

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

WORKSHEET S
 PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY 1. ELECTRONICALLY FILED COST REPORT DATE: 05-31-2012 TIME: 09:57
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY WHITLEY MEMORIAL HOSPITAL (15-0101) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 01/01/2011 AND ENDING 12/31/2011, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

 TITLE

 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5
		PART A 2	PART B 3		
1 HOSPITAL		1,842	2,816		1
2 SUBPROVIDER - IPF					2
3 SUBPROVIDER - IRF					3
4 SUBPROVIDER (OTHER)					4
5 SWING BED - SNF					5
6 SWING BED - NF					6
7 SKILLED NURSING FACILITY					7
8 NURSING FACILITY					8
9 HOME HEALTH AGENCY					9
10 HEALTH CLINIC - RHC					10
11 HEALTH CLINIC - FQHC					11
12 OUTPATIENT REHABILITATION PROVIDER					12
200 TOTAL		1,842	2,816		200

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

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

STATE: IN

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

1
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)			
						V 6	XVIII 7	XIX 8	
3	HOSPITAL	15-0101	23060	1	07/01/1966	N	P	P	3
4	SUBPROVIDER - IPF								4
5	SUBPROVIDER - IRF								5
6	SUBPROVIDER - (OTHER)								6
7	SWING BEDS - SNF								7
8	SWING BEDS - NF								8
9	HOSPITAL-BASED SNF	15-5128	23060		02/01/1993	N	P	N	9
10	HOSPITAL-BASED NF								10
11	HOSPITAL-BASED OLTC								11
12	HOSPITAL-BASED HHA								12
13	SEPARATELY CERTIFIED ASC								13
14	HOSPITAL-BASED HOSPICE								14
15	HOSPITAL-BASED HEALTH CLINIC - RHC								15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC								16
17	HOSPITAL-BASED (CMHC)								17
18	RENAL DIALYSIS								18
19	OTHER								19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 01/01/2011			TO: 12/31/2011				20
21	TYPE OF CONTROL								21

INPATIENT PPS INFORMATION

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

		IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE DAYS 2	OUT-OF- STATE MEDICAID PAID DAYS 3	OUT-OF- STATE MEDICAID ELIGIBLE DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6	
24	IF LINE 22 AND/OR 45 IS 'YES', AND THIS PROVIDER IS AN IPFS HOSPITAL ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	244	135			460		24
25	IF THIS PROVIDER IS AN IRF THEN, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				1			26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				1			27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				BEGINNING:	ENDING:		36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				BEGINNING:	ENDING:		38

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS

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

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

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

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

TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS

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

	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
64	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			64

ENTER IN LINES 65-65.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2
 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY
 CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-
 PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY
 CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5
 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 ÷ COLUMN 4)). (SEE
 INSTRUCTIONS)

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

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

	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			66

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 ÷ COLUMN 4)). (SEE INSTRUCTIONS)

PROGRAM NAME 1	PROGRAM CODE 2	UNWEIGHTED FTEs NONPROVIDER SITE 3	UNWEIGHTED FTEs IN HOSPITAL 4	RATIO (COL.1/ (COL.3+COL.4)) 5	
INPATIENT PSYCHIATRIC FACILITY PPS					
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.				N 70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.				71
INPATIENT REHABILITATION FACILITY PPS					
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.				N 75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.				76
LONG TERM CARE HOSPITAL PPS					
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.				N 80
TEFRA PROVIDERS					
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.				N 85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.				N 86
TITLE V AND XIX INPATIENT SERVICES					
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.				N Y 90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.				N N 91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.				N 92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.				N N 93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.				N Y 94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.				5.000 95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.				N Y 96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.				5.000 97
RURAL PROVIDERS					
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?				1 2 N 105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.				106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.				107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.				N 108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.		PHY- OCCUP- SICAL ATIONAL N	RESPI- RATORY	109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	1		118
119	WHAT IS THE LIABILITY LIMIT FOR THE MALPRACTICE INSURANCE POLICY? ENTER IN COLUMN 1 THE MONETARY LIMIT PER LAWSUIT. ENTER IN COLUMN 2 THE MONETARY LIMIT PER POLICY YEAR.		250,000 5,000,000	119
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? AS AMENDED BY THE MEDICAID EXTENDER ACT (MMEA) §108? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

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

141	NAME: PARKVIEW HEALTH SYSTEM, INC. CONTRACTOR'S NAME: NATIONAL GOVERNMENT SERVICE CONTRACTOR'S NUMBER: 8			141
142	STREET: 10501 CORPORATE DRIVE P.O. BOX: PO BOX 56			142
143	CITY: FORT WAYNE STATE: IN ZIP CODE: 46895-5600			143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	N		145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.	N		146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		149

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

SEE 42 CFR §413.13)	PART A	PART B
155 HOSPITAL	1	2
156 SUBPROVIDER - IPF	N	N 155
157 SUBPROVIDER - IRF	N	N 156
158 SUBPROVIDER - (OTHER)	N	N 157
159 SNF	N	N 158
160 HHA	N	N 159
161 CMHC	N	N 160

MULTICAMPUS

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

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

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

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

COMPLETED BY ALL HOSPITALS

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

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

CAPITAL RELATED COST

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

INTEREST EXPENSE

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

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

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

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)		
	1	2	3	4	5	6		
SALARIES								
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	17,699,123	-2,156,817	15,542,306	588,793.00	26.40	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A							4
4.01	PHYSICIANS-PART A - DIRECT TEACHING							4.01
5	PHYSICIAN-PART B							5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (IN APPROVED PROGRAMS)							7.01
8	HOME OFFICE PERSONNEL		3,106,184		3,106,184	76,404.00	40.65	8
9	SNF	44	1,964,472	318,500	2,282,972	129,380.00	17.65	9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		1,218,263	144,198	1,362,461	62,786.00	21.70	10
OTHER WAGES & RELATED COSTS								
11	CONTRACT LABOR (SEE INSTRUCTIONS)							11
12	MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A		81,214		81,214	683.00	118.91	13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		3,106,184		3,106,184	76,404.00	40.65	14
15	HOME OFFICE: PHYSICIAN-PART A							15
16	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)							16
WAGE-RELATED COSTS								
17	WAGE-RELATED COSTS (CORE)		3,716,385		3,716,385			17
18	WAGE-RELATED COSTS (OTHER)							18
19	EXCLUDED AREAS		1,138,772		1,138,772			19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A							22
23	PHYSICIAN PART B							23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)							25
OVERHEAD COSTS - DIRECT SALARIES								
26	EMPLOYEE BENEFITS		1,318,924	-1,318,924				26
27	ADMINISTRATIVE & GENERAL		6,061,799	-2,623,370	3,438,429	64,853.00	53.02	27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)							28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		203,692	24,573	228,265	11,636.00	19.62	30
31	LAUNDRY & LINEN SERVICE		12,006	-3,826	8,180	599.00	13.66	31
32	HOUSEKEEPING		156,905	18,929	175,834	16,900.00	10.40	32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)							33
34	DIETARY		290,255	-181,623	108,632	6,864.00	15.83	34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)							35
36	CAFETERIA			213,823	213,823	14,956.00	14.30	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		30,417	3,669	34,086	1,035.00	32.93	38
39	CENTRAL SERVICES AND SUPPLY			188,746	188,746	9,702.00	19.45	39
40	PHARMACY		439,222	52,987	492,209	11,581.00	42.50	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY			278,479	278,479	15,237.00	18.28	41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	14,592,939	-2,156,817	12,436,122	512,389.00	24.27	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	3,182,735	462,698	3,645,433	192,166.00	18.97	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	11,410,204	-2,619,515	8,790,689	320,223.00	27.45	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	3,187,398		3,187,398	77,087.00	41.35	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	3,716,385		3,716,385		42.28%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	18,313,987	-2,619,515	15,694,472	397,310.00	39.50	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	8,513,220	-3,346,537	5,166,683	153,363.00	33.69	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
 PART IV

PART A - CORE LIST

	AMOUNT REPORTED	
RETIREMENT COST		
1 401K EMPLOYER CONTRIBUTIONS		1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	306,195	2
3 QUALIFIED AND NON-QUALIFIED PENSION PLAN COST	897,819	3
4 PRIOR YEAR PENSION SERVICE COST		4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)		
5 401K/TSA PLAN ADMINISTRATION FEES		5
6 LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES	37,885	7
HEALTH AND INSURANCE COST		
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	2,393,611	8
9 PRESCRIPTION DRUG PLAN		9
10 DENTAL, HEARING AND VISION PLAN		10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	21,671	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	48,352	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15 WORKERS' COMPENSATION INSURANCE	32,628	15
16 RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)		16
TAXES		
17 FICA-EMPLOYERS PORTION ONLY	1,062,496	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19 UNEMPLOYMENT INSURANCE		19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES		20
OTHER		
21 EXECUTIVE DEFERRED COMPENSATION	27,351	21
22 DAY CARE COSTS AND ALLOWANCES		22
23 TUITION REIMBURSEMENT	27,149	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	4,855,157	24
PART B - OTHER THAN CORE RELATED COST		
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
05/31/2012 09:57

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

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

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

		Y/N	DATE				
		1	2				
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR WAS THERE NO MEDICARE UTILIZATION? ENTER 'Y' FOR YES IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N	1				
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	N	2				
							TOTAL
	GROUP				SNF	SWING BED	(COLS.
	1				DAYS	SNF DAYS	2 + 3)
					2	3	4
3	RUX						3
4	RUL						4
5	RVX						5
6	RVL						6
7	RHX						7
8	RHL			8			8
9	RMX						9
10	RML						10
11	RLX						11
12	RUC			92			92
13	RUB			267			267
14	RUA			220			220
15	RVC			125			125
16	RVB			238			238
17	RVA			194			194
18	RHC			37			37
19	RHB			42			42
20	RHA			85			85
21	RMC			41			41
22	RMB			33			33
23	RMA			55			55
24	RLB						24
25	RLA						25
26	ES3						26
27	ES2						27
28	ES1						28
29	HE2						29
30	HE1						30
31	HD2						31
32	HD1						32
33	HC2						33
34	HC1						34
35	HB2			3			3
36	HB1						36
37	LE2						37
38	LE1						38
39	LD2						39
40	LD1						40
41	LC2						41
42	LC1						42
43	LB2						43
44	LB1						44
45	CE2						45
46	CE1						46
47	CD2						47
48	CD1			1			1
49	CC2						49
50	CC1						50
51	CB2						51
52	CB1			27			27
53	CA2						53
54	CA1			19			19
55	SE3						55
56	SE2						56
57	SE1						57
58	SSC						58
59	SSB						59
60	SSA						60
61	IB2						61
62	IB1						62
63	IA1						63
64	IA2						64
65	BB2						65
66	BB1						66
67	BA2						67
68	BA1			12			12

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

		SNF	SWING BED	TOTAL
		DAYS	SNF DAYS	(COLS.
GROUP		2	3	2 + 3)
1				4
69	PE2			69
70	PE1			70
71	PD2			71
72	PD1	3		3 72
73	PC2			73
74	PC1	5		5 74
75	PB2			75
76	PB1	2		2 76
77	PA2			77
78	PA1			78
199	AAA			199
200	TOTAL	1,509		1,509 200

		CBSA AT	CBSA
		BEGINNING	ON/AFTER
		OF COST	OF THE COST
		REPORTING	REPORTING
		PERIOD	PERIOD (IF
		1	APPLICABLE)
			2

SNF SERVICES

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

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

		EXPENSES	PERCENTAGE	EXPENSES?
		1	2	3
202	STAFFING			202
203	RECRUITMENT			203
204	RETENTION OF EMPLOYEES			204
205	TRAINING			205
206	OTHER (SPECIFY)			206
207	TOTAL SNF REVENUE (WORKSHEET G-2, PART I, LINE 7, COLUMN 3)	3,788,559		207

ASSOCIATED
 WITH
 DIRECT
 PATIENT
 CARE AND
 RELATED

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 200, COL. 3 DIVIDED BY LINE 200, COL. 8)				0.371395	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				1,173,815	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				N	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?					4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID					5
6	MEDICAID CHARGES				9,569,181	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				3,553,946	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5)				2,380,131	8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP				1,598	9
10	STAND-ALONE SCHIP CHARGES				14,081	10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)				5,230	11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9)				3,632	12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13)					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS					18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)				2,383,763	19
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL		
		1	2	3		
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FAMILY	1,403,447	695,534	2,098,981		20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	521,233	258,318	779,551		21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	3,159	9,387	12,546		22
23	COST OF CHARITY CARE	518,074	248,931	767,005		23
24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM					N 24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)			4,216,885		26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			114,262		27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			4,102,623		28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			1,523,694		29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			2,290,699		30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			4,674,462		31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL	RECLASSIFI-	
		1	2	(COL. 1 + COL. 2)	CATIONS	
				3	4	
GENERAL SERVICE COST CENTERS						
1	00100		1,880,197	1,880,197	-1,111,955	1
2	00200				1,139,507	2
2.01	00201				197,942	2.01
3	00300					3
4	00400	1,318,924	3,785,640	5,104,564	-1,318,924	4
5	00500	6,061,799	1,930,469	7,992,268	-260,722	5
6	00600					6
7	00700	203,692	940,849	1,144,541	-1,923	7
8	00800	12,006	108,887	120,893	1,448	8
9	00900	156,905	134,897	291,802	18,929	9
10	01000	290,255	133,727	423,982	-270,765	10
11	01100				302,472	11
12	01200					12
13	01300	30,417		30,417	3,669	13
14	01400		-1,664	-1,664	-2	14
15	01500	439,222	1,727,863	2,167,085	-840,569	15
16	01600					16
17	01700					17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	2,122,895	238,646	2,361,541	-352,289	30
43	04300				170,252	43
44	04400	1,964,472	692,005	2,656,477	442,047	44
ANCILLARY SERVICE COST CENTERS						
50	05000	869,790	360,906	1,230,696	95,570	50
52	05200	28,419	-1,279	27,140	436,216	52
53	05300		953,041	953,041	-291	53
54	05400	939,458	471,190	1,410,648	60,728	54
60	06000		1,092,900	1,092,900	-2,332	60
62.30	06250					62.30
65	06500	370,555	104,177	474,732	32,102	65
66	06600	580,444	260,876	841,320	-314,567	66
67	06700		145,764	145,764	214,909	67
68	06800		78,786	78,786	68,101	68
69	06900		68,462	68,462	-1,449	69
71	07100		800,572	800,572	-208,613	71
72	07200				207,087	72
73	07300				886,279	73
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
90	09000	46,696	3,295	49,991	8,449	90
91	09100	1,044,911	139,187	1,184,098	88,323	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
95	09500	901,040	221,863	1,122,903	104,575	95
SPECIAL PURPOSE COST CENTERS						
118		17,381,900	16,271,256	33,653,156	-205,796	118
NONREIMBURSABLE COST CENTERS						
190	19000					190
192	19200	190	2,471,440	2,471,630	-30,689	192
194	07950		-140,305	-140,305	186,796	194
194.01	07951	14,262	1,242	15,504	1,688	194.01
194.02	07952	279,653	644,430	924,083	40,702	194.02
194.03	07953		90,000	90,000		194.03
194.04	07954	23,118	88,364	111,482	7,299	194.04
194.05	07955					194.05
200		17,699,123	19,426,427	37,125,550		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
GENERAL SERVICE COST CENTERS					
1	00100	768,242	171,105	939,347	1
2	00200	1,139,507	925,905	2,065,412	2
2.01	00201	197,942		197,942	2.01
3	00300				3
4	00400	3,785,640	-187,761	3,597,879	4
5	00500	7,731,546	-1,440,645	6,290,901	5
6	00600				6
7	00700	1,142,618	-290	1,142,328	7
8	00800	122,341	-446	121,895	8
9	00900	310,731		310,731	9
10	01000	153,217	-28,472	124,745	10
11	01100	302,472	-22,843	279,629	11
12	01200				12
13	01300	34,086		34,086	13
14	01400	-1,666	236,685	235,019	14
15	01500	1,326,516	-697,705	628,811	15
16	01600		439,172	439,172	16
17	01700				17
19	01900				19
20	02000				20
21	02100				21
22	02200				22
23	02300				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	2,009,252		2,009,252	30
43	04300	170,252		170,252	43
44	04400	3,098,524	-12,753	3,085,771	44
ANCILLARY SERVICE COST CENTERS					
50	05000	1,326,266		1,326,266	50
52	05200	463,356		463,356	52
53	05300	952,750	-919,236	33,514	53
54	05400	1,471,376	-48,087	1,423,289	54
60	06000	1,090,568		1,090,568	60
62.30	06250				62.30
65	06500	506,834	-1,413	505,421	65
66	06600	526,753	-1,300	525,453	66
67	06700	360,673		360,673	67
68	06800	146,887		146,887	68
69	06900	67,013		67,013	69
71	07100	591,959		591,959	71
72	07200	207,087		207,087	72
73	07300	886,279		886,279	73
76.97	07697				76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
90	09000	58,440		58,440	90
91	09100	1,272,421	-1,873	1,270,548	91
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
95	09500	1,227,478		1,227,478	95
SPECIAL PURPOSE COST CENTERS					
118		33,447,360	-1,589,957	31,857,403	118
NONREIMBURSABLE COST CENTERS					
190	19000				190
192	19200	2,440,941	-2,188,989	251,952	192
194	07950	46,491		46,491	194
194.01	07951	17,192		17,192	194.01
194.02	07952	964,785	-342,976	621,809	194.02
194.03	07953	90,000		90,000	194.03
194.04	07954	118,781	-16,779	102,002	194.04
194.05	07955				194.05
200		37,125,550	-4,138,701	32,986,849	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE	SALARY		OTHER	
				LINE #			
	1	2		3	4	5	
1 CAFETERIA RECLASS	A	CAFETERIA		11	213,823	88,649	1
500 TOTAL RECLASSIFICATIONS					213,823	88,649	500
CODE LETTER - A							
1 OB RECLASS	B	NURSERY		43	139,760	13,632	1
2 DELIVERY ROOM & LABOR ROOM				52	355,276	34,652	2
500 TOTAL RECLASSIFICATIONS					495,036	48,284	500
CODE LETTER - B							
1 ASSOCIATION DUES RECLASS	C	OAK POINTE		194.02		777	1
500 TOTAL RECLASSIFICATIONS						777	500
CODE LETTER - C							
1 LTC A&G COST	D	SKILLED NURSING FACILITY		44	95,694	148,879	1
500 TOTAL RECLASSIFICATIONS					95,694	148,879	500
CODE LETTER - D							
1 BUILDING AND EQUIP LEASE	E	CAP REL COSTS-BLDG & FIXT		1		85,848	1
2 CAP REL COSTS-MVBLE EQUIP				2		70,304	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
500 TOTAL RECLASSIFICATIONS						156,152	500
CODE LETTER - E							
1 HOSPITAL PORTION OF BUILDING RECLAS	F	CAP REL COSTS-BLDG & FIXT		1		30,712	1
500 TOTAL RECLASSIFICATIONS						30,712	500
CODE LETTER - F							
1 INSURANCE RECLASS	G	CAP REL COSTS-BLDG & FIXT		1		3,434	1
2 CAP REL COSTS-MVBLE EQUIP				2		25,148	2
3 SNF CAPITAL				2.01		8,708	3
4 OAK POINTE				194.02		8,780	4
5 CAP REL COSTS-MVBLE EQUIP				2		1,161	5
6 SNF CAPITAL				2.01		179	6
7 OAK POINTE				194.02		178	7
8 ADMINISTRATIVE & GENERAL				5		5,681	8
500 TOTAL RECLASSIFICATIONS						53,269	500
CODE LETTER - G							
1 DEPRECIATION RECLASS	H	CAP REL COSTS-MVBLE EQUIP		2		1,041,724	1
2 SNF CAPITAL				2.01		189,055	2
500 TOTAL RECLASSIFICATIONS						1,230,779	500
CODE LETTER - H							
1 LAUNDRY TRANSFER RECLASS	I	LAUNDRY & LINEN SERVICE		8		5,274	1
2 SKILLED NURSING FACILITY				44	5,273		2
500 TOTAL RECLASSIFICATIONS					5,273	5,274	500
CODE LETTER - I							
1 TAXES RECLASS	J	CAP REL COSTS-MVBLE EQUIP		2		1,170	1
500 TOTAL RECLASSIFICATIONS						1,170	500
CODE LETTER - J							

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE LINE #	SALARY	OTHER	
1		2	3	4	5	
1 SALARY RECLASS	K	ADMINISTRATIVE & GENERAL	5		2,624,041	1
2		CENTRAL SERVICES & SUPPLY	14	188,746		2
3		MEDICAL RECORDS & LIBRARY	16	278,479		3
500 TOTAL RECLASSIFICATIONS				467,225	2,624,041	500
CODE LETTER - K						
1 REHAB THERAPY DEPT RECLASS	L	OCCUPATIONAL THERAPY	67	204,628	10,899	1
2		SPEECH PATHOLOGY	68	58,009	3,094	2
500 TOTAL RECLASSIFICATIONS				262,637	13,993	500
CODE LETTER - L						
1 DRUGS CHARGED TO PATIENT RECLASS	M	DRUGS CHARGED TO PATIENTS	73		892,975	1
500 TOTAL RECLASSIFICATIONS					892,975	500
CODE LETTER - M						
1 SALARY BENEFITS RECLASS	N	ADMINISTRATIVE & GENERAL	5	96,365		1
2		OPERATION OF PLANT	7	24,573		2
3		LAUNDRY & LINEN SERVICE	8	1,448		3
4		HOUSEKEEPING	9	18,929		4
5		DIETARY	10	35,016		5
6		NURSING ADMINISTRATION	13	3,669		6
7		PHARMACY	15	52,987		7
8		ADULTS & PEDIATRICS	30	196,380		8
9		NURSERY	43	16,860		9
10		SKILLED NURSING FACILITY	44	217,533		10
11		OPERATING ROOM	50	104,929		11
12		DELIVERY ROOM & LABOR ROOM	52	46,288		12
13		RADIOLOGY-DIAGNOSTIC	54	113,334		13
14		RESPIRATORY THERAPY	65	44,703		14
15		PHYSICAL THERAPY	66	38,339		15
16		OCCUPATIONAL THERAPY	67	24,686		16
17		SPEECH PATHOLOGY	68	6,998		17
18		CLINIC	90	5,633		18
19		EMERGENCY	91	126,056		19
20		AMBULANCE SERVICES	95	108,698		20
21		PHYSICIANS' PRIVATE OFFICES	192	23		21
22		PAIN CLINIC	194.01	1,721		22
23		OAK POINTE	194.02	30,967		23
24		COMMUNITY & VOLUNTEER SERVICE	194.04	2,789		24
500 TOTAL RECLASSIFICATIONS				1,318,924		500
CODE LETTER - N						
1 CLINIC DIETICIAN RECLASS	O	CLINIC	90	2,816		1
500 TOTAL RECLASSIFICATIONS				2,816		500
CODE LETTER - O						
1 CORPORATE DIRECT ALLOC RECLASS	P	OCCUPATIONAL HEALTH	194		46,490	1
2		COMMUNITY & VOLUNTEER SERVICE	194.04		4,510	2
500 TOTAL RECLASSIFICATIONS					51,000	500
CODE LETTER - P						
1 OCCUPATIONAL HEALTH RECLASS	Q	OCCUPATIONAL HEALTH	194		140,306	1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
500 TOTAL RECLASSIFICATIONS					140,306	500
CODE LETTER - Q						
1 IMPLANTABLE MEDICAL SUPPLIES	R	IMPL. DEV. CHARGED TO PATIENT	72		207,087	1
500 TOTAL RECLASSIFICATIONS					207,087	500
CODE LETTER - R						
GRAND TOTAL (INCREASES)				2,861,428	5,693,347	

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 CAFETERIA RECLASS	A	DIETARY	10	213,823	88,649	1
500 TOTAL RECLASSIFICATIONS				213,823	88,649	500
CODE LETTER - A						
1 OB RECLASS	B	ADULTS & PEDIATRICS	30	495,036	48,284	1
2						2
500 TOTAL RECLASSIFICATIONS				495,036	48,284	500
CODE LETTER - B						
1 ASSOCIATION DUES RECLASS	C	SKILLED NURSING FACILITY	44		777	1
500 TOTAL RECLASSIFICATIONS					777	500
CODE LETTER - C						
1 LTC A&G COST	D	ADMINISTRATIVE & GENERAL	5	95,694	148,879	1
500 TOTAL RECLASSIFICATIONS				95,694	148,879	500
CODE LETTER - D						
1 BUILDING AND EQUIP LEASE	E	ADMINISTRATIVE & GENERAL	5		10,356	10 1
2		OPERATION OF PLANT	7		24,672	10 2
3		RESPIRATORY THERAPY	65		10,968	3
4		PHYSICAL THERAPY	66		39,852	10 4
5		ADMINISTRATIVE & GENERAL	5		9,251	5
6		OPERATION OF PLANT	7		1,824	6
7		DIETARY	10		493	7
8		CENTRAL SERVICES & SUPPLY	14		2	8
9		PHARMACY	15		581	9
10		ADULTS & PEDIATRICS	30		5,349	10
11		SKILLED NURSING FACILITY	44		13,601	11
12		OPERATING ROOM	50		9,359	12
13		ANESTHESIOLOGY	53		291	13
14		RADIOLOGY-DIAGNOSTIC	54		1,796	14
15		RESPIRATORY THERAPY	65		1,388	15
16		PHYSICAL THERAPY	66		19,918	16
17		EMERGENCY	91		2,328	17
18		AMBULANCE SERVICES	95		4,123	18
500 TOTAL RECLASSIFICATIONS					156,152	500
CODE LETTER - E						
1 HOSPITAL PORTION OF BUILDING RECLAS	F	PHYSICIANS' PRIVATE OFFICES	192		30,712	10 1
500 TOTAL RECLASSIFICATIONS					30,712	500
CODE LETTER - F						
1 INSURANCE RECLASS	G	ADMINISTRATIVE & GENERAL	5		46,070	12 1
2		ADMINISTRATIVE & GENERAL	5		1,518	12 2
3		SKILLED NURSING FACILITY	44		5,681	12 3
4						4
5						12 5
6						12 6
7						7
8						8
500 TOTAL RECLASSIFICATIONS					53,269	500
CODE LETTER - G						
1 DEPRECIATION RECLASS	H	CAP REL COSTS-BLDG & FIXT	1		1,230,779	9 1
2						9 2
500 TOTAL RECLASSIFICATIONS					1,230,779	500
CODE LETTER - H						
1 LAUNDRY TRANSFER RECLASS	I	LAUNDRY & LINEN SERVICE	8	5,274		1
2		SKILLED NURSING FACILITY	44		5,273	2
500 TOTAL RECLASSIFICATIONS				5,274	5,273	500
CODE LETTER - I						
1 TAXES RECLASS	J	CAP REL COSTS-BLDG & FIXT	1		1,170	13 1
500 TOTAL RECLASSIFICATIONS					1,170	500
CODE LETTER - J						

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 SALARY RECLASS	K	ADMINISTRATIVE & GENERAL	5	2,624,041		1
2		CENTRAL SERVICES & SUPPLY	14		188,746	2
3		MEDICAL RECORDS & LIBRARY	16		278,479	3
500 TOTAL RECLASSIFICATIONS CODE LETTER - K				2,624,041	467,225	500
1 REHAB THERAPY DEPT RECLASS	L	PHYSICAL THERAPY	66	262,637	13,993	1
2						2
500 TOTAL RECLASSIFICATIONS CODE LETTER - L				262,637	13,993	500
1 DRUGS CHARGED TO PATIENT RECLASS	M	PHARMACY	15		892,975	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - M					892,975	500
1 SALARY BENEFITS RECLASS	N	EMPLOYEE BENEFITS	4	1,318,924		1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
16						16
17						17
18						18
19						19
20						20
21						21
22						22
23						23
24						24
500 TOTAL RECLASSIFICATIONS CODE LETTER - N				1,318,924		500
1 CLINIC DIETICIAN RECLASS	O	DIETARY	10	2,816		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - O				2,816		500
1 CORPORATE DIRECT ALLOC RECLASS	P	ADMINISTRATIVE & GENERAL	5		51,000	1
2						2
500 TOTAL RECLASSIFICATIONS CODE LETTER - P					51,000	500
1 OCCUPATIONAL HEALTH RECLASS	Q	RADIOLOGY-DIAGNOSTIC	54		50,810	1
2		LABORATORY	60		2,332	2
3		RESPIRATORY THERAPY	65		245	3
4		PHYSICAL THERAPY	66		16,506	4
5		OCCUPATIONAL THERAPY	67		25,304	5
6		ELECTROCARDIOLOGY	69		1,449	6
7		MEDICAL SUPPLIES CHRGED TO PA	71		1,526	7
8		DRUGS CHARGED TO PATIENTS	73		6,696	8
9		EMERGENCY	91		35,405	9
10		PAIN CLINIC	194.01		33	10
500 TOTAL RECLASSIFICATIONS CODE LETTER - Q					140,306	500
1 IMPLANTABLE MEDICAL SUPPLIES	R	MEDICAL SUPPLIES CHRGED TO PA	71		207,087	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - R					207,087	500
GRAND TOTAL (DECREASES)				5,018,245	3,536,530	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND	105,745					105,745		1
2 LAND IMPROVEMENTS	683,845	10,595		10,595	389,483	304,957	78,333	2
3 BUILDINGS AND FIXTURES	16,886,910	59,951		59,951	12,967,014	3,979,847	372,558	3
4 BUILDING IMPROVEMENTS	42,430	5,639		5,639		48,069	42,430	4
5 FIXED EQUIPMENT	9,838,379	40,349		40,349	9,032,214	846,514	109,760	5
6 MOVABLE EQUIPMENT	10,281,622	5,033,302		5,033,302	721,370	14,593,554	5,255,431	6
7 HIT DESIGNATED ASSETS								7
8 SUBTOTAL (SUM OF LINES 1-7)	37,838,931	5,149,836		5,149,836	23,110,081	19,878,686	5,858,512	8
9 RECONCILING ITEMS	-8,490				-80,187	71,697		9
10 TOTAL (LINE 7 MINUS LINE 9)	37,847,421	5,149,836		5,149,836	23,190,268	19,806,989	5,858,512	10

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

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

DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	1,879,027				1,170		1,880,197
2 CAP REL COSTS-MVBLE EQUIP							2
2.01 SNF CAPITAL							2.01
3 TOTAL (SUM OF LINES 1-2)	1,879,027				1,170		1,880,197

PART III - RECONCILIATION OF CAPITAL COST CENTERS

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

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3		RATIO (SEE INSTR.) 4	INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS 7	TOTAL
			(COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4					(SUM OF COLS. 5-7) 8
1 CAP REL COSTS-BLDG & FIXT	1,734,005		1,734,005	0.087229				1	
2 CAP REL COSTS-MVBLE EQUIP	13,564,677		13,564,677	0.682373				2	
2.01 SNF CAPITAL	4,580,004		4,580,004	0.230398				2.01	
3 TOTAL (SUM OF LINES 1-2)	19,878,686		19,878,686	1.000000				3	

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

DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	819,353	116,560		3,434			939,347
2 CAP REL COSTS-MVBLE EQUIP	1,967,629	70,304		26,309	1,170		2,065,412
2.01 SNF CAPITAL	189,055			8,887			197,942
3 TOTAL	2,976,037	186,864		38,630	1,170		3,202,701

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)					4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)					7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)	A	-290	OPERATION OF PLANT	7	8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-18,277			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	1,815,589			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-15,275	CAFETERIA	11	14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17 SALE OF DRUGS TO OTHER THAN PATIENTS					17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS					18
19 NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)					19
20 VENDING MACHINES					20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33 MISCELLANEOUS REVENUE	B	-6,693	ADMINISTRATIVE & GENERAL	5	33
34 LAUNDRY SERVICE	B	-446	LAUNDRY & LINEN SERVICE	8	34
35 POSTURE ASSESSMENTS	B	-1,300	PHYSICAL THERAPY	66	35
36 SALE OF LTC SUPPLIES	B	-12,519	SKILLED NURSING FACILITY	44	36
37 NON-PATIENT RADIOLOGY REV.	B	-13,786	RADIOLOGY-DIAGNOSTIC	54	37
38 NON-PATIENT LAB REV.	B	-1,413	RESPIRATORY THERAPY	65	38
39 TELEVISION OFFSET	A	-6,060	CAP REL COSTS-MVBLE EQUIP	2	39
40 ANSWERING SERVICE	A	-1,897	ADMINISTRATIVE & GENERAL	5	40
41 PHYSICIAN RECRUITING	A	-25,000	ADMINISTRATIVE & GENERAL	5	41
42 MEALS ON WHEELS	A	-28,472	DIETARY	10	42
43 VISITOR MEALS	A	-7,568	CAFETERIA	11	43
44 PHARMACY SALES	A	-685,594	PHARMACY	15	44
45 COMMUNITY HEALTH & VOLUNTEER SVCS	A	-53,794	ADMINISTRATIVE & GENERAL	5	45
46 SELF INSURANCE	A	-1,212,415	EMPLOYEE BENEFITS	4	46
47 LOBBY EXPENSE	A	-3,523	ADMINISTRATIVE & GENERAL	5	47
48 LOBBY EXPENSE	A	-234	SKILLED NURSING FACILITY	44	48
49 LOBBY EXPENSE	A	-40	OAK POINTE	194.02	49
49.01 RENT EXPENSE - RAD	A	-34,301	RADIOLOGY-DIAGNOSTIC	54	49.01
49.02 RENT EXPENSE - MEDICATION ASSIST P	A	-16,779	COMMUNITY & VOLUNTEER SERVICES	194.04	49.02
49.03 RENT EXPENSE - PHYSICIANS CLINIC	A	-33,317	PHYSICIANS' PRIVATE OFFICES	192	49.03
49.04 RENT EXPENSE - OAK POINTE	A	-342,936	OAK POINTE	194.02	49.04
49.05 INTERUNIT RENT EXPENSE	A	-361,746	CAP REL COSTS-BLDG & FIXT	1	49.05
49.06 OPERATING INTEREST EXPENSE	A	-12,111	PHARMACY	15	49.06
49.07 NON-ALLOW - PROF SERVICES	A	-911,649	ANESTHESIOLOGY	53	49.07
49.08 TRANSCRIPTION ADD-BACK	A	8,817	EMERGENCY	91	49.08
49.09 SUBSIDY ADJUSTMENT	A	-2,155,672	PHYSICIANS' PRIVATE OFFICES	192	49.09
50 TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-4,138,701			50

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

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ- USTMENTS (COL. 4-5)	WKST A-7 REF
1	2	3	4	5	6	7
1	1	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	532,851		9 1
2	2	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	931,965		9 2
3	5	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	3,913,262	5,263,000	-1,349,738 3
4	4	EMPLOYEE BENEFITS	HOME OFFICE ALLOCATION	883,936		883,936 4
4.01	14	CENTRAL SERVICES & SUPPLY	HOME OFFICE ALLOCATION	236,685		236,685 4.01
4.02	4	EMPLOYEE BENEFITS	HOME OFFICE ALLOCATION	51,159		51,159 4.02
4.03	16	MEDICAL RECORDS & LIBRARY	HOME OFFICE ALLOCATION	439,172		439,172 4.03
4.04	4	EMPLOYEE BENEFITS	HOME OFFICE ALLOCATION	89,559		89,559 4.04
4.05	194.02	OAK POINTE	HOME OFFICE ALLOCATION	215,000	215,000	
5		TOTALS (SUM OF LINES 1-4)		7,293,589	5,478,000	1,815,589 5
		TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.				

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

THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(b)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

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

- (1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:
- A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
 - B. CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
 - C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION.
 - D. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN RELATED ORGANIZATION.
 - E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
 - F. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
 - G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY:

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT	
1	2	3	4	5	6	7	8	9	
1	91 EMERGENCY DR A	27,500		27,500	171,400	204	16,810	841	1
2	53 ANESTHESIOLOGY DR B	53,714		53,714	200,300	479	46,127	2,306	2
200	TOTAL	81,214		81,214		683	62,937	3,147	200

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
 05/31/2012 09:57

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
LINE NO.		12	13	14	15	16	17	18	
10	11								
1	91 EMERGENCY					16,810	10,690	10,690	1
2	53 ANESTHESIOLOGY					46,127	7,587	7,587	2
200	TOTAL					62,937	18,277	18,277	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP	CAP	CAP	CAP RELATE	EMPLOYEE
	FOR COST				
	ALLOCATION	FIXTURES	EQUIPMENT	SNF	
	(FROM WKST	1	2	2.01	4
	A, COL.7)				
	0				
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT	939,347	939,347			1
2 CAP REL COSTS-MVBLE EQUIP	2,065,412		2,065,412		2
2.01 SNF CAPITAL	197,942			197,942	2.01
4 EMPLOYEE BENEFITS	3,597,879	8,473	18,630		3,624,982
5 ADMINISTRATIVE & GENERAL	6,290,901	107,714	236,838		801,957
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT	1,142,328	133,004	292,445		53,239
8 LAUNDRY & LINEN SERVICE	121,895	14,175	31,168		1,908
9 HOUSEKEEPING	310,731	4,481	9,854		41,010
10 DIETARY	124,745	22,078	48,544		25,337
11 CAFETERIA	279,629	14,906	32,775		49,871
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION	34,086	4,281	9,412		7,950
14 CENTRAL SERVICES & SUPPLY	235,019	21,668	47,643		44,022
15 PHARMACY	628,811	11,260	24,757		114,799
16 MEDICAL RECORDS & LIBRARY	439,172	6,128	13,474		64,950
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	2,009,252	232,596	511,429		425,473
43 NURSERY	170,252	1,526	3,355		36,529
44 SKILLED NURSING FACILITY	3,085,771			189,719	532,464
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	1,326,266	56,812	124,917		227,337
52 DELIVERY ROOM & LABOR ROOM	463,356	9,164	20,149		100,286
53 ANESTHESIOLOGY	33,514				53
54 RADIOLOGY-DIAGNOSTIC	1,423,289	66,337	145,861		245,546
60 LABORATORY	1,090,568	27,258	59,934		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	505,421	9,501	20,890		96,852
66 PHYSICAL THERAPY	525,453	46,235	101,661	8,223	83,065
67 OCCUPATIONAL THERAPY	360,673				53,484
68 SPEECH PATHOLOGY	146,887				15,162
69 ELECTROCARDIOLOGY	67,013	11,252	24,740		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	591,959				71
72 IMPL. DEV. CHARGED TO PATIENT	207,087				72
73 DRUGS CHARGED TO PATIENTS	886,279				73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	58,440	8,264	18,171		12,862
91 EMERGENCY	1,270,548	59,551	130,939		273,108
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES	1,227,478	28,374	62,388		235,504
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	31,857,403	905,038	1,989,974	197,942	3,542,715
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		5,204	11,443		190
192 PHYSICIANS' PRIVATE OFFICES	251,952				50
194 OCCUPATIONAL HEALTH	46,491	23,363	51,369		194
194.01 PAIN CLINIC	17,192				3,728
194.02 OAK POINTE	621,809				72,447
194.03 FOUNDATION	90,000				194.03
194.04 COMMUNITY & VOLUNTEER SERVICES	102,002	3,220	7,081		6,042
194.05 VACANT SPACE		2,522	5,545		194.05
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	32,986,849	939,347	2,065,412	197,942	3,624,982

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	SUBTOTAL (COLS.0-4) 4A	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 SNF CAPITAL						2.01
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	7,437,410	7,437,410				5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	1,621,016	471,876	2,092,892			7
8 LAUNDRY & LINEN SERVICE	169,146	49,238	36,621	255,005		8
9 HOUSEKEEPING	366,076	106,564	11,577		484,217	9
10 DIETARY	220,704	64,247	57,037	560	15,920	10
11 CAFETERIA	377,181	109,797	38,509		10,749	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	55,729	16,223	11,059		3,087	13
14 CENTRAL SERVICES & SUPPLY	348,352	101,405	55,979		15,625	14
15 PHARMACY	779,627	226,949	29,089		8,119	15
16 MEDICAL RECORDS & LIBRARY	523,724	152,456	15,831		4,419	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	3,178,750	925,331	600,909	81,398	167,726	30
43 NURSERY	211,662	61,615	3,942	1,669	1,100	43
44 SKILLED NURSING FACILITY	3,807,954	1,108,483		88,329		44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,735,332	505,153	146,773	13,300	40,967	50
52 DELIVERY ROOM & LABOR ROOM	592,955	172,609	23,674	1,097	6,608	52
53 ANESTHESIOLOGY	33,514	9,756				53
54 RADIOLOGY-DIAGNOSTIC	1,881,033	547,567	171,380	22,690	47,836	54
60 LABORATORY	1,177,760	342,845	70,419	139	19,655	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	632,664	184,168	24,545	1,687	6,851	65
66 PHYSICAL THERAPY	764,637	222,585	119,447	2,977	33,340	66
67 OCCUPATIONAL THERAPY	414,157	120,561		1,912		67
68 SPEECH PATHOLOGY	162,049	47,172		544		68
69 ELECTROCARDIOLOGY	103,005	29,985	29,068		8,114	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	591,959	172,319				71
72 IMPL. DEV. CHARGED TO PATIENT	207,087	60,283				72
73 DRUGS CHARGED TO PATIENTS	886,279	257,995				73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	97,737	28,451	21,350		5,959	90
91 EMERGENCY	1,734,146	504,808	153,848	32,927	42,942	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	1,553,744	452,293	73,303	4,405	20,460	95
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	31,665,389	7,052,734	1,694,360	253,634	459,477	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,647	4,846	13,445		3,753	190
192 PHYSICIANS' PRIVATE OFFICES	252,002	73,358	304,065	1,282		192
194 OCCUPATIONAL HEALTH	121,223	35,288	60,357		16,847	194
194.01 PAIN CLINIC	20,920	6,090	5,830	89		194.01
194.02 OAK POINTE	694,256	202,097				194.02
194.03 FOUNDATION	90,000	26,199				194.03
194.04 COMMUNITY & VOLUNTEER SERVICES	118,345	34,450	8,320		2,322	194.04
194.05 VACANT SPACE	8,067	2,348	6,515		1,818	194.05
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	32,986,849	7,437,410	2,092,892	255,005	484,217	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	10	11	13	14	15	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 SNF CAPITAL						2.01
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY	358,468					10
11 CAFETERIA		536,236				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		1,950	88,048			13
14 CENTRAL SERVICES & SUPPLY		18,330		539,691		14
15 PHARMACY		21,839		30,223	1,095,846	15
16 MEDICAL RECORDS & LIBRARY		28,469				16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	358,468	135,327	45,003	28,101	4	30
43 NURSERY		10,140	2,830	2,657	1	43
44 SKILLED NURSING FACILITY				37,318		44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		65,908	18,195	82,020	15	50
52 DELIVERY ROOM & LABOR ROOM		28,079		6,870	2	52
53 ANESTHESIOLOGY				370		53
54 RADIOLOGY-DIAGNOSTIC		72,148		21,655	180	54
60 LABORATORY				115		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		31,199		20,963	7	65
66 PHYSICAL THERAPY		10,920		3,193	592	66
67 OCCUPATIONAL THERAPY		25,739		2,074	380	67
68 SPEECH PATHOLOGY		2,730		582	108	68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				179,221		71
72 IMPL. DEV. CHARGED TO PATIENT				62,537		72
73 DRUGS CHARGED TO PATIENTS					1,088,537	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC		3,510		791	2	90
91 EMERGENCY		79,948	22,020	25,665	61	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES				27,926	5,957	95
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	358,468	536,236	88,048	532,281	1,095,846	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES				1,111		192
194 OCCUPATIONAL HEALTH						194
194.01 PAIN CLINIC				46		194.01
194.02 OAK POINTE				6,062		194.02
194.03 FOUNDATION						194.03
194.04 COMMUNITY & VOLUNTEER SERVICES				191		194.04
194.05 VACANT SPACE						194.05
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	358,468	536,236	88,048	539,691	1,095,846	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
2.01 SNF CAPITAL					2.01
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY	724,899				16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	157,521	5,678,538		5,678,538	30
43 NURSERY	13,991	309,607		309,607	43
44 SKILLED NURSING FACILITY		5,042,084		5,042,084	44
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	47,988	2,655,651		2,655,651	50
52 DELIVERY ROOM & LABOR ROOM		831,894		831,894	52
53 ANESTHESIOLOGY		43,640		43,640	53
54 RADIOLOGY-DIAGNOSTIC	140,703	2,905,192		2,905,192	54
60 LABORATORY		1,610,933		1,610,933	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY		902,084		902,084	65
66 PHYSICAL THERAPY	79,739	1,237,430		1,237,430	66
67 OCCUPATIONAL THERAPY	34,433	599,256		599,256	67
68 SPEECH PATHOLOGY	3,914	217,099		217,099	68
69 ELECTROCARDIOLOGY		170,172		170,172	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		943,499		943,499	71
72 IMPL. DEV. CHARGED TO PATIENT		329,907		329,907	72
73 DRUGS CHARGED TO PATIENTS		2,232,811		2,232,811	73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC		157,800		157,800	90
91 EMERGENCY	246,610	2,842,975		2,842,975	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES		2,138,088		2,138,088	95
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	724,899	30,848,660		30,848,660	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		38,691		38,691	190
192 PHYSICIANS' PRIVATE OFFICES		631,818		631,818	192
194 OCCUPATIONAL HEALTH		233,715		233,715	194
194.01 PAIN CLINIC		32,975		32,975	194.01
194.02 OAK POINTE		902,415		902,415	194.02
194.03 FOUNDATION		116,199		116,199	194.03
194.04 COMMUNITY & VOLUNTEER SERVICES		163,628		163,628	194.04
194.05 VACANT SPACE		18,748		18,748	194.05
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	724,899	32,986,849		32,986,849	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION		DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	CAP RELATE COSTS SNF 2.01	SUBTOTAL 2A	
GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
2.01	SNF CAPITAL						2.01
4	EMPLOYEE BENEFITS		8,473	18,630		27,103	4
5	ADMINISTRATIVE & GENERAL		107,714	236,838		344,552	5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT		133,004	292,445		425,449	7
8	LAUNDRY & LINEN SERVICE		14,175	31,168		45,343	8
9	HOUSEKEEPING		4,481	9,854		14,335	9
10	DIETARY		22,078	48,544		70,622	10
11	CAFETERIA		14,906	32,775		47,681	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		4,281	9,412		13,693	13
14	CENTRAL SERVICES & SUPPLY		21,668	47,643		69,311	14
15	PHARMACY		11,260	24,757		36,017	15
16	MEDICAL RECORDS & LIBRARY		6,128	13,474		19,602	16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		232,596	511,429		744,025	30
43	NURSERY		1,526	3,355		4,881	43
44	SKILLED NURSING FACILITY				189,719	189,719	44
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		56,812	124,917		181,729	50
52	DELIVERY ROOM & LABOR ROOM		9,164	20,149		29,313	52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC		66,337	145,861		212,198	54
60	LABORATORY		27,258	59,934		87,192	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		9,501	20,890		30,391	65
66	PHYSICAL THERAPY		46,235	101,661	8,223	156,119	66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY		11,252	24,740		35,992	69
71	MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENT						72
73	DRUGS CHARGED TO PATIENTS						73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		8,264	18,171		26,435	90
91	EMERGENCY		59,551	130,939		190,490	91
92	OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES		28,374	62,388		90,762	95
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (SUM OF LINES 1-117)		905,038	1,989,974	197,942	3,092,954	118
NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		5,204	11,443		16,647	190
192	PHYSICIANS' PRIVATE OFFICES						192
194	OCCUPATIONAL HEALTH		23,363	51,369		74,732	194
194.01	PAIN CLINIC						194.01
194.02	OAK POINTE						194.02
194.03	FOUNDATION						194.03
194.04	COMMUNITY & VOLUNTEER SERVICES		3,220	7,081		10,301	194.04
194.05	VACANT SPACE		2,522	5,545		8,067	194.05
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)		939,347	2,065,412	197,942	3,202,701	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	EMPLOYEE BENEFITS 4	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 SNF CAPITAL						2.01
4 EMPLOYEE BENEFITS	27,103					4
5 ADMINISTRATIVE & GENERAL	5,996	350,548				5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	398	22,240	448,087			7
8 LAUNDRY & LINEN SERVICE	14	2,321	7,840	55,518		8
9 HOUSEKEEPING	307	5,023	2,479		22,144	9
10 DIETARY	189	3,028	12,212	122	728	10
11 CAFETERIA	373	5,175	8,245		492	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	59	765	2,368		141	13
14 CENTRAL SERVICES & SUPPLY	329	4,779	11,985		715	14
15 PHARMACY	858	10,696	6,228		371	15
16 MEDICAL RECORDS & LIBRARY	486	7,185	3,389		202	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	3,181	43,612	128,654	17,721	7,670	30
43 NURSERY	273	2,904	844	363	50	43
44 SKILLED NURSING FACILITY	3,982	52,257		19,232		44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,700	23,809	31,424	2,896	1,873	50
52 DELIVERY ROOM & LABOR ROOM	750	8,135	5,069	239	302	52
53 ANESTHESIOLOGY		460				53
54 RADIOLOGY-DIAGNOSTIC	1,836	25,808	36,692	4,940	2,188	54
60 LABORATORY		16,159	15,077	30	899	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	724	8,680	5,255	367	313	65
66 PHYSICAL THERAPY	621	10,491	25,574	648	1,525	66
67 OCCUPATIONAL THERAPY	400	5,682		416		67
68 SPEECH PATHOLOGY	113	2,223		118		68
69 ELECTROCARDIOLOGY		1,413	6,223		371	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		8,122				71
72 IMPL. DEV. CHARGED TO PATIENT		2,841				72
73 DRUGS CHARGED TO PATIENTS		12,160				73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	96	1,341	4,571		273	90
91 EMERGENCY	2,042	23,792	32,939	7,169	1,964	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	1,761	21,317	15,694	959	936	95
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	26,488	332,418	362,762	55,220	21,013	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		228	2,879		172	190
192 PHYSICIANS' PRIVATE OFFICES		3,457	65,100	279		192
194 OCCUPATIONAL HEALTH		1,663	12,922		770	194
194.01 PAIN CLINIC	28	287	1,248	19		194.01
194.02 OAK POINTE	542	9,525				194.02
194.03 FOUNDATION		1,235				194.03
194.04 COMMUNITY & VOLUNTEER SERVICES	45	1,624	1,781		106	194.04
194.05 VACANT SPACE		111	1,395		83	194.05
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	27,103	350,548	448,087	55,518	22,144	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	10	11	13	14	15	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 SNF CAPITAL						2.01
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY	86,901					10
11 CAFETERIA		61,966				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		225	17,251			13
14 CENTRAL SERVICES & SUPPLY		2,118		89,237		14
15 PHARMACY		2,524		4,997	61,691	15
16 MEDICAL RECORDS & LIBRARY		3,290				16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	86,901	15,638	8,818	4,646		30
43 NURSERY		1,172	554	439		43
44 SKILLED NURSING FACILITY				6,170		44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		7,616	3,565	13,562	1	50
52 DELIVERY ROOM & LABOR ROOM		3,245		1,136		52
53 ANESTHESIOLOGY				61		53
54 RADIOLOGY-DIAGNOSTIC		8,337		3,581	10	54
60 LABORATORY				19		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		3,605		3,466		65
66 PHYSICAL THERAPY		1,262		528	33	66
67 OCCUPATIONAL THERAPY		2,974		343	21	67
68 SPEECH PATHOLOGY		315		96	6	68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				29,635		71
72 IMPL. DEV. CHARGED TO PATIENT				10,340		72
73 DRUGS CHARGED TO PATIENTS					61,282	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC		406		131		90
91 EMERGENCY		9,239	4,314	4,244	3	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES				4,617	335	95
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	86,901	61,966	17,251	88,011	61,691	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES				184		192
194 OCCUPATIONAL HEALTH						194
194.01 PAIN CLINIC				8		194.01
194.02 OAK POINTE				1,002		194.02
194.03 FOUNDATION						194.03
194.04 COMMUNITY & VOLUNTEER SERVICES				32		194.04
194.05 VACANT SPACE						194.05
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	86,901	61,966	17,251	89,237	61,691	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
2.01 SNF CAPITAL					2.01
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY	34,154				16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	7,422	1,068,288		1,068,288	30
43 NURSERY	659	12,139		12,139	43
44 SKILLED NURSING FACILITY		271,360		271,360	44
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	2,261	270,436		270,436	50
52 DELIVERY ROOM & LABOR ROOM		48,189		48,189	52
53 ANESTHESIOLOGY		521		521	53
54 RADIOLOGY-DIAGNOSTIC	6,629	302,219		302,219	54
60 LABORATORY		119,376		119,376	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY		52,801		52,801	65
66 PHYSICAL THERAPY	3,757	200,558		200,558	66
67 OCCUPATIONAL THERAPY	1,622	11,458		11,458	67
68 SPEECH PATHOLOGY	184	3,055		3,055	68
69 ELECTROCARDIOLOGY		43,999		43,999	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		37,757		37,757	71
72 IMPL. DEV. CHARGED TO PATIENT		13,181		13,181	72
73 DRUGS CHARGED TO PATIENTS		73,442		73,442	73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC		33,253		33,253	90
91 EMERGENCY	11,620	287,816		287,816	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES		136,381		136,381	95
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	34,154	2,986,229		2,986,229	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		19,926		19,926	190
192 PHYSICIANS' PRIVATE OFFICES		69,020		69,020	192
194 OCCUPATIONAL HEALTH		90,087		90,087	194
194.01 PAIN CLINIC		1,590		1,590	194.01
194.02 OAK POINTE		11,069		11,069	194.02
194.03 FOUNDATION		1,235		1,235	194.03
194.04 COMMUNITY & VOLUNTEER SERVICES		13,889		13,889	194.04
194.05 VACANT SPACE		9,656		9,656	194.05
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	34,154	3,202,701		3,202,701	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	CAP RELATE COSTS SNF SQUARE FEET	EMPLOYEE BENEFITS GROSS SALARIES	RECON-CILIATION	
	1	2	2.01	4	5A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	116,963					1
2 CAP REL COSTS-MVBLE EQUIP		116,963				2
2.01 SNF CAPITAL			26,287			2.01
4 EMPLOYEE BENEFITS	1,055	1,055		15,542,306		4
5 ADMINISTRATIVE & GENERAL	13,412	13,412		3,438,429	-7,437,410	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	16,561	16,561		228,265		7
8 LAUNDRY & LINEN SERVICE	1,765	1,765		8,180		8
9 HOUSEKEEPING	558	558		175,834		9
10 DIETARY	2,749	2,749		108,632		10
11 CAFETERIA	1,856	1,856		213,823		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	533	533		34,086		13
14 CENTRAL SERVICES & SUPPLY	2,698	2,698		188,746		14
15 PHARMACY	1,402	1,402		492,209		15
16 MEDICAL RECORDS & LIBRARY	763	763		278,479		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCS-SALARY & FRINGES APPRVD						21
22 I&R SRVCS-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	28,962	28,962		1,824,239		30
43 NURSERY	190	190		156,620		43
44 SKILLED NURSING FACILITY			25,195	2,282,972		44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	7,074	7,074		974,719		50
52 DELIVERY ROOM & LABOR ROOM	1,141	1,141		429,983		52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	8,260	8,260		1,052,792		54
60 LABORATORY	3,394	3,394				60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	1,183	1,183		415,258		65
66 PHYSICAL THERAPY	5,757	5,757	1,092	356,146		66
67 OCCUPATIONAL THERAPY				229,314		67
68 SPEECH PATHOLOGY				65,007		68
69 ELECTROCARDIOLOGY	1,401	1,401				69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	1,029	1,029		55,145		90
91 EMERGENCY	7,415	7,415		1,170,967		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	3,533	3,533		1,009,738		95
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	112,691	112,691	26,287	15,189,583	-7,437,410	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	648	648				190
192 PHYSICIANS' PRIVATE OFFICES				213		192
194 OCCUPATIONAL HEALTH	2,909	2,909				194
194.01 PAIN CLINIC				15,983		194.01
194.02 OAK POINTE				310,620		194.02
194.03 FOUNDATION						194.03
194.04 COMMUNITY & VOLUNTEER SERVICES	401	401		25,907		194.04
194.05 VACANT SPACE	314	314				194.05
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	939,347	2,065,412	197,942	3,624,982		202
203 UNIT COST MULT-WS B PT I	8.031147	17.658678	7.530034	0.233233		203
204 COST TO BE ALLOC PER B PT II				27,103		204
205 UNIT COST MULT-WS B PT II				0.001744		205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL ACCUM COST 5	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 8	HOUSE- KEEPING SQUARE FEET 9	DIETARY MEALS SERVED 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 SNF CAPITAL						2.01
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	25,549,439					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	1,621,016	100,871				7
8 LAUNDRY & LINEN SERVICE	169,146	1,765	205,923			8
9 HOUSEKEEPING	366,076	558		83,612		9
10 DIETARY	220,704	2,749	452	2,749	16,519	10
11 CAFETERIA	377,181	1,856		1,856		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	55,729	533		533		13
14 CENTRAL SERVICES & SUPPLY	348,352	2,698		2,698		14
15 PHARMACY	779,627	1,402		1,402		15
16 MEDICAL RECORDS & LIBRARY	523,724	763		763		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	3,178,750	28,962	65,731	28,962	16,519	30
43 NURSERY	211,662	190	1,348	190		43
44 SKILLED NURSING FACILITY	3,807,954		71,329			44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,735,332	7,074	10,740	7,074		50
52 DELIVERY ROOM & LABOR ROOM	592,955	1,141	886	1,141		52
53 ANESTHESIOLOGY	33,514					53
54 RADIOLOGY-DIAGNOSTIC	1,881,033	8,260	18,323	8,260		54
60 LABORATORY	1,177,760	3,394	112	3,394		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	632,664	1,183	1,362	1,183		65
66 PHYSICAL THERAPY	764,637	5,757	2,404	5,757		66
67 OCCUPATIONAL THERAPY	414,157		1,544			67
68 SPEECH PATHOLOGY	162,049		439			68
69 ELECTROCARDIOLOGY	103,005	1,401		1,401		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	591,959					71
72 IMPL. DEV. CHARGED TO PATIENT	207,087					72
73 DRUGS CHARGED TO PATIENTS	886,279					73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	97,737	1,029		1,029		90
91 EMERGENCY	1,734,146	7,415	26,589	7,415		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	1,553,744	3,533	3,557	3,533		95
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	24,227,979	81,663	204,816	79,340	16,519	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,647	648		648		190
192 PHYSICIANS' PRIVATE OFFICES	252,002	14,655	1,035			192
194 OCCUPATIONAL HEALTH	121,223	2,909		2,909		194
194.01 PAIN CLINIC	20,920	281	72			194.01
194.02 OAK POINTE	694,256					194.02
194.03 FOUNDATION	90,000					194.03
194.04 COMMUNITY & VOLUNTEER SERVICES	118,345	401		401		194.04
194.05 VACANT SPACE	8,067	314		314		194.05
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	7,437,410	2,092,892	255,005	484,217	358,468	202
203 UNIT COST MULT-WS B PT I	0.291099	20.748203	1.238351	5.791238	21.700345	203
204 COST TO BE ALLOC PER B PT II	350,548	448,087	55,518	22,144	86,901	204
205 UNIT COST MULT-WS B PT II	0.013720	4.442179	0.269606	0.264842	5.260670	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAFETERIA FTES	NURSING ADMINIS- TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY TIME SPENT	
	11	13	14	15	16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 SNF CAPITAL						2.01
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	1,375					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	5	170,756				13
14 CENTRAL SERVICES & SUPPLY	47		1,787,153			14
15 PHARMACY	56		100,082	898,973		15
16 MEDICAL RECORDS & LIBRARY	73				10,000	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	347	87,276	93,056	3	2,173	30
43 NURSERY	26	5,488	8,797	1	193	43
44 SKILLED NURSING FACILITY			123,575			44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	169	35,287	271,603	12	662	50
52 DELIVERY ROOM & LABOR ROOM	72		22,750	2		52
53 ANESTHESIOLOGY			1,224			53
54 RADIOLOGY-DIAGNOSTIC	185		71,709	148	1,941	54
60 LABORATORY			380			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	80		69,418	6		65
66 PHYSICAL THERAPY	28		10,573	486	1,100	66
67 OCCUPATIONAL THERAPY	66		6,869	312	475	67
68 SPEECH PATHOLOGY	7		1,926	89	54	68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGED TO PATIENTS			593,485			71
72 IMPL. DEV. CHARGED TO PATIENT			207,087			72
73 DRUGS CHARGED TO PATIENTS				892,975		73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	9		2,619	2		90
91 EMERGENCY	205	42,705	84,989	50	3,402	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES			92,474	4,887		95
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	1,375	170,756	1,762,616	898,973	10,000	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES			3,679			192
194 OCCUPATIONAL HEALTH						194
194.01 PAIN CLINIC			152			194.01
194.02 OAK POINTE			20,074			194.02
194.03 FOUNDATION						194.03
194.04 COMMUNITY & VOLUNTEER SERVICES			632			194.04
194.05 VACANT SPACE						194.05
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	536,236	88,048	539,691	1,095,846	724,899	202
203 UNIT COST MULT-WS B PT I	389.989818	0.515636	0.301984	1.218998	72.489900	203
204 COST TO BE ALLOC PER B PT II	61,966	17,251	89,237	61,691	34,154	204
205 UNIT COST MULT-WS B PT II	45.066182	0.101027	0.049932	0.068624	3.415400	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION

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

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	5,678,538		5,678,538		5,678,538	30
43 NURSERY	309,607		309,607		309,607	43
44 SKILLED NURSING FACILITY	5,042,084		5,042,084		5,042,084	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,655,651		2,655,651		2,655,651	50
52 DELIVERY ROOM & LABOR ROOM	831,894		831,894		831,894	52
53 ANESTHESIOLOGY	43,640		43,640	7,587	51,227	53
54 RADIOLOGY-DIAGNOSTIC	2,905,192		2,905,192		2,905,192	54
60 LABORATORY	1,610,933		1,610,933		1,610,933	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	902,084		902,084		902,084	65
66 PHYSICAL THERAPY	1,237,430		1,237,430		1,237,430	66
67 OCCUPATIONAL THERAPY	599,256		599,256		599,256	67
68 SPEECH PATHOLOGY	217,099		217,099		217,099	68
69 ELECTROCARDIOLOGY	170,172		170,172		170,172	69
71 MEDICAL SUPPLIES CHRGD TO	943,499		943,499		943,499	71
72 IMPL. DEV. CHARGED TO PATIE	329,907		329,907		329,907	72
73 DRUGS CHARGED TO PATIENTS	2,232,811		2,232,811		2,232,811	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	157,800		157,800		157,800	90
91 EMERGENCY	2,842,975		2,842,975	10,690	2,853,665	91
92 OBSERVATION BEDS	911,206		911,206		911,206	92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	2,138,088		2,138,088		2,138,088	95
200 SUBTOTAL (SEE INSTRUCTIONS)	31,759,866		31,759,866	18,277	31,778,143	200
201 LESS OBSERVATION BEDS	911,206		911,206		911,206	201
202 TOTAL (SEE INSTRUCTIONS)	30,848,660		30,848,660		30,866,937	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	6,096,872		6,096,872			30
43 NURSERY	342,765		342,765			43
44 SKILLED NURSING FACILITY	3,788,559		3,788,559			44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,454,899	7,861,120	10,316,019	0.257430	0.257430	0.257430 50
52 DELIVERY ROOM & LABOR ROOM	766,517	104,814	871,331	0.954739	0.954739	0.954739 52
53 ANESTHESIOLOGY	244,288	573,669	817,957	0.053352	0.053352	0.062628 53
54 RADIOLOGY-DIAGNOSTIC	2,215,779	21,278,828	23,494,607	0.123654	0.123654	0.123654 54
60 LABORATORY	1,691,935	5,895,034	7,586,969	0.212329	0.212329	0.212329 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	920,754	2,244,648	3,165,402	0.284982	0.284982	0.284982 65
66 PHYSICAL THERAPY	462,214	1,370,375	1,832,589	0.675236	0.675236	0.675236 66
67 OCCUPATIONAL THERAPY	328,234	586,796	915,030	0.654903	0.654903	0.654903 67
68 SPEECH PATHOLOGY	164,409	158,195	322,604	0.672958	0.672958	0.672958 68
69 ELECTROCARDIOLOGY	233,784	57,616	291,400	0.583981	0.583981	0.583981 69
71 MEDICAL SUPPLIES CHRGD TO	640,828	1,413,007	2,053,835	0.459384	0.459384	0.459384 71
72 IMPL. DEV. CHARGED TO PATIE	671,918	499,984	1,171,902	0.281514	0.281514	0.281514 72
73 DRUGS CHARGED TO PATIENTS	3,089,914	4,953,856	8,043,770	0.277583	0.277583	0.277583 73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	7,105	71,137	78,242	2.016820	2.016820	2.016820 90
91 EMERGENCY	1,403,047	8,247,908	9,650,955	0.294580	0.294580	0.295687 91
92 OBSERVATION BEDS		1,019,907	1,019,907	0.893421	0.893421	0.893421 92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES		3,654,320	3,654,320	0.585085	0.585085	0.585085 95
200 SUBTOTAL (SEE INSTRUCTIONS)	25,523,821	59,991,214	85,515,035			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	25,523,821	59,991,214	85,515,035			202

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS

WORKSHEET C
 PART II

CHECK APPLICABLE BOX: [] TITLE V [XX] TITLE XIX

COST CENTER DESCRIPTION	TOTAL COST (WKST B, PART I COL. 26) 1	CAPITAL COST (WKST B, PART II COL. 26) 2	OPERATING COST NET OF CAPITAL COST (COL. 1 - COL. 2) 3	CAPITAL REDUCTION 4	
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	2,655,651	270,436	2,385,215	13,522	50
52 DELIVERY ROOM & LABOR ROOM	831,894	48,189	783,705	2,409	52
53 ANESTHESIOLOGY	43,640	521	43,119	26	53
54 RADIOLOGY-DIAGNOSTIC	2,905,192	302,219	2,602,973	15,111	54
60 LABORATORY	1,610,933	119,376	1,491,557	5,969	60
62.30 BLOOD CLOTTING FOR HEMOPHIL					62.30
65 RESPIRATORY THERAPY	902,084	52,801	849,283	2,640	65
66 PHYSICAL THERAPY	1,237,430	200,558	1,036,872	10,028	66
67 OCCUPATIONAL THERAPY	599,256	11,458	587,798	573	67
68 SPEECH PATHOLOGY	217,099	3,055	214,044	153	68
69 ELECTROCARDIOLOGY	170,172	43,999	126,173	2,200	69
71 MEDICAL SUPPLIES CHRGD TO	943,499	37,757	905,742	1,888	71
72 IMPL. DEV. CHARGED TO PATIE	329,907	13,181	316,726	659	72
73 DRUGS CHARGED TO PATIENTS	2,232,811	73,442	2,159,369	3,672	73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	157,800	33,253	124,547	1,663	90
91 EMERGENCY	2,842,975	287,816	2,555,159	14,391	91
92 OBSERVATION BEDS	911,206		911,206		92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES	2,138,088	136,381	2,001,707	6,819	95
200 SUBTOTAL	20,729,637	1,634,442	19,095,195	81,723	200
201 LESS OBSERVATION BEDS	911,206		911,206		201
202 TOTAL	19,818,431	1,634,442	18,183,989	81,723	202

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS

WORKSHEET C
 PART II (CONT)

CHECK APPLICABLE BOX: [] TITLE V [XX] TITLE XIX

COST CENTER DESCRIPTION	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAPITAL AND OPERATING COST REDUCTION 6	TOTAL CHARGES (WKST C, PART I, COL. 8) 7	OUTPATIENT COST TO CHARGE RATIO (COL. 6 ÷ COL. 7) 8	
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	119,261	2,522,868	10,316,019	0.244558	50
52 DELIVERY ROOM & LABOR ROOM	39,185	790,300	871,331	0.907003	52
53 ANESTHESIOLOGY	2,156	41,458	817,957	0.050685	53
54 RADIOLOGY-DIAGNOSTIC	130,149	2,759,932	23,494,607	0.117471	54
60 LABORATORY	74,578	1,530,386	7,586,969	0.201712	60
62.30 BLOOD CLOTTING FOR HEMOPHIL					62.30
65 RESPIRATORY THERAPY	42,464	856,980	3,165,402	0.270733	65
66 PHYSICAL THERAPY	51,844	1,175,558	1,832,589	0.641474	66
67 OCCUPATIONAL THERAPY	29,390	569,293	915,030	0.622158	67
68 SPEECH PATHOLOGY	10,702	206,244	322,604	0.639310	68
69 ELECTROCARDIOLOGY	6,309	161,663	291,400	0.554780	69
71 MEDICAL SUPPLIES CHRGD TO	45,287	896,324	2,053,835	0.436415	71
72 IMPL. DEV. CHARGED TO PATIE	15,836	313,412	1,171,902	0.267439	72
73 DRUGS CHARGED TO PATIENTS	107,968	2,121,171	8,043,770	0.263704	73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	6,227	149,910	78,242	1.915979	90
91 EMERGENCY	127,758	2,700,826	9,650,955	0.279851	91
92 OBSERVATION BEDS	45,560	865,646	1,019,907	0.848750	92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES	100,085	2,031,184	3,654,320	0.555831	95
200 TOTAL (SUM OF LINES 118-199)					200
200 SUBTOTAL	954,759	19,693,155	75,286,839		200
201 LESS OBSERVATION BEDS	45,560	865,646	1,019,907		201
202 TOTAL	909,199	18,827,509	74,266,932		202

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
 PERIOD FROM 01/01/2011 TO 12/31/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST	REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT (COL.1 MINUS COL.2)	(COL.1 MINUS COL.2)	(COL.3 + COL.4)	PGM DAYS	(COL.5 x COL.6)	
	1	2	3	5	6	7	
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS	1,068,288		1,068,288	5,160	207.03	1,384	286,530 30
31 INTENSIVE CARE UNIT							31
32 CORONARY CARE UNIT							32
33 BURN INTENSIVE CARE UNIT							33
34 SURGICAL INTENSIVE CARE UNIT							34
35 OTHER SPECIAL CARE (SPECIFY)							35
40 SUBPROVIDER - IPF							40
41 SUBPROVIDER - IRF							41
42 SUBPROVIDER I							42
43 NURSERY	12,139		12,139	404	30.05		43
44 SKILLED NURSING FACILITY	271,360		271,360	19,306	14.06	1,509	21,217 44
45 NURSING FACILITY							45
200 TOTAL (LINES 30-199)	1,351,787		1,351,787	24,870		2,893	307,747 200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

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

COST CENTER DESCRIPTION	CAP-REL	TOTAL	RATIO OF	INPATIENT	CAPITAL	
	COST	CHARGES	COST TO			
	(FROM WKST	(FROM WKST	CHARGES	PROGRAM	(COL. 3 x	
	B, PT. II,	C, PT. I,	(COL.1 +	CHARGES	COL.4)	
	COL. 26)	COL. 8)	COL.2)			
	1	2	3	4	5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	270,436	10,316,019	0.026215	450,623	11,813	50
52 DELIVERY ROOM & LABOR ROOM	48,189	871,331	0.055305			52
53 ANESTHESIOLOGY	521	817,957	0.000637	46,082	29	53
54 RADIOLOGY-DIAGNOSTIC	302,219	23,494,607	0.012863	840,934	10,817	54
60 LABORATORY	119,376	7,586,969	0.015734	546,148	8,593	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY	52,801	3,165,402	0.016681	393,444	6,563	65
66 PHYSICAL THERAPY	200,558	1,832,589	0.109440	50,535	5,531	66
67 OCCUPATIONAL THERAPY	11,458	915,030	0.012522	14,739	185	67
68 SPEECH PATHOLOGY	3,055	322,604	0.009470	4,900	46	68
69 ELECTROCARDIOLOGY	43,999	291,400	0.150992	105,343	15,906	69
71 MEDICAL SUPPLIES CHRGD TO PA	37,757	2,053,835	0.018384	94,349	1,735	71
72 IMPL. DEV. CHARGED TO PATIENT	13,181	1,171,902	0.011248	166,292	1,870	72
73 DRUGS CHARGED TO PATIENTS	73,442	8,043,770	0.009130	907,311	8,284	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	33,253	78,242	0.425002	2,111	897	90
91 EMERGENCY	287,816	9,650,955	0.029823	484,051	14,436	91
92 OBSERVATION BEDS	171,422	1,019,907	0.168076			92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES						95
200 TOTAL (SUM OF LINES 50-199)	1,669,483	71,632,519	71,632,519	4,106,862	86,705	200

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

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

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	5,160		1,384		30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY	404				43
44 SKILLED NURSING FACILITY	19,306		1,509		44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	24,870		2,893		200

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

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

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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[] TITLE V	[XX] HOSPITAL (15-0101)	[] SUB (OTHER)	[] ICF/MR	[XX] PPS		
APPLICABLE	[XX] TITLE XVIII-PT A	[] IPF	[] SNF		[] TEFRA		
BOXES	[] TITLE XIX	[] IRF	[] NF				
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	10,316,019			450,623		1,088,181	50
52 DELIVERY ROOM & LABOR ROOM	871,331						52
53 ANESTHESIOLOGY	817,957			46,082		99,551	53
54 RADIOLOGY-DIAGNOSTIC	23,494,607			840,934		3,844,667	54
60 LABORATORY	7,586,969			546,148		140,463	60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	3,165,402			393,444		524,188	65
66 PHYSICAL THERAPY	1,832,589			50,535			66
67 OCCUPATIONAL THERAPY	915,030			14,739			67
68 SPEECH PATHOLOGY	322,604			4,900			68
69 ELECTROCARDIOLOGY	291,400			105,343		20,459	69
71 MEDICAL SUPPLIES CHRGD TO P	2,053,835			94,349		144,429	71
72 IMPL. DEV. CHARGED TO PATIEN	1,171,902			166,292		52,544	72
73 DRUGS CHARGED TO PATIENTS	8,043,770			907,311		1,184,558	73
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	78,242			2,111		18,409	90
91 EMERGENCY	9,650,955			484,051		1,466,622	91
92 OBSERVATION BEDS	1,019,907					261,547	92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES							95
200 TOTAL (SUM OF LINES 50-199)	71,632,519			4,106,862		8,845,618	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

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

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO CHARGE FROM WKST C, PT I, COL. 9 1	RATIO PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCS NOT SUBJECT TO DED & COINS 7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.257430	1,088,181			280,130		50
52 DELIVERY ROOM & LABOR ROOM	0.954739						52
53 ANESTHESIOLOGY	0.053352	99,551			5,311		53
54 RADIOLOGY-DIAGNOSTIC	0.123654	3,844,667			475,408		54
60 LABORATORY	0.212329	140,463			29,824		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.284982	524,188			149,384		65
66 PHYSICAL THERAPY	0.675236						66
67 OCCUPATIONAL THERAPY	0.654903						67
68 SPEECH PATHOLOGY	0.672958						68
69 ELECTROCARDIOLOGY	0.583981	20,459			11,948		69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.459384	144,429			66,348		71
72 IMPL. DEV. CHARGED TO PATIENT	0.281514	52,544			14,792		72
73 DRUGS CHARGED TO PATIENTS	0.277583	1,184,558			328,813		73
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	2.016820	18,409			37,128		90
91 EMERGENCY	0.294580	1,466,622			432,038		91
92 OBSERVATION BEDS	0.893421	261,547			233,672		92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES	0.585085						95
200 SUBTOTAL (SEE INSTRUCTIONS)		8,845,618			2,064,796		200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)		8,845,618			2,064,796		202

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

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

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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[] TITLE V	[] HOSPITAL	[] SUB (OTHER)	[] ICF/MR	[XX] PPS
APPLICABLE	[XX] TITLE XVIII-PT A	[] IPF	[XX] SNF (15-5128)		[] TEFRA
BOXES	[] TITLE XIX	[] IRF	[] NF		
COST CENTER DESCRIPTION	TOTAL	RATIO OF	O/P RATIO	INPAT PGM	O/P PGM
	CHARGES	COST TO	OF COST TO	PASS-THRU	PASS-THRU
	(FROM WKST	CHARGES	CHARGES	COSTS	COSTS
	C, PT. I,	(COL. 5 +	(COL. 6 +	INPAT	(COL. 9 x
	COL. 8)	COL. 7)	COL. 7)	PGM	COL. 10)
	7	8	9	CHARGES	COL. 12)
				10	12
				11	13
ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	10,316,019			50
52	DELIVERY ROOM & LABOR ROOM	871,331			52
53	ANESTHESIOLOGY	817,957			53
54	RADIOLOGY-DIAGNOSTIC	23,494,607		1,360	54
60	LABORATORY	7,586,969		2,936	60
62.30	BLOOD CLOTTING FOR HEMOPHILI				62.30
65	RESPIRATORY THERAPY	3,165,402			65
66	PHYSICAL THERAPY	1,832,589		108,375	66
67	OCCUPATIONAL THERAPY	915,030		104,010	67
68	SPEECH PATHOLOGY	322,604		58,800	68
69	ELECTROCARDIOLOGY	291,400			69
71	MEDICAL SUPPLIES CHRGED TO P	2,053,835		125	71
72	IMPL. DEV. CHARGED TO PATIEN	1,171,902			72
73	DRUGS CHARGED TO PATIENTS	8,043,770		71,661	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS					
90	CLINIC	78,242			90
91	EMERGENCY	9,650,955			91
92	OBSERVATION BEDS	1,019,907			92
OTHER REIMBURSABLE COST CENTERS					
95	AMBULANCE SERVICES				95
200	TOTAL (SUM OF LINES 50-199)	71,632,519		347,267	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

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

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCS NOT SUBJECT TO	COST SERVICES	COST SVCS NOT SUBJECT TO	
	CHARGE RATIO FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.257430						50
52 DELIVERY ROOM & LABOR ROOM	0.954739						52
53 ANESTHESIOLOGY	0.053352						53
54 RADIOLOGY-DIAGNOSTIC	0.123654						54
60 LABORATORY	0.212329						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.284982						65
66 PHYSICAL THERAPY	0.675236						66
67 OCCUPATIONAL THERAPY	0.654903						67
68 SPEECH PATHOLOGY	0.672958						68
69 ELECTROCARDIOLOGY	0.583981						69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.459384						71
72 IMPL. DEV. CHARGED TO PATIENT	0.281514						72
73 DRUGS CHARGED TO PATIENTS	0.277583						73
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	2.016820						90
91 EMERGENCY	0.294580						91
92 OBSERVATION BEDS	0.893421						92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES	0.585085						95
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
 05/31/2012 09:57

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED	TOTAL PATIENT DAYS	PER DIEM (COL. 3 + COL. 4)	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	CAP-REL COST (COL. 1 MINUS COL. 2)				(COL. 5 x COL. 6)	
	1	2	3	4	5	6	7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	1,068,288		1,068,288	5,160	207.03	166	34,367	30
31 INTENSIVE CARE UNIT								31
32 CORONARY CARE UNIT								32
33 BURN INTENSIVE CARE UNIT								33
34 SURGICAL INTENSIVE CARE UNIT								34
35 OTHER SPECIAL CARE (SPECIFY)								35
40 SUBPROVIDER - IPF								40
41 SUBPROVIDER - IRF								41
42 SUBPROVIDER I								42
43 NURSERY	12,139		12,139	404	30.05	44	1,322	43
44 SKILLED NURSING FACILITY	271,360		271,360	19,306	14.06	10,675	150,091	44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	1,351,787		1,351,787	24,870		10,885	185,780	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [] TITLE XVIII-PT A [XX] TITLE XIX	[XX] HOSPITAL (15-0101) [] IPF [] IRF	[] SUB (OTHER)	[XX] PPS [] TEFRA [] OTHER			
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5		
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	270,436	10,316,019	0.026215	124,022	3,251	50
52	DELIVERY ROOM & LABOR ROOM	48,189	871,331	0.055305	53,743	2,972	52
53	ANESTHESIOLOGY	521	817,957	0.000637	12,293	8	53
54	RADIOLOGY-DIAGNOSTIC	302,219	23,494,607	0.012863	86,148	1,108	54
60	LABORATORY	119,376	7,586,969	0.015734	83,535	1,314	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
65	RESPIRATORY THERAPY	52,801	3,165,402	0.016681	37,408	624	65
66	PHYSICAL THERAPY	200,558	1,832,589	0.109440	3,425	375	66
67	OCCUPATIONAL THERAPY	11,458	915,030	0.012522	561	7	67
68	SPEECH PATHOLOGY	3,055	322,604	0.009470			68
69	ELECTROCARDIOLOGY	43,999	291,400	0.150992	8,481	1,281	69
71	MEDICAL SUPPLIES CHRGD TO PA	37,757	2,053,835	0.018384	35,863	659	71
72	IMPL. DEV. CHARGED TO PATIENT	13,181	1,171,902	0.011248	39,843	448	72
73	DRUGS CHARGED TO PATIENTS	73,442	8,043,770	0.009130	206,986	1,890	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	33,253	78,242	0.425002	206	88	90
91	EMERGENCY	287,816	9,650,955	0.029823	48,504	1,447	91
92	OBSERVATION BEDS	171,422	1,019,907	0.168076			92
OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES						95
200	TOTAL (SUM OF LINES 50-199)	1,669,483	71,632,519	71,632,519	741,018	15,472	200

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

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

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
 05/31/2012 09:57

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	5,160		166		30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY	404		44		43
44 SKILLED NURSING FACILITY	19,306		10,675		44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	24,870		10,885		200

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
 05/31/2012 09:57

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

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

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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

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

COST CENTER DESCRIPTION	TOTAL	RATIO OF	O/P RATIO	INPAT PGM	O/P PGM	O/P PGM
	CHARGES	COST TO	OF COST TO			
	(FROM WKST	CHARGES	CHARGES	INPAT	PASS-THRU	PASS-THRU
	C, PT. I,	(COL. 5 +	(COL. 6 +	PGM	(COL. 8 x	(COL. 9 x
	COL. 8)	COL. 7)	COL. 7)	CHARGES	COL. 10)	COL. 12)
	7	8	9	10	11	12
						13
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	10,316,019			124,022		50
52 DELIVERY ROOM & LABOR ROOM	871,331			53,743		52
53 ANESTHESIOLOGY	817,957			12,293		53
54 RADIOLOGY-DIAGNOSTIC	23,494,607			86,148		54
60 LABORATORY	7,586,969			83,535		60
62.30 BLOOD CLOTTING FOR HEMOPHILI						62.30
65 RESPIRATORY THERAPY	3,165,402			37,408		65
66 PHYSICAL THERAPY	1,832,589			3,425		66
67 OCCUPATIONAL THERAPY	915,030			561		67
68 SPEECH PATHOLOGY	322,604					68
69 ELECTROCARDIOLOGY	291,400			8,481		69
71 MEDICAL SUPPLIES CHRGED TO P	2,053,835			35,863		71
72 IMPL. DEV. CHARGED TO PATIEN	1,171,902			39,843		72
73 DRUGS CHARGED TO PATIENTS	8,043,770			206,986		73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	78,242			206		90
91 EMERGENCY	9,650,955			48,504		91
92 OBSERVATION BEDS	1,019,907					92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	3,654,320					95
200 TOTAL (SUM OF LINES 50-199)	71,632,519			741,018		200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

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

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO CHARGE RATIO FROM WKST C, PT II, COL. 8 1	PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCES NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCES NOT SUBJECT TO DED & COINS 7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.244558		199,852			48,875	50
52 DELIVERY ROOM & LABOR ROOM	0.907003		4,155			3,769	52
53 ANESTHESIOLOGY	0.050685		38,079			1,930	53
54 RADIOLOGY-DIAGNOSTIC	0.117471		868,396			102,011	54
60 LABORATORY	0.201712		244,448			49,308	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.270733		24,365			6,596	65
66 PHYSICAL THERAPY	0.641474		35,788			22,957	66
67 OCCUPATIONAL THERAPY	0.622158		15,221			9,470	67
68 SPEECH PATHOLOGY	0.639310		3,857			2,466	68
69 ELECTROCARDIOLOGY	0.554780		35,203			19,530	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.436415		24,715			10,786	71
72 IMPL. DEV. CHARGED TO PATIENT	0.267439		26,189			7,004	72
73 DRUGS CHARGED TO PATIENTS	0.263704		141,547			37,327	73
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	1.915979		2,652			5,081	90
91 EMERGENCY	0.279851		489,549			137,001	91
92 OBSERVATION BEDS	0.848750		54,765			46,482	92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES	0.555831		192,659			107,086	95
200 SUBTOTAL (SEE INSTRUCTIONS)			2,401,440			617,679	200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)			2,401,440			617,679	202

COMPUTATION OF INPATIENT OPERATING COST

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	5,160	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	5,160	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	5,160	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,384	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	5,678,538	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5,678,538	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	6,096,872	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	6,096,872	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.931385	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,181.56	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	5,678,538	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,100.49 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 1,523,078 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 1,523,078 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
42 NURSERY (TITLES V AND XIX ONLY)					42

INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS
 43 INTENSIVE CARE UNIT 43
 44 CORONARY CARE UNIT 44
 45 BURN INTENSIVE CARE UNIT 45
 46 SURGICAL INTENSIVE CARE UNIT 46
 47 OTHER SPECIAL CARE (SPECIFY) 47
 48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200) 1,048,949 48
 49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS) 2,572,027 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 286,530 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 86,705 51
 52 TOTAL PROGRAM EXCLUDABLE COST 373,235 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 2,198,792 53

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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 828 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 1,100.49 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 911,206 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) 5
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST					(SEE INSTR.)
90 CAPITAL-RELATED COST	1,068,288	5,678,538	0.188127	911,206	171,422 90
91 NURSING SCHOOL COST					91
92 ALLIED HEALTH COST					92
93 ALL OTHER MEDICAL EDUCATION					93

COMPUTATION OF INPATIENT OPERATING COST

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	19,306	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	19,306	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	19,306	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,509	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	5,042,084	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5,042,084	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	5,042,084	37

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
PERIOD FROM 01/01/2011 TO 12/31/2011

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VERSION: 2011.10
05/31/2012 09:57

WORKSHEET D-1
PARTS III & IV

COMPUTATION OF INPATIENT OPERATING COST

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

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

70	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COSTS (LINE 37)	5,042,084	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (LINE 70 ÷ LINE 2)	261.17	71
72	PROGRAM ROUTINE SERVICE COST (LINE 9 x LINE 71)	394,106	72
73	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM (LINE 14 x LINE 35)		73
74	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS (LINE 72 + LINE 73)	394,106	74
75	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS (FROM WKST B, PART II, COL. 26, LINE 45)		75
76	PER DIEM CAPITAL-RELATED COSTS (LINE 75 ÷ LINE 2)		76
77	PROGRAM CAPITAL-RELATED COSTS (LINE 9 x LINE 76)		77
78	INPATIENT ROUTINE SERVICE COST (LINE 74 MINUS LINE 77)		78
79	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS (FROM PROVIDER RECORDS)		79
80	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION (LINE 78 MINUS LINE 79)		80
81	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		81
82	INPATIENT ROUTINE SERVICE COST LIMITATION (LINE 9 x LINE 81)		82
83	REASONABLE INPATIENT ROUTINE SERVICE COSTS (SEE INSTRUCTIONS)	394,106	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (SEE INSTRUCTIONS)	201,605	84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (SEE INSTRUCTIONS)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (SUM OF LINES 83 THROUGH 85)	595,711	86

COMPUTATION OF INPATIENT OPERATING COST

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	5,160	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	5,160	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	5,160	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	166	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	404	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	44	16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	5,678,538	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5,678,538	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	6,096,872	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	6,096,872	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.931385	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,181.56	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	5,678,538	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,100.49 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 182,681 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 182,681 41

	TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (COL. 1 ÷ COL. 2)	PROGRAM DAYS	PROGRAM COST (COL. 3 x COL. 4)
	1	2	3	4	5
42 NURSERY (TITLES V AND XIX ONLY)	309,607	404	766.35	44	33,719 42

INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS
 43 INTENSIVE CARE UNIT 43
 44 CORONARY CARE UNIT 44
 45 BURN INTENSIVE CARE UNIT 45
 46 SURGICAL INTENSIVE CARE UNIT 46
 47 OTHER SPECIAL CARE (SPECIFY) 47
 48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200) 230,596 48
 49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS) 446,996 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 35,689 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 15,472 51
 52 TOTAL PROGRAM EXCLUDABLE COST 51,161 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 395,835 53

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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 828 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

	ROUTINE COST (FROM LINE 27)	COL. 1 ÷ COL. 2	TOTAL OBS. BED COST (FROM LINE 89)	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.)
	1	2	3	4
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST				
90 CAPITAL-RELATED COST				90
91 NURSING SCHOOL COST				91
92 ALLIED HEALTH COST				92
93 ALL OTHER MEDICAL EDUCATION				93

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

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

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		2,019,742		30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.257430	450,623	116,004	50
52 DELIVERY ROOM & LABOR ROOM	0.954739			52
53 ANESTHESIOLOGY	0.062628	46,082	2,886	53
54 RADIOLOGY-DIAGNOSTIC	0.123654	840,934	103,985	54
60 LABORATORY	0.212329	546,148	115,963	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.284982	393,444	112,124	65
66 PHYSICAL THERAPY	0.675236	50,535	34,123	66
67 OCCUPATIONAL THERAPY	0.654903	14,739	9,653	67
68 SPEECH PATHOLOGY	0.672958	4,900	3,297	68
69 ELECTROCARDIOLOGY	0.583981	105,343	61,518	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.459384	94,349	43,342	71
72 IMPL. DEV. CHARGED TO PATIENT	0.281514	166,292	46,814	72
73 DRUGS CHARGED TO PATIENTS	0.277583	907,311	251,854	73
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	2.016820	2,111	4,258	90
91 EMERGENCY	0.295687	484,051	143,128	91
92 OBSERVATION BEDS	0.893421			92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		4,106,862	1,048,949	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		4,106,862		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

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

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS					30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.257430				50
52 DELIVERY ROOM & LABOR ROOM	0.954739				52
53 ANESTHESIOLOGY	0.053352				53
54 RADIOLOGY-DIAGNOSTIC	0.123654	1,360		168	54
60 LABORATORY	0.212329	2,936		623	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.284982				65
66 PHYSICAL THERAPY	0.675236	108,375		73,179	66
67 OCCUPATIONAL THERAPY	0.654903	104,010		68,116	67
68 SPEECH PATHOLOGY	0.672958	58,800		39,570	68
69 ELECTROCARDIOLOGY	0.583981				69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.459384	125		57	71
72 IMPL. DEV. CHARGED TO PATIENT	0.281514				72
73 DRUGS CHARGED TO PATIENTS	0.277583	71,661		19,892	73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	2.016820				90
91 EMERGENCY	0.294580				91
92 OBSERVATION BEDS	0.893421				92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES					95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		347,267		201,605	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		347,267			202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

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

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		266,304		30
43 NURSERY		22,777		43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.257430	124,022	31,927	50
52 DELIVERY ROOM & LABOR ROOM	0.954739	53,743	51,311	52
53 ANESTHESIOLOGY	0.062628	12,293	770	53
54 RADIOLOGY-DIAGNOSTIC	0.123654	86,148	10,653	54
60 LABORATORY	0.212329	83,535	17,737	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.284982	37,408	10,661	65
66 PHYSICAL THERAPY	0.675236	3,425	2,313	66
67 OCCUPATIONAL THERAPY	0.654903	561	367	67
68 SPEECH PATHOLOGY	0.672958			68
69 ELECTROCARDIOLOGY	0.583981	8,481	4,953	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.459384	35,863	16,475	71
72 IMPL. DEV. CHARGED TO PATIENT	0.281514	39,843	11,216	72
73 DRUGS CHARGED TO PATIENTS	0.277583	206,986	57,456	73
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	2.016820	206	415	90
91 EMERGENCY	0.295687	48,504	14,342	91
92 OBSERVATION BEDS	0.893421			92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		741,018	230,596	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		741,018		202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	1,861,638	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	5,461	2
3	MANAGED CARE SIMULATED PAYMENTS		3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	35.73	4
INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS			
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)		5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)		6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(1)		7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS.		7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)		9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS		10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)		12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR		13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO		14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3		15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT		18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)		19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)		20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)		21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)		22
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON			
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)		29
DISPROPORTIONATE SHARE ADJUSTMENT			
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.0118	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)	0.1716	31
32	SUM OF LINES 30 AND 31	0.1834	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0467	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	86,938	34
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES			
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		41
42	DIVIDE LINE 41 BY LINE 40 (IF LESS THAN 10%, YOU DO NOT QUALIFY FOR ADJUSTMENT)		42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (LINE 43 DIVIDED BY LINE 41 DIVIDED BY 7 DAYS)		44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (SEE INSTRUCTIONS)		45
46	TOTAL ADDITIONAL PAYMENT (LINE 45 TIMES LINE 44 TIMES LINE 41)		46
47	SUBTOTAL (SEE INSTRUCTIONS)	1,954,037	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)		48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	1,954,037	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	152,364	50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A

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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)		52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)		58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	2,106,401	59
60	PRIMARY PAYER PAYMENTS	3,237	60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	2,103,164	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	328,184	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES		63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	74,493	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	52,145	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	64,343	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	1,827,125	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		70
70.96	LOW VOLUME PAYMENT ADJUSTMENT - 1	193,052	70.96
71	AMOUNT DUE PROVIDER (LINE 67 MINUS LINE 68 PLUS/MINUS LINES 69 AND 70)	2,020,177	71
72	INTERIM PAYMENTS	2,018,335	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	1,842	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	136,458	75
TO BE COMPLETED BY CONTRACTOR			
90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2		90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2		91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (SEE INSTRUCTIONS)		95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (SEE INSTRUCTIONS)		96

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

CHECK APPLICABLE BOX: HOSPITAL IPF IRF
 SUB (OTHER) SNF (15-5128)

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)		1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (SEE INSTRUCTIONS)		2
3	PPS PAYMENTS		3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)		11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES		12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)		14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)	1.000000	17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))		19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS))		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)		21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 §2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)		26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)		27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)		30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)		32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	COMPOSITE RATE ESRD (FROM WKST I-5, LINE 11)		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)		37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)		40
41	INTERIM PAYMENTS		41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)		43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

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

INPATIENT
 PART A

PART B

DESCRIPTION	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4		
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		2,017,422		1,309,946	1	
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		25,332	2	
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 08/25/2011	913		NONE	3.01	
	.02				3.02	
	PROGRAM .03				3.03	
	TO .04				3.04	
	PROVIDER .05				3.05	
	.06				3.06	
	.07				3.07	
	.08				3.08	
	.09				3.09	
	.50	NONE		NONE	3.50	
	.51				3.51	
	PROVIDER .52				3.52	
	TO .53				3.53	
	PROGRAM .54				3.54	
	.55				3.55	
	.56				3.56	
	.57				3.57	
	.58				3.58	
	.59				3.59	
	.99	913			3.99	
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)						
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		2,018,335		1,335,278	4	

TO BE COMPLETED BY CONTRACTOR

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

8 NAME OF CONTRACTOR: _____ CONTRACTOR NUMBER: _____ DATE: _____

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

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

INPATIENT
 PART A

PART B

DESCRIPTION	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		596,863		1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 PROGRAM .03 TO .04 PROVIDER .05 .06 .07 .08 .09 .50 .51 PROVIDER .52 TO .53 PROGRAM .54 .55 .56 .57 .58 .59 .99	NONE	NONE	3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)				
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		596,863		4

TO BE COMPLETED BY CONTRACTOR

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

8 NAME OF CONTRACTOR: _____ CONTRACTOR NUMBER: _____ DATE: _____

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
05/31/2012 09:57

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK
APPLICABLE BOX

HOSPITAL (15-0101) CAH

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			
1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	1,368	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	1,384	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	1,318	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	4,332	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	85,515,035	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	2,098,981	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)		8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)		32

PROVIDER CCN: 15-0101 WHITLEY MEMORIAL HOSPITAL
PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
05/31/2012 09:57

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART VI

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

1	PROSPECTIVE PAYMENT AMOUNT		
2	RESOURCE UTILIZATION GROUP (RUGS) PAYMENT	694,640	1
3	ROUTINE SERVICE OTHER PASS THROUGH COSTS		2
4	ANCILLARY SERVICE OTHER PASS THROUGH COSTS		3
5	SUBTOTAL (SUM OF LINES 1-3)	694,640	4
6	COMPUTATION OF NET COST OF COVERED SERVICES		
7	MEDICAL AND OTHER SERVICES		5
8	DEDUCTIBLES		6
9	COINSURANCE	97,777	7
10	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		8
11	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		9
12	ALLOWABLE REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		10
13	UTILIZATION REVIEW		11
14	SUBTOTAL (SUM OF LINES 4, 5 MINUS 6 & 7 PLUS 10 AND 11) (SEE INSTRUCTIONS)	596,863	12
15	INPATIENT PRIMARY PAYER PAYMENTS		13
16	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		14
17	SUBTOTAL (LINE 12 MINUS 13 ± LINE 14)	596,863	15
18	INTERIM PAYMENTS	596,863	16
19	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		17
20	BALANCE DUE PROVIDER/PROGRAM (LINE 15 MINUS THE SUM OF LINES 16 AND 17)		18
21	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		19

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART VII

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

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

COMPUTATION OF NET COST OF COVERED SERVICES		
1	INPATIENT HOSPITAL SNF/NF SERVICES	1
2	MEDICAL AND OTHER SERVICES	617,679 2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)	3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	617,679 4
5	INPATIENT PRIMARY PAYER PAYMENTS	5
6	OUTPATIENT PRIMARY PAYER PAYMENTS	6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	617,679 7
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
8	ROUTINE SERVICE CHARGES	8
9	ANCILLARY SERVICE CHARGES	3,142,458 9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE	10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION	11
12	TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)	3,142,458 12
CUSTOMARY CHARGES		
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000 15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	3,142,458 16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))	2,524,779 17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))	18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)	19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)	20
21	COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)	617,679 21
PROSPECTIVE PAYMENT AMOUNT		
22	OTHER THAN OUTLIER PAYMENTS	22
23	OUTLIER PAYMENTS	23
24	PROGRAM CAPITAL PAYMENTS	24
25	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)	25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS	26
27	SUBTOTAL (SUM OF LINES 22 THROUGH 26)	27
28	CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)	28
29	SUM OF LINES 27 AND 21	617,679 29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30	EXCESS OF REASONABLE COST (FROM LINE 18)	30
31	SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)	617,679 31
32	DEDUCTIBLES	32
33	COINSURANCE	33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	34
35	UTILIZATION REVIEW	35
36	SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)	617,679 36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	37
38	SUBTOTAL (LINE 36 ± LINE 37)	617,679 38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)	39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)	617,679 40
41	INTERIM PAYMENTS	617,679 41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	43

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	69,498			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	5,889,491			4
5	OTHER RECEIVABLES	76,125			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7	INVENTORY	103,683			7
8	PREPAID EXPENSES	154,346			8
9	OTHER CURRENT ASSETS	39,431			9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	6,332,574			11
FIXED ASSETS					
12	LAND	105,745			12
13	LAND IMPROVEMENTS	304,956			13
14	ACCUMULATED DEPRECIATION	-202,330			14
15	BUILDINGS	3,979,847			15
16	ACCUMULATED DEPRECIATION	-2,963,957			16
17	LEASEHOLD IMPROVEMENTS	48,069			17
18	ACCUMULATED AMORTIZATION	-42,712			18
19	FIXED EQUIPMENT	846,514			19
20	ACCUMULATED DEPRECIATION	-449,903			20
21	AUTOMOBILES AND TRUCKS	212,812			21
22	ACCUMULATED DEPRECIATION	-118,931			22
23	MAJOR MOVABLE EQUIPMENT	14,632,057			23
24	ACCUMULATED DEPRECIATION	-8,095,203			24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS				27
28	ACCUMULATED DEPRECIATION				28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	8,256,964			30
OTHER ASSETS					
31	INVESTMENTS	37,490,981			31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	70,153			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	37,561,134			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	52,150,672			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	805,175			37
38	SALARIES, WAGES & FEES PAYABLE	858,491			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)				40
41	DEFERRED INCOME	137,950			41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS				43
44	OTHER CURRENT LIABILITIES	130,079			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	1,931,695			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE	285,249			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	25,010,127			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	25,295,376			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	27,227,071			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	24,923,601			52
53	SPECIFIC PURPOSE FUND BALANCE				53
54	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				56
57	PLANT FUND BALANCE - INVESTED IN PLANT				57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				58
59	TOTAL FUND BALANCES (SUM OF LINES 52-58)	24,923,601			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	52,150,672			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		46,986,407							1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		3,707,905							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		50,694,312							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5									5
6									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)									10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		50,694,312							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)	21,754,877								12
13 GENERAL FUND BALANCE		4,015,834							13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)		25,770,711							18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		24,923,601							19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	7,495,258		7,495,258	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				6
7 SKILLED NURSING FACILITY	3,788,559		3,788,559	7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	11,283,817		11,283,817	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	11,283,817		11,283,817	18
19 ANCILLARY SERVICES	14,639,524		14,639,524	19
20 OUTPATIENT SERVICES		58,742,274	58,742,274	20
21 RHC				21
22 FQHC				22
23 HOME HEALTH AGENCY		3,654,320	3,654,320	23
25 AMBULANCE				25
26 ASC				26
27 HOSPICE				27
28 OTHER (SPECIFY)				28
TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	25,923,341	62,396,594	88,319,935	

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		37,125,550	29
30 BAD DEBT	3,818,745		30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		3,818,745	36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		40,944,295	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	88,319,935	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	45,657,775	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	42,662,160	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	40,944,295	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	1,717,865	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	1,692,785	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE	8,011	9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	446	13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	113,154	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS	744,430	15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	685,594	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	39,351	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (CLINIC RENTAL)	243,722	24
24.01	OTHER (GAIN ON DISPOSAL OF ASSETS)	-28,912	24.01
24.02	OTHER (COUNTY REIMBURSEMENT OF AMBULANCE S)	235,610	24.02
24.03	OTHER (REVENUE FROM SALE OF SCRAP)	13,786	24.03
24.04	OTHER (MISCELLANEOUS)	574,392	24.04
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	4,322,369	25
26	TOTAL (LINE 5 PLUS LINE 25)	6,040,234	26
27	OTHER EXPENSES (UNREALIZED GAIN (LOSS))	2,332,329	27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	2,332,329	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	3,707,905	29

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT			
1 CAPITAL DRG OTHER THAN OUTLIER		150,293	1
2 CAPITAL DRG OUTLIER PAYMENTS		2,071	2
3 TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		12.16	3
4 NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)			4
5 INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)			5
6 INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)			6
7 PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)			7
8 PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)			8
9 SUM OF LINES 7 AND 8			9
10 ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)			10
11 DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)			11
12 TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)		152,364	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

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

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

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