## WHITLEY MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 05-31-2019 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0101 Worksheet S Peri od. From 01/01/2017 Parts I-III AND SETTLEMENT SUMMARY 12/31/2017 Date/Time Prepared: То 5/29/2018 4:12 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically filed cost report Date: 5/29/2018 Time: 4:12 pm use only Manually submitted cost report 2 [ ]If this is an amended report enter the number of times the provider resubmitted this cost report ]Medicare Utilization. Enter "F" for full or "L" for low. 3 Ο Ē 4 

 [1] Cost Report Status
 6. Date Received:

 (1) As Submitted
 7. Contractor No.

 (2) Settled without Audit
 8. [N] Initial Report for this Provider CCN

 (3) Settled with Audit
 9. [N] Final Report for this Provider CCN

 Contractor 5. use only Δ (3) Settled with Audit 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 OF INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WHITLEY MEMORIAL HOSPITAL (15-0101) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations. ]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature. (Si aned) Officer or Administrator of Provider(s) Title

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	77, 494	2, 176	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	77, 494	2, 176	0	0	200. 00

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

	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DAT	A	Provi dei	- CCN: 1	5-0101	Period: From 01/0	1/2017	Workshe Part I	et S-2	
								1/2017	Date/Ti		
	1.00	2.0	00	3	. 00			4.00	5/29/20	018 4:1	0 pm
	Hospital and Hospital Health Care Cor		00		. 00			4.00			
0	Street: 1260 E STATE ROAD 205	PO Box:									1.
0	City: COLUMBIA CITY	State: II				1	ty: WHITLE				2.
		Component Na		CCN umber	CBSA Number	Provi der Type	- Date Certifie		ent Syst F, O, or		
			NC.		Number	Type			XVIII		1
		1.00	2	2.00	3.00	4.00	5.00	6.00			1
	Hospital and Hospital-Based Componen						1		-		
0		WHITLEY MEMORIAL	15	50101	23060	1	07/01/196	56 N	P	P	3.
0	Subprovider - IPF	HOSPI TAL									4.
0	Subprovider - IRF										5.
0	Subprovider - (Other)										6.
0	Swing Beds - SNF										7.
0	Swing Beds - NF										8.
0	Hospital-Based SNF										9.
00 00	Hospital-Based NF Hospital-Based OLTC										10.   11.
00	Hospi tal -Based HHA										12.
00	Separately Certified ASC										13.
00	Hospi tal -Based Hospi ce										14.
00	Hospital-Based Health Clinic - RHC										15.
00	Hospital-Based Health Clinic - FQHC										16.
00 00	Hospital-Based (CMHC) I Renal Dialysis										17.
	Other										19
							Fro	m:	То	:	
							1. (		2.0		
00	Cost Reporting Period (mm/dd/yyyy)						01/01/		12/31/	/2017	20.
00	Type of Control (see instructions) Inpatient PPS Information						2				21.
00	Does this facility qualify and is it	currently receivi	ing pavmen	ts for (	di sprop	ortionate	Y		N		22.
	share hospital adjustment, in accorda										
	for yes or "N" for no. Is this facili				106(c)	(2) (Pi ckl	e				
~ -	amendment hospital?) In column 2, ent										
01	Did this hospital receive interim und period? Enter in column 1, "Y" for ye						Y		Y		22.
	reporting period occurring prior to (										
	for no for the portion of the cost re										
	(see instructions)		0								
02	Is this a newly merged hospital that						N		N		22.
	determined at cost report settlement or "N" for no, for the portion of the						s				
	in column 2, "Y" for yes or "N" for r						n				
	or after October 1.			0001 10	oor tring	porrodro					
03	Did this hospital receive a geographi								N		22.
	of the OMB standards for delineating										
	in column 1, "Y" for yes or "N" for r prior to October 1. Enter in column 2										
	cost reporting period occurring on or						e				
	hospital contain at least 100 but not						h				
	42 CFR 412.105)? Enter in column 3, '										
00	Which method is used to determine Med							3	N		23.
	1, enter 1 if date of admission, 2 if method of identifying the days in thi	2			0						
	used in the prior cost reporting peri										
			In-State	In-Sta		ut-of	Out-of	Medi ca	aid 0	ther	
			Medi cai d	Medi ca		State	State	HMO da	5	li cai d	
			paid days	eligib			Medicaid		C	lays	
				unpai days	·	d days	eligible unpaid				
		-	1.00	2.00		3.00	4.00	5.00	) 6	o. 00	1
00	If this provider is an IPPS hospital,	enter the	135		796	0	8	0.00	483		24.
	in-state Medicaid paid days in columr	n 1, in-state									
	Medicaid eligible unpaid days in colu										
	out-of-state Medicaid paid days in co										
	out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible but										
	column 5, and other Medicaid days in										
00	If this provider is an IRF, enter the	e in-state	0		О	О	0		o		25.
-	Medicaid paid days in column 1, the i		0			-					
	Medicaid eligible unpaid days in colu										
		2 out of state		1					1		1
	out-of-state Medicaid days in column										
	out-of-state Medicaid days in column Medicaid eligible unpaid days in colu HMO paid and eligible but unpaid days	umn 4, Medicaid									

OSPITAL AND	al Systems WHITLEY HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT		AL HOSPITAL Provider CC		Period: From 01/01/20	17 Part	heet S-2 I	
					To 12/31/20		Time Pre 2018 4:1	
					Urban/Rural	S Date o	of Geogr	
0.00 Enter y	our standard geographic classification (not wa	ne) str	atus at the her	inning of the	1.00	1 2	. 00	26.
cost re 0.00 Enter y	porting period. Enter "1" for urban or "2" for our standard geographic classification (not way ng period. Enter in column 1, "1" for urban or	rural. ge) sta	atus at the end	of the cost		1		20.
.00  If this	he effective date of the geographic reclassifi- is a sole community hospital (SCH), enter the in the cost reporting period.			CH status in		0		35.
					Begi nni ng:		di ng:	
	pplicable beginning and ending dates of SCH st ods in excess of one and enter subsequent date		Subscript line	36 for number	1.00	2	. 00	36
is in e	is a Medicare dependent hospital (MDH), enter ffect in the cost reporting period. hospital a former MDH that is eligible for th				N	0		37
accorda i nstruc	nce with FY 2016 OPPS final rule? Enter "Y" fo tions)	r yes (	or "N" for no.	(see	N			
greater	37 is 1, enter the beginning and ending dates than 1, subscript this line for the number of ubsequent dates.							38
					Y/N 1.00		Y/N . 00	
hospita for yes	is facility qualify for the inpatient hospital Is in accordance with 42 CFR §412.101(b)(2)(i) or "N" for no. Does the facility meet the mil- CFR 412.101(b)(2)(i) or (ii)? Enter in column tions)	or (ii eage re	)? Enter in co equirements in	lumn 1 "Y" accordance	e Y	2	Y	39
0.00 Is this "N" for	hospital subject to the HAC program reduction no in column 1, for discharges prior to Octob olumn 2, for discharges on or after October 1.	er 1. I	Enter "Y" for y	2	N		Ν	40
	Stallin 2, for discharges on or after october 1.	(366 )	histi de ti olisj			V XVII		
	tive Payment System (PPS)-Capital							
with 42 0.00 Is this	is facility qualify and receive Capital paymen CFR Section §412.320? (see instructions) facility eligible for additional payment exce t to 42 CFR §412.348(f)? If yes, complete Wkst	ption 1	for extraordina	ary circumstar	nces	N N N N	N	45
3.00 Is the	a new hospital under 42 CFR §412.300(b) PPS c facility electing full federal capital payment					N N N N	N	47 48
	g Hospitals a hospital involved in training residents in a for no	approve	ed GME programs	? Enter "Y"	for yes	N		56
7.00 If line GME pro is "Y" for yes	56 is yes, is this the first cost reporting p grams trained at this facility? Enter "Y" for did residents start training in the first mont or "N" for no in column 2. If column 2 is "Y mplete Wkst. D, Parts III & IV and D-2, Pt. II	yes o h of th ", com	r "N" for no ir nis cost report plete Worksheet	n column 1. If ing period?	column 1 Enter "Y"	N		57
defi nec	56 is yes, did this facility elect cost reimb in CMS Pub. 15-1, chapter 21, §2148? If yes,	comple <sup>-</sup>	te Wkst. D-5.		as	N		58
0.00 Are cos	ts claimed on line 100 of Worksheet A? If yes	, compl	ete Wkst. D-2,	Pt. I. NAHE 413.85	Worksheet	N Pass-	Through	59
				Y/N	Line #	Qual i f	fication ion Code	
00 1				1.00	2.00	3	. 00	
	claiming nursing and allied health education grams that meet the criteria under §413.85?	see in	structions)	N				60
		Y/N	IME	Direct GME	IME	Dire	ct GME	
		1.00	2.00	3.00	4.00		. 00	
section column	r hospital receive FTE slots under ACA 5503? Enter "Y" for yes or "N" for no in 1. (see instructions)	N			0.	00	0.00	
FTEs fr ending	he average number of unweighted primary care om the hospital's 3 most recent cost reports and submitted before March 23, 2010. (see							61
FTE cou and pri	he current year total unweighted primary care nt (excluding OB/GYN, general surgery FTEs, mary care FTEs added under section 5503 of							61
.03 Enter t	see instructions) he base line FTE count for primary care general surgery residents, which is used for ning compliance with the 75% test. (see							61

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE			AL HOSPITAL Provider C	CN: 15-0101	Peri od:	u of Form CMS-2 Worksheet S-2	
					From 01/01/2017 To 12/31/2017		
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
<ul> <li>61.04 Enter the number of unweighted prisurgery allopathic and/or osteopar current cost reporting period. (see 61.05 Enter the difference between the land/or general surgery FTEs and the second se</li></ul>	hic FTEs in the instructions). paseline primary						61.04
primary care and/or general surger 61.04 minus line 61.03). (see ins 61.06 Enter the amount of ACA §5503 awai used for cap relief and/or FTEs th care or general surgery. (see ins	ructions) d that is being nat are nonprimary						61.06
Care of general surgery. (see this		Pro	gram Name	Program Cod	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	1
61.10 Of the FTEs in line 61.05, special special ty, if any, and the number for each new program. (see instruction column 1, the program name. Enter program code. Enter in column 3, unweighted count. Enter in column FTE unweighted count.	of FTE residents ctions) Enter in in column 2, the che IME FTE				0.00	0.00	61. 10
61.20 Of the FTEs in line 61.05, specify program specialty, if any, and the residents for each expanded progra instructions) Enter in column 1, Enter in column 2, the program coo 3, the IME FTE unweighted count. In the direct GME FTE unweighted count.	e number of FTE am. (see the program name. de. Enter in column Enter in column 4,				0. OC	0.00	61.20
						1.00	
ACA Provisions Affecting the Heal 62.00 Enter the number of FTE residents					riad far which	0.00	62.00
your hospital received HRSA PCRE 1 62.01 Enter the number of FTE residents	funding (see instruction to the transformed set of the transformed from a function of the transformed set of transformed se	ti ons) Teachi	ng Health Cen	ter (THC) int			62.00
during in this cost reporting peri Teaching Hospitals that Claim Res				ns)			-
63.00 Has your facility trained residen	s in nonprovider se	ttings	during this c			N	63.00
"Y" for yes or "N" for no in colu	<u>IN I. IT YES, COMPLE</u>	<u>te line</u>	<u>s 64 througn</u>	Unwei ghted FTEs		Ratio (col. 1/ (col. 1 + col.	
				Nonprovi der Si te	- Hospital	2))	
Spotion EEOA of the ACA Doct Vice	ETE Docidanta in Na	pprovid-	on Sottings	1.00	2.00	3.00	
Section 5504 of the ACA Base Year period that begins on or after Ju				inis base yea	a is your cost r	eporting	
64.00 Enter in column 1, if line 63 is y in the base year period, the number resident FTEs attributable to rota settings. Enter in column 2 the in resident FTEs that trained in your of (column 1 divided by (column 1	ves, or your facilit er of unweighted non ations occurring in number of unweighted hospital. Enter in	y train -primar all non non-pr column	ed residents y care provider imary care 3 the ratio	0.	00 0. 00	0. 000000	64.00
	Program Name		gram Code	Unweighted FTEs Nonprovider Site	FTEsin	Ratio (col. 3/ (col. 3 + col. 4))	
			2.00	3.00			4

		ATA Provider	Fr	riod: om 01/01/2017	Worksheet S-2 Part I	
			To	12/31/2017	Date/Time Pre 5/29/2018 4:1	epared 0 pm
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	1
			FTEs Nonprovider	FTEs in Hospital	(col. 3 + col. 4))	
			Si te	позрі таї	4))	
	1.00	2.00	3.00	4.00	5.00	
5.00 Enter in column 1, if line 63			0.00	0.00	0. 000000	65.0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3						
divided by (column 3 + column 4)). (see instructions)						
		<u> </u>	Unwei ghted	Unwei ghted	Ratio (col. 1/	/
			FTEs	FTEs in	(col. 1 + col.	
			Nonprovider Site	Hospi tal	2))	
			1.00	2.00	3.00	1
Section 5504 of the ACA Current Y	/ear FTE Residents i	n Nonprovider Settin				
.00 Enter in column 1 the number of u FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	ccurring in all nonp nweighted non-prima nl. Enter in column	rovider settings. ry care resident 3 the ratio of	0. 00	0.00	0. 000000	) 66.0
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs	FTEs in	(col. 3 + col.	
			Nonprovider Site	Hospi tal	4))	
.00 Enter in column 1, the program	1.00	2.00		Hospi tal 4.00 0.00	5.00	_
.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00	2.00	Si te 3. 00	4.00	5.00	_
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column	1.00	2.00	Si te 3. 00	4.00	5.00 D 0.000000	_
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	25		Si te 3. 00 0. 00	4.00 0.00 1.0	5.00 0.000000 0.000000 0.0000000	) 67.1
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	≥ <u>S</u> rchiatric Facility (		Si te 3. 00 0. 00	4.00 0.00 1.0	5.00 0.000000 0.000000 0.0000000	67.0
<pre>name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)</pre>	≥S /chiatric Facility ( the facility have a fore November 15, 2 umn 2: Did this fac ≷ 412.424 (d)(1)(iii ate which program y	IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident )(D)? Enter "Y" for	Site 3.00 0.00 1.00	4.00 0.00 0.00 1.0 rovi der? N ne most c. (see ng c.	5.00 0.000000 0.000000 0.0000000	70. (
<pre>name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)</pre>	2S rchiatric Facility ( the facility have a efore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii cate which program y / PPS nabilitation Facilit	IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident )(D)? Enter "Y" for ear began during thi	Site 3.00 0.00 1.00	4.00 0.00 0.00 1.0 rovi der? N ne most c. (see ng c.	5.00         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.0000000         0.000000         0.000000         0.000000         0.000000         0.000000	_

Heal th	Financial Systems WHITLEY MEMORI	AL_HOSPI TAL		In Lie	u of Form CMS	5-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		Period: From 01/01/2017	Worksheet S- Part I	-2
				To 12/31/2017	Date/Time Pr 5/29/2018 4:	
			I.			
	Long Term Care Hospital PPS				1.00	
	Is this a long term care hospital (LTCH)? Enter "Y" for yes				N	80.00
81.00	Is this a LTCH co-located within another hospital for part of	or all of the	cost reporting	g period? Enter	N	81.00
	"Y" for yes and "N" for no. TEFRA Providers					_
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)		2		N	85.00
86.00	Did this facility establish a new Other subprovider (exclude §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	ed unit) under	42 CFR Section	on		86.00
87.00	Is this hospital an extended neoplastic disease care hospita	al classified	under section		N	87.00
	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			V	XI X	
				1.00	2.00	_
	Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospita yes or "N" for no in the applicable column.	al services? E	nter "Y" for	N	Y	90.00
91.00	is this hospital reimbursed for title V and/or XIX through t			Ν	N	91.00
92.00	full or in part? Enter "Y" for yes or "N" for no in the appl Are title XIX NF patients occupying title XVIII SNF beds (du				N	92.00
92.00	instructions) Enter "Y" for yes or "N" for no in the applica				IN	92.00
93.00	Does this facility operate an ICF/IID facility for purposes	of title V an	d XIX? Enter	Ν	N	93.00
94.00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for n	o in the	Ν	N	94.00
05 00	applicable column.					05.00
	If line 94 is "Y", enter the reduction percentage in the app Does title V or XIX reduce operating cost? Enter "Y" for yes			0. 00 N	0. 00 N	95.00 96.00
70.00	applicable column.					/0.00
	If line 96 is "Y", enter the reduction percentage in the app			0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the ir stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f			Y	Y	98.00
	column 1 for title V, and in column 2 for title XIX.	-				
98.01	Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti			Y	Y	98.01
	title XIX.					
98.02	Does title V or XIX follow Medicare (title XVIII) for the ca bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes c			Y	Y	98.02
	for title V, and in column 2 for title XIX.					
98.03	Does title V or XIX follow Medicare (title XVIII) for a crit			N	N	98.03
	reimbursed 101% of inpatient services cost? Enter "Y" for ye for title V, and in column 2 for title XIX.	es or in Tor				
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH			N	N	98.04
	outpatient services cost? Enter "Y" for yes or "N" for no ir in column 2 for title XIX.	n column I tor	title V, and			
98.05	Does title V or XIX follow Medicare (title XVIII) and add ba				Y	98.05
	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c column 2 for title XIX.	column 1 for t	itle V, and in	ר		
98.06	Does title V or XIX follow Medicare (title XVIII) when cost			Y	Y	98.06
	Pts. I through IV? Enter "Y" for yes or "N" for no in columr column 2 for title XIX.	n 1 for title	V, and in			
	Rural Providers					
	Does this hospital qualify as a CAH?	inclucivo mot	had of norman	N		105.00 106.00
108.00	If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)	-The usive met	nou or payment			108.00
107.00	If this facility qualifies as a CAH, is it eligible for cost					107.00
	training programs? Enter "Y" for yes or "N" for no in columr yes, the GME elimination is not made on Wkst. B, Pt. I, col.			t		
	reimbursed. If yes complete Wkst. D-2, Pt. II.		5			
108.00	Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA Tee sche	dule? See 42	N		108.00
		Physi cal	Occupati ona		Respi ratory	/
109 00	If this hospital qualifies as a CAH or a cost provider, are	1.00 N	2.00	3.00	4.00	109.00
	therapy services provided by outside supplier? Enter "Y"					
	for yes or "N" for no for each therapy.					
					1.00	_
110.00	Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter "				N	110.00
	complete Worksheet E, Part A, lines 200 through 218, and Wor					
	appl i cabl e.					

Health Financial Systems     WHITLEY MEMORIAL HOSP       HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA     Pro	vider CCN: 15-0101	Period: From 01/0		u of For Workshe Part I Date/Ti 5/29/20	et S-2 me Pre	2 epared:
		1.0	0	2.	00	1
111.00 If this facility qualifies as a CAH, did it participate in the Fro Health Integration Project (FCHIP) demonstration for this cost rep "Y" for yes or "N" for no in column 1. If the response to column 1 integration prong of the FCHIP demo in which this CAH is participa Enter all that apply: "A" for Ambulance services; "B" for addition for tele-health services.	orting period? Ento is Y, enter the ting in column 2.					111.00
			1.00	2.00	3.00	1
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" f is yes, enter the method used (A, B, or E only) in column 2. If co 3 either "93" percent for short term hospital or "98" percent for psychiatric, rehabilitation and long term hospitals providers) bas Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for ye 117.00 Is this facility legally-required to carry malpractice insurance?	lumn 2 is "E", entr long term care (in ed on the definitions s or "N" for no.	er in column cludes on in CMS			0	115. 00 116. 00 117. 00
no. 118.00Is the malpractice insurance a claims-made or occurrence policy? E	nter 1 if the poli	cy is	1			118.00
claim-made. Enter 2 if the policy is occurrence.	Premi um	s Loss	es	Insur	ance	
	1.00	2.0		3.		
18.01 List amounts of malpractice premiums and paid losses:	91,	855 1	89, 852		158, 708	3118.0
18.02 Are malpractice premiums and paid losses reported in a cost center		1.0	0	2.	00	118.0
Administrative and General? If yes, submit supporting schedule li and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harml §3121 and applicable amendments? (see instructions) Enter in colum "N" for no. Is this a rural hospital with < 100 beds that qualifie Hold Harmless provision in ACA §3121 and applicable amendments? (s Enter in column 2, "Y" for yes or "N" for no.	ess provision in A n 1, "Y" for yes o s for the Outpatien	-		Ν		119. 00 120. 00
21.00 Did this facility incur and report costs for high cost implantable	devices charged to	D Y				121.00
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined i Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y the Worksheet A line number where these taxes are included.	n §1903(w)(3) of t ", enter in column	ne N 2				122. 0
Transplant Center Information 25.00Does this facility operate a transplant center? Enter "Y" for yes	and "N" for no. If	N				125. 0
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, enter th in column 1 and termination date, if applicable, in column 2.	e certification da	te				126. 0
27.00 If this is a Medicare certified heart transplant center, enter the in column 1 and termination date, if applicable, in column 2.						127.0
28.00 If this is a Medicare certified liver transplant center, enter the in column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter the						128. 0 129. 0
column 1 and termination date, if applicable, in column 2. 30.00 f this is a Medicare certified pancreas transplant center, enter						130. 0
date in column 1 and termination date, if applicable, in column 2. 31.00 If this is a Medicare certified intestinal transplant center, enter date in column 1 and termination date if applicable in column 2.	r the certification	n				131.0
date in column 1 and termination date, if applicable, in column 2. 32.00[f this is a Medicare certified islet transplant center, enter the	certification date	e				132.0
in column 1 and termination date, if applicable, in column 2. 33.00 If this is a Medicare certified other transplant center, enter the in column 1 and termination date, if applicable, in column 2.	certification dat	e				133. 0
34.00 If this is an organ procurement organization (OPO), enter the OPO and termination date, if applicable, in column 2.	number in column 1					134. 0
All Providers	in CMS Dub 1E 1	Y		1 = 1 4	135	140. 00
140.00 Are there any related organization or home office costs as defined chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, a are claimed, enter in column 2 the home office chain number. (see	nd home office cos			15H	JJZ	140.00

Health Financial Systems	WHITLEY N	MEMORIAL	HOSPI TAL				In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	ł	Provider CC	N: 15-	0101		: 1/01/2017 2/31/2017	Worksheet S-2 Part I Date/Time Pre	epared:
1.00		2.00					3.00	5/29/2018 4:1	10 pm
If this facility is part of a chain	organization, ente		nes 141 throu	uah 14	3 the r	name an		of the	
home office and enter the home offi									
141.00 Name: PARKVIEW HEALTH SYSTEM, INC.	Contractor's Na			I ANS Co	ontract	or's Nu	umber: 0810	1	141.00
		SERV							
142.00 Street: 10501 CORPORATE DRIVE	PO Box:		OX 5600	7:	n Codo		44.00		142.00
143.00City: FORT WAYNE	State:	IN		Z1	p Code	:	4089	5-5600	143.00
								1.00	-
144.00 Are provider based physicians' cost	s included in Works	heet A?						Y	144.00
							1.00	2.00	1.15.00
145.00 If costs for renal services are cla inpatient services only? Enter "Y" no, does the dialysis facility incl period? Enter "Y" for yes or "N" f	for yes or "N" for u ude Medicare utiliza	no in co	olumn 1. lfc	col umn					145.00
146.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/dd	changed from the p column 1. (See CMS )						Ν		146.00
									_
147 00 Was there a share is the static	al basi of Estars 11/1	for	on "N" £-					1.00	147.00
147.00Was there a change in the statistic 148.00Was there a change in the order of								N N	147.00 148.00
149.00 Was there a change to the simplifie					"N" for	no.		N	149.00
	<u> </u>		Part A		art B		ītle V	Title XIX	
			1.00		2.00		3.00	4.00	
Does this facility contain a provid									
or charges? Enter "Y" for yes or "N 155.00Hospi tal	TOP NO FOR EACH C	omponen	N N	and P	<u>агt в.</u> N	(See 4	<u>2 CFR 9413</u> N	N	155.00
156.00 Subprovi der – TPF			N		N		N	N	156.00
157.00 Subprovi der – IRF			N		Ν		Ν	N	157.00
158. 00 SUBPROVI DER									158.00
159.00 SNF			N		N		N	N	159.00
160.00HOME HEALTH AGENCY 161.00CMHC			N		N N		N N	N N	160.00 161.00
					IN		N	IN	101.00
								1.00	
Multicampus									4/5 00
165.00 Is this hospital part of a Multicam Enter "Y" for yes or "N" for no.	pus hospital that ha	as one o	or more campu	ises II	n diffe	rent C	BSAS?	N	165.00
	Name		County	Sta	ite Zi	p Code	CBSA	FTE/Campus	
	0		1.00	2. (	00	3.00	4.00	5.00	
166.00 If line 165 is yes, for each campus enter the name in column								0.00	0166.00
0, county in column 1, state in									
column 2, zip code in column 3,									
CBSA in column 4, FTE/Campus in									
column 5 (see instructions)									
								1.00	-
Health Information Technology (HIT)						nt Act			
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 105 reasonable cost incurred for the HI	is "Y") and is a m	eani ngfu	ıl user (line			, ente	∽ the	Y	167.00 0168.00
168.01 If this provider is a CAH and is no exception under §413.70(a)(6)(ii)?	t a meaningful user Enter "Y" for yes o	, does t r "N" fo	his provider or no. (see i	nstruc	ctions)				168. 01
169.00 If this provider is a meaningful us transition factor. (see instruction		) and is	s not a CAH (	line	105 is	"N"), (	enter the	9.9	9169.00
	5)					Be	gi nni ng	Endi ng	
							1.00	2.00	170
170.00 Enter in columns 1 and 2 the EHR be period respectively (mm/dd/yyyy)	ginning date and en	ding dat	te for the re	eportin	ng	10	/01/2016	09/30/2017	170.00
							1.00	2.00	
171.00 If line 167 is "Y", does this provi section 1876 Medicare cost plans re "Y" for yes and "N" for no in colum 1876 Medicare days in column 2. (se	ported on Wkst. S-3 n 1. If column 1 is	, Pt. I,	line 2, col	. 6? [	Enter	'n	N		0171.00

0SPI T	Financial Systems WHITLEY MEMORI AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	AL HOSPITAL Provider C	CN: 15-0101	Peri od:	u of Form CMS Worksheet S-	
00111				From 01/01/2017 To 12/31/2017	Part II	epared
				Y/N	Date 012	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	for all NO re	sponses. Ent	er all dates in t	he	_
	Provider Organization and Operation					_
00	Has the provider changed ownership immediately prior to the	begi nni ng of	the cost	N		1.
	reporting period? If yes, enter the date of the change in co	olumn 2. (see				
			Y/N 1.00	Date 2.00	V/I 3.00	_
. 00	Has the provider terminated participation in the Medicare Pu	rogram? [f	N 1.00	2.00	3.00	2.
	yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.					
. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of cf discustors the start of the sta	ffices, drug er or its f the board	Y			3.
	of directors through ownership, control, or family and other relationships? (see instructions)					
			Y/N	Туре	Date	
			1.00	2.00	3.00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certi	ified Dublic	Y	A		4.
. 00	Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions.	or Compiled,	Y	A		4.
. 00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit reco		N			5.
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities					
. 00	Column 1: Are costs claimed for nursing school? Column 2:	lf yes, is th	ne provider i	s N		6.
00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see ins	atruati ana		N		-
. 00 . 00	Were nursing school and/or allied health programs? If Y see inst cost reporting period? If yes, see instructions.		l during the	N N		7. 8.
. 00	Are costs claimed for Interns and Residents in an approved g		al education	Ν		9.
0. 00	program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated of the sector provided of the sector		he current	Ν		10.
1.00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	Ν		11.
					Y/N 1.00	
2 00	Bad Debts	coo instanti	Long		Y	10
2.00 3.00	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.			ost reporting	Y N	12. 13.
4. 00	If line 12 is yes, were patient deductibles and/or co-paymer Bed Complement	nts waived? If	°yes, see in	structions.	Ν	14.
5.00	Did total beds available change from the prior cost reporti		yes, see ins t A		Y t B	15.
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only?	N	1	N		16.
5. 00	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)	Ν		N		10.
7.00	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	Y	04/18/2018	Y	04/18/2018	17.
8. 00	in columns 2 and 4. (see instructions) 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 this	Y		Y		18.
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	Ν		N		19.

Health Financial Systems

WHITLEY MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Health Financial Systems WHITLEY MEM	ORIAL HOSPITAL		In Lie	eu of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		F	Period: From 01/01/2017 Fo 12/31/2017		
			10 12/31/2017	5/29/2018 4:	
		iption	Y/N	Y/N	
		0	1.00	3.00	00.00
20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
	Y/N	Date	Y/N	Date	
	1.00	2.00	3.00	4.00	
21.00 Was the cost report prepared only using the provider's	N		N		21.00
records? If yes, see instructions.					
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EX	CEPT CHILDRENS H	IOSPI TALS)			
Capital Related Cost				1	
22.00 Have assets been relifed for Medicare purposes? If yes, s					22.00
23.00 Have changes occurred in the Medicare depreciation expension reporting period? If yes, see instructions.	se due to apprais	sals made durir	ng the cost		23.00
24.00 Were new leases and/or amendments to existing leases enter	ered into durina	this cost repo	orting period?		24.00
If yes, see instructions					
25.00 Have there been new capitalized leases entered into durir	ng the cost repor	ting period? I	f yes, see		25.00
instructions.	the east report:	ng pariod2 lf			24.00
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during instructions.	the cost reporti	ng period? II	yes, see		26.00
27.00 Has the provider's capitalization policy changed during t	he cost reportir	ng period?lfy	/es, submit		27.00
сору.					
Interest Expense					
28.00 Were new loans, mortgage agreements or letters of credit period? If yes, see instructions.	entered into dur	ing the cost r	reporting		28.00
29.00 Did the provider have a funded depreciation account and/o	or bond funds (De	ebt Service Res	serve Fund)		29.00
treated as a funded depreciation account? If yes, see ins			,		
30.00 Has existing debt been replaced prior to its scheduled ma	turity with new	debt? If yes,	see		30.00
instructions. 31.00 Has debt been recalled before scheduled maturity without	Locumpon of now	dobt2 If yoc	500		31.00
instructions.	I SSUAILCE OF HEW	debt? IT yes,	See		31.00
Purchased Servi ces				1	
32.00 Have changes or new agreements occurred in patient care s		ed through cont	ractual		32.00
arrangements with suppliers of services? If yes, see inst					
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 a no, see instructions.	ippiled pertainir	ng to competiti	ve bidding? IT		33.00
Provi der-Based Physi ci ans				1	
34.00 Are services furnished at the provider facility under an	arrangement with	n provider-base	ed physi ci ans?	Y	34.00
If yes, see instructions.					
35.00 If line 34 is yes, were there new agreements or amended e		nts with the pr	rovi der-based		35.00
physicians during the cost reporting period? If yes, see	THSTRUCTIONS.		Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00 Were home office costs claimed on the cost report?			Y		36.00
37.00 If line 36 is yes, has a home office cost statement been If yes, see instructions.	prepared by the	nome office?	Y		37.00
38.00   fline 36 is yes, was the fiscal year end of the home of	office different	from that of	Ν		38.00
the provider? If yes, enter in column 2 the fiscal year e					
39.00 If line 36 is yes, did the provider render services to ot	her chain compor	nents? If yes,	N		39.00
see instructions.	a home off 0		N1		40.00
40.00   f line 36 is yes, did the provider render services to th	ie nome office?	Tr yes, see	N		40.00
	1.	00	2.	00	
Cost Report Preparer Contact Information	EDLO				41.00
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	ERI C		NI CKESON		41.00
respectively.					
42.00 Enter the employer/company name of the cost report	PARKVI EW HEALT	H SYSTEM, INC.			42.00
preparer.					
43.00 Enter the telephone number and email address of the cost	(260) 373-8406	)	REI MBURSEMENT@	PARKVI EW. COM	43.00
report preparer in columns 1 and 2, respectively.	I		I		

Heal th	Financial Systems W	WHITLEY MEMORIA	AL HOSPIT	AL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUEST	FI ONNAI RE	Provi	der CCN: 15-0101		eriod: rom 01/01/2017	Worksheet S-2 Part II	
					To			pared: 0 pm
				3.00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/	′position [	DI RECTOR,	REI MBURSEMENT				41.00
	held by the cost report preparer in columns 1,	2, and 3,						
	respecti vel y.							
42.00	Enter the employer/company name of the cost re	port						42.00
	preparer.							
43.00	Enter the telephone number and email address o	of the cost						43.00
	report preparer in columns 1 and 2, respective	el y.						

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	WHITLEY MEMORIA	AL HOSPIIAL Provider CC	N: 15 0101	Period:	u of Form CMS-2 Worksheet S-3	
HUSPI I	AL AND HUSPITAL HEALTH CARE COMPLEX STATISTIC		Provider CC	. 15-0101	From 01/01/2017 To 12/31/2017	Part I Date/Time Prej 5/29/2018 4:10	pared:
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	30			0	1.00
2.00 3.00 4.00 5.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF					0	2.00 3.00 4.00 5.00
6. 00 7. 00 8. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT		30	10, 9	50 0.00	0	6. 00 7. 00 8. 00
9.00 10.00 11.00 12.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						9.00 10.00 11.00 12.00
13.00 14.00 15.00 16.00 17.00 18.00	NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER	43.00	30	10, 9	50 0. 00	0 0 0	13.00 14.00 15.00 16.00 17.00 18.00
19.00 20.00 21.00 22.00 23.00 24.00	SUBROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE	44.00	0		0	0	18.00 19.00 20.00 21.00 22.00 23.00 24.00
24. 10 25. 00 26. 00	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	30. 00					24. 10 25. 00 26. 00
26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00 32.01	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	89. 00	30 0		0	0	26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00 32.01
33. 00 33. 01	LTCH non-covered days LTCH si te neutral days and di scharges						33. 00 33. 01

HOSPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	<u>WHITLEY MEMORIA</u> AL DATA	Provider C	CN: 15-0101	Period: From 01/01/2017		u of Form CMS-2 Worksheet S-3 Part I		
					То	12/31/2017	Date/Time Pre 5/29/2018 4:1		
		I/P Days	/ O/P Visits	/ Trips		Full Time B	Full Time Equivalents		
	Component	Title XVIII	Title XIX	Total All Patients		Total Interns & Residents	Employees On Payroll		
		6.00	7.00	8.00		9.00	10.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1, 284	78	3, 9	58			1.00	
2.00	HMO and other (see instructions)	1, 083	1, 225					2.00	
3.00	HMO I PF Subprovider	0	0					3.00	
4.00	HMO IRF Subprovider	0	0					4.00	
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0			5.00	
6.00	Hospital Adults & Peds. Swing Bed NF		0		0			6.00	
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 284	78	3, 9	58			7.00	
8.00	INTENSIVE CARE UNIT							8.00	
9.00	CORONARY CARE UNIT							9.00	
10.00	BURN INTENSIVE CARE UNIT							10.00	
11.00	SURGICAL INTENSIVE CARE UNIT							11.00	
12.00	OTHER SPECIAL CARE (SPECIFY)		FO		17			12.00	
13.00 14.00	NURSERY Total (see instructions)	1, 284	50 128		17	0.00	255.00	13.00 14.00	
14.00	CAH visits	1, 204	120	4,7	0	0.00	255.00	14.00	
16.00	SUBPROVIDER - IPF	0	0		0			16.00	
17.00	SUBPROVI DER – I RF							17.00	
18.00	SUBPROVI DER							18.00	
19.00	SKILLED NURSING FACILITY	0	0		0	0.00	0.00	19.00	
20. 00	NURSING FACILITY							20.00	
21.00	OTHER LONG TERM CARE			1				21.00	
22.00	HOME HEALTH AGENCY							22.00	
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23.00	
24.00	HOSPICE							24.00	
24.10	HOSPICE (non-distinct part)	0	0		0			24.10	
25.00	CMHC - CMHC							25.00	
26.00	RURAL HEALTH CLINIC		0		~	0.00	0.00	26.00	
26.25 27.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.00 0.00	0.00 255.00		
27.00	Total (sum of lines 14–26) Observation Bed Days		147	1, 5	0.4	0.00	255.00	27.00	
29.00	Ambul ance Trips	0	147	1,5	74			29.00	
30.00	Employee discount days (see instruction)	0			83			30.00	
31.00	Employee discount days - IRF				0			31.00	
32.00	Labor & delivery days (see instructions)	0	69	1	26			32.00	
32.01	Total ancillary labor & delivery room	0	07		0			32.01	
	outpatient days (see instructions)				-			51	
33.00	LTCH non-covered days	0						33.00	
33.01	LTCH site neutral days and discharges	0						33.01	

позет I	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CCN: 15-0101		Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part I Date/Time Pre 5/29/2018 4:10	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers 11.00	12.00	12 00	14.00	Patients 15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00	13.00	14.00 34 531	15.00	1.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 12. 00 13. 00 14. 00 15. 00 14. 00 15. 00 20. 00 21. 00 22. 00 23. 00 24. 10 25. 00 26. 00	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSI VE CARE UNIT CORONARY CARE UNIT BURN INTENSI VE CARE UNIT SURGICAL INTENSI VE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	0. 00 0. 00	0		82 0 0 0 34 531	1, 704	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 14. 00 15. 00 14. 00 20. 00 21. 00 22. 00 23. 00 24. 10 25. 00 26. 00
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	0. 00 0. 00					26. 25 27. 00
28.00	Observation Bed Days						28.00
29.00 30.00	Ambulance Trips Employee discount days (see instruction)						29.00 30.00
30.00	Employee discount days (see fistraction)						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days				0		33.00

PI T <i>i</i>	Financial Systems AL WAGE INDEX INFORMATION			Provider C		<u>In Lie</u> Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part II	pare
		Wkst. A Line Number	Amount Reported	Reclassificati on 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)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							-
0	Total salaries (see	200.00	16, 991, 384	4, 329, 620	21, 321, 00	4 698, 477. 00	30. 52	1.
0	instructions) Non-physician anesthetist Part		C	o		0. 00	0.00	2.
	A							
0	Non-physician anesthetist Part B		C	0		0.00	0.00	3
0	Physician-Part A -		101, 529	0	101, 52	9 673.00	150.86	4
1	Administrative Physicians - Part A - Teaching		C	0		0.00	0.00	4
0	Physician and Non		C			0.00		
0	Physician-Part B Non-physician-Part B for		C	0		0. 00	0.00	6
0	hospital -based RHC and FQHC		C			0.00	0.00	
0	services Interns & residents (in an	21.00	C	0		0. 00	0.00	7
0	approved program)	21.00	C			0.00	0.00	<b>1</b>
1	Contracted interns and residents (in an approved		C	0		0.00	0.00	7
0	programs) Home office and/or related		4, 329, 620	0	4, 329, 620	0 140, 118. 00	30.90	8
	organization personnel		4, 327, 020		4, 527, 62	140, 110.00	30.70	
0 00	SNF	44.00	1 E77 E40	, o		0.00 9 77,387.00		
00	Excluded area salaries (see instructions)		1, 577, 540	22, 549	1, 000, 08	9 11, 301.00	20.00	
	OTHER WAGES & RELATED COSTS			i				
00	Contract Labor: Direct Patient Care		530, 538	0	530, 53	8 7, 379. 00	71.90	11
00	Contract Labor: Top Level management and other		C	0		0.00	0. 00	12
	management and administrative services							
00	Contract Labor: Physician-Part		C	0	(	0.00	0. 00	13
00	A - Administrative Home office and/or related		C	0		0.00	0.00	14
	orgainzation salaries and							
01	wage-related costs Home office salaries		4, 329, 620	0	4, 329, 620	0 140, 118. 00	30. 90	14
	Related organization salaries		C			0.00		
00	Home office: Physician Part A		C	0	(	0.00	0.00	15
00	- Administrative Home office and Contract		C	0		0.00	0.00	16
	Physicians Part A - Teaching			_				
	WAGE-RELATED COSTS Wage-related costs (core) (see		4, 793, 768	0	4, 793, 76	0		1 17
00	instructions)		4,793,700		4, 775, 70			
00	Wage-related costs (other)		C	0	(	C		18
00	(see instructions) Excluded areas		491, 423	0	491, 42	3		19
	Non-physician anesthetist Part		C	0		С		20
00	A Non-physician anesthetist Part		C	0		b		21
00	B Physician Part A - Administrative		C	0		D		22
01	Physician Part A - Teaching		C	о		b		22
	Physician Part B		C	0	(	D		23
	Wage-related costs (RHC/FQHC) Interns & residents (in an		C					24 25
	approved program) Home office wage-related		1, 805, 208	-	1, 805, 20	8		25
	(core)							
51	Related organization wage-related (core)		C	0	(			25
52	Home office: Physician Part A - Administrative -		C	0	(	D		25
	wage-related (core)							
53	Home office & Contract Physicians Part A - Teaching -		C	0	(	C		25
	wage-related (core)							
	OVERHEAD COSTS - DIRECT SALARIE						J -	
00	Employee Benefits Department Administrative & General	4.00 5.00	1, 686, 102 1, 598, 397			0.00 7 19,703.00		

Heal th	Financial Systems		WHITLEY MEMOR	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO	F	Period: From 01/01/2017 Fo 12/31/2017	Worksheet S-3 Part II Date/Time Pre 5/29/2018 4:10	pared:
		Wkst. A Line		Reclassi fi cati			Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	$(col.2 \pm col.$	Salaries in	col. 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		0	0	(	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	(	0.00	0.00	29.00
30.00	Operation of Plant	7.00	381, 386	46, 779	428, 165	5 18, 803. 00	22. 77	30.00
31.00	Laundry & Linen Service	8.00	0	0	(	0.00	0.00	31.00
32.00	Housekeepi ng	9.00	421, 510	51, 700	473, 210	36, 309. 00	13.03	32.00
33.00	Housekeeping under contract (see instructions)		0	0	(	0.00	0.00	33.00
34.00	Dietary	10.00	444, 900	-300, 202	144, 698	3 10, 939. 00	13. 23	34.00
35.00	Dietary under contract (see instructions)		0	0	(	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	344, 449	344, 449	20, 226. 00	17.03	36.00
37.00	Maintenance of Personnel	12.00	0	0	(	0.00	0.00	37.00
38.00	Nursing Administration	13.00	191, 797	23, 525	215, 322	2 5, 596. 00	38.48	38.00
39.00	Central Services and Supply	14.00	0	0	(	0.00	0.00	39.00
40.00	Pharmacy	15.00	589, 287	72, 278	661, 565	5 13, 161. 00	50. 27	40.00
41.00	Medi cal Records & Medi cal Records Library	16.00	0	0	(	0.00		
42.00	Soci al Servi ce	17.00	0	0	(	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	(	0.00	0.00	43.00

Heal th	Financial Systems		WHITLEY MEMOR	IAL HOSPITAL		In Lieu of Form CMS-2552-10			
HOSPI T	AL WAGE INDEX INFORMATION			Provider CC	-	Period: From 01/01/2017 Fo 12/31/2017		pared:	
		Worksheet A		Recl assi fi cati	,		Average Hourly		
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷		
				(from	(col.2 ± col.		col. 5)		
				Worksheet A-6)		col. 4			
		1.00	2.00	3.00	4.00	5.00	6.00		
	PART III - HOSPITAL WAGE INDEX	SUMMARY							
1.00	Net salaries (see		12, 661, 764	4, 329, 620	16, 991, 38	4 558, 359. 00	30. 43	1.00	
	instructions)								
2.00	Excluded area salaries (see		1, 577, 540	22, 549	1, 600, 08	77, 387. 00	20.68	2.00	
	instructions)								
3.00	Subtotal salaries (line 1		11, 084, 224	4, 307, 071	15, 391, 29	5 480, 972. 00	32.00	3.00	
	minus line 2)								
4.00	Subtotal other wages & related		4, 860, 158	0	4, 860, 15	3 147, 497. 00	32.95	4.00	
	costs (see inst.)								
5.00	Subtotal wage-related costs		6, 598, 976	0	6, 598, 97	6 0.00	42.87	5.00	
	(see inst.)								
6.00	Total (sum of lines 3 thru 5)		22, 543, 358	4, 307, 071	26, 850, 42	628, 469. 00	42.72	6.00	
7.00	Total overhead cost (see		5, 313, 379	3, 068, 207	8, 381, 58	5 124, 737. 00	67.19	7.00	
	instructions)								
		-						-	

Heal th	Financial Systems WHITLEY MEMOR	I AL HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	AL WAGE RELATED COSTS	Provider CCN: 15-0101	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part IV	pared:
				Amount	
				Reported 1.00	
	PART IV - WAGE RELATED COSTS			1.00	
	Part A - Core List				
	RETIREMENT COST				
1.00	401K Employer Contributions			0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			276, 528	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			714, 472	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan			4, 505	6.00
7.00	Employee Managed Care Program Administration Fees			46, 769	7.00
	HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			2, 905, 773	
8.01	Health Insurance (Self Funded without a Third Party Adminis			0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administra	ator)		0	8.02
8.03	Heal th Insurance (Purchased)			0	8.03
9.00	Prescription Drug Plan			0	9.00
10.00	Dental, Hearing and Vision Plan			0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)			28, 978	
12.00	Accident Insurance (If employee is owner or beneficiary)			0	
13.00	Disability Insurance (If employee is owner or beneficiary)			78, 567	13.00 14.00
14.00 15.00	Long-Term Care Insurance (If employee is owner or beneficia 'Workers' Compensation Insurance	ii y)		0 23, 581	
16.00		raardi parvi acerual i roqui ro	nd by EASP 106	23, 561	16.00
10.00	Non cumulative portion)	Taorumary accruai require	eu by TASE 100.	0	10.00
	TAXES				
17.00	FICA-Employers Portion Only			1, 118, 473	17.00
18.00	Medicare Taxes - Employers Portion Only			0	18.00
19.00	Unemployment Insurance			0	19.00
20.00	State or Federal Unemployment Taxes			0	20.00
	OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost instructions))	Reported on lines 1 throu	ugh 4 above. (see	45, 765	21.00
22.00	Day Care Cost and Allowances			0	22.00
23.00	Tuition Reimbursement			46, 284	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			5, 289, 695	24.00
	Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0	25.00

Heal th	Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0101	Peri od:	Worksheet S-3	
				From 01/01/2017		
				To 12/31/2017	Date/Time Pre 5/29/2018 4:1	
	Cost Center Description			Contract Labor		
				1.00	2.00	
	PART V - Contract Labor and Benefit Cost					
	Hospital and Hospital-Based Component Identi	fication:				
1.00	Total facility's contract labor and benefit	cost		530, 538	5, 289, 695	1.00
2.00	Hospi tal			530, 538	5, 289, 695	2.00
3.00	Subprovider - IPF					3.00
4.00	Subprovider - IRF					4.00
5.00	Subprovider - (Other)			0	0	5.00
6.00	Swing Beds - SNF			0	0	6.00
7.00	Swing Beds - NF			0	0	7.00
8.00	Hospital-Based SNF			0	0	8.00
9.00	Hospital-Based NF					9.00
10.00	Hospital-Based OLTC					10.00
11.00	Hospital-Based HHA					11.00
12.00	Separately Certified ASC					12.00
13.00	Hospital-Based Hospice					13.00
14.00	Hospital-Based Health Clinic RHC					14.00
15.00	Hospital-Based Health Clinic FQHC					15.00
16.00	Hospital-Based-CMHC					16.00
17.00	Renal Dialysis					17.00
18.00	Other			0	0	18.00

Heal th	Financial Systems WHITLEY MEMORIAL H	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
		Provider CCN	N: 15-0101	Peri od:	Worksheet S-1	0
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 4:1	
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by lin	e 202 columr	18)	0. 224943	1.00
	Medicaid (see instructions for each line)			,		1
2.00	Net revenue from Medicaid				2, 249, 479	
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement			ni d?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr		0			
6.00 7.00	Medicaid charges				20, 580, 080	
7.00 8.00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program (	lino 7 minu	c cum of lir	voc 2 and E. if	4, 629, 345 2, 379, 866	
8.00	<pre>&lt; zero then enter zero)</pre>		S SUII OF FFI	ies z anu s, TT	2, 379, 000	0.00
	Children's Health Insurance Program (CHIP) (see instructions fo	r each line	)			
9.00	Net revenue from stand-alone CHIP		,		0	9.00
10.00	Stand-alone CHIP charges				0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	
12.00	Difference between net revenue and costs for stand-alone CHIP (	(line 11 min	us line 9; i	f < zero then	0	12.00
	enter zero)					
13.00	Other state or local government indigent care program (see inst Net revenue from state or local indigent care program (Not incl				2, 967, 850	13.00
13.00	Charges for patients covered under state or local indigent care				22, 522, 407	
14.00	10)		ot merudeu		22, 322, 407	14.00
15.00	State or local indigent care program cost (line 1 times line 14	+)			5, 066, 258	15.00
16.00	Difference between net revenue and costs for state or local ind		program (lir	ne 15 minus line	2, 098, 408	16.00
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state.	/local indig	jent care program	ms (see	
17.00	instructions for each line) Private grants, donations, or endowment income restricted to fu	Indi na chari	ty care		0	17.00
18.00	Government grants, appropriations or transfers for support of h					
19.00	Total unreimbursed cost for Medicaid , CHIP and state and Iocal 8, 12 and 16)			s (sum of lines	4, 478, 274	
			Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col. 2)	
			1.00	2.00	3.00	
20.00	Uncompensated Care (see instructions for each line)		1 007 0	1 100 007	2 027 (50	00.00
20.00	Charity care charges and uninsured discounts for the entire fac (see instructions)	TITY	1, 807, 82	1, 129, 827	2, 937, 650	20.00
21.00	Cost of patients approved for charity care and uninsured discou	ints (see	406, 65	57 1, 129, 827	1, 536, 484	21.00
211 00	instructions)		100, 00	., ., ., ., ., ., ., ., ., ., ., ., ., .	1,000,101	2
22.00	Payments received from patients for amounts previously written	off as	2	6, 798	7, 015	22.00
	chari ty care					
23.00	Cost of charity care (line 21 minus line 22)		406, 44	1, 123, 029	1, 529, 469	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patien	nt days beyo	nd a length	of stay limit		24.00
	imposed on patients covered by Medicaid or other indigent care		5	5		
25.00	If line 24 is yes, enter the charges for patient days beyond th	ne indigent	care program	n's length of	0	25.00
24 00	stay limit	tructions)			10 459 049	24 00
26.00 27.00	Total bad debt expense for the entire hospital complex (see ins Medicare reimbursable bad debts for the entire hospital complex		uctions)		10, 658, 948 77, 731	
	Medicare allowable bad debts for the entire hospital complex (s				119, 586	
28.00	Non-Medicare bad debt expense (see instructions)				10, 539, 362	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see i	nstructions)		2, 412, 611	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	( )			3, 942, 080	
	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			8, 420, 354	

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	WHITLEY MEMORIA	L HOSPITAL Provider CC	N. 15 0101 D	In Lie eriod:	u of Form CMS-2 Worksheet A	2552-10
REULAS	STFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	- EXPENSES	Provider CC	F	rom 01/01/2017 o 12/31/2017	Date/Time Pre	narod
						5/29/2018 4:1	
	Cost Center Description	Sal ari es	Other	+ col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance	
				,	, , ,	(col. 3 +-	
	-	1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	
	GENERAL SERVICE COST CENTERS	1.00		0.00	1.00	0.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP		4, 707, 034	4, 707, 034			1.00
2.00 3.00	00300 OTHER CAP REL COSTS		97,000	0 97, 000		1, 671, 749 0	2.00 3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 686, 102	5, 552, 877	7, 238, 979		5, 552, 877	4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	1, 598, 397	20, 631, 244	22, 229, 641	-240, 169		5.00
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0 381, 386	0 1, 196, 954	0 1, 578, 340	0 -55, 551	0 1, 522, 789	6.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	281, 087	281, 087		281, 087	8.00
9.00	00900 HOUSEKEEPI NG	421, 510	171, 282	592, 792		642, 146	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	444, 900	283, 481	728, 381	-524, 958 569, 025	203, 423 569, 025	10.00 11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300 NURSING ADMINISTRATION	191, 797	152	191, 949	23, 525	215, 474	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	0	0	0	0	14.00
15.00 16.00	01600 MEDICAL RECORDS & LIBRARY	589, 287 0	2, 713, 625	3, 302, 912	-1, 612, 483	1, 690, 429 0	15.00 16.00
17.00	01700 SOCIAL SERVICE	Ö	ō	0	Ő	0	17.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.00
20. 00 21. 00	02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	20.00 21.00
21.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	2 840 052	055 200	2 704 242	-120, 929	2 502 414	20.00
30. 00 43. 00	03000 ADULTS & PEDIATRICS 04300 NURSERY	2, 849, 053 0	855, 290 0	3, 704, 343 0		3, 583, 414 138, 186	30.00 43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0		0	44.00
E0.00	ANCI LLARY SERVICE COST CENTERS	891, 841	408, 197	1 200 029	107, 710	1 407 749	
50. 00 52. 00	05200 DELIVERY ROOM & LABOR ROOM	891, 841	408, 197	1, 300, 038 85, 933		1, 407, 748 423, 643	
53.00	05300 ANESTHESI OLOGY	0	720, 335	720, 335		720, 335	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 833, 436	954, 209	2, 787, 645		3, 005, 033	
60.00 62.30	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	2, 935, 017	2, 935, 017	0	2, 935, 017 0	60.00 62.30
65.00	06500 RESPIRATORY THERAPY	457, 082	169, 464	626, 546	-	607, 278	65.00
66.00	06600 PHYSI CAL THERAPY	1, 261, 571	325, 549	1, 587, 120		850, 494	66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	567, 822 54, 725	567, 822 54, 725	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 061, 235	1, 061, 235		652, 789	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0			
	07607 CARDI AC REHABI LI TATI ON	0	0	0	1,007,907	1,007,987	76.97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	8, 698	1, 977	10, 675	1, 067	11, 742	76. 98
76. 99	07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	76.99
90.00	09000 CLINIC	0	0	0	0	0	90.00
90. 01	09001 I NTENSI VE OUT PATI ENT PROGRAM	0	0	0	0	0	90. 01
91.00	09100 EMERGENCY	2, 713, 932	1, 821, 751	4, 535, 683	327, 825	4, 863, 508	91.00
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	1, 558, 487	358, 159	1, 916, 646	-1, 912	1, 914, 734	95.00
440.00	SPECIAL PURPOSE COST CENTERS	44 070 004	45 0.47 000	(0.040.004	001 000	(4,007,000	110.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	16, 972, 331	45, 247, 000	62, 219, 331	-281, 338	61, 937, 993	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	32, 641	32, 641	0	32, 641	
	19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 OCCUPATI ONAL HEALTH	18, 276	756, 867 -93	775, 143 -93			192.00 194.00
	07950 OCCUPATIONAL HEALTH	o	-93	-93 0			194.00 194.01
194.02	07952 OAK POINTE	О	0	0	0	0	194. 02
	07953 FOUNDATION	0	95,004	95, 004			
	07954 COMMUNI TY & VOLUNTEER SERVI CES 07955 VACANT SPACE	777 0	149, 037 0	149, 814 0	23, 765 0	173, 579 0	194.04 194.05
194.06	07956 TELEHEALTH MEDICINE	Ö	14, 195	14, 195	0	14, 195	194. 06
200.00	TOTAL (SUM OF LINES 118 through 199)	16, 991, 384	46, 294, 651	63, 286, 035	0	63, 286, 035	200. 00

LASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	OF EXPENSES	Provider CCI	I: 15-010	From 01/01/2	
				To 12/31/2	017 Date/Time Prepa 5/29/2018 4:10
Cost Center Description		Net Expenses			
	(See A-8) F 6.00	For Allocation 7.00			
GENERAL SERVICE COST CENTERS	0.00	1100			
0 00100 CAP REL COSTS-BLDG & FIXT	-2, 138, 512	1, 628, 109			
0 00200 CAP REL COSTS-MVBLE EQUIP	-316	1, 671, 433			
0 00300 OTHER CAP REL COSTS	0	0			
0 00400 EMPLOYEE BENEFITS DEPARTMENT	-3, 009, 058	2, 543, 819			
0 00500 ADMI NI STRATI VE & GENERAL	-6, 330, 348	15, 659, 124			
0 00600 MAINTENANCE & REPAIRS	0	0			
0 00700 OPERATION OF PLANT	-101, 572	1, 421, 217			
0 00800 LAUNDRY & LINEN SERVICE	0	281,087			
	0	642, 146			
00 01000 DI ETARY	40 E1(	203, 423			
00 01100 CAFETERIA 00 01200 MAINTENANCE OF PERSONNEL	-40, 516	528, 509			
00 01300 NURSI NG ADMI NI STRATI ON	0	215, 474			
00 01400 CENTRAL SERVICES & SUPPLY	0	215, 474			
00 01500 PHARMACY	-923, 853	766, 576			
00 01600 MEDICAL RECORDS & LIBRARY	,23,033	00,070			
00 01700 SOCI AL SERVI CE	0	0			
00 01900 NONPHYSICIAN ANESTHETISTS	0	0			
00 02000 NURSI NG SCHOOL	0	o			
00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0			
00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0			
00 02300 PARAMED ED PRGM-(SPECIFY)	0	o			
INPATIENT ROUTINE SERVICE COST CENTERS					
00 03000 ADULTS & PEDIATRICS	33, 188	3, 616, 602			3
00 04300 NURSERY	0	138, 186			4
00 04400 SKI LLED NURSI NG FACI LI TY	0	0			<i>L</i>
ANCI LLARY SERVICE COST CENTERS	10.005	1 007 0(0			
00 05000 OPERATING ROOM	-10, 385	1, 397, 363			Ę
00 05200 DELIVERY ROOM & LABOR ROOM 00 05300 ANESTHESIOLOGY	0 -699, 733	423, 643 20, 602			Ę
00 05400 RADI OLOGY-DI AGNOSTI C	-1, 035	3,003,998			Ę
00 06000 LABORATORY	-1,035	2, 935, 017			
30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	2, 755, 017			
00 06500 RESPIRATORY THERAPY	-76, 151	531, 127			
00 06600 PHYSI CAL THERAPY	-381, 752	468, 742			e
00 06700 OCCUPATI ONAL THERAPY	0	567, 822			e
00 06800 SPEECH PATHOLOGY	0	54, 725			e
00 06900 ELECTROCARDI OLOGY	0	0			6
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	652, 789			
00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	408, 446			
00 07300 DRUGS CHARGED TO PATIENTS	0	1, 687, 987			
97 07697 CARDI AC REHABI LI TATI ON	0	0			
98 07698 HYPERBARI C OXYGEN THERAPY	0	11, 742			
99 07699 LI THOTRI PSY	0	0			
OUTPATIENT SERVICE COST CENTERS					
00 09000 CLINIC	0	0			
01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0			
00 09100 EMERGENCY	-24, 590	4, 838, 918			
00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS					
00 09500 AMBULANCE SERVICES	-2, 708	1, 912, 026			
SPECIAL PURPOSE COST CENTERS	-2,700	1, 712, 020			
SUBTOTALS (SUM OF LINES 1 through 117)	-13, 707, 341	48, 230, 652			11
NONREI MBURSABLE COST CENTERS	,	.,, 002			
0. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	32, 641			19
00 19200 PHYSI CLANS' PRI VATE OFFI CES	-329, 614	455, 017			19
. 00 07950 OCCUPATI ONAL HEALTH	0	0			19
. 01 07951 PAIN CLINIC	0	o			19
. 02 07952 OAK POINTE	0	О			19
. 03 07953 FOUNDATI ON	0	342, 996			19
. 04 07954 COMMUNITY & VOLUNTEER SERVICES	-1,070	172, 509			19
. 05 07955 VACANT SPACE	0	О			19
. 06 07956 TELEHEALTH MEDICINE	0	14, 195			19
.00 TOTAL (SUM OF LINES 118 through 199)	-14,038,025	49, 248, 010			20

h Financial Systems SSIFICATIONS		WHITLEY MEMOR	Provi der CCN: 15	-0101 Peri od:	Lieu of Form CMS-2552- Worksheet A-6
				From 01/01/2 To 12/31/2	2017 Date/Time Prepared
	Increases			I .	5/29/2018 4:10 pm
Cost Center	Line #	Sal ary	Other		
2.00 A - CAFETERIA RECLASS	3.00	4.00	5.00		
CAFETERIA RECLASS	11.00	344, 449	224, 576		1.
0		344, 449	224, 576		
B – OB RECLASS					
NURSERY	43.00	57, 125	81,061		1.
DELIVERY ROOM & LABOR	<u>ROOM 52.00</u>	<u>135, 3</u> 04 192, 429	<u>191, 999</u> 273, 060		2.
E - BUILDING AND EQUIP	LEASE	192, 429	273,000		
CAP REL COSTS-BLDG & F		0	494, 936		1.
CAP REL COSTS-MVBLE EQ	UI P 2.00	0	47, 546		2.
	0.00	0	0		3.
	0.00	0	0		4.
	0.00 0.00	0	0		5.
	0.00	0	0		
	0.00	0	Ő		8.
	0.00	0	0		9.
)	0.00	0	0		10.
	0.00	0	0		11.
	0.00	0	0		12.
	0.00 0.00	0	0		13.
	0.00	0	0		14.
	0.00	0	0		16.
	0.00	0	0		17.
)	0.00	0	0		18.
0		0	542, 482		
G - INSURANCE RECLASS	LVT 1.00	0	27 500		1
CAP REL COSTS-BLDG & F CAP REL COSTS-MVBLE EQ	1	0 0	37, 500 54, 354		1.
		o	<u> </u>		2.
H - DEPRECIATION RECLA	SS				
CAP REL COSTS-MVBLE EQ	UI P 2.00	0	<u>1, 569, 8</u> 49		1.
0		0	1, 569, 849		
K – SALARY RECLASS ADMI NI STRATI VE & GENER	AL 5.00	4 220 (20	0		1.
	<u>AL5.00</u>	<u>4, 329, 620</u> 4, 329, 620	<u>0</u>		1.
L - REHAB THERAPY DEPT	RECLASS	1, 02 , , 02 0			
OCCUPATI ONAL THERAPY	67.00	543, 460	24, 381		1.
SPEECH PATHOLOGY		5 <u>2, 3</u> 76	<u> </u>		2.
		595, 836	26, 730		
M - DRUGS CHARGED TO P DRUGS CHARGED TO PATIE		0	1, 687, 987		1.
	0.00		0		2.
	0.00	0	0		3.
	0.00	0	0		4.
	0.00	0	<u>0</u>		5.
0		0	1, 687, 987		
N - PTO ACCRUAL RECLAS ADMI NI STRATI VE & GENER		196, 050	0		1.
OPERATION OF PLANT	AL 5.00 7.00	46, 779	0		2.
HOUSEKEEPING	9.00	51,700	Ő		3.
DI ETARY	10.00	54, 569	0		4.
NURSING ADMINISTRATION	13.00	23, 525	0		5.
PHARMACY	15.00	72, 278	0		6.
ADULTS & PEDIATRICS	30.00	349, 448	0		7.
OPERATING ROOM	50.00	109, 388	0		9.
DELIVERY ROOM & LABOR RADIOLOGY-DIAGNOSTIC	ROOM 52.00 54.00	10, 407 224, 879	0		10.
RESPIRATORY THERAPY	65.00	56, 063	0		12.
PHYSICAL THERAPY	66.00	154, 737	0		13.
HYPERBARIC OXYGEN THER		1, 067	0		14.
EMERGENCY	91.00	332, 875	0		16.
PHYSICIANS' PRIVATE OF		2, 242	0		17.
COMMUNITY & VOLUNTEER SERVICES	194.04	95	0		18.
		1, 686, 102	— — <sub>0</sub>		
0 - CLINIC DIETICIAN R	ECLASS	1,000,102	<u> </u>		
PHYSICIANS' PRIVATE OF		1 <u>0, 3</u> 22	0		1.
0		10, 322			
P - CORPORATE DI RECT A			000 077		
FOUNDATI ON	194.03 194.04	9, 015 875	238, 977 23, 184		1.
COMMUNITY & VOLUNTEER					

Heal th	Financial Systems		WHITLEY MEMORI	AL HOSPITAL		In Lieu of Form CMS-2552-		
RECLAS	SIFICATIONS			Provider C	CN: 15-0101	Peri od:	Worksheet A-	6
						From 01/01/2017 To 12/31/2017	Date/Time Pr 5/29/2018 4:	epared: 10 pm
		Increases						
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
	0		9, 890	262, 161				
	Q - OCCUPATIONAL HEALTH RECLA	ISS						
1.00	OCCUPATIONAL HEALTH	194.00	0	93				1.00
4.00		0.00	0	0				4.00
	0		0	93				
	R - IMPLANTABLE MEDICAL SUPPL	_I ES						
1.00	IMPL. DEV. CHARGED TO	72.00	0	408, 446				1.00
	PATI ENTS							
	0		0	408, 446				
	S - INTEREST EXPENSE							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	97, 000				1.00
	0 — — — — — — —		0	97,000				
500.00	Grand Total: Increases		7, 168, 648	5, 184, 238				500.00

	Financial Systems SIFICATIONS		WHITLEY MEMORIA		CCN: 15-0101	In Lie Period:	u of Form CMS-2552-1 Worksheet A-6
REULAS	SEFECATIONS			Provider		From 01/01/2017 To 12/31/2017	Date/Time Prepared: 5/29/2018 4:10 pm
		Decreases		L. L	-		
	Cost Center 6.00	Li ne # 7.00	Salary 8.00	0ther 9.00	Wkst. A-7 Ref 10.00		
	A - CAFETERIA RECLASS	7.00	8.00	9.00	10.00		
1.00	DI ETARY		344, 449	22 <u>4, 5</u> 76		ַ	1.0
	0		344, 449	224, 576	•		
1.00	B - OB RECLASS ADULTS & PEDIATRICS	30.00	192, 429	273, 060			1.0
2.00		0.00	0	0		o l	2.0
	0		192, 429	273, 060			
1.00	E - BUI LDI NG AND EQUI P LEASE ADMI NI STRATI VE & GENERAL	5.00	0	56, 410	1		1.0
2.00	OPERATION OF PLANT	7.00	0	101, 265			2.0
3.00	RESPI RATORY THERAPY	65.00	О	72, 786		b	3. 0
4.00	PHYSICAL THERAPY	66.00	0	264, 475			4.0
5.00 6.00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5.00 7.00	0	15, 904 1, 065			5.0
7.00	HOUSEKEEPING	9.00	0	2, 346			7.0
8.00	DI ETARY	10.00	0	180		C	8.0
9.00 10.00	PHARMACY ADULTS & PEDIATRICS	15.00 30.00	0	1, 709 4, 888			9.0 10.0
10.00	OPERATING ROOM	50.00	0	4, 888			11.0
12.00	RADI OLOGY-DI AGNOSTI C	54.00	Ő	3, 385			12.0
13.00	RESPI RATORY THERAPY	65.00	О	2, 545		b	13.0
14.00	PHYSICAL THERAPY	66.00	0	4, 322			14.0
15.00 16.00	EMERGENCY AMBULANCE SERVICES	91.00 95.00	0	5, 050 1, 076			15. 0 16. 0
17.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3, 032			10.0
18.00	COMMUNITY & VOLUNTEER	194.04	О	389	•	b	18.0
	SERVICES		— —	542, 482		-	
	G - INSURANCE RECLASS		U	542, 402	·		
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	91, 854			1.0
2.00			0	0		2	2.0
	O H - DEPRECIATION RECLASS		0	91,854	•		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 569, 849		9	1.0
	0		0	1, 569, 849	)		
1.00	K – SALARY RECLASS ADMI NI STRATI VE & GENERAL	5.00	0	4, 329, 620			1.0
1.00			— — — <del>o</del>	4, 329, 620			1.0
	L - REHAB THERAPY DEPT RECLAS						
1.00	PHYSI CAL THERAPY	66.00 0.00	595, 836 0	26, 730 0			1.0
2.00	b	0.00	<u>595, 836</u>			5	2.0
	M - DRUGS CHARGED TO PATIENT						
1.00	PHARMACY	15.00	0	1, 683, 052		D .	1.0
2.00 3.00	OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C	50.00 54.00	0	23 4, 032			2. 0 3. 0
4.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	4, 032			4.0
5.00	AMBULANCE_SERVICES	95.00	0	836		2	5.0
	0 N - PTO ACCRUAL RECLASS		0	1, 687, 987			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1, 686, 102	0	)	b	1.0
2.00		0.00	0	0	)	C	2.0
3.00		0.00	0	0		D	3.0
4.00 5.00		0.00 0.00	0	0			4.0 5.0
6.00		0.00	0	0			6.0
7.00		0.00	Ō	0	)		7.0
9.00		0.00	0	0		D	9.0
10. 00 11. 00		0.00 0.00	0	0			10. 0 11. 0
12.00		0.00	0	0			12.0
13.00		0.00	0	0	)	c	13.0
14.00		0.00	0	0			14.0
16. 00 17. 00		0.00 0.00	0	0 0			16. 0 17. 0
18.00		0.00	0	0			18.0
	0		1, 686, 102	0		1	
1 00	0 - CLINIC DIETICIAN RECLASS	10.00	10, 322				1.0
1.00	DI ETARY		10, 322 10, 322	0	<u> </u> '	<u>0</u>	1.0
	P - CORPORATE DI RECT ALLOC RE			-		- I	
1.00	ADMI NI STRATI VE & GENERAL	5.00	9, 890	262, 161			1.0
2.00	<u> </u>		9, 890	0000000			2.0
	1-		,, 0,0	202,101	1	1	I

Heal th	Financial Systems	WHITLEY MEMOR	WHITLEY MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10		
RECLAS	SIFICATIONS			Provider C	CCN: 15-0101	Peri od:	Worksheet A-	6
						From 01/01/2017 To 12/31/2017	Date/Time Pr 5/29/2018 4:	epared: 10 pm
		Decreases						
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref	· .		
	6. 00	7.00	8.00	9.00	10.00			
	Q - OCCUPATIONAL HEALTH RECLA	ISS						
1.00	RADI OLOGY-DI AGNOSTI C	54.00	0	74		0		1.00
4.00	OCCUPATI ONAL THERAPY	67.00	0	19		0		4.00
	0		0	93				
	R - IMPLANTABLE MEDICAL SUPPL	I ES						
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	408, 446		0		1.00
	PATI ENT							
	0		0	408, 446				
	S - INTEREST EXPENSE							
1.00	OTHER CAP_REL_COSTS	3.00	0	97,000	1	4		1.00
	0		0	97, 000				
500.00	Grand Total: Decreases		2, 839, 028	9, 513, 858				500.00

неагтп	Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CC		Period: From 01/01/2017 To 12/31/2017	Worksheet A-7 Part I Date/Time Prep 5/29/2018 4:10	pared:
				Acqui si ti ons		372772010 4.10	5 pm
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES					
1.00	Land	260, 976	0		0 0	0	1.00
2.00	Land Improvements	2, 469, 451	0		0 0	0	2.00
3.00	Buildings and Fixtures	14, 588, 065	20, 192		0 20, 192	0	3.00
4.00	Building Improvements	48, 824	0		0 0	0	4.00
5.00	Fixed Equipment	6, 263, 961	0		0 0	-3, 500	5.00
6.00	Movable Equipment	14, 553, 613	1, 563, 504		0 1, 563, 504	222, 816	6.00
7.00	HIT designated Assets	3, 738, 447	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	41, 923, 337	1, 583, 696		0 1, 583, 696	219, 316	8.00
9.00	Reconciling Items	2, 265, 538	1, 324, 829		0 1, 324, 829	0	9.00
10.00	Total (line 8 minus line 9)	39, 657, 799	258, 867		0 258, 867	219, 316	10.00
		Endi ng Bal ance	Fully				
		5	Depreciated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES					
1.00	Land	260, 976	0				1.00
2.00	Land Improvements	2, 469, 451	44, 862				2.00
3.00	Buildings and Fixtures	14, 608, 257	237, 338				3.00
4.00	Building Improvements	48, 824	48, 824				4.00
5.00	Fixed Equipment	6, 267, 461	53, 545				5.00
6.00	Movable Equipment	15, 894, 301	6, 067, 037				6.00
7.00	HIT designated Assets	3, 738, 447	0				7.00
8.00	Subtotal (sum of lines 1-7)	43, 287, 717	6, 451, 606				8.00
9.00	Reconciling Items	3, 590, 367	0				9.00
10.00	Total (line 8 minus line 9)	39, 697, 350	6, 451, 606				10.00

Heal th	Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0101	Peri od:	Worksheet A-7	
					From 01/01/2017		norod.
					To 12/31/2017	Date/Time Pre 5/29/2018 4:1	
			SL	JMMARY OF CAP	I TAL	0/2//2010 1.1	
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	1	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	4, 707, 034	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	4, 707, 034	0		0 0	0	3.00
		SUMMARY O	F CAPITAL				
				-			
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)	15 00	-			
	14.00     15.00       PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1 00		SHEET A, COLUM					1 00
1.00	CAP REL COSTS-BLDG & FIXT	0	4, 707, 034				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	4, 707, 034				3.00

Heal th	n Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2017 To 12/31/2017		
		COMI	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C			05 (05 04)			
1.00	CAP REL COSTS-BLDG & FIXT	25, 605, 846		20/000/010		0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	17, 354, 232				0	2.00
3.00	Total (sum of lines 1-2)	42, 960, 078	579, 195 TION OF OTHER (		3 1.000000 SUMMARY 0		3.00
		ALLUCA	TION OF OTHER (	APITAL	SUMMARY	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capital-Relate d Costs	cols.5 through 7)			
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0	(	998, 673	494, 936	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	(	1, 569, 533		2.00
3.00	Total (sum of lines 1-2)	0	0	(	2, 568, 206	542, 482	3.00
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	•		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	-	1	1	1		
1.00	CAP REL COSTS-BLDG & FIXT	0	01/000		97,000		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	01/001		0 0	1, 671, 433	2.00
3.00	Total (sum of lines 1-2)	0	91, 854	(	97,000	3, 299, 542	3.00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
ADJUSTMENTS TO EXPENSES	Provider CCN: 15-010	1 Period: Worksheet A-8
		From 01/01/2017

100001	MENTS TO EXPENSES				From 01/01/2017 To 12/31/2017	Date/Time Prep 5/29/2018 4:10	
			Tc	Expense Classification o D/From Which the Amount is			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center 3.00	Li ne #	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL	1.00		AP REL COSTS-BLDG & FIXT	1.00		1.00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		OCA	AP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3.00
	(chapter 2)						
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by		О		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay		o		0.00	0	7.00
	stations excluded) (chapter		_				
8.00	21) Television and radio service	А	-307 OF	PERATION OF PLANT	7.00	0	8.00
9.00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician	A-8-2	-30, 696		0.00	0	10.00
11.00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11.00
12.00	(chapter 23) Related organization	A-8-1	-8, 175, 943			0	12.00
	transactions (chapter 10)	A-0-1	-0, 175, 945				
13.00 14.00	Laundry and linen service Cafeteria-employees and guests	В	0 -17, 694 CA	AFFTERIA	0.00		
15.00	Rental of quarters to employee		0		0.00		
16. 00	and others Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17.00	patients Sale of drugs to other than	В	-16, 707 PH	IARMACY	15.00	0	17.00
	patients	, D					
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19. 00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00		
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	,	0		0.00	0	22. 00
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	ORE	SPI RATORY THERAPY	65.00		23. 00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	OPH	IYSI CAL THERAPY	66.00		24. 00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0 * *	** Cost Center Deleted ***	114.00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL COSTS-BLDG & FIXT		OCA	AP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27.00	Depreciation - CAP REL		0 CA	AP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		ONC	NPHYSI CI AN ANESTHETI STS	19.00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	CCUPATI ONAL THERAPY	0.00 67.00	0	29.00 30.00
30.00	therapy costs in excess of limitation (chapter 14)	A-0-3		OUATIONAL INERAFT	67.00		30.00
30. 99	Hospice (non-distinct) (see instructions)		OAD	DULTS & PEDIATRICS	30.00		30. 99
31.00	Adjustment for speech pathology costs in excess of	A-8-3	OSF	PEECH PATHOLOGY	68.00		31.00
32.00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32.00
	Depreciation and Interest						

Heal th	Financial Systems		WHITLEY MEMORI	AL HOSPITAL	In Lie	eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-0101	Period: From 01/01/2017 To 12/31/2017		pared:
				Expense Classification o	n Worksheet A	0/2//2010 4.1	
				To/From Which the Amount is	s to be Adjusted		
	Cost Center Description		Amount	Cost Center	Line #	Wkst. A-7 Ref.	
00.01		1.00	2.00	3.00	4.00	5.00	00.01
33.01	TELEMETRY ADJUSTMENT	A B		ADULTS & PEDIATRICS	30.00		
35.00	POSTURE ASSESSMENTS	A		PHYSI CAL THERAPY ANESTHESI OLOGY	66.00		
36.00 37.00	ANESTHESIA PROFESSIONAL FEES MISC REVENUE	B		RADI OLOGY-DI AGNOSTI C	53.00 54.00		
37.00	NON-PATIENT LAB REV.	B		RESPIRATORY THERAPY	65.00		
39.00	TELEVI SI ON OFFSET	A		CAP REL COSTS-MVBLE EQUIP	2.00		39.00
40.00	ANSWERI NG SERVI CE	A		ADMI NI STRATI VE & GENERAL	5.00		
41.00	PHYSICIAN RECRUITING	A		ADMI NI STRATI VE & GENERAL	5.00		
42.00	MEALS ON WHEELS	A	20,000		0.00		
43.00	VI SI TOR MEALS	A	-22, 822	CAFETERI A	11.00		1
44.00	PHARMACY SALES	A	-898, 352		15.00		•
45.00	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00		
46.00	SELF INSURANCE	A	-3, 009, 058	EMPLOYEE BENEFITS DEPARTMEN	IT 4.00	0	46.00
48.00	LOBBY EXPENSE	A	-3, 025	ADMINISTRATIVE & GENERAL	5.00	0	48.00
48.01	INTERUNIT RENT EXPENSE	A	-72, 785	RESPI RATORY THERAPY	65.00	0	48.01
48.02	INTERUNIT RENT EXPENSE	A		PHYSI CAL THERAPY	66.00		
48.03	INTERUNIT RENT EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00		
48.04	INTERUNIT RENT EXPENSE	A		OPERATION OF PLANT	7.00		
48. 05	LOBBY EXPENSE	A		COMMUNITY & VOLUNTEER SERVICES	194.04		
48.06	LIQUOR	A		ADMINI STRATI VE & GENERAL	5.00		
48.07	SPONSORSHIPS	A		ADMINI STRATI VE & GENERAL	5.00		48.07
48.08	PHYS ADMIN SAL ADD BACK	A		ADMI NI STRATI VE & GENERAL	5.00		
49.00	OPERATING INTEREST	A	- /	PHARMACY	15.00		1
49.01	OPERATING INTEREST	A		OPERATING ROOM	50.00		
49.02	RENT EXPENSE - PHYSICIANS' CLINIC	A	-	PHYSICIANS' PRIVATE OFFICES			
49.03	MI SC REVENUE	В		ADULTS & PEDIATRICS	30.00		
49.07	MI SC REVENUE	В		OPERATING ROOM	50.00		1
49.10	HOSPITALIST/SURGEON ON CALL	A		ADMINISTRATIVE & GENERAL	5.00	0	
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-14, 038, 025				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof. Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	REAL HOSPETAL	In Lie	eu of Form CMS-	2552-10	
				Peri od:	Worksheet A-8	-1
OFFICE COSTS				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 4:1	
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3. 00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	INTERCOMPANY RENT	0	2, 138, 512	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	REMOVE PPG SUBSIDY	0	8, 954, 041	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	12, 568, 610	9, 652, 000	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			12, 568, 610	20, 744, 553	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

110		been posted to worksheet A,	corumns r anu/or z, the amount			or this part.		
					Related Organization(s) and/or Home Office			
		Symbol (1)	Name	Percentage of	Name	Percentage of		
				Ownershi p		Ownershi p		
		1.00	2.00	3.00	4.00	5.00		
	B INTERPRETATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE							

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

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

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

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

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

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

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

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

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

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

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES OFFICE COSTS	FROM RELATED ORGANIZATIONS AND HOME		Period: From 01/01/2017 To 12/31/2017	Worksheet A-8-1 Date/Time Prepared:

			5/29/2018 4:1	0 pm
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
-	A. COSTS INCUR	RED AND ADJUST	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	-2, 138, 512	9		1.00
2.00	-8, 954, 041	0		2.00
3.00	2, 916, 610	0		3.00
4.00	0	0		4.00
5.00	-8, 175, 943			5.00

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

1103 1101	been posted to norkaneet A,		
	Related Organization(s)		
	and/or Home Office		
	Type of Business	1	
	5.		
	6.00	1	
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

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

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

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

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

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

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

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

Heal th	Financial Syste	ems	WHITLEY MEMOR	RIAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
PROVIDER BASED PHYSICIAN ADJUSTMENT				Provider CCN: 15-0101		Peri od:	Worksheet A-8-2	
						From 01/01/2017 To 12/31/2017		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	U pili
	WRSt. A EINC #	I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	67, 500	0		211, 500	422	1.00
2.00	53.00	ANESTHESI OLOGY	24, 000	0	24,000	239, 400	179	2.00
3.00		AMBULANCE SERVICES	10, 029			211, 500	72	3.00
4.00	0.00		0		-	-	0	4.00
5.00	0.00		0	-	(	-	0	5.00
6.00	0.00		0	0	(	0	0	6.00
7.00	0.00		0	0	(	0 0	0	7.00
8.00	0.00		0	0	(	0 0	0	8.00
9.00	0.00		0	-	(	0 0	0	9.00
10.00	0.00		0	0	(	0	0	10.00
200.00			101, 529				673	200.00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE Limit	Continuing	Component Share of col.	of Malpractice Insurance	
					Educati on	12 Share of Col.	Thsurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		EMERGENCY	42, 910				0	1.00
2.00		ANESTHESI OLOGY	20, 602	1, 030			0	2.00
3.00		AMBULANCE SERVICES	7, 321	366			0	3.00
4.00	0, 00		0	0	(	0	0	4,00
5.00	0.00		0			0	0	5.00
6.00	0.00		0	0	(	0	0	6.00
7.00	0.00		0	0	(	0	0	7.00
8.00	0.00		0	0	(	0	0	8.00
9.00	0.00		0	0	(	0	0	9.00
10.00	0.00		0	0	(	0	0	10.00
200.00			70, 833	3, 542	(	0 0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	0.00	14	14.00	17.00	10.00		
1 00	1.00	2.00 EMERGENCY	15.00	16.00	17.00	18.00		1 00
1.00 2.00		ANESTHESI OLOGY	-	,				1.00 2.00
2.00			0		2,708			2.00
3.00 4.00	0.00	AMBULANCE SERVICES		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				3.00 4.00
4.00 5.00	0.00			-				4.00 5.00
5.00 6.00	0.00					-		5.00 6.00
7.00	0.00		0	-	-			7.00
8.00	0.00							7.00 8.00
9.00	0.00		0	-				9, 00
10.00	0.00		0			~		10.00
200.00	0.00		0			~		200.00
	I	1					ı 1	

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS	WHITLEY MEMORI	AL HOSPITAL Provider CO	F	In Lie Period: From 01/01/2017 To 12/31/2017	u of Form CMS- Worksheet B Part I Date/Time Pre	
				0 12/31/2017	5/29/2018 4:1	
		CAPITAL RELATED COSTS				
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT	1, 628, 109	1, 628, 109				1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P	1, 671, 433	0	1, 671, 433			2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINI STRATIVE & GENERAL	2, 543, 819 15, 659, 124	528, 356	C 542, 417	_, _ , _ ,	17, 459, 389	4.00 5.00
6. 00 00600 MAI NTENANCE & REPAI RS	13, 037, 124	0	542, 417		0	1
7.00 00700 OPERATION OF PLANT	1, 421, 217	123, 329	126, 610	51, 084	1, 722, 240	1
8.00 00800 LAUNDRY & LINEN SERVICE	281, 087	5, 762			292, 765	
9.00 00900 HOUSEKEEPING	642, 146	4, 816			708, 365	
10. 00  01000  DI ETARY 11. 00  01100  CAFETERI A	203, 423	20, 647			262, 530 616, 792	1
12. 00 01200 MAINTENANCE OF PERSONNEL	528, 509	23, 284	23, 903		010, 792	11.00 12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	215, 474	1, 403		°,	244,008	1
14.00 01400 CENTRAL SERVICES & SUPPLY	0	16, 671			33, 785	14.00
15. 00 01500 PHARMACY	766, 576	14, 449			874, 789	
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	0	5, 135	5, 272		10, 407 0	
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	0				0	
20. 00 02000 NURSI NG SCHOOL	0	0		) O	0	1
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	C	0 0	0	21.00
22. 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	C	0	0	22.00
23. 00 02300 PARAMED ED PRGM-(SPECI FY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	C	0 0	0	23.00
30. 00 03000 ADULTS & PEDIATRICS	3, 616, 602	225, 521	231, 523	358,654	4, 432, 300	30.00
43. 00 04300 NURSERY	138, 186	0			145, 002	
44.00 O4400 SKI LLED NURSI NG FACI LI TY	0	0	C	00	0	44.00
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM	1 207 2/2	134, 683	138, 267	119, 457	1, 789, 770	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 397, 363 423, 643	134, 003			451, 151	1
53. 00 05300 ANESTHESI OLOGY	20, 602	0	C		20, 602	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 003, 998				3, 613, 281	
	2, 935, 017	31, 545			2, 998, 946	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 65. 00 06500 RESPIRATORY THERAPY	0 531, 127	0 24, 942	-	-	0 642, 898	
66. 00 06600 PHYSI CAL THERAPY	468, 742	84, 672			738, 230	
67.00 06700 OCCUPATI ONAL THERAPY	567, 822	0	C		632, 662	
68. 00 06800 SPEECH PATHOLOGY	54, 725	0	C	6, 249	60, 974	
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	652, 789	0			0 652, 789	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	408, 446			0	408, 446	
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 687, 987	0	c	0 0	1, 687, 987	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	C	0	0	
76. 98 07698 HYPERBARI C 0XYGEN THERAPY 76. 99 07699 LI THOTRI PSY	11, 742	0		.,	12, 907 0	1
OUTPATIENT SERVICE COST CENTERS	0	0			0	70.77
90. 00 09000 CLINIC	0	0	C	0 0	0	90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0	
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 838, 918	160, 168	164, 430	363, 515	5, 527, 031 0	
OTHER REIMBURSABLE COST CENTERS					0	92.00
95. 00 09500 AMBULANCE SERVI CES	1, 912, 026	0	C	185, 943	2, 097, 969	95.00
SPECIAL PURPOSE COST CENTERS	1					
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	48, 230, 652				48, 138, 015	
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	32, 641	3, 062			38, 846 534, 024	190.00
192. 00 19200 PHYSICIANS PRIVATE OFFICES 194. 00 07950 OCCUPATI ONAL HEALTH	455, 017	37, 169	38, 158	3,000		192.00
194.01 07951 PAIN CLINIC	0	0	C	0		194.01
194. 02 07952 OAK POI NTE	0	0	C	0 0		194. 02
	342, 996	0	0	1, 076	344, 072	
194.04 07954 COMMUNITY & VOLUNTEER SERVICES 194.05 07955 VACANT SPACE	172, 509	3, 030	3, 111	208	178, 858	194. 04 194. 05
194. 05 07955 VACANT_SPACE 194. 06 07956 TELEHEALTH_MEDICINE	0 14, 195					194.05 194.06
200.00 Cross Foot Adjustments	17,175			0	0	200.00
201.00 Negative Cost Centers		0	C	0	0	201.00
202.00   TOTAL (sum lines 118 through 201)	49, 248, 010	1, 628, 109	1, 671, 433	2, 543, 819	49, 248, 010	J202.00

Health Financial Systems	WHITLEY MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Pre 5/29/2018 4:1	pared:
Cost Center Description	ADMI NI STRATI VE		OPERATION OF		HOUSEKEEPI NG	
	& GENERAL 5.00	REPAI RS 6.00	PLANT 7.00	LINEN SERVICE 8.00	9.00	
GENERAL SERVICE COST CENTERS	3.00	0.00	7.00	0.00	7.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	17, 459, 389					5.00
6.00 00600 MAI NTENANCE & REPAI RS	0	0	0 ( ( 0 45			6.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE	945, 913 160, 796	0	2, 668, 15 15, 74			7.00 8.00
9. 00 00900 HOUSEKEEPI NG	389, 058	0	13, 16		1, 110, 584	9.00
10. 00 01000 DI ETARY	144, 190	0	56, 41		23, 741	10.00
11. 00 01100 CAFETERIA	338, 763	0	63, 62		26, 773	11.00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0		0 0	0	12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	134, 017 18, 556	0	3, 83 45, 55		1, 614 19, 169	13.00 14.00
15. 00 01500 PHARMACY	480, 464	0	39, 48		16, 614	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	5, 716	0	14, 03		5, 905	16.00
17.00 01700 SOCIAL SERVICE	0	0		0 0	0	17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS 20.00 02000 NURSING SCHOOL	0	0		0 0	0	19.00
20.00 02000 NURSING SCHOOL 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0 0	0	20.00
22. 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	22.00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	0		0 0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS	2 424 270	0	(1) 05	10 5/4	250.21/	20.00
30. 00 03000 ADULTS & PEDI ATRI CS 43. 00 04300 NURSERY	2, 434, 370 79, 640	0	616, 25	6 19, 564 0 31, 540	259, 316 0	30.00 43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	040	0		0 0	0	44.00
ANCI LLARY SERVI CE COST CENTERS	· · · · · ·					
50. 00 05000 OPERATI NG ROOM	983, 003	0	368, 03		154, 867	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	247, 787	0		0 74,682	0	52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	11, 315 1, 984, 537	0	490, 40	° .	206, 359	53.00 54.00
60. 00 06000 LABORATORY	1, 647, 123	0	86, 19		36, 272	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62.30
65. 00 06500 RESPIRATORY THERAPY	353, 101	0	68, 15		28, 680	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	405, 461 347, 479	0	231, 37	2 23, 992 0 19, 587	97, 360 0	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	33, 489	0		0 1, 886	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	358, 534	0		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	224, 332	0		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 97 07697 CARDIAC REHABILITATION	927, 100	0		0 0	0	73.00 76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	7,089	0		0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0	0		0 0	0	76.99
		0			0	
90. 00 09000 CLINIC 90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0			0	90.00 90.01
91. 00 09100 EMERGENCY	3, 035, 633	0	437, 67	1 143, 871	184, 170	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	1 150 07/	0		0 00 050		05.00
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	1, 152, 276	0		0 23, 353	0	95.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	16, 849, 742	0	2, 549, 94	0 469, 307	1, 060, 840	118.00
NONREI MBURSABLE COST CENTERS	1		-			1
190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	21, 336	0	8, 36			190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 194. 00 07950 OCCUPATI ONAL HEALTH	293, 304	0	101, 56	6 0 0 0		192.00 194.00
194. 01 07951 PAIN_CLINIC	0	0		0 0		194.00
194. 02 07952 OAK POI NTE	0	0		0 0		194. 02
	188, 976	0		0 0		194.03
194.0407954 COMMUNITY & VOLUNTEER SERVICES 194.0507955 VACANT SPACE	98, 235	0	8, 28			194. 04 194. 05
194. 06 07956 TELEHEALTH MEDICINE	7, 796	0		0 0		194.05
200.00 Cross Foot Adjustments		Ű				200. 00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00   TOTAL (sum lines 118 through 201)	17, 459, 389	0	2, 668, 15	3 469, 307	1, 110, 584	202.00

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 01/01/2017	Worksheet B Part I	
				To 12/31/2017	Date/Time Pre	pared:
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE O	F NURSI NG	5/29/2018 4:1 CENTRAL	0 pm
			PERSONNEL	ADMI NI STRATI ON		
	10.00	11.00	12.00	13.00	SUPPLY 14.00	
GENERAL SERVICE COST CENTERS				1		
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUI P 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
6.00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE						7.00
9. 00 00900 HOUSEKEEPING						9.00
10. 00 01000 DI ETARY	486, 880					10.00
11. 00 01100 CAFETERIA 12. 00 01200 MAINTENANCE OF PERSONNEL	0	1, 045, 952 0		0		11.00
13. 00 01300 NURSING ADMINISTRATION	0	13, 020		0 396, 494		12.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0		0 0	117, 064	
15. 00  01500  PHARMACY 16. 00  01600  MEDI CAL_RECORDS_&_LI BRARY	0	30, 380 0		0 0 0 0	2, 605 0	1
17. 00 01700 SOCIAL SERVICE	0	0		0 0	0	1
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0		0 0	0	
20.00 02000 NURSING SCHOOL 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	
21.00 02100 I & SERVI CES-SALARY & FRI NGES APPRV 22.00 02200 I & SERVI CES-OTHER PRGM COSTS APPRV	0	0		0 0	0	
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	0		0 0	0	1
INPATIENT ROUTINE SERVICE COST CENTERS	404,000	450.040		0 404 007	0.447	
30. 00 03000 ADULTS & PEDI ATRI CS 43. 00 04300 NURSERY	486, 880 0	153, 348 17, 842		0 124, 837 0 0	2, 147 3, 461	30.00 43.00
44.00 04400 SKI LLED NURSI NG FACI LI TY	0	0		0 0	0, 101	1
ANCI LLARY SERVI CE COST CENTERS		70.405		0 57.045	4/ 0/5	
50.00 05000 0PERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	70, 405 42, 436		0 57, 315 0 34, 546	16, 045 8, 208	
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0,200	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	165, 886		0 0	6, 985	
60. 00  06000  LABORATORY 62. 30  06250  BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0 0 0	0	1
65. 00 06500 RESPI RATORY THERAPY	0	40, 507		0 0	4, 049	
66. 00 06600 PHYSI CAL THERAPY	0	74, 745		0 0	733	
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	30, 380 6, 269		0 0 0 0	598 58	1
69. 00 06900 ELECTROCARDI OLOGY	0	0, 209		0 0	0	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	27, 775	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	16, 928	
76. 97 07697 CARDIAC REHABILITATION	0	0		0 0	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76. 98
76. 99 07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0	0		0 0	0	76.99
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90.01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0		0 0	0	90.01
91.00 09100 EMERGENCY	0	220, 863		0 179, 796	18, 284	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVICES	0	165, 404		0 0	6, 652	95.00
SPECIAL PURPOSE COST CENTERS	404,000	4 004 405		0 00( 404	444 500	1110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	486, 880	1,031,485		0 396, 494	114, 528	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	1, 151	190.00
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	9, 645		0 0		192.00
194. 00 07950 OCCUPATI ONAL HEALTH 194. 01 07951 PAIN CLINIC	0	0		0 0 0 0		194.00 194.01
194. 02 07952  0AK_POI NTE	0	0		0 0		194.01
194. 03 07953 FOUNDATI ON	0	4, 822		0 0	0	194.03
194. 04 07954  COMMUNI TY & VOLUNTEER SERVI CES 194. 05 07955  VACANT SPACE	0	0		0 0 0 0		194.04 194.05
194. 06 07956 TELEHEALTH MEDICINE	0	0		0 0		194.05
200.00 Cross Foot Adjustments		0		-		200.00
201.00 Negative Cost Centers	0	1 045 052		0 0		201.00
202.00   TOTAL (sum lines 118 through 201)	486, 880	1, 045, 952	I	0 396, 494	117, 064	1202.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	WHITLEY MEMORIA	Provi der CC	CN: 15-0101	Period: From 01/01/2017	u of Form CMS- Worksheet B Part I	
					To 12/31/2017		epared
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY		CE NONPHYSI CI AN ANESTHETI STS	NURSING SCHOOL	
		15.00	16.00	17.00	19.00	20.00	-
. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.0
2.00	00200 CAP REL COSTS-MUBLE EQUIP						2.0
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
. 00	00500 ADMI NI STRATI VE & GENERAL						5.0
o. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6.0 7.0
. 00 3. 00	00800 LAUNDRY & LINEN SERVICE						8.0
. 00	00900 HOUSEKEEPI NG						9.0
0.00	01000 DI ETARY						10.0
1.00							11.0
2.00 3.00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION						12.0
4.00	01400 CENTRAL SERVICES & SUPPLY						14.0
5.00	01500 PHARMACY	1, 444, 334					15.0
6.00	01600 MEDICAL RECORDS & LIBRARY	0	36, 060				16.0
7.00	01700 SOCIAL SERVICE	0	0		0		17.0
9.00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0	0		0 0	0	19.0 20.0
1.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0	0	20.0
2.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0		22.0
3.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0		23.0
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
0.00 3.00	03000 ADULTS & PEDI ATRI CS 04300 NURSERY	61 0	1, 882 400		0 0	0	
4.00	04400 SKI LLED NURSI NG FACI LI TY	0	400		0 0	0	
	ANCI LLARY SERVICE COST CENTERS						
0.00	05000 OPERATI NG ROOM	409	451		0 0	0	
2.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
3.00 4.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 1, 642	0 13, 414		0 0	0	
0. 00	06000 LABORATORY	1, 042	13, 414		0 0	0	
2.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62.3
5.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65.0
6.00	06600 PHYSI CAL THERAPY	2, 026	3, 739		0 0	0	66.0
7.00 8.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	1, 147 296		0 0	0	
9.00 9.00	06900 ELECTROCARDI OLOGY	0	290		0 0	0	
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.0
3.00	07300 DRUGS CHARGED TO PATIENTS	1, 427, 034	0		0 0	0	
	07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY	0	0		0 0	0	
	07699 LI THOTRI PSY	0	0		0 0	0	
	OUTPATIENT SERVICE COST CENTERS		-1		-		
0.00	09000 CLI NI C	0	0		0 0	0	
	09001 INTENSIVE OUT PATIENT PROGRAM	0	0		0 0	0	
1.00 2.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	9, 431	14, 731		0 0	0	91.0 92.0
2.00	OTHER REIMBURSABLE COST CENTERS	I					72.0
5.00	09500 AMBULANCE SERVICES	3, 720	0		0 0	0	95.0
	SPECIAL PURPOSE COST CENTERS						
18.00	NONREI MBURSABLE COST CENTERS	1, 444, 323	36, 060		0 0	0	118. 0
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.0
	19200 PHYSI CLANS' PRI VATE OFFI CES	9	0		0 0		192.0
	07950 OCCUPATIONAL HEALTH 07951 PAIN CLINIC	0	0		0 0		194. 0 194. 0
	07951 PAIN CEINIC	0	0		0 0		194.0
	07953 FOUNDATI ON	Ő	0 0		0 0		194.0
	07954 COMMUNITY & VOLUNTEER SERVICES	2	0		0 0		194. 0
	07955 VACANT SPACE	0	0		0 0		194.0
	07956 TELEHEALTH MEDICINE	0	0		0 0		194.0
00.00		0	0		0 0		200. 0 201. 0
01.00							

CLOST ALLIDEATION - GENERAL SERVICE COSTS         Prevalues	Heal th Financial Systems	WHITLEY MEMORI				eu of Form CMS-2	2552-10
Intervise a RESIDENTS         Intervise a RESIDENTS         Intervise a Residents         Intervise a Residents           Cost Center Description         StableTail         StableTail         StableTail         StableTail           Cost Center Description         Intervise A RESIDENTS         PROV         StableTail         StableTail           Cost Center Description         Intervise A Residents         PROV         StableTail         StableTail           Cost Center Description         Intervise A Residents         PROV         StableTail         StableTail           Cost Center Description         Intervise A Residents         PROV         StableTail         StableTail           Cost Center Description         Intervise A Residents         Intervise A Residents         A Residents         A Residents           Cost Center Description         Intervise A Residents         Intervise A Residents         A Residents         A Residents           Cost Center Description         Intervise A Residents         Intervise A Residents         A Residents         A Residents           Cost Center A Residents         Intervise A Residents         Intervise A Residents         A Residents         A Residents           Cost Cost Center A Residents         Intervise A Residents         Intervise A Residents         A Residentail         A Residents	COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	1	From 01/01/2017	Part I	nared
Cost Center Description         FRV/CSS_SH26/FRV/CS.0F.00         PRAMED ED (PROVI         Subtract         Intern & cost Provid           1:00         COSTO CAP HEL COST-CAVIENS         21:00         22:00         23:00         24:00         20:00           1:00         COSTO CAP HEL COST-CAVIENS         0         20:00		INTEDNS &	PESIDENTS			5/29/2018 4:1	0 pm
V A FRI NDS         PROV         PROV         PROV         PROV         Residents. Cost Augment           0         CUENCAL SERVICE COST OLUTIES         21.00         22.00         24.00         35.00         1.00           0         000000 (AP FEL, COST OLUTIES         0         20.00         22.00         24.00         35.00         1.00           0.00000 (AP FEL, COST OLUTIES         0         0.00000 (AP FEL, COST OLUTIES         0.000000 (AP FEL, COST OLUTIES         0.0000000 (AP FEL, COST OLUTIES         0.00000000000000000000000000000000000							
Image: stand set of the set of t	Cost Center Description				Subtotal		
21.00         22.00         21.00         24.00         75.00           1.00         01000 CAP MIL CONST FLING & LEW         1.00		APPRV	APPRV				
HNI MAL STRATE COST CONTENT         Image: Cost Content of the A FLAT         Image: Cost Cost Content of the A FLAT         Image: Cost Cost Cost Cost Cost Cost Cost Cost		21.00	22.00	22.00	24.00	Adjustments	
2.00 0200 CAP REL COSTS-JVBLE EQUIP 4 2.00 0200 CAP REL COSTS-JVBLE EQUIP 4 4.00 5.00 0200 CAP REL COSTS-JVBLE COUP 4 5.00 0200 CAP REL COSTS COSTS-JVBLE COUP 4 5.00 0200 CAP REL COSTS-JVBLE COUP 4 5.00 0200 CAP REL COSTS-JVBLE COUP 4 5.00 0200 CAP REL COSTS-JVBLE COSTS-JVBLE COUP 4 5.00 0200 CAP REL COSTS-JVBLE COSTS-JVBLE CONTS-JVBLE CONTS-	GENERAL SERVICE COST CENTERS	21.00	22.00	23.00	24.00	25.00	
4.00         DAND OF BENEFITS DEPARTMENT         4.00           00         DOSON MAIN INSTANT VAL         4.00           00         DOSON MAIN INSTANT VAL         6.00           00         DOSON MAINTSANT VAL         7.00           00         DOSON MAINTSANT VAL         7.00           00         DOSON MARSING ANDIN STRATTON         10.00           11.00         DISON MARSING ANDIN STRATTON         11.00           12.00         DISON MARSING ANDIN STRATTON         11.00           13.00         DISON MARSING ANDIN STRATTON         11.00           14.00         DISON MARSING ANDIN STRATTON         11.00           15.00         DISON MARSING ANDIN STRATTON         11.00           10.00         DISON MARSING ANDIN STRATTON         11.00           10.00         DISON MARSING ANDIN STRATTON         0         11.00           10.00         DISON MARSING ANDIN STRATTON         0         0         20.00           10.00         DISON MARSING ANDIN STRATTON							
6.00         Decody UNI NITENANCE & REPAIRS         6.00         6.00         6.00         6.00         6.00         8.00         9.00							
7.00         00700         DEERATION OF FLANT         7.00           00         00800         AURINPY & LINEN SERVICE         9.00           0.00         00700         DETAPY         14.00           0.00         00700         DETAPY         14.00           0.00         00400         DETAPY         14.00           0.000         00400         DETAPY         14.00           0.000         00400         DETAPY         0         0           0.000         00400         DETAPY         0         0							
9 - 00 00900   HOLSELEP IN C 10.00 01000   TTAY 11.00 01100   CAFTERIA A 11.00 01000   CAFTERIA A 11.00 0100   CAFTERIA A 11.00 01000   CAFTERIA A 11.00 0100   CAFTERIA A 11.00 0100 000   CAFTERIA A 11.00 0100   CAFTERI							
10.00         010000         01000         01000 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
12:00       01200 (MAIN TERANCE OF PERSONNELL       12:00	10. 00 01000 DI ETARY						10.00
13.00       01300       NURSEN & AXMIN STRATION       13.00       13							
15. 00       01500 (PHARBARY       15. 00       15.	13.00 01300 NURSING ADMINISTRATION						13.00
16. 00       01000       MEDI CAL RECORDS & LI BRARY       6. 00       6. 00         17. 00       01700       01900       NORHYSI CAL AMESTRUTE STS       9. 0       9. 00							
19.00       01900 NUMPHYSICALALAMESTRES ISS       99.00         20.00       02000 LAR SERVICES-SALARY & FRINGES APPRV       0       21.00       22.00<	16. 00 01600 MEDI CAL RECORDS & LI BRARY						16.00
20.00         02000         NURS INS CSHOOL.         22.00							
12.00         02200 IAR SERVICES-OTHER PROM COSTS APPRV         0         22.00         23.00	20. 00 02000 NURSI NG SCHOOL						20.00
13.00         102300         PREMI-CSPECT FY)         0         23.00           INPARTURT NOTINE TOR THOR SERVICE COST CENTERS         0         0         0         8.530.961         0         0         30.00           30.00         04000 SKI LED NURSING FACILITY         0         0         0         0         0         0         44.00           AND CLARY SERVICE COST CENTERS         0         0         0         3.495.778         0         50.00         0         0         3.495.778         0         50.00         50.00         50.00         0         0         0         0         3.495.778         0         50.00         53.00         61.00         52.00         52.00         52.00         53.00         60.00         0         0         0         0         53.00         66.00         60.00         66.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.0		0	0				
90. 00         03000 [ADULTS & PEDIATRICS         0         0         0         8. 530, 961         0	23.00 02300 PARAMED ED PRGM-(SPECIFY)				0		
43. 00       0       0       0       277.885       0       43. 00         44. 00       44. 00       44. 00       Advolute cost centers       0		0	0		0 8, 530, 961	0	30,00
ARCILLARY SERVICE COST CENTERS         Image: Control of Contrecont	43. 00 04300 NURSERY	0	0		0 277, 885	0	43.00
52:00         DS200         DELLVERY ROOM & LABOR ROOM         0         0         858, 810         0         52:00           53:00         05300         AMSTHESI OLOGY         0         0         31:917         0         53:00           63:00         05400         ADJON AMESTHESI OLOGY         0         0         65:55,917         0         64:00           60:00         AGOON ALBORATORY         0         0         0         4:768,602         60:00           61:00         OSCOU PESIP NATIORY THERAPY         0         0         0         1:339,268         65:00           66:00         06600 PHYSI CLATHERAPY         0         0         0         1:339,268         65:00           67:00         06700 OCCUPATIONAL THERAPY         0         0         0         1:339,268         65:00           68:00         06800 SPECCH PATHOLOGY         0         0         0         10:33,953         67:00           69:00         00         0         0         0         0         10:33,953         67:00           71:00         07300         DISDICAL SURGED TO PATIENTS         0         0         0         10:30,0730         73:00         73:00         73:00         73:00		0	0		0 0	0	44.00
53.00       05300       ARSTHESIOLOGY       0       0       31,917       0       53.00         64.00       05400       RADIOLOGY PIA GAUOSTI C       0       0       6,555,917       54.00         64.00       0500       LABORATORY       0       0       0       4,768,602       66.00         65.00       0500       RESPI RATORY THERAPY       0       0       0       1,139,268       66.00         66.00       06000       RESPI RATORY THERAPY       0       0       0       1,577,658       66.00         67.00       67.00       COUDO CULPATIONAL THERAPY       0       0       0       1,039,098       67.00         68.00       068000 SPECH PATHOLOGY       0       0       0       0       0       68.00         71.00       07100 MEDI CAL, SUPPLIES CHARGED TO PATIENTS       0       0       0       10.039,098       71.00         72.00       07300 DRUSC CHARCED TO PATIENTS       0       0       0       64.97.06       72.00         76.90       07698       176480 HYPERARI C OXYGEN THERAPY       0       0       0       90.01       76.99         00.01       90001 HVDE ENVICE COST CENTERS       0       0       0       <						-	
60.00         00         0         4,768,602         0         60.00           62.30         6250         RLOD CLOTTING FOR HEMOPHILLACS         0         1, 139, 258         0         0         0         0         1, 137, 76, 58         0						-	
62.30       665.00       CODTTING FOR HEMOPHILIACS       0       0       0       62.30         65.00       06500       RESPIRATORY THERAPY       0       0       0       1,139,268       0       65.00         66.00       06600       PHYSICAL THERAPY       0       0       0       1,577,558       0       66.00         67.00       0C000 SPECE HATHONAL THERAPY       0       0       0       1,031,853       0       67.00         68.00       069000       SPECE HATHOLOGY       0       0       0       0       0       68.00         69.00       00000 SPECE HARGED TO PATIENT       0       0       0       1,039,098       0       71.00         71.00       0700 IMPL, DEV, CHARGED TO PATIENTS       0       0       0       4,042,121       0       73.00         73.00       07697       CARDIA CREABD TO PATIENTS       0       0       0       0       0       0       0       0       0       72.00         76.90       7698       IYERBARI C 0XYGEN THERAPY       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0		0	-			-	
66.00         06600         PHYSI CAL THERAPY         0         0         1,577,658         0         66.00           67.00         067000         0CCUPATI ONAL THERAPY         0         0         1,031,853         0         67.00           68.00         06600         SPECCH PATHOLOGY         0         0         102,972         68.00           69.00         06600         SPECCH PATHOLOGY         0         0         1,039,098         0         71.00           71.00         70100         MDICAL SUPPLIES CHARGED TO PATIENTS         0         0         1,439,098         0         71.00           73.00         70597         CARDIAC REHABILITATION         0         0         4,42,121         0         73.00           76.97         07697         IARDIAC REHABILITATION         0         0         0         0         76.97           00.00         07699         LITHOTRIPSY         0         0         0         0         76.99           00.00         07699         LITHOTRIPSY         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0		0	-		,	-	
67.00         06700         0CCUPATIONAL THERAPY         0         0         1, 031, 853         0         67.00           68.00         06800         SPEECH PATHOLOGY         0<		0	0				
69.00         06900         ELECTROCARDIOLOGY         0 <td>67. 00 06700 OCCUPATI ONAL THERAPY</td> <td>0</td> <td>0</td> <td></td> <td>0 1, 031, 853</td> <td></td> <td></td>	67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 1, 031, 853		
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       0       1,039,098       0       71.00         72.00       07300       DMPL. DEV. CHARGED TO PATIENTS       0       0       649,706       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       649,706       0       73.00         76.97       7669       HYERARAI C XYGEN THERAPY       0       0       0       0       76.99         76.99       07699       LI THOTRI PSY       0       0       0       0       76.99         00.00       90001       LIN C       0       0       0       0       0       76.99         01.01       0       0       0       0       0       0       0       0       76.99         01.01       0       0       0       0       0       0       0       90.01         90.00       90001       INTENT VE COST CENTERS       0       0       0       90.01       91.00       92.00       95.00       95.00       95.00       95.00       95.00       95.00       95.00       95.00       95.00       95.00       95.00       95.00       95.00		0	0			-	
73.00       D7300       DRUGS CHARGED TO PATIENTS       0       0       4,042,121       0       73.00         76.97       O7697       CARDIAC REHABILITATION       0       0       0       0       0       76.97         76.97       O7691       KYERABRI C 0XYGEN THERAPY       0       0       0       19.996       0       76.98         76.99       OUTPATIENT SERVICE COST CENTERS       0 <td>71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT</td> <td>-</td> <td></td> <td></td> <td></td> <td></td> <td></td>	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	-					
76. 97       07697       CARDI AC REHABILITATION       0       0       0       0       0       76. 97         76. 98       07698       HYPERBARIC OXYGEN THERAPY       0       0       0       19, 996       0       76. 99         0.0       007699       LI THOTRI PSY       0       0       0       0       0       0       76. 99         0.0       00000       CLINI C       0		0	0				
76.99         O7699         LI THOTRI PSY         O	76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
OUTPATI ENT SERVICE COST CENTERS           90. 00         OPOCO (CLI NIC         O <t< td=""><td></td><td>-</td><td>-</td><td></td><td></td><td></td><td></td></t<>		-	-				
90. 01         09001         INTENSIVE OUT PATIENT PROGRAM         0         0         0         0         0         0         0         0         90. 01         91. 00         91. 00         91. 00         91. 00         91. 00         91. 00         92. 00         92. 00         92. 00         92. 00         92. 00         92. 00         92. 00         92. 00         92. 00         92. 00         93. 449, 374         0         95. 00         95. 00           118. 00         SUBTOTALS (SUM OF LINES 1 through 117)         0         0         0         73, 221         0         190. 00         194. 00         192. 00         194. 01         192. 00         194. 01         192. 00         194. 01         192. 00         0         0	OUTPATIENT SERVICE COST CENTERS	-			-		
91.00       09100       EMERGENCY       0       0       0       9,771,481       0       91.00         92.00       09200       005ERVATION BEDS (NON-DISTINCT PART       0       0       0       92.00							
OTHER         REI MBURSABLE         COST         CENTERS         O         O         O         3, 449, 374         O         95. 00         SPECIAL         PURPOSE         COST         CENTERS         O         O         O         O         Addition of the second o	91.00 09100 EMERGENCY	0	0			0	91.00
95.00         09500         AMBULANCE SERVICES         0         0         3, 449, 374         0         95.00           SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         0         0         0         47, 343, 397         0         118.00           NONREI MBURSABLE COST CENTERS           190.00         19200 GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         73, 221         0         190.00           192.00         19200         PHYSI CI ANS' PRI VATE OFFICES         0         0         0         192.00           194.00         07950         OCUPATI ONAL HEALTH         0         0         0         0         194.00           194.02         07952         OAK POI NTE         0         0         0         0         194.00           194.02         07953         FOUNDATI ON         0         0         0         0         194.02           194.04         07954         COMNATI ON         0         0         0         0         194.02           194.04         07954         COMNDATI ON         0         0         0         0         194.03           194.04<	92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS					0	92.00
118.00         SUBTOTALS (SUM OF LINES 1 through 117)         0         0         47,343,397         0         118.00           NONREL MBURSABLE COST CENTERS         NONREL MBURSABLE COST CENTERS         0         0         0         73,221         0         190.00           192.00         19200         PHYSI CI ANS' PRI VATE OFFI CES         0         0         0         982,474         0         192.00           194.00         07950         OCCUPATI ONAL HEALTH         0         0         0         0         194.00           194.00         07950         OCCUPATI ONAL HEALTH         0         0         0         0         194.00           194.02         07952         OAK POI NTE         0         0         0         0         194.01           194.02         07952         OAK POI NTE         0         0         0         0         194.02           194.03         07953         FOUNDATI ON         0         0         0         194.03           194.04         07954         COMUNITY & VOLUNTEER SERVICES         0         0         0         194.04           194.05         07955         VACANT SPACE         0         0         0         194.05	95. 00 09500 AMBULANCE SERVICES	0	0		0 3, 449, 374	0	95.00
NONREI MBURSABLE COST CENTERS           190.00         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         73, 221         0         190.00           192.00         19200         PHYSI CI ANS' PRI VATE OFFI CES         0         0         0         982, 474         0         192.00           194.00         07950         OCCUPATI ONAL HEALTH         0         0         0         0         194.00           194.01         07952         OAK POI NTE         0         0         0         0         194.00           194.02         07952         OAK POI NTE         0         0         0         0         194.00           194.02         07952         OAK POI NTE         0         0         0         0         194.02           194.03         07953         FOUNDATI ON         0         0         0         0         194.02           194.04         07954         COMNUNI TY & VOLUNTEER SERVICES         0         0         0         289,057         0         194.04           194.05         07955         VACANT SPACE         0         0         0         0         194.05           194.06         07956         TELEHEALTH MEDI CI NE         0		0	0		0 47, 343, 397	0	118.00
192.00       PHYSI CI ANS' PRI VATE OFFICES       0       0       982, 474       0       192.00         194.00       07950       OCCUPATI ONAL HEALTH       0       0       0       0       194.00         194.01       07951       PAI N CLI NI C       0       0       0       0       194.00         194.02       07952       OAK POI NTE       0       0       0       0       194.02         194.02       07952       OAK POI NTE       0       0       0       0       194.02         194.03       07953       FOUNDATI ON       0       0       0       537,870       194.03         194.04       07954       COMMUNI TY & VOLUNTEER SERVICES       0       0       289,057       194.04         194.05       07955       VACANT SPACE       0       0       21,991       194.04         194.05       07955       VACANT SPACE       0       0       21,991       194.06         194.06       07956       TELEHEALTH MEDI CI NE       0       0       21,991       0       194.06         200.00       Cross Foot Adj ustments       0       0       0       0       200.00         201.00       Negati v					0 72 221		100.00
194.01       07951       PALN CLINIC       0       0       0       0       194.01         194.02       07952       OAK POINTE       0       0       0       0       194.02         194.03       07953       FOUNDATION       0       0       0       0       194.03         194.04       07954       COMMUNI TY & VOLUNTEER SERVICES       0       0       0       289,057       0       194.04         194.05       07955       VACANT SPACE       0       0       0       0       194.05         194.06       07954       COMMUNI TY & VOLUNTEER SERVICES       0       0       0       0       194.04         194.05       07955       VACANT SPACE       0       0       0       194.05       194.05         194.06       07956       TELEHEALTH MEDICINE       0       0       0       21,991       194.06         200.00       Cross Foot Adjustments       0       0       0       0       200.00         201.00       Negative Cost Centers       0       0       0       0       201.00							
194. 02       07952       OAK POI NTE       0       0       0       0       194. 02         194. 03       07953       FOUNDATI ON       0       0       0       537, 870       0       194. 03         194. 04       07954       COMMUNI TY & VOLUNTEER SERVICES       0       0       0       289, 057       0       194. 04         194. 05       07955       VACANT SPACE       0       0       0       0       194. 05         194. 06       07956       TELEHEALTH MEDICINE       0       0       0       21, 991       0       194. 05         200. 00       Cross Foot Adjustments       0       0       0       0       0       200. 00         201. 00       Negative Cost Centers       0       0       0       0       0       201. 00		0	0		0 0		
194.04       07954       COMMUNI TY & VOLUNTEER SERVICES       0       0       289,057       0       194.04         194.05       07955       VACANT SPACE       0       0       0       0       194.05         194.06       07956       TELEHEALTH MEDICINE       0       0       0       21,991       0       194.06         200.00       Cross Foot Adjustments       0       0       0       0       200.00         201.00       Negative Cost Centers       0       0       0       0       0       201.00	194. 02 07952 OAK POI NTE	0	0		0 0		
194.05         07955         VACANT SPACE         0         0         0         194.05           194.06         07956         TELEHEALTH MEDICINE         0         0         0         21,991         0         194.06           200.00         Cross Foot Adjustments         0         0         0         0         200.00           201.00         Negative Cost Centers         0         0         0         0         201.00		0	0				
200.00         Cross Foot Adjustments         0         0         0         0         200.00           201.00         Negative Cost Centers         0         0         0         0         0         0         201.00	194.0507955 VACANT SPACE	0	0		0 0	0	194.05
201.00         Negative Cost Centers         0 </td <td></td> <td>0</td> <td>0</td> <td></td> <td>0 21, 991</td> <td></td> <td></td>		0	0		0 21, 991		
202.00         TOTAL (sum lines 118 through 201)       0        0        0        49, 248, 010        0 202.00	201.00 Negative Cost Centers	0	0			0	201.00
	202.00   TOTAL (sum lines 118 through 201)	0	0		0 49, 248, 010	0	202.00

	Financial Systems LOCATION - GENERAL SERVICE COSTS	WHITLEY MEMORIA	Provider CCN: 15-0101	In Lieu of Form CMS Period: Worksheet B From 01/01/2017 Part I	
				To 12/31/2017 Date/Time Pr 5/29/2018 4:	epared
	Cost Center Description	Total 26.00			
(	GENERAL SERVICE COST CENTERS	20100			
00	00100 CAP REL COSTS-BLDG & FIXT				1. (
00 0	00200 CAP REL COSTS-MVBLE EQUIP				2.0
	00400 EMPLOYEE BENEFITS DEPARTMENT				4.0
	00500 ADMI NI STRATI VE & GENERAL				5.0
	00600 MAINTENANCE & REPAIRS				6. (
	00700 OPERATION OF PLANT				7.0
	00800 LAUNDRY & LINEN SERVICE				8.0
	00900 HOUSEKEEPI NG 01000 DI ETARY				9. (
	01100 CAFETERIA				10. (
	01200 MAINTENANCE OF PERSONNEL				12. (
	01300 NURSI NG ADMI NI STRATI ON				13. (
	01400 CENTRAL SERVICES & SUPPLY				14. (
	01500 PHARMACY				15. (
	01600 MEDICAL RECORDS & LIBRARY				16. (
	01700 SOCIAL SERVICE				17. (
00 0	01900 NONPHYSICIAN ANESTHETISTS				19.
. 00 0	02000 NURSING SCHOOL				20.0
. 00 0	02100 I&R SERVICES-SALARY & FRINGES APPRV				21.0
	02200 I&R SERVICES-OTHER PRGM COSTS APPRV				22.0
-	02300 PARAMED ED PRGM-(SPECIFY)				23. (
-	INPATIENT ROUTINE SERVICE COST CENTERS				
	03000 ADULTS & PEDIATRICS	8, 530, 961			30. (
	04300 NURSERY	277, 885			43.
- E	04400 SKI LLED NURSI NG FACI LI TY	0			44. (
	ANCI LLARY SERVICE COST CENTERS	2 405 770			
	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	3, 495, 778 858, 810			50. 52.
	05300 ANESTHESI OLOGY	31, 917			53.0
	05400 RADI OLOGY-DI AGNOSTI C	6, 555, 917			54.
	06000 LABORATORY	4, 768, 602			60.
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			62.
	06500 RESPI RATORY THERAPY	1, 139, 268			65.0
. 00 0	06600 PHYSI CAL THERAPY	1, 577, 658			66. (
. 00 (	06700 OCCUPATI ONAL THERAPY	1, 031, 853			67.0
	06800 SPEECH PATHOLOGY	102, 972			68. (
	06900 ELECTROCARDI OLOGY	0			69.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,039,098			71.0
	07200 IMPL. DEV. CHARGED TO PATIENTS	649, 706			72.
	07300 DRUGS CHARGED TO PATIENTS	4, 042, 121			73.0
	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY	10,006			76. 9
	07699 LI THOTRI PSY	19, 996 0			76.
	DUTPATIENT SERVICE COST CENTERS	U U			- /0.
	09000 CLINIC	0			90.
	09001 I NTENSI VE OUT PATI ENT PROGRAM	0			90.0
	09100 EMERGENCY	9, 771, 481			91.0
00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.
	OTHER REIMBURSABLE COST CENTERS				
	09500 AMBULANCE SERVICES	3, 449, 374			95.0
	SPECIAL PURPOSE COST CENTERS	1			
3.00	SUBTOTALS (SUM OF LINES 1 through 117)	47, 343, 397			118. (
	VONREIMBURSABLE COST CENTERS	70.004			100
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	73, 221			190.
	19200 PHYSI CLANS' PRI VATE OFFI CES 07950 OCCUPATI ONAL HEALTH	982, 474			192. ( 194. (
	07950 OCCOPATIONAL HEALTH	0			194.
	07951 PATH CETHIC 07952 OAK POINTE	0			194.
	07953 FOUNDATI ON	537, 870			194.
	07954 COMMUNITY & VOLUNTEER SERVICES	289, 057			194.
	07955 VACANT SPACE	0			194.
	07956 TELEHEALTH MEDICINE	21, 991			194. (
0.00	Cross Foot Adjustments	0			200. 0
1.00	Negative Cost Centers	0			201. (
	TOTAL (sum lines 118 through 201)	49, 248, 010			202. (

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	WHITLEY MEMORI	AL HOSPITAL	Fr	eriod: com 01/01/2017	u of Form CMS-2 Worksheet B Part II Date/Time Pre	
			To	0 12/31/2017	5/29/2018 4:1	o pm
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00         00200         CAP REL COSTS-MVBLE EQUI P           4.00         00400         EMPLOYEE BENEFITS DEPARTMENT           5.00         00500         ADMI NI STRATI VE & GENERAL           6.00         00600         MAI NTENANCE & REPAI RS           7.00         00700         OPERATI ON OF PLANT           8.00         00800         LAUNDRY & LI NEN SERVI CE           9.00         00900         HOUSEKEEPI NG	0 3, 601, 442 0 0 0 0	0 528, 356 0 123, 329 5, 762 4, 816 4, 816	0 542, 417 0 126, 610 5, 916 4, 944 4, 944	0 4, 672, 215 0 249, 939 11, 678 9, 760	0 0 0 0 0 0	2.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 01000 DI ETARY	0	20, 647	21, 196	41, 843	0	10.00
11. 00       01100       CAFETERIA         12. 00       01200       MAI NTENANCE OF PERSONNEL         13. 00       01300       NURSI NG ADMI NI STRATI ON         14. 00       01400       CENTRAL SERVI CES & SUPPLY         15. 00       01500       PHARMACY         16. 00       01600       MEDI CAL RECORDS & LI BRARY         17. 00       01700       SOCI AL SERVI CE         19. 00       01900       NONPHYSI CI AN ANESTHETI STS	0 0 0 0 0 0 0 0	23, 284 0 1, 403 16, 671 14, 449 5, 135 0 0	23, 903 0 1, 441 17, 114 14, 833 5, 272 0 0	47, 187 0 2, 844 33, 785 29, 282 10, 407 0 0	0 0 0 0 0 0 0 0 0 0 0	11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00
20.00 02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
21.00 02100 I & SERVI CES-SALARY & FRI NGES APPRV 22.00 02200 I & SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	0	0	21.00 22.00
23. 00 02200 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	
INPATIENT ROUTINE SERVICE COST CENTERS				-1		
30. 00 03000 ADULTS & PEDI ATRI CS	0	225, 521	231, 523	457, 044	0	
43.00 04300 NURSERY	0	0	0	0	0	43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	44.00
50. 00 05000 OPERATING ROOM	0	134, 683	138, 267	272, 950	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0	179, 465 31, 545	184, 240 32, 384	363, 705 63, 929	0	54.00 60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	51, 545	32, 364 0	03, 929	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0	24, 942	25, 606	50, 548	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	84, 672	86, 925	171, 597	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	0	0	69.00 71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	
76. 98 07698 HYPERBARI C 0XYGEN THERAPY 76. 99 07699 LI THOTRI PSY	0	0	0	0	0	
OUTPATIENT SERVICE COST CENTERS						/0. //
90. 00 09000 CLI NI C	0	0	0	0	0	
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0	90.01
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	160, 168	164, 430	324, 598	0	91.00 92.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>			0		72.00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS	0 (01 (10	4 504 040	4 (07 004	( 010 011		110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	3, 601, 442	1, 584, 848	1, 627, 021	6, 813, 311	0	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 062	3, 143	6, 205	0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	37, 169	38, 158	75, 327		192.00
194. 00 07950 OCCUPATI ONAL HEALTH	0	0	0	0		194.00
194. 01 07951 PALN CLINIC 194. 02 07952 OAK POINTE	0	0	0	0		194. 01 194. 02
194. 02 07952 0AK POINTE 194. 03 07953  FOUNDATI ON	0	0	0	0		194. 02 194. 03
194. 04 07954 COMMUNITY & VOLUNTEER SERVICES	0	3, 030	3, 111	6, 141		194.04
194. 05 07955 VACANT SPACE	0	0	0	0		194. 05
194. 06 07956 TELEHEALTH MEDICINE	0	0	0	0	0	194.06
200.00Cross Foot Adjustments201.00Negative Cost Centers		0	0	0	0	200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	3, 601, 442	1, 628, 109	1, 671, 433	6, 900, 984	0	202.00

Health Financial Systems	WHITLEY MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0101	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Pre 5/29/2018 4:1	pared:
Cost Center Description	ADMI NI STRATI VE N		OPERATION OF		HOUSEKEEPI NG	
	& GENERAL 5.00	REPAI RS 6.00	PLANT 7.00	LI NEN SERVICE 8.00	9.00	
GENERAL SERVICE COST CENTERS	5.00	0.00	7.00	8.00	9.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	4, 672, 215					5.00
6.00 00600 MAI NTENANCE & REPAI RS	0	0				6.00
7.00 00700 OPERATION OF PLANT	253, 131	0	503, 07			7.00
8.00 00800 LAUNDRY & LINEN SERVICE	43,030	0	2,96		11/ 255	8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	104, 114 38, 586	0 0	2, 48 10, 63		116, 355 2, 487	9.00 10.00
11. 00 01100 CAFETERIA	90, 655	0			2,487	11.00
12. 00 01200 MAINTENANCE OF PERSONNEL	,0,000	0		0 0	2,000	12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	35, 864	0	72		169	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	4, 966	0	8, 58	39 0	2,008	14.00
15.00 01500 PHARMACY	128, 575	0	7,44	4 0	1, 741	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	1, 530	0	2, 64	6 0	619	16.00
17.00 01700 SOCIAL SERVICE	0	0		0 0	0	17.00
19.00 01900 NONPHYSI CLAN ANESTHETI STS	0	0		0 0	0	19.00
20.00 02000 NURSI NG SCHOOL	0	0		0 0	0	20.00
21.00 02100 I & SERVICES-SALARY & FRINGES APPRV 22.00 02200 I & SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	21.00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV 23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0		0 0	0	22.00 23.00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0	1	0 0	0	23.00
30. 00 03000 ADULTS & PEDI ATRI CS	651, 451	0	116, 19	2, 404	27, 169	30.00
43. 00 04300 NURSERY	21, 312	0		0 3, 876	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		0 0	0	44.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM	263, 057	0			16, 225	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	66, 309 3, 028	0		0 9, 178 0 0	0	52.00 53.00
54. 00  05400 RADI OLOGY - DI AGNOSTI C	531,073	0	92, 46		21, 620	
60. 00 06000 LABORATORY	440, 779	0	16, 25		3, 800	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	94, 492	0	12, 85	51 231	3, 005	65.00
66.00 06600 PHYSI CAL THERAPY	108, 504	0	43, 62		10, 200	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	92, 987	0		0 2,407	0	67.00
68. 00 06800 SPEECH PATHOLOGY	8, 962	0		0 232	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	95, 946	0		0 0	0	69.00 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	60, 033	0			0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	248, 097	0		0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	1, 897	0		0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0		0 0	0	76.99
		0			0	
90. 00 09000 CLINIC 90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0		0 0	0	90. 00 90. 01
91. 00 09100 EMERGENCY	812, 337	0		17,682	19, 295	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	012, 337	0	02, 32	17,002	17,275	92.00
OTHER REIMBURSABLE COST CENTERS	L L		I			
95. 00 09500 AMBULANCE SERVICES	308, 355	0		0 2,870	0	95.00
SPECIAL PURPOSE COST CENTERS	r					
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	4, 509, 070	0	480, 78	57, 677	111, 143	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	E 710	0	1 5		240	100.00
190. 00 19000 GFFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	5, 710 78, 490	0 0				190. 00 192. 00
194. 00 07950 OCCUPATIONAL HEALTH	78,490	0	17, 13	0 0		192.00
194. 01 07951 PALN CLINIC	0	0		0 0		194.00
194. 02 07952 OAK POI NTE	Ő	0		0 0		194. 02
194. 03 07953 FOUNDATI ON	50, 571	0		0 0		194. 03
194.04 07954 COMMUNI TY & VOLUNTEER SERVICES	26, 288	0	1, 56	0		194.04
194. 05 07955 VACANT SPACE	0	0		0 0		194.05
194. 06 07956 TELEHEALTH MEDI CI NE	2, 086	0		0 0	0	194.06
200.00 Cross Foot Adjustments		0		0	0	200. 00 201. 00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	4, 672, 215	0	503, 07	0 0 70 57,677		
202.00 TOTAL (Sum THES TO UN OUGH 201)	7,072,210	0	1 505, 0	57,077	110, 555	1202.00

Health Financial Systems		WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED	COSTS		Provider C		eriod: rom 01/01/2017	Worksheet B	
				T		Part II Date/Time Pre	
Cost Center Descri	ption	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	5/29/2018 4:1 CENTRAL	0 pm
		DILINAR	0/11 21 21 11 11	PERSONNEL	ADMI NI STRATI ON	SERVICES &	
		10.00	11.00	12.00	13.00	SUPPLY 14.00	
GENERAL SERVICE COST CE	NTERS	10.00	11.00	12.00	13.00	14.00	
1.00 00100 CAP REL COSTS-BLD							1.00
2.00 00200 CAP REL COSTS-MVBI 4.00 00400 EMPLOYEE BENEFITS							2.00 4.00
5. 00 00500 ADMI NI STRATI VE & (							5.00
6.00 00600 MAI NTENANCE & REP/							6.00
7.00 00700 OPERATION OF PLAN 8.00 00800 LAUNDRY & LINEN SI							7.00 8.00
9. 00 00900 HOUSEKEEPI NG							9.00
10. 00 01000 DI ETARY		93, 554					10.00
11.00 01100 CAFETERIA 12.00 01200 MAINTENANCE OF PEI		0 O	152, 643 0				11.00
13. 00 01300 NURSI NG ADMI NI STR/	1	0	1, 900	-			13.00
14.00 01400 CENTRAL SERVICES &	& SUPPLY	0	0	-		49, 348	
15.00 01500 PHARMACY 16.00 01600 MEDICAL RECORDS &		0	4, 434 0			1, 098 0	
17. 00 01700 SOCIAL SERVICE	LI DRAKT	0	0			0	
19.00 01900 NONPHYSICIAN ANES	THETI STS	0	0	0	-	0	
20. 00 02000 NURSI NG SCHOOL 21. 00 02100 I &R SERVI CES-SALAI		0	0	0	-	0	
21. 00 02100 I &R SERVI CES-SALAI 22. 00 02200 I &R SERVI CES-OTHEI	1	0	0	-	-	0	
23.00 02300 PARAMED ED PRGM-(	SPECI FY)	0	0	0	0	0	
30.00 O3000 ADULTS & PEDIATRI		93, 554	22.270	0	12.0//	905	30.00
30. 00 03000 ADULTS & PEDIATRI ( 43. 00 04300 NURSERY		93, 554 0	22, 379 2, 604			905 1, 459	•
44.00 04400 SKILLED NURSING F		0	0		0	0	•
ANCI LLARY SERVICE COST 50.00 05000 OPERATI NG ROOM	CENTERS	0	10, 275	0	5, 999	6, 764	50.00
52.00 05200 DELIVERY ROOM & L/	ABOR ROOM	0	6, 193			3, 460	
53.00 05300 ANESTHESI OLOGY		0	0	-		0	
54. 00 05400 RADI OLOGY-DI AGNOS 60. 00 06000 LABORATORY	TIC	0	24, 209 0			2, 944 0	
62. 30 06250 BLOOD CLOTTING FOI	R HEMOPHI LI ACS	0	0			0	
65.00 06500 RESPI RATORY THERA	γ	0	5, 911			1, 707	•
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THER	ADV	0	10, 908 4, 434			309 252	•
68. 00 06800 SPEECH PATHOLOGY	י יר	0	915			232	68.00
69.00 06900 ELECTROCARDI OLOGY		0	0		-	0	
71.00 07100 MEDICAL SUPPLIES ( 72.00 07200 IMPL. DEV. CHARGEI		0	0	0		11, 708 7, 136	•
73.00 07300 DRUGS CHARGED TO I		0	0	s s	Ű	0	
76. 97 07697 CARDI AC REHABILITA		0	0			0	
76. 98 07698 HYPERBARI C 0XYGEN 76. 99 07699 LI THOTRI PSY	THERAPY	0	0	0		0 0	
OUTPATIENT SERVICE COST	CENTERS		0		0	0	70.77
90. 00 09000 CLINIC		0	0			0	•
90. 01 09001 I NTENSI VE OUT PATI 91. 00 09100 EMERGENCY	ENT PROGRAM	0	0 32, 231	-		0 7, 708	
92.00 09200 OBSERVATI ON BEDS	(NON-DISTINCT PART	0	52, 251		10, 017	7,700	92.00
OTHER REIMBURSABLE COST		al					
95.00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CE		0	24, 139	0	0	2, 804	95.00
118.00 SUBTOTALS (SUM OF	LINES 1 through 117)	93, 554	150, 532	0	41, 500	48, 278	118.00
NONREI MBURSABLE COST CE 190. 00 19000 GIFT, FLOWER, COFI		0				405	100.00
190. 00 19000 GFFT, FLOWER, COFT 192. 00 19200 PHYSI CLANS' PRI VA		0	0 1, 407				190. 00 192. 00
194.0007950 OCCUPATIONAL HEAL		Ō	0	0	0	0	194.00
194.0107951 PALN CLINIC 194.0207952 OAK POINTE		0	0	-			194. 01 194. 02
194. 02 07952 0AK_POINTE 194. 03 07953  FOUNDATI ON		0	0 704	-			194.02
194.04 07954 COMMUNI TY & VOLUN	TEER SERVICES	Ō	0	0	0	84	194.04
194. 05 07955 VACANT SPACE		0	0	0	0		194.05
194.06 07956 TELEHEALTH MEDICII 200.00 Cross Foot Adjustr	1	0	0		0	0	194. 06 200. 00
201.00 Negative Cost Cen	ters	0	0	0			201.00
202.00  TOTAL (sum lines )	118 through 201)	93, 554	152, 643	0	41, 500	49, 348	202.00

Heal th Financial Systems	WHITLEY MEMORIA		N 45 0101 -		u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	F	veriod: rom 01/01/2017 o 12/31/2017	Worksheet B Part II Date/Time Pre 5/29/2018 4:1	
Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS	NURSI NG SCHOOL	
	15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS						1 1 00
1.00       00100       CAP REL COSTS-BLDG & FIXT         2.00       00200       CAP REL COSTS-MVBLE EQUIP         4.00       00400       EMPLOYEE BENEFITS DEPARTMENT         5.00       00500       ADMI NI STRATI VE & GENERAL         6.00       00600       MAI NTENANCE & REPAI RS         7.00       00700       OPERATI ON OF PLANT         8.00       00800       LAUNDRY & LI NEN SERVI CE         9.00       00900       HOUSEKEEPI NG         10.00       01100       CAFETERI A         12.00       01200       MAI NTENANCE OF PERSONNEL         13.00       01300       NURSI NG ADMI NI STRATI ON         14.00       01400       CENTRAL SERVI CES & SUPPLY         15.00       01500       PHARMACY         16.00       01600       MEDI CAL SERVI CE         17.00       01700       SOCI AL SERVI CE         19.00       01900       NONPHYSI CI AN ANESTHETI STS         20.00       02000       NURSI NG SCHOOL	172, 574 0 0 0 0	15, 202 0 0 0		0	0	1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 20.00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	C			21.00
22. 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23. 00 02300 PARAMED ED PRGM-(SPECIFY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	C	)		23.00
30. 00 03000 ADULTS & PEDIATRICS	7	794	C	)		30.00
43. 00 04300 NURSERY	0	169	C			43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	C			44.00
ANCI LLARY SERVI CE COST CENTERS	40	100				50.00
50. 00 05000 OPERATING ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	49 0	190 0				50.00 52.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	196	5, 655	-			54.00
60. 00 06000 LABORATORY	0	0	C			60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.30
65. 00 06500 RESPIRATORY THERAPY	0	0	-			65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	242	1, 576 483				66.00 67.00
68.00 06800 SPEECH PATHOLOGY	0	403 125				68.00
69. 00 06900 ELECTROCARDI OLOGY	o	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	c c			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	170, 508	0	C			73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
76. 98 07698 HYPERBARI C 0XYGEN THERAPY 76. 99 07699 LI THOTRI PSY	0	0				76. 98 76. 99
OUTPATIENT SERVICE COST CENTERS		0		1		, 0. 77
90. 00 09000 CLI NI C	0	0	C	)		90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0	-			90.01
91.00 09100 EMERGENCY	1, 127	6, 210	C			91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS						92.00
95.00 09500 AMBULANCE SERVICES	444	0	C			95.00
SPECIAL PURPOSE COST CENTERS		0		1		/0.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	172, 573	15, 202			0	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
192. 00 19200 PHYSICIANS' PRIVATE OFFICES 194. 00 07950 OCCUPATI ONAL HEALTH	1	0				192.00 194.00
194. 00 07950 OCCOPATIONAL HEALTH 194. 01 07951 PAIN CLINIC		0				194.00
194. 02 07952 OAK POINTE	0	0				194.01
194. 03 07953 FOUNDATI ON	o	0		)		194.03
194. 04 07954 COMMUNI TY & VOLUNTEER SERVICES	0	0	C	)		194.04
194. 05 07955 VACANT SPACE	0	0	C			194.05
194. 06 07956 TELEHEALTH MEDICINE	0	0	C	-	-	194.06
200.00Cross Foot Adjustments201.00Negative Cost Centers		~	l c	0		200.00
201.00 Negative cost centers 202.00 TOTAL (sum lines 118 through 201)	0 172, 574	0 15, 202		-		201.00
	1/2, 3/4	13, 202		0	. U	1-02.00

	ancial Systems	WHITLEY MEMORI				eu of Form CMS-	2552-10
ALLOCATION	OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0101	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Pre	pared:
		INTERNS &	RESI DENTS			5/29/2018 4:1	
	Cost Center Description	SERVI CES-SALAR Y & FRI NGES APPRV	SERVI CES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		21.00	22.00	23.00	24.00	25.00	
	RAL SERVICE COST CENTERS						1 1 00
$\begin{array}{ccccccc} 2.00 & 0020 \\ 4.00 & 0040 \\ 5.00 & 0050 \\ 6.00 & 0050 \\ 6.00 & 0070 \\ 8.00 & 0070 \\ 8.00 & 0090 \\ 10.00 & 0100 \\ 11.00 & 0100 \\ 12.00 & 0120 \\ 13.00 & 0130 \\ 14.00 & 0140 \\ 15.00 & 0150 \\ 16.00 & 0160 \\ 17.00 & 0170 \\ 19.00 & 0190 \end{array}$	101       CAP REL COSTS-BLDG & FIXT         102       CAP REL COSTS-MVBLE EQUIP         103       CAP REL COSTS-MVBLE EQUIP         104       EMPLOYEE BENEFITS DEPARTMENT         105       ADMINISTRATIVE & GENERAL         106       MAINTENANCE & REPAIRS         107       OPERATION OF PLANT         108       LAUNDRY & LINEN SERVICE         109       HOUSEKEEPING         1010       LATRY         102       CAFETERIA         103       MAINTENANCE OF PERSONNEL         104       NURSI NG ADMINISTRATION         105       CENTRAL SERVICES & SUPPLY         106       PHARMACY         107       PHARMACY         108       SOCI AL SERVICE         109       NONPHYSICIAN ANESTHETISTS         100       NONPHYSICIAN ANESTHETISTS						$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 19. \ 00\\ 20. \ 00\\ \end{array}$
	0 I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
	0 I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
	0 PARAMED ED PRGM-(SPECIFY) TIENT ROUTINE SERVICE COST CENTERS				0		23.00
	0 ADULTS & PEDIATRICS				1, 384, 966	0	30.00
	0 NURSERY				29, 420	0	
	0 SKILLED NURSING FACILITY				0	0	44.00
	LLARY SERVICE COST CENTERS				651, 718	0	50.00
	0 DELIVERY ROOM & LABOR ROOM				88, 756	0	
	O ANESTHESI OLOGY				3, 028	0	53.00
	0 RADI OLOGY-DI AGNOSTI C				1, 050, 887	0	54.00
	0 LABORATORY 0 BLOOD CLOTTING FOR HEMOPHILIACS				524, 768	0	60.00 62.30
	0 RESPIRATORY THERAPY				168, 745	0	
	0 PHYSI CAL THERAPY				349, 909	0	66.00
	O OCCUPATIONAL THERAPY				100, 563	0	
	0 SPEECH PATHOLOGY				10, 258	0	68.00
	0 ELECTROCARDI OLOGY 0 MEDI CAL SUPPLI ES CHARGED TO PATI ENT				0 107, 654	0	
	0 IMPL. DEV. CHARGED TO PATIENTS				67, 169		
	O DRUGS CHARGED TO PATIENTS				418, 605	0	
	27 CARDI AC REHABI LI TATI ON				0	0	
	88 HYPERBARI C OXYGEN THERAPY 99 LI THOTRI PSY				1, 897	0	•
	ATIENT SERVICE COST CENTERS	<u> </u>		<u> </u>			
	O CLINIC				0	0	
	1 INTENSIVE OUT PATIENT PROGRAM				0	0	•
	00 EMERGENCY 00 OBSERVATION BEDS (NON-DISTINCT PART				1, 322, 528	0	
72.00 0720 OTHE	R REIMBURSABLE COST CENTERS	I I				0	72.00
	O AMBULANCE SERVI CES				338, 612	0	95.00
	I AL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			_	1	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0		0 6, 619, 483	0	118.00
	EIMBURSABLE COST CENTERS				14, 347	0	190.00
	0 PHYSI CI ANS' PRI VATE OFFI CES				179, 354		192.00
	O OCCUPATIONAL HEALTH				0		194.00
					0		194.01
	2 OAK POINTE 3 FOUNDATI ON				51, 275		194. 02 194. 03
	4 COMMUNITY & VOLUNTEER SERVICES				34, 439	0	194.04
194.050795	5 VACANT SPACE				0	0	194.05
	6 TELEHEALTH MEDICINE				2, 086	0	194.06
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers	0	0		0 0		200. 00 201. 00
201.00	TOTAL (sum lines 118 through 201)	0	0		6, 900, 984		201.00
		, °I	9			'	

	Financial Systems	WHITLEY MEMORIA	L_HOSPI TAL	In Lieu of Form CMS-	2552-
LLOCAT	ION OF CAPITAL RELATED COSTS		Provider CCN: 15-0101	Period: Worksheet B From 01/01/2017 Part II	
				To 12/31/2017 Date/Time Pre 5/29/2018 4:1	
	Cost Center Description	Total 26.00	- · · ·		
G	ENERAL SERVICE COST CENTERS	20.00			
1	00100 CAP REL COSTS-BLDG & FIXT				1.0
	00200 CAP REL COSTS-MVBLE EQUIP				2.0
1	00400 EMPLOYEE BENEFITS DEPARTMENT				4.0
	00500 ADMINISTRATIVE & GENERAL				5.0
	00600 MAI NTENANCE & REPAI RS				6.
	00700 OPERATION OF PLANT				7.
	00800 LAUNDRY & LINEN SERVICE				8.
	00900 HOUSEKEEPI NG				9.
	D1000 DI ETARY				10.
					11.
	01200 MAINTENANCE OF PERSONNEL				12.
	01300 NURSI NG ADMI NI STRATI ON				13.
	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY				14.
					16.
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE				17.
	01900 NONPHYSICIAN ANESTHETISTS				17.
	D2000 NURSING SCHOOL				20.
	02100 I&R SERVICES-SALARY & FRINGES APPRV				20.
	2200 I&R SERVICES-SALART & TRINGES AFFRV				21.
	2200 PARAMED ED PRGM-(SPECIFY)				22.
_	NPATIENT ROUTINE SERVICE COST CENTERS				23.
	03000 ADULTS & PEDIATRICS	1, 384, 966			30.
	04300 NURSERY	29, 420			43.
	04400 SKILLED NURSING FACILITY	27,420			44.
	NCI LLARY SERVICE COST CENTERS	U			
	D5000 OPERATI NG ROOM	651, 718			50.
	05200 DELIVERY ROOM & LABOR ROOM	88, 756			52.
	05300 ANESTHESI OLOGY	3, 028			53.
	05400 RADI OLOGY-DI AGNOSTI C	1,050,887			54.
	06000 LABORATORY	524, 768			60.
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			62.
	06500 RESPI RATORY THERAPY	168, 745			65.
	06600 PHYSI CAL THERAPY	349, 909			66.
	06700 OCCUPATI ONAL THERAPY	100, 563			67.
	06800 SPEECH PATHOLOGY	10, 258			68.
	06900 ELECTROCARDI OLOGY	0			69.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	107, 654			71.
	07200 IMPL. DEV. CHARGED TO PATIENTS	67, 169			72.
	07300 DRUGS CHARGED TO PATIENTS	418, 605			73.
	07697 CARDI AC REHABI LI TATI ON	0			76.
	07698 HYPERBARI C OXYGEN THERAPY	1, 897			76.
	07699 LI THOTRI PSY	0			76.
	DUTPATIENT SERVICE COST CENTERS	· · · · · ·			
	09000 CLI NI C	0			90.
	09001 INTENSIVE OUT PATIENT PROGRAM	0			90.
	09100 EMERGENCY	1, 322, 528			91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.
	THER REIMBURSABLE COST CENTERS				
	09500 AMBULANCE SERVI CES	338, 612			95.
	SPECIAL PURPOSE COST CENTERS				
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	6, 619, 483			118.
	IONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	14, 347			190.
	19200 PHYSI CLANS' PRI VATE OFFI CES	179, 354			192.
	07950 OCCUPATIONAL HEALTH	0			194.
	07951 PAIN CLINIC	0			194.
4. 02 C	07952 OAK POINTE	0			194.
	07953 FOUNDATI ON	51, 275			194.
	07954 COMMUNITY & VOLUNTEER SERVICES	34, 439			194.
	07955 VACANT SPACE	0			194.
	07956 TELEHEALTH MEDICINE	2, 086			194.
0. 00	Cross Foot Adjustments	0			200.
01.00	Negative Cost Centers	0			201.
	TOTAL (sum lines 118 through 201)				202.

Health Financial Systems COST ALLOCATION - STATIS		WHITLEY MEMORI	AL HOSPITAL	CN: 15-0101 P	Period:	u of Form CMS- Worksheet B-1	
					rom 01/01/2017 o 12/31/2017	Date/Time Pre 5/29/2018 4:1	
		CAPI TAL REL	ATED COSTS				
Cost Center	Description	BLDG & FI XT (SQUARE FEET)	MVBLE EQUI P (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci l i ati on	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE CO							
1.00         00100         CAP         REL         COST           2.00         00200         CAP         REL         COST           4.00         00400         EMPLOYEE         BEN           5.00         00500         ADMI NI STRATI	TS-MVBLE EQUIP NEFITS DEPARTMENT	153, 136 0 49, 696	153, 136 0 49, 696	21, 321, 004		31, 788, 621	1.00 2.00 4.00 5.00
6. 00 00600 MAI NTENANCE	& REPAIRS	0	0	C	0 0	0	6.00
7.00 00700 OPERATION OF 8.00 00800 LAUNDRY & LI		11, 600 542	11, 600 542			1, 722, 240 292, 765	
9.00 00900 HOUSEKEEPING		453			-	708, 365	
10.00 01000 DI ETARY		1, 942				262, 530	
11. 00 01100 CAFETERI A 12. 00 01200 MAI NTENANCE		2, 190	2, 190	344, 449	0	616, 792	
13.00 01300 NURSI NG ADMI		132	132	215, 322	0	244, 008	
14.00 01400 CENTRAL SERV	/ICES & SUPPLY	1, 568			0	33, 785	•
15.00 01500 PHARMACY 16.00 01600 MEDICAL RECC		1, 359 483				874, 789 10, 407	
17.00 01700 SOCIAL SERVI		403	403		0	0	
19.00 01900 NONPHYSI CI AN		0	0	C	0	0	
20.00 02000 NURSI NG SCHO 21.00 02100 I &R SERVI CES	DOL S-SALARY & FRINGES APPRV	0	0		0	0	
	S-OTHER PRGM COSTS APPRV	0	0		0	0	
23.00 02300 PARAMED ED F	PRGM-(SPECIFY)	0	0	C	0	0	
30.00 03000 ADULTS & PED	SERVICE COST CENTERS	21 212	21 212	2 004 073	2 0	4 422 200	30.00
43. 00 04300 NURSERY	JATRICS	21, 212 0	21, 212				
44.00 04400 SKILLED NURS		0					
ANCI LLARY SERVI CE		10 ( ( 0	12 (/0	1 001 000		1 700 770	1 50 00
50.00 05000 OPERATING RC 52.00 05200 DELIVERY R00		12, 668 0	12, 668	1, 001, 229 230, 563			
53.00 05300 ANESTHESI OLC		0	0	200,000	0	20, 602	
54.00 05400 RADI OLOGY-DI	AGNOSTI C	16, 880	16, 880			3, 613, 281	
60. 00 06000 LABORATORY 62. 30 06250 BLOOD CLOTTI	NG FOR HEMOPHILIACS	2, 967 0	2,967		0	2, 998, 946	1
65. 00 06500 RESPI RATORY		2, 346		513, 145	0	642, 898	
66. 00 06600 PHYSI CAL THE		7, 964				738, 230	
67.00 06700 OCCUPATI ONAL 68.00 06800 SPEECH PATHO		0	0	543, 460 52, 376		632, 662 60, 974	
69.00 06900 ELECTROCARDI	OLOGY	0	0	02,070		0	69.00
71.00 07100 MEDI CAL SUPP		0	0	C	0		
72.00 07200 I MPL. DEV. 0 73.00 07300 DRUGS CHARGE	CHARGED TO PATIENTS	0				408, 446 1, 687, 987	
76. 97 07697 CARDI AC REHA		0	0	c c	0	0	
76. 98 07698 HYPERBARI C 0	DXYGEN THERAPY	0	0	9, 765		12, 907	
76. 99 07699 LI THOTRI PSY OUTPATI ENT SERVI CE	E COST CENTERS	0	0	C	0	0	76.99
90. 00 09000 CLI NI C		0	0	C	0	0	90.00
90. 01 09001 I NTENSI VE OL	JT PATIENT PROGRAM	0	0		0		
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON	BEDS (NON-DISTINCT PART	15, 065	15, 065	3, 046, 807	0	5, 527, 031	91.00 92.00
OTHER REIMBURSABLE	E COST CENTERS						72.00
95.00 09500 AMBULANCE SE		0	0	1, 558, 487	0	2, 097, 969	95.00
	SUM OF LINES 1 through 117)	149, 067	149, 067	21, 279, 402	-17, 459, 389	30, 678, 626	118.00
NONREI MBURSABLE CO 190.00 19000 GIFT, FLOWER		288	288	C	0	38, 846	190.00
192. 00 19200 PHYSI CI ANS'	PRIVATE OFFICES	3, 496				534, 024	192.00
194.00079500CCUPATIONAL 194.0107951PAINCLINIC	- HEALTH	0	0		0		194.00 194.01
194. 02 07952 OAK POINTE		0	0		0		194.01
194. 03 07953 FOUNDATI ON		0	0	9, 015		344, 072	194. 03
194.04 07954 COMMUNI TY &		285	285	1, 747	0	178, 858	
194.0507955 VACANT SPACE 194.0607956 TELEHEALTH M		0					194.05 194.06
200.00 Cross Foot A		0					200.00
201.00 Negative Cos		4 /00 10-		0.540.015		17 450 000	201.00
202.00 Cost to be a Part I)	allocated (per Wkst. B,	1, 628, 109	1, 671, 433	2, 543, 819		17, 459, 389	202.00
	ultiplier (Wkst. B, Part I)	10. 631785	10. 914697	0. 119310		0. 549234	203. 00

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
				From 01/01/2017 Fo 12/31/2017	Date/Time Pre 5/29/2018 4:1	
	CAPI TAL REL	ATED COSTS				
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFI TS	Reconciliation	& GENERAL	
			DEPARTMENT (GROSS SALARI ES)		(ACCUM. COST)	
	1.00	2.00	4.00	5A	5.00	
204.00 Cost to be allocated (per Wkst. B, Part II)			(	0	4, 672, 215	204.00
205.00 Unit cost multiplier (Wkst. B, Part			0.00000	D	0. 146978	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

	Financial Systems LOCATION - STATISTICAL BASIS	WHITLEY MEMOR	AL HOSPITAL	CN: 15 0101	In Lie	u of Form CMS-: Worksheet B-1	2552-10
CUST AL	LUCATION - STATISTICAL DASIS			F	rom 01/01/2017 o 12/31/2017	Date/Time Pre 5/29/2018 4:1	
	Cost Center Description	MAI NTENANCE & REPAI RS (SQUARE FEET)	PLANT	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
F	GENERAL SERVICE COST CENTERS			1	1		
2.00 4.00 5.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	0					1.00 2.00 4.00 5.00 6.00
8.00 9.00 10.00	00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A		91, 840 542 453 1, 942 2, 190	319, 708 C C	90, 845 1, 942 2, 190	12, 252 0	7.00 8.00 9.00 10.00 11.00
12. 00 13. 00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION	0	0 132	C C	0 132	0	12. 00 13. 00
	01400 CENTRAL SERVICES & SUPPLY	0	1, 568		1, 568	0	14.00
16.00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	0	1, 359 483 0		1, 359 483 0	0 0 0	15.00 16.00 17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL	0	0	C	0	0	19.00 20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	C	0	0	21.00
	02200 I&R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY)	0	0		0	0 0	22.00 23.00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	21, 212	13, 328	21, 212	12, 252	30.00
43.00	04300 NURSERY	0	0	21, 486	0	0	43.00
	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	0	C	0	0	44.00
50.00	05000 OPERATI NG ROOM	0	12, 668			0	50.00
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0	50, 876 C	0	0 0	52.00 53.00
	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	16, 880 2, 967	50, 011 43		0	54.00 60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	2, 907	43 C	0	0	62.30
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	2, 346 7, 964			0	65.00 66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	13, 343	0	0	67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0	1, 285 C	0	0 0	68.00 69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0 0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	c c	0	0	73.00
	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C 0XYGEN THERAPY	0	0		0	0	
76. 99	07699 LI THOTRI PSY	0	0		-	0	
90.00	DUTPATIENT SERVICE COST CENTERS	0	0	C	0	0	
	09001 INTENSIVE OUT PATIENT PROGRAM 09100 EMERGENCY	0	-	0 98, 009	0 15, 065	0	90.01 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART DTHER REIMBURSABLE COST CENTERS		13, 005	/3, 007	13,003	0	92.00
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	0	15, 909	0	0	95.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	87, 771	319, 708	86, 776	12, 252	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	288				190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES 07950 OCCUPATI ONAL HEALTH	0	3, 496 0		3, 496 0		192.00 194.00
194.01	07951 PALN CLINIC 07952 OAK POINTE	0	0	C	0	0	194. 01 194. 02
194.03	07953 FOUNDATI ON	0	0	c c	0	0	194. 03
	07954 COMMUNI TY & VOLUNTEER SERVI CES 07955 VACANT SPACE	0	285		285		194.04 194.05
194.06	07956 TELEHEALTH MEDI CI NE	0	0	c c	0		194.06
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers						200.00 201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	2, 668, 153			486, 880	202. 00
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	0. 000000	29. 052189 503, 070			39. 738818 93, 554	203. 00 204. 00
205.00	Unit cost multiplier (Wkst. B, Part    )	0. 000000	5. 477679	0. 180405	1. 280808	7.635815	205.00

Health Financial Systems	WHITLEY MEMOR	I AL_HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
		_		rom 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 4:1	
Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		
	REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	
	(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF			
			LAUNDRY)			
	6.00	7.00	8.00	9.00	10.00	
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)		l				

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	WHITLEY MEMORI				eriod:	u of Form CMS- Worksheet B-1	
				F T	rom 01/01/2017 o 12/31/2017	Date/Time Pre 5/29/2018 4:1	
Cost Center Description	CAFETERI A (FTES)	MAI NTENANCE PERSONNEL (NUMBER HOUSED)	. /	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS)	SUPPLY	PHARMACY (COSTED REQUIS.)	
	11.00	12.00		13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS           1.00         00100         CAP REL COSTS-BLDG & FIXT							1.00
2.00         00200         CAP REL COSTS-MVBLE EQUI P           4.00         00400         EMPLOYEE BENEFI TS DEPARTMENT           5.00         00500         ADMI NI STRATI VE & GENERAL           6.00         00600         MAI NTENANCE & REPAI RS           7.00         00700         OPERATI ON OF PLANT           8.00         00800         LAUNDRY & LI NEN SERVI CE           9.00         00900         HOUSEKEEPI NG           10.00         D1 ETARY         11.00           11.00         CAFETERI A         1200           13.00         D1300         NURSI NG ADMI NI STRATI ON           14.00         O1400         CENTRAL SERVI CES & SUPPLY           15.00         01500         PHARMACY           16.00         MEDI CAL RECORDS & LI BRARY           17.00         O1700         SOCI AL SERVI CE           19.00         O1900         NURSI NG SCHOOL           21.00         02100         I &R SERVI CES-SALARY & FRI NGES APPRV           22.00         02200         I &R SERVI CES-OTHER PRGM COSTS APPRV           23.00         D2300         PARAMED ED PRGM- (SPECI FY)	2, 169 0 27 0 63 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0	1, 010 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 302, 978 51, 253 0 0 0 0 0 0 0 0 0 0	1, 609, 510 0 0 0 0 0 0 0 0 0 0	2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 13.00 14.00 15.00
INPATIENT ROUTINE SERVICE COST CENTERS           30.00         O3000         ADULTS & PEDIATRICS	318		0	318	42, 238	68	
43. 00 04300 NURSERY 44. 00 04400 SKI LLED NURSI NG FACI LI TY	37		0	0	68, 092 0	0	
ANCI LLARY SERVI CE COST CENTERS							
50. 00 05000 OPERATI NG ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM	146		0	146 88	315, 641 161, 482	456 0	50.00 52.00
53. 00 05300 ANESTHESI OLOGY	0		0	0	0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	344		0	0	137, 408	1, 830	1
60. 00 06000 LABORATORY 62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	0 0	
65. 00 06500 RESPIRATORY THERAPY	84		0	0	79, 653	0	65.00
66. 00 06600 PHYSI CAL THERAPY	155		0	0	14, 423	2, 258	
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	63		0	0	11, 774 1, 134	0	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	0		0	0	1, 134	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	546, 404	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0		0	0	333, 009	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0		0	0	0	1,0,0,201	
76. 97 07697 CARDI AC REHABI LI TATI ON 76. 98 07698 HYPERBARI C 0XYGEN THERAPY	0		0	0	0	0	•
76. 99 07699 LI THOTRI PSY	0		0	0	0	0	
OUTPATIENT SERVICE COST CENTERS	1						
90. 00 09000 CLINIC 90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0		0	0	0	0	
91. 00 09100 EMERGENCY	458		0	458	359, 698	10, 510	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART							92.00
	242		0	0	120,070	4 145	
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	343		0	0	130, 870	4, 145	95.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 139		0	1, 010	2, 253, 079	1, 609, 498	118.00
NONREI MBURSABLE COST CENTERS					00 ( 11		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	20		0	0	22, 641 23, 358		190. 00 192. 00
194. 00 07950 OCCUPATI ONAL HEALTH	20		0	0	23, 358		192.00
194. 01 07951 PAIN CLINIC	0		0	0	0		194.01
194. 02 07952 OAK POINTE	0		0	0	0		194.02
194. 03 07953 FOUNDATI ON 194. 04 07954 COMMUNI TY & VOLUNTEER SERVICES	10		0	0	3, 900		194. 03 194. 04
194. 05 07955 VACANT SPACE	0		0	0	0, 700		194.05
194. 06 07956 TELEHEALTH MEDICINE	0		0	0	0	0	194.06
200.00 Cross Foot Adjustments							200.00
201.00Negative Cost Centers202.00Cost to be allocated (per Wkst. B,	1, 045, 952		0	396, 494	117, 064	1, 444, 334	201.00
Part I)	., 010, 702		Ĭ	575, 774	117,004		
203.00Unit cost multiplier (Wkst. B, Part I)204.00Cost to be allocated (per Wkst. B,	482. 227755 152, 643	0. 0000	000	392. 568317 41, 500	0. 050832 49, 348	0. 897375 172, 574	

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2017	Worksheet B-1	
				To 12/31/2017	Date/Time Pre 5/29/2018 4:1	
Cost Center Description	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	
	(FTES)	PERSONNEL	ADMI NI STRATI O	N SERVICES &	(COSTED	
		(NUMBER		SUPPLY	REQUIS.)	
		HOUSED)	(DIRECT NRSIN	G (COSTED		
			HRS)	REQUIS.)		
	11.00	12.00	13.00	14.00	15.00	
205.00 Unit cost multiplier (Wkst. B, Part	70. 374827	0. 000000	41.08910	9 0. 021428	0. 107221	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	WHITLEY MEMOR	IAL HOSPITAL Provider C	°N: 15-0101 F	In Lie Period:	u of Form CMS-: Worksheet B-1	
COST ALLOCATION - STATISTICAL DASIS			F	From 01/01/2017 To 12/31/2017	Date/Time Pre	
	1		,	0 12/31/2017	5/29/2018 4:1	
					I NTERNS & RESI DENTS	
Cost Center Description	MEDI CAL	SOCI AL SERVI CE	NONPHYSI CI AN	NURSI NG SCHOOL		
	RECORDS &		ANESTHETI STS		Y & FRINGES	
	LIBRARY (TIME SPENT)	(TIME SPENT)	(ASSI GNED TI ME)	(ASSI GNED TI ME)	APPRV (ASSI GNED	
	·		,		TIME)	
GENERAL SERVICE COST CENTERS	16.00	17.00	19.00	20.00	21.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
6. 00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG						8.00 9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11.00
12. 00 01200 MAI NTENANCE OF PERSONNEL 13. 00 01300 NURSI NG ADMI NI STRATI ON						12.00 13.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY						14.00
15. 00 01500 PHARMACY						15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	10,000					16.00
17. 00 01700 SOCI AL SERVI CE 19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	-	(			17.00 19.00
20. 00 02000 NURSI NG SCHOOL	0	0		0		20.00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	-			0	
22.00 02200 I & SERVI CES-OTHER PRGM COSTS APPRV 23.00 02300 PARAMED ED PRGM-(SPECI FY)	0	-				22.00 23.00
INPATIENT ROUTINE SERVICE COST CENTERS			1			25.00
30. 00 03000 ADULTS & PEDI ATRI CS	522				0	
43. 00  04300  NURSERY 44. 00  04400  SKI LLED NURSI NG FACI LI TY	111				0	
ANCI LLARY SERVICE COST CENTERS				, 0	0	44.00
50. 00 05000 OPERATI NG ROOM	125				0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY		-			0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 720	-		-	0	
60. 00 06000 LABORATORY	0	0	C	0	0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 65. 00 06500 RESPIRATORY THERAPY		-		0	0	62.30 65.00
66. 00 06600 PHYSI CAL THERAPY	1,037	-			0	
67.00 06700 OCCUPATI ONAL THERAPY	318	0	C	0	0	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	82				0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT					0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 97 07697 CARDIAC REHABILITATION	0	0	0	0	0	
76. 97 07697 CARDIAC REHABILITATION 76. 98 07698 HYPERBARIC OXYGEN THERAPY					0	
76. 99 07699 LI THOTRI PSY	0	0	0	) 0	0	1
					0	90.00
90. 00  09000  CLINIC 90. 01  09001  INTENSIVE OUT PATIENT PROGRAM	0				0	
91.00 09100 EMERGENCY	4, 085	0	C	0	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						92.00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS	-	-				
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	10,000	0	(	0 0	0	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 194. 00 07950 0CCUPATI 0NAL HEALTH	0					192.00 194.00
194. 01 07951 PAIN CLINIC		0				194.00
194. 02 07952 OAK POI NTE	0	0	c c	0	0	194. 02
194. 03 07953 FOUNDATION	0	0		0		194.03
194.04 07954 COMMUNITY & VOLUNTEER SERVICES 194.05 07955 VACANT SPACE						194. 04 194. 05
194. 06 07956 TELEHEALTH MEDI CI NE	0	0		0		194.06
200.00 Cross Foot Adjustments						200.00
201.00Negative Cost Centers202.00Cost to be allocated (per Wkst. B,	36, 060	0	,		0	201.00 202.00
Part I)	30,000					
203.00 Unit cost multiplier (Wkst. B, Part I)	3. 606000	0. 000000	0.00000	0. 000000	0.000000	203.00

Heal th Fi	nancial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS			Provider CO		Period: From 01/01/2017	Worksheet B-1	
					Γο 12/31/2017	Date/Time Pre 5/29/2018 4:1	
						I NTERNS & RESI DENTS	
	Cost Center Description	MEDI CAL RECORDS &	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	NURSI NG SCHOOL	SERVI CES-SALAR Y & FRI NGES	
		LIBRARY	(TIME SPENT)	(ASSI GNED	(ASSI GNED	APPRV	
		(TIME SPENT)		TI ME)	TI ME)	(ASSI GNED TI ME)	
		16.00	17.00	19.00	20.00	21.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	15, 202	0	(	0 0	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part	1. 520200	0. 000000	0.00000	0. 000000	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0. 000000		207. 00

	nancial Systems CATION - STATISTICAL BASIS	WHITLEY MEMORI	AL HOSPITAL Provider CCN	N: 15-0101	Peri od:	u of Form CMS- Worksheet B-1	
					From 01/01/2017 To 12/31/2017	Date/Time Pre	
	Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGMCOSTS APPRV (ASSIGNED TIME)	PARAMED ED PRGM (ASSI GNED TI ME)		<u> </u>	5/29/2018 4:1	
OFN		22.00	23.00		· · · · · · · · · · · · · · · · · · ·		
	ERAL SERVICE COST CENTERS 00 CAP REL COSTS-BLDG & FIXT						1.00
$\begin{array}{cccc} 2.\ 00 \\ 4.\ 00 \\ 5.\ 00 \\ 5.\ 00 \\ 005 \\ 6.\ 00 \\ 007 \\ 8.\ 00 \\ 007 \\ 8.\ 00 \\ 009 \\ 10.\ 00 \\ 011 \\ 12.\ 00 \\ 011 \\ 12.\ 00 \\ 012 \\ 13.\ 00 \\ 012 \\ 13.\ 00 \\ 014 \\ 15.\ 00 \\ 015 \\ 16.\ 00 \\ 016 \\ 17.\ 00 \\ 019 \end{array}$	00       CAP REL COSTS-MVBLE EQUI P         00       EMPLOYEE BENEFITS DEPARTMENT         00       ADMI NI STRATI VE & GENERAL         00       MAI NTENANCE & REPAI RS         00       OPERATI ON OF PLANT         00       LAUNDRY & LI NEN SERVI CE         00       OUSEKEEPI NG         00       DI ETARY         00       MAI NTENANCE OF PERSONNEL         00       NURSI NG ADMI NI STRATI ON         00       CENTRAL SERVI CES & SUPPLY         00       PHARMACY         00       SOCI AL SERVI CE         00       NONPHYSI CI AN ANESTHETI STS						2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
21.00 021 22.00 022	00 NURSING SCHOOL 00 I&R SERVICES-SALARY & FRINGES APPRV 00 I&R SERVICES-OTHER PRGM COSTS APPRV 00 PARAMED ED PRGM-(SPECIFY)	0	0				20.00 21.00 22.00 23.00
I NP	ATIENT ROUTINE SERVICE COST CENTERS						1
	00 ADULTS & PEDI ATRI CS 00 NURSERY	0	0				30.00 43.00
44.00 044	00 SKILLED NURSING FACILITY	0	0				44.00
	ILLARY SERVICE COST CENTERS	0	0				50.00
	OO DELIVERY ROOM & LABOR ROOM	0	0				52.00
	00 ANESTHESI OLOGY 00 RADI OLOGY-DI AGNOSTI C	0	0				53.00 54.00
60.00 060	OO LABORATORY	0	0				60.00
	50 BLOOD CLOTTING FOR HEMOPHILIACS 00 RESPIRATORY THERAPY	0	0				62.30 65.00
	00 PHYSI CAL THERAPY	0	0				66.00
	OO OCCUPATIONAL THERAPY	0	0				67.00
	00 SPEECH PATHOLOGY 00 ELECTROCARDI OLOGY	0	0				68.00 69.00
71.00 071	OO MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
	00 IMPL. DEV. CHARGED TO PATIENTS 00 DRUGS CHARGED TO PATIENTS	0	0				72.00
	97 CARDI AC REHABI LI TATI ON	0	0				76.97
	98 HYPERBARI C OXYGEN THERAPY 99 LI THOTRI PSY	0	0				76.98
	PATIENT SERVICE COST CENTERS	<u> </u>	0				76.99
		0	0				90.00
	01 INTENSIVE OUT PATIENT PROGRAM 00 EMERGENCY	0	0				90.01 91.00
92.00 092	OO OBSERVATION BEDS (NON-DISTINCT PART	Ŭ					92.00
	ER REI MBURSABLE COST CENTERS	0	0				95.00
	CIAL PURPOSE COST CENTERS	0	0				95.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) REIMBURSABLE COST CENTERS	0	0				118.00
	00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
	00 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00
	50 OCCUPATIONAL HEALTH 51 PAIN CLINIC	0					194.00 194.01
194.02079	52 OAK POINTE	0	0				194. 02
1		0	0				194.03
	154 COMMUNI TY & VOLUNTEER SERVI CES 155 VACANT SPACE	0	0				194.04 194.05
	56 TELEHEALTH MEDICINE	0	0				194.05
200.00	Cross Foot Adjustments						200.00
201.00 202.00	Negative Cost Centers Cost to be allocated (per Wkst. B,		0				201.00
202.00	Part I)		0				202.00
	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000				203.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0101 Period: From 01/01/2017 To 12/31/2017 Date/Tim 5/29/201	e Prepared:
To 12/31/2017 Date/Tin	Prepared:
	$r_{+}$ io pill
I NTERNS &	
Cost Center Description           RESIDENTS           SERVICES-OTHER           PRGM COSTS	
APPRV (ASSI GNED	
(ASSI GNED TI ME)	
TIME)	
22.00 23.00	
204.00 Cost to be allocated (per Wkst. B, 0 0 0 Part II)	204.00
205.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.000000	205.00
206.00 NAHE adjustment amount to be allocated 0 (per Wkst. B-2)	206. 00
207.00 NÄHE unit cost multiplier (Wkst. D, 0.000000 Parts III and IV)	207.00

Health Financial Systems	WHITLEY MEMOR	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0101	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/29/2018 4:1	
		Title	× XVIII	Hospi tal	PPS	
				Costs	110	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs		Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	8, 530, 961		8, 530, 9	51 0	8, 530, 961	30.00
43. 00 04300 NURSERY	277, 885		277, 8	35 0	277, 885	
44.00 04400 SKILLED NURSING FACILITY	0			0 0	0	44.00
ANCILLARY SERVICE COST CENTERS	-					
50. 00 05000 OPERATI NG ROOM	3, 495, 778		3, 495, 7		3, 495, 778	
52.00 05200 DELIVERY ROOM & LABOR ROOM	858, 810		858, 8		858, 810	
53. 00 05300 ANESTHESI OLOGY	31, 917		31, 9		35, 315	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 555, 917		6, 555, 9		6, 555, 917	
60. 00 06000 LABORATORY	4, 768, 602		4, 768, 6	02 0	4, 768, 602	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	1, 139, 268		1 11 10 77 2		1, 139, 268	1
66. 00 06600 PHYSI CAL THERAPY	1, 577, 658		1, 577, 6		1, 577, 658	
67.00 06700 OCCUPATI ONAL THERAPY	1, 031, 853		1, 031, 8		1, 031, 853	
68.00 06800 SPEECH PATHOLOGY	102, 972	0	102, 9	72 0	102, 972	
69. 00 06900 ELECTROCARDI OLOGY	0			0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 039, 098		1, 039, 0		1, 039, 098	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	649, 706		649, 7		649, 706	
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 042, 121		4, 042, 1	21 0	4, 042, 121	
76. 97 07697 CARDI AC REHABI LI TATI ON	0			0 0	0	1 / 0/ //
76. 98 07698 HYPERBARI C OXYGEN THERAPY	19, 996		19, 9	96 0	19, 996	
76. 99 07699 LI THOTRI PSY	0			0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLINIC	0			0 0	0	1 /01 00
90.01 09001 INTENSIVE OUT PATIENT PROGRAM	0			0 0	0	
91. 00 09100 EMERGENCY	9, 771, 481		9, 771, 4			
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	2, 449, 277		2, 449, 2	77	2, 449, 277	92.00
OTHER REI MBURSABLE COST CENTERS			0.445.5		0.450.555	0.5.05
95.00 09500 AMBULANCE SERVICES	3, 449, 374		3, 449, 3			
200.00 Subtotal (see instructions)	49, 792, 674	0				
201.00 Less Observation Beds	2, 449, 277	_	2, 449, 2		2, 449, 277	
202.00  Total (see instructions)	47, 343, 397	0	47, 343, 3	30, 696	47, 374, 093	202.00

Health Financial Systems	WHITLEY MEMORI	AL_HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2017 To 12/31/2017	5/29/2018 4:1	epared: 0 pm
		Title	e XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpati ent	Outpatient	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	6, 961, 777		6, 961, 77			30.00
43. 00 04300 NURSERY	1, 748, 179		1, 748, 17	'9		43.00
44.00 04400 SKILLED NURSING FACILITY	0			0		44.00
ANCI LLARY SERVI CE COST CENTERS				- (		
50.00 05000 OPERATING ROOM	5, 590, 620	17, 514, 828				
52.00 05200 DELIVERY ROOM & LABOR ROOM	8, 155, 982	293, 194				
53. 00 05300 ANESTHESI OLOGY	526, 117	2, 303, 671				
54.00 05400 RADI OLOGY-DI AGNOSTI C	3, 944, 704	55, 084, 319				
60. 00 06000 LABORATORY	3, 169, 626	20, 554, 134				
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0.000000		
65. 00 06500 RESPI RATORY THERAPY	2,001,980	6, 359, 093				
66. 00 06600 PHYSI CAL THERAPY	230, 562	4, 217, 257				
67.00 06700 OCCUPATI ONAL THERAPY	139, 777	1, 359, 224			0.00000	
68.00 06800 SPEECH PATHOLOGY	17, 248	319, 801				
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0.000000		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 032, 273	1, 403, 857				
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 077, 510	2, 368, 835			0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 397, 378	13, 925, 577	18, 322, 95		0.00000	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0.000000		
76. 98 07698 HYPERBARI C OXYGEN THERAPY	28, 479	86, 964	115, 44		0.00000	
76. 99 07699 LI THOTRI PSY	0	0		0 0.000000	0.00000	76.99
OUTPATIENT SERVICE COST CENTERS	-1					
90. 00 09000 CLINIC	0	0		0 0.000000		
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0		0 0.000000		
91.00 09100 EMERGENCY	2, 973, 846	34, 826, 534				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2, 146, 402	2, 146, 40	1. 141108	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS			1	_		
95. 00 09500 AMBULANCE SERVI CES	0	5, 708, 639			0.00000	
200.00 Subtotal (see instructions)	41, 996, 058	168, 472, 329	210, 468, 38	37		200.00
201.00 Less Observation Beds						201.00
202.00  Total (see instructions)	41, 996, 058	168, 472, 329	210, 468, 38	37		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES         Provider CCN: 15-0101         Period: From 0/101/2017 To 12/31/2017         Worksheet C Part 1           Cost Center Description         PPS Inpatient Ratio         Title XVIII         Hospital         PPS           INPATIENT ROUTINE SERVICE COST CENTERS         30.00         30.00         30.00         43.00         44.00           AND OF ADDID SERVICE COST CENTERS         30.00         43.00         44.00         44.00           AND OF ADDID SERVICE COST CENTERS         0.151297         50.00         52.00         52.00           50.00         052000 DELIVERY ROOM & LABOR ROOM         0.151297         50.00         52.00         53.00         53.00         53.00         54.00         66.00         60.20         62.00         66.00         62.20         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         67.00         68.00         67.00         67.00         68.00         67.00         67.00         67.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         67.00         66.00         66.00	Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
To         12/31/2017         Date/Time Prepared: 5/29/2018 4:10.pm           INPATIENT ROUTINE SERVICE COST CENTERS         Title XVIII         Hospital         PPS           0.00         03000 ADULTS & PEDIATRICS         30.00         43.00         44.00         44.00         44.00         44.00         44.00         44.00         44.00         44.00         50.00<			Provider CCN: 15-0101		
Cost Center Description         PPS Inpatient Ratio         Title XVIII         Hospital         PPS           30.00         03000 ADULTS & PEDLATRICS         30.00         30.00         30.00         30.00         30.00         30.00         43.00         44.00           44.00         Add00 SKILLED NURSING FACILITY         44.00         44.00         44.00         44.00         44.00         55.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         52.00         50.00         52.00				To 12/31/2017	
Cost Center Description         PPS Inpatient Ratio         PSI Inpatient Ratio         PSI Inpatient Ratio         PSI Inpatient Ratio         PSI Inpatient Ratio           30.00         03000 ADULTS & PEDIATRICS         30.00         30.00         30.00         30.00         30.00         30.00         30.00         43.00         44.00         44.00         44.00         44.00         44.00         44.00         44.00         44.00         44.00         55.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         52.00         51.00         51.00         51.00         52.00         52.00         51.00         54.00         54.00         54.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00					5/29/2018 4:10 pm
Ratio         11.00           11.00         11.00           30.00         03000 ADULTS & PEDIATRICS         30.00           43.00         04300 NURSERY         30.00           44.00         04400 SKILLED NURSING FACILITY         44.00           ANDULLARY SERVICE COST CENTERS         50.00           50.00         05000 DELVERY ROM & LABOR ROM         0.151297           50.00         05300 ANUSTHESI OLOGY         0.012480           51.00         05300 ANESTHESI OLOGY         0.012480           53.00         05300 ANESTHESI OLOGY         0.111063           54.00         05400 RADIOLOSY-DI AGNOSTI C         0.111063           60.00         06000 LABORATORY         0.0201005           62.30         065250 BLOOD CLOTTING FOR HEMOPHILIACS         0.000000           63.00         06500 RESPI RATORY THERAPY         0.354704           66.00         06700 OCUPATIONAL THERAPY         0.365259           66.00         66.00         66.00           67.00         06700 OCUPATIONAL THERAPY         0.363510           67.00         06700 OCUPATIONAL THERAPY         0.363510           68.00         6900         69.00           69.00         06700 MEDICLALARED TO PATIENT         0.426536     <			Title XVIII	Hospi tal	PPS
11.00         11.00           30.00         03000 ADULTS & PEDIATRCS         30.00           43.00         04300 NURSERY         43.00           44.00         24000 SKILED NURSING FACILITY         43.00           ANCILLARY SERVICE COST CENTERS         50.00           50.00         05000 (PECATING ROOM         0.151297           50.00         50200 DELIVERY ROOM & LABOR ROOM         0.101644           51.00         05300 ARSTHESI OLOCY         0.012480           51.00         050200 RESPI RATORY         0.210105           64.00         6500 RESPI RATORY         0.201005           65.00         06500 RESPI RATORY THERAPY         0.384704           65.00         06500 OCUTTING FOR HEMOPHILIACS         0.000000           66.00         06500 SECCH PATHOLOGY         0.384704           66.00         06600 PHYSICAL THERAPY         0.384704           67.00         06000 ELECTROCARD IDAGY         0.305510           68.00         06800 SEECH PATHOLOGY         0.305510           72.00         07300 RUL CARGED TO PATIENT         0.426536           73.00         07300 RULCS CARGED TO PATIENTS         0.28800           74.99         0.733211         76.99           76.99         0.7697 CARDIA	Cost Center Description				
INPATIENT ROUTINE SERVICE COST CENTERS         30.00           30.00         03000 ADULTS & PEDIATRICS         43.00           43.00         04300 INURSERY         43.00           ANCILLARY SERVICE COST CENTERS         44.00           50.00         05000 DELXTING FACILITY         44.00           ANCILLARY SERVICE COST CENTERS         50.00           50.00         05000 DELVENY ROM & LABOR ROOM         0.151297           50.00         05300 ANESTHESI OLOGY         0.012480           51.00         05000 DLABORATORY         0.01044           52.00         065000 ILABORATORY         0.21005           52.00         065000 RESPIRATING FOR HEMOPHILIACS         0.000000           62.30         06500 RESPIRATORY THERAPY         0.354704           63.00         06600 PEPSICAL THERAPY         0.354704           64.00         06400 OLOGO OLCUPTI ONAL THERAPY         0.365470           65.00         06600 RESPIRATIONY THERAPY         0.365470           66.00         06600 PEPECH PATHOLOGY         0.305510           68.00         06900 ELECTROCARDI OLOGY         0.305510           70.00         07200 INPL. DEV. CHARGED TO PATIENTS         0.28636           71.00         72.00         7300 DRUGS CHARED TO PATIENTS         0.28					
30. 00       03000       ADULTS & PEDIATRICS       30. 00         43. 00       04300       NURSERY       43. 00         44. 00       OVADON NURSERY       44. 00         ANCILLARY SERVICE COST CENTERS       44. 00         50. 00       DSC000 (DPERATING ROM       0. 151297         50. 00       DSC000 (DPERATING ROM       0. 012480         53. 00       05300 (ANESTHESI OLOGY       0. 111063         54. 00       05400 (RADIOLOGY-DIAGNOSTIC       0. 111063         62. 30       DS250 (DECUTTIN FOR HEMOPHILIACS       0. 000000         63. 00       06500 (PERSPI RATORY THERAPY       0. 136259         64. 00       06700 (DCCUPATIONAL THERAPY       0. 354704         65. 00       06500 (DCCUPATIONAL THERAPY       0. 365510         66. 00       06600 (DCCUPATIONAL THERAPY       0. 305510         66. 00       06600 (DCCUPATIONAL THERAPY       0. 426536         71. 00       07100 (DEUCAL SUPPLIES CHARGED TO PATIENT       0. 426536         72. 00       07200 IMPL, DEV, CHARGED TO PATIENT       0. 426536         73. 00       07300 DRUGS CHARGED TO PATIENTS       0. 220604         74. 90       0. 000000       73. 00         76. 97       07697 (CARDI AC REHABILI TATION       0. 000000     <		11.00			
43.00       04300       NURSERY       43.00         44.00       04400       SKI LLED. NURSING FACI LLTY       44.00         ANCI LLARY SERVICE COST CENTERS       50.00       50.00       DEPERATI NG ROOM       0.151297       50.00         52.00       DESODO DELI VERY ROOM & LABOR ROOM       0.101644       52.00       53.00         53.00       05300 ANESTHESI OLOGY       0.012480       53.00         54.00       D5400 RADI OLOGY -DI AGNOSTI C       0.111063       54.00         60.00       Cooloo LABORATORY       0.201005       60.00         61.00       D6000 LABORATORY       0.136259       60.00         65.00       06500 RESPI RATORY THERAPY       0.384704       65.00         66.00       06600 PHYSI CAL THERAPY       0.385510       67.00         67.00       COCUPATI ONAL THERAPY       0.426536       71.00         67.00       D7100 DELOC PATI ENTS       0.220604       71.00         71.00       O7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.220604       73.00         73.00       O7300 DRUGS CHARGED TO PATI ENTS       0.220604       73.00         76.98       07697 CARDI AC REHABILI TATI NO       0.000000       76.97         76.98       07698 HYPERBARI C OXYGEN THERA		1			
44.00       AVAOU       SKI LLED NURSING FACILITY       44.00         ANCI LLARY SERVICE COST CENTERS       50.00         05.00       DOSOOO (OPERATIN GROOM       0.151297         50.00       DOSOOO (PERATIN GROOM       0.101644       52.00         53.00       OS300 (ARSTHESI OLOGY       0.111063       53.00         64.00       D6400 (RADI OLOGY-DI AGNOSTI C       0.111063       54.00         65.00       O6500 (RESPI RATORY       0.201005       60.00         62.30       O6500 (RESPI RATORY THERAPY       0.136259       65.00         65.00       O6600 (RESPI RATORY THERAPY       0.354704       66.00         66.00       O6600 (SPEECH PATHOLOGY       0.305510       68.00         67.00       OCOPTI ONAL THERAPY       0.365510       68.00         69.00       O6900 (ELCTROCARDI OLOGY       0.305510       68.00         69.00       OF00 (CLUBAL SUPPLIES CHARGED TO PATIENT       0.426536       71.00         71.00       T100 (MEDI CAL SUPPLIES CHARGED TO PATIENTS       0.188520       72.00         73.00       DRUGS CHARGED TO PATIENTS       0.220604       73.00         74.90       DIGSERVATION       0.000000       76.99         75.90       DIG99 LITHERTENSUP       0.00					
ANCI LLARY SERVICE COST CENTERS         50.00         OSCOOL         OPERATING ROOM         0.151297         50.00         60.00         60.00         60.00         62.30         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         67.00         68.00         68.00         68.00         68.00         68.00         68.00         68.00         68.00         69.00         71.00         71.00         71.00         72.00<					
50.00       05000       0PERATING ROOM       0.151297       50.00         52.00       05200       DELIVERY ROOM & LABOR ROOM       0.101644       52.00         53.00       05200       DELIVERY ROOM & LABOR ROOM       0.111663       53.00         54.00       05400       RADIOLOGY-DIAGNOSTIC       0.111063       54.00         60.00       06000       LABORATORY       0.201005       62.30         06250       BLOOD CLOTTING FOR HEMOPHILIACS       0.000000       62.30         06500       RESPIRATORY THERAPY       0.354704       65.00         66.00       06000       LECTROCARDIOLOGY       0.354704       66.00         67.00       06700       OCCUPATIONAL THERAPY       0.688360       67.00         68.00       06800       SPEECH PATHOLOGY       0.305510       68.00         69.00       GFT00       OT100 MEDICAL SUPPLIES CHARGED TO PATIENT       0.426536       71.00         71.00       OT200 I MPL. DEV. CHARGED TO PATIENTS       0.18250       72.00         73.00       7300       PUGS CHARGED TO PATIENTS       0.220604       73.00         76.97       CARDIAC REHABILITATION       0.000000       76.97         76.98       OT699 LITHORIPSY       0.13211					44.00
52.00       05200       DELI VERY ROOM & LABOR ROOM       0.101644       52.00         53.00       05300       ANESTHESI OLOGY       0.012480       53.00         64.00       05400       RAD LOGY-DI AGNOSTI C       0.111063       54.00         60.00       06000       LABORATORY       0.201005       60.00         62.30       06250       BLOD CLOTTING FOR HEMOPHILIACS       0.000000       62.30         65.00       05600       RSPI RATORY THERAPY       0.354704       66.00         66.00       06000       PHYSI CAL THERAPY       0.354704       66.00         67.00       06000       PLECTROCARDI OLOGY       0.305510       68.00         68.00       06600       PELETROCARDI OLOGY       0.000000       69.00         67.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.486536       71.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.220604       73.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.220604       73.00         76.97       OAS94       HPERABRI C OXYGEN THERAPY       0.000000       76.97         76.97       OAS94       HPERABRI C OXYGEN THERAPY       0.0000000       76.97		0.454007			
53.00       05300       ANESTHESI OLOGY       0.012480       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0.111063       54.00         60.00       LABORATORY       0.201005       62.30         62.30       06550       BLOOD CLOTTING FOR HEMOPHI LI ACS       0.000000       62.30         65.00       06500       RESPI RATORY THERAPY       0.136259       65.00         66.00       OCCUPATI ONAL THERAPY       0.354704       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0.305510       68.00         67.00       06700       DCCUPATI ONAL THERAPY       0.888360       67.00         68.00       06800       SPECH PATHOLOGY       0.300510       68.00         69.00       OCCUPATI ONAL THERAPY       0.426536       71.00         71.00       OT100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0.426536       72.00         73.00       OT200       IMPL. DEV. CHARGED TO PATI ENTS       0.220604       73.00         76.97       CA598       HYPERBARI C OXYGEN THERAPY       0.173211       76.97         76.98       OT699 LITHOTRI PSY       0.000000       90.01       90.01         90.00       OPOTOCI LINTIC PART INT PROGRAM					
54.00       05400       RADI OLOGY - DI AGNOSTI C       0.111063       54.00         60.00       06000       LABORATORY       0.201005       60.00         62.30       06250       BLODD CLOTTI NG FOR HEMOPHI LI ACS       0.000000       62.30         65.00       06500       RESPI RATORY THERAPY       0.136259       65.00         66.00       06600       PHYSI CAL THERAPY       0.354704       66.00         67.00       0CCUPATI ONAL THERAPY       0.305510       68.00         68.00       06800       SPEECH PATHOLOGY       0.305510       68.00         69.00       06600 REDICARDI OLOGY       0.000000       69.00         71.00       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.426536       71.00         72.00       O7200 IMPL. DEV. CHARGED TO PATI ENTS       0.188520       72.00         73.00       07300 DRUGS CHARGED TO PATI ENTS       0.173211       76.97         76.97       CARDI AC REHABI LI TATI ON       0.000000       76.97         76.99       D7697 LI NT C REHABI LI TATI ON       0.000000       76.97         76.99       D7697 LI NI C       0.000000       90.01       90.01         90.00       OPO00 CLI NI C       0.0000000       90.01       90.01 </td <td></td> <td></td> <td></td> <td></td> <td></td>					
60.00       06000       LABORATORY       0.201005       60.00         62.30       06250       BLOD CLOTTI NG FOR HEMOPHI LI ACS       0.000000       62.30         65.00       06500       RESPI RATORY THERAPY       0.136259       66.00         66.00       06600       PHYSI CAL THERAPY       0.354704       66.00         67.00       06700       CCUPATI ONAL THERAPY       0.688360       67.00         68.00       06800 SPEECH PATHOLOGY       0.305510       68.00         69.00       06900       ELECTROCARDI OLOGY       0.300000       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.426536       71.00         72.00       07200 IMPL.       DEV. CHARGED TO PATI ENTS       0.188520       72.00         73.00       DRUGS CHARGED TO PATI ENTS       0.188520       76.97         74.90       0.7697       CARDI AC REHABI LI TATI ON       0.000000       76.97         75.90       07698       HYPERBARI C 0XYGEN THERAPY       0.173211       76.98         76.91       OTHOR TENT SERVICE COST CENTERS       0.0000000       90.01         90.00       90000       INTENSI VE OUT PATI ENT PROGRAM       0.0000000       90.01         90.00 <t< td=""><td></td><td></td><td></td><td></td><td></td></t<>					
62.30       06250       BLOOD CLOTTI NG FOR HEMOPHI LI ACS       0.000000       62.30         65.00       06500       RESPI RATORY THERAPY       0.136259       65.00         66.00       06600       PHYSI CAL THERAPY       0.354704       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0.688360       67.00         68.00       06800       SPEECH PATHOLOGY       0.305510       68.00         69.00       G6900       ELECTROCARDI OLOGY       0.000000       68.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0.426536       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.188520       72.00         73.00       07300       DRUAC SCHARGED TO PATI ENTS       0.220604       73.00         76.97       ROFIA CR REHABI LI TATI ON       0.000000       76.97         76.98       07692       LI THOTRI PSY       0.173211       76.98         76.99       DTOPOL AC REHABI LI TATI ON       0.000000       90.01         90.00       OPODOC CLI NI C       0.0000000       90.01         91.00       OPODOC DUT AT THOT PATI ENT PROGRAM       0.0000000       90.01         92.00       090000       LI NENSI					
65.00       06500       RESPI RATORY THERAPY       0.136259       65.00         66.00       06600       PHYSI CAL THERAPY       0.354704       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0.688360       67.00         68.00       06800       SPECH PATHOLOGY       0.305510       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.426536       71.00         72.00       07200 I MPL. DEV. CHARGED TO PATI ENT       0.138520       72.00         73.00       OT300 DRUGS CHARGED TO PATI ENTS       0.188520       73.00         76.97       CARDI AC REHABI LI TATI ON       0.000000       76.97         76.98       07698       HYPERBAR C OXYGEN THERAPY       0.173211       76.98         70.69       07900       CLI NI C       0.000000       90.00         90.00       09000       CLI NI C       0.000000       90.01         91.00       09000       CLI NI C       0.000000       90.01         92.00       09200       DESERVATI ON BEDS (NON-DI STI NCT PART       1.141108       92.00         92.00       09200       DESERVATI ON BEDS					
66.00       06600       PHYSI CAL THERAPY       0.354704       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0.688360       67.00         68.00       06800       SPEECH PATHOLOGY       0.305510       68.00         69.00       06900       ELECTROCARDI OLOGY       0.00000       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0.426536       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.188520       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.20604       73.00         76.97       O7697       CARDI AC REHABILI TATI ON       0.000000       76.97         76.99       07699       LI THOTRI PSY       0.173211       76.98         76.99       07000       CLINI C       0.000000       90.00         90.00       090001       INTENSI VE OUT PATIENT PROGRAM       0.000000       90.01         91.00       09100       EMERGENCY       0.259153       91.00         92.00       OBSERVATI ON BEDS (NON-DI STI NCT PART       1.141108       92.00         07500       MBULANCE SERVICES       0.604712       95.00         95.00       O9500       AMBULA					
67.00       06700       0CCUPATIONAL THERAPY       0.688360       67.00         68.00       06800       SPEECH PATHOLOGY       0.305510       68.00         69.00       06900       ELECTROCARDIOLOGY       0.000000       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0.426536       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.188520       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.220604       73.00         76.97       CARDIAC REHABILITATION       0.000000       76.97         76.98       07698       HYPERBARI C 0XYGEN THERAPY       0.173211       76.98         76.99       07699       LITHOTRI PSY       0.000000       76.99         0UTPATIENT SERVICE COST CENTERS       0.000000       76.99       90.00         90.00       09000       LINT ON PATIENT PROGRAM       0.000000       90.01         91.00       O9100       EMERGENCY       0.259153       91.00         92.00       OBSERVATION BEDS (NON-DISTINCT PART       1.141108       92.00         95.00       O9500       AMBULANCE SERVICES       0.604712       95.00         95.00       09500 AMBULANCE SERVICIONS) </td <td></td> <td></td> <td></td> <td></td> <td></td>					
68.00       06800       SPEECH PATHOLOGY       0.305510       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       69.00         71.00       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0.426536       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.188520       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.220604       73.00         76.97       CARDI AC REHABI LI TATI ON       0.000000       76.97         76.98       07698       HYPERBARI C OXYGEN THERAPY       0.173211       76.98         0.09000       CLI NI C       0.000000       76.99       76.99         0.00000       CUTPATI ENT SERVICE COST CENTERS       0.000000       90.00         0.00000       CUINI C       0.000000       90.00       90.00         90.00       09000       LINIC       0.000000       90.01         91.00       09100       EMEGENCY       0.259153       91.00         92.00       OBSERVATION BEDS (NON-DI STINCT PART       1.141108       92.00         01.00       OP5000       AMBULANCE SERVI CES       0.604712       95.00         200.00       Subtotal (see instructions)       200.00       2					
69.00       06900       ELECTROCARDIOLOGY       0.000000       69.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       0.426536       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.188520       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.220604       73.00         76.97       07697       CARDIAC REHABILITATION       0.000000       76.97         76.98       07698       HYPERBARIC OXYGEN THERAPY       0.173211       76.98         76.99       07699       LI THOTRI PSY       0.000000       76.99         00000       09000       CLI NI C       0.000000       90.00         090.00       09000       INTENSI VE OUT PATI ENT PROGRAM       0.000000       90.01         91.00       09010       EMERGENCY       0.259153       91.00         92.00       DSERVATI ON BEDS (NON-DI STINCT PART       1.141108       92.00         07500       OPS000       AMBULANCE SERVI CES       0.604712       95.00         95.00       09500       Subtotal (see instructions)       200.00       201.00         201.00       Less Observation Beds       0.604712       201.00					
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0.426536       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.188520       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.220604       73.00         76.97       CARDIAC REHABILITATION       0.000000       76.97         76.98       07698       HYPERBARI C OXYGEN THERAPY       0.173211       76.98         76.99       07699       LI THOTRI PSY       0.000000       76.99         00000       0010       ERVICE COST CENTERS       90.00       90.00         90.00       09000       CLI NI C       0.000000       90.01         91.00       09000       CLI NI C       0.000000       90.01         91.00       09100       EMRGENCY       0.259153       91.00         92.00       0BSERVATI ON BEDS (NON-DI STINCT PART       1.141108       92.00         95.00       09500       AMBULANCE SERVICES       0.604712       95.00         200.00       Subtotal (see instructions)       200.00       201.00       201.00         201.00       Less Observation Beds       0.604712       95.00       200.00					
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.188520       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.220604       73.00         76.97       07697       CARDIAC REHABILITATION       0.000000       76.97         76.98       07698       HYPERBARI C OXYGEN THERAPY       0.173211       76.98         76.99       DITHORI PSY       0.000000       76.97         00000       OUTPATIENT SERVICE COST CENTERS       90.00       90.00         90.00       09000       CLINIC       0.000000       90.01         90.00       09000       CLINIC       0.000000       90.01         91.00       09000       CLINIC       90.00       90.01         92.00       OBSERVATION BEDS (NON-DI STINCT PART       1.141108       92.00         95.00       09500       AMBULANCE SERVICES       0.604712       95.00         200.00       Subtotal (see instructions)       200.00       201.00       201.00         201.00       Less Observation Beds       0.604712       200.00					
73.00       07300       DRUGS CHARGED TO PATIENTS       0.220604       73.00         76.97       07697       CARDIAC REHABILITATION       0.000000       76.97         76.98       07698       HYPERBARI C 0XYGEN THERAPY       0.173211       76.98         76.99       01TPATIENT SERVICE COST CENTERS       0.000000       76.99         0UTPATIENT SERVICE COST CENTERS       0.000000       90.00         90.00       09000       LINTENSIVE OUT PATIENT PROGRAM       0.000000       90.01         91.00       09100       EMERGENCY       0.259153       91.00         92.00       092000       OBSERVATION BEDS (NON-DISTINCT PART       1.141108       92.00         95.00       09500       AMBULANCE SERVICES       0.604712       95.00       95.00         200.00       Subtotal (see instructions)       0.604712       200.00       201.00         201.00       Less Observation Beds       201.00       201.00       201.00					
76.97         07697         CARDI AC REHABILITATION         0.000000         76.97           76.98         07698         HYPERBARI C 0XYGEN THERAPY         0.173211         76.98           76.99         07699         LI THOTRI PSY         0.000000         76.99           0UTPATI ENT SERVICE COST CENTERS         0.000000         90.00         90.00           90.00         09000         CLI NI C         0.000000         90.01           90.01         09000         INTENSI VE OUT PATI ENT PROGRAM         0.000000         90.01           91.00         09100         EMERGENCY         0.259153         91.00           92.00         09SERVATI ON BEDS (NON-DI STINCT PART         1.141108         92.00           07HER REIMBURSABLE COST CENTERS         0.604712         95.00         95.00           200.00         Subtotal (see instructions)         0.604712         200.00         201.00           201.00         Less Observation Beds         0.604712         200.00         201.00         201.00					
76.98       07698       HYPERBARI C 0XYGEN THERAPY       0.173211       76.98         76.99       07699       LI THOTRI PSY       0.00000       76.99         0UTPATI ENT SERVICE COST CENTERS       0.000000       90.00       90.00         90.00       09000       CLI NI C       0.000000       90.00         90.01       09001       INTENSI VE OUT PATI ENT PROGRAM       0.000000       90.01         91.00       09100       EMERGENCY       0.259153       91.00         92.00       OBSERVATI ON BEDS (NON-DI STI NCT PART       1.141108       92.00         0THER REI MBURSABLE COST CENTERS       0.604712       95.00         95.00       09500       AMBULANCE SERVICES       0.604712       95.00         200.00       Subtotal (see instructions)       200.00       201.00       201.00					
76.99         07699         LI THOTRI PSY         0.00000         76.99           OUTPATI ENT SERVICE COST CENTERS         0.00000         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.01         90.00         90.01         90.00         90.01         90.00         90.01					
OUTPATI ENT_SERVICE_COST_CENTERS         90.00         9000         CLINIC         90.00         90.00         90.00         90.00         90.01         90.00         90.01         90.00         90.01         91.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         95.00         95.00         95.00         95.00         95.00         95.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00					
90.00         09000         CLINIC         0.00000         90.00           90.01         09001         INTENSIVE OUT PATIENT PROGRAM         0.000000         90.01           91.00         09100         EMERGENCY         0.259153         91.00           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART         1.141108         92.00           0THER         REIMBURSABLE COST CENTERS         95.00         09500         AMBULANCE SERVICES         95.00           200.00         Subtotal (see instructions)         0.604712         95.00         200.00         201.00		0. 000000			76. 99
90. 01         09001         INTENSIVE OUT PATIENT PROGRAM         0.000000         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         90. 01         91. 00         91. 00         92. 00<					
91.00         09100         EMERGENCY         0.259153         91.00         92.00	90. 00 09000 CLINIC	0. 000000			90.00
92.00         OP200         OBSERVATION         BEDS (NON-DISTINCT PART         1.141108         92.00           0THER         REI MBURSABLE COST CENTERS         95.00         9500         AMBULANCE SERVICES         0.604712         95.00         95.00         200.00         Subtotal (see instructions)         200.00         201.00	90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0. 000000			90.01
OTHER REI MBURSABLE COST CENTERS95. 0009500AMBULANCE SERVI CES0. 60471295. 00200. 00Subtotal (see instructions)200. 00200. 00201. 00Less Observation Beds201. 00	91.00 09100 EMERGENCY	0. 259153			91.00
95.00         09500         AMBULANCE SERVICES         0.604712         95.00           200.00         Subtotal (see instructions)         200.00         200.00         201.00         201.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 141108			92.00
200.00         Subtotal (see instructions)         200.00         200.00         201.00 <td>OTHER REIMBURSABLE COST CENTERS</td> <td></td> <td></td> <td></td> <td></td>	OTHER REIMBURSABLE COST CENTERS				
201.00 Less Observation Beds 201.00	95. 00 09500 AMBULANCE SERVI CES	0. 604712			95.00
	200.00 Subtotal (see instructions)				
202.00   Total (see instructions)   202.00	201.00 Less Observation Beds				201.00
	202.00 Total (see instructions)				202.00

Health Fina	ancial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATI O	IN OF RATIO OF COSTS TO CHARGES		Provider C		Period:	Worksheet C	
					From 01/01/2017 To 12/31/2017	Part I Date/Time Pre	parad
					10 12/31/2017	5/29/2018 4:1	n nm
			Titl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4.00	5.00	
	ATIENT ROUTINE SERVICE COST CENTERS	1	I	1			-
	DO ADULTS & PEDIATRICS	8, 530, 961		8, 530, 96		8, 530, 961	
	DO NURSERY	277, 885		277, 88		,	•
	DO SKILLED NURSING FACILITY	0			0 0	0	44.00
	LLARY SERVICE COST CENTERS	0 405 330				0 105 770	
	DO OPERATING ROOM	3, 495, 778		3, 495, 77			
	DO DELIVERY ROOM & LABOR ROOM	858, 810		858, 81		858, 810	
		31, 917		31, 91			•
	DO RADI OLOGY-DI AGNOSTI C	6, 555, 917		6, 555, 91		6, 555, 917	
		4, 768, 602		4, 768, 60		4, 768, 602	•
	50 BLOOD CLOTTING FOR HEMOPHILIACS	0		1 100 0/	0 0	0	
		1, 139, 268		1,107/20		1, 139, 268	
	DO PHYSICAL THERAPY DO OCCUPATIONAL THERAPY	1, 577, 658 1, 031, 853		1, 577, 65		1, 577, 658 1, 031, 853	
	DO SPEECH PATHOLOGY			1, 031, 85		1, 031, 853	•
	DO ELECTROCARDI OLOGY	102, 972		102, 97	2 0	102, 972	1
	DO MEDICAL SUPPLIES CHARGED TO PATIENT	1,039,098		1, 039, 09	0	1, 039, 098	
	DO IMPL. DEV. CHARGED TO PATIENTS	649, 706		649, 70		649, 706	1
	DO DRUGS CHARGED TO PATIENTS	4, 042, 121		4, 042, 12		4, 042, 121	
	97 CARDIAC REHABILITATION	4,042,121		4,042,12	0 0	4, 042, 121	1
	98 HYPERBARI C OXYGEN THERAPY	19, 996		19, 99	<u> </u>	19, 996	
	99 LI THOTRI PSY	0		17, 75	0 0	0	1
	PATIENT SERVICE COST CENTERS	0		1	0	0	,0. ,,
		0			0 0	0	90.00
	D1 I NTENSI VE OUT PATI ENT PROGRAM	0			0 0	0	
	DO EMERGENCY	9, 771, 481		9, 771, 48	1 24, 590	-	
	DO OBSERVATION BEDS (NON-DISTINCT PART	2, 449, 277		2, 449, 27		2, 449, 277	•
	ER REIMBURSABLE COST CENTERS					=	1
	DO AMBULANCE SERVICES	3, 449, 374		3, 449, 37	4 2,708	3, 452, 082	95.00
200.00	Subtotal (see instructions)	49, 792, 674					
201.00	Less Observation Beds	2, 449, 277		2, 449, 27	7	2, 449, 277	201.00
202.00	Total (see instructions)	47, 343, 397	( C	47, 343, 39	7 30, 696	47, 374, 093	202.00

Health Financial Systems	WHITLEY MEMORI	AL_HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/29/2018 4:1	epared: O pm
		Titl	e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	6, 961, 777		6, 961, 77			30.00
43. 00 04300 NURSERY	1, 748, 179		1, 748, 17	79		43.00
44.00 04400 SKILLED NURSING FACILITY	0			0		44.00
ANCI LLARY SERVI CE COST CENTERS	· · · · · ·					
50.00 05000 OPERATI NG ROOM	5, 590, 620	17, 514, 828			0.00000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	8, 155, 982	293, 194			0.00000	
53. 00 05300 ANESTHESI OLOGY	526, 117	2, 303, 671			0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 944, 704	55, 084, 319			0.00000	
60. 00 06000 LABORATORY	3, 169, 626	20, 554, 134			0.00000	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0.000000	0.00000	
65. 00 06500 RESPI RATORY THERAPY	2, 001, 980	6, 359, 093			0.00000	
66. 00 06600 PHYSI CAL THERAPY	230, 562	4, 217, 257			0.00000	
67.00 06700 OCCUPATI ONAL THERAPY	139, 777	1, 359, 224			0.00000	
68.00 06800 SPEECH PATHOLOGY	17, 248	319, 801			0.00000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0.000000	0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 032, 273	1, 403, 857			0.00000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 077, 510	2, 368, 835			0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 397, 378	13, 925, 577	18, 322, 95		0.00000	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0.000000	0.00000	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	28, 479	86, 964			0.00000	
76. 99 07699 LI THOTRI PSY	0	0		0 0.000000	0.00000	76.99
OUTPATIENT SERVICE COST CENTERS	1					
90. 00 09000 CLI NI C	0	0		0 0.000000	0.00000	
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0		0 0.000000	0.00000	
91.00 09100 EMERGENCY	2, 973, 846	34, 826, 534			0.00000	
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0	2, 146, 402	2, 146, 40	02 1.141108	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS	1					
95.00 09500 AMBULANCE SERVICES	0	5, 708, 639			0.00000	
200.00 Subtotal (see instructions)	41, 996, 058	168, 472, 329	210, 468, 38	37		200.00
201.00 Less Observation Beds						201.00
202.00   Total (see instructions)	41, 996, 058	168, 472, 329	210, 468, 38	37		202.00

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lieu	」of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0101	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/29/2018 4:10 pm
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30, 00
43. 00 04300 NURSERY				43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY				44.00
ANCI LLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 151297			50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 101644			52.00
53. 00 05300 ANESTHESI OLOGY	0. 012480			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 111063			54.00
60. 00 06000 LABORATORY	0. 201005			60,00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62.30
65. 00 06500 RESPIRATORY THERAPY	0. 136259			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 354704			66, 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 688360			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 305510			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 426536			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 420530			71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 220604			73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 220004			76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 173211			76.98
76. 99 07699 LI THOTRI PSY	0. 000000			76.99
OUTPATIENT SERVICE COST CENTERS	0.000000			70.99
90. 00 09000 CLINIC	0. 000000			90, 00
90. 00 109000 CETNIC 90. 01 109001 INTENSIVE OUT PATIENT PROGRAM	0.000000			90.00
91. 00 09100 EMERGENCY	0. 259153			90.01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 141108			91.00
07100 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 141108			92.00
95. 00 09500 AMBULANCE SERVICES	0.604712			95.00
200.00 Subtotal (see instructions)	0. 604712			200.00
				200.00
				201.00
202.00  Total (see instructions)				J202. 00

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA REDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provider C	CN: 15-0101	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part II Date/Time Pre 5/29/2018 4:1	pared: 0 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost	Operating Cos		Operating Cost	
	(Wkst. B, Part	(Wkst. B, Part	Net of Capita	al Reduction	Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	3, 495, 778	651, 718			0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	858, 810	88, 756			0	
53. 00 05300 ANESTHESI OLOGY	31, 917	3, 028	28, 88	39 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	6, 555, 917	1, 050, 887	5, 505, 03	80 0	0	54.00
60. 00 06000 LABORATORY	4, 768, 602	524, 768	4, 243, 83	34 0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	1, 139, 268	168, 745	970, 52	23 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 577, 658	349, 909	1, 227, 74	19 0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	1, 031, 853	100, 563	931, 29	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	102, 972	10, 258	92, 71	4 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 039, 098	107, 654	931, 44	4 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	649, 706	67, 169	582, 53	37 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 042, 121	418, 605	3, 623, 51	6 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	19, 996	1, 897	18, 09	09 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	C		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS			_			
90. 00 09000 CLI NI C	0	C		0 0	0	90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	C		0 0	0	90.01
91.00 09100 EMERGENCY	9, 771, 481	1, 322, 528	8, 448, 95	53 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 449, 277	397, 630	2, 051, 64	7 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	3, 449, 374	338, 612	3, 110, 76	02 0	0	95.00
200.00 Subtotal (sum of lines 50 thru 199)	40, 983, 828	5, 602, 727				200. 00
201.00 Less Observation Beds	2, 449, 277	397, 630				201.00
202.00   Total (line 200 minus line 201)	38, 534, 551	5, 205, 097	33, 329, 45	0	0	202.00

Health Financial Systems	WHITLEY MEMORIA	AL HOSPITAL		In Lie	u of Form CMS	-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA REDUCTIONS FOR MEDICAID ONLY	TIOS NET OF	Provider C		Period: From 01/01/2017 To 12/31/2017	5/29/2018 4:	
			e XIX	Hospi tal	PPS	
Cost Center Description		Total Charges				
	Capital and	(Worksheet C,	Cost to Charg	e		
	Operating Cost F	Part I, column		6		
	Reduction	8)	/ col. 7)			
	6.00	7.00	8.00			
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	3, 495, 778	23, 105, 448	0. 15129	7		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	858, 810	8, 449, 176	0. 10164	4		52.00
53. 00 05300 ANESTHESI OLOGY	31, 917	2, 829, 788	0.01127	'9		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 555, 917	59, 029, 023	0. 11106	3		54.00
60.00 06000 LABORATORY	4, 768, 602	23, 723, 760	0. 20100	05		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.0000	00		62.30
65. 00 06500 RESPI RATORY THERAPY	1, 139, 268	8, 361, 073	0. 13625	i9		65.00
66. 00 06600 PHYSI CAL THERAPY	1, 577, 658	4, 447, 819	0. 35470	04		66.00
67.00 06700 OCCUPATI ONAL THERAPY	1,031,853	1, 499, 001	0. 68836	0		67.00
68.00 06800 SPEECH PATHOLOGY	102, 972	337, 049	0. 3055	0		68.00
69.00 06900 ELECTROCARDI OLOGY	0	0	0.0000	00		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,039,098	2, 436, 130	0. 42653	6		71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	649, 706	3, 446, 345	0. 18852	20		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4,042,121	18, 322, 955	0. 22060	)4		73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0.0000	00		76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	19, 996	115, 443	0. 1732	1		76.98
76. 99 07699 LI THOTRI PSY	0	0	0.0000	00		76.99
OUTPATIENT SERVICE COST CENTERS	· · · · ·		·			
90. 00 09000 CLINIC	0	0	0.0000	00		90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0.0000	00		90.01
91.00 09100 EMERGENCY	9, 771, 481	37, 800, 380	0. 25850	2		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 449, 277	2, 146, 402				92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	3, 449, 374	5, 708, 639	0.60423	8		95.00
200.00 Subtotal (sum of lines 50 thru 199)	40, 983, 828	201, 758, 431				200.00
201.00 Less Observation Beds	2, 449, 277	0				201.00
202.00 Total (line 200 minus line 201)	38, 534, 551	201, 758, 431				202.00

Health Financial Systems	WHITLEY MEMORIA	AL HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider CO		Peri od:	Worksheet D	
				From 01/01/2017		
				To 12/31/2017	Date/Time Pre	
					5/29/2018 4:10	Jрт
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 384, 966	0	1, 384, 96	5, 552	249.45	30.00
43. 00 NURSERY	29, 420	1	29, 42		36.01	43.00
44.00 SKILLED NURSING FACILITY	0	1		0 0	0.00	44.00
200.00 Total (lines 30 through 199)	1, 414, 386		1, 414, 38	6, 369	1'	200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		col. 5 x col.				
	· · · · · · · · · · · · · · · · · · ·	6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 284	320, 294				30.00
43.00 NURSERY	0	0			1	43.00
44.00 SKILLED NURSING FACILITY	ol	0				44.00
200.00 Total (lines 30 through 199)	1, 284	320, 294	-		•	200.00
			1			200

Health Financial Systems	WHITLEY MEMOR	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Pre 5/29/2018 4:1	
		Title	xviii	Hospi tal	PPS	<u>o pili</u>
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,				column 4)	
	Part II, col.	8)	2)	i ondi goo		
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	651, 718	23, 105, 448	0. 02820	6 693, 340	19, 556	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	88, 756	8, 449, 176	0. 01050	5 8, 173	86	52.00
53. 00 05300 ANESTHESI OLOGY	3, 028	2, 829, 788	0. 00107	0 88, 140	94	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 050, 887	59, 029, 023	0. 01780	3 1, 377, 844	24, 530	54.00
60. 00 06000 LABORATORY	524, 768	23, 723, 760	0. 02212	0 1, 012, 276	22, 392	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0. 00000	0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	168, 745	8, 361, 073	0. 02018	2 947, 005	19, 112	65.00
66. 00 06600 PHYSI CAL THERAPY	349, 909	4, 447, 819	0. 07867	0 106, 787	8, 401	66.00
67.00 06700 OCCUPATI ONAL THERAPY	100, 563	1, 499, 001	0. 06708	7 66, 302	4, 448	67.00
68.00 06800 SPEECH PATHOLOGY	10, 258	337, 049	0. 03043	5 8, 594	262	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0. 00000	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	107, 654	2, 436, 130	0. 04419	1 273, 510	12, 087	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	67, 169	3, 446, 345	0. 01949	0 448, 791	8, 747	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	418, 605	18, 322, 955	0. 02284	6 1, 207, 152	27, 579	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0. 00000	0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	1, 897	115, 443	0. 01643	2 0	0	76.98
76. 99 07699 LI THOTRI PSY	0	0	0. 00000	0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0	0.00000	0 0	0	90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0. 00000	0 0	0	90.01
91.00 09100 EMERGENCY	1, 322, 528	37, 800, 380	0. 03498	7 1, 095, 097	38, 314	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	397, 630	2, 146, 402	0. 18525	4 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00   Total (lines 50 through 199)	5, 264, 115	196, 049, 792		7, 333, 011	185, 608	200. 00

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTH	ER PASS THROUGH COSTS	Provider C		Period: From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 4:1	pared: 0 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School Nu Post-Stepdown Adjustments	-	Post-Stepdowr Adjustments	n Cost	All Other Medical Education Cost	
INDATIENT DOUTINE CEDVICE COST CENTERS	1A	1.00	2A	2.00	3.00	
INPATI ENT ROUTI NE SERVICE COST CENTERS           30.00         03000         ADULTS & PEDIATRICS           43.00         04300         NURSERY           44.00         04400         SKI LLED NURSING FACILITY           200.00         Total (Lines 30 through 199)		000000000000000000000000000000000000000			000000000000000000000000000000000000000	
Cost Center Description	Adjustment (s Amount (see 1 instructions) mi	Total Costs sum of cols. through 3, nus col. 4)	Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5.00	6.00	7.00	8.00	
INPATI ENT ROUTI NE SERVICE COST CENTERS           30.00         03000         ADULTS & PEDIATRICS           43.00         04300         NURSERY           44.00         04400         SKI LLED NURSING FACILITY           200.00         Total (Lines 30 through 199)	0	000000000000000000000000000000000000000	5, 55 81 6, 36	7 0.00 0 0.00	0	43.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00			·		
INPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000         ADULTS & PEDI ATRI CS           43. 00         04300         NURSERY           44. 00         04400         SKI LLED NURSI NG FACI LI TY           200. 00         Total (lines 30 through 199)	0 0 0 0					30.00 43.00 44.00 200.00

Heal th	Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEA SH COSTS	RVICE OTHER PASS			Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Pre 5/29/2018 4:1	pared: 0 pm
				XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3.00	
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	C		0 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60.00	06000 LABORATORY	0	C		0 0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C		0 0	0	62.30
65.00	06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	C		0 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
76.97	07697 CARDI AC REHABI LI TATI ON	0	C		0 0	0	76.97
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	C		0 0	0	76. 98
76.99	07699 LI THOTRI PSY	0	C		0 0	0	76.99
	OUTPATIENT SERVICE COST CENTERS			·			1
90.00	09000 CLI NI C	0	0	)	0 0	0	90.00
90.01	09001 I NTENSI VE OUT PATI ENT PROGRAM	0	C		0 0	0	90.01
91.00	09100 EMERGENCY	0	C		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95.00
200.00	Total (lines 50 through 199)	0	C		0 0	0	200. 00

Health Financial Systems	WHITLEY MEMOR	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2017 To 12/31/2017		parad
				10 12/31/2017	5/29/2018 4:1	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of col 1		(from Wkst. C,	to Charges	
	Education Cost	through col.	Cost (sum of		(col. 5 ÷ col.	
		4)	col. 2, 3 and	8)	7)	
			4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50. 00 05000 OPERATING ROOM	0	0	0	23, 105, 448		•
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		8, 449, 176		
53. 00 05300 ANESTHESI OLOGY	0	0		2, 829, 788		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		59, 029, 023		
	0	0		23, 723, 760		
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0			0.00000	
65. 00 06500 RESPI RATORY THERAPY	0			8, 361, 073		
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	0			4, 447, 819		
68.00 06800 SPEECH PATHOLOGY	0			1, 499, 001 337, 049		•
69. 00 06900 ELECTROCARDI OLOGY	0			337,049	0. 000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			2, 436, 130		
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0			2, 436, 130		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0			18, 322, 955		
76. 97 07697 CARDI AC REHABI LI TATI ON	0			10, 322, 933	0. 000000	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0			115, 443		
76. 99 07699 LI THOTRI PSY	0			0	0.000000	
OUTPATIENT SERVICE COST CENTERS	0		· · · · ·		0.00000	, 0. , ,
90. 00 09000 CLINIC	0	0		0 1	0.00000	90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0			0. 000000	
91. 00 09100 EMERGENCY	0	0		37, 800, 380		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		2, 146, 402		
OTHER REIMBURSABLE COST CENTERS			· · · · · · · · · · · · · · · · · · ·	2,110,102		1 2.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	C		196, 049, 792		200.00
	1		1		i .	

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2017	Part IV	
				To 12/31/2017	Date/Time Prep 5/29/2018 4:10	
		Title	XVIII	Hospi tal	PPS	o pili
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.	0	Costs (col.	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 000000	693, 340		0 2, 245, 489	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	8, 173		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	88, 140		0 302, 013	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 377, 844	1	0 10, 212, 640	0	54.00
60. 00 06000 LABORATORY	0. 000000	1, 012, 276	1	0 51, 048	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0.000000	947,005		0 1, 633, 484	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0.000000	106, 787		0 47, 277	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0.000000	66, 302		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	8, 594		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0.000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	273, 510		0 218, 484	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0.000000	448, 791		0 126, 573	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	1, 207, 152		0 4, 187, 631	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0.000000	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0.000000	0		0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0.000000	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0.000000	0		0 0	0	90.01
91.00 09100 EMERGENCY	0.000000	1, 095, 097		0 5, 894, 936	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0		0 6,408	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		7, 333, 011		0 24, 925, 983	0	200.00
						-

Health Financial Systems	WHITLEY MEMORI	AL_HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2017	Worksheet D Part V	
				To 12/31/2017	Date/Time Pre 5/29/2018 4:1	
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 O5000 OPERATING ROOM	0. 151297	2, 245, 489		0 0	339, 736	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 101644			0 0	0	
53. 00 05300 ANESTHESI OLOGY	0. 011279			0 0	3, 406	•
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 111063			0 0	1, 134, 246	
60. 00 06000 LABORATORY	0. 201005			0 0	10, 261	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 136259	1, 633, 484		0 0	222, 577	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 354704	47, 277		0 0	16, 769	
67.00 06700 OCCUPATI ONAL THERAPY	0. 688360			0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 305510	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 426536	218, 484		0 0	93, 191	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 188520	126, 573		0 0	23, 862	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 220604	4, 187, 631		0 0	923, 808	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 173211	0		0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90.01 09001 INTENSIVE OUT PATIENT PROGRAM	0. 000000	0		0 0	0	90.01
91.00 09100 EMERGENCY	0. 258502	5, 894, 936		0 0	1, 523, 853	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 141108	6, 408	1	0 0	7, 312	92.00
OTHER REIMBURSABLE COST CENTERS						]
95. 00 09500 AMBULANCE SERVICES	0. 604238			0		95.00
200.00 Subtotal (see instructions)		24, 925, 983		0 0	4, 299, 021	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		24, 925, 983		0 0	4, 299, 021	202.00

Health Fina	ancial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	-2552-10
APPORTI ONM	IENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pro 5/29/2018 4:	epared: 10 pm
				XVIII	Hospi tal	PPS	
		Cos					
	Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00				
ANCI	LLARY SERVICE COST CENTERS						
$\begin{array}{c cccccc} 50.\ 00 & 0500\\ 52.\ 00 & 0520\\ 53.\ 00 & 0530\\ 54.\ 00 & 0540\\ 60.\ 00 & 0600\\ 62.\ 30 & 0620\\ 65.\ 00 & 0660\\ 67.\ 00 & 0670\\ 68.\ 00 & 0680\\ 69.\ 00 & 0680\\ 69.\ 00 & 0680\\ 71.\ 00 & 07120\\ 72.\ 00 & 0720\\ 73.\ 00 & 0733\\ 76.\ 97 & 0766\\ 76.\ 98 & 0766\end{array}$	00 OPERATI NG ROOM 00 DELI VERY ROOM & LABOR ROOM 00 ANESTHESI OLOGY 00 RADI OLOGY-DI AGNOSTI C 00 LABORATORY 00 LABORATORY 00 CLOTTI NG FOR HEMOPHI LI ACS 00 RESPI RATORY THERAPY 00 OCCUPATI ONAL THERAPY 00 OCCUPATI ONAL THERAPY 00 OCCUPATI ONAL THERAPY 00 SPEECH PATHOLOGY 00 ELECTROCARDI OLOGY 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 00 IMPL. DEV. CHARGED TO PATI ENTS 00 DRUGS CHARGED TO PATI ENTS 00 DRUGS CHARGED TO PATI ENTS 00 ANDI AC REHABI LI TATI ON 98 HYPERBARI C OXYGEN THERAPY	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					50.00 52.00 53.00 54.00 60.00 62.30 65.00 66.00 67.00 68.00 69.00 71.00 72.00 73.00 76.97 76.98
	99 LI THOTRI PSY	0	0				76.99
90.00         0900           90.01         0900           91.00         0910           92.00         0920	PATIENT SERVICE COST CENTERS DO CLINIC DI INTENSIVE OUT PATIENT PROGRAM DO EMERGENCY DO OBSERVATION BEDS (NON-DISTINCT PART ER REIMBURSABLE COST CENTERS	0 0 0 0	0				90.00 90.01 91.00 92.00
	OO AMBULANCE SERVICES Subtotal (see instructions) Less PBP Clinic Lab. Services-Program Only Charges Net Charges (line 200 - line 201)	0 0 0	0				95. 00 200. 00 201. 00 202. 00

	WHITLET WEWORT	AL_HOSPITAL		In Lie	eu of Form CMS-2	2552-10
PPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Peri od:	Worksheet D	
				From 01/01/2017		
				To 12/31/2017	Date/Time Pre	
					5/29/2018 4:10	Эрт
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost		1	
	Part II, col.		(col. 1 - col		1	
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
D. 00 ADULTS & PEDIATRICS	1, 384, 966	0	1, 384, 96	6 5, 552	249.45	30.00
3. 00 NURSERY	29, 420		29, 42		36.01	43.00
4.00 SKILLED NURSING FACILITY	0			0 0		44.00
00.00 Total (lines 30 through 199)	1, 414, 386		1, 414, 38	6, 369		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
D. 00 ADULTS & PEDIATRICS	78	19, 457	/			30.00
3. 00 NURSERY	50	1, 801			,	43.00
4.00 SKILLED NURSING FACILITY	0	. 0			,	44.00
00.00 Total (lines 30 through 199)	128	21, 258	2		,	200.00
			1		,	200.00

Health Financial Systems	WHITLEY MEMOR	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Pre 5/29/2018 4:1	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	651, 718	23, 105, 448	0. 02820	6 555, 534	15, 669	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	88, 756					
53. 00 05300 ANESTHESI OLOGY	3, 028	2, 829, 788	0.00107	'0 81, 177	87	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 050, 887			112, 270	1, 999	54.00
60. 00 06000 LABORATORY	524, 768	23, 723, 760	0. 02212	191, 905	4, 245	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	168, 745	8, 361, 073	0. 02018	54, 102	1, 092	65.00
66. 00 06600 PHYSI CAL THERAPY	349, 909	4, 447, 819	0. 07867	0 1, 365	107	66.00
67.00 06700 OCCUPATIONAL THERAPY	100, 563	1, 499, 001	0. 06708	684	46	67.00
68.00 06800 SPEECH PATHOLOGY	10, 258	337, 049	0. 03043	5 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0	0. 00000	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	107, 654	2, 436, 130	0. 04419	54, 440	2, 406	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	67, 169	3, 446, 345	0. 01949	11, 171	218	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	418, 605	18, 322, 955	0. 02284	6 260, 498	5, 951	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0. 00000	0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	1, 897	115, 443	0. 01643	2 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0. 00000	0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS			•			
90. 00 09000 CLINIC	0	0	0.0000	0 0	0	90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0. 00000	0 0	0	90.01
91.00 09100 EMERGENCY	1, 322, 528	37, 800, 380	0. 03498	78, 772	2, 756	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	397, 630	2, 146, 402	0. 18525		0	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	5, 264, 115	196, 049, 792		1, 863, 543	39, 425	200. 00

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	R PASS THROUGH COSTS	Provider C		Period: From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 4:1	
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School Nu Post-Stepdown Adjustments 1A	rsing School	Allied Health Post-Stepdowr Adjustments 2A	n Cost	All Other Medical Education Cost 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	17	1.00	27	2.00	5.00	
All ENT ROOTINE SERVICE COST CENTERS           30. 00         03000         ADULTS & PEDIATRICS           43. 00         04300         NURSERY           44. 00         04400         SKI LLED NURSI NG FACI LI TY           200. 00         Total (Lines 30 through 199)	0 0 0	0 0 0 0		0 0 0 0 0 0 0 0	0 0 0	
Cost Center Description	Adjustment (s Amount (see 1 instructions) mi	Total Costs sum of cols. through 3, nus col. 4)	Days	t Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS       30.00     03000       43.00     04300       04300     NURSERY       44.00     04400       SKILLED NURSING FACILITY       200.00     Total (lines 30 through 199)	0	000000000000000000000000000000000000000	5, 55 81 6, 36	7 0.00 0 0.00	50 0	43.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		0,00	<u></u>	120	200.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000         ADULTS & PEDI ATRI CS           43. 00         04300         NURSERY           44. 00         04400         SKI LLED NURSI NG FACI LI TY           200. 00         Total (lines 30 through 199)						30. 00 43. 00 44. 00 200. 00

Heal th	Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI SH COSTS	RVICE OTHER PASS			Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Pre 5/29/2018 4:1	pared: 0 pm
				e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3.00	
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	C		0 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
60.00	06000 LABORATORY	0	C		0 0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C		0 0	0	62.30
65.00	06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	C	)	0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	C	)	0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	C	)	0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	C	)	0 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C	)	0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	C	)	0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C	)	0 0	0	73.00
76.97	07697 CARDIAC REHABILITATION	0	C	)	0 0	0	76.97
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	C	)	0 0	0	76.98
76.99	07699 LI THOTRI PSY	0	C	)	0 0	0	76.99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	C	)	0 0	0	90.00
90.01	09001 INTENSIVE OUT PATIENT PROGRAM	0	C	)	0 0	0	90.01
91.00	09100 EMERGENCY	0	C	)	0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95.00
200.00	Total (lines 50 through 199)	0	0		0 0	0	200. 00

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2017 To 12/31/2017		narod
				10 12/31/2017	5/29/2018 4:1	
		Ti tl	e XIX	Hospi tal	PPS	<u>o p</u>
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	through col.	Cost (sum of		(col. 5 ÷ col.	
		4)	col. 2, 3 and	8)	7)	
			4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	-	-	1			
50.00 05000 OPERATING ROOM	0	0	0	23, 105, 448		•
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	8, 449, 176		
53. 00 05300 ANESTHESI OLOGY	0	0	0	2, 829, 788		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		59, 029, 023		
	0	0		23, 723, 760		
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0.00000	
65. 00 06500 RESPIRATORY THERAPY	0	0		8, 361, 073		
66. 00 06600 PHYSI CAL THERAPY	0	0		4, 447, 819		
67.00 06700 OCCUPATIONAL THERAPY	0	0		1, 499, 001		•
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0			337,049	0.000000	
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0			0 2 424 120		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			2, 436, 130 3, 446, 345		
73. 00 07200 DRUGS CHARGED TO PATIENTS	0			18, 322, 955		
76. 97 07697 CARDI AC REHABI LI TATI ON	0			10, 322, 900	0.000000	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0			115, 443		
76. 99 07699 LI THOTRI PSY	0			0 115, 445	0. 000000	
OUTPATIENT SERVICE COST CENTERS	0	0		0	0.00000	70. 77
90. 00 09000 CLINIC	0	0		0	0.00000	90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0			0.000000	
91. 00 09100 EMERGENCY	0	0		37, 800, 380		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		2, 146, 402		
OTHER REIMBURSABLE COST CENTERS	0		· · · · ·	2, 110, 402	0.00000	12.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	C		196, 049, 792		200.00
	-	-			1	

Health Financial Systems	WHITLEY MEMORIA	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2017 To 12/31/2017	Part IV Date/Time Pre	norod.
				To 12/31/2017	5/29/2018 4:1	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0.000000	555, 534		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	461, 625		0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0. 000000	81, 177		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	112, 270		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	191, 905		0 0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0. 000000	54, 102		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 365		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	684		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	54, 440		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	11, 171		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	260, 498		0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0.000000	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0.000000	0		0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0.000000	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0.000000	0		0 0	0	90.01
91.00 09100 EMERGENCY	0.000000	78, 772		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS				1		
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		1, 863, 543		0 0	0	200.00
				1		

Health Fina	ncial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Peri od:	Worksheet D	
					From 01/01/2017 To 12/31/2017	Part V Date/Time Pre	nared
					10 12/31/2017	5/29/2018 4:1	0 pm
			Titl	e XIX	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
		1.00		(see inst.)	(see inst.)	5.00	
ANGL		1.00	2.00	3.00	4.00	5.00	
	LLARY SERVICE COST CENTERS	0. 151297	0	010.07	4 0	0	50.00
	O DELIVERY ROOM & LABOR ROOM	0. 151297	0	812, 37 1, 00			
	O ANESTHESI OLOGY	0. 101844	0			-	
			0	75, 48		0	
	0 RADI OLOGY-DI AGNOSTI C 0 LABORATORY	0. 111063 0. 201005	0	2, 733, 19			
			0	1, 073, 15		-	
	O BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	212 52	0 0	0	
	0 RESPI RATORY THERAPY 0 PHYSI CAL THERAPY	0. 136259	0	312, 53		0	
		0.354704	0	142, 46			00.00
	O OCCUPATIONAL THERAPY	0.688360	0	28, 14		0	
	O SPEECH PATHOLOGY	0.305510	0	38, 72		0	
		0.000000	0	100 51	0 0	0	
	O MEDI CAL SUPPLIES CHARGED TO PATIENT	0. 426536	0	109, 51		0	
	O IMPL. DEV. CHARGED TO PATIENTS	0. 188520	0	60, 71		0	
	0 DRUGS CHARGED TO PATIENTS 7 CARDIAC REHABILITATION	0. 220604	0	467, 84	0 0	0	
	8 HYPERBARIC OXYGEN THERAPY	0. 000000 0. 173211	0		0 0		
	9 LITHOTRIPSY	0. 173211	0				
	ATIENT SERVICE COST CENTERS	0.00000	0		0 0	0	/0.99
90.00 0900		0. 000000	0		0 0	0	90.00
	1 INTENSIVE OUT PATIENT PROGRAM	0. 000000	0		0 0		
	0 EMERGENCY	0. 258502	0	3, 195, 01	1 0		
	O OBSERVATION BEDS (NON-DISTINCT PART	1. 141108	0	53, 195, 01			
	R REIMBURSABLE COST CENTERS	1. 141100	0		4 0	0	92.00
	O AMBULANCE SERVICES	0. 604238	0	326, 48	4		95.00
200.00	Subtotal (see instructions)	0.004230	0	9, 377, 17		n –	200.00
201.00	Less PBP Clinic Lab. Services-Program		0	, , , , , , , , , , , , , , , , , , , ,	0 0		201.00
201.00	Only Charges				0		201.00
202.00	Net Charges (line 200 - line 201)		0	9, 377, 17	8 0	0	202.00
1					1		

Heal th	Financial Systems	WHITLEY MEMOR	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-0101	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/29/2018 4:	epared: 10 pm
		1		e XIX	Hospi tal	PPS	
			sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
	ANCI LLARY SERVI CE COST CENTERS	100.010					
	05000 OPERATING ROOM	122, 910					50.00
	05200 DELIVERY ROOM & LABOR ROOM	102	0				52.00
	05300 ANESTHESI OLOGY	851	0				53.00
	05400 RADI OLOGY-DI AGNOSTI C	303, 557					54.00
	06000 LABORATORY	215, 709	0				60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.30
	06500 RESPI RATORY THERAPY	42, 585					65.00
	06600 PHYSI CAL THERAPY	50, 534					66.00
	06700 OCCUPATI ONAL THERAPY	19, 375					67.00
	06800 SPEECH PATHOLOGY	11, 831	0				68.00
	06900 ELECTROCARDI OLOGY	0	0				69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	46, 710					71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	11, 446					72.00
	07300 DRUGS CHARGED TO PATIENTS	103, 207	0				73.00
	07697 CARDI AC REHABI LI TATI ON	0	0				76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	0				76. 98
76.99	07699 LI THOTRI PSY	0	0				76.99
	OUTPATIENT SERVICE COST CENTERS			1			
	09000 CLINIC	0	0				90.00
	09001 INTENSIVE OUT PATIENT PROGRAM	0	0				90.01
	09100 EMERGENCY	825, 917					91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	609	0				92.00
	OTHER REIMBURSABLE COST CENTERS	1		I			
	09500 AMBULANCE SERVICES	197, 274					95.00
200.00		1, 952, 617	0				200. 00
201.00	5	0					201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	1, 952, 617	0				202.00

Total series         Title XVIII         Hospital           PART I - ALL PROVIDER COMPONENTS         1.00           IMPAILED LASS         Deprivate room days and seling-hed days, excluding newhorm)         5.552           IMPAILED LASS         Deprivate room days, excluding seling-hed and classrvation bed days).         5.552           Deprivate room days (excluding seling-hed and classrvation bed days).         5.552         0           Demotion days (excluding seling-hed and classrvation bed days).         5.552         0         0           Semi-private room days (excluding seling-hed and classrvation bed days).         5.552         0         0           Semi-private room days (excluding seling-hed and classrvation bed days).         1.00         0         0           Total seling-hed X type inpatient days (including private room days).         5.552         0         0           Total seling-hed X type inpatient days (including private room days).         0         0         0         0           Total seling-hed X type inpatient days (including private room days).         0         0         0         0           Total impotiont days including private room days applicable to the Program (oxcluding asing-bed and newborn days).         0         1           Total impotiont days including private room days.         0         1         0         1         0		Financial Systems WHITLEY MEMORIAL ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0101	Peri od:	u of Form CMS-2 Worksheet D-1	
Cost Center Description         Interval         Josephan           MART I ALL PROVIDER COMPARINES         1.00           MART ENT AXS         1.00           Impattent days (Including private room days, and seing-bed days, excluding seating bed and neatorn days)         5.552           Dispattent days (Including private room days, and seing-bed days, excluding private room days), and bedervaling bed and neatorn days)         5.552           Observation         5.552         1.00           Total seing-bed SF type inpatient days (Including private room days) through December 31 of the cost         0.00           Total seing-bed SF type inpatient days (Including private room days) after December 31 of the cost         0.00           Trapering period				From 01/01/2017	Date/Time Pre	nare
Cost Center Description         1.00           PART 1 - ALL PROVIDER COMPONENTS         1.00           IMMAILENT DAYS         1.00 private room days, and sking-hed days and sking-hed days, excluding newborn)         5.552           00 Impatient days (including private room days, askilding swing-hed and newborn days)         5.552           00 Impatient days (including private room days, askilding private room days)         5.552           00 Into Complete this line.         0           01 Total swing-hed SKF type Impatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)         0           01 Total swing-hed KF type Impatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)         0           01 Total swing-hed KF type Impatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)         0           00 Total impatient days applicable to title XVIII on this line)         0         1           01 Total swing-hed KF type impatient days applicable to title VIII and (if calendar year, enter 0 on this line)         0         1           02 Swing-hed KF type impatient days applicable to title VIII on this line)         0         1         1           03 Swing-hed KF type impatient days applicable to title VIII on this line)         0         1         1           04 Sw					5/29/2018 4:10	0 pm
PART 1 - ALL PROVIDER COMPONENTS           IMPAILING LAWS           IMPAILING LAWS </th <th></th> <th>Cost Contor Description</th> <th>Title XVIII</th> <th>Hospi tal</th> <th>PPS</th> <th></th>		Cost Contor Description	Title XVIII	Hospi tal	PPS	
INPART ENT DAYS		cost center bescription			1.00	
00       Inpatient days (including private room days, excluding swing-bed and newborn days, excluding swing-bed and newborn days, excluding swing-bed and newborn days).       5.552         00       inpatient days (including private room days, excluding swing-bed and newborn days).       0         00       inpatient days (including private room days).       0         00       including swing-bed days).       17 yukare room days.       0         00       including private room days.       3,958         00       including private room days.       0       0         01       including private room days.       0       0         02       including private room days.       0       0         03       ingatient days including private room days.       0       0         04       ingatient days.       0       0       0         05       sing-bed NF type inpatient days applicable to title XVIII only (including private room days.)       0       0         05       sing-bed NF type inpatient days applicable to title XVIII only (including private room days.)       0       0						
00       Inpatient days (Including private room days, excluding swing-bed and nextorm days)       5,552         00       Inpatient days (Including swing-bed and observation bed days)       3,958         01       Inpatient days (Including swing-bed and observation bed days)       3,958         01       Inti swing-bed Sit type inpatient days (Including private room days) through December 31 of the cost       0         01       Total swing-bed Sit type inpatient days (Including private room days) after December 31 of the cost       0         01       Total swing-bed Sit type inpatient days (Including private room days) after December 31 of the cost       0         01       Total swing-bed Sit type inpatient days (Including private room days) after December 31 of the cost       0         01       Total swing-bed Sit type inpatient days applicable to title XVIII only (Including private room days)       0       1         01       Through December 31 of the cost reporting period (If calendar year, enter 0 on this line)       0       1         02       Swing-bed Sit type inpatient days applicable to title XVIII only (Including private room days)       0       1         03       Swing-bed Sit type inpatient days applicable to title XVIII only (Including private room days)       0       1         03       Swing-bed Sit type inpatient days applicable to title XVIII only (Including private room days)       0       1         04 <td>~~</td> <td></td> <td></td> <td></td> <td>E EE2</td> <td>1</td>	~~				E EE2	1
00       Private room days (excluding swing-bed and observation bed days). If you have only private room days.       0       3         01       Beil-private room days (excluding swing-bed and observation bed days)       10       9       9       3       9       8         01       Seel-private room days (excluding swing-bed and observation bed days)       10 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
do not complete this line.       3.968         Sami-private room days (excluding swing-bed and observation bed days)       5.968         01       Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost       0.6         02       Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost       0.7         03       Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost       0.6         04       Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost       0.6         05       Total swing-bed MF type inpatient days explicable to title XVIII only (including private room days) after       0.6         05       Sing-bed SMF type inpatient days explicable to title XVIII only (including private room days) after       0.6         06       Sing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after       0.6         06       Sing-bed SMF type inpatient days applicable to title XVIII only (including private room days)       0.1         07       Total swing-bed SMF type inpatient days applicable to title XVIII only (including private room days)       0.1         06       Sing-bed SMF type inpatient days applicable to title XVIII only (including swing-bed days)       0.1         07       Total swing-bed SMF type inpatient days applicable to title XVIII only (including swing-be	00			rivate room davs.		
00       Total swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period (inclendar year, enter 0 on this line).       0       0         01       Total swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period (inclendar year, enter 0 on this line).       0       0         01       Total swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period (inclendar year, enter 0 on this line).       0       0         02       Total inpatient days including sy (including private room days) after December 31 of the cost reporting period (inclendar year, enter 0 on this line).       0       0         03       Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (inclendar year, enter 0 on this line).       0       10         04       Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (inclendar year, enter 0 on this line).       0       10         05       Swing-bed NF type inpatient days applicable to title XVIII only (including private room days).       0       12         06       Keing-bendari SW type inpatient days applicable to title XVIII only (including swing-bed days).       0       13         05       Norther cost reporting period (inclendar year, enter 0 on this line).       0       14						
reporting period       interval						
00       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)       0       0         01       Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       0         01       Total inpatient days including private room days applicable to the Program (excluding swing-bed and the cost reporting period (if calendar year, enter 0 on this line)       0       0         01       Total inpatient days applicable to the Vite Vill only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       0         01       Swing-bed SNF type inpatient days applicable to thits VVII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       0         03       Swing-bed NF type inpatient days applicable to thits VVII only (including private room days)       0       11         04       Total inversery days (ittle V or XIX only)       0       12         04       Swing-bed NF type inpatient days applicable to services through December 31 of the cost       0.00       12         05       Swing-bed NF type inpatient days applicable to services through December 31 of the cost       0.00       12         04       Total inversery days (ittle V or XIX only)       0	00		om days) through Decembe	er 31 of the cost	0	5
reporting period (if calendar year, enter 0 on this line)       0         Total swing-bed NF type inpatient days (including private room days) through becember 31 of the cost reporting period (if calendar year, enter 0 on this line)       0         Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0         Of Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0         OW swing-bed NF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0         OW swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0         OW swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)       0       12         Wing-bed ANF type inpatient days applicable to the Program (excluding swing-bed days)       0       12         Wing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)       0       12         Wing-bed NF type inpatient days applicable to services through December 31 of the cost       0.00       13         Wing-bed NF type inpatient days applicable to services after December 31 of the cost       0.00       1	00		om davs) after December	31 of the cost	0	6
reporting period       0         Total simplesd N Type inpatient days (including private room days) after December 31 of the cost       0         Total simplesd NA Type inpatient days applicable to title XVIII only (including private room days)       1,284         Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)       0         Swing-bed SNF type inpatient days applicable to title XVII only (including private room days)       0         OS Swing-bed NF type inpatient days applicable to title XVI only (including private room days)       0         OS Swing-bed NF type inpatient days applicable to title XVI only (including private room days)       0         OT total sing-bed NF type inpatient days applicable to title XVI only (including private room days)       0         OT total swing-bed NF type inpatient days applicable to the Program (excluding private room days)       0         OT total swing-bed NF type inpatient days applicable to the Program (excluding private room days)       0         OT total swing-bed NF type inpatient days applicable to services through December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0         OM dati care rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days)       0         OM dati care rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (includicare rate for swing-bed SNF services applicable to services after December 31 of the cos					-	
00       Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days applicable to the Program (excluding swing-bed and newborn days).       1,224         00       Total inpatient days including private room days applicable to the the Program (excluding swing-bed and the cost reporting period (isce instructions).       0,100         00       Swing-bed SWE type inpatient days applicable to title XVIII only (including private room days) after 0,111       0,111         00       Swing-bed SWE type inpatient days applicable to title XVIII only (including private room days) after 0,111       0,111         01       Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after 0,111       0,111         01       Swing-bed NF type inpatient days applicable to title XV or XIX only (including private room days) (1,112       0,112         01       Total nursery days (title V or XIX only)       0,112         02       Nursery days (title V or XIX only)       0,114         03       Minde CD ADUSTINNIT       0,000         04       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost       0,000         04       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost       0,000         05       Wing-bed Cost applicable to NF type services after December 31 of the cost       0,00       0,00     <	00		m days) through December	r 31 of the cost	0	7
reporting period (if calendar year, enter 0 on this line)       1.284         Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)       1.284         Swing-bed SMF type inpatient days applicable to till EXVIII only (including private room days) after       0         Swing-bed SMF type inpatient days applicable to till EXVIII only (including private room days) after       0         Swing-bed NF type inpatient days applicable to till EXVIII only (including private room days) after       0         OS Swing-bed NF type inpatient days applicable to till EX VIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)       0         OB Swing-bed NF type inpatient days applicable to tille S Vor XIX only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)       0         OB Medically necessary private room days applicable to services through December 31 of the cost       0.00         OM Medicare rate for swing-bed SWF services applicable to services after December 31 of the cost       0.00         OM Medicare rate for swing-bed NF services applicable to services after December 31 of the cost       0.00         OM Medicare rate for swing-bed NF services applicable to services after December 31 of the cost       0.00         OM Medicare rate for swing-bed NF services applicable to services after December 31 of the cost       0.00         OM Medicard rate for swing-bed NF services after D	~~		m dava) ofter December	21 of the east	0	
00       Total Inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)       1,284 9         01       Swing-bed SNF type Inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (ical calcular curvations)       0         02       Swing-bed SNF type Inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calcular year, enter 0 on this line)       0         03       Swing-bed NF type inpatient days applicable to title V or XIX only (including private room days) after becember 31 of the cost reporting period (if calcular year, enter 0 on this line)       0         04       Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)       0       1         05       Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)       0       1         04       Matcally necessary private room days applicable to services through December 31 of the cost reporting period       0.00       1         06       Matcally negatient days applicable to services after December 31 of the cost reporting period       0.00       1         07       Matcally necessary private room days applicable to services after December 31 of the cost reporting period       0.00       1         08       Matcally necessing applicable to SNF type services after December 31 of the cost reporting period       0.00       0	00		in days) after beceniber .	ST OF THE COST	0	°
0.00       Swing-bed Swi type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (see instructions) through becember 31 of the cost reporting period (in calendar year, enter 0 on this line)       0       0         0.00       Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (in calendar year, enter 0 on this line)       0       0         0.00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       10         0.01       Medically necessary private room days applicable to the Program (excluding swing-bed days)       0       11         0.01       Numsery days (title V or XIX only)       0       0       10         0.01       Medically necessary private room days applicable to services through December 31 of the cost       0.00       11         0.02       Mix Set Multi P of XIX only)       0       11       11         0.01       Medical rate for swing-bed NF services applicable to services after December 31 of the cost       0.00       10         0.02       Medical rate for swing-bed NF services applicable to services after December 31 of the cost       0.00       12         0.02       Medical rate for swing-bed NF services after December 31 of the cost reporting period (line 6 x inig	00		o the Program (excluding	g swing-bed and	1, 284	9
through December 31 of the cost reporting period (see instructions)       0         Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after       0         December 31 of the cost reporting period       0       11         Swing-bed NF type inpatient days applicable to title X V XIX only (including private room days)       0       12         Swing-bed NF type inpatient days applicable to title X V or XIX only (including private room days)       0       13         Medically necessary private room days applicable to title X V or XIX only (including swing-bed days)       0       14         Mix R EED ADUSTNEAT       0       0       14         Nurs EED ADUSTNEAT       0       0       14         Mix G EED ADUSTNEAT       0       0       14         Mix G EED ADUSTNEAT       0       0       14         Mix G EED ADUSTNEAT       0       0       14         Medicard rate for swing-bed SNF services applicable to services after December 31 of the cost       0       0         Medicard rate for swing-bed NF services applicable to services after December 31 of the cost       0       0         Medicard rate for swing-bed NF services after December 31 of the cost       0       0       10         Medicard rate for swing-bed NF type services after December 31 of the cost reporting period (line 0       2						
0.0       Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       1         0.0       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       1         0.0       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       1         0.0       Medically necessary private room days applicable to the Program (excluding swing-bed days)       0       1         0.0       Mousrery days (title V or XIX only)       0       1         0.0       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (ing period in a period of the cost reporting period (line for swing-bed KF services applicable to services after December 31 of the cost 0.00       1         0.0       Medicaid rate for swing-bed KF services applicable to services after December 31 of the cost 0.00       1         0.0       Medicaid rate for swing-bed KF services applicable to services after December 31 of the cost reporting period (line 5 x line 17)       1         0.0       Medicaid rate for swing-bed KF services applicable to services after December 31	. 00			room days)	0	10
December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0         Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)       0         0       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)       0         0       Swing-bed NF type inpatient days applicable to title V or XIX only (including swing-bed days)       0         0       Medically necessary private room days applicable to the Program (excluding swing-bed days)       0         0       Norservices wing-bed SNF services applicable to services through December 31 of the cost       0.00         0       Medically necessary wing-bed SNF services applicable to services after December 31 of the cost       0.00         0       Medical rate for swing-bed SNF services applicable to services after December 31 of the cost       0.00         0       Medicard rate for swing-bed NF services applicable to services after December 31 of the cost       0.00         0       Medicard rate for swing-bed NF type services through December 31 of the cost reporting period       0.02         0       Total general Inpatient routine service cost (see instructions)       8, 530, 961 21         0       Sing-bed cost applicable to SF type services after December 31 of the cost reporting period (line 6 x line 30)       22         0       Sing-bed cost applicable to NF type services after December 31 of the cost reporting	00			room days) after	0	11
Intrough December 31 of the cost reporting period       1         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)       1         10       Total nursery days (title V or XIX only)       0       1         10       Nursery days (title V or XIX only)       0       1         11       Nursery days (title V or XIX only)       0       1         12       Nursery days (title V or XIX only)       0       1         13       Nursery days (title V or XIX only)       0       1         14       Nursery days (title V or XIX only)       0       1         15       Nursery days (title V or XIX only)       0       1         16       Nedicating are rate for swing-bed SNF services applicable to services after December 31 of the cost       0.00         16       Identicating are rate for swing-bed NF services applicable to services after December 31 of the cost       0.00         17       reporting period       8.530,961 2       2         10       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 × 11ne 19)       8.530,961 2       2         10       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 × 11ne 18)       0		December 31 of the cost reporting period (if calendar year, e	nter 0 on this line)	5 /	C C	
0.00       Swing-Ded NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)       0       13         0.00       Medical Ly necessary private room days applicable to the Program (excluding swing-bed days)       0       14         0.01       Total nursery days (title V or XIX only)       0       16         0.01       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       0.00       17         0.01       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00       17         0.02       Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00       18         0.03       Total general inpatient routine service cost (see instructions)       8,530,961       21         0.04       Total general inpatient routine services through December 31 of the cost reporting period (line 5 x line 12)       8,530,961       22         0.05       wing-bed cost applicable to SF type services through December 31 of the cost reporting period (line 6 x line 12)       0       22         0.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 12)       0       22         0.00       Swing-bed cost sepplicable t	. 00		X only (including priva	te room days)	0	12
after December 31 of the cost reporting period (if calendar year, enter 0 n this line)       0         Medically necessary private room days applicable to the Program (excluding swing-bed days)       0         100       Total nursery days (title V or XIX only)       0         101       Medicater for swing-bed SNF services applicable to services through December 31 of the cost reporting period       0.00         101       Medicater for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00         102       Medicater for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00         103       Medicater for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00         104       Medicater for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00         105       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period       0.00         105       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period       0.00         107       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period       0.00         108       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period       0.00         108       Swing-bed cost applicable to NF type ser	00		V only (including prive	to room daya)	0	11
00       Medical Ly necessary private room days applicable to the Program (excluding swing-bed days)       0       1         01       Total nursery days (title V or XIX only)       0       1         00       Nursery days (title V or XIX only)       0       1         00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       0.00       1         00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00       0.00       1         01       Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 0.00       0.00       1         02       Total general inpatient routine service cost (see instructions)       8, 530, 961       21         03       Sing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)       8, 530, 961       22         04       Sing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 18)       0       22         05       Sing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 18)       0       22         04       Sing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0       22         05       Sing-bed cost (see instru	. 00				0	13
00       Nursery days <sup>2</sup> (title V or XIX only)       0       11         SWI NG BE DADUSTNEMT       0       11         00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00       17         00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost of the cost reporting period       0.00       16         00       Medicare rate for swing-bed NF services applicable to services after December 31 of the cost of the cost reporting period       0.00       12         00       Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00       22         00       Total general inpatient routine service cost (see instructions)       8, 530, 961 21       22         00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)       0       22         00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)       0       22         00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0       22         00       Swing-bed cost (see instructions)       0       22       22       22         00       Swing-bed cost (see instructions) <td>. 00</td> <td></td> <td></td> <td></td> <td>0</td> <td>14</td>	. 00				0	14
SWING BED ADJUSTMENT         0           100         Nedicare rate for swing-bed SNF services applicable to services through December 31 of the cost         0.00           117         Nedicare rate for swing-bed SNF services applicable to services after December 31 of the cost         0.00           118         0.00         117           119         110         Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost         0.00           110         Medical rate for swing-bed NF services applicable to services after December 31 of the cost         0.00           110         Medical rate for swing-bed NF services applicable to services after December 31 of the cost         0.00           111         110         110         110         110           110         Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6         110           111         110         110         110           111         110         110         110           111         110         110         110           111         110         110         110           111         110         110         110           111         110         110         110           1111         110         110					-	
00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       0.00       17         00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost cost reporting period       0.00       16         00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost cost cost applicable to services after December 31 of the cost cost cost applicable to SNF type services after December 31 of the cost cost cost applicable to SNF type services through December 31 of the cost cost cost services applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)       8,530,961 21         00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)       0         01       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19)       0         02       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20)       0         03       Swing-bed cost (see instructions)       0       0         04       General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       0       0         05       Swing-bed cost (long swing-bed charges)       0       0       0         05       General inpatient routine service cost reporting swing-bed charges)       0       0	. 00				0	16
reporting period000Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost0.00110Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost0.00120Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost0.00130Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost0.001400Medicaid rate for swing-bed NF services cost (see instructions)8,530,9611500160231600160231700016018001602310000160231000001601000016023111100240011180024011180024011180024011180002412111800241300024141800241516000160001711101101819 <td>00</td> <td></td> <td>es through December 31 (</td> <td>of the cost</td> <td>0.00</td> <td>1 17</td>	00		es through December 31 (	of the cost	0.00	1 17
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7 x line 19)       7 x line 20)       7 x line 20) <td< td=""><td></td><td>x line 18)</td><td></td><td></td><td></td><td></td></td<>		x line 18)				
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.00       Private room cost differential adjustment (line 3 x line 35)       0       36         .00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)       0       37         PART II - HOSPITAL AND SUBPROVIDERS ONLY       PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       0       36         .00       Adjusted general inpatient routine service cost per diem (see instructions)       1,536.56       38         .00       Program general inpatient routine service cost (line 9 x line 38)       1,972,943       39         .00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40		5 1 1 5		5.1.01137		
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PART II - HOSPITAL AND SUBPROVIDERS ONLY         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS         .00       Adjusted general inpatient routine service cost per diem (see instructions)       1,536.56         .00       Program general inpatient routine service cost (line 9 x line 38)       1,972,943         .00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0	. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	8, 530, 961	37
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	. 00	Program general inpatient routine service cost (line 9 x line	38)			39
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OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0101	Peri od:	eu of Form CMS- Worksheet D-1	
					From 01/01/2017 To 12/31/2017	Date/Time Pre	
				e XVIII	Hospi tal	5/29/2018 4:1 PPS	10 pm
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Costlr	npatient Days		÷	(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	-
. 00	NURSERY (title V & XIX only)	0	C	0.	00 0	C	) 42.
00	Intensive Care Type Inpatient Hospital Units	5					1 12
. 00 . 00	INTENSIVE CARE UNIT CORONARY CARE UNIT						43
. 00	BURN INTENSIVE CARE UNIT						45
	SURGICAL INTENSIVE CARE UNIT						46
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
	cost center bescription					1.00	
. 00	Program inpatient ancillary service cost (W					1, 429, 882	
. 00	Total Program inpatient costs (sum of lines	41 through 48)(se	e instructio	ons)		3, 402, 825	5 49
. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program in	natient routine se	ervices (from	Wkst D su	m of Parts L and	320, 294	1 50
. 00	<pre>III)</pre>			- incot: D, Su		020,271	
. 00	Pass through costs applicable to Program in	patient ancillary	services (fr	om Wkst. D,	sum of Parts II	185, 608	3 51.
2. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				505, 902	2 52.
B. 00	Total Program inpatient operating cost excl		ated, non-phy	sician anest	hetist, and	2, 896, 923	
	medical education costs (line 49 minus line	52)					
. 00	TARGET AMOUNT AND LIMIT COMPUTATION					C	
. 00	Program discharges Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					C	
. 00	Difference between adjusted inpatient opera	ting cost and targ	get amount (I	ine 56 minus	line 53)	C	
. 00	Bonus payment (see instructions)	anarting pariod a	ding 100(	indated and a	ampounded by the		
. 00	Lesser of lines 53/54 or 55 from the cost r market basket	eporting period er	101 NG 1996, L	ipdated and c	ompounded by the	0.00	59
. 00	Lesser of lines 53/54 or 55 from prior year	cost report, upda	ated by the m	narket basket		0.00	60
. 00	If line 53/54 is less than the lower of lin					C	) 61
	which operating costs (line 53) are less th amount (line 56), otherwise enter zero (see		(TINES 54 X	60), or 1% o	r the target		
2.00	Relief payment (see instructions)					C	62
. 00	Allowable Inpatient cost plus incentive pay	ment (see instruc	tions)			C	) 63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine co	sts through Decem	per 31 of the	cost report	ing period (See		64
. 00	instructions) (title XVIII only)	sts through becen		cost report	ing period (see		04.
5.00	Medicare swing-bed SNF inpatient routine co	sts after Decembe	- 31 of the d	ost reportin	g period (See	C	65
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient rout	ino coste (lino 6	1 plus lipo 4	5) (+i +l o VVI	LL only) For	c c	66
. 00	CAH (see instructions)	The costs (The o	+ prus rine c	S)(title xvi	i ony). Toi		
7.00	Title V or XIX swing-bed NF inpatient routi	ne costs through (	December 31 d	of the cost r	eporting period	C	67.
	(line 12 x line 19)			***			
3. 00	Title V or XIX swing-bed NF inpatient routi (line 13 x line 20)	ne costs arter Dec	cemper 31 or	the cost rep	briing period		68
. 00	Total title V or XIX swing-bed NF inpatient	routine costs (li	ne 67 + line	e 68)		C	69
	PART III - SKILLED NURSING FACILITY, OTHER I					I	
. 00 . 00	Skilled nursing facility/other nursing faci Adjusted general inpatient routine service				)		70
. 00	Program routine service cost (line 9 x line		ie 70 ÷ 111e	2)			72
. 00	Medically necessary private room cost appli	cable to Program					73
. 00	Total Program general inpatient routine ser	•					74
. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service of	COSTS (TROM V	Orksneet B,	Part II, column		75
. 00	Per diem capital-related costs (line 75 ÷ l	ine 2)					76
. 00	Program capital-related costs (line 9 x lin						77
. 00 . 00	Inpatient routine service cost (line 74 min Aggregate charges to beneficiaries for exce		wider rocor	(c)			78
00	Total Program routine service costs for com	· · ·		,	nus line 79)		80
. 00	Inpatient routine service cost per diem lim	•		( / o			81
. 00	Inpatient routine service cost limitation (						82
. 00	Reasonable inpatient routine service costs		)				83
. 00 . 00	Program inpatient ancillary services (see i Utilization review - physician compensation		5)				84
	Total Program inpatient operating costs (su						86
	PART IV - COMPUTATION OF OBSERVATION BED PA						
	Total observation bed days (see instruction	s)				1, 594	
. 00 . 00	Adjusted general inpatient routine cost per	diam (lina 27 · )	ing 2)			1, 536. 56	00

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2017	Worksheet D-1	
				To 12/31/2017	Date/Time Pre 5/29/2018 4:1	pared: 0 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	1, 384, 966	8, 530, 961	0. 16234	6 2, 449, 277	397, 630	90.00
91.00 Nursing School cost	0	8, 530, 961	0.00000	0 2, 449, 277	0	91.00
92.00 Allied health cost	0	8, 530, 961	0.00000	0 2, 449, 277	0	92.00
93.00 All other Medical Education	0	8, 530, 961	0. 00000	0 2, 449, 277	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0101	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Pre	pare
		Title XIX	Hospi tal	5/29/2018 4: 10 PPS	<u>o</u> pr
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS			5 550	
	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			5, 552 5, 552	
	Private room days (excluding swing-bed and observation bed da		rivate room days,	0,002	
	do not complete this line.		-	2 050	
00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro	5 /	er 31 of the cost	3, 958 0	
	reporting period				
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private roc	om days) through December	31 of the cost	0	7
	reporting period				
00	Total swing-bed NF type inpatient days (including private roc reporting period (if calendar year, enter 0 on this line)	om days) arter December (	31 OF THE COST	0	8
00	Total inpatient days including private room days applicable t	to the Program (excluding	g swing-bed and	78	9
00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII c	only (including privato r	com davc)	0	10
00	through December 31 of the cost reporting period (see instruc		oom days)	0	
00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11
00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12
00	through December 31 of the cost reporting period	x only (meruaning privat	to room days)	0	'2
00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
00	Medically necessary private room days applicable to the Progr			0	14
00	Total nursery days (title V or XIX only)		5 /	817	
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			50	16
	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 d	of the cost	0.00	17
00	reporting period			0.00	
00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost	0.00	11
00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	0.00	19
00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb	2	ing pariod (line	8, 530, 961 0	
00	5 x line 17)	Set St Of the Cost report	ing period (inte	0	22
00	Swing-bed cost applicable to SNF type services after December	- 31 of the cost reportin	ng period (line 6	0	23
00	x line 18) Swing-bed cost applicable to NF type services through Decembe	or 31 of the cost reporti	ng period (line	0	24
	7 x line 19)		<b>3 1 1</b>		
00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
00	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		8, 530, 961	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	ed and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)		lui geo)	0	
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷line 28)		0. 000000 0. 00	
	Average semi-private room per diem charge (line 2) + line 3)			0.00	
	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35
	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	8, 530, 961	37
	27 minus line 36)				-
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	IUSTMENTS			-
00	Adjusted general inpatient routine service cost per diem (see	e instructions)		1, 536. 56	
	Program general inpatient routine service cost (line 9 x line			119, 852	
00	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39			0 119, 852	40

OMPUI	ATION OF INPATIENT OPERATING COST		Provider 0	CN: 15-0101	Peri od:	Worksheet D-1	
					From 01/01/2017 To 12/31/2017		epare
				le XIX	Hospi tal	5/29/2018 4: 1 PPS	lÒ pr
	Cost Center Description	Total	Total	Average Per		Program Cost	
	·	Inpatient Cost	npatient Days		÷	(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
. 00	NURSERY (title V & XIX only)	277, 885	81				42.
	Intensive Care Type Inpatient Hospital Units						
. 00	INTENSIVE CARE UNIT						43
. 00	CORONARY CARE UNI T BURN INTENSIVE CARE UNI T						44
	SURGI CAL I NTENSI VE CARE UNI T						46
. 00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	
. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			294, 563	48
. 00	Total Program inpatient costs (sum of lines			ons)		431, 422	49
00	PASS THROUGH COST ADJUSTMENTS	ationt routing	and and (from	wiket D eu	m of Dorto I and	21.250	- FO
. 00	Pass through costs applicable to Program inp	attent routine :	services (iro	N WKSL. D, SU	II OF PARTS F AND	21, 258	50
. 00	Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	39, 425	51
00	and IV)	EQ and E1)				10.100	
. 00 . 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated, non-ph	vsician anest	hetist. and	60, 683 370, 739	
	medical education costs (line 49 minus line		· · · · · · · · · · · · · · · · ·	,			
00	TARGET AMOUNT AND LIMIT COMPUTATION						
. 00 . 00	Program discharges Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0.00	
. 00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (	ine 56 minus	line 53)	0	
. 00 . 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting poriod	opding 1004	undated and a	ampounded by the	0.00	
. 00	market basket	porting period (	enuing 1990, i		unpounded by the	0.00	09
. 00	Lesser of lines 53/54 or 55 from prior year					0.00	
. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less tha					0	61
	amount (line 56), otherwise enter zero (see		s (ITTIES 54 X	00), 01 1% 0	i the target		
	Relief payment (see instructions)					0	
. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decer	mber 31 of the	e cost report	ing period (See	0	64
	instructions)(title XVIII only)	0			01		
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the o	cost reportin	g period (See	0	65
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line (	64 plus line (	65)(title XVI	ll only). For	c	66
	CAH (see instructions)						
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost r	eporting period	0	67
8. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after De	ecember 31 of	the cost rep	ortina period	l o	68.
	(line 13 x line 20)				51		
. 00	Total title V or XIX swing-bed NF inpatient			,		0	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil				)		70
. 00	Adjusted general inpatient routine service c				, ,		71
. 00	Program routine service cost (line 9 x line			25)			72
. 00 . 00	Medically necessary private room cost applic Total Program general inpatient routine serv	0	•				73
. 00	Capital -related cost allocated to inpatient	•			Part II, column		75
	26, line 45)		-				
. 00 . 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76
. 00	Inpatient routine service cost (line 74 minu						78
. 00	Aggregate charges to beneficiaries for exces	s costs (from p		· · · · · · · · · · · · · · · · · · ·			79
00	Total Program routine service costs for comp		ost limitatio	n (line 78 mi	nus line 79)		80
. 00 . 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		)				81
. 00	Reasonable inpatient routine service costs (						83
. 00	Program inpatient ancillary services (see in	structions)					84
. 00	Utilization review - physician compensation						85
. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		ouyn 85)			1	86
. 00	Total observation bed days (see instructions					1, 594	
8. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se		line 2)			1, 536. 56	
00						2, 449, 277	

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2017	Worksheet D-1	
				To 12/31/2017	Date/Time Pre 5/29/2018 4:1	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	1, 384, 966	8, 530, 961	0. 162340	6 2, 449, 277	397, 630	90.00
91.00 Nursing School cost	0	8, 530, 961	0. 00000	2, 449, 277	0	91.00
92.00 Allied health cost	0	8, 530, 961	0.00000	2, 449, 277	0	92.00
93.00 All other Medical Education	0	8, 530, 961	0.00000			93.00

	ancial Systems WH ANCILLARY SERVICE COST APPORTIONMENT	ITLEY MEMORIAL HOSPITAL Provider C	CN: 15 0101	Period:	eu of Form CMS- Worksheet D-3	
INPAILENT	ANGILLARY SERVICE COST APPORTIONWENT	Provider C	CN. 15-0101	From 01/01/2017		0
				To 12/31/2017		
		Title	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	st Inpatient	I npati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
	ATLENT ROUTINE SERVICE COST CENTERS		1	1 002 000	1	1 20 00
	00 ADULTS & PEDI ATRI CS 00 NURSERY			1, 893, 998		30.00 43.00
	I LLARY SERVI CE COST CENTERS					43.00
	DO OPERATING ROOM		0. 1512	97 693, 340	104, 900	50.00
	DO DELIVERY ROOM & LABOR ROOM		0. 1012			
	00 ANESTHESI OLOGY		0. 0124			
	00 RADI OLOGY-DI AGNOSTI C		0. 0124			
	00 LABORATORY		0. 2010			
	50 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000			
	00 RESPI RATORY THERAPY		0. 1362			
	00 PHYSI CAL THERAPY		0. 3547			66.00
	00 OCCUPATI ONAL THERAPY		0. 6883			
	DO SPEECH PATHOLOGY		0.3055			
69.00 0690	00 ELECTROCARDI OLOGY		0.0000			69.00
71.00 0710	00 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 4265	36 273, 510	116, 662	2 71.00
72.00 0720	00 IMPL. DEV. CHARGED TO PATIENTS		0. 1885	20 448, 791	84, 606	72.00
73.00 0730	DO DRUGS CHARGED TO PATIENTS		0. 2206	04 1, 207, 152	266, 303	3 73.00
	97 CARDI AC REHABI LI TATI ON		0.0000	00 C	C	76.97
	98 HYPERBARI C OXYGEN THERAPY		0. 1732		) C	1 . 0 0
	99 LI THOTRI PSY		0.0000	00 C	) C	) 76.99
	PATIENT SERVICE COST CENTERS				1	
90.00 090			0.0000		) C	
	01 INTENSIVE OUT PATIENT PROGRAM		0.0000		) C	
	DO EMERGENCY		0. 2591			
	00 OBSERVATION BEDS (NON-DISTINCT PART		1. 1411	08 C	) C	92.00
	ER REIMBURSABLE COST CENTERS		1		1	
	00 AMBULANCE SERVICES					95.00
200.00	Total (sum of lines 50 through 94 and 96 t			7, 333, 011		
201.00	Less PBP Clinic Laboratory Services-Progra	m only charges (line 61)				201.00
202.00	Net charges (line 200 minus line 201)		1	7, 333, 011		202.00

Heal th	Financial Systems	WHITLEY MEMORIAL HOSPITAL			In Lie	u of Form CMS-	2552-10
I NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0101	Perio		Worksheet D-3	
					01/01/2017 12/31/2017	Date/Time Pre	parad
				10	12/31/2017	5/29/2018 4:1	
		Titl	e XIX	H	lospi tal	PPS	<u>o piii</u>
	Cost Center Description		Ratio of Cos		npatient	Inpati ent	
	· · · · · · · · · · · · · · · · · · ·		To Charges		Program	Program Costs	
					Charges	(col. 1 x col.	
						2)	
			1.00		2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1				
30.00	03000 ADULTS & PEDIATRICS				339, 553		30.00
43.00	04300 NURSERY				113, 148		43.00
	ANCI LLARY SERVI CE COST CENTERS			1			
50.00	05000 OPERATING ROOM		0. 1512		555, 534	84, 051	
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 1016		461, 625	46, 921	1
53.00	05300 ANESTHESI OLOGY		0.0124		81, 177	1, 013	
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 1110		112, 270	12, 469	1
60.00	06000 LABORATORY		0.2010		191, 905	38, 574	1
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000		0	0	
65.00	06500 RESPI RATORY THERAPY		0. 1362		54, 102	7, 372	1
66.00	06600 PHYSI CAL THERAPY		0.3547		1, 365	484	
67.00	06700 OCCUPATI ONAL THERAPY		0. 6883		684	471	
68.00	06800 SPEECH PATHOLOGY		0.3055		0	0	
69.00			0.0000		0	0	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT		0. 4265		54, 440	23, 221	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 1885		11, 171	2, 106	
73.00 76.97	07300 DRUGS CHARGED TO PATIENTS		0.2206		260, 498	57, 467	1
	07697 CARDI AC REHABI LI TATI ON		0.0000		0	0	
	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY		0. 1732		0	0	1
/0.99			0.0000	50	0	0	/0.99
90, 00	OUTPATIENT SERVICE COST CENTERS		0.0000	20	0	0	90.00
90.00 90.01	09001 I NTENSI VE OUT PATI ENT PROGRAM		0.0000		0	0	
90.01	09100 EMERGENCY		0. 0000		78, 772	20, 414	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 1411		/8, //2	20, 414	1
72.00	OTHER REIMBURSABLE COST CENTERS		1. 1411	50	U	0	72.00
95 00	09500 AMBULANCE SERVICES				1		95.00
200.00		96 through 98)			1, 863, 543	294, 563	
200.00					1,000,040	277, 303	201.00
201.00					1, 863, 543		202.00
			1	1	,, 510		1

ALCUL	Financial Systems WHITLEY MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0101	Peri od: From 01/01/2017 To 12/31/2017	u of Form CMS-2 Worksheet E Part A Date/Time Pre	pared:
		Title XVIII	Hospi tal	5/29/2018 4:10 PPS	U pm
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
. 00 . 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr	ing prior to October 1 (	see	0 1, 785, 945	1.00 1.0 <sup>-</sup>
. 02	instructions) DRG amounts other than outlier payments for discharges occurr	ing on or after October	1 (see	450, 667	1.02
. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	or di scharges occurri ng	prior to October	0	1. 03
. 04	DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions)	or discharges occurring	on or after	0	1.04
. 00 . 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			17, 712 0	2.00 2.0
. 02 . 00	Outlier payment for discharges for Model 4 BPCI (see instruct Managed Care Simulated Payments	ions)		0 0	2.02 3.00
. 00	Bed days available divided by number of days in the cost repo Indirect Medical Education Adjustment	rting period (see instru	uctions)	25.63	4.00
. 00	FTE count for allopathic and osteopathic programs for the most or before 12/31/1996. (see instructions)	t recent cost reporting	period ending on	0.00	5.00
. 00	FTE count for allopathic and osteopathic programs which meet for new programs in accordance with 42 CFR 413.79(e)	the criteria for an add-	on to the cap	0.00	6.00
. 00 . 01	MMA Section 422 reduction amount to the LME cap as specified ACA $\S$ 5503 reduction amount to the LME cap as specified under		0.00 0.00	7.00 7.0	
. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).			0.00	8. 00
. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				
. 02					
. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line instructions)	es (8, 8,01 and 8,02) (	see	0.00	9.00
0.00 1.00	FTE count for allopathic and osteopathic programs in the curre FTE count for residents in dental and podiatric programs.	ent year from your recor	rds	0.00 0.00	10.00
2.00	Current year allowable FTE (see instructions)				12.0
3.00	Total allowable FTE count for the prior year.			0.00	
4.00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	ar ended on or after Sep	otember 30, 1997,		14.0
5.00 6.00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program				15. C
7.00	Adjustment for residents displaced by program or hospital clos	sure			17.0
8. 00	Adjusted rolling average FTE count				18.0
9.00	Current year resident to bed ratio (line 18 divided by line 4	).		0.00000	
0.00	Prior year resident to bed ratio (see instructions)			0.00000	
	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
2.00 2.01	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)			0	22. 0 22. 0
3.00	Indirect Medical Education Adjustment for the Add-on for § 42 Number of additional allopathic and osteopathic IME FTE resid		CFR 412.105		23.0
4. 00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)	,		0.00	
5.00	If the amount on line 24 is greater than -O-, then enter the instructions)	lower of line 23 or line	e 24 (see	0.00	25. C
6.00 7.00	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)			0. 000000 0. 000000	
8.00	IME add-on adjustment amount (see instructions)			0.000000	27.0
8.01	IME add-on adjustment amount - Managed Care (see instructions)	)		0	28.0
9.00	Total IME payment ( sum of lines 22 and 28)	/		0	
9. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0 Disproportionate Share Adjustment	1)		0	29.0
0.00	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instruc	ctions)	1.45	30. C
1.00	Percentage of Medicaid patient days (see instructions)			28.53	
2.00	Sum of lines 30 and 31			29.98	
3.00	Allowable disproportionate share percentage (see instructions	<b>`</b>		12.00	33.0

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Period:	Worksheet E	2552-1
			From 01/01/2017 To 12/31/2017	Part A Date/Time Prep 5/29/2018 4:10	
		Title XVIII	Hospi tal	PPS	o pili
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
35.00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		E 077 402 147	6, 766, 695, 164	35.00
35.00	Factor 3 (see instructions)		0. 000028279	0. 000051769	
	Hospital uncompensated care payment (If line 34 is zero, enter	zero on this line) (see		350, 304	
	instructions)				
35.03	Pro rata share of the hospital uncompensated care payment amou	. ,	126, 430		
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03		214, 726		36.00
40.00	Additional payment for high percentage of ESRD beneficiary dis Total Medicare discharges on Worksheet S-3, Part I excluding c		0		40.00
40.00	652, 682, 683, 684 and 685 (see instructions)	i senarges for ms bitos	0		+0.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 68	33, 684 an 685. (see	0		41.00
	instructions)				
41.01	Total ESRD Medicare covered and paid discharges excluding MS-D	DRGs 652, 682, 683, 684	0		41. 0 <sup>-</sup>
42.00	an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not qualif	v for adjustment)	0.00		42.0
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682		0.00		43.0
	instructions)	.,,	_		
44.00	Ratio of average length of stay to one week (line 43 divided b	by line 41 divided by 7	0. 000000		44.0
45 00	days)		0.00		45.0
45.00 46.00	Average weekly cost for dialysis treatments (see instructions) Total additional payment (line 45 times line 44 times line 41.		0.00		45.0
47.00	Subtotal (see instructions)	01)	2, 536, 148		47.0
48.00	Hospital specific payments (to be completed by SCH and MDH, sm	nall rural hospitals	0		48.0
	only. (see instructions)				
				Amount	
49.00	Total payment for inpatient operating costs (see instructions)			1.00 2,536,148	49.0
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and			188, 226	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.0
52.00	Direct graduate medical education payment (from Wkst. E-4, lin	ne 49 see instructions).		0	52.0
53.00	Nursing and Allied Health Managed Care payment			0	53.0
54.00 54.01	Special add-on payments for new technologies			0	54.0 54.0
55.00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69	2)		0	55.0
56.00	Cost of physicians' services in a teaching hospital (see intru			0	56.0
57.00	Routine service other pass through costs (from Wkst. D, Pt. II	-	rough 35).	0	57.0
58.00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 11 line 200)	-	0	58.0
59.00	Total (sum of amounts on lines 49 through 58)			2, 724, 374	
60.00 61.00	Primary payer payments	Lipo (0)		0	60. 0 61. 0
62.00	Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries	TTHE 80)		2, 724, 374 434, 059	
63.00	Coinsurance billed to program beneficiaries			0	63.0
64.00	Allowable bad debts (see instructions)			50, 558	
65.00	Adjusted reimbursable bad debts (see instructions)			32, 863	
66.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		50, 558	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	and a to MS DDCa (as	a instructions)	2, 323, 178	67.0
68.00 69.00	Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96).		· · · · · ·	0	68.0 69.0
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		)	0	70.0
70.50	Rural Community Hospital Demonstration Project (§410A Demonstr	ation) adjustment (see i	nstructions)	0	70.5
70. 87	Demonstration payment adjustment amount before sequestration	-		0	70.8
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.8
70.89	Pioneer ACO demonstration payment adjustment amount (see instr	ructions)			70.8
70. 90 70. 91	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.9 70.9
70.91	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	70.9
70.92	HVBP payment adjustment amount (see instructions)			35, 818	
				0	
70. 94	HRR adjustment amount (see instructions)			0	,

	Provider CC	N: 15-0101	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Pre 5/29/2018 4:1	pare 0 pm
	Title		Hospi tal	PPS	
		FF۱	′ (yyyy)	Amount	
			0	1.00	
.96 Low volume adjustment for federal fiscal year (yyyy) (Enter	in column O		2017	355, 867	70.
<ul> <li>the corresponding federal year for the period prior to 10/1)</li> <li>Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period ending on or a</li> </ul>	in column O		2018	99, 125	
.98 Low Volume Payment-3				0	
.99 HAC adjustment amount (see instructions)				0	
.00 Amount due provider (line 67 minus lines 68 plus/minus lines	s 69 & 70)			2, 813, 988	
.01 Sequestration adjustment (see instructions)				56, 280	
02 Demonstration payment adjustment amount after sequestration				0	
.00 Interim payments				2, 680, 214	
.00 Tentative settlement (for contractor use only)	aa 70 J			0	73
00 Balance due provider/program (line 71 minus lines 71.01, 71. 73)				77, 494	
.00 Protested amounts (nonallowable cost report items) in accord	bance with			76, 922	75
CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					1
.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see in	etructions)			0	90
.00 Capital outlier from Wkst. L, Pt. I, line 2				0	
00 Operating outlier reconciliation adjustment amount (see inst	tructions)			0	
00 Capital outlier reconciliation adjustment amount (see instru				0	
00 The rate used to calculate the time value of money (see inst	· ·			0.00	
00 Time value of money for operating expenses (see instructions				0.00	
.00 Time value of money for capital related expenses (see instructions	· ·			0	
			Prior to 10/1		1.0
			1.00	2.00	
HSP Bonus Payment Amount					
D.00 HSP bonus amount (see instructions)			0	0	100
HVBP Adjustment for HSP Bonus Payment					
1.00 HVBP adjustment factor (see instructions)			0.000000000	0.000000000	
2.00 HVBP adjustment amount for HSP bonus payment (see instruction	ons)		0	0	102
HRR Adjustment for HSP Bonus Payment					1
3.00 HRR adjustment factor (see instructions)			0.0000	0.0000	
4.00 HRR adjustment amount for HSP bonus payment (see instruction			0	0	104
					1000
Rural Community Hospital Demonstration Project (§410A Demons					200
0.00 Is this the first year of the current 5-year demonstration p	period under t	ne 21st			
0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no.	period under ti	ne 21st			
0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement		ne 21st			201
<ul> <li>0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no.</li> <li>Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii</li> </ul>		ne 21st			
<ul> <li>0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no.</li> <li>Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii</li> <li>2.00 Medicare discharges (see instructions)</li> </ul>		ne 21st			202
<ul> <li>0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii</li> <li>2.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> </ul>	ne 49)		nt 5-year demonst	ration	202
<ul> <li>0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no.</li> <li>Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii</li> <li>2.00 Medicare discharges (see instructions)</li> </ul>	ne 49)		nt 5-year demonst	ration	202
<ul> <li>0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 2.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i</li> </ul>	ne 49)		nt 5-year demonst	ration	202 203
<ul> <li>0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii</li> <li>2.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>Computation of Demonstration Target Amount Limitation (N/A i period)</li> <li>4.00 Medicare target amount</li> </ul>	ne 49)		nt 5-year demonst	ration	202 203 204 204
<ul> <li>0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>0.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii</li> <li>0.00 Medicare discharges (see instructions)</li> <li>0.00 Case-mix adjustment factor (see instructions)</li> <li>Computation of Demonstration Target Amount Limitation (N/A i period)</li> <li>0.00 Medicare target amount</li> <li>0.00 Medicare inpatient routine cost cap (line 202 times line 204)</li> <li>0.00 Medicare inpatient routine cost cap (line 202 times line 205</li> </ul>	ne 49) n first year (		nt 5-year demonst	ration	202 203 204 204
<ul> <li>0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii</li> <li>2.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>Computation of Demonstration Target Amount Limitation (N/A i period)</li> <li>4.00 Medicare target amount</li> <li>5.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>6.00 Medicare inpatient routine cost cap (line 202 times line 205 Adjustment to Medicare Part A Inpatient Reimbursement</li> </ul>	ne 49) n first year ( 5)		nt 5-year demonst	ration	201 202 203 204 205 206
<ul> <li>0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>0.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii</li> <li>0.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>Computation of Demonstration Target Amount Limitation (N/A i period)</li> <li>4.00 Medicare target amount</li> <li>5.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>6.00 Medicare inpatient routine cost cap (line 202 times line 205 Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>7.00 Program reimbursement under the §410A Demonstration (see instructions)</li> </ul>	n first year ( 5) structions)		nt 5-year demonst	ration	202 203 204 205 206 207
<ul> <li>0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>0.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii</li> <li>0.00 Medicare discharges (see instructions)</li> <li>0.00 Case-mix adjustment factor (see instructions)</li> <li>0.00 Medicare target amount</li> <li>0.00 Medicare target amount</li> <li>0.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>0.00 Medicare inpatient routine cost cap (line 202 times line 204)</li> <li>0.00 Medicare to Medicare Part A Inpatient Reimbursement</li> <li>7.00 Program reimbursement under the §410A Demonstration (see ins</li> <li>3.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A</li> </ul>	n first year ( 5) structions)		nt 5-year demonst	ration	202 203 204 205 206 207 208
<ul> <li>0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii</li> <li>2.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>Computation of Demonstration Target Amount Limitation (N/A i period)</li> <li>4.00 Medicare target amount</li> <li>5.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>6.00 Medicare inpatient routine cost cap (line 202 times line 204)</li> <li>6.00 Medicare neimbursement under the §410A Demonstration (see inst Adjustment to Medicare IPPS payments (see instructions)</li> </ul>	n first year ( 5) structions)		nt 5-year demonst	rati on	202 203 204 205 206 207 208 209
<ul> <li>0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii</li> <li>2.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>Computation of Demonstration Target Amount Limitation (N/A i period)</li> <li>4.00 Medicare target amount</li> <li>5.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>6.00 Medicare inpatient routine cost cap (line 202 times line 204)</li> <li>6.00 Medicare reimbursement under the §410A Demonstration (see ins</li> <li>8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A</li> <li>9.00 Adjustment to Medicare IPPS payments (see instructions)</li> </ul>	n first year o 5) Structions) A, line 59)		nt 5-year demonst	rati on	202 203 204 205 206 207 208 209 210
<ul> <li>0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>0.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii</li> <li>2.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>Computation of Demonstration Target Amount Limitation (N/A i period)</li> <li>4.00 Medicare target amount</li> <li>5.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>6.00 Medicare inpatient routine cost cap (line 202 times line 205 Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>7.00 Program reimbursement under the §410A Demonstration (see ins 0.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A 9.00 Adjustment to Medicare IPPS payments (see instructions)</li> <li>0.00 Total adjustment to Medicare IPPS payments (see instructions)</li> </ul>	n first year o 5) Structions) A, line 59)		nt 5-year demonst	ration	202 203 204 205 206 207 208 209 210
<ul> <li>0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii</li> <li>2.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>Computation of Demonstration Target Amount Limitation (N/A i period)</li> <li>4.00 Medicare target amount</li> <li>5.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>6.00 Medicare inpatient routine cost cap (line 202 times line 204)</li> <li>6.00 Medicare Part A Inpatient Reimbursement</li> <li>7.00 Program reimbursement under the §410A Demonstration (see inst Adjustment to Medicare IPPS payments (see instructions)</li> <li>0.00 Medicare for future use</li> <li>1.00 Total adjustment to Medicare IPPS payments (see instructions)</li> </ul>	n first year o 5) structions) A, line 59) S)		nt 5-year demonst	ration	202 203 204 205 206 207 208 209 210 211
<ul> <li>0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii</li> <li>2.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>Computation of Demonstration Target Amount Limitation (N/A i period)</li> <li>4.00 Medicare target amount</li> <li>5.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>6.00 Medicare inpatient routine cost cap (line 202 times line 204)</li> <li>6.00 Medicare Part A Inpatient Reimbursement</li> <li>7.00 Program reimbursement under the §410A Demonstration (see ins</li> <li>8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A</li> <li>9.00 Adjustment to Medicare IPPS payments (see instructions)</li> <li>0.00 Reserved for future use</li> <li>1.00 Total adjustment to Medicare Part A IPPS payments (from line</li> </ul>	n first year o 5) structions) A, line 59) S)		nt 5-year demonst	ration	202 203 204 205 206 207 208 209 210 211 212
<ul> <li>0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii</li> <li>2.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>Computation of Demonstration Target Amount Limitation (N/A i period)</li> <li>4.00 Medicare target amount</li> <li>5.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>6.00 Medicare inpatient routine cost cap (line 202 times line 204)</li> <li>6.00 Medicare Part A Inpatient Reimbursement</li> <li>7.00 Program reimbursement under the §410A Demonstration (see inst Adjustment to Medicare IPPS payments (see instructions)</li> <li>0.00 Medicare for future use</li> <li>1.00 Total adjustment to Medicare IPPS payments (see instructions)</li> </ul>	n first year o 5) structions) A, line 59) 5) e 211)	of the curre	nt 5-year demonst	ration	202 203 204 205 206 207 208 209 210 211

w vo	LUME CALCULATION EXHIBIT 4			Provider C		eriod: rom 01/01/2017	Worksheet E	+ 4
						o 12/31/2017	Part A Exhibi Date/Time Pre	oare
				Title	XVIII	Hospi tal	5/29/2018 4: 10 PPS	) pr
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement		0n/After 10/01	through 4)	
00	DDC answerte athen there anti-	0	1.00	2.00	3.00	4.00	5.00	1
00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1
01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 01	1, 785, 945	0	1, 785, 945		1, 785, 945	1
02	DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	450, 667	0		450, 667	450, 667	1
)3	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	o		0	1
)4	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1
00	Outlier payments for	2.00	17, 712	0	14, 428	3, 284	17, 712	2
01	discharges (see instructions) Outlier payments for	2. 02	0	0	0	0	0	2
00	discharges for Model 4 BPCI Operating outlier	2. 01	0	0	0	0	0	3
00	reconciliation Managed care simulated	3. 00	0	0	0	0	0	4
	payments Indirect Medical Education Adju	ustment						
00	Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0.00000	0. 000000		5
00	A, line 21 (see instructions) IME payment adjustment (see	22.00	0	0	0	0	0	6
)1	instructions) IME payment adjustment for	22.00	0	0	0	0	0	e
	managed care (see instructions)							
	Indirect Medical Education Adju					0,000000		
00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0. 000000	0. 000000	0. 000000		7
0	IME adjustment (see instructions)	28.00	0	0	0	0	0	8
1	IME payment adjustment add on for managed care (see	28.01	0	0	C	0	0	8
00	instructions) Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	ç
)1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	ç
00	Disproportionate Share Adjustme		0.1055	0.1055	0.10	0.1055		
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 1200	0. 1200	0. 1200	0. 1200		10
00	Disproportionate share adjustment (see instructions)	34.00	67, 098	0	53, 578	13, 520	67, 098	11
01	Uncompensated care payments	36.00	214, 726		126, 431	88, 295	214, 726	11
00	Additional payment for high per Total ESRD additional payment	centage of ESF 46.00	≀D beneficiary 0	di scharges 0	0	0	0	12
00	(see instructions) Subtotal (see instructions)	47.00	2, 536, 148	0	1, 980, 382	555, 766	2, 536, 148	13
00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	48.00	0	0	0	0	0	14
00	(see instructions) Total payment for inpatient operating costs (see	49.00	2, 536, 148	0	1, 980, 382	555, 766	2, 536, 148	15
00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I,	50.00	188, 226	0	141, 929	46, 297	188, 226	16
00	if applicable) Special add-on payments for new technologies	54.00	0	0	O	0	0	17
01 02	Net organ aquisition cost Credits received from	68.00	0	0	0	0	0	17 17

	Financial Systems		WHITLEY MEMORI		N 15 0101		u of Form CMS-2	2552-1
LOW VO	LUME CALCULATION EXHIBIT 4			Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Exhibi Date/Time Pre 5/29/2018 4:1	pared:
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0		0 0	0	18.0
19.00	SUBTOTAL			0	2, 122, 31	1 602, 063	2, 724, 374	10 00
17.00		W/S L, line	(Amounts from L)	0	2, 122, 31	1 002,003	2,724,374	17.00
		0	1.00	2,00	3.00	4,00	5,00	
20.00	Capital DRG other than outlier	1.00	170, 514				170, 514	20.0
	Model 4 BPCI Capital DRG other than outlier	1. 01	17, 712	0	13, 24	8 4, 464	17, 712	20. 0
21.00	Capital DRG outlier payments	2.00	0	0	-3, 28	4 3, 284	0	21.0
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	0	21.0
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0.0000	0.000	0 0.0000	-	22. 0
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	0	23.0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.0000	0. 000	0 0.0000		24.0
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	0	25.0
26.00	Total prospective capital payments (see instructions)	12.00	188, 226	0	141, 92	9 46, 297	188, 226	26. 0
		W/S E, Part A						
		line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00 28.00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70. 96			0. 16767 355, 86		355, 867	27.0 28.0
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				99, 125	99, 125	29. 0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Υ					100. 0

	Financial Systems WHITLEY MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0101	Peri od:	wof Form CMS-2 Worksheet E	N
			From 01/01/2017 To 12/31/2017		pared:
		Title XVIII	Hocni tal	5/29/2018 4:10 PPS	0 pm
			Hospi tal	PP3	
				1.00	
1.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			0	1.00
2.00	Medical and other services reimbursed under OPPS (see instruct	i ons)		4, 299, 021	2.00
3.00	OPPS payments			3, 475, 244	
4.00 4.01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			23, 711	4.00
5.00	Enter the hospital specific payment to cost ratio (see instruc	tions)		0.000	
6.00	Line 2 times line 5			0	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)	V col 12 Line 200		0	
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt. I Organ acquisitions	V, COL. 13, 11he 200		0	9.00 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			0	
	COMPUTATION OF LESSER OF COST OR CHARGES				
10.00	Reasonable charges			0	10.00
12.00 13.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li	ne 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13)	ne 09)		0	
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for p	5	0	0	
16.00	Amounts that would have been realized from patients liable for		n a chargebasis	0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13(e Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17.00
18.00	Total customary charges (see instructions)			0.000000	1
19.00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds li	ne 11) (see	0	19.00
~~ ~~	instructions)				
20. 00	Excess of reasonable cost over customary charges (complete onl instructions)	y if line 11 exceeds li	ne 18) (see	0	20.00
21.00	Lesser of cost or charges (see instructions)			0	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instr		0	23.00	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			3, 498, 955	24.00
25.00	Deductibles and coinsurance (for CAH, see instructions)			730, 525	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for	· CAH, see instructions)		0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	lus the sum of lines 22	and 23] (see	2, 768, 430	27.00
28.00	instructions) Direct graduate medical education payments (from Wkst. E-4, li	po 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	ne 50)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)			2, 768, 430	
31.00	Primary payer payments			905	
32.00	Subtotal (line 30 minus line 31)	FC)		2, 767, 525	32.00
33.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC Composite rate ESRD (from Wkst. I-5, line 11)	ES)		0	33. 00
34.00	Allowable bad debts (see instructions)			69, 028	
35.00	Adjusted reimbursable bad debts (see instructions)			44, 868	
36.00	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		69, 028	
37.00	Subtotal (see instructions)			2, 812, 393	
38.00 39.00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	38.00 39.00
39.00	Pioneer ACO demonstration payment adjustment (see instructions	.)		0	39.00
39.97	Demonstration payment adjustment amount before sequestration	· /		0	
39. 98	Partial or full credits received from manufacturers for replac	ed devices (see instruc	tions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (see instructions) Sequestration adjustment (see instructions)			2, 812, 393	
40. 01 40. 02	Demonstration payment adjustment amount after sequestration			56, 248 0	
41.00	Interim payments			2, 753, 969	
42.00	Tentative settlement (for contractors use only)			0	42.00
43.00	Balance due provider/program (see instructions)			2, 176	
44.00	Protested amounts (nonallowable cost report items) in accordan §115.2	ice with CMS Pub. 15-2,	cnapter 1,	0	44.00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	
91.00					
91.00 92.00 93.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92.00 93.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	CN: 15-0101	Period: From 01/01/2017 To 12/31/2017		
		Title	XVIII	Hospi tal	PPS	•
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00 3.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		2, 680, 21	0 0	2, 753, 969 0	1.00 2.00 3.00
3.00	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3.01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02				0	0	3.02
3.03				0	0	3.03
3.04 3.05				0	0	3.04 3.05
5.05	Provider to Program				0	5.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.5
3.52				0	0	3.52
3.53 3.54				0	0	3.53 3.54
3. 99 3. 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2, 680, 21	14	2, 753, 969	4.00
- 00	TO BE COMPLETED BY CONTRACTOR					F 0/
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.00
5.01	TENTATI VE TO PROVIDER			0	0	5.01
5.02				0	0	5. 02
5.03				0	0	5.03
	Provider to Program				-	
5.50 5.51	TENTATI VE TO PROGRAM			0	0	5.50 5.51
5.51				0	0	5. 52
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5.99
5.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		77, 49	94	2, 176	6.0
6. 02	SETTLEMENT TO PROGRAM		_	0	0	6. 02
7.00	Total Medicare program liability (see instructions)		2, 757, 70		2, 756, 145	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
8.00	Name of Contractor		)	1.00	2.00	8.00

Heal th	Financial Systems	WHITLEY MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provi der	CCN: 15-0101	Period: From 01/01/2017 To 12/31/2017		
					10 12/31/2017	5/29/2018 4: 1	
			Ti t	le XVIII	Hospi tal	PPS	
					-	1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD					1.00	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION						-
1.00	Total hospital discharges as defined in AARA §		S-3 Pt	L col 15 line	14		1.00
							2.00
							3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 su	m of lines 1, 8-	12				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col						5.00
6.00	Total hospital charity care charges from Wkst.						6.00
7.00	CAH only - The reasonable cost incurred for th line 168	e purchase of ce	ertified H	IT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see	instructions)					8.00
9.00	Sequestration adjustment amount (see instructi	ons)					9.00
10.00	Calculation of the HIT incentive payment after	sequestration (	see instr	uctions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & C						
	Initial/interim HIT payment adjustment (see in	istructions)					30.00
	Other Adjustment (specify)						31.00
32.00	Balance due provider (line 8 (or line 10) minu	is line 30 and li	ne 31) (s	ee instruction	s)		32.00

	Financial Systems WHITLEY MEMORI E SHEET (If you are nonproprietary and do not maintain	Provi der C		Period: From 01/01/2017	u of Form CMS-: Worksheet G	
nd-t ly)	ype accounting records, complete the General Fund column			To 12/31/2017	Date/Time Pre 5/29/2018 4:1	pare 0 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
00	CURRENT ASSETS Cash on hand in banks	139, 932			0	1 1
00	Temporary investments	0		0	0	
00	Notes receivable	0		0	0	
00	Accounts receivable	27, 837, 613	(	o o	0	4
00	Other receivable	0		o o	0	5
00	Allowances for uncollectible notes and accounts receivable	-18, 339, 951		0 0	0	6
00	Inventory	399, 733		0 0	0	7
00	Prepaid expenses	3, 532, 227		0 0	0	1 7
00	Other current assets	0		0 0	0	
00	Due from other funds	0		0 0	0	
00	Total current assets (sum of lines 1-10)	13, 569, 554	[(	0 0	0	11
00	FIXED ASSETS	2(0,402			0	1 1 2
00	Land Land improvements	260, 483			0	
00	Accumulated depreciation	2, 469, 451 -417, 628			0	
00	Buildings	14, 657, 081			0	
00	Accumulated depreciation	-1, 492, 107			0	
. 00	Leasehold improvements	-1, 492, 107		-	0	
00	Accumulated depreciation	-48, 824			0	
	Fixed equipment	84, 462		0	0	
	Accumul ated depreciation	-61, 798		0	0	
	Automobiles and trucks	427, 287			0	
	Accumulated depreciation	-300, 121		o o	0	22
. 00	Major movable equipment	14, 796, 388		o o	0	23
00	Accumulated depreciation	-9, 790, 648		0 0	0	24
00	Minor equipment depreciable	6, 866, 613		0 0	0	25
00	Accumul ated depreciation	-1, 316, 662		0 0	0	26
. 00	HIT designated Assets	0	(	0 0	0	27
	Accumulated depreciation	0		0 0	0	1
	Minor equipment-nondepreciable	0		0 0	0	
. 00	Total fixed assets (sum of lines 12-29)	26, 133, 977	(	0 0	0	30
	OTHER ASSETS		I	-1 -1	-	
	Investments	54, 327, 950		0	0	
. 00	Deposits on Leases	0		0 0	0	
. 00	Due from owners/officers	105 500		0	0	
	Other assets Total other assets (sum of lines 21.24)	135, 583			0	
. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	54, 463, 533 94, 167, 064			0	
00	CURRENT LIABILITIES	94, 107, 004	l	<u> </u>	0	- 30
. 00	Accounts payable	1, 317, 226		0 0	0	37
. 00	Salaries, wages, and fees payable	906, 103		0	0	
	Payrol I taxes payable	00,100		0 0	0	
	Notes and Loans payable (short term)	0		0 0	0	
	Deferred income	0		o o	0	
. 00	Accelerated payments	0				42
00	Due to other funds	0	(	0 0	0	43
. 00	Other current liabilities	179, 362		0 0	0	
. 00	Total current liabilities (sum of lines 37 thru 44)	2, 402, 691		0 0	0	45
_	LONG TERM LIABILITIES		1	-1 -		4
. 00	Mortgage payable	0		0 0	0	
00	Notes payable	0		0 0	0	
00	Unsecured Loans	0			0	
00	Other long term liabilities	9, 982, 049		0	0	
00	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	9, 982, 049			0	
00	CAPITAL ACCOUNTS	12, 384, 740			0	
00	General fund balance	81, 782, 324				52
00	Specific purpose fund	01,702,024		0		53
00	Donor created - endowment fund balance - restricted		Ì	0		54
00	Donor created - endowment fund balance - unrestricted			0		55
. 00	Governing body created - endowment fund balance			0		56
. 00	Plant fund balance - invested in plant				0	
. 00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				Ū	
	Total fund balances (sum of lines 52 thru 58)	81, 782, 324		0 10	0	59
. 00		0111021021			Ũ	

Heal th	Financial Systems	WHITLEY MEMORI	AL HOSPITAL			In Lie	u of Form CMS.	2552-10
	ENT OF CHANGES IN FUND BALANCES		Provider CC		Fro To	iod: m 01/01/2017 12/31/2017	Worksheet G- Date/Time Pr 5/29/2018 4:	1 epared:
		General	Fund	Speci al	Purp	ose Fund	Endowment Fund	t l
		1.00	0.00	0.00		4.00	5.00	
1.00	Fund balances at beginning of period	1.00	2.00 81,857,639	3.00		4.00	5.00	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		13, 404, 400					2.00
3.00 4.00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	95, 262, 039		0	0	(	3.00 4.00
4.00 5.00	Additions (creditiadjustillents) (specify)	0			0			5.00
6.00		0			0		(	
7.00 8.00		0			0 0		(	) 7.00 ) 8.00
9.00		0			0			9.00
10. 00 11. 00	Total additions (sum of line 4–9) Subtotal (line 3 plus line 10)		0 95, 262, 039			0		10.00 11.00
12.00	ASSET TRANSFERS	13, 479, 715	93, 202, 039		0	0	(	11.00
13.00		0			0		(	
14.00 15.00		0			0		(	) 14.00 ) 15.00
16.00		0			0		(	16.00
17.00 18.00	Total deductions (our of lines 12 17)	0	12 470 715		0	0	(	) 17.00 18.00
	Total deductions (sum of lines 12-17) Fund balance at end of period per balance		13, 479, 715 81, 782, 324			0		19.00
	sheet (line 11 minus line 18)							
		Endowment Fund	PI ant	Fund				
		6.00	7.00	8.00				
1.00 2.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0			0			1.00
3.00	Total (sum of line 1 and line 2)	0			0			3.00
4.00	Additions (credit adjustments) (specify)		0					4.00
5.00 6.00			0					5.00 6.00
7.00			0					7.00
8.00 9.00			0					8.00 9.00
10.00	Total additions (sum of line 4-9)	0	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0			0			11.00
12.00 13.00	ASSET TRANSFERS		0					12.00 13.00
14.00			0					14.00
15.00 16.00			0					15.00 16.00
16.00 17.00			0					16.00
	Total deductions (sum of lines 12-17)	0			0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			19.00
		· · ·			I			1

STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CCN	: 15-0101	Period: From 01/01/2017 To 12/31/2017	Worksheet G-2 Parts I & II Date/Time Pre 5/29/2018 4:1	pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		7, 332, 82	28	7, 332, 828	
2.00	SUBPROVIDER - IPF					2.0
3.00	SUBPROVIDER - IRF					3.0
4.00	SUBPROVIDER				0	4.0
5.00	Swing bed - SNF			0	0	5.0
6.00	Swing bed - NF			0	0	
7.00 8.00	SKILLED NURSING FACILITY NURSING FACILITY			0	0	7.0
8.00 9.00	OTHER LONG TERM CARE					9.0
9.00 10.00	Total general inpatient care services (sum of lines 1-9)		7, 332, 82		7, 332, 828	
10.00	Intensive Care Type Inpatient Hospital Services		7, 332, 02	20	7, 332, 020	10.0
11.00	INTENSIVE CARE UNIT					11.0
12.00	CORONARY CARE UNIT					12.0
13.00	BURN INTENSIVE CARE UNIT					13.0
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.0
15.00	OTHER SPECIAL CARE (SPECIFY)					15.0
16.00	Total intensive care type inpatient hospital services (sum of	Lines		0	0	
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)		7, 332, 82	28	7, 332, 828	17.0
18.00	Ancillary services		31, 009, 98	36 0	31, 009, 986	18.0
19.00	Outpatient services			0 171, 800, 442	171, 800, 442	19.0
20.00	RURAL HEALTH CLINIC			0 0	0	20.0
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.0
22.00	HOME HEALTH AGENCY					22.0
23.00	AMBULANCE SERVICES			0 5, 752, 665	5, 752, 665	
24.00	СМНС					24.0
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25.0
26.00	HOSPI CE				0	26.0
27.00	OTHER (SPECIFY)	+- WI+	20 242 01		0	27.0
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to wkst.	38, 342, 81	14 177, 553, 107	215, 895, 921	28.0
	G-3, line 1) PART II - OPERATING EXPENSES					-
29.00	Operating expenses (per Wkst. A, column 3, line 200)			63, 286, 035		29.0
30.00	PROVISION FOR BAD DEBT		10, 658, 94			30.0
31.00			10, 000, 7-	0		31.0
32.00				0		32.0
33.00				0		33.0
34.00				0		34.0
35.00				0		35.0
36.00	Total additions (sum of lines 30-35)			10, 658, 948		36.0
37.00	DEDUCT (SPECIFY)			0		37.0
38.00				0		38.0
39.00				0		39.0
40.00				0		40.0
41.00				0		41.0
42.00	Total deductions (sum of lines 37-41)			0		42.0
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42	)(transfer		73, 944, 983		43.0
	to Wkst. G-3, line 4)					

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES	Provi der	CCN: 15-0101	Period: From 01/01/2017 To 12/31/2017	Worksheet G-3 Date/Time Pre 5/29/2018 4:1	pared:
				5/29/2018 4:1	o pin
				1.00	
1.00 Total patient revenues (from Wkst. G	-2, Part I, column 3, line 28)			215, 895, 921	1.00
2.00 Less contractual allowances and disc				136, 388, 416	2.00
3.00 Net patient revenues (line 1 minus l	ne 2)			79, 507, 505	3.00
4.00 Less total operating expenses (from	Wkst. G-2, Part II, line 43)			73, 944, 983	4.00
5.00 Net income from service to patients	(line 3 minus line 4)			5, 562, 522	5.00
OTHER INCOME	•				
6.00 Contributions, donations, bequests,	etc			0	6.00
7.00 Income from investments				856, 830	7.00
8.00 Revenues from telephone and other mi	scellaneous communication services			0	8.00
9.00 Revenue from television and radio se	rvi ce			0	9.00
10.00 Purchase di scounts				0	10.00
11.00 Rebates and refunds of expenses				0	11.00
12.00 Parking lot receipts				0	
13.00 Revenue from Laundry and Linen servi				0	
14.00 Revenue from meals sold to employees	5			208, 307	
15.00 Revenue from rental of living quarte					15.00
16.00 Revenue from sale of medical and sur		nts			16.00
17.00 Revenue from sale of drugs to other					17.00
18.00 Revenue from sale of medical records					18.00
19.00 Tuition (fees, sale of textbooks, un					19.00
20.00 Revenue from gifts, flowers, coffee	shops, and canteen			0	
21.00 Rental of vending machines				0	
22.00 Rental of hospital space				0	
23.00 Governmental appropriations				0	
24.00 OTHER (SPECIFY)				0	2.11.00
24.01 GAIN/(LOSS) ON SALE OF CAPITAL ASSET				4, 409, 947	
24.02 EMS CONTRIBUTION				250, 000	
24.03 OTHER REVENUE				2, 116, 794	
25.00 Total other income (sum of lines 6-2	4)			7, 841, 878	
26.00 Total (line 5 plus line 25)				13, 404, 400	•
27.00 OTHER EXPENSES (SPECIFY)				0	
28.00 Total other expenses (sum of line 27				0	28.00
29.00 Net income (or loss) for the period	(line 26 minus line 28)			13, 404, 400	29.00

ALCULATION OF CAPITAL PAYMENT	Provi der CCN: 15-0101	Period: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Pre 5/29/2018 4:1			
	Title XVIII	Hospi tal	PPS	o piii		
			1.00			
PART I - FULLY PROSPECTIVE METHOD				-		
CAPITAL FEDERAL AMOUNT .00 Capital DRG other than outlier			170, 514	1.		
.01 Model 4 BPCI Capital DRG other than outlier			170, 514			
.00 Capital DRG outlier payments			0			
.01 Model 4 BPCI Capital DRG outlier payments			0			
00 Total inpatient days divided by number of days in the cos	st reporting period (see inst	tructions)	11.42	3.		
.00 Number of interns & residents (see instructions)						
.00 Indirect medical education percentage (see instructions)	Indirect medical education percentage (see instructions)					
1.01) (see instructions)	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)					
30) (see instructions)						
00 Percentage of Medicaid patient days to total days (see in 00 Sum of lines 7 and 8	0.00					
<ul> <li>0.00 Allowable disproportionate share percentage (see instruc</li> <li>.00 Disproportionate share adjustment (see instructions)</li> </ul>	tions)		0.00			
2.00 Total prospective capital payments (see instructions)			188, 226	1		
			100, 220	12		
			1.00			
PART II – PAYMENT UNDER REASONABLE COST						
00 Program inpatient routine capital cost (see instructions)			0			
00 Program inpatient ancillary capital cost (see instruction			0			
00 Total inpatient program capital cost (line 1 plus line 2) 00 Capital cost payment factor (see instructions)	)		0			
00 Capital cost payment factor (see instructions) 00 Total inpatient program capital cost (line 3 x line 4)			0	4		
			0			
			1.00			
PART III - COMPUTATION OF EXCEPTION PAYMENTS						
00 Program inpatient capital costs (see instructions)	otopoo (ooo i potructi)		0			
00 Program inpatient capital costs for extraordinary circum 00 Net program inpatient capital costs (line 1 minus line 2			0			
00 Applicable exception percentage (see instructions)			0.00			
00 Capital cost for comparison to payments (line 3 x line 4)	)		0.00			
00 Percentage adjustment for extraordinary circumstances (s			0.00			
00 Adjustment to capital minimum payment level for extraord	-	kline 6)	0	7		
00 Capital minimum payment level (line 5 plus line 7)			0	-		
00 Current year capital payments (from Part I, line 12, as			0			
00 Current year comparison of capital minimum payment level			0			
.00 Carryover of accumulated capital minimum payment level or Worksheet L, Part III, line 14)		5	0			
.00 Net comparison of capital minimum payment level to capita			0			
8.00 Current year exception payment (if line 12 is positive, o 9.00 Carryover of accumulated capital minimum payment level o			0			
(if line 12 is negative, enter the amount on this line)	ver capital payment for the i	ion owning period	0	14		
			-	1 45		
	e instructions)		0	1 15		
5.00 Current year allowable operating and capital payment (see 5.00 Current year operating and capital costs (see instruction			0			