97 07697 CARDI AC REHABI LI TATI ON 0 0 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 76.98 76.99 07699 LI THOTRI PSY 0 0 0 76.99 00100 UTPATI ENT SERVICE COST CENTERS 90.00 90.00 90.00 90.00 90.00 09000 CLI NI C 0 9,026 0 90.00 90.01 09000 LIT ENT SERVICE COST CENTERS 90.00 90.01 90.01 90.01 91.00 09000 EMERGENCY 0 2,495,201 0 91.00 92.00 92.00 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 197,578 0 92.00 92.00 95.00 95.00 <td>68.00 06800 SPEECH PATHOLOGY</td> <td>0</td> <td>0</td> <td>)</td> <td>0</td> <td></td> <td>68.00</td>	68.00 06800 SPEECH PATHOLOGY	0	0)	0		68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 52,415 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 2,831,016 0 73.00 76.97 07697 CARDI AC REHABILITATION 0 0 0 76.97 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 76.98 76.99 07699 LITHOTRIPSY 0 0 0 76.98 0000 00000 CLINIC 0 9,026 0 90.00 09.001 INTENSI VE OUT PATIENT PROGRAM 0 0 0 90.01 90.001 09001 INTENSI VE OUT PATIENT PROGRAM 0 0 90.01 90.01 91.00 09200 OBSERVATION BEDS (NON-DI STINCT PART 0 197,578 0 92.00 0THER REI MBURSABLE COST CENTERS 0 197,578 0 92.00 92.00 0 09500 AMBULANCE SERVICES 95.00 95.00 95.00 95.00	69.00 06900 ELECTROCARDI OLOGY	0	372, 500)	0		69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 2,831,016 0 73.00 76.97 07697 CARDI AC REHABILITATION 0 0 0 76.97 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 76.98 76.99 07699 LI THOTRI PSY 0 0 0 76.99 0UTPATIENT SERVICE COST CENTERS 0 9,026 0 90.00 90.00 09000 CLI NI C 0 9,026 90.00 90.01 09001 INTENSI VE OUT PATIENT PROGRAM 0 0 90.01 91.00 09100 EMERGENCY 0 2,495,201 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 197,578 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	164, 918		0		71.00
76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 76. 97 76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 76. 99 00TPATI ENT SERVICE COST CENTERS 0 9, 026 0 90. 00 90. 00 09000 CLI NI C 0 9, 026 90. 00 90. 01 09001 INTENSI VE OUT PATI ENT PROGRAM 0 0 90. 01 91. 00 09100 EMERGENCY 0 2, 495, 201 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 197, 578 0 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00 95. 00	72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	52, 415		0		72.00
76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 76.98 76.98 76.99 07699 LI THOTRI PSY 0 0 0 0 76.99 0UTPATI ENT SERVICE COST CENTERS 0 9,026 0 0 90.00 90.00 09000 CLI NI C 0 9,026 0 90.00 90.01 09001 INTENSI VE OUT PATI ENT PROGRAM 0 0 0 90.01 91.00 09100 EMERGENCY 0 2,495,201 0 90.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 197,578 0 92.00 0THER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0	2, 831, 016		0		73.00
76.99 07699 LI THOTRI PSY 0 0 76.99 OUTPATI ENT SERVICE COST CENTERS 0 9,026 0 90.00 91.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 </td <td>76. 97 07697 CARDI AC REHABI LI TATI ON</td> <td>0</td> <td>0</td> <td>)</td> <td>0</td> <td></td> <td>76.97</td>	76. 97 07697 CARDI AC REHABI LI TATI ON	0	0)	0		76.97
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 9,026 0 90.00 90.01 09000 ILINIC 0 0 0 90.01 91.00 09100 EMERGENCY 0 2,495,201 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 197,578 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0)	0		76.98
90.00 09000 CLINIC 0 9,026 0 90.00 90.01 09001 INTENSIVE OUT PATIENT PROGRAM 0 0 0 90.01 91.00 09100 EMERGENCY 0 2,495,201 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 197,578 0 92.00 0 04500 AMBULANCE SERVICES 95.00 95.00 95.00 95.00	76. 99 07699 LI THOTRI PSY	0	0)	0		76.99
90.01 09001 INTENSIVE OUT PATIENT PROGRAM 0 0 0 90.01 91.00 09100 EMERGENCY 0 2,495,201 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 197,578 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00	OUTPATIENT SERVICE COST CENTERS						1
91.00 09100 EMERGENCY 0 2,495,201 0 91.00 91.00 92.00 <th< td=""><td>90. 00 09000 CLI NI C</td><td>0</td><td>9, 026</td><td></td><td>0</td><td></td><td>90.00</td></th<>	90. 00 09000 CLI NI C	0	9, 026		0		90.00
92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 197, 578 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 9500 AMBULANCE SERVICES 95.00 95.00	90. 01 09001 I NTENSI VE OUT PATI ENT PROGRAM	0	0)	0		90.01
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00	91.00 09100 EMERGENCY	0	2, 495, 201		0		91.00
95. 00 09500 AMBULANCE SERVICES 95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	197, 578		0		92.00
]
200.00 Total (lines 50-199) 0 14, 332, 544 0 200.00	95. 00 09500 AMBULANCE SERVI CES						95.00
	200.00 Total (lines 50-199)	0	14, 332, 544		0		200.00

Health Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 150101	Peri od:	Worksheet D	
				From 01/01/2014 To 12/31/2014		narod
				10 12/31/2014	5/21/2015 2:2	
		Titl	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		4 (70 5 7	1	-		1
50. 00 05000 OPERATING ROOM	0. 206626			0 0	0.0,000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 484769			0 0	-	
53. 00 05300 ANESTHESI OLOGY	0. 020842			0 0	3, 817	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 096053			0 0	565, 152	
60. 00 06000 LABORATORY	0. 219187			0 0	36, 473	1
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 385357			0 0	114, 839	1
66. 00 06600 PHYSI CAL THERAPY	0. 331925			0 0	0	
67.00 06700 OCCUPATI ONAL THERAPY	0. 887866			0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 259859			0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 001167			0 0	435	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 406722			0 0	67, 076	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 284430			0 0	14, 908	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 301252			0 0	852, 849	
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			0 0	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			0 0	0	
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS	1	I	1		1	
90. 00 09000 CLINIC	4.873040			0 0		
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0. 000000			0 0	0	
91.00 09100 EMERGENCY	0. 231276			0 0		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 940722	197, 578		0 0	185, 866	92.00
OTHER REIMBURSABLE COST CENTERS					I	
95. 00 09500 AMBULANCE SERVI CES	0. 550866			0		95.00
200.00 Subtotal (see instructions)		14, 332, 544		0 0	2, 809, 315	
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges				-		
202.00 Net Charges (line 200 +/- line 201)		14, 332, 544		0 0	2, 809, 315	202.00

Health Financial Systems	WHITLEY MEMORIA	AL HOSPITAL		In Lieu	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CCN: 150101	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Pre 5/21/2015 2:2	
		Ti tl	e XVIII	Hospi tal	PPS	
	Cost	ts				
Cost Center Description	Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						_
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY-DI AGNOSTI C 60.00 06200 LABORATORY 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS 76.97 OARDI AC REHABILITATION 76.98 HYPERBARI C OXYGEN THERAPY 76.99 07699 76.99 07699						$\begin{array}{c} 50. \ 00\\ 52. \ 00\\ 53. \ 00\\ 54. \ 00\\ 60. \ 00\\ 65. \ 00\\ 65. \ 00\\ 65. \ 00\\ 67. \ 00\\ 68. \ 00\\ 67. \ 00\\ 71. \ 00\\ 72. \ 00\\ 73. \ 00\\ 73. \ 00\\ 76. \ 97\\ 76. \ 98\\ 76. \ 99\end{array}$
OUTPATIENT SERVICE COST CENTERS	U	0				/0. 77
90. 00 90. 00 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 91. 00 92. 00	0 0 0	0 0 0 0				90.00 90.01 91.00 92.00
95.00 09500 AMBULANCE SERVICES 200.00 Subtotal (see instructions) 201.00 Less PBP Clinic Lab. Services-Program 0nl y Charges 0nl y Charges (line 200 +/- line 201)	0 0 0	c				95.00 200.00 201.00 202.00

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	5 Provi der	CCN: 150101	Peri od:	Worksheet D	
THROUGH COSTS		Component	- CON. 155100	From 01/01/2014		norod.
		Component	CCN: 155128	To 12/31/2014	Date/Time Pre 5/21/2015 2:2	
		Ti tl	e XVIII	Skilled Nursing		
				Facility		
Cost Center Description	Non Physician	Nursing School	Allied Healt		Total Cost	
	Anestheti st			Medi cal	(sum of col 1	
	Cost			Education Cost	J J	
	1.00	0.00	0.00	4.00	4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						50.00
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60.00 06000 LABORATORY	0	0		0 0	0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0	0		0 0	0 0	76.99
OUTPATIENT SERVICE COST CENTERS		-		<u>a</u>		
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0		0 0	0	90.01
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0	0			0 0	92.00
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI CES					1	
		0				95.00
200.00 Total (lines 50-199)	0	0	I	0 0	1 0	200. 00

Health Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provi der		Peri od:	Worksheet D	
THROUGH COSTS		0		From 01/01/2014		
		Component	CCN: 155128	To 12/31/2014	Date/Time Pre 5/21/2015 2:2	pared: 6 pm
		Ti tl	e XVIII	Skilled Nursing		
	T			Facility		
Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost		
	Cost (sum of		(col. 5 ÷ col		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	1	45 470 005	0.00000			
50.00 05000 OPERATING ROOM	0					
52.00 05200 DELIVERY ROOM & LABOR ROOM	0					52.00
53. 00 05300 ANESTHESI OLOGY	0	1, 662, 805				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	00///0//00				
60. 00 06000 LABORATORY	0	11, 119, 692				60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000			62.30
65. 00 06500 RESPI RATORY THERAPY	0	2, 509, 885				65.00
66. 00 06600 PHYSI CAL THERAPY	0	2, 756, 458				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	1, 309, 288				67.00
68.00 06800 SPEECH PATHOLOGY	0	1, 326, 452	0.00000	0. 000000	54, 700	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 940, 977	0.00000	0. 000000	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 244, 879	0.00000	0. 000000	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	998, 487	0.00000	0. 000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	11, 631, 829	0.00000	0. 000000	53, 925	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0.00000	0. 000000	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000	0. 000000	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0.00000	0. 000000	0	76.99
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0	81, 766	0.00000	0.00000	0	90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0.00000	0. 000000	0	90.01
91.00 09100 EMERGENCY	0	14, 075, 634	0.00000	0. 000000	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	916, 579	0.00000	0. 000000	0	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	105, 081, 006			414, 761	200. 00

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	5 Provi der	CCN: 150101	Peri od:	Worksheet D	
THROUGH COSTS		C	- CON 155100	From 01/01/2014		
		Component	CCN: 155128	To 12/31/2014	Date/Time Pre 5/21/2015 2:2	epared: 26 pm
		Ti tl	e XVIII	Skilled Nursing	PPS	- F
				Facility		
Cost Center Description	Inpati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)	_		
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS				0		50.00
50. 00 05000 OPERATING ROOM	0	0		0		50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54.00
60. 00 06000 LABORATORY	0	0		0		60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0		62.30
65. 00 06500 RESPI RATORY THERAPY	0	0		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0		73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0		76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0		76.98
76. 99 07699 LI THOTRI PSY	0	0		0		76.99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0		90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0		0		90.01
91. 00 09100 EMERGENCY	0	0		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0		92.00
OTHER REIMBURSABLE COST CENTERS			1			
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50-199)	0	0	1	0		200.00

ealth Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	WHITLEY MEMORI		CCN: 150101 F	Period:	eu of Form CMS-2 Worksheet D	2332 10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	CUSIS	Provider		Period: From 01/01/2014		
					Date/Time Pre	harod
			'	10 12/31/2014	5/21/2015 2:20	
		Tit	le XIX	Hospi tal	PPS	<u>o pin</u>
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,	100, 222 2002 1	Related Cost			
	Part II, col.	/	(col. 1 - col.		1	
	26)	(2)		1	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	886, 413	0	886, 413	3 4, 808	184.36	30.00
43.00 NURSERY	42, 798	i	42, 798	8 856	50.00	43.00
44.00 SKILLED NURSING FACILITY	806, 532	i	806, 532	2 18, 115	44.52	2 44.00
200.00 Total (lines 30-199)	1, 735, 743	·!	1, 735, 743	3 23, 779	1'	200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				1 7
	6.00	7.00			'	
INPATIENT ROUTINE SERVICE COST CENTERS						4
30. 00 ADULTS & PEDIATRICS	223				,	30.00
43. 00 NURSERY	110	5, 500	1		,	43.0
44.00 SKILLED NURSING FACILITY	8, 539	380, 156	,		,	44.0
200.00 Total (lines 30-199)	8, 872	426, 768			,	200.0

Health Financial Systems	WHITLEY MEMOR	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der	CCN: 150101	Period: From 01/01/2014 To 12/31/2014		
		Tit	le XIX	Hospi tal	PPS	•
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	, (column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)	-		
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	534, 919	15, 478, 825	0. 03455	1, 257, 553	43, 459	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	167, 136	3, 313, 497	0. 05044	1 729, 413	36, 792	52.00
53.00 05300 ANESTHESI OLOGY	3, 487	1, 662, 805	0.00209	109, 112	229	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	489, 499	33, 713, 953	0. 01451	9 187, 744	2, 726	54.00
60. 00 06000 LABORATORY	287, 649	11, 119, 692	0. 02586	333, 725	8, 633	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	137, 585	2, 509, 885	0. 05481	7 98, 064	5, 376	65.00
66. 00 06600 PHYSI CAL THERAPY	228, 751	2, 756, 458	0. 08298	1, 756	146	66.00
67.00 06700 OCCUPATI ONAL THERAPY	118, 892	1, 309, 288	0. 09080	1, 500	136	67.00
68.00 06800 SPEECH PATHOLOGY	35, 569	1, 326, 452	0. 02681	5 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	228	1, 940, 977	0.00011	7 21, 458	3	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	100, 388	2, 244, 879	0. 04471	9 153, 210	6, 851	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	28, 565					
73.00 07300 DRUGS CHARGED TO PATIENTS	375, 263					
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0.00000		0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000		0	76.98
76. 99 07699 LI THOTRI PSY	0	0	0.00000		0	76, 99
OUTPATIENT SERVICE COST CENTERS				<u> </u>		
90, 00 09000 CLINIC	97, 413	81, 766	1. 19136	630	751	90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0				0	90, 01
91.00 09100 EMERGENCY	451, 818	14, 075, 634			4, 440	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	150, 808				0	92.00
OTHER REIMBURSABLE COST CENTERS		/-/-				1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	3, 207, 970	105, 081, 006		3, 637, 478	129, 019	

Health Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS			Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 5/21/2015 2:2	
			I e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	(C)	0 0	0	30.00
43. 00 04300 NURSERY	0	c c		0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0			0	0	44.00
200.00 Total (lines 30-199)	0) c		0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	Inpatient		
· ·	Days	5 ÷ col. 6)	Program Days	Program		
	-			Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6.00	7.00	8.00	9.00	1	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	4, 808	0. OC) 22	3 0		30.00
43. 00 04300 NURSERY	856	0.00	11	o o		43.00
44.00 04400 SKILLED NURSING FACILITY	18, 115			9 0		44.00
200.00 Total (lines 30-199)	23, 779		8, 87			200.00

Health Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PAS	S Provi der		Period: From 01/01/2014 To 12/31/2014		pared: 6 pm
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description		Nursing School	Allied Health		Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost		
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1	i		-1		
50. 00 05000 OPERATI NG ROOM	0	C		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	C		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0		0 0	0	90.01
91.00 09100 EMERGENCY	0	C		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	·		•	·		
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	0		0 0	0	200. 00

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provi der		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2014 To 12/31/2014		norod.
				10 12/31/2014	Date/Time Pre 5/21/2015 2:2	6 pm
			le XIX	Hospi tal	PPS	<u> </u>
Cost Center Description	Total	Total Charges	Ratio of Cos		Inpati ent	
		(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of				Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	1	r	1	-		
50.00 05000 OPERATI NG ROOM	0	15, 478, 825				
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	3, 313, 497				
53. 00 05300 ANESTHESI OLOGY	0	1, 662, 805				•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	33, 713, 953				•
60. 00 06000 LABORATORY	0	11, 119, 692				
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000			62.30
65. 00 06500 RESPI RATORY THERAPY	0	2, 509, 885	0.00000			65.00
66. 00 06600 PHYSI CAL THERAPY	0	2, 756, 458				
67.00 06700 OCCUPATI ONAL THERAPY	0	1, 309, 288	0.00000	0 0.000000	1, 500	67.00
68.00 06800 SPEECH PATHOLOGY	0	1, 326, 452	0.00000	0 0.000000	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 940, 977	0.00000	0.000000	21, 458	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 244, 879	0.00000	0.000000	153, 210	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	998, 487	0.00000	0.000000	11, 386	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	11, 631, 829	0. 00000	0.000000	593, 608	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0. 00000	0.000000	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0. 00000	0.000000	0	76.98
76. 99 07699 LI THOTRI PSY	0	0	0. 00000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	81, 766	0.00000	0 0.000000	630	90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0. 00000	0.000000	0	90.01
91.00 09100 EMERGENCY	0	14, 075, 634	0. 00000	0.000000	138, 319	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	916, 579	0. 00000	0.000000	0	92.00
OTHER REI MBURSABLE COST CENTERS				·		1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	105, 081, 006			3, 637, 478	200.00
			•	•		•

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der	CCN: 150101	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2014	Part IV	
				To 12/31/2014	Date/Time Prep 5/21/2015 2:20	
		Ti t	le XIX	Hospi tal	PPS	<u> </u>
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug	h		
	Costs (col. 8	-	Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	C)	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52.00
53.00 05300 ANESTHESI OLOGY	0	0		0		53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0		54.00
60. 00 06000 LABORATORY	0	C		0		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C		0		62.30
65. 00 06500 RESPI RATORY THERAPY	0	C		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0		68.00
69.00 06900 ELECTROCARDI OLOGY	0	C		0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0		73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C		0		76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	C		0		76, 98
76. 99 07699 LI THOTRI PSY	0	C		0		76, 99
OUTPATIENT SERVICE COST CENTERS	-		1			
90, 00 09000 CLINIC	0	0)	0		90,00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0		0		90.01
91.00 09100 EMERGENCY	0	0		0		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0		92.00
OTHER REIMBURSABLE COST CENTERS				- 1		
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	C		0		200.00
	1		1	1	I	

Health Financial Systems	WHITLEY MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES	AND VACCINE COST	Provi der		Period:	Worksheet D	
				From 01/01/2014 To 12/31/2014	Part V Date/Time Pre	nared
				10 12/31/2014	5/21/2015 2:2	6 pm
		Ti t	le XIX	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
		Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
	1.00	2.00	(see inst.) 3.00	(see inst.) 4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	0. 206626	0	1, 658, 81	5 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 484769	0		0 0	0	
53. 00 05300 ANESTHESI OLOGY	0. 020842	0	179, 21	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 096053	0	3, 841, 37		0	54.00
60. 00 06000 LABORATORY	0. 219187	0	1, 100, 36		0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	.,	0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0. 385357	0	188, 35	2 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 331925	0	199, 61		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 887866	0	52, 11		0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 259859	0	145, 83		0	68.00
69.00 06900 ELECTROCARDI OLOGY	0.001167	0	169, 07	2 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 406722	0	289, 92	4 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 284430	0	80, 23	6 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 301252	0	567, 02	6 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS				- 1		
90. 00 09000 CLINIC	4. 873040	0	30, 26	3 0	0	
90. 01 09001 I NTENSI VE OUT PATI ENT PROGRAM	0. 000000	0		0 0	0	90.01
91.00 09100 EMERGENCY	0. 231276	0	2, 944, 33		0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0. 940722	0	226, 83	1 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	0.5500//		500.44			05.00
95. 00 09500 AMBULANCE SERVICES	0. 550866	0	,			95.00
200.00 Subtotal (see instructions)		0	12, 203, 78	6 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Progr Only Charges	am			0 0		201.00
202.00 Net Charges (line 200 +/- line 201)		0	12, 203, 78	6 0	0	202.00
	I I	0	12,203,70	0	0	202.00

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CCN: 150101	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Pro 5/21/2015 2::	
			le XIX	Hospi tal	PPS	
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.) 6.00	(see inst.) 7.00	-			
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00				_
50. 00 05000 OPERATI NG ROOM	342, 754	C				50,00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	342,754					52.00
53. 00 05300 ANESTHESI OLOGY	3, 735	-				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	368, 976					54.00
60. 00 06000 LABORATORY	241, 185					60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	241,103					62.30
65. 00 06500 RESPIRATORY THERAPY	72, 583	-				65.00
66. 00 06600 PHYSI CAL THERAPY	66, 256					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	46, 271		1			67.00
68. 00 06800 SPEECH PATHOLOGY	37,896	-				68.00
69. 00 06900 ELECTROCARDI OLOGY	197	-				69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	117, 918					71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	22, 822					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	170, 818					73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0					76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	-				76.98
76. 99 07699 LI THOTRI PSY	0					76.99
OUTPATIENT SERVICE COST CENTERS	1					
90. 00 09000 CLI NI C	147, 473	C)			90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	c				90.01
91.00 09100 EMERGENCY	680, 954	c				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	213, 385	c				92.00
OTHER REIMBURSABLE COST CENTERS		•				
95. 00 09500 AMBULANCE SERVI CES	292, 190					95.00
200.00 Subtotal (see instructions)	2, 825, 413	0)			200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	2, 825, 413	0	1			202.00

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 150101	Period: From 01/01/2014	Worksheet D-1	
			To 12/31/2014	Date/Time Prep 5/21/2015 2:20	
	Cost Conton Decembration	Title XVIII	Hospi tal	PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	excluding newborn)		4, 808	1 1.
00	Inpatient days (including private room days, excluding swing-be	ed and newborn days)		4, 808	2.
00	Private room days (excluding swing-bed and observation bed days	s). If you have only pr	ivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed	l davs)		3, 990	4
00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	0	5
00	reporting period Total swing-bed SNF type inpatient days (including private room	dave) after December	21 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	ruays) arter becember	ST OF THE COST	0	
00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private room	dave) after December 2	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line)	uays) arter December 3	I UI LINE COST	0	°
00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 177	9
. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII onl	v (including privato r	oom dave)	0	10
. 00	through December 31 of the cost reporting period (see instructi		oom days)	0	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl	y (including private r	oom days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, ent Swing-bed NF type inpatient days applicable to titles V or XIX		e room dave)	0	12
. 00	through December 31 of the cost reporting period	only (meruaring privat	e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13
. 00	after December 31 of the cost reporting period (if calendar yea Medically necessary private room days applicable to the Program			0	14
	Total nursery days (title V or XIX only)	(exer during simily bed	aayoy	0	
. 00	Nursery days (title V or XIX only)			0	16
00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	0.00	1 17
. 00	reporting period	through becomen of e		0.00	
. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instructions)			5, 068, 083	21
	Swing-bed cost applicable to SNF type services through December		ing period (line	0,000,000	22
00	5 x line 17)	1 - C + h + +		0	
. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	I OF THE COST REPORTIN	g period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25
	x line 20)			0	_
	Total swing-bed cost (see instructions)			0	
. 00	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ine 21 minus line 26)		5, 068, 083	27
. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)		-	0	29
	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	
. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu	s line 22) (coo instruct	tions)	0.00	
	Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 x line	, (0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)	5 51)		0.00	
	General inpatient routine service cost net of swing-bed cost ar	nd private room cost di	fferential (line)	5, 068, 083	
	27 minus line 36)	,		-,,,]
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	TMENTS			-
. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS Adjusted general inpatient routine service cost per diem (see i			1, 054. 09	38
	Program general inpatient routine service cost per drem (see 1	-		1, 240, 664	
	Medically necessary private room cost applicable to the Program	-		0	
. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		1, 240, 664	1 11

DMPU	TATION OF INPATIENT OPERATING COST		Provi der	CCN: 150101	Period: From 01/01/2014	Worksheet D-1	1
					To 12/31/2014		
				e XVIII	Hospi tal	5/21/2015 2:2 PPS	∠o pn
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	(0.	00 0	0) 42
. 00	INTENSIVE CARE UNIT						43
. 00	CORONARY CARE UNI T						44
. 00	BURN INTENSIVE CARE UNIT						45
	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)						46
. 00	Cost Center Description						
						1.00	
. 00 . 00	Program inpatient ancillary service cost (W Total Program inpatient costs (sum of lines			ane)		1, 108, 278 2, 348, 942	
. 00	PASS THROUGH COST ADJUSTMENTS	41 through 40)(see mstructro	51157		2, 340, 942	47
. 00	Pass through costs applicable to Program in	patient routine :	services (fro	n Wkst. D, su	m of Parts I and	216, 992	2 50
~~)			Wiet D		140 140	
. 00	Pass through costs applicable to Program in and IV)	patient ancillar	y services (fi	UN WKST. D,	Sum OF Parts II	143, 149	1 51
. 00	Total Program excludable cost (sum of lines	50 and 51)				360, 141	52
. 00	Total Program inpatient operating cost excl		lated, non-ph	ysician anest	netist, and	1, 988, 801	53
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
. 00	Program discharges					C	54
. 00	0					0.00	
. 00	Target amount (line 54 x line 55)					C	
. 00 . 00	Difference between adjusted inpatient opera Bonus payment (see instructions)	ting cost and ta	rget amount (ine 56 minus	line 53)		
. 00	Lesser of lines 53/54 or 55 from the cost rules	eporting period	endi na 1996. u	updated and co	ompounded by the	0.00	
	market basket		Ū		,		
. 00	Lesser of lines 53/54 or 55 from prior year				the amount by	0.00	
. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					C) 61
	amount (line 56), otherwise enter zero (see			00), 01 1.0 0	the target		
	Relief payment (see instructions)					0	
. 00	Allowable Inpatient cost plus incentive pay PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see Instru	ctions)			0) 63
. 00		sts through Dece	mber 31 of th	e cost report	ng period (See	C	64
	instructions)(title XVIII only)	Ũ					
. 00	Medicare swing-bed SNF inpatient routine com instructions)(title XVIII only)	sts after Decemb	er 31 of the o	cost reporting	g period (See	C) 65
. 00	Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 plus line (65)(title XVI	ll onlv). For	C	66
	CAH (see instructions)	· · · · · · · · · · · · · · · · · · ·			<u> </u>	-	
. 00	Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31	of the cost r	eporting period	C	67
3. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	ne costs after D	ecember 31 of	the cost ren	orting period	0	68
. 00	(line 13 x line 20)				si ting por ou		
. 00	Total title V or XIX swing-bed NF inpatient			,		C) 69
. 00	PART III - SKILLED NURSING FACILITY, OTHER I Skilled nursing facility/other nursing faci						70
. 00	Adjusted general inpatient routine service						71
. 00	Program routine service cost (line 9 x line						72
. 00	Medically necessary private room cost appli	U U	•				73
. 00 . 00	Total Program general inpatient routine ser Capital-related cost allocated to inpatient				Part II column		74
. 00	26, line 45)	Fourne Service		NOT KONGET D,	art II, corumn		'
. 00	Per diem capital-related costs (line 75 ÷ 1						76
. 00	Program capital -related costs (line 9 x line						77
. 00 . 00	Inpatient routine service cost (line 74 min Aggregate charges to beneficiaries for exce		rovi den inecon	ds)			78
. 00	Total Program routine service costs for com			· · · · · · · · · · · · · · · · · · ·	nus line 79)		80
00	Inpatient routine service cost per diem lim				-		81
. 00	Inpatient routine service cost limitation (· .				82
. 00 . 00	Reasonable inpatient routine service costs Program inpatient ancillary services (see in	•	3)				83
. 00			ns)				85
. 00	Total Program inpatient operating costs (su	m of lines 83 th					86
	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instruction					818	0 07
1 00		رد				o اظ	3 87
2.00 3.00	Adjusted general inpatient routine cost per		line 2)			1, 054. 09	88

Health Financial Systems	WHITLEY MEMOR	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014	Date/Time Pre 5/21/2015 2:2	pared: 6 pm
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	886, 413	5, 068, 083	0. 17490	1 862, 246	150, 808	90.00
91.00 Nursing School cost	0	5, 068, 083	0.00000	0 862, 246	0	91.00
92.00 Allied health cost	0	5, 068, 083	0.00000	0 862, 246	0	92.00
93.00 All other Medical Education	0	5, 068, 083	0.00000	862, 246	0	93.00

COMPUT	ATION OF INPATIENT OPERATING COST Provi der CCN: 150101 Component CCN: 155128 Period: From 01/01/2014 To 12/31/2014 Title XVIII Skilled Nursing Form 1/01/2014	Worksheet D-1 Date/Time Prep 5/21/2015 2:20 PPS	
	Cost Center Description Facility	1.00	
	PART I - ALL PROVIDER COMPONENTS		
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days, excluding newborn)	18, 115	1.00
2.00	Inpatient days (including private room days, excluding swing-bed days, excluding newborn days)	18, 115	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.00
	do not complete this line.		
4.00 5.00	Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	18, 115 0	4.00 5.00
5.00	reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
7 00	reporting period (if calendar year, enter 0 on this line)	0	7 00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8.00
0.00	reporting period (if calendar year, enter 0 on this line)		0.07
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1, 499	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
14.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
	Total nursery days (title V or XIX only)	0	
16.00	Nursery days (title V or XIX only)	0	16.00
17.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17.00
17.00	reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18.00
19.00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19.00
17.00	reporting period	0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
21.00	reporting period Total general inpatient routine service cost (see instructions)	6, 056, 266	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line)	0, 030, 200	21.00
	5 x line 17)		
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
	7 x line 19)		
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6, 056, 266	27.00
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00 0. 00	
	Average per diem private room cost differential (line 34 x line 31)	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6, 056, 266	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
	Dragram general inpatient couting convice cost (line 0 v line 20)	1	
39.00	Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35)		39.00 40.00

ealth Financial Systems OMPUTATION OF INPATIENT OPERATING COST		AL HOSPITAL Provider	CCN: 150101	Peri od:	eu of Form CMS- Worksheet D-1	
				From 01/01/2014 To 12/31/2014	Date/Time Pre	epared
		Titl	e XVIII	Skilled Nursing	5/21/2015 2:2 PPS	26 pm
			-	Facility		
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
2.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Uni	+c					42. C
3. 00 INTENSIVE CARE UNIT	13					43.0
4. 00 CORONARY CARE UNI T						44. C
5. 00 BURN INTENSIVE CARE UNIT						45.0
6.00 SURGI CAL INTENSIVE CARE UNIT 7.00 OTHER SPECIAL CARE (SPECIFY)						46.0
Cost Center Description		<u> </u>				17.0
	(What D 2 and 2				1.00	40.0
8.00 Program inpatient ancillary service cost 9.00 Total Program inpatient costs (sum of line	•		ns)			48.0
PASS THROUGH COST ADJUSTMENTS			113)			
0.00 Pass through costs applicable to Program i	inpatient routine	services (from	Wkst. D, su	m of Parts I and		50.0
1.00 Pass through costs applicable to Program i	inpatient ancillar	v services (fr	om Wkst D	sum of Parts IJ		51.0
and IV)		,,				
2.00 Total Program excludable cost (sum of line						52.0
3.00 Total Program inpatient operating cost exe medical education costs (line 49 minus lin	5 1	erated, non-phy	sıcıan anest	netist, and		53.0
TARGET AMOUNT AND LIMIT COMPUTATION						
4.00 Program di scharges						54.0
5.00 Target amount per discharge 6.00 Target amount (line 54 x line 55)						55.0
7.00 Difference between adjusted inpatient oper	rating cost and ta	arget amount (l	ine 56 minus	line 53)		57.
8.00 Bonus payment (see instructions)						58.
9.00 Lesser of lines 53/54 or 55 from the cost	reporting period	ending 1996, u	pdated and c	ompounded by the		59.
market basket 0.00 Lesser of lines 53/54 or 55 from prior yea	ar cost report un	dated by the m	arket basket			60.
1.00 If line 53/54 is less than the lower of li				the amount by		61.
which operating costs (line 53) are less		s (lines 54 x	60), or 1% o	f the target		
amount (line 56), otherwise enter zero (se 2.00 Relief payment (see instructions)	ee instructions)					62.0
3.00 Allowable Inpatient cost plus incentive pa	ayment (see instru	uctions)				63.0
PROGRAM INPATIENT ROUTINE SWING BED COST					1	
4.00 Medicare swing-bed SNF inpatient routine (instructions)(title XVIII only)	costs through Dece	ember 31 of the	cost report	ing period (See		64. (
5.00 Medicare swing-bed SNF inpatient routine	costs after Decemb	per 31 of the c	ost reportin	g period (See		65.0
instructions)(title XVIII only)			E) () · · · · · · · · · · · · · · · · ·			
6.00 Total Medicare swing-bed SNF inpatient rol CAH (see instructions)	utine costs (line	64 plus line 6	5)(TITIE XVI	II ONLY). FOr		66. (
7.00 Title V or XIX swing-bed NF inpatient rou	tine costs through	n December 31 c	f the cost r	eporting period		67.0
(line 12 x line 19)	tina aasta aftan P	acompar 21 of	the east rep	arting pariod		1,0,0
8.00 Title V or XIX swing-bed NF inpatient rou (line 13 x line 20)	tine costs after L	ecemper 31 or	the cost rep	briing period		68.0
9.00 Total title V or XIX swing-bed NF inpatien						69. (
PART III - SKILLED NURSING FACILITY, OTHER					(05())(1 70 /
0.00 Skilled nursing facility/other nursing fac 1.00 Adjusted general inpatient routine service					6, 056, 266 334. 32	
2.00 Program routine service cost (line 9 x lin			/		501, 146	
3.00 Medically necessary private room cost appl			ne 35)		0	
4.00 Total Program general inpatient routine so 5.00 Capital-related cost allocated to inpatien	•		orksheet R	Part II column	501, 146	
26, line 45)	The service	COSIS (ITOM M	O NOTECL D,	artif, corunni		1 / 5. 1
6.00 Per diem capital-related costs (line 75 \div					0.00	
7.00 Program capital-related costs (line 9 x li 8.00 Inpatient routine service cost (line 74 mi					0	
9.00 Aggregate charges to beneficiaries for exe		orovi der record	s)		0	
0.00 Total Program routine service costs for co	omparison to the c			nus line 79)	0	80.
1.00 Inpatient routine service cost per diem li					0.00	
2.00 Inpatient routine service cost limitation 3.00 Reasonable inpatient routine service cost:	•				0 501, 146	
4.00 Program inpatient ancillary services (see	•	,			206, 930	
5.00 Utilization review - physician compensation	on (see instructio				0	85.
6.00 Total Program inpatient operating costs (nrough 85)			708, 076	86. 0
7.00 PART IV - COMPUTATION OF OBSERVATION BED F Total observation bed days (see instruction					0	87.0
8.00 Adjusted general inpatient routine cost pe		line 2)				88.0
Augusted general inpatrent routine cost p	•	,				

Health Financial Systems	WHITLEY MEMOR	AL HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der		Period: From 01/01/2014	Worksheet D-1	
			Component		To 12/31/2014		
			Title	e XVIII	Skilled Nursing Facility	PPS	· · ·
Cost Center Description	Cost	Routi	ine Cost	column 1 ÷	Total	Observati on	
	0031		line 27)		Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
	1.00		2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital-related cost	C)	0	0.0000	0 00	0	90.00
91.00 Nursing School cost	C		0	0.0000	0 00	0	91.00
92.00 Allied health cost	C		0	0.0000	0 00	0	92.00
93.00 All other Medical Education	C	D	0	0.0000	0 00	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 150101	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Pre 5/21/2015 2:2	pare
	Cast Contar Description	Title XIX	Hospi tal	PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	Inpatient days (including private room days and swing-bed days,			4, 808	
00 00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days		ivate room davs	4, 808 0	
00	do not complete this line.	j. Ti you have only pr	rvate room days,		
00 00	Semi-private room days (excluding swing-bed and observation bed Total swing-bed SNF type inpatient days (including private room		r 21 of the cost	3, 990 0	
00	reporting period	r days) thi odgir becembe	1 51 01 the cost	0	
00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7
~~	reporting period			0	
00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) arter December 3	f of the cost	0	8
00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	223	9
. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII onl	v (including private r	oom davs)	0	10
	through December 31 of the cost reporting period (see instructi	ons)	5 /		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl December 31 of the cost reporting period (if calendar year, ent		oom days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12
00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	13
	after December 31 of the cost reporting period (if calendar yea	r, enter O on this lir	e)	-	
	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed	days)	0 856	
	Nursery days (title V or XIX only)			110	
00	SWING BED ADJUSTMENT	through December 21 a	f the east	0.00	 17
. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through becember 31 c	T the cost	0.00	
. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19
00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December		ing pariod (line	5, 068, 083 0	
. 00	5 x line 17)	ST OF the cost report	rng period (rine	0	22
. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	1 of the cost reportir	g period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24
00	7 x line 19) Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25
	x line 20)			-	
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		0 5, 068, 083	
. 00	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT			0,000,000	'
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed ch	arges)	0	
	Semi -private room charges (excluding swing-bed charges)			0	
. 00	General inpatient routine service cost/charge ratio (line 27 \div	line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)	s line 22) (coo instruc	tions)	0.00	
	Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 x line	, .	(10HS)	0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	
	General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line	5, 068, 083	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	TMENTS			
	Adjusted general inpatient routine service cost per diem (see i			1,054.09	
				005 0/0	1 20
. 00	Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program			235, 062 0	

JMPUI	ATION OF INPATIENT OPERATING COST		Provi	der	CCN: 150101	Period: From 01/01/201	Worksheet D-	1
						To 12/31/201	4 Date/Time Pro	
				Ti t	le XIX	Hospi tal	5/21/2015 2:: PPS	26 pm
	Cost Center Description	Total Inpatient Cost	-	Days	col. 2)	÷	(col. 3 x col. 4)	
. 00	NUDSERV (title V & VIX only)	1.00	2.00	856	3.00 478.	4.00 17 11	5.00 0 52,59	9 42.
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units			600	470.	17 11	0 52, 59	9 42.
. 00	INTENSIVE CARE UNIT							43
. 00	CORONARY CARE UNIT							44
. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT							45
	OTHER SPECIAL CARE (SPECIFY)							47
	Cost Center Description							
00	Program inpatient ancillary service cost (W	kst D-3 col 3	Line 200)			1.00	3 48
. 00	Total Program inpatient costs (sum of lines				ns)		1, 315, 869	
	PASS THROUGH COST ADJUSTMENTS						- I	
. 00	Pass through costs applicable to Program in [111]	patient routine	services (from	Wkst. D, sur	n of Parts I and	46, 612	2 50
. 00	Pass through costs applicable to Program in	patient ancillar	y services	(fr	om Wkst. D, s	sum of Parts II	129, 019	9 51
	and IV)							
. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated por	-nhv	sician anoc+1	netist and	175, 63	
. 50	medical education costs (line 49 minus line			. Pily			1, 140, 230	
	TARGET AMOUNT AND LIMIT COMPUTATION						1	
. 00	Program discharges Target amount per discharge						0.00	0 54 0 55
. 00	Target amount (line 54 x line 55)							5 56
. 00	Difference between adjusted inpatient opera	ting cost and ta	irget amour	nt (I	ine 56 minus	line 53)		D 57
. 00 . 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting ported	onding 100		ndated and e	ampounded by the		0 58 0 59
. 00	market basket	eporting period	ending 199	'o, u	puateu anu ci	Silipourided by the	0.00	5 59
. 00	Lesser of lines 53/54 or 55 from prior year						0.00	
. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that						(D 61
	amount (line 56), otherwise enter zero (see		s (mes c	14 A	00), 01 1% 0	i the target		
	Relief payment (see instructions)) 62
. 00	Allowable Inpatient cost plus incentive pays PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instru	ictions)				(5 63
. 00	Medicare swing-bed SNF inpatient routine cos	sts through Dece	mber 31 of	the	cost reporti	ing period (See	(0 64
	instructions)(title XVIII only)		04 C I					
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts after Decemb	er 31 of 1	he c	ost reporting	g period (See		0 65
. 00	Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 plus li	ne 6	5)(title XVI	ll only). For	(0 66
00	CAH (see instructions)		Desember	01 -	6 the eret			
. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	ne costs through	December	31 0	t the cost re	eporting period) 67.
. 00	Title V or XIX swing-bed NF inpatient routin	ne costs after D	ecember 31	of	the cost repo	orting period	(68
~~~	(line 13 x line 20)		11		(0)			
. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER M				,			0 69
. 00	Skilled nursing facility/other nursing faci	lity/ICF/MR rout	ine servio	е со	st (line 37)			70
. 00	Adjusted general inpatient routine service		ine 70 ÷ 1	i ne	2)			71
. 00	Program routine service cost (line 9 x line Medically necessary private room cost appli	,	line 14	x li	ne 35)			72
. 00	Total Program general inpatient routine serv	Ű	•					74
. 00	Capital-related cost allocated to inpatient	routine service	e costs (fr	om W	orksheet B, I	Part II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ine 2)						76
. 00	Program capital -related costs (line 9 x line							77
. 00	Inpatient routine service cost (line 74 min	,						78
. 00 . 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for com	• •			· · ·	nus line 70)		79 80
. 00	Inpatient routine service cost per diem lim		.051 1111111					81
. 00	Inpatient routine service cost limitation (	line 9 x line 81	· .					82
. 00	Reasonable inpatient routine service costs	•	is)					83
. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)					84
. 00	Total Program inpatient operating costs (su	m of lines 83 th						86
00	PART IV - COMPUTATION OF OBSERVATION BED PAS						01/	0 07
7.00	Total observation bed days (see instructions						818	
3.00	Adjusted general inpatient routine cost per	diem (line 27 ÷	· IIne //				1, 054. 09	71 00

Health Financial Systems	WHITLEY MEMOR	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014	Worksheet D-1	
				To 12/31/2014	Date/Time Pre 5/21/2015 2:2	pared: 6 pm
		Tit	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	886, 413	5, 068, 083	0. 17490	1 862, 246	150, 808	90.00
91.00 Nursing School cost	0	5, 068, 083	0.00000	0 862, 246	0	91.00
92.00 Allied health cost	0	5, 068, 083	0.00000	0 862, 246	0	92.00
93.00 All other Medical Education	0	5, 068, 083	0. 00000	0 862, 246	0	93.00

Heal th Financ	CILLARY SERVICE COST APPORTIONMENT	WHITLEY MEMORIAL HOSPITAL	CCN: 150101	Peri od:	u of Form CMS- Worksheet D-3	
	CIELARI SERVICE COST AFFORTIONMENT	FIOVIDEI	CCN. 150101	From 01/01/2014		)
				To 12/31/2014		
		Titl	e XVIII	Hospi tal	PPS	-
	Cost Center Description		Ratio of Cos	st Inpatient	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
	ENT ROUTI NE SERVI CE COST CENTERS		1	4 505 (05		
	ADULTS & PEDIATRICS			1, 535, 625		30.00
						43.00
	ARY SERVICE COST CENTERS OPERATING ROOM		0. 2066	26 474, 387	00.021	50.00
	DELIVERY ROOM & LABOR ROOM		0. 2066		98, 021 406	
	ANESTHESI OLOGY		0. 4847			
	RADI OLOGY – DI AGNOSTI C		0. 0398			
	LABORATORY		0. 0980			
	BLOOD CLOTTING FOR HEMOPHILIACS		0.2191		0	
	RESPIRATORY THERAPY		0. 3853			
	PHYSI CAL THERAPY		0. 3319			
	OCCUPATIONAL THERAPY		0.8878			
	SPEECH PATHOLOGY		0. 2598			
	ELECTROCARDI OLOGY		0.0011			
	MEDICAL SUPPLIES CHARGED TO PATIENT		0. 4067			71. OC
	IMPL. DEV. CHARGED TO PATIENTS		0. 2844			72.00
73.00 07300 1	DRUGS CHARGED TO PATIENTS		0. 3012	52 1,006,276		
76.97 07697	CARDI AC REHABI LI TATI ON		0.0000	00 0	C	76.97
76. 98 07698	HYPERBARI C OXYGEN THERAPY		0.0000	00 0	0	76. 98
76.99 07699	LI THOTRI PSY		0.0000	00 0	0	76.99
OUTPAT	IENT SERVICE COST CENTERS					
90.00 09000			4.8730	40 472	2, 300	90.00
	INTENSIVE OUT PATIENT PROGRAM		0.0000		0	90. 01
	EMERGENCY		0. 2319		149, 006	
	OBSERVATION BEDS (NON-DISTINCT PART		0. 9407	22 0	0	92.00
	REIMBURSABLE COST CENTERS		1			
	AMBULANCE SERVICES					95.00
	Total (sum of lines 50-94 and 96-98)			4, 874, 027	1, 108, 278	
	Less PBP Clinic Laboratory Services-P	rogram only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)			4, 874, 027		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT         Provider COX: 150101         Period: From 1701/2014         Worksheet D-3           Component COX: 155128         Title XVIII         Skilled Nursing         Period: From 1701/2014         Date/Time Propared: From 1701/2014           Cost Center Description         Title XVIII         Skilled Nursing         Period: From 1701/2014         Date/Time Propared: From 1701/2014           0.00         03000 Adults & PEDI ATRICS         1.00         2.00         3.00           30.00         03000 Adults & PEDI ATRICS         0         30.00         3.00           50.00         05200 DFEATING ROM         0.206626         0         0         50.00           50.00         05200 DFEATING ROM         0.206626         0         0         50.00           50.00         05200 DFEATING ROM         0.206626         0         0         50.00           51.00         05200 DELIVERY ROM & LABOR ROM         0.206626         0         0         50.00           52.00         05200 DELIVERY ROM & LABOR ROM         0.206427         0         53.00           52.00         05600 BEOR CLORY THERAPY         0.338357         0         66.00           63.00         05600 CLORY THERAPY         0.3387357         0         68.00     <	Health Financial Systems	WHITLEY MEMORIAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
Component CCN: 155128         To         12/31/2014         Date/Time Prepared: 5/21/2015 2: 26 pm           Title XVIII         Skilled Nursing         PPS           Cost Center Description         Ratio of Cost To Charges         Inpatient Program         Program           0         03000 ADULTS & PEDIATRICS         1.00         2.00         3.00           30.00         04300 NURSERY ARCLLLARY SERVICE COST CENTERS         0         43.00           0.00         05000 OPELIVERY ROOM & LABOR ROOM         0.206626         0         0           50.00         05000 DELIVERY ROOM & LABOR ROOM         0.484769         0         53.00           50.00         05000 DELIVERY ROOM & LABOR ROOM         0.206626         0         0         53.00           51.00         05000 DELIVERY REATORY THERAPY         0.38357         0         0         68.00           62.30         06250 BLOOD CLOTTIN GF OR HEMOPHILIACS         0.387866         136,04         120,785         67.00           63.00         06400 SPEATHATION THERAPY         0.387866         136,040         120,785         67.00         68.00           64.00         06600 PMSICAL THERAPY         0.387866         136,040         120,785         67.00         68.00         68.00         67.00	INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150101		Worksheet D-3	3
Cost Center Description         Stille XVIII         Skilled Nursing         PPS           Cost Center Description         Ratio of Cost         Inpatient         Inpatient         Program         Cost Center Description         Inpatient         Program Costs         Cost. Center Description         Inpatient         Program Costs         Cost. Center Description         Inpatient         Program Costs         Cost. Center Description         0         30.00           0.00         03000 ADULTS & PEDIATRICS         0         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00		Component	+ CCN, 155100		Data /Timo Dro	parad
Title XVIII         Skilled Nursing         PPS           Cost Center Description         Ratio of Cost To Charges         Inpatient Program Charges         Inpatient Program Charges		Component	L CUN: 155128	10 12/31/2014		
Cost Center Description         Ratio of Cost To Charges         Inpatient Program Charges         Inpatient Program Charges         Inpatient Program Charges         Inpatient Program Charges           0.00         03000 43.00         0         2.00         3.00           0.00         03000 43.00         04300 04300         0.200         0         0         30.00           0.00         03000 43.00         04300         0.200         0         0         0         30.00           0.00         05000         0ERNTINC ROOM 052.00         05200         0.200626         0         0         50.00           0.00         05200         DELIVERY ROMM & LABOR ROOM 052.00         0.200623         1.785         171         54.00           0.00         06000         LABOR TORY 0.200         0.1187         3.116         6638         60.00           0.00         06000         RESPI RATORY 0.0331925         165,195         54.832         66.00           0.00         06000         RESPI RATORY THERAPY 0.000000         0         0.52.00         0         71.00           0.00         06000         RESPI RATORY THERAPY 0.0000000         0         0.62.30         120.785         54.832         66.00           0.00         0600		Titl	e XVIII	Skilled Nursing		
INPATIENT ROUTINE SERVICE COST CENTERS         Program (Charges)         Program (Costs) (col. 1 x col. 2)           30. 00         03000 / ADULTS & PEDIATRICS         0         30.00         30.00           ANGULLARY SERVICE COST CENTERS         0         0         30.00         30.00           ANGULLARY SERVICE COST CENTERS         0         0         30.00         30.00           ANGULLARY SERVICE COST CENTERS         0         0         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         52.00         0         52.00         0         53.00         53.00         53.00         53.00         53.00         53.00         53.00         53.00         53.00         53.00         53.00         53.00         0         53.00         0         53.00         53.00         0         65.00         0         65.00         0         65.00         0         65.00         0         65.00         0         65.00         0         65.00         0         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         0         65.00         0         65.00         0         6			•			
INPATI ENT ROUTI NE SERVI CE COST CENTERS         (col. 1 x col. 2)           30. 00         03000  ADULTS & PEDI ATRI CS         0         30. 00           30. 00         03000  ADULTS & PEDI ATRI CS         0         30. 00           43. 00         04300  NURSERY         0         30. 00           ANCILLARY SERVI CE COST CENTERS         0         0         30. 00           50. 00         05000  DELI VERY ROM & LABOR ROM         0. 206626         0         0           50. 00         05000  DELI VERY ROM & LABOR ROM         0. 206622         0         53. 00           51. 00         054. 00         054.00         0. 05003         1, 785         171         54. 00           62. 30         06250 BLOD CLOTTINF FOR HEMOPHI LI ACS         0. 000000 CRESPI RATORY         0. 331925         165. 195         54. 832         66. 00           65. 00         06600 RESPI RATORY         0. 331925         165. 195         54. 832         66. 00           66. 00         06600 PHYSI CAL THERAPY         0. 331925         165. 195         54. 832         66. 00           67. 00         06700 CCUPATI ONAL THERAPY         0. 83537         0         0. 65. 00         66.00         06000 PHYSI CAL THERAPY         0. 31925         153. 195         54. 832	Cost Center Description					
INPATIENT ROUTINE SERVICE COST CENTERS         1.00         2.00         3.00           30.00         03000 ADULTS & PEDIATRICS         0         0         30.00           ANCILLARY SERVICE COST CENTERS         0         0         0         30.00           ANCILLARY SERVICE COST CENTERS         0         0         52.00         0         52.00         0         50.00         0         52.00         52.00         0         53.00         0.484769         0         52.00         53.00         53.00         53.00         0.484769         0         52.00         52.00         53.00         0.5200 QREDITING FOR HEMOPHILIACS         0.096053         1,785         171         54.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         <			To Charges			
I.00         2.00         3.00           30.00         03000 ADULTS & PEDIATRICS         0         30.00           30.00         043000 NURSERY         0         43.00           ARCILLARY SERVICE COST CENTERS         0         50.00         52.00           50.00         052000 DELIVERY ROOM & LABOR ROOM         0.206626         0         0           50.00         052000 DELIVERY ROOM & LABOR ROOM         0.20842         0         53.00           50.00         052000 LABORTARDY         0.204607         0.20842         0         53.00           62.30         062500 BLOOD CLOTTI NG FOR HEMOPHILIACS         0.000000         0         62.30           62.30         062500 BLOOD CLOTTI NG FOR HEMOPHILIACS         0.331925         165.195         54.82         66.00           60.00         06000 PHYSI CLAT HERAPY         0.331925         165.195         54.82         66.00         66.00         66.00         66.00         66.00         66.00         9.000         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         68.00         68.00         68.00         68.00         68.00         69.00         14.214         68.00         69.00         7.00				Charges		
INPATIENT ROUTINE SERVICE COST CENTERS         0         30.00         000000 ADULTS & PEDIATRICS         0         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00 <th< td=""><td></td><td></td><td>1.00</td><td>2.00</td><td></td><td></td></th<>			1.00	2.00		
30.00       0000 ADULTS & PEDIATRICS       0       30.00       30.00         43.00       043.00       043.00       043.00       043.00       0       30.00       43.00         ANCILLARY SERVICE COST CENTERS       0       0.206626       0       0       50.00       0         50.00       05000       DELVERY ROM & LABOR ROM       0.484769       0       52.00       53.00         51.00       05300       ANESTHESI OLOGY       0.020842       0       53.00       53.00         54.00       05400       RADIOLGY-DIAGNOSTIC       0.996053       1,785       171       54.00         60.00       06000       LOOD CLOTTING FOR HEMOPHILIACS       0.000000       0       62.30       66.00       6600       65.00       6600       6600       6600       PHYSICAL THERAPY       0.381325       165,195       54.832       66.00       6600       50.00       6600       9600       54.700       14.214       88.00       68.00       6600       6900       6900       ELECTROCARDIOLOGY       0.25985       54,700       14.214       68.00       69.00       71.00       69.00       71.00       69.00       71.00       69.00       71.00       69.00       71.00       69.00 <td< td=""><td>INDATIENT DOUTINE SERVICE COST CENTERS</td><td></td><td>1.00</td><td>2.00</td><td>3.00</td><td></td></td<>	INDATIENT DOUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
43.00       04300       NURSERY       43.00         ANCILLARY SERVICE COST CENTERS       43.00         ANCILLARY SERVICE COST CENTERS       0         52.00       05200       DELIVERY ROOM & LABOR ROOM       0.206626       0       0       52.00         53.00       05300       ANSTHESI OLOGY       0.020842       0       53.00       53.00         54.00       05400       RADIOLOGY-DI AGNOSTI C       0.096053       1,785       171       54.00         60.00       06500       RESPI RATORY THERAPY       0.219187       3,116       683       60.00       62.30         65.00       06500       RESPI RATORY THERAPY       0.381925       165, 195       54,832       66.00         66.00       06600       PHYSI CAL THERAPY       0.381925       166,100       14,214       68.00         67.00       06700       OCUPATI ONAL THERAPY       0.887866       136,040       120,785       67.00         68.00       06800       SPECH PATHOLOGY       0.259859       54,700       14,214       68.00         69.00       06900       LECTROCARDI OLOGY       0.301252       53,925       16,245       73.00         73.00       07300       DRUGS CHARGED TO PATI ENTS				0		30.00
ANCILLARY SERVICE COST CENTERS           50.00         05000         DERATING ROOM         0.206626         0         0         50.00           52.00         05200         DELIVERY ROOM & LABOR ROOM         0.484769         0         52.00           53.00         O5300         ANESTHESI OLOCGY         0.020842         0         0         53.00           54.00         O5400         RADI OLOCY-DI AGNOSTI C         0.096053         1,785         171         54.00           60.00         IABORATORY         0.219187         3,116         683         60.00           65.00         O6500         RSDI RATORY THERAPY         0.38557         0         0         65.00           66.00         O6600         DCUPATIORY THERAPY         0.381925         165,195         54,832         66.00           66.00         O6600         SPEECH PATHOLOGY         0.259859         54,700         14,214         68.00           69.00         O7100         MEDI CAL SUPPLIES CHARGED TO PATIENT         0.406722         0         71.00         72.00           73.00         O7200 I MULS CHARGED TO PATIENTS         0.259459         53,925         16,245         73.00         76.98         76.99         76.98         76.98				0		
50.00       05000       OPERATI NC ROOM       0.206626       0       0       52.00         52.00       05200       DELIVERY ROOM & LABOR ROOM       0.484769       0       0       52.00         53.00       05300       ANESTHESI OLGGY       0.020842       0       0       53.00         54.00       05400       RADI OLGGY-DI AGNOSTI C       0.020842       0       0       53.00         60.00       06000       LABORATORY       0.219187       3.116       683       60.00         62.30       06250       BLODD CLOTTI NG FOR HEMOPHI LI ACS       0.000000       0       62.30         65.00       06600       PHYSI CAL THERAPY       0.385357       0       0       65.00         66.00       06600       DCUPATI ONAL THERAPY       0.887866       136.040       120.785       67.00         067.00       0CCUPATI ONAL THERAPY       0.887866       136.040       120.785       67.00       0       69.00         06800       SPECCH PATHOLOGY       0.259859       54.700       14.214       68.00         69.00       06900       LECTROCARDI OLOGY       0.301252       53.925       16.245       73.00         73.00       07300       RUGS CHARGED					<u> </u>	10.00
53.00       05300       ANESTHESI OLOGY       0.020842       0       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0.096053       1,785       171       54.00         60.00       06000       LABORTORY       0.219187       3,116       683.00       0       623.00       0.000000       0       0       623.00       0.000000       0       0       623.00       0.000000       0       0       623.00       0.000000       0       0       623.00       0.000000       0       0       623.00       0.000000       0       0       623.00       0.000000       0       0       623.00       0.000000       0       0       623.00       0.000000       0       0       623.00       0.000000       0       0       623.00       0.000000       0       0       65.00       0       0.000000       0       0       65.00       0       0.000000       0       0       65.00       0       0.000000       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0			0. 2066	26 0	C	50.00
54.00       05400       RADI OLOGY-DI AGNOSTI C       0.096053       1,785       171       54.00         60.00       06000       LABORATORY       0.219187       3,116       663       60.00         62.30       06200       RESPI RATORY THERAPY       0.385357       0       0       65.00         65.00       06500       RESPI RATORY THERAPY       0.387365       120,785       67.00         66.00       06600       PHYSI CAL THERAPY       0.387866       136,040       120,785       67.00         67.00       06500       SEPECH PATHOLOGY       0.259859       54,700       14,214       68.00         69.00       06900       ELECTROCARDI OLOGY       0.001167       0       0       72.00         71.00       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.284430       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.301252       53,925       16,245       73.00         76.97       ORAPI CAUSCEN THERAPY       0.0000000       0       76.97       76.97         76.98       HYPERBARI COXSCEN THERAPY       0.0000000       0       76.97         76.99       OT69       LITHOTRIPSY       0.0000000       0					C	
60.00       0.6000       LABORATORY       0.219187       3,116       683       60.00         62.30       06250       BLODD CLOTTING FOR HEMOPHILIACS       0.000000       0       62.30         65.00       06500       RESPI RATORY THERAPY       0.385357       0       0       65.00         66.00       06000       PHYSI CAL THERAPY       0.331925       165.195       54,832       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0.887866       136,040       120,785       67.00         68.00       06800       SPEECH PATHOLOGY       0.259859       54,700       14,214       68.00         69.00       00000LECTROCARDI OLOGY       0.001167       0       0       71.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.284430       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.301252       53,925       16,245       73.00         76.97       CARDI AC REHABI LI TATI ON       0.000000       0       0       76.98         76.98       07699       LITHOT RERVICE COST CENTERS       0.000000       0       90.00         90.00       09000       LINIC       0.9000       0 </td <td>53. 00 05300 ANESTHESI OLOGY</td> <td></td> <td>0. 0208</td> <td>42 0</td> <td>c</td> <td>53.00</td>	53. 00 05300 ANESTHESI OLOGY		0. 0208	42 0	c	53.00
62.30       06250       BLOOD CLOTTING FOR HEMOPHILLACS       0.000000       0       62.30         65.00       06500       RESPIRATORY THERAPY       0.385357       0       0       65.00         66.00       06700       0CUPATIONAL THERAPY       0.387866       136,040       120,785       67.00         68.00       06800       SPEECH PATHOLOGY       0.887866       136,040       120,785       67.00         69.00       OG900       ELECTROCARDIOLOGY       0.001167       0       0       69.00         71.00       O7100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0.406722       0       0       71.00         72.00       07300       DRUGS CHARGED TO PATIENTS       0.301252       53,925       16,245       73.00         76.97       CARDIA C REHABILITATION       0.000000       0       76.97       76.97         76.98       07698       HYPERBARI C OXYGEN THERAPY       0.000000       0       76.97         70.09       07691       CARDIA C REHABILITATION       0.000000       0       76.97         76.97       ORADIA C REHABILITATION       0.000000       0       76.97         76.99       07699       LITHOTRIPSY       0.000000       0       90.	54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 0960	53 1, 785	171	54.00
65.00       06500       RESPI RATORY THERAPY       0.385357       0       0       65.00         66.00       06600       PHYSI CAL THERAPY       0.331925       165,195       54,832       66.00         67.00       0CCUPATI ONAL THERAPY       0.887866       136,040       120,785       67.00         68.00       06800       SPEECH PATHOLOGY       0.259859       54,700       14,214       68.00         69.00       06900       ELECTROCARDI OLOGY       0.001167       0       0       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.406722       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.301252       53,925       16,245       73.00         73.00       07697       CARDI AC REHABI LI TATI ON       0.000000       0       76.97         76.98       07698       HYPERBARI C OXYGEN THERAPY       0.000000       0       76.98         76.99       07699       LI NOT RI ENT SERVICE COST CENTERS       90.00       9000       90.00       90.00         90.00       09000       CLI NI C       4.873040       0       90.92       90.00         91.00       090000       DEMERG	60. 00 06000 LABORATORY		0. 2191	37 3, 116	683	60.00
66.00       06000       PHYSI CAL THERAPY       0.331925       165, 195       54, 832       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0.887866       136, 040       120, 785       67.00         68.00       06800       SPECH PATHOLOGY       0.259859       54, 700       14, 214       68.00         69.00       06900       ELECTROCARDI OLOGY       0.001167       0       69.00       69.00       71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.406722       0       71.00       72.00       72.00       72.00       72.00       0.301252       53, 925       16, 245       73.00       73.00       76.97       CARDI AC REHABI LI TATI ON       0.000000       0       76.97       76.97       76.97       CARDI AC REHABI LI TATI ON       0.000000       0       76.97       76.97         76.97       OF699       LI THOTRI PSY       0.0000000       0       0       76.97         0.00       09000       CLINI C       4.873040       0       90.00       90.00       90.00       90.01       90.01       90.01       90.01       90.01       90.01       90.01       90.01       90.01       90.01       90.01       90.01       90.01       90.01	62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000	0 00	0	62.30
67.00       06700       0CCUPATI ONAL THERAPY       0.887866       136,040       120,785       67.00         68.00       06800       SPEECH PATHOLOGY       0.259859       54,700       14,214       68.00         69.00       06900       ELECTROCARDI OLOGY       0.001167       0       0       69.00         71.00       O7100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0.406722       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.284430       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.301252       53,925       16,245       73.00         76.97       76698       HYPERBARI C OXYGEN THERAPY       0.000000       0       0       76.97         76.99       07697       LITHOTRIPSY       0.000000       0       0       76.99         00100       090001       INTENSI VE OUT PATIENT PROGRAM       0.000000       0       0       90.01         90.100       090001       INTENSI VE OUT PATIENT PROGRAM       0.301252       0       90.01       90.01         91.00       99001       INTENSI VE OUT PATIENT PROGRAM       0.000000       0       0       90.01 <t< td=""><td>65. 00 06500 RESPI RATORY THERAPY</td><td></td><td>0. 3853</td><td>57 0</td><td>C</td><td>65.00</td></t<>	65. 00 06500 RESPI RATORY THERAPY		0. 3853	57 0	C	65.00
68.00       06800       SPEECH PATHOLOGY       0.259859       54,700       14,214       68.00         69.00       06900       ELECTROCARDI OLOGY       0.001167       0       0       69.00         71.00       OT100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0.406722       0       0       71.00         72.00       07200       IMPL.       DEV.       CHARGED TO PATI ENTS       0.284430       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.301252       53,925       16,245       73.00         76.97       OR698       HYPERBARI C OXYGEN THERAPY       0.000000       0       0       76.97         76.98       07699       LITHOTRI PSY       0.000000       0       0       76.98         00.00       09000       CLI I C       4.873040       0       90.00       90.00         00.01       INTENSI VE OUT PATI ENT PROGRAM       0.000000       0       0       90.00       90.00         90.00       09000       CLI I C       0       0.231276       0       91.00       92.00         91.00       09200       DSERVATI ON BEDS (NON-DI STI NCT PART       0.940722       0       92.00       92.00 <tr< td=""><td>66. 00 06600 PHYSI CAL THERAPY</td><td></td><td>0. 3319</td><td>25 165, 195</td><td>54, 832</td><td>66.00</td></tr<>	66. 00 06600 PHYSI CAL THERAPY		0. 3319	25 165, 195	54, 832	66.00
69.00       06900       ELECTROCARDIOLOGY       0.001167       0       69.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       0.406722       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.284430       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.301252       53,925       16,245       73.00         76.97       07697       CARDIA C REHABILITATION       0.000000       0       0       76.97         76.98       07598       HYPERBARI C 0XYGEN THERAPY       0.000000       0       0       76.98         76.99       07697       CARDI AC REHABILITATI ON       0.000000       0       0       76.98         76.99       07699       LITHOTRIPSY       0.000000       0       0       76.98         00.00       09000       CLINIC       4.873040       0       0       90.00         90.00       09001       INTENSI VE OUT PATIENT PROGRAM       0.000000       0       91.00         91.00       09100       EMERGENCY       0.231276       0       0       92.00         92.00       OBSERVATION BEDS (NON-DI STINCT PART       0.940722					120, 785	67.00
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0.406722       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.284430       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.301252       53,925       16,245       73.00         76.97       07697       CARDI AC REHABI LI TATI ON       0.000000       0       0       76.97         76.98       07698       HYPERBARI C OXYGEN THERAPY       0.000000       0       0       76.98         76.99       07699       LI THOTRI PSY       0.000000       0       0       76.99         00100       0170       LINIC       4.873040       0       0       90.00         90.00       09000       CLINIC       4.873040       0       90.00       90.01         91.00       09001       INTENSI VE OUT PATI ENT PROGRAM       0.000000       0       91.00       90.01         91.00       09100       EMERGENCY       0.231276       0       0       92.00         92.00       OBSERVATI ON BEDS (NON-DI STI NCT PART       0.940722       0       92.00       92.00         95.00       09500       AMBULANC					14, 214	
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.284430       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.301252       53,925       16,245       73.00         76.97       07697       CARDI AC REHABILITATION       0.000000       0       0       76.97         76.98       07698       HYPERBARI C OXYGEN THERAPY       0.000000       0       0       76.98         76.99       07699       LI THOTRIPSY       0.000000       0       0       76.98         0017PATIENT SERVICE COST CENTERS       0.000000       0       0       90.00       90.00         90.00       09000       CLINIC       4.873040       0       0       90.00         90.01       09001       INTENSI VE OUT PATIENT PROGRAM       0.000000       0       90.01         91.00       09100       EMERGENCY       0.231276       0       0       91.00         92.00       0BSERVATION BEDS (NON-DI STINCT PART       0.940722       0       0       92.00         07HER REIMBURSABLE COST CENTERS       70510       AMBULANCE SERVICES       95.00       95.00       95.00       95.00       95.00       95.00       95.00       200.00       201.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td></td<>						
73.00       07300       DRUGS CHARGED TO PATIENTS       0.301252       53,925       16,245       73.00         76.97       07697       CARDI AC REHABILITATION       0.000000       0       0       76.97         76.98       07698       HYPERBARI C OXYGEN THERAPY       0.000000       0       0       76.98         76.99       07699       LI THOTRI PSY       0.000000       0       0       76.98         70.00       07699       LI THOTRI PSY       0.000000       0       0       76.98         70.00       07699       LI THOTRI PSY       0.000000       0       0       76.98         70.00       07000       CLI NI C       4.873040       0       0       90.00         90.01       09001       INTENSI VE OUT PATIENT PROGRAM       0.000000       0       90.01         91.00       09100       EMERGENCY       0.231276       0       0       91.00         92.00       0BSERVATI ON BEDS (NON-DI STINCT PART       0.940722       0       0       92.00         07400       CMBULANCE SERVI CES       75.00       95.00       95.00       95.00       95.00       200.00       200.00       200.00       200.00       200.00       201.00						
76. 97       07697       CARDI AC REHABILITATION       0.000000       0       76. 97         76. 98       07698       HYPERBARI C 0XYGEN THERAPY       0.000000       0       76. 98         76. 98       07699       LITHOTRIPSY       0.000000       0       76. 98         00000       01709       LITHOTRIPSY       0.000000       0       76. 99         001794TI ENT SERVICE COST CENTERS       0.000000       0       0       90.00         90.00       09000       LITHOTRIPSY       0.000000       0       90.00         90.01       090001       INTENSIVE OUT PATIENT PROGRAM       0.000000       0       90.01         91.00       09100       EMERGENCY       0.231276       0       0       91.00         92.00       0BSERVATION BEDS (NON-DI STINCT PART       0.940722       0       0       92.00         07500       AMBULANCE SERVICES       95.00       09500       AMBULANCE SERVICES       95.00       200.00       200.00       200.00       200.00       200.00       200.00       200.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
76. 98       07698       HYPERBARI C 0XYGEN THERAPY       0.000000       0       76. 98         76. 99       07699       LI THOTRI PSY       0.000000       0       0       76. 99         000       09000       CLINIC       4.873040       0       0       90. 00         90. 00       09000       CLINIC       4.873040       0       90. 00       90. 01         90. 01       09000       INTENSIVE OUT PATIENT PROGRAM       0.000000       0       90. 01       90. 01         91. 00       09100       EMERGENCY       0.231276       0       0       91. 00         92. 00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0.940722       0       0       92. 00         07HER       REI MBURSABLE COST CENTERS       95. 00       09500       AMBULANCE SERVI CES       95. 00       95. 00         200. 00       Total (sum of lines 50-94 and 96-98)       414, 761       206, 930       200. 00       201. 00       201. 00       201. 00       201. 00       201. 00						
76. 99         07699         LI THOTRI PSY         0.00000         0         76. 99           OUTPATI ENT SERVICE COST CENTERS         00000         CLINIC         4.873040         0         0000         90.00           90. 00         09000         CLINIC         4.873040         0         00         90.00           90. 01         09001         INTENSI VE OUT PATI ENT PROGRAM         0.000000         0         90.01           91. 00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART         0.231276         0         0         91.00           92.00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART         0.940722         0         0         92.00           07HER REIMBURSABLE COST CENTERS         09500         AMBULANCE SERVICES         95.00         95.00         95.00         95.00         95.00         95.00         95.00         200.00         200.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00<					-	
OUTPATI ENT SERVICE COST CENTERS           90.00         O9000         CLINIC         4.873040         0         0         90.00           90.01         09001         INTENSIVE OUT PATIENT PROGRAM         0.000000         0         90.01           91.00         09100         EMERGENCY         0.231276         0         0         91.00           92.00         09SERVATI ON BEDS (NON-DI STINCT PART         0.940722         0         0         92.00           0THER REI MBURSABLE COST CENTERS         09500         AMBULANCE SERVICES         95.00         95.00         09500         AMBULANCE SERVICES         95.00         200.00         201.00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         201.00					-	
90. 00         09000         CLINIC         4.873040         0         0         90. 00         90. 00         90. 01         90. 01         90. 01         90. 01         1NTENSIVE OUT PATIENT PROGRAM         0.000000         0         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         91. 00         91. 00         91. 00         92. 00         91. 00         92. 00         92. 00         92. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         92. 00         95. 00         92. 00         95. 00         90. 00         90. 00			0.0000	00000	0	) 76.99
90. 01         09001         INTENSIVE OUT PATIENT PROGRAM         0.000000         0         90. 01           91. 00         09100         EMERGENCY         0.231276         0         0         91. 00           92. 00         09520V         0BSERVATI ON BEDS (NON-DI STINCT PART         0.940722         0         0         92. 00           0THER         REI MBURSABLE COST CENTERS         0         95. 00         09500         AMBULANCE SERVICES         95. 00         205.00         205.00         205.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00 <td></td> <td></td> <td>4 0720</td> <td>10</td> <td></td> <td></td>			4 0720	10		
91.00         09100         EMERGENCY         0.231276         0         0         91.00           92.00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART         0.940722         0         0         92.00           0THER REIMBURSABLE COST CENTERS         09500         AMBULANCE SERVICES         95.00         200.00         201.00         Total (sum of lines 50-94 and 96-98)         414, 761         206, 930         200.00         201.00         201.00         201.00         201.00         0         201.00         201.00         201.00         201.00         201.00         0         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00					-	
92. 00         09200         OBSERVATION BEDS (NON-DISTINCT PART         0.940722         0         92. 00           0THER         REIMBURSABLE COST CENTERS         09500         AMBULANCE SERVICES         95. 00         95.00         200. 00         Total (sum of lines 50-94 and 96-98)         414, 761         206, 930         200. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00						
OTHER REI MBURSABLE COST CENTERS95. 0009500AMBULANCE SERVICES95. 00200. 00Total (sum of lines 50-94 and 96-98)414, 761206, 930201. 00Less PBP Clinic Laboratory Services-Program only charges (line 61)0201. 00					-	
95.00         09500         AMBULANCE SERVICES         95.00           200.00         Total (sum of lines 50-94 and 96-98)         414,761         206,930         200.00           201.00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         201.00			0.9407.	<u> </u>		72.00
200.00         Total (sum of lines 50-94 and 96-98)         414, 761         206, 930         200.00           201.00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         201.00						95 00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00				414 761	206 930	
		Program only charges (line 61)		0	200, 700	
	5			414. 761		202.00

	EY MEMORIAL HOSPITAL	0011 45046		u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150101	Period: From 01/01/2014	Worksheet D-3	8
			To 12/31/2014		epared.
			10 12/01/2011	5/21/2015 2:2	
	Tit	le XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1.00		2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000 ADULTS & PEDI ATRI CS		1	850, 597		30.00
43. 00 04300 NURSERY			444, 375		43.00
ANCI LLARY SERVICE COST CENTERS			444, 373		43.00
50. 00 05000 OPERATI NG ROOM		0. 2066	26 1, 257, 553	259, 843	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 4847			
53. 00 05300 ANESTHESI OLOGY		0. 0396			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 0960			54. OC
60. 00 06000 LABORATORY		0. 2191			
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000		0	
65. 00 06500 RESPI RATORY THERAPY		0. 3853	57 98, 064	37, 790	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 3319	25 1, 756	583	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 8878	66 1, 500	1, 332	67.00
68.00 06800 SPEECH PATHOLOGY		0. 2598	59 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0.0011	67 21, 458		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 4067	22 153, 210	62, 314	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2844	30 11, 386	3, 239	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3012		178, 826	
76. 97 07697 CARDI AC REHABI LI TATI ON		0.0000		0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0.0000		0	
76. 99 07699 LI THOTRI PSY		0.0000	0 00	0	76.99
OUTPATIENT SERVICE COST CENTERS					1
90. 00 09000 CLINIC		4.8730			90.00
90. 01 09001 I NTENSI VE OUT PATI ENT PROGRAM		0.0000		0	
91.00 09100 EMERGENCY		0.2319			
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART		0.9407	22 0	0	92.00
OTHER         REI MBURSABLE         COST         CENTERS           95.00         09500         AMBULANCE         SERVI CES		1			95.00
200.00 Total (sum of lines 50-94 and 96-98)			3, 637, 478	1, 028, 208	
201.00 Less PBP Clinic Laboratory Services-Program or	nly charges (line 61)		3, 037, 478		200.00
202.00 Net Charges (line 200 minus line 201)	in y charges (The 61)		3, 637, 478		201.00
zuz. vuj jivet charges (The zuu illi hus the zut)		I	3, 037, 478	I	1202.00

	Financial Systems WHITLEY MEMORIAL I ATION OF REIMBURSEMENT SETTLEMENT		CCN: 150101	In Lie Period:	u of Form CMS- Worksheet E	-2552-10
	THE OF THE MOONSEMENT SETTEMENT	i i ovi del	50N. 150101	From 01/01/2014 To 12/31/2014	Part A Date/Time Pre 5/21/2015 2:2	
		Ti tl	e XVIII	Hospi tal	PPS	
			0	1.00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00 1.01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurrin	ng prior		0 1, 227, 408		1.00
	to October 1 (see instructions)	0.				
1.02	DRG amounts other than outlier payments for discharges occurrin after October 1 (see instructions)	ig on or		569, 363		1. 02
1.03	DRG for federal specific operating payment for Model 4 BPCI for			0		1.03
1.04	discharges occurring prior to October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for			0		1.04
2.00	discharges occurring on or after October 1 (see instructions) Outlier payments for discharges. (see instructions)			1, 692		2.00
2.00	Outlier reconciliation amount			0		2.00
2.02	Outlier payment for discharges for Model 4 BPCI (see instruction	ons)		0		2.02
3.00 4.00	Managed Care Simulated Payments Bed days available divided by number of days in the cost report	ing		108, 160 27. 76		3. 00 4. 00
	period (see instructions)	-				-
5.00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most	recent		0.00		5.00
< 00	cost reporting period ending on or before 12/31/1996. (see instr			0.00		6.00
5.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance			0.00		6.00
7 00	CFR 413.79(e)	dam 10		0.00		7.00
7.00	MMA Section 422 reduction amount to the IME cap as specified un CFR $412.105(f)(1)(iv)(B)(1)$	idei 42		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified $L$ CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July			0.00		7.01
	then see instructions.	1, 2011				
3.00	Adjustment (increase or decrease) to the FTE count for allopath osteopathic programs for affiliated programs in accordance with			0.00		8.00
	413.75(b), $413.79(c)(2)(iv)$ , $64$ FR 26340 (May 12, 1998), and $67$					
3. 01	(August 1, 2002). The amount of increase if the hospital was awarded FTE cap slot	s undor		0.00		8.01
5.01	section 5503 of the ACA. If the cost report straddles July 1, 2			0.00		0.01
3. 02	instructions. The amount of increase if the hospital was awarded FTE cap slot	s from a		0.00		8. 02
5. 02	closed teaching hospital under section 5506 of ACA. (see instru			0.00		0.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines and 8,02) (see instructions)	6 (8, 8,01		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the currer	nt year		0.00		10.00
11.00	from your records FTE count for residents in dental and podiatric programs.			0.00		11.00
12.00	Current year allowable FTE (see instructions)			0.00		12.00
13.00 14.00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year	ended on		0.00 0.00		13.00 14.00
14.00	or after September 30, 1997, otherwise enter zero.	ended on		0.00		14.00
15.00 16.00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program			0.00 0.00		15.00 16.00
17.00	Adjusment for residents displaced by program or hospital closur	е		0.00		17.00
18.00 19.00	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4).			0.00 0.000000		18.00 19.00
20.00	Prior year resident to bed ratio (see instructions)			0. 000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.00000		21.00
22.00 22.01	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)			0		22.00
	Indirect Medical Education Adjustment for the Add-on for Section		he MMA	0.00		
23.00	Number of additional allopathic and osteopathic IME FTE resider slots under 42 Sec. 412.105 $(f)(1)(iv)(C)$ .	it cap		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	6		0.00		24.00
25.00	If the amount on line 24 is greater than -O-, then enter the lo line 23 or line 24 (see instructions)	ower of		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.00000		26.00
27.00 28.00	IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions)			0. 000000		27.00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0		28.01
29.00 29.01	Total IME payment ( sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0		29.00 29.01
	Disproportionate Share Adjustment		1			
30. 00	Percentage of SSI recipient patient days to Medicare Part A pat (see instructions)	ient days		3. 22		30.00
31.00	Percentage of Medicaid patient days (see instructions)			27.87		31.00
32.00 33.00	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)			31.09 12.00		32.00 33.00
	Disproportionate share adjustment (see instructions)			53, 903		34.00

	Financial Systems WHITLEY MEMORI ATION OF REIMBURSEMENT SETTLEMENT	AL HOSPITAL Provider CCN: 150101	Peri od:	u of Form CMS-2 Worksheet E	2002-10
JALCUL	ATTON OF RELMDURSEMENT SETTLEMENT		From 01/01/2014 To 12/31/2014	Part A Date/Time Pre 5/21/2015 2:20	
		Title XVIII	Hospi tal	PPS	о р
			Prior to	On/After	
		0	0ctober 1 1.00	0ctober 1 2.00	
	Uncompensated Care Adjustment	0	1.00	2.00	
	Total uncompensated care amount (see instructions)		9, 046, 380, 143	7, 647, 644, 885	35.00
35.01	Factor 3 (see instructions)		0. 000024733	0.000030561	35.01
35. 02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		223, 740	233, 718	35.02
35.03	Pro rata share of the hospital uncompensated care payment		167, 345	58, 910	35.03
	amount (see instructions)				
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		226, 255		36.00
	Additional payment for high percentage of ESRD beneficiary	discharges (lines 40 throug	h 46)		
	Total Medicare discharges on Worksheet S-3, Part I	<u> </u>	0		40.00
	excluding discharges for MS-DRGs 652, 682, 683, 684 and				
41.00	685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652,		0		41.00
	682, 683, 684 an 685. (see instructions)		0		
41.01	Total ESRD Medicare covered and paid discharges excluding		0		41.01
42.00	MS-DRGs 652, 682, 683, 684 an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not		0.00		42.00
.2. 00	qualify for adjustment)		0.00		2.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43.00
44.00	682, 683, 684 an 685. (see instructions) Ratio of average length of stay to one week (line 43		0, 000000		44.00
TH. UU	divided by line 41 divided by 7 days)		0.00000		+4.00
45.00	Average weekly cost for dialysis treatments (see		0.00		45.00
44 00	instructions)		0		46.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		2, 078, 621		47.00
48.00	Hospital specific payments (to be completed by SCH and		0		48.00
49.00	MDH, small rural hospitals only. (see instructions) Total payment for inpatient operating costs (see		2, 078, 621		49.00
17.00	instructions)		2,070,021		
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I		143, 634		50.00
51.00	and Pt. II, as applicable) Exception payment for inpatient program capital (Wkst. L,		0		51.00
51.00	Pt. III, see instructions)		0		01.00
52.00	Direct graduate medical education payment (from Wkst. E-4,		0		52.00
53.00	line 49 see instructions). Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,		0		55.00
E4 00	line 69)		0		F ( 00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D,		0		57.00
F.O. 00	Pt. III, column 9, lines 30 through 35).				50.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		2, 222, 255		59.00
60.00	Primary payer payments		4, 723		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		2, 217, 532		61.00
62.00	Deductibles billed to program beneficiaries		328, 436		62.00
63.00	Coinsurance billed to program beneficiaries		6, 843		63.00
64.00 65.00	Allowable bad debts (see instructions)		14,096		64.00
65.00 66.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see		9, 162 -9, 441		65.00 66.00
	instructions)		7,		
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		1, 891, 415		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and		0		69.00
70.00	96). (For SCH see instructions)		_		70.05
70.00 70.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT		0		70.00 70.50
70. 30	Pioneer ACO demonstration payment adjustment amount (see		0		70.30
	instructions)				
70. 90	HSP bonus payment HVBP adjustment amount (see		0		70.90
70. 91	instructions) HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70. 92	Bundled Model 1 discount amount (see instructions)		0		70. 92
	HVBP payment adjustment amount (see instructions)		7, 190		70.93
70.94	HRR adjustment amount (see instructions)		-866		70.94

	Financial Systems WHITLEY MEMORI ATION OF REIMBURSEMENT SETTLEMENT		ider C	CN· ·	150101	Pe	eri od:	u of Form CMS- Worksheet E	2332-1
ALCUL	ATTON OF RELIMBORSEMENT SETTEEMENT	FIOVI	iuei c	CN.	130101		om 01/01/2014	Part A	
						Tc		Date/Time Pro	epared:
			T: +1 -	XX /1				5/21/2015 2:2	26 pm
			Title	XVI	11		Hospital Prior to	On/After	
							October 1	October 1	
	-		0				1.00	2.00	
70. 96	Low volume adjustment for federal fiscal year (yyyy)				20	)14	213, 053		70.9
	(Enter in column 0 the corresponding federal year for the								
	period prior to 10/1)								
70. 97	Low volume adjustment for federal fiscal year (yyyy)				20	)15	102, 615		70.9
	(Enter in column 0 the corresponding federal year for the								
10 00	period ending on or after 10/1)								70.0
	Low Volume Payment-3						0		70.9
	HAC adjustment amount (see instructions)						2 212 407		70.9
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)						2, 213, 407		71.0
71 01	Sequestration adjustment (see instructions)						44, 268		71.0
	Interim payments						2, 116, 014		72.0
	Tentative settlement (for contractor use only)						2, 110, 011		73.0
	Balance due provider (Program) (line 71 minus lines 71.01,						53, 125		74.0
	72, and 73)						007 120		1
75.00	Protested amounts (nonallowable cost report items) in						33, 512		75.0
	accordance with CMS Pub. 15-2, chapter 1, §115.2								
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)								
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see						0		90.0
	instructions)								01.0
	Capital outlier from Wkst. L, Pt. I, line 2 Operating outlier reconciliation adjustment amount (see						0		91.0
72.00	instructions)						0		92.0
93.00	Capital outlier reconciliation adjustment amount (see						0		93.0
	instructions)								
94.00	The rate used to calculate the time value of money (see						0.00		94.0
	instructions)								0.5.0
75.00	Time value of money for operating expenses (see instructions)						0		95.0
00 40	Time value of money for capital related expenses (see						0		96.0
/0.00	instructions)						0		70.0
							Prior to 10/1	On/After 10/1	
						Ī	1.00	2.00	
	HSP Bonus Payment Amount								
	HSP bonus amount (see instructions)						0	(	0 100. 0
	HVBP Adjustment for HSP Bonus Payment								
	HVBP adjustment factor (see instructions)						0		0 101. 0
102.00	HVBP adjustment amount for HSP bonus payment (see instruction	ons)					0	(	102.0
	HRR Adjustment for HSP Bonus Payment						0.0		1.00 -
	HRR adjustment factor (see instructions)						0.0000		103.0
104.00	HRR adjustment amount for HSP bonus payment (see instruction	ns)					0	(	0 104. 0

	Financial Systems		WHITLEY MEMORI		CCN: 150101 P	eri od:	u of Form CMS-2 Worksheet E	
						rom 01/01/2014	Part A Exhibi Date/Time Prep 5/21/2015 2:20	pare
			1		e XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement		0n/After 10/01	through 4)	
00		0	1.00	2.00	3.00	4.00	5.00	1
00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.
01	DRG amounts other than outlier payments for discharges	1. 01	1, 227, 408	0	1, 227, 408	0	1, 227, 408	1.
02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	569, 363	0	0	569, 363	569, 363	1
)3	1 DRG for Federal specific operating payment for Model 4 BPC1 occurring prior to	1. 03	0	0	0	0	0	1
)4	October 1 DRG for Federal specific operating payment for Model 4 BPCL occurring on or after	1. 04	0	0	0	0	0	1
00	October 1 Outlier payments for discharges (see instructions)	2.00	1, 692	0	1, 692	0	1, 692	2
)1	Outlier payments for	2. 02	0	0	0	0	0	2
00	discharges for Model 4 BPCI Operating outlier reconciliation	2. 01	0	0	0	0	0	3
00	Managed care simulated payments	3.00	108, 160	0	108, 160	0	108, 160	4
0	Indirect Medical Education Adju Amount from Worksheet E, Part	ustment 21.00	0. 000000	0. 000000	0. 000000	0. 000000		5
0	A, line 21 (see instructions) IME payment adjustment (see	22.00	0	0	0	0	0	e
)1	instructions) IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6
	Indirect Medical Education Adju	ustment for th	e Add-on for Se	ction 422 of t	he MMA			
00	IME payment adjustment factor	27.00	0. 000000			0.000000		7
0	(see instructions) IME adjustment (see	28.00	0	0			0	
1	instructions) IME payment adjustment add on for managed care (see	28. 01	0	0	0	0	0	8
0	instructions) Total IME payment (sum of	29.00	0	0	0	0	0	9
1	lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and	29.01	0	0	0	О	0	ç
	8.01)							
00	Disproportionate Share Adjustme Allowable disproportionate	ent 33.00	0. 1200	0. 1200	0. 1200	0, 1200		10
00	share percentage (see instructions)	33.00	0. 1200	0. 1200	0. 1200	0. 1200		
00	Disproportionate share adjustment (see instructions)	34.00	53, 903				53, 903	
01	Uncompensated care payments Additional payment for high per	36.00	226, 255		167, 345	58, 910	226, 255	11
00	Total ESRD additional payment	46.00		0 or scriai ges	0	0	0	12
	(see instructions)						Ŭ	
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	2, 078, 621 0	0 0		645, 354 O	2, 078, 621 0	13
00	(see instructions) Total payment for inpatient operating costs (see instructions)	49.00	2, 078, 621	0	1, 433, 267	645, 354	2, 078, 621	15
00	Payment for inpatient program capital	50.00	143, 634	0	98, 309	45, 325		
00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17
01	Net organ aquisition cost	55.00	0	0	0	0	0	17
02	Capital received from manufacturers for replaced	68.00	0	0	0	0		17
. 00	devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)		0	0	0	O	0	18

Health Financial Systems		WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
LOW VOLUME CALCULATION EXHIBIT 4				-	Period: From 01/01/2014 Fo 12/31/2014	Date/Time Pre 5/21/2015 2:2	pared:
			Ti tl	e XVIII	Hospi tal	PPS	
	W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
	line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
	0	1.00	2.00	3.00	4.00	5.00	
19.00 SUBTOTAL			0	1, 531, 570	690, 679	2, 222, 255	19.00
	W/S L, line	(Amounts from L)					
	0	1.00	2.00	3.00	4.00	5.00	
20.00 Capital DRG other than outlier	1.00	142, 595	0	97, 294	45, 301	142, 595	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	(	0 0	0	20. 01
21.00 Capital DRG outlier payments	2.00	1, 039	0	1, 01	5 24	1,039	21.00
21.01 Model 4 BPCI Capital DRG	2.01	0	0		0 0	0	21.01
outlier payments							
22.00 Indirect medical education percentage (see instructions)	5.00	0. 0000	0.0000	0.000	0.0000		22.00
23.00 Indirect medical education adjustment (see instructions)	6.00	0	0	(	0 0	0	23.00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.0000	0.000	0.0000		24.00
25.00 Disproportionate share adjustment (see instructions)	11.00	0	0	(	0 0	0	25.00
26.00 Total prospective capital payments (see instructions)	12.00	143, 634	0	98, 309	45, 325	143, 634	26.00
	W/S E, Part A	(Amounts to E,					
	line	Part A)					
	0	1.00	2.00	3.00	4.00	5.00	
27.00 Low volume adjustment factor				0. 13910	0. 148571		27.00
28.00 Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			213, 053	3	213, 053	28.00
29.00 Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				102, 615	102, 615	29.00
100.00 Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

PART B - MEDICAL AND OTHER HEALTH SERVICES           1.00         Medical and other services (see instruction           2.00         Medical and other services reimbursed under           2.00         Medical and other services reimbursed under           2.00         DES payments           4.00         Outlier payment (see instructions)           5.00         Enter the hospital specific payment to cost           6.00         Ine 2 times line 5           7.00         Sum of line 3 plus line 4 divided by line 6           8.00         Transitional corridor payment (see instruct           9.00         Ancillary service other pass through costs           10.00         Organ acquisitions           11.00         Total cost (sum of lines 1 and 10) (see inst           12.00         Ancillary service charges           13.00         Organ acquisition charges (from Wkst. D-4,           14.00         Total reasonable charges (sum of lines 12 a           14.00         Total reasonable charges (sum of lines 12 and           15.00         Aggregate amount actually collected from pa           17.00         Ratio of line 15 to line 16 (not to exceed           16.00         Amounts that would have been realized from           17.00         Ratio of cost or charges (line 11 minus li           100<	OPPS (see instruct	tions)			:6 pm
<ol> <li>Medical and other services (see instruction Medical and other services reimbursed under OUTLIER payments</li> <li>Outlier payment (see instructions)</li> <li>Enter the hospital specific payment to cost Line 2 times line 5</li> <li>Sum of line 3 plus line 4 divided by line 6</li> <li>Transitional corridor payment (see instruct Ancillary service other pass through costs COMPUTATION OF LESSER OF COST OR CHARCES Reasonable charges</li> <li>Organ acquisition charges (from Wkst. D-4, Total cost (sum of lines 1 and 10) (see ins COMPUTATION OF LESSER OF COST OR CHARCES Reasonable charges</li> <li>Organ acquisition charges (from Wkst. D-4, Total reasonable charges</li> <li>O Aggregate amount actually collected from pa Customary charges</li> <li>O Aggregate amount actually collected from pa d such payment been made in accordance wi had such payment been made in accordance wi natus of line 15 to line 16 (not to exceed to a mounts that would have been realized from had such payment been made in accordance wi instructions)</li> <li>D Excess of reasonable cost over customary ch instructions)</li> <li>D Excess of reasonable cost over customary ch instructions)</li> <li>D Lesser of cost or charges (line 11 minus li 20.00 [Lesser of cost or charges (line 11 minus li 20.00 [Lesser of cost or charges (line 11 minus li 20.00 [Lesser of cost or charges (line 11 minus li 20.00 [Drect graduate medical education payments 30.00 Subtotal ((lines 21 and 24 minus the sum of CAH, see instructions)</li> <li>D Eductibles and coinsurance (for CAH, see i 20.00 Subtotal (sum of lines 27 through 29)</li> <li>O Frimary payer payments</li> <li>O Adjusted reimbursable bad debts (see instructions)</li> <li>AlLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR Adjusted reimbursable bad debts (see instructions)</li> <li>Allowable bad debts (see instructions)</li> <li>M Allowable bad debts (see instructions)</li> <li>M Allowable bad debts (see instructions)</li> <li>M Allowab</li></ol>	OPPS (see instruct	tions)		1.00	
<ul> <li>1.00 Medical and other services (see instruction Medical and other services reimbursed under Medical and other services reimbursed under Description (see instructions)</li> <li>5.00 Enter the hospital specific payment to cost Line 2 times line 5</li> <li>7.00 Sum of line 3 plus line 4 divided by line 6</li> <li>8.00 Transitional corridor payment (see instruct Ancillary service other pass through costs ComPUTATION OF LESSER OF COST OR CHARGES Reasonable charges</li> <li>12.00 Ancillary service charges</li> <li>13.00 Organ acquisition charges (from Wkst. D-4, Total reasonable charges</li> <li>14.00 Total reasonable charges (sum of lines 1 and 10) (see ins Customary charges</li> <li>15.00 Aggregate amount actually collected from pa Amounts that would have been realized from had such payment been made in accordance wi</li> <li>17.00 Ratio of line 15 to line 16 (not to exceed 17.00 Excess of customary charges over reasonable instructions)</li> <li>10.00 Excess of cost or charges (line 11 minus li instructions)</li> <li>21.00 Lesser of cost or charges (line 11 minus li instructions)</li> <li>21.00 Lesser of cost or charges (line 11 minus li 0.01 Total prospective payment (sum of lines 3, COMPUTATION OF REIMBURSEMENT SETLEMENT</li> <li>22.00 Deductibles and coinsurance (for CAH, see i 0.01 Deductibles and coinsurance (for CAH, see i 0.02 CAH, see instructions)</li> <li>28.00 Direct graduate medical education payments</li> <li>29.00 Subtotal ((lines 21 and 24 minus the sum of CAH, see instructions)</li> <li>20.00 Subtotal (sum of lines 27 through 29)</li> <li>21.00 Allowable bad debts (see instructions)</li> <li>23.00 Composite rate ESRD (from Wkst. 1-5, line 1 AlLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR Adjusted reimbursable bad debts (see instructions)</li> <li>23.00 Adjusted reimbursable bad debts (see instructions)</li> <li>24.00 Allowable bad debts (see instructions)</li> <li>25.00 Adjusted reimbursable bad debts (see instructions)</li> <li>26.01 Cheeset amount (for contractors use o Adjusted reimbursable</li></ul>	OPPS (see instruct	tions)		1.00	
<ul> <li>3.00 PPS payments</li> <li>4.00 Outlier payment (see instructions)</li> <li>5.00 Enter the hospital specific payment to cost</li> <li>6.00 Line 2 times line 5</li> <li>7.00 Sum of line 3 plus line 4 divided by line 6</li> <li>8.00 Transitional corridor payment (see instruct</li> <li>9.00 Ancillary service other pass through costs</li> <li>10.00 Organ acquisitions</li> <li>11.00 Total cost (sum of lines 1 and 10) (see ins</li> <li>COMPUTATION OF LESSER OF COST OR CHARGES</li> <li>Reasonable charges</li> <li>12.00 Ancillary service charges (sum of lines 12 a</li> <li>Customary charges</li> <li>15.00 Aggregate amount actually collected from pa</li> <li>16.00 Amounts that would have been realized from had such payment been made in accordance wi</li> <li>17.00 Ratio of line 15 to line 16 (not to exceed</li> <li>18.00 Total customary charges (see instructions)</li> <li>19.00 Excess of customary charges over reasonable instructions)</li> <li>19.00 Excess of cost or charges (line 11 minus li instructions)</li> <li>21.00 Lesser of cost or charges (line 11 minus li 22.00 Interns and residents (see instructions)</li> <li>21.00 Lesser of cost or charges (line 11 minus li 22.00 Interns and residents (see instructions)</li> <li>21.00 Eductibles and coinsurance (for CAH, see i of CAH, see i instructions)</li> <li>28.00 Deductibles and coinsurance relating to amo CAH, see instructions)</li> <li>28.00 Direct graduate medical education payments</li> <li>29.00 ESRD direct medical education costs (from W</li> <li>30.00 Composite rate ESRD (from Wkst. 1-5, line 1</li> <li>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR</li> <li>30.00 Composite rate ESRD (from Wkst. 1-5, line 1</li> <li>31.00 Adjusted reimbursable bad debts (see instructions)</li> <li>33.00 Adjusted reimbursable bad debts (see instructions)</li> <li>34.00 Allowable bad debts for dual eligible benefication amount from PS&amp;R</li> <li>34.00</li></ul>	·	tions)		0	1.00
<ul> <li>4.00 Outlier payment (see instructions)</li> <li>5.00 Enter the hospital specific payment to cost</li> <li>6.00 Line 2 times line 5</li> <li>7.00 Sum of line 3 plus line 4 divided by line 6</li> <li>8.00 Transitional corridor payment (see instruct</li> <li>9.00 Ancillary service other pass through costs</li> <li>10.00 Organ acquisitions</li> <li>11.00 Total cost (sum of lines 1 and 10) (see ins</li> <li>COMPUTATION OF LESSER OF COST OR CHARGES</li> <li>Reasonable charges</li> <li>12.00 Ancillary service charges</li> <li>13.00 Organ acquisition charges (from Wkst. D-4,</li> <li>14.00 Total reasonable charges (sum of lines 12 a</li> <li>Customary charges</li> <li>15.00 Aggregate amount actually collected from pa</li> <li>16.00 Amounts that would have been realized from had such payment been made in accordance wi</li> <li>17.00 Ratio of line 15 to line 16 (not to exceed</li> <li>18.00 Total customary charges (see instructions)</li> <li>19.00 Excess of customary charges over reasonable enstructions)</li> <li>10.00 Excess of reasonable cost over customary charistructions)</li> <li>21.00 Lesser of cost or charges (line 11 minus li instructions)</li> <li>23.00 Cost of physicians' services in a teaching</li> <li>24.00 Deductibles and Coinsurance (for CAH, see i</li> <li>26.00 Deductibles and coinsurance (for CAH, see i</li> <li>27.00 Subtotal (lines 21 and 24 minus the sum of CAH, see i nstructions)</li> <li>28.00 Direct graduate medical education payments</li> <li>29.00 ESRD direct medical education costs (from Wson Subtotal (see instructions)</li> <li>23.00 Composite rate ESRD (from Wst. 1-5, line 1</li> <li>34.100 All owable bad debts (see instructions)</li> <li>35.00 Adjusted reimbursable bad debts (see instructions)</li> <li>36.00 All owable bad debts for dual eligible benef</li> <li>37.00 Subtotal (see instructions)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R</li> <li>39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI</li> <li>39.00 All owable bad debts for dual eligible benef</li> <li>30.01 Ke</li></ul>	notio (occ. incl	ci uns)		2, 809, 315	
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<ul> <li>16.00 Amounts that would have been realized from had such payment been made in accordance wi</li> <li>17.00 Ratio of line 15 to line 16 (not to exceed 18.00 Total customary charges (see instructions)</li> <li>19.00 Excess of customary charges over reasonable instructions)</li> <li>20.00 Excess of reasonable cost over customary charges over reasonable cost over customary charges (line 11 minus li 22.00 Interns and residents (see instructions)</li> <li>21.00 Lesser of cost or charges (line 11 minus li 22.00 Interns and residents (see instructions)</li> <li>23.00 Cost of physicians' services in a teaching 24.00 Total prospective payment (sum of lines 3, COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> <li>25.00 Deductibles and coinsurance (for CAH, see i</li> <li>26.00 Deductibles and Coinsurance relating to amo CAH, see instructions)</li> <li>28.00 Direct graduate medical education payments</li> <li>29.00 Subtotal {(lines 21 and 24 minus the sum of CAH, see instructions)</li> <li>28.00 Direct graduate medical education costs (from W 30.00 Subtotal (sum of lines 27 through 29)</li> <li>21.00 Primary payer payments</li> <li>23.00 Composite rate ESRD (from Wkst. I-5, line 14.00 Allowable bad debts (see instructions)</li> <li>35.00 Adjusted reimbursable bad debts (see instructions)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R</li> <li>99.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI Pioneer ACO demostration payment adjustment</li> <li>9.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>30.00 Ther ato full credits received from manuf</li> <li>9.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>41.00 Allowable bad debts for contractors use of Balance due provider/program (see instructions)</li> <li>42.00 Tentative settlement (for contractors use of Balance due provider/program (see instructions)</li> </ul>					
<ul> <li>had such payment been made in accordance wi</li> <li>Ratio of line 15 to line 16 (not to exceed</li> <li>18.00 Total customary charges (see instructions)</li> <li>19.00 Excess of customary charges over reasonable instructions)</li> <li>20.00 Excess of reasonable cost over customary charges (line 11 minus li</li> <li>21.00 Lesser of cost or charges (line 11 minus li</li> <li>22.00 Interns and residents (see instructions)</li> <li>23.00 Cost of physicians' services in a teaching</li> <li>24.00 Total prospective payment (sum of lines 3, COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> <li>25.00 Deductibles and coinsurance (for CAH, see i</li> <li>26.00 Deductibles and coinsurance (for CAH, see i</li> <li>26.00 Deductibles and coinsurance relating to amo</li> <li>27.00 Subtotal {(lines 21 and 24 minus the sum of CAH, see instructions)</li> <li>28.00 Direct graduate medical education payments</li> <li>29.00 ESRD direct medical education costs (from W</li> <li>30.00 Subtotal (sum of lines 27 through 29)</li> <li>31.00 Primary payer payments</li> <li>32.00 Composite rate ESRD (from Wkst. 1-5, line 1</li> <li>41.00WABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR</li> <li>33.00 KSP-LCC reconciliation amount from PS&amp;R</li> <li>39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI</li> <li>39.00 Subtotal (see instructions)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R</li> <li>39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI</li> <li>39.00 Subtotal (see instructions)</li> <li>30.01 Sequestration adjustment (see instructions)</li> <li>31.02 Pioneer ACO demonstration payment adjustment</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use of a subtotal (see instructions)</li> <li>42.00 Tentative settlement (for contractors use of a subtotal (see instructions)</li> <li>42.00 Balance due provider/program (see instructions)</li> </ul>				0	
<ul> <li>17.00 Ratio of line 15 to line 16 (not to exceed</li> <li>18.00 Total customary charges (see instructions)</li> <li>19.00 Excess of customary charges over reasonable instructions)</li> <li>20.00 Excess of reasonable cost over customary charges over reasonable instructions)</li> <li>21.00 Lesser of cost or charges (line 11 minus li</li> <li>22.00 Interns and residents (see instructions)</li> <li>23.00 Cost of physicians' services in a teaching</li> <li>24.00 Total prospective payment (sum of lines 3, COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> <li>25.00 Deductibles and coinsurance (for CAH, see i</li> <li>26.00 Deductibles and Coinsurance relating to amo</li> <li>27.00 Subtotal {(lines 21 and 24 minus the sum of CAH, see instructions)</li> <li>28.00 Direct graduate medical education payments</li> <li>29.00 ESRD direct medical education costs (from W</li> <li>30.00 Subtotal (sum of lines 27 through 29)</li> <li>31.00 Primary payer payments</li> <li>32.00 Subtotal (line 30 minus line 31)</li> <li>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR</li> <li>33.00 Composite rate ESRD (from Wkst. 1-5, line 1</li> <li>34.10 avable bad debts (see instructions)</li> <li>35.00 Adjusted reimbursable bad debts (see instructions)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R</li> <li>39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI Pioneer ACO demonstration payment adjustment</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>30.01 Sequestration adjustment (see instructions)</li> <li>31.02 Subtotal (see instructions)</li> <li>32.03 Subtotal (see instructions)</li> <li>33.04 There are a struction payment adjustment</li> <li>39.90 THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI Pioneer ACO demonstration payment adjustment</li> <li>39.90 Bartial or full credits received from manuf</li> <li>39.91 Contative settlement (for contractors use of Balance due provider/program (see instructions)</li> <li>30.01 Balance due provider/program (see instructions)</li> <li>30.02 Balan</li></ul>		1 5	n a chargebasis	0	16.00
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<ul> <li>19.00 Excess of customary charges over reasonable instructions)</li> <li>20.00 Excess of reasonable cost over customary characteristic instructions)</li> <li>21.00 Lesser of cost or charges (line 11 minus li instructions)</li> <li>23.00 Cost of physicians' services in a teaching</li> <li>24.00 Total prospective payment (sum of lines 3, COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> <li>25.00 Deductibles and coinsurance (for CAH, see i</li> <li>26.00 Deductibles and Coinsurance relating to amo 21.00 Subtotal {(lines 21 and 24 minus the sum of CAH, see instructions)</li> <li>28.00 Direct graduate medical education payments</li> <li>29.00 ESRD direct medical education costs (from W 30.00 Subtotal (sum of lines 27 through 29)</li> <li>31.00 Primary payer payments</li> <li>32.00 Composite rate ESRD (from Wkst. I-5, line 1 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR 33.00 Composite rate ESRD (from Wkst. I-5, line 1 44.00 Allowable bad debts (see instructions)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI 39.50 Pioneer ACO demonstration payment adjustment 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI 39.50 Pioneer ACO demonstration payment adjustment 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions)</li> <li>39.01 Sequestration adjustment (see instructions)</li> <li>30.02 Subtotal (see instructions)</li> <li>31.03 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI 39.50 Pioneer ACO demonstration payment adjustment 39.99 Recovery OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions)</li> <li>30.01 Sequestration adjustment (see instructions)</li> <li>31.00 Subtotal (see instructions)</li> <li>32.00 Distotal (see instructions)</li> <li>33.00 MSD 40.01 Sequestration adjustment (see instructions)</li> <li>33.00 Balance due provider/program (see instructions)</li> <li>34.00 Balance due provider/prog</li></ul>	1.000000)			0. 000000	17.00
<ul> <li>instructions)</li> <li>20.00 Excess of reasonable cost over customary ch instructions)</li> <li>21.00 Lesser of cost or charges (line 11 minus li</li> <li>22.00 Interns and residents (see instructions)</li> <li>23.00 Cost of physicians' services in a teaching</li> <li>24.00 Total prospective payment (sum of lines 3, COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> <li>25.00 Deductibles and coinsurance (for CAH, see i</li> <li>26.00 Deductibles and coinsurance relating to amo</li> <li>27.00 Subtotal {(lines 21 and 24 minus the sum of CAH, see instructions)</li> <li>28.00 Direct graduate medical education payments</li> <li>29.00 ESRD direct medical education costs (from W</li> <li>30.00 Subtotal (sum of lines 27 through 29)</li> <li>31.00 Primary payer payments</li> <li>32.00 Composite rate ESRD (from Wkst. I-5, line 1</li> <li>34.00 Allowable bad debts (see instructions)</li> <li>35.00 Adjusted reimbursable bad debts (see instructions)</li> <li>35.00 Adjusted reimbursable bad debts (see instructions)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R</li> <li>90 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI Pioneer ACO demonstration payment adjustmen</li> <li>99 Partial or full credits received from manuf</li> <li>99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use of Balance due provider/program (see instructions)</li> <li>40.00 Balance due provider/program (see instructions)</li> </ul>	cost (complete onl	lvifline 18 exceeds li	ne 11) (see	0	
<ul> <li>instructions)</li> <li>21.00 Lesser of cost or charges (line 11 minus li</li> <li>22.00 Interns and residents (see instructions)</li> <li>23.00 Cost of physicians' services in a teaching</li> <li>24.00 Total prospective payment (sum of lines 3, COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> <li>25.00 Deductibles and coinsurance (for CAH, see i</li> <li>26.00 Deductibles and Coinsurance relating to amo</li> <li>27.00 Subtotal {(lines 21 and 24 minus the sum of CAH, see instructions)</li> <li>28.00 Direct graduate medical education payments</li> <li>29.00 ESRD direct medical education costs (from W</li> <li>30.00 Subtotal (sum of lines 27 through 29)</li> <li>31.00 Primary payer payments</li> <li>32.00 Subtotal (line 30 minus line 31)</li> <li>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR</li> <li>33.00 Composite rate ESRD (from Wkst. 1-5, line 1</li> <li>34.00 Allowable bad debts (see instructions)</li> <li>35.00 Adjusted reimbursable bad debts (see instructions)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R</li> <li>39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI Pioneer ACO demonstration payment adjustment</li> <li>39.98 Partial or full credits received from manuf</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>40.01 Sequestration adjustment (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use of Balance due provider/program (see instructions)</li> </ul>				Ű	
<ul> <li>21.00 Lesser of cost or charges (line 11 minus li</li> <li>22.00 Interns and residents (see instructions)</li> <li>23.00 Cost of physicians' services in a teaching</li> <li>24.00 Total prospective payment (sum of lines 3, COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> <li>25.00 Deductibles and coinsurance (for CAH, see i</li> <li>26.00 Deductibles and Coinsurance relating to amo</li> <li>27.00 Subtotal {(lines 21 and 24 minus the sum of CAH, see instructions)</li> <li>28.00 Direct graduate medical education payments</li> <li>29.00 ESRD direct medical education costs (from W 0.00 Subtotal (sum of lines 27 through 29)</li> <li>21.00 Primary payer payments</li> <li>22.00 Subtotal (line 30 minus line 31)</li> <li>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR 0.1 and 0.2 a</li></ul>	arges (complete onl	ly if line 11 exceeds li	ne 18) (see	0	20.00
<ul> <li>22.00 Interns and residents (see instructions)</li> <li>23.00 Cost of physicians' services in a teaching</li> <li>24.00 Total prospective payment (sum of lines 3, COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> <li>25.00 Deductibles and coinsurance (for CAH, see i</li> <li>26.00 Deductibles and Coinsurance relating to amo</li> <li>27.00 Subtotal {(lines 21 and 24 minus the sum of CAH, see instructions)</li> <li>28.00 Direct graduate medical education payments</li> <li>29.00 ESRD direct medical education costs (from W</li> <li>30.00 Subtotal (sum of lines 27 through 29)</li> <li>31.00 Primary payer payments</li> <li>32.00 Subtotal (line 30 minus line 31)</li> <li>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR</li> <li>33.00 Composite rate ESRD (from Wkst. 1-5, line 1</li> <li>34.00 Allowable bad debts (see instructions)</li> <li>35.00 Adjusted reimbursable bad debts (see instructions)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R</li> <li>39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI 99.50 Pioneer ACO demonstration payment adjustmen</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>34.00 Interim payments</li> <li>35.00 Adjusted reimbursable bad debts (see instructions)</li> <li>34.00 THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI 99.50 Pioneer ACO demonstration payment adjustmen</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use of Balance due provider/program (see instructions)</li> <li>41.00 Protested amounts (nonallowable cost report</li> </ul>					
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<ul> <li>24.00 Total prospective payment (sum of lines 3, COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> <li>25.00 Deductibles and coinsurance (for CAH, see i</li> <li>26.00 Deductibles and Coinsurance relating to amo</li> <li>27.00 Subtotal {(lines 21 and 24 minus the sum of CAH, see instructions)</li> <li>28.00 Direct graduate medical education payments</li> <li>29.00 ESRD direct medical education costs (from W</li> <li>30.00 Subtotal (sum of lines 27 through 29)</li> <li>31.00 Primary payer payments</li> <li>32.00 Subtotal (line 30 minus line 31)</li> <li>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR</li> <li>33.00 Composite rate ESRD (from Wkst. 1-5, line 1</li> <li>34.00 Allowable bad debts (see instructions)</li> <li>35.00 Adjusted reimbursable bad debts (see instructions)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R</li> <li>99.00 OTHER ADJUSTMENTS (SE INSTRUCTIONS) (SPECI</li> <li>99.00 Final or full credits received from manuf</li> <li>99.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>40.01 Sequestration adjustment (see instructions)</li> <li>41.00 Tertative settlement (for contractors use o</li> <li>43.00 Balance due provider/program (see instructi</li> <li>44.00 Protested amounts (nonallowable cost report</li> </ul>	bosnital (soo instr	ructions)		0	22.00
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CAH, see instructions) 28.00 Direct graduate medical education payments 29.00 ESRD direct medical education costs (from W 30.00 Subtotal (sum of lines 27 through 29) 31.00 Primary payments 32.00 Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR 33.00 Composite rate ESRD (from Wkst. I-5, line 1 34.00 Allowable bad debts (see instructions) 35.00 Adjusted reimbursable bad debts (see instru 36.00 Allowable bad debts for dual eligible benef 37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI 39.50 Pioneer ACO demonstration payment adjustmen 39.98 Partial or full credits received from manuf 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 41.00 Interim payments 42.00 Tentative settlement (for contractors use of 43.00 Balance due provider/program (see instructi 44.00 Protested amounts (nonallowable cost report				614, 330	
<ul> <li>28.00 Direct graduate medical education payments</li> <li>29.00 ESRD direct medical education costs (from W</li> <li>30.00 Subtotal (sum of lines 27 through 29)</li> <li>31.00 Primary payer payments</li> <li>32.00 Subtotal (line 30 minus line 31)</li> <li>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR</li> <li>33.00 Composite rate ESRD (from Wkst. 1-5, line 1</li> <li>34.00 Allowable bad debts (see instructions)</li> <li>35.00 Adjusted reimbursable bad debts (see instructions)</li> <li>35.00 Adjusted reimbursable bad debts (see instructions)</li> <li>36.00 Allowable bad debts for dual eligible benef</li> <li>37.00 Subtotal (see instructions)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R</li> <li>90 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI</li> <li>99.50 Pioneer ACO demonstration payment adjustment</li> <li>99.98 Partial or full credits received from manuf</li> <li>99.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>40.01 Sequestration adjustment (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use o</li> <li>43.00 Balance due provider/program (see instructi</li> <li>44.00 Protested amounts (nonallowable cost report</li> </ul>	lines 25 and 26) p	plus the sum of lines 22	and 23} (for	1, 661, 772	27.00
<ul> <li>29.00 ESRD direct medical education costs (from W 30.00 Subtotal (sum of lines 27 through 29)</li> <li>31.00 Primary payer payments</li> <li>32.00 Subtotal (line 30 minus line 31) <ul> <li>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR</li> <li>33.00 Composite rate ESRD (from Wkst. 1-5, line 1 34.00 Allowable bad debts (see instructions)</li> <li>35.00 Adjusted reimbursable bad debts (see instructions)</li> <li>35.00 Adjusted reimbursable bad debts (see instructions)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R</li> <li>39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI 99.50 Pioneer ACO demonstration payment adjustment</li> <li>39.98 Partial or full credits received from manuff</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>40.01 Sequestration adjustment (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use of Balance due provider/program (see instructi</li> <li>44.00 Protested amounts (nonallowable cost report</li> </ul> </li> </ul>	(from Wkst E / Li	ipo 50)		0	28.00
<ul> <li>30.00 Subtotal (sum of lines 27 through 29)</li> <li>31.00 Primary payer payments</li> <li>32.00 Subtotal (line 30 minus line 31) <ul> <li>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR</li> <li>33.00 Composite rate ESRD (from Wkst. 1-5, line 1</li> <li>34.00 Allowable bad debts (see instructions)</li> <li>35.00 Adjusted reimbursable bad debts (see instructions)</li> <li>35.00 Adjusted reimbursable bad debts (see instructions)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R</li> <li>39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI Pioneer ACO demonstration payment adjustment</li> <li>39.98 Partial or full credits received from manuf</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>40.01 Sequestration adjustment (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use of Bal ance due provider/program (see instructi</li> <li>44.00 Protested amounts (nonallowable cost report</li> </ul></li></ul>		The SO)		0	
<ul> <li>31.00 Primary payer payments</li> <li>32.00 Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR</li> <li>33.00 Composite rate ESRD (from Wkst. I-5, line 1</li> <li>34.00 Allowable bad debts (see instructions)</li> <li>35.00 Adjusted reimbursable bad debts (see instru</li> <li>36.00 Allowable bad debts for dual eligible benef</li> <li>37.00 Subtotal (see instructions)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R</li> <li>39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI</li> <li>39.50 Pioneer ACO demonstration payment adjustment</li> <li>39.98 Partial or full credits received from manuf</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use of</li> <li>43.00 Balance due provider/program (see instructi</li> <li>44.00 Protested amounts (nonallowable cost report</li> </ul>				1, 661, 772	
ALLOWABLEBADDEBTS(EXCLUDEBADDEBTSFOR33.00Composite rateESRD(fromWkst.I-5,I in e 134.00Allowablebaddebts(see instructions)35.00Adjustedreimbursablebaddebts(see instructions)35.00Adjustedreimbursablebaddebts(see instructions)35.00Allowablebaddebtsfor dualeligiblebenef37.00Subtotal(see instructions)8.00MSP-LCCreconciliation amountfrom PS&R39.00OTHERADJUSTMENTS(SEE INSTRUCTIONS)(SPECI39.50PioneerACOdemonstrationpaymentadjustment39.99Partialorfullcreditsreceivedfrom manuf39.99RECOVERYOFACCELERATEDDEPRECIATION40.00Subtotal(seeinstructions)40.01Sequestrationadjustment(seeinstructions)42.00Tentativesettlement(forcontractorsuse of43.00Balancedue provider/program(seeinstructi44.00Protestedamounts(nonallowablecostreport14.00				241	
<ul> <li>33.00 Composite rate ESRD (from Wkst. I-5, line 1</li> <li>34.00 Allowable bad debts (see instructions)</li> <li>35.00 Adjusted reimbursable bad debts (see instru</li> <li>36.00 Allowable bad debts for dual eligible benef</li> <li>37.00 Subtotal (see instructions)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R</li> <li>39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI</li> <li>39.50 Pioneer ACO demonstration payment adjustmen</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>40.01 Sequestration adjustment (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use o</li> <li>43.00 Balance due provider/program (see instructi</li> <li>44.00 Protested amounts (nonallowable cost report</li> </ul>				1, 661, 531	32.00
<ul> <li>34.00 Allowable bad debts (see instructions)</li> <li>35.00 Adjusted reimbursable bad debts (see instructions)</li> <li>36.00 Allowable bad debts for dual eligible benefits</li> <li>37.00 Subtotal (see instructions)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R</li> <li>39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI</li> <li>39.50 Pioneer ACO demonstration payment adjustmen</li> <li>39.98 Partial or full credits received from manuf</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>40.01 Sequestration adjustment (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use of</li> <li>43.00 Balance due provider/program (see instructi</li> <li>44.00 Protested amounts (nonallowable cost report</li> </ul>		CES)			
<ul> <li>35.00 Adjusted reimbursable bad debts (see instructions)</li> <li>36.00 Allowable bad debts for dual eligible benefits</li> <li>37.00 Subtotal (see instructions)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R</li> <li>39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI 39.50 Pioneer ACO demonstration payment adjustment</li> <li>39.98 Partial or full credits received from manuf</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>40.01 Sequestration adjustment (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use of as an and a settlement (see instructions)</li> <li>43.00 Balance due provider/program (see instructions)</li> </ul>	1)				33.00
<ul> <li>36.00 Allowable bad debts for dual eligible benef</li> <li>37.00 Subtotal (see instructions)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R</li> <li>39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI</li> <li>39.50 Pioneer ACO demonstration payment adjustmen</li> <li>39.98 Partial or full credits received from manuf</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>40.01 Sequestration adjustment (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use of</li> <li>43.00 Balance due provider/program (see instructi</li> <li>44.00 Protested amounts (nonallowable cost report</li> </ul>	ctions)			35, 490 23, 069	
<ul> <li>37.00 Subtotal (see instructions)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R</li> <li>39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI</li> <li>39.50 Pioneer ACO demonstration payment adjustmen</li> <li>39.98 Partial or full credits received from manuf</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>40.01 Sequestration adjustment (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use of</li> <li>43.00 Balance due provider/program (see instructions)</li> <li>40.01 Protested amounts (nonallowable cost report</li> </ul>		ructions)		14, 043	
<ul> <li>39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI</li> <li>39.50 Pioneer ACO demonstration payment adjustmen</li> <li>39.98 Partial or full credits received from manuf</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>40.01 Sequestration adjustment (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use of</li> <li>43.00 Balance due provider/program (see instructi</li> <li>44.00 Protested amounts (nonallowable cost report</li> </ul>		~		1, 684, 600	
<ul> <li>39.50 Pioneer ACO demonstration payment adjustmen</li> <li>39.98 Partial or full credits received from manuf</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>40.01 Sequestration adjustment (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use of</li> <li>43.00 Balance due provider/program (see instructions)</li> <li>40.00 Protested amounts (nonallowable cost report</li> </ul>				0	38.00
<ul> <li>39.98 Partial or full credits received from manuf</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>40.01 Sequestration adjustment (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use of</li> <li>43.00 Balance due provider/program (see instructi</li> <li>44.00 Protested amounts (nonallowable cost report</li> </ul>		、 、		0	
<ul> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>40.01 Sequestration adjustment (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use of Balance due provider/program (see instructi</li> <li>44.00 Protested amounts (nonallowable cost report</li> </ul>			+: \	0	
<ul> <li>40.00 Subtotal (see instructions)</li> <li>40.01 Sequestration adjustment (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use of 43.00 Balance due provider/program (see instruction)</li> <li>44.00 Protested amounts (nonallowable cost report)</li> </ul>	acturers for replac	ced devices (see instruc	tions)	0	39.98
<ul> <li>40.01 Sequestration adjustment (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use of 43.00 Balance due provider/program (see instruction)</li> <li>44.00 Protested amounts (nonallowable cost report)</li> </ul>				1, 684, 600	
<ul> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use of 43.00 Balance due provider/program (see instructi 44.00 Protested amounts (nonallowable cost report</li> </ul>				33, 692	
<ul> <li>42.00 Tentative settlement (for contractors use of 43.00 Balance due provider/program (see instructi 44.00 Protested amounts (nonallowable cost report)</li> </ul>				1, 613, 045	
44.00 Protested amounts (nonallowable cost report	<b>J</b> ·			0	
	,			37, 863	
	items) in accordar	nce with CMS Pub. 15-2,	chapter 1,	0	44.00
§115.2 TO BE COMPLETED BY CONTRACTOR					1
90.00 Original outlier amount (see instructions)				0	90.00
91.00 Outlier reconciliation adjustment amount (				0	
92.00 The rate used to calculate the Time Value of	, 			0	92.00
93.00 Time Value of Money (see instructions) 94.00 Total (sum of lines 91 and 93)	see instructions)				

ALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 150101	Period: From 01/01/2014 To 12/31/2014		pare
		Titl	e XVIII	Hospi tal	PPS	
		Inpatien	it Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		2, 116, 0	14	1, 491, 350	1.
00	Interim payments payable on individual bills, either			0	121, 695	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3.
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	1	1			1
01	ADJUSTMENTS TO PROVIDER			0	0	3
02				0	0	3
03				0	0	3
)4				0	0	3
)5				0	0	3
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	
52				0	0	3
53				0	0	
54	Subtatal (our of lines 2.01.2.40 minus our of lines			0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3
00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 116, 0	14	1, 613, 045	4
	(transfer to Wkst. E or Wkst. E-3, line and column as		2,110,0	••	1,010,010	l .
	appropri ate)					
	TO BE COMPLÉTED BY CONTRACTOR					
0	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
11	Program to Provider TENTATIVE TO PROVIDER	1	1	0	0	1 6
)1 )2	TENTATIVE TO PROVIDER			0	0	5
)2				0	0	5
	Provider to Program		1	3		
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52				0	0	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on					6
)1	the cost report. (1) SETTLEMENT TO PROVIDER		53, 1	25	37, 863	6
)2	SETTLEMENT TO PROVIDER		33, 1	25	37,803	6
)2 )0	Total Medicare program liability (see instructions)		2, 169, 1	0	1, 650, 908	
.0			2,107,1	Contractor	NPR Date	- '
				Number	(Mo/Day/Yr)	
		(	Э	1.00	2.00	
0	Name of Contractor					8

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CCN: 150101 CCN: 155128	Period: From 01/01/2014 To 12/31/2014		
		· ·	e XVIII	Skilled Nursing	5/21/2015 2:20	
			e Aviii	Facility		
		Inpatien	t Part A	Pai	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		614, 1	15 0	0	1. 2.
00	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) Program to Provider					3.
1	ADJUSTMENTS TO PROVIDER			0	0	3
)2				0	0	3
)3				0	0	3
)4 )5				0	0	3
	Provider to Program			0		Ĭ
0	ADJUSTMENTS TO PROGRAM			0	0	3
1				0	0	3
2				0	0	
53 54				0	0	3
9	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		614, 1	15	0	4
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider TENTATIVE TO PROVIDER				0	_
)1 )2	TENTATIVE TO PROVIDER			0	0	
)3				0	0	
	Provider to Program					
0	TENTATI VE TO PROGRAM			0	0	
51				0	0	5
2	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
0	5.50-5.98) Determined net settlement amount (balance due) based on			0	0	6
	the cost report. (1) SETTLEMENT TO PROVIDER			0		
)1 )2	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			0	0	
)2 )0	Total Medicare program liability (see instructions)		614, 1	-	0	
.0				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
	Name of Contractor	(	)	1.00	2.00	8

Heal th	Financial Systems WHITLEY MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150101	Period: From 01/01/2014	Worksheet E-1 Part II	
			To 12/31/2014		oared [.]
			10 12/01/2011	5/21/2015 2:2	
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
4 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		44	4 005	1 00
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		14	1, 385	1.00
2.00 3.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8- Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	12		1, 177 950	2.00 3.00
3.00 4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-	10		3, 990	4.00
4.00 5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	12		120, 657, 431	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 lin	ne 20		2, 122, 530	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of ce		Wkst. S-2. Pt. I	2, 122, 000	7.00
	line 168			-	
8.00	Calculation of the HIT incentive payment (see instructions)			555, 406	8.00
9.00	Sequestration adjustment amount (see instructions)			11, 108	9.00
10.00	Calculation of the HIT incentive payment after sequestration (s	see instructions)		544, 298	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			645, 950	
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and lin	ne 31) (see instruction	s)	-101, 652	32.00

		TLEY MEMORIAL HOSPITAL		u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150101	Peri od:	Worksheet E-3	
		Component CCN: 155128	From 01/01/2014 To 12/31/2014	Part VI Date/Time Pre	narod
			10 12/31/2014	5/21/2015 2:2	6 pm
		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEME SERVICES	INT - ALL UTHER HEALTH SERVICES FOR T	IILE XVIII PARI A	A PPS SNF	
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				1
1.00	Resource Utilization Group Payment (RUGS)			724, 384	1.00
2.00	Routine service other pass through costs			0	2.00
3.00	Ancillary service other pass through costs	0	3.00		
4.00	Subtotal (sum of lines 1 through 3)	724, 384	4.00		
	COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line	as vaccine costs are included in lin	e 1 of W/S E,		5.00
	Part B. This line is now shaded.)				
6.00	Deducti bl e			0	6.00
7.00	Coinsurance			97, 736	
8.00	Allowable bad debts (see instructions)			0	
9.00	Reimbursable bad debts for dual eligible benefici			0	
10.00	Adjusted reimbursable bad debts (see instructions	s)		0	10.00
11.00	Utilization review			0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7,	plus lines 10 and 11)(see instructio	ns)	626, 648	
13.00	Inpatient primary payer payments			0	
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see	e instructions)		0	14.50
14.99	Recovery of Accelerated Depreciation			0	14.99
15.00	Subtotal (see instructions			626, 648	•
15.01	Sequestration adjustment (see instructions) Interim payments			12, 533 614, 115	
	Tentative settlement (for contractor use only)			014, 115	
	Balance due provider/program (line 15 minus lines	15 01 16 and 17		0	17.00
18.00	Protested amounts (nonallowable cost report items		2 chaptor 1	0	19.00
17.00	§115. 2	s) in accordance with two is Pub. 15-	z, chapter i,	0	1 19.00

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column onl		CCN: 150101	Period: From 01/01/2014 To 12/31/2014	Worksheet G Date/Time Pre 5/21/2015 2:2	epare
		General Fund	Specific Purpose Fund		Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	-
0	Cash on hand in banks	-1, 121		0 0	0	1
0	Temporary investments	0		0 0	0	2
0	Notes receivable	0		0 0	0	
0	Accounts receivable	14, 238, 105		0 0	0	
0	Other receivable	103, 500		0 0	0	
0 0	Allowances for uncollectible notes and accounts receivable Inventory	-7, 483, 133 196, 320		0 0	0	
0	Prepaid expenses	22, 063		0 0	0	
0	Other current assets	0		0 0	0	
00	Due from other funds	0		0 0	0	
00	Total current assets (sum of lines 1-10)	7, 075, 734		0 0	0	11
	FIXED ASSETS					
00	Land	16, 206		0 0	0	
00	Land improvements	44, 862		0 0	0	
00 00	Accumulated depreciation Buildings	-44, 862 1, 119, 257		0 0	0	
	Accumulated depreciation	-627, 855		0 0	0	
00	Leasehold improvements	48, 824		0 0	0	
	Accumulated depreciation	-46, 586		0 0	0	
	Fixed equipment	591, 413		0 0	0	
00	Accumulated depreciation	-384, 504		0 0	0	20
	Automobiles and trucks	215, 654		0 0	0	
	Accumulated depreciation	-155, 606		0 0	0	
	Major movable equipment	10, 231, 287		0 0	0	
	Accumulated depreciation Minor equipment depreciable	-6, 882, 191		0 0	0	
	Accumulated depreciation	0		0 0	0	
	HIT designated Assets	0		0 0	0	
	Accumulated depreciation	0		0 0	0	
	Mi nor equi pment-nondepreci abl e	0		0 0	0	29
00	Total fixed assets (sum of lines 12-29)	4, 125, 899		0 0	0	30
	OTHER ASSETS			-		
	Investments	47, 414, 152		0 0	0	
00 00	Deposits on Leases Due from owners/officers	0		0 0	0	
	Other assets	7, 171		0 0	0	
	Total other assets (sum of lines 31-34)	47, 421, 323		0 0	0	
00	Total assets (sum of lines 11, 30, and 35)	58, 622, 956		0 0	0	
	CURRENT LI ABI LI TI ES					
	Accounts payable	635, 191		0 0	0	37
	Salaries, wages, and fees payable	1, 114, 857		0 0	0	
	Payroll taxes payable	0		0 0	0	
	Notes and Loans payable (short term) Deferred income	0			0 0	
	Accel erated payments	0		0 0	0	42
00	Due to other funds	0		0 0	0	
	Other current liabilities	111, 707		0 0	0	
	Total current liabilities (sum of lines 37 thru 44)	1, 861, 755		0 0	0	
	LONG TERM LIABILITIES		1			
	Mortgage payable	0		0 0	0	
00	Notes payable	116, 650		0 0	0	
00 00	Unsecured Loans	0 32, 049, 799		0 0	0	
00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49	32, 049, 799		0 0	0	
00	Total liabilites (sum of lines 45 and 50)	34, 028, 204		0 0	0	
	CAPITAL ACCOUNTS		1			
00	General fund balance	24, 594, 752				52
00	Specific purpose fund			0		53
00	Donor created - endowment fund balance - restricted			0		54
00	Donor created - endowment fund balance - unrestricted			0		55
00	Governing body created - endowment fund balance			0	~	56
00	Plant fund balance - invested in plant				0	
00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58
00	Total fund balances (sum of lines 52 thru 58)	24, 594, 752		0 0	0	59
00		= ., 0 / ., / 02		- I	0	1 ~ ′

CTATEN	Financial Systems IENT OF CHANGES IN FUND BALANCES	WHITLEY MEMORI		CCN: 150101	Peri		u of Form CMS Worksheet G-	
	IENT OF CHANGES IN FUND BALANCES				From To	01/01/2014 12/31/2014	Date/Time Pr 5/21/2015 2:	epared: 26 pm
		General	Fund	Speci al	Purpo	se Fund	Endowment Fur	ld
		1.00	2.00	3,00		4,00	5.00	
1.00	Fund balances at beginning of period	1.00	25, 436, 433			4.00	5.00	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		7, 267, 796					2.00
3.00	Total (sum of line 1 and line 2)		32, 704, 229		~	0		3.00
4.00 5.00	Additions (credit adjustments) (specify)	0			0			0 4.00 0 5.00
6.00		0			0			0 6.00
7.00		0			0			0 7.00
8.00		0			0			0 8.00
9.00		0			0			0 9.00
10.00	Total additions (sum of line 4-9)		0			0		10.00
11. 00 12. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	32, 704, 229		0	0		11.00 0 12.00
12.00	TRANSFERS	8, 109, 477			0			0 12.00
14.00		0			0			0 14.00
15.00		0			0			0 15.00
16.00		0			0			0 16.00
17.00	Tatal daduations (sum of lines 10, 17)	0	0 100 477		0			0 17.00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance		8, 109, 477 24, 594, 752			0		18.00 19.00
17.00	sheet (line 11 minus line 18)		24, 374, 732			Ű		17.00
		Endowment Fund	PI ant	Fund				
		6.00	7 00	8.00				
1.00	Fund balances at beginning of period	6.00	7.00	8.00	0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)	0	7.00	8.00	-			2.00
2.00 3.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)			8.00	0			2.00 3.00
2.00 3.00 4.00	Net income (loss) (from Wkst. G-3, line 29)	0	0	8.00	-			2.00 3.00 4.00
2.00 3.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	0			-			2.00 3.00
2.00 3.00 4.00 5.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	0	0		-			2.00 3.00 4.00 5.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	0	0 0 0 0 0 0		-			2.00 3.00 4.00 5.00 6.00 7.00 8.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0		0			2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9)	0	0 0 0 0 0 0		0			2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0	0 0 0 0 0 0		0			2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9)	0	0 0 0 0 0 0		0			2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 0 0 0 0 0		0			2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00 \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 0 0 0 0 0 0 0 0 0 0 0 0		0			$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ \end{array}$
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0			$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) TRANSFERS	0	0 0 0 0 0 0 0 0 0 0 0 0 0		0			$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0			$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$

STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN: 150101	Period: From 01/01/2014 To 12/31/2014		
				10 12/01/201	5/21/2015 2:2	
	Cost Center Description		I npati ent	Outpati ent	Total	
	T		1.00	2.00	3.00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services		1		1	
1.00	Hospi tal		6, 126, 1	90	6, 126, 190	
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVIDER					4.00
5.00	Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY		4, 969, 6	89	4, 969, 689	
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE		11 005 0	70	11 005 070	9.00
10.00	Total general inpatient care services (sum of lines 1-9)		11, 095, 8	79	11, 095, 879	10.00
11 00	Intensive Care Type Inpatient Hospital Services		1		1	1 1 1 00
11.00	INTENSIVE CARE UNIT					11.00
12.00	CORONARY CARE UNIT					12.00
	BURN INTENSIVE CARE UNIT					13.00
	SURGI CAL I NTENSI VE CARE UNI T					14.00
	OTHER SPECIAL CARE (SPECIFY)	1		0		15.00
16.00	Total intensive care type inpatient hospital services (sum of 1	Thes		0	0	16.00
17.00	11-15) Total inpatient routine care services (sum of lines 10 and 16)		11, 095, 8	70	11, 095, 879	17 00
18.00	Ancillary services		19, 865, 1			
19.00	Outpatient services		19,000,1		0 112, 466, 793	
20.00	RURAL HEALTH CLINIC			0 0		
	FEDERALLY QUALIFIED HEALTH CENTER					
21.00	HOME HEALTH AGENCY			0		22.00
23.00	AMBULANCE SERVICES			0	0 0	
	CMHC			0		24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25.00
26.00	HOSPICE					26.00
27.00	OTHER (SPECI FY)			0	0 0	
	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst	30, 961, 0	61 92, 623, 613	-	
20.00	G-3, line 1)			,2,020,010	120,001,071	20.00
	PART II - OPERATING EXPENSES		1		1	1
29.00	Operating expenses (per Wkst. A, column 3, line 200)			46, 163, 113	3	29.00
30. 00	ADD (SPECIFY)			0		30.00
31.00	BAD DEBT EXPENSE		6, 203, 1	89		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			6, 203, 189	9	36.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)					42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		52, 366, 302	2	43.00
	to Wkst. G-3, line 4)				1	1

<u>Heal th</u>	Financial Systems	WHITLEY MEMORIAL HOSP	I TAL		In Lie	u of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES		Pro	ovider CCN:	150101	Period:	Worksheet G-3	
					From 01/01/2014 To 12/31/2014	Date/Time Pre	nared
	10 12/31/201				10 12/31/2014	5/21/2015 2:20	6 pm
						1.00	
1.00	Total patient revenues (from Wkst. G-2, Par					123, 584, 674 69, 092, 953	1.00
2.00	Less contractual allowances and discounts on patients' accounts						2.00
3.00	Net patient revenues (line 1 minus line 2)					54, 491, 721	3.00
4.00						52, 366, 302	4.00
5.00	Net income from service to patients (line 3	minus line 4)				2, 125, 419	5.00
	OTHER I NCOME						
6.00	Contributions, donations, bequests, etc					154, 611	6.00
7.00	Income from investments					46, 071	7.00
8.00	Revenues from telephone and other miscellan	eous communication servi	ces			0	8.00
9.00	Revenue from television and radio service					0	9.00
	Purchase di scounts					0	10.00
	Rebates and refunds of expenses					0	11.00
	Parking lot receipts					0	12.00
	Revenue from laundry and linen service					492	13.00
	Revenue from meals sold to employees and gu	ests					
	Revenue from rental of living quarters					0	15.00
	Revenue from sale of medical and surgical s		atients			0	16.00
	Revenue from sale of drugs to other than pa					629, 599	
	Revenue from sale of medical records and ab					0	18.00
	Tuition (fees, sale of textbooks, uniforms,					0	19.00
	Revenue from gifts, flowers, coffee shops,	and canteen				24, 602	20.00
	Rental of vending machines					0	21.00
	Rental of hospital space					1, 071, 947	22.00
23.00	Governmental appropriations					972, 900	23.00
24.00	OTHER OPERATING REVENUE - VARIOUS					2, 079, 816	24.00
25.00	Total other income (sum of lines 6-24)					5, 142, 377	25.00
	Total (line 5 plus line 25)					7, 267, 796	
27.00	OTHER EXPENSES (SPECIFY)					0	27.00
28.00	Total other expenses (sum of line 27 and su	bscripts)				0	28.00
29.00	Net income (or loss) for the period (line 2	6 minus line 28)				7, 267, 796	29.00

Health Financial Systems WHITLEY MEMC CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150101	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prep 5/21/2015 2:20			
		Title XVIII	Hospi tal	PPS	<u> </u>		
				1.00			
	PART I - FULLY PROSPECTIVE METHOD						
	CAPITAL FEDERAL AMOUNT Capital DRG other than outlier 142,59						
00	Capital DRG other than outlier				1.0		
01	Model 4 BPCI Capital DRG other than outlier				1.0		
00	Capital DRG outlier payments		1, 039	2.0			
01	Model 4 BPCI Capital DRG outlier payments		0	2.0			
00	Total inpatient days divided by number of days in the cost re	eporting period (see inst	ructions)	11.53	3.0		
00	Number of interns & residents (see instructions)	0.00	4.0				
00	Indirect medical education percentage (see instructions)	0.00 0	5. C				
00							
00	30) (see instructions)	0.00	7.C				
00	Percentage of Medicaid patient days to total days (see instru	0.00	8.0				
00	Sum of lines 7 and 8	0.00	9.0				
. 00	Allowable disproportionate share percentage (see instructions	0.00	10.0				
	Disproportionate share adjustment (line 10 times the sum of I		0	11. (			
. 00	Total prospective capital payments (sum of lines 1, 1.01, 2,	2.01, 6 and 11)		143, 634	12. (		
			-	1.00			
	PART II - PAYMENT UNDER REASONABLE COST			1.00			
00	Program inpatient routine capital cost (see instructions)			0	1.0		
00	Program inpatient ancillary capital cost (see instructions)				2.0		
00	Total inpatient program capital cost (line 1 plus line 2)				3.0		
00	Capital cost payment factor (see instructions)				4. C		
00	Total inpatient program capital cost (line 3 x line 4)			0	5.0		
			-	1.00			
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00			
00	Program inpatient capital costs (see instructions)		0	1.0			
00	Program inpatient capital costs for extraordinary circumstances (see instructions)				2.0		
00	Net program inpatient capital costs (line 1 minus line 2)				3.0		
00	Applicable exception percentage (see instructions)				4.0		
00	Capital cost for comparison to payments (line 3 x line 4)				5.0		
00	Percentage adjustment for extraordinary circumstances (see instructions)				6.0		
00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)				7.0		
00	Capital minimum payment level (line 5 plus line 7)				8.0		
~~	Current year capital payments (from Part I, line 12, as applicable)				9.0		
00	Current year comparison of capital minimum payment level to c			0	10. C		
. 00	Worksheet   Part     line 14)						
. 00 . 00	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pa						
. 00 . 00 . 00	Net comparison of capital minimum payment level to capital pa			01			
. 00 . 00 . 00 . 00	Net comparison of capital minimum payment level to capital pa Current year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over c	the amount on this line		0			
. 00 . 00 . 00 . 00 . 00	Net comparison of capital minimum payment level to capital pa Current year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over o (if line 12 is negative, enter the amount on this line)	the amount on this line capital payment for the f		0	13. C 14. C		
3.00 4.00 5.00	Net comparison of capital minimum payment level to capital pa Current year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over c	the amount on this line capital payment for the f					