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 Period: From 01/01/2018 To 12/31/2018 Vorksheet S Parts I-III To 12/31/2018 Propagate S Parts

		1.5 .2,	5/28/2019 10: 24 am
PART I - COST	REPORT STATUS		
Provi der	1. [X] Electronically filed cost report	Date:	5/28/2019 Time: 10:24 am
use only	2. [] Manually submitted cost report		
	3.[0] If this is an amended report enter the number of 4.[F] Medicare Utilization. Enter "F" for full or "L"		this cost report
Contractor use only	5. [1]Cost Report Status (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N]Initial Report for (3) Settled with Audit 9. [N]Final Report for (4) Reopened (5) Amended	this Provider CCN 12.[0]If lin	's Vendor Code: 4 ne 5, column 1 is 4: Enter r of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY 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 01/01/2018 and ending 12/31/2018 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.

[X]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 gned) JEANNE WI CKENS

Officer or Administrator of Provider(s)

CF0/SVP

Title

(Dated when report is electronically signed.)

			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	-121, 795	25, 175	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	o	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	o	0		0	7. 00
200.00	Total	0	-121, 795	25, 175	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.

Health Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0101 Peri od: Worksheet S-2 From 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 5/28/2019 10: 24 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 1260 E STATE ROAD 205 PO Box: 1.00 State: IN Zip Code: 46725-9492 County: WHITLEY 2.00 City: COLUMBIA CITY 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)

/ XVIII XIX Туре Certi fi ed Number Number 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 WHITLEY MEMORIAL 150101 23060 07/01/1966 N 3.00 HOSPI TAI Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2018 12/31/2018 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1.

Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)

Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) 22.02 22.02 N N Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 N Ν N rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)

23. 00	Which method is used to determine Medicaid days on libelow? In column 1, enter 1 if date of admission, 2 i			3 1	N		23. 00	
	if date of discharge. Is the method of identifying the							
	reporting period different from the method used in the							
	reporting period? In column 2, enter "Y" for yes or							
	In-State In-State				Out-of	Medi cai d	0ther	
		Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
		paid days	eligible	Medicaid	Medi cai d		days	
			unpai d	paid days	el i gi bl e			
			days		unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
24.00	If this provider is an IPPS hospital, enter the	75	459	0	3	63	3 0	24. 00
	in-state Medicaid paid days in column 1, in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid paid days in column 3,							
	out-of-state Medicaid eligible unpaid days in column							
	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.					l		I

Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for

yes or "N" for no.

	Financial Systems WHITLE AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	Y MEMORIAL I	Provider CC	N· 15-0101	Peri od		In Lie		Form kshee		
	TE AND HOST THE HEALTH GARLE GOING EEX TOERTH GARLEGE				From (01/0° 12/3°	1/2018	Par Dat 5/2	t I e/Time 8/201	e Pre 9 10: 2	pared: 24 am
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-o State Medica eligib unpai	e ii d ol e d	Medic HMO d	lays	Oth Medio day	cai d ys	
5 00	If this provider is an IRF, enter the in-state	1.00	2. 00	3. 00	4. 00	0	5.0	0	6. (00	25. (
J. 00	Medicaid paid days in column 1, the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.		0	U	Hele		ural S		of (20000	23.
					01 0	1. C		Date	2.00		
7. 00	Enter your standard geographic classification (not w cost reporting period. Enter "1" for urban or "2" fo Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif If this is a sole community hospital (SCH), enter th	r rural. age) status r "2" for r ication in	at the end ural. If ap column 2.	l of the cos oplicable,	t			1			26. (27. (35. (
7. 00	effect in the cost reporting period.	e number of	perrous so	an status in							
					Be	egi nn 1. 0		E	2. 00		
5. 00	Enter applicable beginning and ending dates of SCH s		cript line	36 for numb	er	1. 0	J		2.00		36.
, 00	of periods in excess of one and enter subsequent dat		r of period	le MDH etatu							37.
137.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period. 137.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in									37.		
. 00	accordance with FY 2016 OPPS final rule? Enter "Y" finstructions) If line 37 is 1, enter the beginning and ending date	s of MDH st	atus. If li	ne 37 is							38.
	greater than 1, subscript this line for the number o enter subsequent dates.	f periods i	n excess of	one and		Y/I	V		Y/N		
						1.0	0		2.00		-
9. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (ii), or the mileage	(iii)? Ent	er in colum nts in	n	Υ			Υ		39.
0. 00	Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. Ente	r "Y" for y			N			N		40.
							1.0			XI X 3. 00	ł
	Prospective Payment System (PPS)-Capital										
	Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc		·			ince	N N		N N	N N	45. 46.
	pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	t. L, Pt. I	II and Wkst	:. L-1, Pt.	I throu	ıgh					
	ls this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen).	N N	- 1	N N	N N	47. 48.
. 00	Teaching Hospitals Is this a hospital involved in training residents in or "N" for no.	approved G	ME programs	? Enter "Y	" for y	/es	N				56.
. 00	If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is ""N", complete Wkst. D, Parts III & IV and D-2, Pt. I	r yes or "N th of this Y", complet	" for no in cost report e Worksheet	n column 1. ing period?	If colu Enter	ımn 1 "Y"					57.
	If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15–1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If ye	complete W	kst. D-5.		s as		N N				58. 59.
. 00	pri e costo ci arinica dii TTHE 100 di MULKSHEEL A! TI ye	s, comprete	WNSL. D-Z,	NAHE 413.8 Y/N	35 Wo	rkshe Li ne	eet A	Pas Qual	s-Thr i fi ca eri on	ati on	
				1. 00		2.0	00		3. 00		

Health Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0101 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/28/2019 10:24 am Y/N IME Direct GME IME Direct GME 5.00 1.00 2.00 3. 00 4.00 0.00 61.00 61.00 Did your hospital receive FTE slots under ACA 0 00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA \$5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) N 63.00 Unwei ghted Unwei ghted Ratio (col. 1/ (col

		1163	1163 111	[(001. 1 1 001.]	
		Nonprovi der	Hospi tal	2))	
		Si te			
		1. 00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings	This base year	is your cost r	eporting	
	period that begins on or after July 1, 2009 and before June 30, 2010.				l
64.	200 Enter in column 1, if line 63 is yes, or your facility trained residents	0.00	0. 00	0. 000000	64.00
	in the base year period, the number of unweighted non-primary care				l
	resident FTEs attributable to rotations occurring in all nonprovider				l
	settings. Enter in column 2 the number of unweighted non-primary care				l
	resident FTEs that trained in your hospital. Enter in column 3 the ratio				
	of (column 1 divided by (column 1 + column 2)). (see instructions)				

Health Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0101 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/28/2019 10:24 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 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) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ahted Unwei ghted Ratio (col. 3/ Program Code FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 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 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

ealth Financial Systems WHITLEY MEMORIAL OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	HOSPITAL Provider CO	N: 15-0101	Period:	u of Form CMS- Worksheet S-2		
SOFT THE THIS TROUT THE HEALTH SINCE SOME EEX TOERTH TOTAL SITTA	Trovider of		From 01/01/2018 To 12/31/2018	Part I Date/Time Pre 5/28/2019 10:	epared:	
				1. 00		
Long Term Care Hospital PPS						
0.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes a 1.00 Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no.			ng period? Enter	N N	80. 0 81. 0	
TEFRA Providers 5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) T 6.00 Did this facility establish a new Other subprovider (excluded §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 0 86. 0	
7.00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	classified u	ınder section	1	N	87. 0	
1000(0)(1)(0)(11)1 211001 1 101 101 101			V	XI X		
T: II V I VIV C :			1. 00	2. 00		
Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital	sarvi cas? Fr	ter "V" for	N	Υ	90. 0	
yes or "N" for no in the applicable column.	14		70.0			
1.00 Is this hospital reimbursed for title V and/or XIX through the			N	N	91. 0	
full or in part? Enter "Y" for yes or "N" for no in the applic 2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual				N	92. 0	
instructions) Enter "Y" for yes or "N" for no in the applicable		011): (366		IN	72.0	
3.00 Does this facility operate an ICF/IID facility for purposes of	title V and	I XIX? Enter	N	N	93. 0	
"Y" for yes or "N" for no in the applicable column. 4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, an	nd "N" for no	in the	N	N	94.0	
applicable column.	id iv 101 fic	in the	IN IN	IN	74.0	
5.00 If line 94 is "Y", enter the reduction percentage in the appli			0.00	0.00	95.0	
6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes o	N	N	96.0			
applicable column. 7.00 If line 96 is "Y", enter the reduction percentage in the appli	0.00	0. 00	97. 0			
B. 00 Does title V or XIX follow Medicare (title XVIII) for the inte	N	Y	98. 0			
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for						
column 1 for title V, and in column 2 for title XIX. 8.01 Does title V or XIX follow Medicare (title XVIII) for the repo	orting of cha	arges on Wkst	. N	Υ	98. 0	
	O1 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. N C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for					
title XIX.						
8.02 Does title V or XIX follow Medicare (title XVIII) for the calc bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or			N	Υ	98. 0	
for title V, and in column 2 for title XIX.	N TOT TIO T	ii coruiiii i				
8.03 Does title V or XIX follow Medicare (title XVIII) for a critic				N	98. 0	
reimbursed 101% of inpatient services cost? Enter "Y" for yes	or "N" for r	no in column	1			
for title V, and in column 2 for title XIX. 8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH re	imbursed 101	% of	N	N	98. 0	
outpatient services cost? Enter "Y" for yes or "N" for no in c					70.0	
in column 2 for title XIX.					00.0	
8.05 Does title V or XIX follow Medicare (title XVIII) and add back Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in col				Y	98.0	
column 2 for title XIX.	41111 1 101 11	tro v, and i	``			
8.06 Does title V or XIX follow Medicare (title XVIII) when cost re	eimbursed for	Wkst. D,	N	Υ	98.0	
Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 column 2 for title XIX.	for title V	, and in				
Rural Providers						
05.00 Does this hospital qualify as a CAH?			N		105. C	
06.00 If this facility qualifies as a CAH, has it elected the all-in for outpatient services? (see instructions)	nclusive meth	od of paymer	it		106. 0	
07.00 f this facility qualifies as a CAH, is it eligible for cost r	ei mbursement	for I&R			107.0	
training programs? Enter "Y" for yes or "N" for no in column 1						
yes, the GME elimination is not made on Wkst. B, Pt. I, col. 2	25 and the pr	ogram is cos	st			
reimbursed. If yes complete Wkst. D-2, Pt. II. 08.00 s this a rural hospital qualifying for an exception to the CR	RNA fee sched	lul e? See 42	2 N		108. C	
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.						
	Physi cal	Occupation		Respiratory	-	
09.00 f this hospital qualifies as a CAH or a cost provider, are	1.00 N	2. 00	3. 00	4. 00	109. 0	
therapy services provided by outside supplier? Enter "Y"	.,				07.0	
for yes or "N" for no for each therapy.						
				1. 00	1	

09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.

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109.00 therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider	CCN: 15-0101	Peri od:	Lieu of Form C Worksheet	
PIOVIGEI	OSIN. 10-0101	From 01/01/2 To 12/31/2	018 Part I	Prepared
·		1.00		
11.00 If this facility qualifies as a CAH, did it participate in the Frontier Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating i Enter all that apply: "A" for Ambulance services; "B" for additional bed for tele-health services.	period? Enter enter the n column 2.	1.00 N	2.00	111.
		-	1.00 2.00 3.	00
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no is yes, enter the method used (A, B, or E only) in column 2. If column 2 a either "93" percent for short term hospital or "98" percent for long to psychiatric, rehabilitation and long term hospitals providers) based on Pub. 15-1, chapter 22, §2208.1.	is "E", enter erm care (incl the definition	in column udes		0 115.
16.00 Is this facility classified as a referral center? Enter "Y" for yes or " 17.00 Is this facility legally-required to carry malpractice insurance? Enter no.		"N" for	N Y	116. 117.
18.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 claim-made. Enter 2 if the policy is occurrence.	if the policy	/ is	1	118.
jordi ili ilidadi. Elitor E ili ilio portoj ro dada rollo.	Premi ums	Losses	Insuranc	е
	1. 00	2.00	3.00	
18.01 List amounts of malpractice premiums and paid losses:	85, 6	539 27,	, 095 147,	641 118.
		1. 00	2.00	
18.02 Are malpractice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing 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 Harmless pr §3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for Hold Harmless provision in ACA §3121 and applicable amendments? (see ins	cost centers ovision in ACA Y" for yes or the Outpatient		N	118. 119. 120.
Enter in column 2, "Y" for yes or "N" for no. 21.00Did this facility incur and report costs for high cost implantable devic	es charged to	Υ		121.
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined in §190 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", ent the Worksheet A line number where these taxes are included.				122.
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes and "N	" for no. If	N		125.
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, enter the cert in column 1 and termination date, if applicable, in column 2.	ification date	>		126.
27.00 If this is a Medicare certified heart transplant center, enter the certi- in column 1 and termination date, if applicable, in column 2.	fication date			127.
28.00 If this is a Medicare certified liver transplant center, enter the certiin column 1 and termination date, if applicable, in column 2.	fication date			128.
29.00 If this is a Medicare certified lung transplant center, enter the certificolumn 1 and termination date, if applicable, in column 2.	ication date i	n		129.
30.00 of this is a Medicare certified pancreas transplant center, enter the ce date in column 1 and termination date, if applicable, in column 2.	rti fi cati on			130.
date in column 1 and termination date, if applicable, in column 2. 81.00 If this is a Medicare certified intestinal transplant center, enter the date in column 1 and termination date, if applicable, in column 2.	certi fi cati on			131.
32.00 f this is a Medicare certified islet transplant center, enter the certi	fication date			132.
in column 1 and termination date, if applicable, in column 2. 33.00 old this is a Medicare certified other transplant center, enter the certified other transplant center, enter the certified of the column 2.	fication date			133.
in column 1 and termination date, if applicable, in column 2. 34.00 If this is an organ procurement organization (0P0), enter the 0P0 number and termination date, if applicable, in column 2.	in column 1			134.
All Providers	S Dub 1E 1	Y	154022	140
40.00 Are there any related organization or home office costs as defined in CM chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and hom are claimed, enter in column 2 the home office chain number. (see instru	e office costs		15H032	140.

Health Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0101 Peri od: Worksheet S-2 From 01/01/2018 Part I То 12/31/2018 Date/Time Prepared: 5/28/2019 10: 24 am 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

Name: PARKVIEW HEALTH SYSTEM, INC. | Contractor's Name: WISCONSIN PHYSICIANS Contractor's Number: 08101 141 00 Name: 141 00 SERVI CE 142.00 Street: 10501 CORPORATE DRIVE PO Box: PO BOX 5600 142.00 46895-5600 143.00 City: FORT WAYNE State: Zip Code: 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 2.00 1.00 145.00|| f costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is 145.00 no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? Ν 146, 00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147.00 N 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1 00 2 00 3.00 4 00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal N Ν Ν N 155.00 156.00 Subprovi der - IPF 156. 00 Ν Ν Ν Ν 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158.00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν Ν 161.00 1.00 Mul ti campus 165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no. Ν 165.00 FTE/Campus Zip Code Name County **CBSA** State | 5.00 3.00 0 1.00 2.00 4.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, 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) incentive in the American Recovery and Reinvestment	Act						
167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Υ	167. 00				
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"),	enter the	1	d168. 00				
reasonable cost incurred for the HIT assets (see instructions)							
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for	a hardship		168. 01				
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "I	N"), enter the	9. 9	9169. 00				
transition factor. (see instructions)							
	Begi nni ng	Endi ng					
	1. 00	2. 00					
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting	10/01/2017	09/30/2018	170. 00				
period respectively (mm/dd/yyyy)							
	1. 00	2. 00					
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in	N	(0 171. 00				
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter							
"Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section							
1876 Medicare days in column 2. (see instructions)							

Heal th	Financial Systems WHITLEY MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-	2552-10	
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider Co		Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II	pared:	
		<u> </u>	· · · · · · · · · · · · · · · · · · ·	Y/N	Date		
				1. 00	2. 00		
	General Instruction: Enter Y for all YES responses. Enter Mmm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation	l for all NO re	esponses. Ente	r all dates in t	the		
1.00	Has the provider changed ownership immediately prior to the	e beainnina of	the cost	N		1.00	
	reporting period? If yes, enter the date of the change in o						
			Y/N	Date	V/I		
0.00		2 0 1 6	1.00	2. 00	3. 00	0.00	
2.00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	mn 3, "V" for	N			2.00	
3.00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	Y			3.00		
	Trefationships: (see That detrons)	Y/N	Туре	Date			
			1.00	2.00	3. 00		
4 0-	Financial Data and Reports		Υ		00/07/55:5		
4. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avaccolumn 3. (see instructions) If no, see instructions.	A	03/27/2019	4. 00			
5.00	Are the cost report total expenses and total revenues diffe		N			5. 00	
	those on the filed financial statements? If yes, submit reconciliation.						
				Y/N 1. 00	Legal Oper. 2.00		
	Approved Educational Activities			1.00	2.00		
6. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	,	ne provider is	N		6. 00	
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	and/or renewed	Ü	N N		7. 00 8. 00	
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	N		9. 00	
10.00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.		he current	N		10. 00	
11. 00	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	N		11. 00	
					Y/N 1. 00		
	Bad Debts					1	
12. 00 13. 00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			st reporting	Y N	12. 00 13. 00	
14. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	yes, see ins	tructions.	N	14. 00	
15. 00	Did total beds available change from the prior cost reporti		yes, see inst t A		t B	15. 00	
		Y/N	Date	Y/N	Date		
	DC*D Data	1. 00	2. 00	3. 00	4. 00		
16. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	N		N		16. 00	
17. 00	instructions) 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. 00	
18. 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. 00	
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00	

Heal th	Financial Systems WHITLEY MEMORI	IAL HOSPITAL		In Lie	u of Form CMS-	2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CC	CN: 15-0101	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Pro 5/28/2019 10:	epared:			
		Descri	ption	Y/N	Y/N	Z T GIII			
		C		1. 00	3. 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 1.00	Date 2.00	Y/N 3. 00	Date				
21. 00	Was the cost report prepared only using the provider's	1.00 N	2.00	3. 00 N	4. 00	21. 00			
	records? If yes, see instructions.								
					1. 00				
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE								
22.00	Capital Related Cost	i notrupti ono				22. 00			
22. 00 23. 00	' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '								
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	· ·				24. 00			
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see		25. 00			
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	ne cost reporti	ng period? I	f yes, see		26. 00			
27. 00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.								
28. 00									
29. 00									
30. 00	treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.								
31. 00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.								
32. 00 33. 00	Purchased Services Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instruction of the services of the servic	uctions.				32. 00 33. 00			
	no, see instructions. Provider-Based Physicians								
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with	provi der-ba	sed physicians?	Y	34. 00			
35. 00	If line 34 is yes, were there new agreements or amended exilphysicians during the cost reporting period? If yes, see in		ts with the	provi der-based		35. 00			
				Y/N	Date				
	Home Office Costs			1. 00	2. 00				
36, 00	Were home office costs claimed on the cost report?			Y		36.00			
	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	repared by the I	home office?			37. 00			
38. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			N		38. 00			
39. 00	If line 36 is yes, did the provider render services to other see instructions.			, N		39. 00			
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00			
		1. (00	2.	00				
	Cost Report Preparer Contact Information								
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ERI C		NI CKESON		41.00			
42. 00	1 '	PARKVIEW HEALTH	H SYSTEM, INC	C.		42. 00			
43. 00	1' '	(260) 373-8406		REI MBURSEMENT@F	PARKVI EW. COM	43. 00			

Heal th	Financial Systems W	HITLEY MEMORIA	AL HOSPITA	L	In Lieu of Form CMS-2552-10				
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provi de	er CCN: 15-0101		ri od: om 01/01/2018 12/31/2018	Date/Time	Prep	pared:	
							5/28/2019	10: 2	24 am_
		-		3. 00					
	Cost Report Preparer Contact Information								
41. 00	Enter the first name, last name and the title/pheld by the cost report preparer in columns 1, respectively.		I RECTOR,	REI MBURSEMENT					41.00
42. 00	Enter the employer/company name of the cost repreparer.	port							42. 00
43. 00	Enter the telephone number and email address of report preparer in columns 1 and 2, respectivel								43. 00

 Heal th Financial
 Systems
 WHITLEY

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provider CCN: 15-0101

					-	Γο 12/31/2018	Date/Time Pre 5/28/2019 10:	
							I/P Days / 0/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
	·	Line Number			Avai I abl e			
		1.00		2.00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		30	10, 95	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4.00	HMO IRF Subprovider							4. 00 5. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0 0	
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation			30	10, 95	0.00		
7.00	beds) (see instructions)			30	10, 95	0.00	,	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)							12. 00
13. 00	NURSERY	43. 00					0	1
14. 00	Total (see instructions)			30	10, 95	0.00	0	14. 00
15.00	CAH visits						0	15. 00
16.00	SUBPROVI DER - I PF							16. 00
17.00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY	44. 00		0)	O	0	19. 00
20.00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE	00.00						24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00 26. 25	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 00 26. 25
27. 00	Total (sum of lines 14-26)	69.00		30			0	27. 00
28. 00	Observation Bed Days			30	'		0	
29. 00	Ambul ance Trips							29.00
30. 00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days (see Fristruction)							31. 00
32. 00	Labor & delivery days (see instructions)			0)		32. 00
32. 01	Total ancillary labor & delivery room			O				32. 01
52.01	outpatient days (see instructions)							02.01
33.00	LTCH non-covered days							33. 00
33. 01	LTCH site neutral days and discharges							33. 01
	-							

Title XVIII							5/28/2019 10:	24 am
No. Hospital Adults & Peds. (columns 5. 6. 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions) 1, 100			I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
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, 100		Component	Title XVIII	Title XIX				
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2. 00 Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 3. 00 HMO IPF Subprovider 4. 00 HOSP Subprovider 5. 00 Hospital Adults & Peds. Swing Bed SNF 6. 00 Hospital Adults & Peds. Swing Bed SNF 7. 00 Total Adults and Peds. (exclude observation beds) 8. 00 INTENSIVE CARE UNIT 8. 00 INTENSIVE CARE UNIT 9. 00 SURGICAL INTENSIVE CARE UNIT 10. 00 Unit NITENSIVE CARE UNIT 10. 00 Unit Special Care (Specify) 11. 00 Unit Special Care (Specify) 12. 00 Unit Special Care (Specify) 13. 00 Unit Special Care (Specify) 14. 00 Total (See instructions) 15. 00 Unit Special Care (Specify) 16. 00 Unit Special Care (Specify) 17. 00 Unit Special Care (Specify) 18. 00 Unit Special Care (Specify) 18. 00 Unit Special Care (Specify) 19. 00 Unit Special Care (Specify) 10. 00 Unit Special Care (Specify) 11. 00 Unit Special Care (Specify) 12. 00 Unit Special Care (Specify) 13. 00 Unit Special Care (Specify) 14. 00 Unit Special Care (Specify) 15. 00 Unit Special Care (Specify) 16. 00 Unit Special Care (Specify) 17. 00 Unit Care (Special Care (Specify) 18. 00 Unit Special Care (Specify) 18. 00 Unit Special Care (Specify) 19. 00 Unit Care (Special			6.00	7. 00				
2.00 HMO and other (see instructions)	1.00	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2	1, 157	47	4, 311			1.00
3.00	2 00		1 404	1 047				2 00
4. 00 HMO IRF Subprovider		` ′						
5.00		· ·	-	-1				
6. 00 Hospital Adults & Peds. Swing Bed NF 1, 157 47 4, 311 7. 00 1 1, 157		1 .	- 1	-	O	,		
7.00			Ĭ	-1	-			
9. 00 COROMARY CARE UNIT 10. 00 BURN INTENSIVE CARE UNIT 11. 00 SURGICAL INTENSIVE CARE UNIT 11. 00 THER SPECIAL CARE (SPECIFY) 11. 00 13. 00 NURSERY 15. 00 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 19. 00 NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 ORDER FEM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 10 HOSPICE (non-distinct part) 25. 00 CMC CARE 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 OBSERVATION BE GLOWN Green instruction) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 20. 00 Observation Bed Days 20. 00 Employee discount days (see instructions) 20. 01 Total ancillary labor & delivery room outpatient days (see instructions) 20. 00 Incled Incleded Subserved Company of the Compan		Total Adults and Peds. (exclude observation	1, 157		4, 311			
10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 1	8.00	INTENSIVE CARE UNIT						8. 00
11. 00 SURGI CAL INTENSIVE CARE UNIT 12. 00 17. 0	9.00	CORONARY CARE UNIT						9. 00
12. 00 OTHER SPECIAL CARE (SPECIFY)								1
13. 00 NURSERY 22 736 13. 00 14. 00 Total (see instructions) 1, 157 69 5, 047 0. 00 254. 00 14. 00 0 15. 00 0 0 15. 00 0 16. 00 0 16. 00 0 16. 00 17. 00 SUBPROVI DER - IPF 18. 00 SUBPROVI DER - IRF 18. 00 SUBPROVI DER IRF 18. 00 O O O O O O O O O								
14, 00								
15. 00 CAH visits		· ·						
16. 00 SUBPROVIDER - IPF 16. 00 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SKILLED NURSING FACILITY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 '	1, 157	69	5, 047	0.00	254. 00	1
17. 00 SUBPROVI DER - IRF 17. 00 18. 00 SUBPROVI DER 18. 00 18. 00 19. 00 SUBPROVI DER 18. 00 18. 00 19. 00		1	0	0	C)		1
18. 00 SUBPROVI DER 18. 00 19. 00 0 0 0 0 0 0 0 0 0		4						
19. 00 SKILLED NURSING FACILITY 0 0 0 0 0 0 0 0 0		4						
20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 Total (sum of lines 14-26) 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 20.00 21.00 22.00 21.00 22.00 23.00 24.10 25.00 0.00 0.00 0.00 0.00 0.00 0.00 0.		4						
21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 44. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 21. 00 22. 00 22. 00 23. 00 24. 10 25. 00 0 0 0 0 0. 00 0 0. 00 0 0. 00 0 0. 00 0 0. 00 254. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 01 33. 00 LTCH non-covered days 0 33. 00		4	0	0	C	0.00	0.00	
22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPI CE 24. 10 HOSPI CE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 26. 00 27. 00 Total (sum of lines 14-26) 28. 00 Observati on Bed Days 29. 00 Ambul ance Trips 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 00 22. 00 23. 00 24. 00 24. 00 25. 00 0 0 0 0 0. 00 0								
23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 29.00 Labor & delivery days (see instructions) 31.00 LTCH non-covered days 23.00 24.00 24.00 24.10 25.00 25.00 26.25 27.00 0.00 0.00 0.00 0.00 26.25 27.00 0.00 254.00 27.00 27.00 28.00 27.00 27.00 28.00 27.00 28.00 27.00 28.00 29.00 27.00 28.00 29.00		4						
24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 24. 00 24. 10 25. 00 26. 05 27. 00 0 0 0 0. 00 0		1						
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 24. 10 25. 00 26. 00 26. 00 0		1						
25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 PURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 30. 00 Semployee discount days 30. 00 Semployee discoun								
26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 26. 00 0 0 0 0 0. 00 0 0. 00 0 254. 00 27. 00 28. 00 0 29. 00 29. 00 29. 00 31. 00 31. 00 32. 01 32. 01 33. 00 33. 00 34. 01 35. 01 35. 01 35. 01 36. 00 37. 00 38. 00 39. 00 30. 00 31. 00 32. 01 33. 00 33. 00					73			
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0.00 26. 25 27. 00 Total (sum of lines 14-26) 0.00 254. 00 27. 00 28. 00 Observation Bed Days 113 1, 678 28. 00 29. 00 Ambul ance Trips 0 Employee discount days (see instruction) 92 30. 00 Employee discount days - IRF 0 31. 00 Labor & delivery days (see instructions) 0 54 113 32. 00 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 0 50 50 50 50 50 50 50 50 50 50 50 50 5		·						
27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 31.00 Total (sum of lines 14-26) 32.00 Ambulance Trips 33.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.00		•	_	_	_			
28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 31.00 Total ancillary labor & delivery room outpatient days (see instructions) 31.00 LTCH non-covered days 32.00 LTCH non-covered days		·	0	0	C			1
29.00 Ambulance Trips 0 29.00 30.00 Employee discount days (see instruction) 92 30.00 31.00 Employee discount days - IRF 0 0 31.00 32.00 Labor & delivery days (see instructions) 0 54 113 32.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 0 32.01 33.00 LTCH non-covered days 0 33.00				4.4.0	4 (70		254. 00	1
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 30.00 31.00 54 113 32.00 32.01 00 332.01 00 332.01		,		113	1, 678			
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 31.00 Sq. 00 Sq			0					1
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 32.00 32.01 0 32.01 0 33.00								
32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 0 32.01			_		•			1
outpati ent days (see instructions) 33.00 LTCH non-covered days 0 33.00			0	54	113			
33.00 LTCH non-covered days 0 33.00	32. 01				C			32. 01
	00.00							00.00
33.01 LICH SLIE Neutral days and discharges U								
	33. UI	LIGH Site neutral days and discharges	o _l			1		33. UI

					To 12/31/2018	Date/Time Pre 5/28/2019 10:	
		Full Time Equivalents		Di sc	harges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12. 00	13. 00	14.00	15. 00	
1. 00 2. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)		(54		1, 880	1. 00 2. 00
3. 00 4. 00 5. 00 6. 00 7. 00	HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)				0		3. 00 4. 00 5. 00 6. 00 7. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
14. 00 15. 00 16. 00 17. 00 18. 00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER	0.00	C) 45	23	1, 880	14. 00 15. 00 16. 00 17. 00 18. 00
19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00 26. 00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	0.00					19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00 26. 00
26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0.00					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 discharges			•			33. 00 33. 01

| Period: | Worksheet S-3 | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0101

					T	12/31/2018	Date/Time Prep	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.			5/28/2019 10:2 Average Hourly Wage (col. 4 ÷ col. 5)	24 alli
				A-6)	3)	col. 4	ŕ	
	PART II - WAGE DATA	1. 00	2. 00	3.00	4.00	5. 00	6. 00	
	SALARI ES							
1. 00	Total salaries (see instructions)	200. 00	17, 683, 072	4, 721, 015	22, 404, 087	691, 454. 00	32. 40	1. 00
2.00	Non-physician anesthetist Part		C	0	0	0.00	0. 00	2. 00
3. 00	Non-physician anesthetist Part		C	0	0	0. 00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		97, 247	0	97, 247	649. 00	149. 84	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		C C	0		0. 00 0. 00		4. 01 5. 00
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		C	o	0	0.00	0. 00	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	C	0	0	0.00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved programs)		C	o	О	0.00	0. 00	7. 01
8.00	Home office and/or related organization personnel		4, 720, 712	0	4, 720, 712	144, 646. 00	32. 64	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	1, 684, 157	0 13, 102	_	0. 00 80, 260. 00		9. 00 10. 00
10.00	instructions) OTHER WAGES & RELATED COSTS		1,004,137	13, 102	1,077,207	00, 200. 00	21.13	10.00
11. 00	Contract Labor: Direct Patient Care		C	0	0	0. 00	0. 00	11. 00
12. 00	Contract labor: Top level management and other management and administrative		C	0	0	0.00	0. 00	12. 00
13. 00	services Contract Labor: Physician-Part		C	0	0	0. 00	0. 00	13. 00
14. 00	A - Administrative Home office and/or related organization salaries and wage-related costs		C	0	0	0.00	0. 00	14. 00
14. 01	Home office salaries		4, 720, 712	0	4, 720, 712	144, 646. 00	32. 64	14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		C	0	0	0. 00 0. 00		14. 02 15. 00
16. 00	- Administrative Home office and Contract		C	0		0.00		16. 00
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see		6, 114, 571	0	6, 114, 571			17. 00
18. 00	instructions) Wage-related costs (other) (see instructions)		С	0	0			18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		644, 702 C	0	644, 702 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part B		C	0	0			21. 00
22. 00	Physician Part A - Administrative		C	0	0			22. 00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		C	0	0			22. 01 23. 00
24. 00	Wage-related costs (RHC/FQHC)		C	Ö	ő			24. 00
25. 00	Interns & residents (in an approved program)		0	0	0			25. 00
25. 50	Home office wage-related (core)		2, 634, 444		,			25. 50
25. 51 25. 52	Related organization wage-related (core) Home office: Physician Part A		C	0	0			25. 51 25. 52
25. 52	- Administrative - wage-related (core)		C					20.02
25. 53	Home office & Contract Physicians Part A - Teaching -		C	О	0			25. 53
	wage-related (core) OVERHEAD COSTS - DIRECT SALARIE	ES						
26. 00 27. 00	Employee Benefits Department Administrative & General	4. 00 5. 00	1, 776, 858 1, 508, 180			0. 00 17, 124. 00		26. 00 27. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/T

					''	0 12/31/2010	5/28/2019 10:	
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± 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		0	0	0	0.00	0. 00	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0.00		29. 00
30. 00	Operation of Plant	7. 00	373, 599	46, 612	420, 211	17, 882. 00		
31. 00	Laundry & Linen Service	8. 00	0	0	0	0.00		
32.00	Housekeepi ng	9. 00	417, 891	52, 138	470, 029	32, 643. 00	14. 40	
33. 00	Housekeeping under contract		0	0	0	0.00	0. 00	33. 00
	(see instructions)							
34. 00	Di etary	10. 00	464, 426	-273, 733	190, 693	10, 816. 00	17. 63	34.00
35. 00	Di etary under contract (see		0	0	0	0.00	0. 00	35. 00
	instructions)							
36. 00	Cafeteri a	11. 00	0	321, 339	321, 339	20, 128. 00	15. 96	36. 00
37. 00	Maintenance of Personnel	12. 00	0	0	0	0.00	0. 00	37. 00
38. 00	Nursing Administration	13. 00	379, 017	47, 288	426, 305	8, 881. 00	48. 00	38. 00
39. 00	Central Services and Supply	14. 00	0	0	0	0.00	0. 00	39. 00
40.00	Pharmacy	15. 00	604, 254	75, 389	679, 643	13, 704. 00	49. 59	40.00
41.00	Medical Records & Medical	16. 00	0	0	0	0.00	0. 00	41.00
	Records Library							
42.00	Soci al Servi ce	17. 00	0	0	0	0.00	0. 00	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2018 | Part III | To 12/31/2018 | Date/Time Prepared: | From (2014) | Prepared: |

					'	0 12/01/2010	5/28/2019 10:	
	·	Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	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, 962, 360	4, 721, 015	17, 683, 375	546, 808. 00	32. 34	1.00
	instructions)							
2.00	Excluded area salaries (see		1, 684, 157	13, 102	1, 697, 259	80, 260. 00	21. 15	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		11, 278, 203	4, 707, 913	15, 986, 116	466, 548. 00	34. 26	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		4, 720, 712	0	4, 720, 712	144, 646. 00	32. 64	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		8, 749, 015	0	8, 749, 015	0.00	54. 73	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		24, 747, 930	4, 707, 913	29, 455, 843	611, 194. 00	48. 19	6. 00
7.00	Total overhead cost (see		5, 524, 225	3, 401, 053	8, 925, 278	121, 178. 00	73. 65	7. 00
	instructions)							

WHITLEY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
Provi der CCN: 15-0101	Peri od: Worksheet S-3
	From 01/01/2018 Part IV

	To 12/31/2018		
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	310, 875	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	1, 525, 651	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	2, 791	6. 00
7.00	Employee Managed Care Program Administration Fees	43, 735	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3, 414, 535	8. 02
8.03	Health 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)	34, 832	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	78, 932	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	19, 032	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		
	TAXES		
17. 00	FICA-Employers Portion Only	1, 207, 948	17. 00
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	77, 643	21. 00
	instructions))		
22. 00	Day Care Cost and Allowances	0	22. 00
23.00		46, 090	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	6, 762, 064	24.00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Peri od: From 01/01/2018 To 12/31/2018		pared:
Cost Center Description		Contract Labor	Benefit Cost	

			5/28/2019 10: 3	24 am
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	6, 762, 064	1. 00
2.00	Hospi tal	0	6, 762, 064	2. 00
3.00	Subprovi der - I PF			3. 00
4.00	Subprovi der - I RF			4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swi ng Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF	0	0	8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11.00	Hospi tal -Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17. 00	Renal Dialysis			17.00
18. 00	Other	o	0	18. 00

	Financial Systems WHITLEY MEMORIAL HOSPITA		In Lie	u of Form CMS-2	
HOSPI 1	TAL UNCOMPENSATED AND INDIGENT CARE DATA Provid	er CCN: 15-0101	Peri od: From 01/01/2018	Worksheet S-1	0
			To 12/31/2018	Date/Time Pre	pared:
				5/28/2019 10:	24 am
				1. 00	
	Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by	y line 202 colum	n 8)	0. 220940	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	2, 159, 468			
3. 00 4. 00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplemental pay	Y	3. 00 4. 00		
5. 00	If line 4 is no, then enter DSH and/or supplemental payments from Med		aiu:	' o	5.00
6. 00	Medicaid charges	ii cai a		18, 249, 104	
7.00	Medicaid cost (line 1 times line 6)			4, 031, 957	
8.00	Difference between net revenue and costs for Medicaid program (line 7	minus sum of li	nes 2 and 5; if	1, 872, 489	8.00
	< zero then enter zero)				
0.00	Children's Health Insurance Program (CHIP) (see instructions for each	line)		27,000	0.00
9. 00 10. 00	Net revenue from stand-alone CHIP Stand-alone CHIP charges			27, 989 70, 647	1
11. 00	Stand-alone CHIP cost (line 1 times line 10)			15, 609	•
12. 00	Difference between net revenue and costs for stand-alone CHIP (line 1	1 minus line 9:	if < zero then	0	•
	enter zero)				
	Other state or local government indigent care program (see instruction				
13.00	Net revenue from state or local indigent care program (Not included of			2, 964, 559	
14. 00	Charges for patients covered under state or local indigent care progr 10)	am (Not included	in lines 6 or	23, 631, 941	14. 00
15. 00	State or local indigent care program cost (line 1 times line 14)			5, 221, 241	15. 00
16.00	Difference between net revenue and costs for state or local indigent	care program (li	ne 15 minus line	2, 256, 682	
	13; if < zero then enter zero)				
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)	state/local indi	gent care program	ns (see	
17.00		charity care		0	17. 00
18. 00	Government grants, appropriations or transfers for support of hospita			0	
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indig 8, 12 and 16)	jent care progran	ns (sum of lines	4, 129, 171	19.00
	10, 12 and 10)	Uni nsured	Insured	Total (col. 1	
		pati ents		+ col . 2)	
		1.00	2. 00	3. 00	
20. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility	1, 997, 4	137 651, 479	2, 648, 916	20 00
20.00	(see instructions)	1, 7,7,	031, 477	2,040,710	20.00
21. 00	Cost of patients approved for charity care and uninsured discounts (s	see 441, 3	651, 479	1, 092, 793	21.00
	instructions)				
22. 00	Payments received from patients for amounts previously written off as	,	6, 618	7, 524	22. 00
23. 00	charity care Cost of charity care (line 21 minus line 22)	440, 4	108 644, 861	1, 085, 269	23 00
20.00	Tooler of Grant (1116 21 million 1116 22)	1.107	011/001	17 0007 207	20.00
				1. 00	
			n of stay limit	N	24. 00
24. 00	Does the amount on line 20 column 2, include charges for patient days				
	imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indi		m's length of	0	25.00
25. 00	imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indi stay limit	gent care progra	nm's length of		
25. 00 26. 00	imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indi	gent care progra ons)	m's length of	13, 279, 381	26. 00
25. 00 26. 00 27. 00	imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indi stay limit Total bad debt expense for the entire hospital complex (see instructi	gent care progra ons) instructions)	m's length of		26. 00 27. 00
25. 00 26. 00 27. 00 27. 01	imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indi stay limit Total bad debt expense for the entire hospital complex (see instructi Medicare reimbursable bad debts for the entire hospital complex (see	gent care progra ons) instructions)	m's length of	13, 279, 381 98, 806 152, 009 13, 127, 372	26. 00 27. 00 27. 01 28. 00
26. 00 27. 00 27. 01 28. 00 29. 00	imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indistay limit Total bad debt expense for the entire hospital complex (see instructi Medicare reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt expense (gent care progra ons) instructions) tructions)	-	13, 279, 381 98, 806 152, 009 13, 127, 372 2, 953, 565	26. 00 27. 00 27. 01 28. 00 29. 00
25. 00 26. 00 27. 00 27. 01 28. 00 29. 00 30. 00	imposed on patients covered by Medicaid or other indigent care progralf line 24 is yes, enter the charges for patient days beyond the indistay limit Total bad debt expense for the entire hospital complex (see instructi Medicare reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see instructions)	gent care progra ons) instructions) tructions)	-	13, 279, 381 98, 806 152, 009 13, 127, 372	26. 00 27. 00 27. 01 28. 00 29. 00 30. 00

Heal th	Financial Systems	WHITLEY MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provi der CO		Period: From 01/01/2018 To 12/31/2018	Worksheet A Date/Time Pre 5/28/2019 10:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS				0/5 00/		
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP		4, 776, 972	4, 776, 97		3, 811, 966	1. 00 2. 00
3.00	00300 OTHER CAP REL COSTS		97, 000	97, 00	0 1, 780, 386 0 -97, 000		3.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 776, 858	5, 816, 264				
5.00	00500 ADMINISTRATIVE & GENERAL	1, 508, 180	24, 218, 024				1
6.00	00600 MAINTENANCE & REPAIRS	0	0)	0 0	0	6. 00
7.00	00700 OPERATION OF PLANT	373, 599	1, 430, 157			1, 744, 789	
8. 00 9. 00	O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING	417, 891	287, 373 173, 388			287, 373 641, 373	
10. 00	01000 DI ETARY	464, 426	309, 963			280, 966	
11. 00	01100 CAFETERI A	0	0	,,,,,,	0 540, 687	540, 687	1
12.00	01200 MAINTENANCE OF PERSONNEL	0	0		0 0	0	
13. 00	01300 NURSI NG ADMI NI STRATI ON	379, 017	3, 274	382, 29	1 47, 288		1
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	(04.254	100 (00	702.04	0 72 421	0 0 0 274	
16. 00	01600 MEDICAL RECORDS & LIBRARY	604, 254	188, 689 0	792, 94	3 73, 431 0 0	866, 374 0	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	Ö	0		o o	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	O	0		0 0	0	19. 00
20. 00	02000 NURSI NG SCHOOL	0	0		0 0	0	20. 00
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRV	0	0	1	0	0	21. 00
22. 00 23. 00	02200 1 & R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY)	0	0		0	0	22. 00 23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	U	0		<u>U</u>	0	23.00
30. 00	03000 ADULTS & PEDIATRICS	3, 038, 622	619, 211	3, 657, 83	3 -306, 329	3, 351, 504	30. 00
43.00	04300 NURSERY	0	0	1	0 272, 612	272, 612	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0		0 0	0	44. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	896, 480	369, 974	1, 266, 45	4 109, 527	1, 375, 981	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	89, 156	945			836, 198	
53. 00	05300 ANESTHESI OLOGY	0	971, 055			971, 055	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 852, 809	1, 096, 298				
60.00	06000 LABORATORY	O	3, 022, 460	3, 022, 46	0	3, 022, 460	
62. 30 65. 00	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY	655, 765	191, 923	847, 68	8 821	848, 509	62. 30 65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 251, 282	337, 435			868, 382	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 544, 024	544, 024	1
68. 00	06800 SPEECH PATHOLOGY	0	0		0 53, 395	53, 395	1
69.00	06900 ELECTROCARDI OLOGY	0	020.224	020.22	0	0 574 027	69.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	930, 224 0	930, 22	4 -355, 287 0 355, 287	574, 937 355, 287	1
	07300 DRUGS CHARGED TO PATIENTS	o	2, 319, 446	2, 319, 44			
	07697 CARDIAC REHABILITATION	0	0		0 0	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	712	2, 379				76. 98
76. 99	07699 LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	76. 99
90. 00	09000 CLINIC	O	0	1	0 0	0	90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	o	0		0 0	Ö	90. 01
91.00	09100 EMERGENCY	2, 689, 864	2, 122, 549	4, 812, 41	330, 175	5, 142, 588	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
05 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	1, 664, 738	401, 329	2, 066, 06	7 -1, 727	2, 064, 340	95. 00
73.00	SPECIAL PURPOSE COST CENTERS	1,004,730	401, 327	2,000,00	-1,727	2,004,340	75.00
118.00		17, 663, 653	49, 686, 332	67, 349, 98	5 -8, 025	67, 341, 960	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0 19, 670	34, 105			· ·	190.00
	07950 OCCUPATIONAL HEALTH	19, 670	754, 327 120				194. 00
	07951 PAIN CLINIC	Ö	0	1	o o		194. 01
194. 02	07952 OAK POINTE	o	0		0 0	0	194. 02
	07953 FOUNDATION	-303	0	-30			194. 03
	07954 COMMUNITY & VOLUNTEER SERVICES	52	135, 380	135, 43			
	07955 VACANT SPACE 07956 TELEHEALTH MEDICINE	0	10, 500	10, 50	0 0 0		194. 05 194. 06
200.00		17, 683, 072	50, 620, 764				
	, , , , , , , , , , , , , , , , , , , ,		, -,	, , , , , , , , , ,			

Peri od: From 01/01/2018 To 12/31/2018 Date/Ti me Prepared: 5/28/2019 10: 24 am

				5/28/2019 10: 24	4 am_
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
		6. 00	7. 00		
GEN	IERAL SERVICE COST CENTERS				
1.00 001	OO CAP REL COSTS-BLDG & FLXT	-2, 138, 512	1, 673, 454		1.00
2.00 002	200 CAP REL COSTS-MVBLE EQUIP	-185	1, 780, 201		2.00
3.00 003	300 OTHER CAP REL COSTS	o	o		3.00
	100 EMPLOYEE BENEFITS DEPARTMENT	-3, 036, 995	2, 779, 269		4.00
	500 ADMINISTRATIVE & GENERAL	-7, 643, 013	17, 783, 796		5. 00
	500 MAI NTENANCE & REPAI RS	7,043,013	17, 703, 770		6. 00
	700 OPERATION OF PLANT	-1	-		7. 00
		-105, 491	1, 639, 298		
	300 LAUNDRY & LINEN SERVICE	0	287, 373		8. 00
	POO HOUSEKEEPI NG	0	641, 373		9. 00
	000 DI ETARY	0	280, 966		10.00
11.00 011	IOO CAFETERI A	-142, 382	398, 305		11.00
12. 00 012	200 MAINTENANCE OF PERSONNEL	0	0		12.00
13.00 013	BOO NURSING ADMINISTRATION	ol	429, 579		13.00
4	100 CENTRAL SERVICES & SUPPLY	0	0		14.00
	500 PHARMACY	-708, 634	157, 740		15. 00
4	500 MEDICAL RECORDS & LIBRARY	700,004	137, 740		16. 00
		0	0		
1	700 SOCIAL SERVICE	0	0		17.00
	900 NONPHYSI CI AN ANESTHETI STS	0	0		19. 00
	000 NURSI NG SCHOOL	0	0		20. 00
21. 00 021	100 I&R SERVICES-SALARY & FRINGES APPRV	0	0		21. 00
22. 00 022	200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		22.00
23. 00 023	BOO PARAMED ED PRGM-(SPECIFY)	0	0		23.00
INP	PATIENT ROUTINE SERVICE COST CENTERS	•			
	000 ADULTS & PEDIATRICS	37, 223	3, 388, 727		30.00
	BOO NURSERY	0/,220	272, 612		43. 00
	100 SKILLED NURSING FACILITY	o	272,012		44. 00
		U	U		44.00
	CILLARY SERVICE COST CENTERS	0 (5/	4 047 005		F0 00
	OOO OPERATING ROOM	-8, 656	1, 367, 325		50. 00
	200 DELIVERY ROOM & LABOR ROOM	0	836, 198		52.00
53. 00 053	BOO ANESTHESI OLOGY	-958, 855	12, 200		53.00
54.00 054	100 RADI OLOGY-DI AGNOSTI C	-5	3, 111, 491		54.00
60.00 060	000 LABORATORY	0	3, 022, 460		60.00
62. 30 062	250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
	500 RESPI RATORY THERAPY	-75, 986	772, 523		65.00
	500 PHYSI CAL THERAPY	-359, 860	508, 522		66. 00
	700 OCCUPATI ONAL THERAPY	0	544, 024		67. 00
		0	•		
	300 SPEECH PATHOLOGY	U	53, 395		68. 00
1	900 ELECTROCARDI OLOGY	0	0		69. 00
1	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	574, 937		71. 00
	200 IMPL. DEV. CHARGED TO PATIENTS	0	355, 287		72.00
73. 00 073	BOO DRUGS CHARGED TO PATIENTS	0	2, 319, 446		73.00
76. 97 076	597 CARDIAC REHABILITATION	0	0		76. 97
76. 98 076	698 HYPERBARI C OXYGEN THERAPY	o	3, 180		76. 98
	599 LI THOTRI PSY	o	0		76. 99
	PATIENT SERVICE COST CENTERS	<u> </u>			
	DOO CLINIC	O	0		90. 00
	001 INTENSIVE OUT PATIENT PROGRAM	o	0		90. 00
1	1	ŀ			
4	OO EMERGENCY	-1, 319, 785	3, 822, 803		91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
	IER REI MBURSABLE COST CENTERS				
95.00 095	500 AMBULANCE SERVICES	-3, 968	2, 060, 372		95.00
SPE	CLAL PURPOSE COST CENTERS				
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	-16, 465, 104	50, 876, 856	1	118. 00
	IREI MBURSABLE COST CENTERS				
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	n	34, 105	1	190. 00
	200 PHYSICIANS' PRIVATE OFFICES	-339, 854	442, 593		192. 00
		-337,034			
	P50 OCCUPATIONAL HEALTH	O O	120		194.00
	P51 PAIN CLINIC	0	0		194. 01
	952 OAK POINTE	0	0		194. 02
	P53 FOUNDATI ON	0	-303		194. 03
194. 04 079	P54 COMMUNITY & VOLUNTEER SERVICES	-1, 341	133, 666	1	194. 04
	P55 VACANT SPACE	o	0	1	194. 05
	P56 TELEHEALTH MEDICINE	o	10, 500		194. 06
200. 00	TOTAL (SUM OF LINES 118 through 199)	-16, 806, 299	51, 497, 537		200. 00
200.00	1.1 (55 5. 225 116 till dagir 177)	. 5, 500, 277	3., 1,7, 007	l ²	

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/28/2019 10:24 am Provider CCN: 15-0101

					5/28/2019 10:	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	A - CAFETERIA RECLASS					
1.00	CAFETERI A	<u>11.</u> 00	321, 339	21 <u>9, 3</u> 48		1.00
	0		321, 339	219, 348		
	B - OB RECLASS					
1.00	NURSERY	43. 00	224, 061	48, 551		1. 00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	604, 079	130, 895		2. 00
	0		828, 140	179, 446		
	E - BUILDING AND EQUIP LEASE		<u> </u>	<u>.</u>		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	514, 008		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	118, 109		2. 00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	o	624		3. 00
4. 00	CAL REE COSTS BEDG & TTAT	0.00	Ö	0		4. 00
5. 00	1	0.00	0	0		5. 00
		l l	1	0		1
6.00	1	0.00	0	٥		6. 00
7. 00		0.00	0	0		7. 00
8. 00		0.00	0	0		8. 00
9. 00		0.00	0	0		9. 00
10. 00		0.00	0	0		10.00
11.00		0.00	0	0		11. 00
12.00		0.00	0	0		12. 00
13.00		0.00	0	0		13. 00
14. 00		0.00	Ö	Ō		14. 00
15. 00		0.00	Ö	0		15. 00
16. 00		0.00	Ö	0		16. 00
	1		· · · · · · · · · · · · · · · · · · ·	0		
17. 00		0.00	0	U		17. 00
18. 00		0.00	0	0		18. 00
	0		0	632, 741		
	G - INSURANCE RECLASS					
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	37, 513		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP		0	48, 126		2. 00
	0		0	85, 639		
	H - DEPRECIATION RECLASS			<u>.</u>		
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1, 614, 151		1. 00
	0			1, 614, 151		
	K - SALARY RECLASS	 		., ,		
1.00	ADMI NI STRATI VE & GENERAL	5. 00	4, 720, 712	0		1.00
	0		4, 720, 712	— — <u> </u>		
	L - REHAB THERAPY DEPT RECLAS	25	1, 720, 712	<u> </u>		
1.00	OCCUPATI ONAL THERAPY	67. 00	519, 762	24, 262		1.00
	1					1
2. 00	SPEECH PATHOLOGY		51, 012			2. 00
	U DEGLACO		570, 774	26, 645		
	N - PTO ACCRUAL RECLASS					
1. 00	ADMINISTRATIVE & GENERAL	5. 00	188, 166	0		1. 00
2.00	OPERATION OF PLANT	7.00	46, 612	0		2. 00
3.00	HOUSEKEEPI NG	9. 00	52, 138	0		3. 00
4.00	DI ETARY	10.00	57, 944	0		4. 00
5.00	NURSING ADMINISTRATION	13. 00	47, 288	0		5. 00
6.00	PHARMACY	15. 00	75, 389	0		6, 00
7. 00	ADULTS & PEDIATRICS	30.00	379, 110	0		7. 00
9. 00	OPERATING ROOM	50.00	111, 848	0		9. 00
10. 00	DELIVERY ROOM & LABOR ROOM	52. 00	11, 123	0		10.00
		· · · · · · · · · · · · · · · · · · ·	231, 163	U		4
11.00	RADI OLOGY-DI AGNOSTI C	54.00		0		11.00
12.00	RESPIRATORY THERAPY	65.00	81, 816	O		12.00
13. 00	PHYSI CAL THERAPY	66.00	156, 115	0		13. 00
14.00	HYPERBARIC OXYGEN THERAPY	76. 98	89	0		14. 00
16. 00	EMERGENCY	91.00	335, 596	0		16. 00
17.00	PHYSICIANS' PRIVATE OFFICES	192.00	2, 454	0		17. 00
18.00	COMMUNITY & VOLUNTEER	194. 04	7	0		18. 00
	SERVI CES					1
		+	1, 776, 858	— — _ō		1
	O - CLINIC DIETICIAN RECLASS		, .,	-		
1. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	10, 338	0		1.00
1. 50	0		10, 338	— — <u>ö</u>		55
	R - IMPLANTABLE MEDICAL SUPPL	IFS	10, 330	U		
1 00				255 207		1 00
1. 00	IMPL. DEV. CHARGED TO	72. 00	0	355, 287		1.00
	PATI ENTS	$\vdash \!\!\!\!\! +$	— — <u> </u> +			
	U LATERECT SYSSIES		0	355, 287		1
	S - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	•_	<u> </u>		1. 00
	0		0	97, 000		1
	T - RECLASS HOSPITALISTS TO A	ADULTS & PED				
1.00	ADULTS & PEDIATRICS	30. 00	0	327, 642		1.00
	TOTALS			327, 642		1
	'	. '			,	•

Heal th	Financial Systems		WHITLEY MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
RECLASS	SIFICATIONS			Provi der C	CCN: 15-0101	Peri od:	Worksheet A-	5
						From 01/01/2018	D 1 /T' D	
						To 12/31/2018	Date/Time Pro 5/28/2019 10:	
		Increases					372072017 10	24 0111
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3. 00	4. 00	5.00				
	U - RECLASS FOUNDATION SALARI	ES TO OTHER						
1.00	FOUNDATI ON	194.03	303	0				1. 00
	TOTALS		303	0				
500.00	Grand Total: Increases		8, 228, 464	3, 537, 899				500.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0101

						12/31/2018	5/28/2019 10: 24 am
		Decreases	6.1	0.11			
	Cost Center 6.00	Li ne # 7.00	Salary	Other	Wkst. A-7 Ref.		
	A - CAFETERIA RECLASS	7.00	8. 00	9. 00	10. 00		
1.00	DI ETARY	10.00	321, 339	219, 348	0		1. 00
	0		321, 339	219, 348			
	B - OB RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	828, 140	179, 446			1.00
2. 00		0.00	<u>0</u> 828, 140	00 179, 446	=		2. 00
	E - BUILDING AND EQUIP LEASE		020, 140	177, 440			
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0	58, 584	10		1.00
2.00	OPERATION OF PLANT	7. 00	o	105, 167	10		2. 00
3.00	RESPIRATORY THERAPY	65. 00	0	75, 590			3. 00
4.00	PHYSI CAL THERAPY	66. 00	0	274, 670			4. 00
5.00	ADMINISTRATIVE & GENERAL	5. 00	0	15, 696			5. 00
6. 00 7. 00	OPERATION OF PLANT HOUSEKEEPING	7. 00 9. 00	O O	412 2, 044			6. 00 7. 00
8.00	DI ETARY	10. 00	0	342			8. 00
9. 00	PHARMACY	15. 00	o	1, 958			9. 00
10.00	ADULTS & PEDIATRICS	30.00	o	5, 495			10. 00
11.00	OPERATING ROOM	50. 00	O	2, 321	0		11.00
12.00	RADI OLOGY-DI AGNOSTI C	54. 00	0	68, 774			12. 00
13. 00	RESPI RATORY THERAPY	65. 00	0	5, 405			13. 00
14.00	PHYSI CAL THERAPY	66.00	0	4, 361	0		14. 00
15. 00 16. 00	EMERGENCY AMBULANCE SERVICES	91. 00 95. 00	0	5, 421 1, 727	0		15. 00 16. 00
17. 00	PHYSICIANS' PRIVATE OFFICES	192.00	0	4, 342			17. 00
18. 00	COMMUNITY & VOLUNTEER	194. 04	Ö	432			18. 00
	SERVI CES						101.00
	0			632, 741			
	G - INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	85, 639			1.00
2.00		0.00		0	12		2. 00
	H - DEPRECIATION RECLASS		U	85, 639			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 614, 151	9		1. 00
	0		 	1, 614, 151			
	K - SALARY RECLASS						
1. 00	ADMI NI STRATI VE & GENERAL		0	<u>4, 720, 7</u> 12			1.00
	L - REHAB THERAPY DEPT RECLASS	<u> </u>	0	4, 720, 712			
1.00	PHYSICAL THERAPY	66.00	570, 774	26, 645	0		1.00
2. 00	THISTORE THERAIT	0.00	0	20, 043			2. 00
			570, 774				
	N - PTO ACCRUAL RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1, 776, 858	0			1.00
2. 00 3. 00		0. 00 0. 00	0	0	1		2.00
4.00		0.00	O O	0			3. 00 4. 00
5. 00		0.00	Ö	0			5. 00
6. 00		0.00	ō	0	0		6. 00
7.00		0.00	О	0	0		7. 00
9.00		0.00	0	0	0		9. 00
10. 00		0. 00	0	0	0		10. 00
11.00		0.00	0	0	0		11.00
12. 00 13. 00		0. 00 0. 00	O O	0	0		12. 00 13. 00
14. 00		0.00	0	0	0		14. 00
16. 00		0.00	o	0	o		16. 00
17. 00		0.00	o	0	0		17. 00
18.00	L	0.00	0	0			18. 00
	0		1, 776, 858	0			
1 00	O - CLINIC DIETICIAN RECLASS	10.00	10 220				1 00
1. 00	DI ETARY		1 <u>0, 338</u> 10, 338	0			1.00
	R - IMPLANTABLE MEDICAL SUPPLI	FS	10, 330				
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	355, 287	0		1.00
	PATI ENT						
	0		0	355, 287			
.	S - INTEREST EXPENSE	, T	1				
1. 00	OTHER CAP REL COSTS	3.00	0	97,000			1.00
	T - RECLASS HOSPITALISTS TO A	NIITO & DED	O	97, 000			
1. 00	ADMINISTRATIVE & GENERAL	5. 00	Ol	327, 642	n		1.00
50	TOTALS		 	327, 642			00
	. '		!	•	, '		1

Heal th Financial Systems

RECLASSIFICATIONS

Provider CCN: 15-0101
Period:
From 01/01/2018
To 12/31/2018
Pate/Time Prepared:
5/28/2019 10: 24 am

Decreases

Cost Center Line # Salary Other Wkst. A-7 Ref.

						5/28/2019 10	: 24 am	
		Decreases						
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.			
	6. 00	7. 00	8. 00	9. 00	10.00			
	U - RECLASS FOUNDATION SALARIES TO OTHER							
1.00	FOUNDATI ON	194. 03	0	303	(1. 00	
	TOTALS		0	303				
500.00	Grand Total: Decreases		3, 507, 449	8, 258, 914			500.00	

					То	12/31/2018	Date/Time Prep 5/28/2019 10:	pared: 24 am
				Acqui si ti ons	;		072072017 10.	e i aiii
		Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
		Bal ances					Retirements	
		1.00	2. 00	3. 00		4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	T BALANCES						
1.00	Land	260, 976	0		0	0	0	1.00
2.00	Land Improvements	2, 469, 451	23, 374		0	23, 374	0	2.00
3.00	Buildings and Fixtures	14, 608, 256	144, 309		0	144, 309	0	3.00
4.00	Building Improvements	48, 824	0		0	0	0	4. 00
5.00	Fixed Equipment	6, 267, 461	0		0	0	-3, 500	5. 00
6.00	Movable Equipment	15, 894, 301	951, 172		0	951, 172	367, 754	6.00
7.00	HIT designated Assets	3, 710, 657	49, 140		0	49, 140	0	7. 00
8.00	Subtotal (sum of lines 1-7)	43, 259, 926	1, 167, 995		0	1, 167, 995	364, 254	8. 00
9.00	Reconciling Items	3, 562, 578	-1, 281, 298		0	-1, 281, 298	0	9. 00
10.00	Total (line 8 minus line 9)	39, 697, 348	2, 449, 293		0	2, 449, 293	364, 254	10.00
		Endi ng Bal ance	Fully					
			Depreci ated					
			Assets					
		6. 00	7. 00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	260, 976	0					1. 00
2.00	Land Improvements	2, 492, 825	44, 862					2. 00
3.00	Buildings and Fixtures	14, 752, 565	238, 565					3. 00
4.00	Building Improvements	48, 824	48, 824					4. 00
5.00	Fi xed Equipment	6, 270, 961	57, 045					5. 00
6.00	Movable Equipment	16, 477, 719	6, 704, 100					6. 00
7.00	HIT designated Assets	3, 759, 797	0					7. 00
8.00	Subtotal (sum of lines 1-7)	44, 063, 667	7, 093, 396					8. 00
9.00	Reconciling Items	2, 281, 280	0					9. 00
10. 00	Total (line 8 minus line 9)	41, 782, 387	7, 093, 396					10. 00

Heal th	Financial Systems	WHITLEY MEMORI	IAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0101	Peri od:	Worksheet A-7	
					From 01/01/2018 To 12/31/2018		
			SL	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10.00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	IN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	4, 776, 972	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, 776, 972	0		0 0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	(SHEET A, COLUM	IN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	4, 776, 972				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
0 00				1		,	

0 0 0

4, 776, 972

1. 00 2. 00 3. 00

1.00 CAP REL COSTS-BLDG & FLX1
2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

Heal th	Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2018	Worksheet A-7 Part III	
					To 12/31/2018		pared: 24 am
		COMI	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio (col. 1 - col.	instructions)		
				2)	•		
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI						
1.00	CAP REL COSTS-BLDG & FLXT	27, 388, 730				0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	16, 674, 938					2. 00
3.00	Total (sum of lines 1-2)	44, 063, 668					3. 00
		ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY O	OF CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
		6.00	7. 00	8. 00	9. 00	10. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS	-				
1.00	CAP REL COSTS-BLDG & FIXT	0	0	(1, 024, 309		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	(1, 613, 966		
3.00	Total (sum of lines 1-2)	0	0		2, 638, 275	632, 741	3. 00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see			Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI						
1.00	CAP REL COSTS-BLDG & FIXT	0	,		97, 000		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0			0	1, 780, 201	2. 00
3. 00	Total (sum of lines 1-2)	0	85, 639		97, 000	3, 453, 655	3. 00

| Period: | Worksheet A-8 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Provi der CCN: 15-0101

				Ţ.	o 12/31/2018	Date/Time Prep 5/28/2019 10:2	
				Expense Classification on		3/28/2019 10.2	4 alli
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00 1. 00	5. 00 0	1. 00
2. 00	COSTS-BLDG & FLXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
	COSTS-MVBLE EQUIP (chapter 2)		0	CAP REE COSTS-WVBEE EQUIP			
3. 00	Investment income - other (chapter 2)		0		0. 00	0	3. 00
4.00	Trade, quantity, and time		0		0. 00	О	4. 00
5.00	discounts (chapter 8) Refunds and rebates of		0		0.00	О	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
	suppliers (chapter 8)		-				
7. 00	Tel ephone servi ces (pay stations excluded) (chapter		0		0. 00	0	7. 00
0.00	21)	Δ.	22.4	ODERATION OF DIANT	7 00	0	0.00
8. 00	Television and radio service (chapter 21)	A	-324	OPERATION OF PLANT	7. 00		8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -2, 281, 888		0. 00	0	9. 00 10. 00
	adj ustment	N 0 2					
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00
12. 00	Related organization transactions (chapter 10)	A-8-1	-8, 208, 560			0	12. 00
13. 00	Laundry and Linen service		0		0.00	0	13. 00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-142, 382	CAFETERI A	11. 00 0. 00	0	14. 00 15. 00
	and others		O				
16. 00	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	4E 720	PHARMACY	15. 00	0	17. 00
17.00	pati ents	В	-45, 720	PHARWACT	15.00		17.00
18. 00	Sale of medical records and abstracts		0		0. 00	0	18. 00
19. 00	Nursing and allied health		0		0. 00	0	19. 00
	education (tuition, fees, books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00	0	20. 00 21. 00
21.00	interest, finance or penalty		0		0.00	J	21.00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to						
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
	(chapter 21)					_	
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FLXT	1. 00	0	26. 00
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	•	29. 00 30. 00
00.00	therapy costs in excess of	7.00	0	OCCUPATIONAL THEIRA	07.00		00.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3		SPEECH PATHOLOGY	68. 00		31. 00
51.00	pathology costs in excess of	A-0-3	U	DI LEGIT I ATTIOLOGI	06.00		31.00
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0. 00	О	32. 00
	Depreciation and Interest INTEREST EXPENSE	_	2 052	ADMINISTRATIVE & GENERAL	5. 00		33. 00
<u></u>	INILALSI LAPENSE	A	3, 052	אוואוטאוואו אוואואוואוואוואוואוואוואוואוואוואו	ე. 00	્	JJ. UU

From 01/01/2018 | To 12/31/2018 | Date/Time Prepared:

				''	0 12/31/2010	5/28/2019 10:	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is			
					,		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4. 00	5. 00	
33. 01	TELEMETRY ADJUSTMENT	A	37, 225	ADULTS & PEDIATRICS	30.00	0	33. 01
35.00	POSTURE ASSESSMENTS	В	-85, 194	PHYSI CAL THERAPY	66.00	0	35. 00
36.00	ANESTHESIA PROFESSIONAL FEES	A	0	ANESTHESI OLOGY	53.00	0	36. 00
37.00	MI SC REVENUE	В	0	RADI OLOGY-DI AGNOSTI C	54.00	0	37. 00
38.00	NON-PATIENT LAB REV.	В	-396	RESPI RATORY THERAPY	65.00	0	38. 00
39.00	TELEVISION OFFSET	A	-185	CAP REL COSTS-MVBLE EQUIP	2.00	9	39. 00
40.00	ANSWERING SERVICE	A	-1, 897	ADMINISTRATIVE & GENERAL	5. 00	0	40. 00
41.00	PHYSICIAN RECRUITING	A	-24, 999	ADMINISTRATIVE & GENERAL	5. 00	0	41.00
42.00	MEALS ON WHEELS	A	0		0.00	0	42.00
43.00	VISITOR MEALS	A	0	CAFETERI A	11. 00	0	43.00
44.00	PHARMACY SALES	A	-656, 171	PHARMACY	15. 00	0	44.00
45.00	HAF EXPENSE ADJUSTMENT	A	-1, 637, 099	ADMINISTRATIVE & GENERAL	5. 00	0	45. 00
46.00	SELF INSURANCE	A	-3, 036, 995	EMPLOYEE BENEFITS DEPARTMENT	4.00	О	46. 00
48. 00	LOBBY EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	О	48. 00
48. 01	LOBBY EXPENSE	A	-1, 341	COMMUNITY & VOLUNTEER	194. 04	О	48. 01
			•	SERVI CES			
48. 02	LOBBY EXPENSE	A	-5	RADI OLOGY-DI AGNOSTI C	54.00	0	48. 02
48. 03	LOBBY EXPENSE	A	-2	ADULTS & PEDIATRICS	30.00	0	48. 03
48. 04	INTERUNIT RENT EXPENSE	A	-75, 590	RESPI RATORY THERAPY	65.00	0	48. 04
48. 05	INTERUNIT RENT EXPENSE	A	-274, 666	PHYSI CAL THERAPY	66.00	0	48. 05
48. 06	INTERUNIT RENT EXPENSE	A	-58, 584	ADMINISTRATIVE & GENERAL	5. 00	0	48. 06
48. 07	INTERUNIT RENT EXPENSE	A	-105, 167	OPERATION OF PLANT	7. 00	0	48. 07
48. 08	LIQUOR	A	-1, 251	ADMINISTRATIVE & GENERAL	5. 00	0	48. 08
48. 09	PHYS ADMIN SAL ADD BACK	A	152, 464	ADMINISTRATIVE & GENERAL	5. 00	0	48. 09
49.00	RENT EXPENSE - PHYSICIANS'	A	-339, 854	PHYSICIANS' PRIVATE OFFICES	192.00	0	49. 00
	CLINIC						
49. 01	OPERATING INTEREST	A	-6, 743	PHARMACY	15. 00	0	49. 01
49. 02	OPERATING INTEREST	A	-8, 656	OPERATING ROOM	50.00	0	49. 02
49. 03	MI SC REVENUE	В	-720	AMBULANCE SERVICES	95.00	0	49. 03
49. 07	MI SC REVENUE	В	0	OPERATING ROOM	50.00	0	49. 07
50.00	TOTAL (sum of lines 1 thru 49)		-16, 806, 299				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

 ⁽²⁾ Basis for adjustment (see instructions).
 A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

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

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

Heal th	Financial Systems	WHITLEY MEMOR	RIAL HOSPITAL	In Lie	eu of Form CMS-	2552-10
		RELATED ORGANIZATIONS AND HOM		Peri od:	Worksheet A-8	3-1
OFFICE	COSTS			From 01/01/2018 To 12/31/2018		epared:
					5/28/2019 10:	24 am_
	Li ne 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 ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	GANIZATIONS 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	10, 279, 702	2. 00
3.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	15, 153, 346	10, 158, 996	3. 00
4.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE INTEREST EXPENSE	0	784, 696	4.00
5.00	TOTALS (sum of lines 1-4).			15, 153, 346	23, 361, 906	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.

 The best posted to normalize the contains that and of 21 the amount arronable choard be that cated the contains the time parti-									
			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. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME 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	В	0. 00 PARKVI EW HEALTH 100. 00	6. 00
7.00		0.00	7. 00
8.00		0.00	8. 00
9.00		0.00	9. 00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

Transfer column 6, line 5 to Worksheet A-8, column 2,

line 12.

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems			WHITLEY MEMORIAL HOSPITAL				In Lieu of Form CMS-2552-1				
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED (ORGANI ZATI ON	S AND HOME	Provi der	CCN:	15-0101	Peri od:	Worksheet	A-8-1
OFFICE	COSTS								From 01/01/2018		_
									To 12/31/2018	Date/Time	Prepared:
	No+	Wkst. A-7 Ref.								5/28/2019	10: 24 alli
		WKSt. A-7 Rei.									
	Adjustments										
	(col. 4 minus										
	col. 5)*										
	6. 00	7. 00									
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQU	UIRED AS A R	ESULT OF TRA	NSACTI ONS	WITH	I RELATED C	RGANIZATIONS OR (CLAIMED	
	HOME OFFICE CO	STS:									
1.00	-2, 138, 512	9									1.00
2.00	-10, 279, 702	0									2.00
3.00	4, 994, 350	0									3.00
4.00	-784, 696	0									4.00
5.00	-8, 208, 560										5. 00
* The	amounts on line	es 1-4 (and sub	scripts a	as appropria	te) are tran	sferred ir	det	ail to Wor	ksheet A, column	6, lines as	 S
									ganization or hom		
has not	been posted to	o Worksheet A,	columns 1	I and/or 2,	the amount a	llowable s	shoul	d be indic	ated in column 4	of this par	rt.
	Related Orga	ani zati on(s)									
	and/or Ho	me 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.

	HOME OFFICE	6. 00
7.00		7. 00
8.00		8. 00
8. 00 9. 00		9. 00
10.00		10.00
10. 00 100. 00		100.00

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

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

Type of Business

- 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.

					'	12/31/2010	5/28/2019 10:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		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	1, 368, 999	1, 298, 999	70, 000	211, 500	484	1. 00
2.00	53. 00	ANESTHESI OLOGY	971, 055		18, 000	239, 400	106	2. 00
3.00	95. 00	AMBULANCE SERVICES	9, 247	0	9, 247	211, 500	59	3. 00
4.00	0.00		0		0	0	0	4. 00
5.00	0.00		0	0	0	0	0	5. 00
6.00	0.00		0	0	0	0	0	6. 00
7.00	0.00		0	0	0	0	0	7. 00
8.00	0.00		0	0	0	0	0	8. 00
9.00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			2, 349, 301	2, 252, 054	97, 247		649	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Continuing	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8.00	9. 00	12. 00	13. 00	14. 00	
1.00		EMERGENCY	49, 214		0	0	0	1. 00
2.00	53.00	ANESTHESI OLOGY	12, 200			0	0	
3.00		AMBULANCE SERVICES	5, 999	300	0	0	0	
4.00	0.00	1	0	0	0	0	0	
5.00	0.00		0	0	0	0	0	5. 00
6.00	0. 00		0	0	0	0	0	6. 00
7.00	0.00		0	0	0	0	0	7. 00
8.00	0. 00		0	0	0	0	0	8. 00
9.00	0. 00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10. 00
200.00			67, 413		0	0	0	200. 00
	Wkst. A Line #	1	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	4.00	0.00	14	1/ 00	47.00	10.00		
1 00	1.00	2.00	15. 00	16. 00	17. 00	18.00		4 00
1.00		EMERGENCY	0	1		1, 319, 785		1.00
2.00		ANESTHESI OLOGY	0			958, 855		2. 00
3.00		AMBULANCE SERVICES	0	5, 999		3, 248		3. 00
4.00	0.00		0	0	0	0		4. 00
5.00	0.00		0	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	0 004 000		10.00
200. 00	l	I	0	67, 413	29, 834	2, 281, 888	l	200. 00

Heal th	Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	ILLOCATION - GENERAL SERVICE COSTS		Provi der CC	CN: 15-0101 Pe Fr To	eriod: com 01/01/2018	Worksheet B Part I Date/Time Pre 5/28/2019 10:	pared:
	Cost Center Description	Net Expenses for Cost Allocation	CAPITAL REL	ATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		(from Wkst A col. 7)					
	T	0	1. 00	2.00	4. 00	4A	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT	1, 673, 454	1, 673, 454				1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	1, 780, 201	1,073,434	1, 780, 201			2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 779, 269	0	0	2, 779, 269		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	17, 783, 796	520, 972	554, 207	796, 047	19, 655, 022	5. 00
6.00	00600 MAI NTENANCE & REPAI RS	1 (30 300	121 (05	120, 242	0 50, 100	1 042 202	6.00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE	1, 639, 298 287, 373	121, 605 5, 682	129, 362 6, 044	52, 128 0	1, 942, 393 299, 099	7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	641, 373	4, 749		58, 308	709, 482	9.00
10.00	01000 DI ETARY	280, 966	20, 358	21, 657	23, 656	346, 637	10.00
11.00	01100 CAFETERI A	398, 305	22, 958	·	39, 863	485, 549	11.00
12. 00 13. 00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	429, 579	0 1, 384	0 1, 472	0 52, 884	0 485, 319	12. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	429, 379	16, 438	17, 486	52, 664	33, 924	14. 00
15. 00	01500 PHARMACY	157, 740		15, 155	84, 311	271, 453	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	5, 063	5, 386	0	10, 449	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00 19. 00
19. 00 20. 00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV	0	Ö	o	Ö	0	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	3, 388, 727	222, 370	236, 554	321, 244	4, 168, 895	30. 00
43. 00	04300 NURSERY	272, 612	0	230, 334	27, 795	300, 407	43. 00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
EO 00	ANCI LLARY SERVI CE COST CENTERS	1 2/7 225	122 001	141 272	125 005	1 7// 402	FO 00
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	1, 367, 325 836, 198	132, 801 0	141, 272 0	125, 085 87, 377	1, 766, 483 923, 575	50. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	12, 200	Ö	o	0,,0,,	12, 200	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 111, 491	178, 445		258, 521	3, 738, 285	1
60.00	06000 LABORATORY	3, 022, 460	31, 104	33, 088	0	3, 086, 652	60.00
62. 30 65. 00	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY	772, 523	24, 594	0 26, 162	91, 498	0 914, 777	62. 30 65. 00
66. 00	06600 PHYSI CAL THERAPY	508, 522	145, 266	154, 532	103, 785	912, 105	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	544, 024	0	0	64, 478	608, 502	67. 00
68. 00	06800 SPEECH PATHOLOGY	53, 395	0	0	6, 328	59, 723	68. 00
69. 00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	574, 937	0	0	0	0 574, 937	69.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	355, 287	0	0	0	355, 287	
	07300 DRUGS CHARGED TO PATIENTS	2, 319, 446	0	0	0	2, 319, 446	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	3, 180	0	0	99 0	3, 279 0	76. 98 76. 99
70. 77	OUTPATIENT SERVICE COST CENTERS		J	3		0	70. 77
90.00	09000 CLI NI C	0	0	0	0	0	90. 00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0	142.742	172 144	275 214	4 524 022	90. 01
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 822, 803	162, 762	173, 144	375, 314	4, 534, 023 0	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS					0	72.00
95.00	09500 AMBULANCE SERVI CES	2, 060, 372	0	0	206, 514	2, 266, 886	95. 00
118. 00	SPECIAL PURPOSE COST CENTERS	50, 876, 856	1 (20 700	1 724 024	2 775 225	FO 704 700	110 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	50, 876, 856	1, 630, 798	1, 734, 824	2, 775, 235	50, 784, 789	1118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	34, 105	3, 019		0	40, 336	1
	19200 PHYSICIANS' PRIVATE OFFICES 07950 OCCUPATIONAL HEALTH	442, 593 120	36, 649	38, 987	4, 027	522, 256 120	192. 00 194. 00
	07950 OCCOPATIONAL HEALTH	120	0	0	0		194. 00
	07952 OAK POINTE	0	Ö	o	ő	0	194. 02
	07953 FOUNDATION	-303	0	0	o		194. 03
	07954 COMMUNITY & VOLUNTEER SERVICES	133, 666	2, 988	3, 178	7	139, 839	
	07955 VACANT SPACE 07956 TELEHEALTH MEDICINE	10, 500	0	0	O O	10, 500	194. 05 194. 06
200.00		10, 300	J	١			200. 00
201.00	Negative Cost Centers		0	0	_ 0	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	51, 497, 537	1, 673, 454	1, 780, 201	2, 779, 269	51, 497, 537	202. 00

					T	o 12/31/2018	Date/Time Pre 5/28/2019 10:	
	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE 8	& OF	PERATION OF	LAUNDRY &	HOUSEKEEPI NG	24 0111
		& GENERAL	REPAI RS		PLANT	LINEN SERVICE		
	GENERAL SERVICE COST CENTERS	5. 00	6. 00	_	7. 00	8. 00	9. 00	
1. 00	00100 CAP REL COSTS-BLDG & FIXT			Т				1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP			İ			1	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						1	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	19, 655, 022					ı	5. 00
6.00	00600 MAINTENANCE & REPAIRS	0		0			1	6. 00
7. 00	00700 OPERATION OF PLANT	1, 198, 944		0	3, 141, 337		ı	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	184, 619		0	17, 314	501, 032	4 4/4 004	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	437, 928			14, 471	0	1, 161, 881	9. 00 10. 00
11. 00	01100 CAFETERI A	213, 962 299, 706			62, 037 69, 959	0	23, 180 26, 140	11.00
12. 00	01200 MAI NTENANCE OF PERSONNEL	277,700		0	07, 737	0	20, 140	12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	299, 564		o	4, 217	O	1, 576	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	20, 940		0	50, 090	0	18, 716	14. 00
15.00	01500 PHARMACY	167, 555		0	43, 413	0	16, 221	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	6, 450		0	15, 429	0	5, 765	16. 00
17. 00	01700 SOCIAL SERVICE	0		0	0	0	0	17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0			0	0	0	19.00
20. 00 21. 00	02000 NURSI NG SCHOOL 02100 I &R SERVI CES-SALARY & FRI NGES APPRV	0			0	0	0	20. 00 21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0			0	0	0	22.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	l o		o	0	o	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	-1		-		-1		
30.00	03000 ADULTS & PEDIATRICS	2, 573, 255		0	677, 617	22, 564	253, 190	30. 00
43.00	04300 NURSERY	185, 427		0	0	34, 829	0	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0		0	0	0	0	44. 00
F0 00	ANCILLARY SERVICE COST CENTERS	4 000 0/0		ما	404 (70	50.074	454 000	F0 00
50.00	05000 OPERATING ROOM	1, 090, 363		0	404, 678 0		151, 208 0	50.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	570, 078 7, 530			0	94, 040	0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 307, 460		0	543, 767	79, 018	203, 178	54. 00
60. 00	06000 LABORATORY	1, 905, 239		0	94, 781	54	35, 415	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	564, 647		0	74, 943	2, 158	28, 002	65. 00
66. 00	06600 PHYSI CAL THERAPY	562, 998		0	442, 661	17, 212	165, 400	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	375, 598		0	0	13, 148	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	36, 864		0	0	1, 291	0	68. 00
69. 00 71. 00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0 354, 880			0	0	0	69. 00 71. 00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	219, 301			0	0	0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 431, 680		0	0	0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0		o	0	O	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	2, 024		0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0		0	0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS	1						
90.00	09000 CLINIC	0		0	0	0	0	90.00
90. 01	O9001 INTENSIVE OUT PATIENT PROGRAM O9100 EMERGENCY	2, 798, 641			0 495, 977	152 500	0 185, 321	90. 01 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 790, 041		٩	493, 977	152, 509	100, 321	91.00
72.00	OTHER REIMBURSABLE COST CENTERS							72.00
95. 00	09500 AMBULANCE SERVI CES	1, 399, 238		o	0	31, 335	0	95. 00
	SPECIAL PURPOSE COST CENTERS							
118.00		19, 214, 891		0	3, 011, 354	501, 032	1, 113, 312	118. 00
	NONREI MBURSABLE COST CENTERS	,						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	24, 897		0	9, 200		3, 438	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	322, 363		0	111, 679	0	41, 729	
	DO7950 OCCUPATIONAL HEALTH DO7951 PAIN CLINIC	74			0	0		194. 00 194. 01
	2 07952 OAK POINTE	0			0	0		194. 01
	3 O7953 FOUNDATION	0		0	0	0		194. 03
	107954 COMMUNITY & VOLUNTEER SERVICES	86, 316		0	9, 104	o		194. 04
	07955 VACANT SPACE	0		О	0	o		194. 05
194.06	07956 TELEHEALTH MEDICINE	6, 481		0	0	О	0	194. 06
200.00							1	200. 00
201.00		0		0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	19, 655, 022		0	3, 141, 337	501, 032	1, 161, 881	1202.00

			'	0 12/31/2010	5/28/2019 10:	
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF		CENTRAL	
			PERSONNEL	ADMI NI STRATI ON	SERVI CES & SUPPLY	
	10.00	11. 00	12. 00	13.00	14. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 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 ADMINISTRATIVE & GENERAL						5. 00
6. 00 00600 MAI NTENANCE & REPAI RS						6.00
7.00 00700 0PERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY	645, 816					10. 00
11. 00 01100 CAFETERI A	0	881, 354				11. 00
12.00 01200 MAINTENANCE OF PERSONNEL	o	0	(12.00
13.00 O1300 NURSING ADMINISTRATION	0	17, 619	(808, 295		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	(0	123, 670	14. 00
15. 00 01500 PHARMACY	0	27, 043	(0	2, 983	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	9	0	0	16.00
17. 00 01700 SOCI AL SERVI CE 19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0	(0	17. 00 19. 00
20. 00 02000 NURSI NG SCHOOL	0	0			0	20. 00
21. 00 02100 I &R SERVI CES-SALARY & FRI NGES APPRV	0	0			0	21. 00
22. 00 02200 &R SERVI CES-OTHER PRGM COSTS APPRV	Ö	0		o o	0	22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	o	0		o	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS				'		
30. 00 03000 ADULTS & PEDIATRICS	645, 816	140, 541	(276, 141	1, 804	30. 00
43. 00 04300 NURSERY	0	12, 702			2, 784	43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0	0	(0	0	44. 00
ANCILLARY SERVICE COST CENTERS	ما	F0. 002		115 021	12.0/5	F0 00
50.00 05000 0PERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	59, 003 34, 828			13, 965 7, 512	50. 00 52. 00
53. 00 05300 ANESTHESI OLOGY	0	34, 626 A			7, 512	53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	124, 971		´l	6, 313	54. 00
60. 00 06000 LABORATORY	o	0		ol ol	0,010	60. 00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	О	0	(o	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	0	38, 516	(0	5, 506	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	60, 642	(0	1, 016	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	24, 584	(0	776	67. 00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	5, 327			0	68. 00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	O O	0			0 50, 331	69. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			0, 331	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	Ö	0		o o	4, 656	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	o	0		o	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	o	0	(o	129	76. 98
76. 99 07699 LI THOTRI PSY	0	0	(0	0	76. 99
OUTPATIENT SERVICE COST CENTERS			T			
90. 00 09000 CLI NI C	0	0	(0	90.00
90. 01 09001 NTENSI VE OUT PATI ENT PROGRAM 91. 00 09100 EMERGENCY	0	0 177, 008		0 347, 792	0 17, 257	90. 01 91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART	٩	177,006	1	347, 792	17, 237	91.00
OTHER REIMBURSABLE COST CENTERS			l			72.00
95. 00 09500 AMBULANCE SERVI CES	O	142, 590	(0	7, 106	95. 00
SPECIAL PURPOSE COST CENTERS				, -,	,	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	645, 816	865, 374	(808, 295	122, 138	118. 00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	9, 834			152	192. 00
194. 00 07950 OCCUPATI ONAL HEALTH	0	0	(1		194. 00
194. 01 07951 PALN CLINIC 194. 02 07952 OAK POLNTE	0	0	(1		194. 01 194. 02
194. 03 07953 FOUNDATION	0	6, 146		1		194. 02 194. 03
194. 04 07954 COMMUNITY & VOLUNTEER SERVICES	ol Ol	0, 140 N				194. 03
194. 05 07955 VACANT SPACE	0	0				194. 05
194. 06 07956 TELEHEALTH MEDICINE	o	0		ol ol		194. 06
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	o	0	(201. 00
202.00 TOTAL (sum lines 118 through 201)	645, 816	881, 354	(808, 295	123, 670	202. 00

			'	0 12/31/2010	5/28/2019 10:	
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						
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
6.00 00600 MAINTENANCE & REPAIRS						6. 00
7.00 O0700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11. 00
12.00 O1200 MAINTENANCE OF PERSONNEL						12. 00
13.00 O1300 NURSING ADMINISTRATION						13. 00
14.00 O1400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00 01500 PHARMACY	528, 668					15. 00
16.00 O1600 MEDICAL RECORDS & LIBRARY	0	38, 093				16. 00
17. 00 01700 SOCI AL SERVI CE	0	0	0			17. 00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0		19. 00
20. 00 02000 NURSI NG SCHOOL	0	0	0		0	20. 00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21. 00
22.00 02200 1 &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22. 00
23.00 O2300 PARAMED ED PRGM-(SPECIFY)	0	0	0			23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	54	2, 015	0	0	0	30. 00
43. 00 04300 NURSERY	0	358	0	0		43. 00
44.00 O4400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 302	438	0	0	1	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	1	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	387	14, 056	0	0	0	54.00
60. 00 06000 LABORATORY	0	0	0	0	0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	0	0	0	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	348	4, 129		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 169	0	0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0	305	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	522, 688	0	0	0	0	73. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	_	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS				1		
90. 00 09000 CLI NI C	0	0	0			90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0		_		90. 01
91. 00 09100 EMERGENCY	1, 499	15, 623	0	0	0	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS	0.050			_		
95. 00 09500 AMBULANCE SERVI CES	2, 359	0	0	0	0	95. 00
SPECIAL PURPOSE COST CENTERS	500 (07			_		
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	528, 637	38, 093	0	0	0	118. 00
NONREI MBURSABLE COST CENTERS	_		_	_	_	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	31	0		_		192. 00
194. 00 07950 OCCUPATI ONAL HEALTH	0	0	0	_		194. 00
194. 01 07951 PAIN CLINIC	0	0	0	_		194. 01
194. 02 07952 OAK POI NTE	0	0	0	_		194. 02
194. 03 07953 FOUNDATI ON	0	0	0	_		194. 03
194. 04 07954 COMMUNITY & VOLUNTEER SERVICES	0	0	0	_		194. 04
194. 05 07955 VACANT SPACE	0	0	0	_		194. 05
194. 06 07956 TELEHEALTH MEDICINE	0	0	0	0		194. 06
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers	0	0	0			201. 00
202.00 TOTAL (sum lines 118 through 201)	528, 668	38, 093	0	0	0	202. 00

| Period: | Worksheet B | From 01/01/2018 | Part | To | 12/31/2018 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0101

				o 12/31/2018	Date/Time Pre	
	INTERNS &	RESI DENTS			5/28/2019 10:	24 am
Cost Center Description	SERVI CES-SALAR	SEDVICES OTHER	PARAMED ED	Subtotal	Intern &	
cost deliter bescription	Y & FRINGES	PRGM COSTS	PRGM	Subtotal	Residents Cost	
	APPRV	APPRV			& Post Stepdown	
					Adjustments	
	21. 00	22. 00	23. 00	24. 00	25. 00	
GENERAL SERVICE COST CENTERS 1.00 O0100 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 ADMI NI STRATI VE & GENERAL 6. 00 00600 MAI NTENANCE & REPAI RS						5. 00 6. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY						9. 00 10. 00
11. 00 01100 CAFETERI A						11. 00
12. 00 01200 MAI NTENANCE OF PERSONNEL						12.00
13.00 O1300 NURSI NG ADMINI STRATI ON 14.00 O1400 CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
15. 00 01500 PHARMACY						15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY						16.00
17. 00 01700 SOCI AL SERVI CE 19. 00 01900 NONPHYSI CI AN ANESTHETI STS						17. 00 19. 00
20. 00 02000 NURSI NG SCH00L						20. 00
21. 00 02100 1 &R SERVI CES-SALARY & FRINGES APPRV	0	0				21. 00
22.00 02200 1 &R SERVICES-OTHER PRGM COSTS APPRV 23.00 02300 PARAMED ED PRGM-(SPECIFY)		0				22. 00 23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS 43. 00 04300 NURSERY	0	0			0 0	30. 00 43. 00
44.00 04400 SKI LLED NURSING FACILITY	0	0				44. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				50. 00 52. 00
53. 00 05300 ANESTHESI OLOGY	0	0				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	C			54. 00
60.00 06000 LABORATORY 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0, 122, 111	0	60. 00 62. 30
65. 00 06500 RESPI RATORY THERAPY	0	0		1	1	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	C	2, .00, 0	0	66. 00
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	0	0		.,,	0	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	Ö	Ö			ő	69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(980, 148		71.00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0		574, 588 4, 278, 470		72. 00 73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	Ö	Ö	Č		0	76. 97
76. 98 O7698 HYPERBARI C OXYGEN THERAPY	0	0		· ·	0	76. 98
76. 99 07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	U	0) 0	0	76. 99
90. 00 09000 CLI NI C	0	0	C	0	0	90. 00
90.01 09001 INTENSIVE OUT PATIENT PROGRAM 91.00 09100 EMERGENCY	0	0			0	90. 01 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0, 723, 030	0	92. 00
OTHER REIMBURSABLE COST CENTERS	_				_	
95. 00 09500 AMBULANCE SERVI CES SPECI AL PURPOSE COST CENTERS	0	0	C	3, 849, 514	0	95. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	C	50, 148, 563	0	118. 00
NONREI MBURSABLE COST CENTERS				70.00/		400.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0				190. 00 192. 00
194. 00 07950 OCCUPATI ONAL HEALTH	0	0	d	194	0	194. 00
194. 01 07951 PALN CLINIC	0	0	0	0		194. 01 194. 02
194. 02 07952 OAK POLNTE 194. 03 07953 FOUNDATI ON	0	0		5, 843		194. 02 194. 03
194.04 07954 COMMUNITY & VOLUNTEER SERVICES	O	0		238, 706	0	194. 04
194. 05 07955 VACANT SPACE 194. 06 07956 TELEHEALTH MEDICINE	0	0		14 001		194. 05 194. 06
200.00 Cross Foot Adjustments	0	0) 16, 981) 0		200. 00
201.00 Negative Cost Centers	0	0	C		0	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	0	(51, 497, 537	0	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS WHITLEY MEMORIAL HOSPITAL

Provider CCN: 15-0101

				5/28/2019 10:	
		Cost Center Description	Total		
	CENED	NI CEDVICE COST CENTEDS	26. 00		
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT			1.00
2.00		CAP REL COSTS-BLDG & FIXT			2.00
4.00		EMPLOYEE BENEFITS DEPARTMENT			4. 00
5. 00	1	ADMINISTRATIVE & GENERAL			5. 00
6. 00	1	MAINTENANCE & REPAIRS			6. 00
7. 00	1	OPERATION OF PLANT			7. 00
8.00	1	LAUNDRY & LINEN SERVICE			8. 00
9. 00	1	HOUSEKEEPI NG			9. 00
10.00	1	DI ETARY			10.00
11. 00	1	CAFETERI A			11. 00
12. 00	1	MAINTENANCE OF PERSONNEL			12.00
13.00	1	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00		PHARMACY			15. 00
16.00	01600	MEDICAL RECORDS & LIBRARY			16. 00
17.00	01700	SOCIAL SERVICE			17. 00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19. 00
20.00	02000	NURSI NG SCHOOL			20. 00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21. 00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22. 00
23. 00	02300	PARAMED ED PRGM-(SPECIFY)			23. 00
	I NPAT	ENT ROUTINE SERVICE COST CENTERS			
30.00		ADULTS & PEDIATRICS	8, 761, 892		30.00
43.00		NURSERY	536, 507		43. 00
44. 00		SKILLED NURSING FACILITY	0		44. 00
		_ARY SERVICE COST CENTERS			1
50.00		OPERATI NG ROOM	3, 656, 245		50.00
52. 00		DELIVERY ROOM & LABOR ROOM	1, 698, 464		52. 00
53. 00	1	ANESTHESI OLOGY	19, 730		53. 00
54.00	1	RADI OLOGY-DI AGNOSTI C	7, 017, 435		54.00
60.00		LABORATORY	5, 122, 141		60.00
62. 30		BLOOD CLOTTING FOR HEMOPHILIACS	0		62. 30
65. 00	1	RESPIRATORY THERAPY	1, 628, 549		65. 00
66.00	1	PHYSI CAL THERAPY	2, 166, 511		66. 00
67.00	1	OCCUPATIONAL THERAPY	1, 023, 777		67. 00
68. 00 69. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	103, 510 0		68. 00 69. 00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT	980, 148		71. 00
71.00	1	IMPL. DEV. CHARGED TO PATIENTS	574, 588		71.00
73. 00		DRUGS CHARGED TO PATTENTS	4, 278, 470		73. 00
76. 97		CARDI AC REHABILITATION	4, 278, 470		76. 97
76. 98		HYPERBARI C OXYGEN THERAPY	5, 432		76. 98
76. 79		LI THOTRI PSY	0		76. 99
70. 77		TIENT SERVICE COST CENTERS	<u> </u>		70.77
90.00		CLINIC	0		90.00
90. 01		INTENSIVE OUT PATIENT PROGRAM	0		90. 01
91. 00		EMERGENCY	8, 725, 650		91.00
92.00		OBSERVATION BEDS (NON-DISTINCT PART			92.00
	OTHER	REIMBURSABLE COST CENTERS	<u> </u>		
95.00		AMBULANCE SERVICES	3, 849, 514		95. 00
	SPECIA	AL PURPOSE COST CENTERS			
118.00)	SUBTOTALS (SUM OF LINES 1 through 117)	50, 148, 563		118. 00
	NONRE	MBURSABLE COST CENTERS			
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	79, 206		190. 00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1, 008, 044		192. 00
		OCCUPATIONAL HEALTH	194		194. 00
		PAIN CLINIC	0		194. 01
		OAK POINTE	0		194. 02
	1	FOUNDATI ON	5, 843		194. 03
		COMMUNITY & VOLUNTEER SERVICES	238, 706		194. 04
		VACANT SPACE	0		194. 05
	1	TELEHEALTH MEDICINE	16, 981		194. 06
200.00		Cross Foot Adjustments	0		200. 00
201.00		Negative Cost Centers	0		201. 00
202.00	ון	TOTAL (sum lines 118 through 201)	51, 497, 537		202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0101

					То	12/31/2018	Date/Time Pre 5/28/2019 10:	
				CAPI TAL REI	LATED COSTS		372072017 10.	24 (111)
		0 1 0 1 5 11	D: 11	DI DO A FLYT	MANUE FOLLIE		ENDLOVEE	
		Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs	4.00	0.00	0.4	4.00	
	GENER	AL SERVICE COST CENTERS	0	1. 00	2.00	2A	4. 00	
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
2.00		CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT	0	520.072	0	0	0	4. 00
5. 00 6. 00		ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	4, 028, 677 0	520, 972 0		5, 103, 856 0	0	5. 00 6. 00
7. 00		OPERATION OF PLANT	O	121, 605	-	250, 967	0	7. 00
8.00	1	LAUNDRY & LINEN SERVICE	0	5, 682		11, 726	0	8. 00
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY	0	4, 749 20, 358		9, 801 42, 015	0	9. 00 10. 00
11. 00	1	CAFETERIA	0	20, 336 22, 958		47, 381	0	11.00
12. 00	1	MAINTENANCE OF PERSONNEL	0	0		0	0	12. 00
13.00	1	NURSING ADMINISTRATION	0	1, 384		2, 856	0	13.00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	0	16, 438 14, 247		33, 924 29, 402	0	14. 00 15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY	o o	5, 063		10, 449	0	16. 00
17. 00		SOCIAL SERVICE	o	0	0	0	0	17. 00
19.00	1	NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	19.00
20. 00 21. 00	1	NURSING SCHOOL I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	20. 00 21. 00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRV	Ö	0	Ö	o	0	22. 00
23. 00		PARAMED ED PRGM-(SPECIFY)	0	0	0	O	0	23. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	0	222, 370	236, 554	458, 924	0	30. 00
43. 00	1	NURSERY	0	222, 370		436, 924	0	43. 00
44. 00		SKILLED NURSING FACILITY	0	0		ō	0	44. 00
50.00		LARY SERVICE COST CENTERS	1	100 001	1 44 070	07. 070		
50. 00 52. 00		OPERATING ROOM DELIVERY ROOM & LABOR ROOM	0	132, 801 0		274, 073 0	0	50. 00 52. 00
53. 00		ANESTHESI OLOGY	o o	0	- 1	o	0	53. 00
54.00		RADI OLOGY-DI AGNOSTI C	O	178, 445		368, 273	0	54. 00
60.00	1	LABORATORY	0	31, 104	33, 088	64, 192	0	60. 00 62. 30
62. 30 65. 00	1	BLOOD CLOTTING FOR HEMOPHILIACS RESPIRATORY THERAPY	0	24, 594	26, 162	50, 756	0	65. 00
66.00	1	PHYSI CAL THERAPY	Ö	145, 266		299, 798	0	66. 00
67. 00		OCCUPATIONAL THERAPY	0	0	0	0	0	67. 00
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	0	0	0	0	68. 00 69. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	o	0	71.00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00		DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76. 97 76. 98	1	CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76. 97 76. 98
76. 99		LI THOTRI PSY	l o	0	Ö	o	0	
	OUTPA [*]	TIENT SERVICE COST CENTERS						
90. 00 90. 01		CLINIC INTENSIVE OUT PATIENT PROGRAM	0	0	-	0	0	
91.00		EMERGENCY	0	162, 762	-	335, 906	0	91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART		,	,	0		92. 00
05.00		REI MBURSABLE COST CENTERS						05.00
95. 00		AL PURPOSE COST CENTERS	0	0	0	0	0	95. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4, 028, 677	1, 630, 798	1, 734, 824	7, 394, 299	0	118. 00
	NONRE	IMBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 019		6, 231		190. 00
		PHYSICIANS' PRIVATE OFFICES OCCUPATIONAL HEALTH	0	36, 649 0	38, 987	75, 636		192. 00 194. 00
		PAIN CLINIC	Ö	0	o o	o		194. 01
		OAK POINTE	0	0	0	О		194. 02
	1	FOUNDATION	0	0	0 2 170	0		194. 03
	1	COMMUNITY & VOLUNTEER SERVICES VACANT SPACE		2, 988 0	3, 178	6, 166 0		194. 04 194. 05
		TELEHEALTH MEDICINE	Ö	0	o o	o		194. 06
200.00		Cross Foot Adjustments				o		200. 00
201. 00 202. 00		Negative Cost Centers TOTAL (sum lines 118 through 201)	4, 028, 677	0 1, 673, 454	0 1, 780, 201	0 7, 482, 332		201. 00 202. 00
202. UL	' I	TOTAL (Sum TITIES TTO LITTUUGH 201)	4,020,077	1, 0/3, 454	1, /00, 201	1,402,332	Ü	₁ 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0101

Peri od: Worksheet B From 01/01/2018 Part II To 12/31/2018 Date/Time Prepared:

5/28/2019 10:24 am Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL REPAI RS **PLANT** LINEN SERVICE 7.00 9.00 5.00 6.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5, 103, 856 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 562, 300 7.00 311, 333 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 47, 940 0 3, 099 62, 765 8.00 00900 HOUSEKEEPI NG 113, 718 126, 109 9.00 0 2, 590 0 9 00 10.00 01000 DI ETARY 55, 560 11, 105 2, 516 10.00 11.00 01100 CAFETERI A 77,825 12, 523 0 2,837 11.00 01200 MAINTENANCE OF PERSONNEL Ω 0 12 00 12 00 0 C0 13.00 01300 NURSING ADMINISTRATION 77, 788 755 171 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 5, 437 8, 966 0 2,031 14.00 0 01500 PHARMACY 7, 771 1, 761 15.00 43.509 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 1.675 Ω 2.762 626 16.00 0 17.00 01700 SOCIAL SERVICE 0 0 C 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 19 00 0 0 0 19.00 0 02000 NURSING SCHOOL 20.00 0 0 0 20.00 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 21.00 0 Ω 0 0 21 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 668, 203 0 121, 292 2.827 27, 481 30.00 43.00 04300 NURSERY 48, 150 0 0 4, 363 43.00 44.00 04400 SKILLED NURSING FACILITY 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 283, 137 0 72, 438 6,624 16, 412 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 148,033 11, 781 0 52.00 53.00 05300 ANESTHESI OLOGY 1.955 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 599, 184 0 54.00 97, 334 9.899 22,053 54.00 60.00 06000 LABORATORY 494, 738 0 16, 966 3,844 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 C 0 62.30 65 00 06500 RESPIRATORY THERAPY 146 623 Ω 13 415 270 3.039 65 00 06600 PHYSI CAL THERAPY 66.00 146, 195 0 79, 236 2, 156 17, 952 66.00 06700 OCCUPATIONAL THERAPY 97, 533 1,647 0 67.00 67.00 C 68.00 06800 SPEECH PATHOLOGY 9,573 0 68.00 162 0 06900 ELECTROCARDI OLOGY 0 0 69.00 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 92, 153 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 56, 946 0 0 0 0 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 371, 768 Ω 0 0 73 00 0 07697 CARDIAC REHABILITATION 76.97 0 0 0 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 526 0 0 0 76. 98 76.98 0 76.99 07699 LI THOTRI PSY 0 0 0 76.99 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 90.00 0 90.01 09001 INTENSIVE OUT PATIENT PROGRAM 0 0 0 0 90.01 09100 EMERGENCY 88, 780 19, 104 91.00 91.00 726, 721 20.115 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 363, 343 0 0 3, 925 95.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 4, 989, 566 0 539, 032 62, 765 120, 838 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 6, 465 1, 647 373 190. 00 4, 529 192. 00 83, 709 0 19, 991 0 194. 00 07950 OCCUPATIONAL HEALTH 19 Ω C 0 0 194, 00 194. 01 07951 PAIN CLINIC 0 0 0 0 0 194. 01 194. 02 07952 OAK POINTE 0 0 0 194. 02 0 0 194. 03 07953 FOUNDATION 0 0 0 194, 03 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 22, 414 C 1,630 0 369 194. 04 194. 05 07955 VACANT SPACE 0 0 0 194. 05 C 194. 06 07956 TELEHEALTH MEDICINE 0 194.06 0 0 0 1,683 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 5, 103, 856 562, 300 62, 765 126, 109 202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0101

| Period: | Worksheet B | From 01/01/2018 | Part II | Date/Time Prepared: | 5/28/2019 | 10: 24 am

CONTROL CONT						5/28/2019 10:	24 am
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92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0THER REI MBURSABLE COST CENTERS 0 22,742 0 0 0 2,894 95. 00 0 0 2,894 95. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	l	1					1
OTHER REIMBURSABLE COST CENTERS O 22,742 O O 2,894 95.00		0	28, 230	(36, 307	7, 027	
95. 00 09500 AMBULANCE SERVICES 0 22, 742 0 0 2, 894 95. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 111, 196 138, 018 0 84, 380 49, 734 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 544 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 1, 568 0 0 62 192. 00 194. 00 194. 01 194. 01 194. 01 194. 02 194. 01 194. 02 194. 02 194. 03 194. 04 194. 04 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 06 194. 05 194. 06 194. 05 194. 06 194. 05 194. 06 1	· · · · · · · · · · · · · · · · · · ·						92.00
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 111, 196 138, 018 0 84, 380 49, 734 118. 00 NONREI MBURSABLE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 111, 196 138, 018 0 84, 380 49, 734 118. 00 NONREI MBURSABLE COST CENTERS SUBTOTALS (SUM OF LINES SUBTOTALS S							
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 111, 196 138, 018 0 84, 380 49, 734 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19200		0	22, 742	<u> </u>	0	2, 894	95. 00
NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 544 190.00 192.00							1
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 19000 19200 19		7) 111, 196	138, 018	C	84, 380	49, 734	118. 00
192. 00 1920							1
194. 00 07950 0CCUPATI ONAL HEALTH 0 0 0 0 0 0 194. 00 194. 01 194. 01 194. 01 194. 02 194. 02 194. 03 194. 03 194. 04 194. 04 194. 05 1950 19		1					
194. 01 07951 PAIN CLINIC 0 0 0 0 0 194. 01 194. 02 194. 02 07952 OAK POINTE 0 0 0 0 0 0 194. 02 194. 03 07953 FOUNDATION 0 980 0 0 0 194. 03 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 0 0 0 0 0 18 194. 05 07955 VACANT SPACE 0 0 0 0 0 0 194. 05 194. 06 07956 TELEHEALTH MEDICINE 0 0 0 0 0 194. 05 200. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	1, 568				
194. 02 07952 OAK POINTE 0 0 0 0 0 194. 02 194. 03 07953 FOUNDATION 0 980 0 0 0 194. 03 194. 04 07954 COMMUNI TY & VOLUNTEER SERVICES 0 0 0 0 0 18 194. 04 194. 05 07955 VACANT SPACE 0 0 0 0 0 0 194. 05 194. 06 07956 TELEHEALTH MEDICINE 0 0 0 0 0 194. 05 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	C	0		
194. 03 07953 FOUNDATION 0 980 0 0 0 194. 03 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 0 0 0 0 0 18 194. 04 194. 05 07955 VACANT SPACE 0 0 0 0 0 0 194. 05 194. 06 07956 TELEHEALTH MEDICINE 0 0 0 0 0 194. 06 200. 00 Negative Cost Centers 0 0 0 0 0 0 0 201. 00		0	0	C	0		
194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 0 0 0 0 18 194. 04 194. 05 07955 VACANT SPACE 0 0 0 0 0 194. 05 194. 06 07956 TELEHEALTH MEDICINE 0 0 0 0 0 194. 06 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 201. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00		0	0	C	0		
194. 05 07955 VACANT SPACE 0 0 0 0 194. 05 194. 06 07956 TELEHEALTH MEDICINE 0 0 0 0 194. 06 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 201. 00		0	980	(C	이		
194. 06 07956 TELEHEALTH MEDICINE 0 0 0 0 194. 06 200. 00 Cross Foot Adjustments 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00		0	0	(C	이		
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00		0	0	(C	이		
201.00 Negative Cost Centers 0 0 0 0 201.00		0	0	(C	이	0	
202.00 TOTAL (sum lines 118 through 201) 111,196 140,566 0 84,380 50,358 202.00		0	0	•			
	202.00 TOTAL (sum lines 118 through 201)	111, 196	140, 566	l c	84, 380	50, 358	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0101

Peri od: Worksheet B From 01/01/2018 Part II To 12/31/2018 Date/Time Prepared:

5/28/2019 10:24 am Cost Center Description **PHARMACY** MEDI CAL SOCIAL SERVICE NONPHYSICIAN NURSING SCHOOL RECORDS & **ANESTHETISTS** LI BRARY 15. 00 17.00 19. 00 20.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 87, 971 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 15, 512 16.00 17.00 01700 SOCIAL SERVICE 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 0 0 19.00 02000 NURSING SCHOOL 0 Ω 20.00 20 00 C 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV C 21.00 02200 | &R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 9 30.00 03000 ADULTS & PEDIATRICS 821 0 30.00 0 43.00 04300 NURSERY 146 0 43.00 44.00 04400 SKILLED NURSING FACILITY 0 0 44 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 178 50.00 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 52.00 0 C 0 05300 ANESTHESI OLOGY 53.00 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 5,724 54.00 06000 LABORATORY 0 60.00 0 C 60.00 0 62 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62 30 Ω 06500 RESPIRATORY THERAPY 65.00 65.00 06600 PHYSI CAL THERAPY 1, 682 0 66.00 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 0 476 67.00 06800 SPEECH PATHOLOGY 0 68 00 68 00 124 0 69.00 06900 ELECTROCARDI OLOGY C 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 86, 976 0 73 00 76.97 07697 CARDIAC REHABILITATION 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 76. 98 07699 LI THOTRI PSY 76.99 0 0 76.99 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 90.00 90. 01 09001 INTENSIVE OUT PATIENT PROGRAM 0 0 90.01 0 91.00 09100 EMERGENCY 6, 361 91.00 249 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 0 95.00 09500 AMBULANCE SERVICES 393 0 95.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 87, 966 15, 512 0 0 0 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 5 192 00 194. 00 07950 OCCUPATIONAL HEALTH 0 0 194.00 0 194. 01 07951 PAIN CLINIC 0 0 0 0 194. 01 194. 02 07952 OAK POINTE 0 0 194.02 194. 03 07953 FOUNDATI ON 0 C 194. 03 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 0 0 194. 04 0 0 194. 05 07955 VACANT SPACE 194. 05 0 194. 06 07956 TELEHEALTH MEDICINE 0 0 194. 06 200.00 Cross Foot Adjustments 0 200. 00 0 0 201.00 201.00 Negative Cost Centers 0 202.00 TOTAL (sum lines 118 through 201) 87. 971 15, 512 0 0 202, 00

Health Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0101 Peri od: Worksheet B From 01/01/2018 Part II Date/Time Prepared: 12/31/2018 5/28/2019 10:24 am INTERNS & RESIDENTS Cost Center Description SERVI CES-SALAR SERVI CES-OTHER PARAMED ED Subtotal Intern & Y & FRINGES PRGM COSTS Residents Cost PRGM **APPRV APPRV** & Post Stepdown Adjustments 21. 00 22.00 23.00 24. 00 25. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16, 00 17 00 01700 SOCIAL SERVICE 17 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 20.00 02000 NURSING SCHOOL 20.00

			To 12/31/2018 Date/Time Pr 5/28/2019 10	
	Cost Center Description	Total	372072017 10	24 0111
	Tanana	26. 00		
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200 CAP REL COSTS-BLDG & TTXT			2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL			5. 00
6.00	00600 MAINTENANCE & REPAIRS			6. 00
7.00	00700 OPERATION OF PLANT			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
9.00	00900 HOUSEKEEPI NG			9. 00
10.00	01000 DI ETARY			10.00
11. 00 12. 00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL			11. 00 12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON			13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY			14. 00
15. 00	1 1			15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY			16. 00
17.00	01700 SOCIAL SERVICE			17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS			19. 00
	02000 NURSI NG SCHOOL			20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV			21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV			22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS			23. 00
30. 00	03000 ADULTS & PEDIATRICS	1, 442, 729		30.00
43. 00	04300 NURSERY	55, 819		43. 00
44. 00	04400 SKILLED NURSING FACILITY	00,017		44. 00
	ANCILLARY SERVICE COST CENTERS	-'		
50.00	05000 OPERATING ROOM	680, 277		50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	175, 572		52. 00
53. 00	05300 ANESTHESI OLOGY	1, 955		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 125, 033		54.00
60.00	06000 LABORATORY	579, 747		60.00
62. 30 65. 00	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY	0 222, 488		62. 30 65. 00
66. 00	06600 PHYSI CAL THERAPY	557, 163		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	103, 893		67. 00
68. 00	06800 SPEECH PATHOLOGY	10, 709		68. 00
69. 00	06900 ELECTROCARDI OLOGY	o		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	112, 647		71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	56, 946		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	460, 640		73. 00
76. 97	1 1	0		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	578		76. 98
76. 99	OUTPATIENT SERVICE COST CENTERS	0		76. 99
90. 00	09000 CLINI C	0		90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	o		90. 01
91.00	09100 EMERGENCY	1, 268, 800		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92. 00
	OTHER REIMBURSABLE COST CENTERS			
95. 00	09500 AMBULANCE SERVI CES	393, 297		95. 00
110 00	SPECIAL PURPOSE COST CENTERS	7 240 202		110.00
118.00		7, 248, 293		118. 00
190 00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	15, 260		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	185, 500		192. 00
	07950 OCCUPATIONAL HEALTH	183, 300		194. 00
	07951 PAIN CLINIC	Ó		194. 01
	07952 OAK POINTE	o		194. 02
	07953 FOUNDATI ON	980		194. 03
	07954 COMMUNITY & VOLUNTEER SERVICES	30, 597		194. 04
	07955 VACANT SPACE	0		194. 05
	07956 TELEHEALTH MEDICINE	1, 683		194. 06
200.00	1 1	0		200. 00
201. 00 202. 00		0 7, 482, 332		201. 00 202. 00
202.00	TOTAL (Sum Times 110 through 201)	1, 402, 332		1202.00

					1	o 12/31/2018	Date/Time Pre	
			CAPITAL REL	ATED COSTS			5/28/2019 10:	24 alli
		Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
					(GROSS SALARI ES)			
	OENED	AL CERVILOR COST OFFITERS	1. 00	2. 00	4.00	5A	5. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT	159, 632					1. 00
2.00	1	CAP REL COSTS-MVBLE EQUIP	,	159, 632				2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	0	0	, ,		21 042 010	4.00
5. 00 6. 00	1	ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	49, 696 0	49, 696 0	6, 417, 058	-19, 655, 022 0	31, 842, 818 0	5. 00 6. 00
7. 00	00700	OPERATION OF PLANT	11, 600	11, 600	420, 211	0	1, 942, 393	7. 00
8.00		LAUNDRY & LINEN SERVICE	542	542		0	299, 099	8.00
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY	453 1, 942	453 1, 942			709, 482 346, 637	9. 00 10. 00
11. 00	01100	CAFETERI A	2, 190				485, 549	11. 00
12.00	1	MAINTENANCE OF PERSONNEL	0	0	· -	0	0	12.00
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	132 1, 568	132 1, 568		0	485, 319 33, 924	13. 00 14. 00
15. 00	1	PHARMACY	1, 359			0	271, 453	
16.00		MEDICAL RECORDS & LIBRARY	483	483		0	10, 449	16.00
17. 00 19. 00	1	SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS	0	0		0	0	17. 00 19. 00
20. 00		NURSI NG SCHOOL	0	0	Ö	0	Ö	20. 00
21. 00		I &R SERVI CES-SALARY & FRI NGES APPRV	0	0	0	0	0	21. 00
22. 00 23. 00		I&R SERVICES-OTHER PRGM COSTS APPRV PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	22. 00 23. 00
20.00	I NPAT	IENT ROUTINE SERVICE COST CENTERS	0	<u> </u>				20.00
30.00		ADULTS & PEDIATRICS	21, 212	21, 212			4, 168, 895	30.00
43. 00 44. 00	1	NURSERY SKILLED NURSING FACILITY	0	0		0	300, 407 0	43. 00 44. 00
44.00		LARY SERVICE COST CENTERS	0			J	0	44.00
50.00	1	OPERATING ROOM	12, 668				1, 766, 483	50. 00
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	0	0		0	923, 575 12, 200	52. 00 53. 00
54. 00	1	RADI OLOGY-DI AGNOSTI C	17, 022	17, 022		0	3, 738, 285	54.00
60.00	06000	LABORATORY	2, 967	2, 967	0		3, 086, 652	60. 00
62. 30 65. 00		BLOOD CLOTTING FOR HEMOPHILIACS RESPIRATORY THERAPY	0 2, 346	0 2, 346	· -	0	0 914, 777	62. 30 65. 00
66. 00	1	PHYSI CAL THERAPY	2, 346 13, 857	13, 857		0	914, 777	66. 00
67. 00		OCCUPATIONAL THERAPY	0	0	519, 762	0	608, 502	67. 00
68. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	0	51, 012	0	59, 723	68.00
69. 00 71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1 0	0	0 574, 937	69. 00 71. 00
72. 00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	355, 287	72. 00
73.00		DRUGS CHARGED TO PATIENTS	0	0	0	0	2, 319, 446	
76. 97 76. 98	1	CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY	0	0		0	0 3, 279	
76. 99		LI THOTRI PSY	0	0			0	
00.00		TIENT SERVICE COST CENTERS						00.00
90. 00 90. 01		CLINIC INTENSIVE OUT PATIENT PROGRAM	0	0		0	0	90. 00 90. 01
91.00	09100	EMERGENCY	15, 526			-	4, 534, 023	91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART						92. 00
95. 00		REIMBURSABLE COST CENTERS AMBULANCE SERVICES	0	0	1, 664, 738	0	2, 266, 886	95. 00
		AL PURPOSE COST CENTERS		-	., ., ., ., .,		_,,	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	155, 563	155, 563	22, 371, 566	-19, 655, 022	31, 129, 767	118. 00
190.00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	288	288	0	0	40, 336	190. 00
		PHYSI CI ANS' PRI VATE OFFI CES	3, 496			0	522, 256	192. 00
		OCCUPATIONAL HEALTH	0	0	0	0		194. 00
	1	PAIN CLINIC OAK POINTE	0	0		0		194. 01 194. 02
		FOUNDATION	0	0	·		0	194. 03
		COMMUNITY & VOLUNTEER SERVICES	285	285	59	0	139, 839	
		VACANT SPACE TELEHEALTH MEDICINE	0	0	0	0	0 10, 500	194. 05
200.00		Cross Foot Adjustments	0	0	١			200. 00
201.00		Negative Cost Centers						201. 00
202.00		Cost to be allocated (per Wkst. B, Part I)	1, 673, 454	1, 780, 201	2, 779, 269		19, 655, 022	202. 00
203.00)	Unit cost multiplier (Wkst. B, Part I)	10. 483199	11. 151906	0. 124052		0. 617251	203. 00
	•					. '	, , , , , , , , , , , , , , , , , , , ,	

Health Fina	ncial Systems	WHITLEY MEMORI	I AL HOSPI TAL		In Lieu of Form CMS-2552-10			
COST ALLOCA	COST ALLOCATION - STATISTICAL BASIS				Period: From 01/01/2018			
					Го 12/31/2018 	Date/Time Pre 5/28/2019 10:	pared: <u>24 am</u>	
		CAPITAL REL	LATED COSTS					
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS	Reconci I i ati on	ADMINISTRATIVE & GENERAL		
		(OGO/ME TEET)	(340/11/2 1221)	DEPARTMENT (GROSS		(ACCUM. COST)		
				SALARI ES)				
		1. 00	2. 00	4. 00	5A	5. 00		
204. 00	Cost to be allocated (per Wkst. B, Part II)			(5, 103, 856	204. 00	
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000000		0. 160283	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 Provider CCN: 15-0101

		To 12/31/20				118 Date/Time Prepare 5/28/2019 10:24		
	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)		
		6. 00	7.00	LAUNDRY) 8. 00	9. 00	10.00		
-	GENERAL SERVICE COST CENTERS							
	00100 CAP REL COSTS BLDG & FIXT						1. 00 2. 00	
1	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00	
1	00500 ADMINISTRATIVE & GENERAL						5. 00	
6.00	00600 MAINTENANCE & REPAIRS	0					6.00	
	00700 OPERATION OF PLANT	0	98, 336	1			7. 00	
	00800 LAUNDRY & LINEN SERVICE	0	542	· ·			9.00	
1	00900 H0USEKEEPI NG 01000 DI ETARY	0	453 1, 942	1	97, 341 1, 942	13, 272		
1	01100 CAFETERI A	0	2, 190	l .	2, 190			
	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0		
1	01300 NURSI NG ADMINI STRATI ON	0	132	l .	132	0		
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	1, 568 1, 359	l .	1, 568 1, 359	0		
	01600 MEDICAL RECORDS & LIBRARY		483	l .	483	0		
	01700 SOCI AL SERVI CE	0	0	Ö	0	Ö		
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00	
	02000 NURSI NG SCHOOL	0	0	0	0	0		
	02100 &R SERVICES-SALARY & FRINGES APPRV 02200 &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0	0		
	02300 PARAMED ED PRGM-(SPECIFY)				0	0		
+	INPATIENT ROUTINE SERVICE COST CENTERS						1 20.00	
	03000 ADULTS & PEDIATRICS	0	21, 212	13, 036	21, 212	13, 272	30.00	
	04300 NURSERY	0		1		0	1	
	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	44.00	
	05000 OPERATING ROOM	0	12, 668	30, 547	12, 668	0	50.00	
1	05200 DELIVERY ROOM & LABOR ROOM	0		54, 330		ő		
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00	
	05400 RADI OLOGY-DI AGNOSTI C	0	17, 022		·	0		
1	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	2, 967	31	2, 967	0		
	06500 RESPIRATORY THERAPY	0	2, 346	1, 247	2, 346	1		
1	06600 PHYSI CAL THERAPY	0	13, 857	1		ő		
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	7, 596	0	0	67.00	
	06800 SPEECH PATHOLOGY	0	0	746	0	0	1	
1	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0		
	07200 IMPL. DEV. CHARGED TO PATIENTS		0		0	0		
	07300 DRUGS CHARGED TO PATIENTS	0	Ö	Ō	0	Ō		
	07697 CARDIAC REHABILITATION	0	0	0	0	0		
	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0		
- +	07699 LITHOTRIPSY DUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	76. 99	
	09000 CLINIC	0	0	0	0	0	90.00	
	09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0		
	09100 EMERGENCY	0	15, 526	88, 109	15, 526	0		
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00	
	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	0	18, 103	0	0	95.00	
	SPECIAL PURPOSE COST CENTERS			10, 103			75.00	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	94, 267	289, 462	93, 272	13, 272]118. 00	
	NONREI MBURSABLE COST CENTERS	1	1	1	1	_	ļ	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0					190. 00 192. 00	
	07950 OCCUPATIONAL HEALTH						194. 00	
	07951 PAIN CLINIC	0	Ö	Ö	0		194. 01	
	07952 OAK POINTE	0	0	0	0	0	194. 02	
	07953 FOUNDATION	0	0	0	0	l	194. 03	
1	07954 COMMUNITY & VOLUNTEER SERVICES	0	285	0	285	•	194. 04 194. 05	
	07955 VACANT SPACE 07956 TELEHEALTH MEDICINE		0		0		194. 06	
200.00	Cross Foot Adjustments						200. 00	
201.00	Negative Cost Centers	1					201.00	
202.00	Cost to be allocated (per Wkst. B,	0	3, 141, 337	501, 032	1, 161, 881	645, 816	202.00	
202 00	Part I)	0.000000	21 044024	1 720000	11 024102	40 440024	203 00	
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	0.000000	31. 944934 562, 300	1				
_0 1. 00	Part II)		302, 300	02, 703	120, 107	111, 170		
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	5. 718150	0. 216833	1. 295538	8. 378240	205. 00	
	11)							

Health Financial Systems	WHITLEY MEMORI	I AL HOSPI TAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0101		Period: From 01/01/2018	Worksheet B-1		
				To 12/31/2018			
Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY		
	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)							

Heal th	Financial Systems	WHITLEY MEMORI	AL HOSPITAL			In Lie	u of Form CMS-	2552-10
COST AL	LOCATION - STATISTICAL BASIS		Provi der	- CCN		eri od:	Worksheet B-1	
					To	rom 01/01/2018 0 12/31/2018	Date/Time Pre	pared:
	Cost Center Description	CAFETERI A (FTES)	MAI NTENANCE PERSONNEL (NUMBER HOUSED)	. AI	NURSING DMINISTRATION DIRECT NRSING	CENTRAL SERVI CES & SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	24 am
		11 00	12.00		HRS)	REQUIS.)	15.00	
	GENERAL SERVICE COST CENTERS	11. 00	12. 00		13. 00	14. 00	15. 00	
1. 00	DO100 CAP REL COSTS-BLDG & FIXT D0200 CAP REL COSTS-MVBLE EQUIP D0400 EMPLOYEE BENEFITS DEPARTMENT D0500 ADMINISTRATIVE & GENERAL D0600 MAINTENANCE & REPAIRS D0700 OPERATION OF PLANT D0800 LAUNDRY & LINEN SERVICE D0900 HOUSEKEEPING D1000 DIETARY D1100 CAFETERIA D1200 MAINTENANCE OF PERSONNEL D1300 NURSING ADMINISTRATION D1400 CENTRAL SERVICES & SUPPLY D1500 PHARMACY D1600 MEDICAL RECORDS & LIBRARY D1700 SOCIAL SERVICE D1900 NONPHYSICIAN ANESTHETISTS D1900 NURSING SCHOOL D1901 L&R SERVICES-SALARY & FRINGES APPRV D1901 L&R SERVICES-OTHER PRGM COSTS APPRV D1900 PARAMED ED PRGM-(SPECIFY)	2, 151 0 43 0 66 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 004 0 0 0 0 0 0 0	2, 289, 191 55, 219 0 0 0 0 0 0	1, 577, 092 0 0 0 0 0 0 0	1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00 23. 00
	NPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	343		o	343	33, 388	161	30. 00
	04300 NURSERY	31		0	0	51, 538	0	43. 00
	04400 SKILLED NURSING FACILITY	0		0	0	0	0	44. 00
50. 00 (52. 00 (53. 00 (54. 00 (6. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6	ANCILLARY SERVICE COST CENTERS D5000 OPERATING ROOM D5200 DELIVERY ROOM & LABOR ROOM D5300 ANESTHESIOLOGY D5400 RADIOLOGY-DIAGNOSTIC	144 85 0 305		0 0 0 0	144 85 0	258, 498 139, 061 0 116, 862	3, 884 0 0 1, 153	52. 00 53. 00 54. 00
62. 30 65. 00	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY	0 0 94		0	0 0 0	0 0 101, 919	0 0 0	60. 00 62. 30 65. 00
1	D6600 PHYSI CAL THERAPY D6700 OCCUPATI ONAL THERAPY	148 60		0	0	18, 815 14, 372	1, 039 0	66. 00 67. 00
	06800 SPEECH PATHOLOGY	13		0	0	0	0	68. 00
	06900 ELECTROCARDI OLOGY	0		0	0	0	0	69.00
1	D7100 MEDICAL SUPPLIES CHARGED TO PATIENT D7200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	931, 635	0	71. 00 72. 00
1	07300 DRUGS CHARGED TO PATIENTS	0		0	o	86, 182	1, 559, 255	
	07697 CARDIAC REHABILITATION	0		0	0	0	0	76. 97
	D7698 HYPERBARI C OXYGEN THERAPY D7699 LI THOTRI PSY	0		0	0	2, 379	0	
H-	DUTPATIENT SERVICE COST CENTERS	0		<u> </u>	O _I		0	70. 77
1	09000 CLI NI C	0		0	0	0	0	90.00
	D9001 INTENSIVE OUT PATIENT PROGRAM D9100 EMERGENCY	0 432		0	0 432	0 319, 431	0 4, 472	
1	D9200 OBSERVATION BEDS (NON-DISTINCT PART	432			432	317, 431	4, 472	92.00
	OTHER REIMBURSABLE COST CENTERS					,		
	09500 AMBULANCE SERVICES	348		0	0	131, 536	7, 037	95. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	2, 112		o	1, 004	2, 260, 835	1, 577, 001	118. 00
	NONREI MBURSABLE COST CENTERS	T						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0 24		0	0	24, 715 2, 809		190. 00 192. 00
	07950 OCCUPATIONAL HEALTH	0		0	0	2, 809		194. 00
194. 01	D7951 PAIN CLINIC	0		0	0	o	0	194. 01
	07952 OAK POI NTE	0		0	0	0		194. 02
1	D7953 FOUNDATION D7954 COMMUNITY & VOLUNTEER SERVICES	15		0	0	832		194. 03 194. 04
	07955 VACANT SPACE	0		0	Ö	0		194. 05
	D7956 TELEHEALTH MEDICINE	0		0	0	o	0	194. 06
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers							200. 00 201. 00
201.00	Cost to be allocated (per Wkst. B,	881, 354		o	808, 295	123, 670	528, 668	
	Part I)					·		
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	409. 741516 140, 566		000	805. 074701 84, 380	0. 054023 50, 358	0. 335217 87, 971	203. 00 204. 00

Heal th Finar	ncial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2018 To 12/31/2018	Date/Time Pre 5/28/2019 10:	
	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	65. 349140	0. 000000	84. 04382	5 0. 021998	0. 055781	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 Provider CCN: 15-0101 Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared:

COST Center Description					0 12/31/2018	5/28/2019 10: 2	
AMERICAN SOLIDA SPRUICE SOLIDA SPRUICES SALA SPRUICES SA							
SECRIPS LIBRARY CONTINUES THE SPENT THE SPEN	Cost Center Description	MEDI CAL	SOCIAL SERVICE	NONPHYSICIAN	NURSI NG SCHOOL		
BIRWING CTIME SPENI) CRSS (RINE) CRS	oost center bescription		SOCIAL SERVICE		NORST NO SCHOOL		
CARDEN SERVICE COST CENTERS 16.00 17.00 19.00 20.00 21.00 10.00 10.00 10.00 10.00 10.00 10.00 10.000 10.			(TIME SPENT)	(ASSI GNED	(ASSI GNED		
10.00 10.00 20.00 21.00 17.00 19.00 20.00 21.00 1.00		(TIME SPENT)		TIME)	TIME)		
CHERNEL SINVICE COST CENTERS		16.00	17.00	10.00	20.00		
1.00	GENERAL SERVICE COST CENTERS	10.00	17.00	17.00	20.00	21.00	
4.00 00:000 EMPLOYEE BEREFITS DEPARTMENT							1.00
5 00 00 0000 ADM INSTRATIVE & CENERAL 0 00 0000 DEPARTOR OF PLANT 1 00 00000 DEPARTOR OF PLANT 1 10 00 10000 DEPARTOR OF PRESONNEL 1 10 00 10 00 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
0.00 00-000 MAINTENINCE & REPAIRS 0.00 00-000 CHANGEY & LINEN SERVICE 0.00 00-000 CHANGEY & CH							
7.00 00700 DEPATION OF PLANT							
8.00 0.0000 JANISHOY & LINEN SERVICE 9.00 0.000 0.000 CAFFERING 9.00 C							
10.00 1000 DETARY							
11.00 11.00 CAFETERIA	9. 00 00900 HOUSEKEEPI NG						9. 00
12.00 10200 MAINTENANCE OF PERSONNEL 13.00 10300 MURSIN KA MAIN INSTRATION 13.00 10300 MURSIN KA MAIN INSTRATION 14.00 10.00 10.00 MURSIN KA MAIN INSTRATION 15.00 10.00 10.00 MURSIN KA MAIN INSTRATION 15.00 10.00 10.00 MURSIN KA MAIN INSTRATION 15.00 10.00							
13.00 13.00 MIRSINS AMMINISTRATION 13.00 15.00 1							
14.00 01400 PARAMACY 10,000 116.00 17.00 17.00							
15.00 01500 PHARMACY 10.000 15.00 16.00 17.00 16.00 17.00							
17.00 01700 (NOPPHYSICAL MARISTHETISTS 0 0 0 19.00 1900 (NOPPHYSICAL MARISTHETISTS 0 0 0 0 0 20.00 00000 (NURSH NS SCHOOL) 0 0 0 0 0 0 21.00 22.00 02000 (NURSH NS SCHOOL) 0 0 0 0 0 0 21.00 22.00 02000 (NURSH NS SCHOOL) 0 0 0 0 0 0 22.00 02.00 02000 (NURSH NS SCHOOL) 0 0 0 0 0 0 0 22.00 02000 (NURSH NS SCHOOL) 0 0 0 0 0 0 0 0 0							15.00
9.00 0.1900 NONIPHYSI CLAN AMESTHETI STS 0 0 0 0 2.0.00 2.00 2.00 0.200 UNISING SCHOOL NURSING SCHOOL	4 I	10, 000	1				
20.00		0	0				
21.00		0					
22.00 02200 RAR SERVICES-OTHER PRGM COSTS APPRY 0 0 0 0 22.00		0	Ö			0	
INPART ENT ROUTH NE SERVICE COST CENTERS 529		0	0				
30. 00 30000 ADULTS & PEDIATRICS 529 0 0 0 0 3.0 0 0 44. 00 0 0 0 0 0 0 0 0 0		0	0				23. 00
43.00 04300 NURSERY 94 0 0 0 0 34.00		F20	1 0	1		0	20.00
44. 00 04-00 SKILLED NURSING FACILITY							
ANCILLARY SERVICE COST CENTERS					l l		
S2 00 05200 05200 05200 05200 05200 05200 05200 05200 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 0540							
53.00 05300 ANESTHÉSI OLOGY 0 0 0 0 0 0 0 53.00		115					
54.00		0					
0.0 0.0000 0.0000 0.0		3 600	1		-		
62. 30 06250 06500 CLITTING FOR HEMOPHILIACS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		3,040			- 1		
66.00 06600 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06800 06900		0	Ö		-		
67.00 06700 06700 06200 06700 06200 0680	4 I	0	0	1	-		
68.00 06900 06900 06900 0 0 0 0 0 0 0 0 0	4 I		0	1	-		
69-00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0 0 71.00	+ I	1	1	1	- 1		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 76.97 076	+ I	0	1	1	-		
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73. 00 76. 97 07697 CARDI AC REHABI LITATI ON 0 0 0 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 76. 99 07699 LITHOTRI PSY 0 0 0 0 0 0 76. 99 07699 UTHATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 0 0 0 0 0 91. 00 09000 CLI NI C 0 0 0 0 0 91. 00 09000 DRITENSI VE OUT PATIENT PROGRAM 0 0 0 0 0 92. 00 09200 08SERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 97. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 97. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 97. 00 09000 0 0 0 0 97. 00 09000 0 0 0 0 97. 00 09000 0 0 0 0 97. 00 09000 0 0 0 0 97. 00 00 0 0 0 0 98. 00 00 0 0 0 0 99. 00 00 0 0 0 0 99. 00 00 0 0 0 0 99. 00 00 0 0 0 0 99. 00 00 0 0 0 0 99. 00 00 0 0 0 0 99. 00 00 0 0 0 0 99. 00 00 0 0 0 0 99. 00 00 0 0 0 0 99. 00 00 0 0 0 0 99. 00 00 0 0 0 0 99. 00 00 0 0 0 0 99. 00 00 0 0 0 0 99. 00 00 0 0 0 0 99. 00 00 0 0 0 0 99. 00 00 0 0 0 0 99. 00 00 0 0 0 0 99. 00 00 0 0 0 0 99. 00 00 0 0 0 99. 00 00 0 0 0 0 99. 00 00 0 0 0 99. 00 00 0 0 0 99. 00 00 0 0 0 99. 00 00 0 0 0 99. 00 00 0 0 0 99. 00 00 0 0 0 99. 00 00 0 0 0 0 99. 00 00 0 0 0 0 99. 00 00 0 0 0 99. 00 00 0 0 0 0 99. 00 00 0 0 0 0 99. 00 00 0 0 0 0 99. 00 00 0 0 0 0 0 99. 00 00 0 0 0 0 99. 00 00 0 0 0 0 99. 00 00 0 0 0 0 99. 00 00 00 0 0 0 99. 00 00 0 0 0 0 99. 00 00 00 0	+ I	0	0	•	l l	1	
76. 97 07697 CARDIAC REHABILITATION 0 0 0 0 0 0 76. 97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 0 0 0 76. 98 76. 99 07699 LITHOTRIPSY 0 0 0 0 0 0 0 76. 98 76. 99 07699 LITHOTRIPSY 0 0 0 0 0 0 0 76. 98 76. 99 07699 LITHOTRIPSY 0 0 0 0 0 0 0 0 76. 98 79. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	C	0	1	
76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 0 0 76. 98 76. 99 07699 LITHOTRI PSY 0 0 0 0 0 0 0 90. 00 09000 CLI NI C 09000 CLI NI C 0 0 0 0 0 0 90. 01 09001 INTENSI VE OUT PATI ENT PROGRAM 0 0 0 0 0 0 0 91. 00 09100 EMERGENCY 4, 101 0 0 0 0 0 0 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 0 0 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0 0 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0 0 97. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0 0 99. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0 0 99. 00 09500 09500 AMBULANCE SERVI CES 0 0 0 0 0 0 0 99. 00 09500 0 0 0 0 0 0 0 99. 00 09500 09500 09500 0 0 0 0 0 0 0 0 0	4 I	0	0	C	0		
76. 99 07699 LITHOTRI PSY 0UTPATILENT SERVICE COST CENTERS 90. 00 9000 CLI NI C 90. 01 09001 I NTENSI VE OUT PATI ENT PROGRAM 90. 00 9000 CLI NI C 90. 01 09001 I NTENSI VE OUT PATI ENT PROGRAM 90. 00 09000 CLI NI C 90. 00 10 09001 I NTENSI VE OUT PATI ENT PROGRAM 90. 00 09000 DEBERGENCY 92. 00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART 92. 00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART 95. 00 09500 JABULANCE SERVI CES 96. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	· · · · · · · · · · · · · · · · · · ·	0	0		1		
OUTPATIENT SERVICE COST CENTERS OUTPATIENT PROGRAM OUTPATIENT PROG			-			1	
90. 01 09001 INTENSI VE OUT PATI ENT PROGRAM 0 0 0 0 0 0 0 0 0							
91. 00 09100 EMERGENCY 4, 101 0 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0		0	l e				
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0		0					
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95. 00 09500 AMBULANCE SERVICES 0 0 0 0 0 0 0 0 0							72.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 10,000 0 0 0 0 0 118. 00	95. 00 09500 AMBULANCE SERVICES	0	0	C	0	0	95.00
NONREI MBURSABLE COST CENTERS NO 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN O O O O O O O O O							
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 1920 O 1920 PhYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 192. 00 192. 00 194. 00 07950 OCCUPATI ONAL HEALTH 0 0 0 0 0 0 0 194. 00 194. 01 07951 PAIN CLINIC 0 0 0 0 0 0 194. 01 194. 01 194. 02 07952 OAK POINTE 0 0 0 0 0 0 194. 01 194. 02 194. 03 07953 FOUNDATI ON 0 0 0 0 0 194. 03 194. 04 07954 COMMUNITY & VOLUNTEER SERVI CES 0 0 0 0 0 0 194. 03 194. 04 194. 05 07955 VACANT SPACE 0 0 0 0 0 0 194. 05 194. 06 07956 TELEHEALTH MEDICI NE 0 0 0 0 0 194. 06 200. 00 0 0 0 194. 06 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	118.00 SUBTOTALS (SUM OF LINES 1 through 117)	10, 000	0	C	0	0 1	118. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192. 00 194. 00 07950 OCCUPATI ONAL HEALTH 0 0 0 0 0 0 194. 00 194. 01 07951 PAI N CLINIC 0 0 0 0 0 0 194. 01 194. 02 07952 OAK POI NTE 0 0 0 0 0 0 0 194. 02 194. 03 07953 FOUNDATI ON 0 0 0 0 0 194. 02 194. 03 07954 COMMUNI TY & VOLUNTEER SERVI CES 0 0 0 0 0 194. 04 194. 05 07955 VACANT SPACE 0 0 0 0 0 0 194. 05 194. 06 07956 TELEHEALTH MEDI CI NE 0 0 0 0 0 194. 06 200. 00 0 0 0 194. 06 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	1			0.1	190 00
194. 00 07950 OCCUPATIONAL HEALTH 0 0 0 0 0 0 194. 00 194. 01 194. 01 194. 01 194. 02 07951 PAIN CLINIC 0 0 0 0 0 0 194. 01 194. 02 194. 03 07952 OAK POINTE 0 0 0 0 0 0 194. 02 194. 03 07953 FOUNDATION 0 0 0 0 0 0 194. 03 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 0 0 0 0 0 0 194. 04 194. 05 07955 VACANT SPACE 0 0 0 0 0 0 194. 05 194. 06 07956 TELEHEALTH MEDICINE 0 0 0 0 0 194. 05 194. 06 07956 Cross Foot Adjustments 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
194. 02 07952 OAK POINTE 0 0 0 0 0 194. 02 194. 03 07953 FOUNDATION 0 0 0 0 0 194. 03 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 0 0 0 0 0 194. 05 194. 05 07955 VACANT SPACE 0 0 0 0 0 0 194. 05 194. 06 07956 TELEHEALTH MEDICINE 0 0 0 0 0 194. 06 200. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 38,093 0 0 0 0 0 0 0 202. 00		0	o				
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194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 0 0 0 0 0 194. 04 194. 05 194. 06 07955 VACANT SPACE 0 0 0 0 0 194. 05 194. 06 07956 TELEHEALTH MEDICINE 0 0 0 0 194. 06 200. 00 0 0 194. 06 200. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 38,093 0 0 0 0 0 202. 00		0	0		-		
194. 05 07955 VACANT SPACE 0 0 0 0 0 194. 05 194. 06 07956 TELEHEALTH MEDICINE 0 0 0 0 0 194. 06 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) 38,093 0 0 0 0 0 202. 00				1	-		
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200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 38,093 0 0 0 0 202.00		0	0	ď		0 1	194. 06
202.00 Cost to be allocated (per Wkst. B, 38,093 0 0 0 202.00	200.00 Cross Foot Adjustments					2	200.00
Part I)							
		38, 093	0	C	네 이	0 2	202. 00
0. 000000		3, 809300	0. 000000	0. 000000	0. 000000	0. 000000	203. 00
	(moti 5)	1.307000	, 2. 300000	. 2. 300000		2. 230000 2	

Health Fina	ncial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Li€	eu of Form CMS-2	2552-10
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der C		Period: From 01/01/2018	Worksheet B-1	
					To 12/31/2018		
						I NTERNS & RESI DENTS	
	Cost Center Description		SOCIAL SERVICE		NURSING SCHOOL		
		RECORDS &		ANESTHETI STS		Y & FRINGES	
		LI BRARY	(TIME SPENT)	(ASSI GNED	(ASSI GNED	APPRV	
		(TIME SPENT)		TIME)	TIME)	(ASSI GNED	
						TIME)	
		16.00	17.00	19.00	20.00	21. 00	
204. 00	Cost to be allocated (per Wkst. B, Part II)	15, 512	C		0 0	0	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	1. 551200	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

Health Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0101 Period: Worksheet B-1

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0101 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/28/2019 10:24 am INTERNS & **RESI DENTS** Cost Center Description SERVI CES-OTHER PARAMED ED PRGM COSTS **PRGM** (ASSI GNED **APPRV** (ASSI GNED TIME) TIME) 23.00 22.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16,00 17.00 01700 SOCIAL SERVICE 17 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 20.00 02000 NURSING SCHOOL 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30 00 0 0 43.00 04300 NURSERY 0 0 43.00 04400 SKILLED NURSING FACILITY 0 44.00 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0000000000000000 0 52.00 53.00 05300 ANESTHESI OLOGY 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54 00 54 00 60.00 06000 LABORATORY 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 62.30 06500 RESPIRATORY THERAPY 0 65.00 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 0 69 00 69 00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 73.00 07697 CARDIAC REHABILITATION 76 97 76 97 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 76.98 07699 LI THOTRI PSY 0 76. 99 76.99 0 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0 0 90 00 90.01 09001 INTENSIVE OUT PATIENT PROGRAM 0 0 90.01 0 91.00 09100 EMERGENCY 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 0 0 118.00 118,00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 190.00 0 0 192.00 194. 00 07950 OCCUPATIONAL HEALTH 194. 00 0 194. 01 07951 PAIN CLINIC 0 0 0 0 194.01 194. 02 07952 OAK POINTE 0 194.02 194. 03 07953 FOUNDATI ON 0 194.03 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 0 194.04 194. 05 07955 VACANT SPACE 0 194.05 0 194. 06 07956 TELEHEALTH MEDICINE Ω 194.06 Cross Foot Adjustments 200.00 200. 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 202.00 Part I) 203 00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.000000 203.00

Heal th Fina	ncial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form C	MS-2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provider Co	CN: 15-0101	Peri od: From 01/01/2018 To 12/31/2018	Worksheet Date/Time 5/28/2019	Prepared:
	Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS APPRV (ASSI GNED TI ME) 22.00	PARAMED ED PRGM (ASSI GNED TI ME)				
204. 00	Cost to be allocated (per Wkst. B, Part II)	0	0		,		204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	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

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0101	Peri od: Worksheet C From 01/01/2018 Part I To 12/31/2018 Date/One Prepared:

	:24 am
Title XVIII Hospital PPS	
Costs	
Cost Center Description Total Cost Therapy Limit Total Costs RCE Total Costs	
(from Wkst. B, Adj. Disallowance	
Part I, col.	
26)	
1.00 2.00 3.00 4.00 5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	
30. 00 03000 ADULTS & PEDI ATRI CS 8, 761, 892 8, 761, 892 0 8, 761, 89	2 30.00
43. 00 04300 NURSERY 536, 507 536, 507 536, 507	7 43.00
44.00 04400 SKI LLED NURSI NG FACI LI TY 0 0 0	0 44.00
ANCI LLARY SERVI CE COST CENTERS	
50. 00 05000 OPERATI NG ROOM 3, 656, 245 3, 656, 245 0 3, 656, 24	5 50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 1,698,464 1,698,464 0 1,698,464	4 52.00
53. 00 05300 ANESTHESI OLOGY 19, 730 19, 730 5, 800 25, 53	0 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 7, 017, 435 7, 017, 435 0 7, 017, 435	5 54.00
60. 00 06000 LABORATORY 5, 122, 141 5, 122, 141 0 5, 122, 14	1 60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0	0 62.30
65. 00 06500 RESPI RATORY THERAPY 1, 628, 549 0 1, 628, 549 0 1, 628, 549	9 65.00
66. 00 06600 PHYSI CAL THERAPY 2, 166, 511 0 2, 166, 511 0 2, 166, 51	1 66. 00
67. 00 06700 0CCUPATI ONAL THERAPY 1, 023, 777 0 1, 023, 777 0 1, 023, 777	7 67. 00
68. 00 06800 SPEECH PATHOLOGY 103, 510 0 103, 510 0 103, 5	0 68.00
69. 00 06900 ELECTROCARDI OLOGY 0 0 0	0 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 980, 148 980, 148 0 980, 148	8 71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 574, 588 574, 588 0 574, 58	8 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 4, 278, 470 4, 278, 470 0 4, 278, 47	0 73.00
76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0	0 76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY 5, 432 5, 432 0 5, 43	2 76. 98
76. 99 07699 LI THOTRI PSY 0 0 0	0 76. 99
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLI NI C 0 0 0	0 90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM 0 0 0	0 90. 01
91. 00 09100 EMERGENCY 8, 725, 650 8, 725, 650 20, 786 8, 746, 43	6 91.00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 2, 454, 914 2, 454, 914 2, 454, 914 2, 454, 91	4 92.00
OTHER REI MBURSABLE COST CENTERS	
95. 00 09500 AMBULANCE SERVI CES 3, 849, 514 3, 849, 514 3, 248 3, 852, 76	2 95.00
200.00 Subtotal (see instructions) 52,603,477 0 52,603,477 29,834 52,633,3	
201.00 Less Observation Beds 2, 454, 914 2, 454, 914 2, 454, 91	
202.00 Total (see instructions) 50, 148, 563 0 50, 148, 563 29, 834 50, 178, 39	7 202. 00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0101	Peri od: Worksheet C
		From 01/01/2018 Part I
		To 12/21/2010 Doto/Time December d.

					To 12/31/2018	Date/Time Prep 5/28/2019 10:	
		_	Title	XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Rati o	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.		10, 384, 197		10, 384, 19			30. 00
43.		1, 552, 147		1, 552, 14	7		43. 00
44.		0			0		44. 00
	ANCI LLARY SERVI CE COST CENTERS			1			
50.		4, 785, 270	16, 889, 975			0. 000000	50.00
52.		3, 954, 296	182, 735			0. 000000	52.00
53.		477, 481	2, 271, 309				53. 00
54.		4, 005, 449	52, 577, 128			0. 000000	54.00
60.		4, 249, 882	24, 541, 095			0. 000000	60.00
62.		0	0	1	0. 000000	0. 000000	62. 30
65.		2, 478, 041	7, 658, 673			0. 000000	65. 00
66.		227, 879	4, 255, 434			0. 000000	66. 00
67.		129, 911	1, 242, 424			0. 000000	67. 00
68.	I I	22, 647	287, 780	310, 42		0. 000000	68. 00
69.		0	0		0.000000		69. 00
71.		1, 049, 470	1, 935, 404			0.000000	71. 00
72.		612, 896	2, 031, 050			0.000000	72. 00
73.		4, 814, 148	16, 724, 334	21, 538, 48		0.000000	73. 00
76.		0	0		0.000000	0.000000	76. 97
76.		39, 839	101, 405	141, 24		0.000000	76. 98
76.		0	0		0.000000	0.000000	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.		0	0		0.000000	0.000000	90.00
90.		0	0		0.000000	0.000000	90. 01
91.	00 09100 EMERGENCY	4, 045, 285	40, 267, 599	44, 312, 88	4 0. 196910	0.000000	91.00
92.	00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	5, 276, 101	5, 276, 10	0. 465289	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.	00 09500 AMBULANCE SERVICES	0	7, 907, 095	7, 907, 09	5 0. 486843	0.000000	95. 00
200	.00 Subtotal (see instructions)	42, 828, 838	184, 149, 541	226, 978, 37	9		200. 00
201	.00 Less Observation Beds						201. 00
202	.00 Total (see instructions)	42, 828, 838	184, 149, 541	226, 978, 37	9	 	202. 00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0101	Peri od: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/28/2019 10:24 am

					5/28/2019 10:	24 am_
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS					30. 00
43.00	04300 NURSERY					43.00
44.00	04400 SKILLED NURSING FACILITY					44. 00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 168683				50.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 410551				52. 00
53.00	05300 ANESTHESI OLOGY	0. 009288				53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 124021				54. 00
60.00	06000 LABORATORY	0. 177908				60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000				62. 30
65.00	06500 RESPI RATORY THERAPY	0. 160658				65.00
66.00	06600 PHYSI CAL THERAPY	0. 483239				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 746011				67.00
68.00	06800 SPEECH PATHOLOGY	0. 333444				68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 328372				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 217322				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 198643				73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000				76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 038458				76. 98
76. 99	07699 LI THOTRI PSY	0. 000000				76. 99
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	0. 000000				90. 00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0. 000000				90. 01
91.00	09100 EMERGENCY	0. 197379				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 465289				92. 00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0. 487254	·			95. 00
200.00	Subtotal (see instructions)					200. 00
201.00	Less Observation Beds					201. 00
202.00	Total (see instructions)					202. 00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0101	Period: Worksheet C From 01/01/2018 Part I
		To 12/31/2018 Date/Time Prepared:

				o 12/31/2018	Date/Time Pre 5/28/2019 10:	pared: 24 am
		Ti tl	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	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	8, 761, 892		8, 761, 892		8, 761, 892	
43. 00 04300 NURSERY	536, 507		536, 507	0	536, 507	
44.00 O4400 SKILLED NURSING FACILITY	0		C	0	0	44. 00
ANCILLARY SERVICE COST CENTERS			•			
50.00 05000 OPERATING ROOM	3, 656, 245		3, 656, 245		3, 656, 245	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 698, 464	l e	1, 698, 464		1, 698, 464	
53. 00 05300 ANESTHESI OLOGY	19, 730		19, 730		25, 530	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	7, 017, 435		7, 017, 435	0	7, 017, 435	54.00
60. 00 06000 LABORATORY	5, 122, 141		5, 122, 141	0	5, 122, 141	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		C	0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	1, 628, 549	0	1, 628, 549	0	1, 628, 549	65. 00
66. 00 06600 PHYSI CAL THERAPY	2, 166, 511	0	2, 166, 511	0	2, 166, 511	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 023, 777	0	1, 023, 777	0	1, 023, 777	67. 00
68.00 06800 SPEECH PATHOLOGY	103, 510	0	103, 510	0	103, 510	
69. 00 06900 ELECTROCARDI OLOGY	0		C	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	980, 148		980, 148	0	980, 148	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	574, 588		574, 588	0	574, 588	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 278, 470		4, 278, 470	0	4, 278, 470	73. 00
76. 97 07697 CARDIAC REHABILITATION	0		C	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	5, 432		5, 432	0	5, 432	76. 98
76. 99 07699 LI THOTRI PSY	0		C	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0		C	0	0	90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0		C	0	0	90. 01
91. 00 09100 EMERGENCY	8, 725, 650		8, 725, 650	20, 786	8, 746, 436	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 454, 914		2, 454, 914		2, 454, 914	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	3, 849, 514		3, 849, 514			
200.00 Subtotal (see instructions)	52, 603, 477	0	52, 603, 477	29, 834	52, 633, 311	
201.00 Less Observation Beds	2, 454, 914		2, 454, 914		2, 454, 914	
202.00 Total (see instructions)	50, 148, 563	0	50, 148, 563	29, 834	50, 178, 397	202. 00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0101	Peri od: Worksheet C
		From 01/01/2018 Part I
		To 12/21/2010 Doto/Time December d.

43. 00 04300 NURSERY 1, 552, 147 1, 552, 147 43.	ed: am
Cost Center Description	
+ col. 7) Ratio Inpatient Ratio	
Ratio Ratio	
NPATI ENT ROUTI NE SERVI CE COST CENTERS 10, 384, 197 10, 384, 197 30. 00 04300 NURSERY 1, 552, 147 1, 552, 147 43.	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 10,384,197 10,384,197 30.43.00 04300 NURSERY 1,552,147 1,552,147 43.	
30. 00 03000 ADULTS & PEDI ATRI CS 10, 384, 197 10, 384, 197 30. 43. 00 04300 NURSERY 1, 552, 147 1, 552, 147 43.	
43. 00 04300 NURSERY 1, 552, 147 1, 552, 147 43.	
	. 00
	. 00
	. 00
ANCILLARY SERVICE COST CENTERS	
	. 00
	. 00
	. 00
	. 00
60. 00 06000 LABORATORY 4, 249, 882 24, 541, 095 28, 790, 977 0. 177908 0. 000000 60.	. 00
	. 30
	. 00
66. 00 06600 PHYSI CAL THERAPY 227, 879 4, 255, 434 4, 483, 313 0. 483239 0. 000000 66.	. 00
67. 00 06700 0CCUPATI ONAL THERAPY 129, 911 1, 242, 424 1, 372, 335 0. 746011 0. 000000 67.	. 00
68. 00 06800 SPEECH PATHOLOGY 22, 647 287, 780 310, 427 0. 333444 0. 000000 68.	. 00
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0. 000000 0. 000000 69.	. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1,049,470 1,935,404 2,984,874 0.328372 0.000000 71.	. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 612, 896 2, 031, 050 2, 643, 946 0. 217322 0. 000000 72.	. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 4,814,148 16,724,334 21,538,482 0.198643 0.000000 73.	. 00
76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0. 000000 0. 000000 76.	. 97
76. 98 07698 HYPERBARI C 0XYGEN THERAPY 39, 839 101, 405 141, 244 0. 038458 0. 000000 76.	. 98
	. 99
OUTPATIENT SERVICE COST CENTERS	
	. 00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM 0 0 0 0. 000000 0 0. 000000 90.	. 01
91. 00 09100 EMERGENCY 4, 045, 285 40, 267, 599 44, 312, 884 0. 196910 0. 000000 91.	. 00
	. 00
OTHER REIMBURSABLE COST CENTERS	
	. 00
200.00 Subtotal (see instructions) 42,828,838 184,149,541 226,978,379 200.	
201.00 Less Observation Beds 201.	
202.00 Total (see instructions) 42,828,838 184,149,541 226,978,379 202.	

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0101	Peri od: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/28/2019 10:24 am

					5/28/2019 10:	24 am_
			Title XIX	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS					30. 00
43.00	04300 NURSERY					43.00
44.00	04400 SKILLED NURSING FACILITY					44. 00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 168683				50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 410551				52. 00
53.00	05300 ANESTHESI OLOGY	0. 009288				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 124021				54.00
60.00	06000 LABORATORY	0. 177908				60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000				62. 30
65.00	06500 RESPIRATORY THERAPY	0. 160658				65. 00
66.00	06600 PHYSI CAL THERAPY	0. 483239				66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 746011				67.00
68.00	06800 SPEECH PATHOLOGY	0. 333444				68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000				69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 328372				71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 217322				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 198643				73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000				76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 038458				76. 98
76. 99	07699 LI THOTRI PSY	0. 000000				76. 99
	OUTPATIENT SERVICE COST CENTERS					1
90.00	09000 CLI NI C	0. 000000				90. 00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0. 000000				90. 01
91.00	09100 EMERGENCY	0. 197379				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 465289				92.00
	OTHER REIMBURSABLE COST CENTERS					1
95.00	09500 AMBULANCE SERVI CES	0. 487254				95. 00
200.00	Subtotal (see instructions)					200.00
201.00						201.00
202.00	Total (see instructions)					202. 00

Health Financial Systems WHITLEY MEM CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Tim WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101

					12/31/2010	5/28/2019 10:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost		Operating Cos		Operating Cost	
		(Wkst. B, Part	(Wkst. B, Part	Net of Capital	Reducti on	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		3, 656, 245	680, 277			0	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 698, 464	175, 572	1, 522, 892	2 0	0	52.00
53.00	05300 ANESTHESI OLOGY	19, 730	1, 955			0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	7, 017, 435	1, 125, 033	5, 892, 402	2 0	0	54. 00
60.00	06000 LABORATORY	5, 122, 141	579, 747	4, 542, 394	1 0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0) (0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	1, 628, 549	222, 488	1, 406, 06	0	0	65. 00
66. 00		2, 166, 511	557, 163	1, 609, 348	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 023, 777	103, 893	919, 88	1 0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	103, 510	10, 709	92, 80°	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0) (0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	980, 148	112, 647	867, 50°	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	574, 588	56, 946	517, 642	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 278, 470	460, 640	3, 817, 830	0	0	73. 00
76. 97	07697 CARDIAC REHABILITATION	o	0)	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	5, 432	578	4, 854	1 0	0	76. 98
76. 99	07699 LI THOTRI PSY	o	0) (0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00		0	O	(0	0	90. 00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0	0)	0	0	90. 01
91.00	09100 EMERGENCY	8, 725, 650	1, 268, 800	7, 456, 850	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 454, 914	404, 226	2, 050, 688	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	3, 849, 514	393, 297	3, 456, 21	7 0	0	95. 00
200.00	Subtotal (sum of lines 50 thru 199)	43, 305, 078	6, 153, 971	37, 151, 10	0	0	200. 00
201.00	Less Observation Beds	2, 454, 914	404, 226	2, 050, 688	0	0	201. 00
202.00	Total (line 200 minus line 201)	40, 850, 164	5, 749, 745	35, 100, 419	0	0	202. 00

Heal th Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY

Worksheet C From 01/01/2018 To 12/31/2018 To 12/31/2018 To 12/31/2018 To 5/28/2019 10: 24 am

						5/28/2019 10:	24 am
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and		Cost to Charge			
		Operating Cost	Part I, column	Ratio (col. 6			
		Reducti on	8)	/ col. 7)			
		6.00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	3, 656, 245	21, 675, 245	0. 168683	3		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 698, 464	4, 137, 031	0. 410551			52. 00
53.00	05300 ANESTHESI OLOGY	19, 730	2, 748, 790	0. 007178	3		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	7, 017, 435	56, 582, 577	0. 124021			54.00
60.00	06000 LABORATORY	5, 122, 141	28, 790, 977	0. 177908	3		60. 00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0. 000000			62. 30
65.00	06500 RESPI RATORY THERAPY	1, 628, 549	10, 136, 714	0. 160658	3		65. 00
66.00	06600 PHYSI CAL THERAPY	2, 166, 511	4, 483, 313	0. 483239			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 023, 777	1, 372, 335	0. 746011			67. 00
68.00	06800 SPEECH PATHOLOGY	103, 510	310, 427	0. 333444			68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	0.000000			69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	980, 148	2, 984, 874	0. 328372	2		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	574, 588	2, 643, 946	0. 217322	2		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 278, 470	21, 538, 482	0. 198643	3		73. 00
	07697 CARDI AC REHABI LI TATI ON	0	0	0. 000000			76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	5, 432	141, 244	0. 038458	3		76. 98
76. 99	07699 LI THOTRI PSY	0	0	0. 000000			76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0.000000)		90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0. 000000			90. 01
91. 00	09100 EMERGENCY	8, 725, 650	44, 312, 884	0. 196910			91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 454, 914	5, 276, 101				92.00
	OTHER REIMBURSABLE COST CENTERS		., .,		•		
95.00	09500 AMBULANCE SERVICES	3, 849, 514	7, 907, 095	0. 486843	3		95. 00
200.00		43, 305, 078	215, 042, 035				200. 00
201.00	· · · · · · · · · · · · · · · · · · ·	2, 454, 914	0				201. 00
202.00		40, 850, 164	215, 042, 035				202. 00

Health Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od: From 01/01/2018	Worksheet D Part I	
				To 12/31/2018		pared: 24 am
		Ti tl e	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	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, 442, 729	0	1, 442, 72			
43. 00 NURSERY	55, 819		55, 81	9 736	75. 84	43. 00
44.00 SKILLED NURSING FACILITY	0			0	0.00	44. 00
200.00 Total (lines 30 through 199)	1, 498, 548		1, 498, 54	8 6, 725		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)	1			
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1, 157	278, 721				30.00
43. 00 NURSERY	0	0)			43. 00
44.00 SKILLED NURSING FACILITY	0	0)			44. 00
200.00 Total (lines 30 through 199)	1, 157	278, 721				200. 00

Health Financial Systems		WHITLEY MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT	ANCILLARY SERVICE CAPITAL	_ COSTS	Provider CCN: 15-0101	Peri od:	Worksheet D

		I AL HOSPI TAL		III LI C	u of Form CMS-2	2332-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL	L COSTS	Provi der Co		Peri od:	Worksheet D	
				From 01/01/2018	Part II	nanad.
				To 12/31/2018	Date/Time Pre 5/28/2019 10:	
		Title	xVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost		Capital Costs	
·	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col		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	680, 277				16, 532	
52.00 05200 DELIVERY ROOM & LABOR ROOM	175, 572				395	52. 00
53. 00 05300 ANESTHESI OLOGY	1, 955				45	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 125, 033				24, 781	
60. 00 06000 LABORATORY	579, 747	28, 790, 977			23, 485	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000		0	62. 30
65. 00 06500 RESPI RATORY THERAPY	222, 488				20, 589	65. 00
66. 00 06600 PHYSI CAL THERAPY	557, 163				12, 278	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	103, 893	1, 372, 335			4, 189	67. 00
68. 00 06800 SPEECH PATHOLOGY	10, 709	310, 427			328	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000		0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	112, 647	2, 984, 874			7, 194	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	56, 946	2, 643, 946	0. 02153	128, 067	2, 758	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	460, 640	21, 538, 482	0. 02138	7 1, 146, 760	24, 526	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	578	141, 244	0. 00409	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 CLI NI C	0	0	0.00000		0	90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0.00000	0 0	0	90. 01
91. 00 09100 EMERGENCY	1, 268, 800				35, 600	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	404, 226	5, 276, 101	0. 07661	5 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	5, 760, 674	207, 134, 940		6, 822, 724	172, 700	200. 00

Health Financial Systems	WHITLEY MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA				Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part III	pared:
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School Nu	ursing School	Allied Health	Allied Health	All Other	
	Post-Stepdown		Post-Stepdowr	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0	0	30.00
43. 00 04300 NURSERY	0	0)	0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0)	0		44. 00
200.00 Total (lines 30 through 199)	0	0)	0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment (sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions) m	ninus col. 4)				
	4.00	5.00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	5, 98	9 0.00	1, 157	30. 00
43. 00 04300 NURSERY		0	73	6 0.00	0	43.00
44.00 04400 SKILLED NURSING FACILITY		0)	0.00	0	44. 00
200.00 Total (lines 30 through 199)		0	6, 72	5	1, 157	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
43. 00 04300 NURSERY	0					43.00
44.00 04400 SKILLED NURSING FACILITY	0					44. 00
200.00 Total (lines 30 through 199)	0					200. 00

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	FANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0101	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared:

					12, 01, 2010	5/28/2019 10:	
				XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
			Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	(0	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	(0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54.00
60.00	06000 LABORATORY	0	0	(0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0	0	(0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	(0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	(0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
76. 97	O7697 CARDI AC REHABI LI TATI ON	0	0	(0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	(0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0	(0	0	90. 00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0	0	(0	0	90. 01
91.00	09100 EMERGENCY	0	0	(0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		()	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0	(0	0	200. 00

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0101	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2018	Part IV

THROUGH COSTS				rom 01/01/2018 fo 12/31/2018	Date/Time Pre	
		T: 41 -	V() (1 1 1	11: 4-1	5/28/2019 10: 3	24 am_
0 1 0 1 0 1 1	A11 011		XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
	Education Cost		Cost (sum of	· ·	(col. 5 ÷ col.	
		4)	cols. 2, 3, and 4)	8)	7)	
	4.00	5. 00	6.00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
50. 00 05000 OPERATI NG ROOM	0	0	(21, 675, 245	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		4, 137, 031	0. 000000	
53. 00 05300 ANESTHESI OLOGY	0	0		2, 748, 790		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		56, 582, 577		
60. 00 06000 LABORATORY	0	0		28, 790, 977		
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0. 000000	
65. 00 06500 RESPIRATORY THERAPY	0	Ö		10, 136, 714	0. 000000	
66. 00 06600 PHYSI CAL THERAPY	0	O		4, 483, 313		
67. 00 06700 OCCUPATIONAL THERAPY	0	0		1, 372, 335		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0		310, 427	0. 000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		2, 984, 874	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		2, 643, 946	0.000000	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		21, 538, 482	0.000000	73. 00
76. 97 07697 CARDIAC REHABILITATION	0	0		0	0.000000	76. 97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		141, 244	0.000000	76. 98
76. 99 07699 LI THOTRI PSY	0	0	(0	0.000000	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	(0	0.000000	90.00
90.01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0	(0	0.000000	90. 01
91. 00 09100 EMERGENCY	0	0	(44, 312, 884	0.000000	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(5, 276, 101	0.000000	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	0	0	(207, 134, 940	 	200. 00

Health Financial Systems	WHITLEY MEMORIA	AL HOSPITAL		In lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS		Provider CO		Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV	pared:
		Title	XVIII	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	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	526, 735		2, 349, 167	0	00.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	9, 302		0	0	02.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	63, 581		298, 770	0	00.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 246, 341		9, 708, 487	0	
60. 00 06000 LABORATORY	0. 000000	1, 166, 313		195, 496	0	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0	0	02.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	938, 017		1, 652, 780	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	98, 794		48, 363	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	55, 331		0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000	9, 522		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	190, 623		244, 027	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	128, 067		166, 791	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 146, 760		4, 856, 000	0	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0	0	76. 99
OUTPATIENT SERVICE COST CENTERS	<u> </u>		<u>'</u>	<u>'</u>		1
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0. 000000	0		0	0	90. 01
91. 00 09100 EMERGENCY	0. 000000	1, 243, 338		6, 181, 439	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		396, 027	0	92.00
OTHER RELIMBURSABLE COST CENTERS	•		•			1

6, 822, 724

0 200. 00

0 92.00 95.00

26, 097, 347

0

92. 00 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST		Peri od: From 01/01/2018	Worksheet D Part V

					From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
						5/28/2019 10:	24 am_
			Title	XVIII	Hospi tal	PPS	
				Charges	_	Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
		1.00	0.00	(see inst.)	(see inst.)	F 00	
	ANOLLI ADV. CEDVI OF COCT. CENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	
F0 00	ANCILLARY SERVICE COST CENTERS	0.4/0/00	0.040.477			20/ 0/5	F0 00
50.00	05000 OPERATING ROOM	0. 168683	2, 349, 167		0	396, 265	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 410551	0		0	0	52.00
53. 00	05300 ANESTHESI OLOGY	0. 007178	298, 770		0	2, 145	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 124021	9, 708, 487		0	1, 204, 056	
60.00	06000 LABORATORY	0. 177908	195, 496		0	34, 780	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	1	0	0	
65. 00	06500 RESPI RATORY THERAPY	0. 160658	1, 652, 780		0	265, 532	
66. 00	06600 PHYSI CAL THERAPY	0. 483239	48, 363	(0	23, 371	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 746011	0	(0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 333444	0	(0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	0	(0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 328372	244, 027	(0	80, 132	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 217322	166, 791	(0	36, 247	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 198643	4, 856, 000	C	0	964, 610	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 038458	0	(0	0	76. 98
76. 99	07699 LI THOTRI PSY	0. 000000	0		0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000	0	(0	0	90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0. 000000	0	(0	0	90. 01
91.00	09100 EMERGENCY	0. 196910	6, 181, 439	1	0	1, 217, 187	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 465289	396, 027	1 0	0	184, 267	92. 00
	OTHER REIMBURSABLE COST CENTERS				"		
95.00	09500 AMBULANCE SERVICES	0. 486843)		95. 00
200.00	Subtotal (see instructions)		26, 097, 347	1 0	0	4, 408, 592	200. 00
201. 00	, ,			1	ol o		201. 00
	Only Charges						
202. 00			26, 097, 347	(0	4, 408, 592	202. 00

Health Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C	CN: 15-0101	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Pre 5/28/2019 10:3	pared: 24 am
		Title	e XVIII	Hospi tal	PPS	
	Co:	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				

		00.	313		
	Cost Center Description	Cost	Cost		
		Rei mbursed	Rei mbursed		
		Servi ces	Services Not		
		Subject To	Subject To		
		Ded. & Coins.			
		(see inst.)	(see inst.)		
		6. 00	7. 00		
	ANCI LLARY SERVI CE COST CENTERS		1		4
	05000 OPERATING ROOM	0	0)	50. 00
	05200 DELIVERY ROOM & LABOR ROOM	0	0)	52. 00
	05300 ANESTHESI OLOGY	0	0)	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	0)	54. 00
60.00	06000 LABORATORY	0	0		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62. 30
65.00	06500 RESPI RATORY THERAPY	0	0		65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		73. 00
	07697 CARDI AC REHABI LI TATI ON	0	0)	76. 97
	07698 HYPERBARI C OXYGEN THERAPY		0		76. 98
	07699 LI THOTRI PSY		0		76. 99
	OUTPATIENT SERVICE COST CENTERS				1 / 5. //
	09000 CLI NI C	0	0)	90.00
	09001 INTENSIVE OUT PATIENT PROGRAM		0		90. 01
	09100 EMERGENCY		0		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0)	92. 00
	OTHER REIMBURSABLE COST CENTERS				72.00
	09500 AMBULANCE SERVICES	0			95. 00
200.00			0		200. 00
201.00					201. 00
2 30	Only Charges				1
202.00	Net Charges (line 200 - line 201)	0	0		202. 00
	1 3.4 (I .	1

Health Financial Systems	WHITLEY MEMORI	IAL HOSPITAL		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2018 To 12/31/2018		pared: 24 am	
			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				
	Part II, col.		(col . 1 - col				
	26)		2)				
	1.00	2. 00	3. 00	4. 00	5. 00		
INPATIENT ROUTINE SERVICE COST CENTERS	1						
30.00 ADULTS & PEDIATRICS	1, 442, 729	[C	1, 442, 72	9 5, 989			
43. 00 NURSERY	55, 819		55, 81	9 736	75. 84	43.00	
44.00 SKILLED NURSING FACILITY	0			0	0.00	44.00	
200.00 Total (lines 30 through 199)	1, 498, 548		1, 498, 54	8 6, 725		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 & PEDI ATRI CS	47	11, 322	2			30.00	
43. 00 NURSERY	22	1, 668	3			43. 00	
44.00 SKILLED NURSING FACILITY	0	[C)			44. 00	
200.00 Total (lines 30 through 199)	69	12, 990)			200. 00	

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lie	eu of Form CMS-2552-10
ADDODEL CHIMENET OF LAIDATLENE ANGLE	LADY CEDULAE AADLEAL ACCTO	D J CON 15 0101	D 1 1	W I I I D

Heal th Financi	al Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		AL COSTS	Provi der C		Period: From 01/01/2018 To 12/31/2018	Date/Time Pre 5/28/2019 10:	pared: 24 am	
				e XIX	Hospi tal	PPS		
Co	ost Center Description	Capi tal	Total Charges			Capital Costs		
			(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		
	RY SERVICE COST CENTERS							
	PERATING ROOM	680, 277				16, 321		
	ELIVERY ROOM & LABOR ROOM	175, 572	4, 137, 031	0. 04243	9 730, 748	31, 012	52. 00	
53. 00 05300 AI	NESTHESI OLOGY	1, 955	2, 748, 790	0. 00071	1 77, 579	55	53. 00	
54. 00 05400 R/	ADI OLOGY-DI AGNOSTI C	1, 125, 033	56, 582, 577	0. 01988	3 111, 955	2, 226	54.00	
60. 00 06000 L	ABORATORY	579, 747	28, 790, 977	0. 02013	6 370, 531	7, 461	60.00	
62. 30 06250 BI	LOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	0 0	0	62. 30	
65. 00 06500 RI	ESPI RATORY THERAPY	222, 488	10, 136, 714	0. 02194	9 108, 535	2, 382	65.00	
66. 00 06600 PI	HYSI CAL THERAPY	557, 163	4, 483, 313	0. 12427	5 3, 045	378	66.00	
67. 00 06700 00	CCUPATIONAL THERAPY	103, 893	1, 372, 335	0. 07570	1, 614	122	67.00	
68. 00 06800 SI	PEECH PATHOLOGY	10, 709	310, 427	0. 03449	8 253	9	68. 00	
69. 00 06900 EI	LECTROCARDI OLOGY	0	0	0.00000	0 0	0	69.00	
71. 00 07100 MI	EDICAL SUPPLIES CHARGED TO PATIENT	112, 647	2, 984, 874	0. 03773	9 105, 409	3, 978	71.00	
72.00 07200 11	MPL. DEV. CHARGED TO PATIENTS	56, 946	2, 643, 946	0. 02153	8 0	0	72. 00	
73. 00 07300 DI	RUGS CHARGED TO PATIENTS	460, 640	21, 538, 482	0. 02138	7 296, 420	6, 340	73. 00	
76. 97 07697 CA	ARDIAC REHABILITATION	0	O	0.00000	0	0	76. 97	
76. 98 07698 H	YPERBARIC OXYGEN THERAPY	578	141, 244	0.00409	2 0	0	76. 98	
76. 99 07699 LI	I THOTRI PSY	0	O	0.00000	0	0	76. 99	
OUTPATI	ENT SERVICE COST CENTERS	<u>'</u>			<u>'</u>		1	
90. 00 09000 CI		0	C	0.00000	0 0	0	90.00	
90. 01 09001 11	NTENSIVE OUT PATIENT PROGRAM	0	0	0. 00000	0	0	1	
	MERGENCY	1, 268, 800	44, 312, 884	0. 02863	3 127, 168	3, 641	91.00	
92. 00 09200 01	BSERVATION BEDS (NON-DISTINCT PART	404, 226				0	1	
	EIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		•			1	
	MBULANCE SERVICES						95.00	
200. 00 To	otal (lines 50 through 199)	5, 760, 674	207, 134, 940		2, 453, 285	73, 925	200. 00	

Health Financial Systems	WHITLEY MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA		Provi der CO		Period: From 01/01/2018 To 12/31/2018	Worksheet D Part III Date/Time Pre 5/28/2019 10:	
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School N	ursing School	Allied Health	Allied Health	All Other	
	Post-Stepdown		Post-Stepdowr	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0	0	30. 00
43. 00 04300 NURSERY	0	0		0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	O	0		0		44.00
200.00 Total (lines 30 through 199)	o	0		0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment ((sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions) n	ninus col. 4)				
	4. 00	5.00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	5, 98		47	30. 00
43. 00 04300 NURSERY		0	73	6 0.00	22	43.00
44.00 04400 SKILLED NURSING FACILITY		0		0.00	0	44. 00
200.00 Total (lines 30 through 199)		0	6, 72	5	69	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30. 00
43. 00 04300 NURSERY	0					43. 00
44. 00 04400 SKILLED NURSING FACILITY	0					44. 00
200.00 Total (lines 30 through 199)	0					200. 00

Heal	th Financial Systems	WHITLEY ME	MORIAL HOSPITA	L	In Lieu	u of Form CMS-2552-10
	ORTIONMENT OF INPATIENT/OUTPATIENT DUGH COSTS	ANCILLARY SERVICE OTHER I	PASS Provi de	r CCN: 15-0101	From 01/01/2018	Worksheet D Part IV Date/Time Prepared:

				'	0 12/31/2010	5/28/2019 10:	24 am
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician		Nursing School	Allied Health	Allied Health	
		Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	0	0	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0) C	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0) C	0	0	54. 00
60.00	06000 LABORATORY	0	0) C	0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0) C	0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0	0	0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0) C	0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	0	0) C	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0) c	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0) c	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0) c	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0) c	0	0	73. 00
76. 97	07697 CARDIAC REHABILITATION	0	0) c	0	0	76. 97
76. 98	07698 HYPERBARIC OXYGEN THERAPY	0	0) c	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	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	0	0	0	0	90. 01
91.00	09100 EMERGENCY	0	0	0	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		C		0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0) C	0	0	200. 00

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0101	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2018	

THROUGH	1 COSTS				Fo 12/31/2018		pared: 24 am
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)			
	ANGLE ARY OFRICE COOT OFFITTERS	4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	1 .					
	05000 OPERATING ROOM	0	0		21, 675, 245	l	
	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	4, 137, 031	0.000000	1
	05300 ANESTHESI OLOGY	0	0	(2, 748, 790	•	
	05400 RADI OLOGY-DI AGNOSTI C	0	0		56, 582, 577		1
	06000 LABORATORY	0	0	(28, 790, 977		
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0.000000	1
	06500 RESPI RATORY THERAPY	0	0		10, 136, 714	0.000000	
	06600 PHYSI CAL THERAPY	0	0		4, 483, 313		
	06700 OCCUPATI ONAL THERAPY	0	0	(1, 372, 335		
	06800 SPEECH PATHOLOGY	0	0) (310, 427	l	1
	06900 ELECTROCARDI OLOGY	0	0) (0	0.000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(2, 984, 874	0.000000	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	2, 643, 946	0.000000	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0) (21, 538, 482	0.000000	73. 00
76. 97	07697 CARDIAC REHABILITATION	0	0)	0	0.000000	76. 97
76. 98	07698 HYPERBARIC OXYGEN THERAPY	0	0)	141, 244	0.000000	76. 98
76. 99	07699 LI THOTRI PSY	0	0	(0	0.000000	76. 99
0	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	0	0	(0	0.000000	90. 00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0	0) (0	0.000000	90. 01
91.00	09100 EMERGENCY	0	0) (44, 312, 884	0.000000	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(5, 276, 101	0.000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0) (207, 134, 940	l	200. 00

Health Financial Systems	WHITLEY MEMORIA	L HOSPITAL		In Lieu of Form CMS-2552-1		
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCII THROUGH COSTS	LLARY SERVICE OTHER PASS			Peri od: From 01/01/2018 To 12/31/2018		
		Ti tl	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)		V COL 10)		v col 12)	

					3/20/2019 10. 2		24 dili
			Ti tl	e XIX	Hospi tal PPS		
	Cost Center Description	Outpati ent	I npati 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.		Costs (col. 8		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12. 00	13. 00	
	ANCILLARY SERVICE COST CENTERS	·					
50.00	05000 OPERATI NG ROOM	0. 000000	520, 028	0	0	0	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	730, 748		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000	77, 579	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	111, 955	0	0	0	54.00
60.00	06000 LABORATORY	0. 000000	370, 531	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	108, 535	0	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	3, 045	0	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	1, 614	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	253	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	105, 409	0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	296, 420	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	<u>'</u>		'		<u> </u>	
90.00	09000 CLI NI C	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	127, 168	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 SERVI CES						95. 00
200.00			2, 453, 285	0	0	0	200. 00

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0101	Peri od:	Worksheet D

From 01/01/2018 | Part V To 12/31/2018 | Date/Time Prepared: 5/28/2019 10: 24 am Title XIX Hospi tal PPS Costs Charges Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Rei mbursed Ratio From Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 168683 1, 133, 277 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.410551 0 0 0 0 0 0 0 0 0 0 0 0 0 52.00 05300 ANESTHESI OLOGY 0.007178 53 00 0 112, 702 53 00 0 |05400| RADI OLOGY-DI AGNOSTI C 54.00 0.124021 0 3, 277, 481 0 54.00 60.00 06000 LABORATORY 0. 177908 1, 883, 041 0 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0 62.30 0 06500 RESPIRATORY THERAPY 65.00 0.160658 600, 438 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 483239 203, 061 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.746011 55, 329 0 67.00 06800 SPEECH PATHOLOGY 0 333444 68 00 68 00 155, 358 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 328372 183, 972 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0. 217322 102, 606 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 73 00 0.198643 825, 364 0 73.00 76. 97 07697 CARDIAC REHABILITATION 0.000000 0 0 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.038458 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0.000000 0 76. 99 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 0 0 0 90.00 09001 INTENSIVE OUT PATIENT PROGRAM 0.000000 0 0 0 0 90.01 90.01 09100 EMERGENCY 0. 196910 6, 093, 696 0 91.00 91.00 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 465289 92.00 92.00 1,541 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0. 486843 518, 671 95.00 200.00 Subtotal (see instructions) 0 0 0 200. 00 15, 146, 537 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 0 202.00 15, 146, 537

Health Financial Systems		WHITL	EY MEMORIAI	_ HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVI	CES AND VACCI	NE COST	Provider CCN: 15-0	From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared:

				To 12/31/2018	Date/Time Prepared: 5/28/2019 10:24 am
		Ti tl	e XIX	Hospi tal	PPS
	Cos				
Cost Center Description	Cost	Cost			
	Rei mbursed	Reimbursed			
	Servi ces	Services Not			
	Subject To	Subject To			
	Ded. & Coins.	Ded. & Coins.			
	(see inst.)	(see inst.)			
	6. 00	7. 00			
ANCILLARY SERVICE COST CENTERS	104.4/5				
50. 00 05000 OPERATI NG ROOM	191, 165				50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0			52. 00
53. 00 05300 ANESTHESI OLOGY	809	0			53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	406, 476				54.00
60. 00 06000 LABORATORY	335, 008	0			60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0			62. 30
65. 00 06500 RESPI RATORY THERAPY	96, 465	0			65. 00
66. 00 06600 PHYSI CAL THERAPY	98, 127	0			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	41, 276				67. 00
68. 00 06800 SPEECH PATHOLOGY	51, 803	0			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	60, 411	0			71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	22, 299	0			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	163, 953	0			73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0			76. 98
76. 99 07699 LI THOTRI PSY	0	0			76. 99
OUTPATIENT SERVICE COST CENTERS					00.00
90. 00 09000 CLI NI C	0	0			90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	1 100 010	0			90. 01
91. 00 09100 EMERGENCY	1, 199, 910				91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	717	0			92.00
95. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 O9500 AMBULANCE SERVI CES	252 511				95. 00
	252, 511	0			
200.00 Subtotal (see instructions)	2, 920, 930	0			200. 00
201.00 Less PBP Clinic Lab. Services-Program Only Charges					201. 00
202.00 Net Charges (line 200 - line 201)	2, 920, 930	0			202.00
202.00 Net Charges (Title 200 - Title 201)	2, 920, 930	ı	I		J202. 00

Health Financial Systems	WHITLEY MEMORIAL HOSPIT	AL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi	er CCN: 15-0101	Peri od: From 01/01/2018	Worksheet D-1
				Date/Time Prepared: 5/28/2019 10:24 am
		Title XVIII	Hospi tal	PPS

		Title XVIII	Hospi tal	5/28/2019 10: PPS	24 am
	Cost Center Description	11.00 2011	nosp. ta.		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			5, 989	1.00
2.00	Inpatient days (including private room days, excluding swing-l		ivata maam daya	5, 989 0	2. 00 3. 00
3.00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pr	i vate i ooiii days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		4, 311	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	5. 00
/ 00	reporting period	d) -6t D	21 -6 +6		/ 00
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private roor	m days) after December 3	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 157	9.00
7.00	newborn days)	o the trogram (energating	oming bod and	.,	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		oom dove) ofter	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, en		dolli days) arter	U	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
40.00	through December 31 of the cost reporting period				40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)			0	
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
00	reporting period	so till dagi. December e. e		0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
17.00	reporting period	3 through becomber 31 of	the cost	0.00	17.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	=)		8, 761, 892	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	0, 701, 072	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	and 31 of the cost reporti	na period (line	0	24. 00
	7 x line 19)	·			
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		8, 761, 892	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 -	: line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	,		0. 00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	1: 00) (0. 00 0. 00	1
34. 00 35. 00					34. 00 35. 00
36. 00					36. 00
37. 00					37. 00
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			1
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 463. 00	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		1, 692, 691	
40.00	Medically necessary private room cost applicable to the Program general inpatient routine service cost (Line 20)			1 602 601	
41.00	Total Program general inpatient routine service cost (line 39	+ IIIIE 40 <i>)</i>	l	1, 692, 691	J 41. UU

<u>Heal t</u> h	Financial Systems	WHITLEY MEMORI	AL HOSPITAL		<u>In L</u> ie	eu of Form CMS-2	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST		Provi der (CCN: 15-0101	Period: From 01/01/2018	Worksheet D-1	
					To 12/31/2018	Date/Time Pre	pared:
-			Titl	e XVIII	Hospi tal	5/28/2019 10: PPS	<u> 24 am</u>
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	Inpatient Day		÷	(col. 3 x col.	
		1.00	2. 00	col. 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0		0.0	00 0		42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT					I	43.00
44. 00	CORONARY CARE UNIT						44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46.00	1						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	·					1. 00	
48. 00	Program inpatient ancillary service cost (Wk			one)		1, 261, 855 2, 954, 546	
49.00	Total Program inpatient costs (sum of lines : PASS THROUGH COST ADJUSTMENTS	41 (111 Ough 46) (see mstructi	OHS)		2, 954, 540	49.00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sur	of Parts I and	278, 721	50.00
51. 00		ationt ancillar	v sarvicas (f	From Wkst D s	rum of Darte II	172, 700	51.00
31.00	and IV)	attent ancittar	y services (i	TOIII WKSt. D, S	sum of rarts if	172,700	31.00
52.00	Total Program excludable cost (sum of lines					451, 421	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		lated, non-ph	iysician anestr	etist, and	2, 503, 125	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	02)					
	Program di scharges					0	
56.00	Target amount per discharge Target amount (line 54 x line 55)					0.00	1
57. 00	, ,	ing cost and ta	rget amount (line 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)					0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	enaing 1996,	updated and co	ompounaea by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	
61. 00	If line 53/54 is less than the lower of line					0	61.00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		S (TITIES 54 X	. 60), 01 1% 01	the target		
	Relief payment (see instructions)	•				0	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63.00
64. 00		ts through Dece	mber 31 of th	e cost reporti	ng period (See	0	64. 00
/F 00	instructions)(title XVIII only)		04 6 11		1 1 (6		45.00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts arter Decemb	er 31 of the	cost reportino	j period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	o costs through	Docombor 21	of the cost re	porting ported	0	67. 00
67.00	(line 12 x line 19)	e costs through	December 31	or the cost re	portring perrou		07.00
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost repo	orting period	0	68. 00
69 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + lin	ne 68)		0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	, AND ICF/IID	ONLY			
70. 00 71. 00	Skilled nursing facility/other nursing facil	,		•			70. 00 71. 00
71.00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine /U = IINe	: 4)			72.00
73. 00	Medically necessary private room cost applic						73. 00
74. 00 75. 00	Total Program general inpatient routine serv	•		•	Part II column		74. 00 75. 00
75.00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (110M	WOI KSHEEL B, F	art II, COLUMN		/ 5.00
76.00	Per diem capital-related costs (line 75 ÷ li	,					76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu	,					77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces	,	rovi der recor	ds)			79. 00
	Total Program routine service costs for comp		ost limitatio	n (line 78 mir	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (* .				83. 00
84. 00	Program inpatient ancillary services (see in	structions)					84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
55. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS		. sagn 65)				30.00
87. 00	Total observation bed days (see instructions)	11 0			1, 678	1
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	iine 2)			1, 463. 00 2, 454, 914	
00	(30) (30)					2, .51, 714	

Health Financial Systems	WHITLEY MEMORI	IAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od: From 01/01/2018	Worksheet D-1	
				To 12/31/2018		
		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, 442, 729	8, 761, 892	0. 16466	0 2, 454, 914	404, 226	90.00
91.00 Nursing School cost	0	8, 761, 892	0.00000	0 2, 454, 914	0	91.00
92.00 Allied health cost	0	8, 761, 892	0.00000	0 2, 454, 914	0	92.00
93.00 All other Medical Education	0	8, 761, 892	0.00000	0 2, 454, 914	0	93.00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0101	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 10:24 am
	Title XIX	Hospi tal	PPS

		Title XIX	Hospi tal	5/28/2019 10: PPS	24 am	
	Cost Center Description			1. 00		
	PART I - ALL PROVIDER COMPONENTS					
1. 00 2. 00 3. 00	On Inpatient days (including private room days, excluding swing-bed and newborn days) On Private room days (excluding swing-bed and observation bed days). If you have only private room days,					
4. 00 5. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private room reporting period		31 of the cost	4, 311 0	4. 00 5. 00	
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December :	31 of the cost	0	6. 00	
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00	
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	1 of the cost	0	8. 00	
9. 00	Total inpatient days including private room days applicable to newborn days)	0 1		47	9. 00	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct	tions)	,	0	10. 00	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nter O on this line)	,	0	11.00	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	3	,	0	12.00	
13. 00 14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra	ear, enter O on this line	e)	0	13. 00 14. 00	
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	an (excluding swing-bed to	lays)	736 22		
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00	
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	<u> </u>		0.00		
19. 00	reporting period					
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	J		0.00		
21. 00	reporting period Total general inpatient routine service cost (see instructions			8, 761, 892	21. 00	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost reporti	ng period (line	0	22. 00	
23. 00	Swing-bed cost applicable to SNF type services after December \mathbf{x} line 18)	31 of the cost reporting	g period (line 6	0	23. 00	
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	·		0	24. 00	
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00	
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		0 8, 761, 892	26. 00 27. 00	
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00	
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges)	line 20)		0. 000000	30.00	
32.00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 - line 3)	FITTHE 28)		0.00000	31. 00 32. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00	
34. 00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00		
35. 00	Average per diem private room cost differential (line 34 x lin			0.00	35. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36. 00	
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	fferential (line	8, 761, 892	37. 00	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	IOTHENTO				
00.05	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			4 440 ==	00.00	
38. 00	Adjusted general inpatient routine service cost per diem (see	•		1, 463. 00	38.00	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		68, 761 0	39. 00 40. 00	
	Total Program general inpatient routine service cost (line 39)	,		68, 761		

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OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	WHITLEY MEMORI	Provider C	CN: 15-0101	Peri od:	u of Form CMS-2 Worksheet D-1	
					From 01/01/2018 To 12/31/2018	Date/Time Pre 5/28/2019 10:	
			Ti tl	e XIX	Hospi tal	PPS	24 aiii
	Cost Center Description	Total Inpati ent Cost	Total Inpatient Days 2.00	Average Per Diem (col. 1 col. 2) 3.00		Program Cost (col. 3 x col. 4) 5.00	
2. 00	NURSERY (title V & XIX only)	1. 00 536, 507	736			16, 037	42.0
	Intensive Care Type Inpatient Hospital Units					,	
3. 00	INTENSIVE CARE UNIT						43.0
4. 00 5. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. C
	SURGICAL INTENSIVE CARE UNIT						46.0
7. 00	OTHER SPECIAL CARE (SPECIFY)						47. 0
	Cost Center Description					1. 00	
8. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			607, 046	48. (
9. 00	Total Program inpatient costs (sum of lines			ns)		691, 844	
0 00	PASS THROUGH COST ADJUSTMENTS			WI+ D	£ Dt-	12.000	,
0. 00	Pass through costs applicable to Program inp	atient routine	services (Tron	WKST. D, SU	m or Parts I and	12, 990	50.0
1. 00	Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D,	sum of Parts II	73, 925	51.0
2 00	and IV)	FO 1 F4\				0/ 01=	
2. 00 3. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non-nhy	sician anost	hetist and	86, 915 604, 929	
5. 00	medical education costs (line 49 minus line		. a tou, Hon-phy			004, 929] 33. (
	TARGET AMOUNT AND LIMIT COMPUTATION						
4. 00 5. 00							54. (55. (
6. 00						0.00	
7. 00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	1
8. 00	, ,					0	
9. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	ending 1996, L	pdated and c	ompounded by the	0.00	59. (
0. 00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the m	arket basket		0.00	60.0
1. 00	If line 53/54 is less than the lower of line					0	61. (
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% o	f the target		
2. 00	1	instructions)				0	62.0
3. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63.0
4. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Doso	mbor 21 of the	cost roport	ing pariod (Saa	0	64. 0
4.00	instructions) (title XVIII only)	ts through bece	liibei 31 01 the	cost report	ing perrod (see	O	04.0
5. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reportin	g period (See	0	65.0
6. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	no costs (lino	64 plus lino 6	5) (+i +l o V/I	II only) For	0	66. (
0. 00	CAH (see instructions)	ne costs (Title	04 prus rriie c	5)(title XVI	ii oniy). Toi	0	00.0
7. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 c	f the cost r	eporting period	0	67.0
8 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	a costs after N	ecember 31 of	the cost ren	orting period	0	68. 0
0.00	(line 13 x line 20)	e costs after D	ecember 31 01	the cost rep	ortring perrou	O	00. 0
9. 00	Total title V or XIX swing-bed NF inpatient					0	69.0
0. 00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil)		70. (
1. 00	Adjusted general inpatient routine service c)		71. (
2. 00	Program routine service cost (line 9 x line	71)					72. 0
3. 00 4. 00	Medically necessary private room cost applic	9	•	,			73.0
4. 00 5. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•	,		Part II. column		74. 0 75. 0
	26, line 45)				,		
6.00	Per diem capital related costs (line 75 ÷ li	,					76. (
7. 00 8. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. (78. (
9. 00	Aggregate charges to beneficiaries for exces	,	rovi der record	s)			79. (
0.00	,		ost limitation	(line 78 mi	nus line 79)		80.
1. 00 2. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81. (82. (
2. 00 3. 00	Reasonable inpatient routine service cost it ill tation (i		•				83. (
4. 00	Program inpatient ancillary services (see in		•				84. (
	Utilization review - physician compensation						85. (
6. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 85)				86.0
7. 00	Total observation bed days (see instructions					1, 678	87. 0
	Adjusted general inpatient routine cost per	•	line 2)			1, 463. 00	
8. 00	Observation bed cost (line 87 x line 88) (se		11110 2)			2, 454, 914	

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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, 442, 729	8, 761, 892	0. 16466	0 2, 454, 914	404, 226	90.00
91.00 Nursing School cost	0	8, 761, 892	0.00000	0 2, 454, 914	0	91.00
92.00 Allied health cost	0	8, 761, 892	0.00000	0 2, 454, 914	0	92.00
93.00 All other Medical Education	0	8, 761, 892	0.00000	0 2, 454, 914	0	93. 00

INPATIENT A	NNCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0101	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Preps/28/2019 10:3	pared:
		Ti tl e	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	The state of the s	I npati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
	TIENT ROUTINE SERVICE COST CENTERS					
	O ADULTS & PEDIATRICS			1, 891, 263		30.00
43. 00 0430						43.00
	LLARY SERVICE COST CENTERS					
	O OPERATI NG ROOM		0. 1686			50.00
	O DELIVERY ROOM & LABOR ROOM		0. 4105		3, 819	
	O ANESTHESI OLOGY		0. 0092		591	53. 0
	O RADI OLOGY-DI AGNOSTI C		0. 1240		154, 572	
	O LABORATORY		0. 1779		207, 496	
	O BLOOD CLOTTING FOR HEMOPHILIACS		0.0000		0	
	O RESPIRATORY THERAPY		0. 1606		150, 700	
	O PHYSI CAL THERAPY		0. 4832		47, 741	
	O OCCUPATIONAL THERAPY		0. 7460		41, 278	
	O SPEECH PATHOLOGY		0. 3334		3, 175	
	O ELECTROCARDI OLOGY		0.0000		0	
	O MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3283		62, 595	
	O I MPL. DEV. CHARGED TO PATIENTS		0. 2173		27, 832	
	O DRUGS CHARGED TO PATIENTS 7 CARDIAC REHABILITATION		0. 1986 0. 0000		227, 796 0	
	7 CARDIAC REHABILITATION 8 HYPERBARIC OXYGEN THERAPY		0.0000		0	76. 98
	9 LI THOTRI PSY		0.0384		0	
	ATIENT SERVICE COST CENTERS		0.0000	00 0	U	76. 9
	O CLINIC		0.0000	00 0	0	90. 0
	1 INTENSIVE OUT PATIENT PROGRAM		0.0000		0	
	O EMERGENCY		0.0000		245, 409	
	O OBSERVATION BEDS (NON-DISTINCT PART		0. 1973		245, 409	1
	R REIMBURSABLE COST CENTERS		0.4032	07 0	U	72.0
	O AMBULANCE SERVICES					95. 0
200. 00 200. 00	Total (sum of lines 50 through 94 and 96 through 98)			6, 822, 724	1, 261, 855	
200.00	Less PBP Clinic Laboratory Services-Program only charge:	s (line 61)		0, 822, 724		201. 0
202.00	Net charges (line 200 minus line 201)	3 (TITIE OI)		6, 822, 724		202. 00

Health Financial Systems WHITLEY ME	MORIAL HOSPITAL		In lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0101	Peri od:	Worksheet D-3	
			From 01/01/2018		
			To 12/31/2018	Date/Time Pre 5/28/2019 10:	pared:
-	Ti +I	e XIX	Hospi tal	972872019 10: . PPS	24 alli
Cost Center Description	11 (1	Ratio of Cos		Inpati ent	
3331 33111311 33331 1 211 311		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
			, and the second	2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			432, 077		30. 00
43. 00 04300 NURSERY			427, 339		43. 00
ANCILLARY SERVICE COST CENTERS		1			
50. 00 05000 OPERATI NG ROOM		0. 16868			
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 4105			
53. 00 O5300 ANESTHESI OLOGY		0.00928			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 12402		13, 885	
60. 00 06000 LABORATORY		0. 17790		65, 920	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000		0	62. 30
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		0. 1606! 0. 4832:		17, 437	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 4832		1, 471 1, 204	
68. 00 06800 SPEECH PATHOLOGY		0. 7460		1, 204	68.00
69. 00 06900 SPEECH PATHOLOGY		0. 00000		0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3283		34, 613	
72. 00 07200 MPL. DEV. CHARGED TO PATIENTS		0. 3263		34,013	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 19864		58, 882	
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 00000		0	
76. 98 O7698 HYPERBARI C OXYGEN THERAPY		0. 0384		0	76. 98
76. 99 07699 LI THOTRI PSY		0.00000		0	76. 99
OUTPATIENT SERVICE COST CENTERS		0.0000	3		70.77
90. 00 09000 CLINIC		0.00000	00 0	0	90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM		0. 00000		0	90. 01
91. 00 09100 EMERGENCY		0. 1973		25, 100	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 46528		0	
OTHER REIMBURSABLE COST CENTERS		,			1
95. 00 09500 AMBULANCE SERVICES					95. 00
200.00 Total (sum of lines 50 through 94 and 96 through 9	98)		2, 453, 285	607, 046	200. 00
201.00 Less PBP Clinic Laboratory Services-Program only of			0		201. 00
202.00 Net charges (line 200 minus line 201)	•		2, 453, 285		202. 00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0101	From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/28/2019 10:24 am

			10 12/31/2010	5/28/2019 10:	
		Title XVIII Hospital		PPS	
	DART A LUDATI SUT HOODI TAL OFFINI OFFI HUDER LIDE			1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			0	1 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (see				1. 00 1. 01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurri	ng on or after October	1 (see	599, 996	1. 02
1.03	instructions) DRG for federal specific operating payment for Model 4 BPCI for	or discharges occurring	prior to October	0	1. 03
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring	on or after	0	1. 04
2.00	October 1 (see instructions) Outlier payments for discharges. (see instructions)			15, 003	2.00
2. 01	Outlier reconciliation amount	ana)		0	2. 01
2. 02 3. 00	Outlier payment for discharges for Model 4 BPCI (see instructi Managed Care Simulated Payments	OIIS)		0	2. 02 3. 00
4. 00	Bed days available divided by number of days in the cost report	rting period (see instru	ctions)	25. 20	4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most	t recent cost reporting	period ending on	0. 00	5. 00
6. 00	or before 12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs that meet the	ne criteria for an add-o	n to the cap for	0. 00	6. 00
7. 00	new programs in accordance with 42 CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified u	under 42 CED 8412 105(f)	(1) (i v) (D) (1)	0. 00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under			0.00	7. 00
8.00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopar affiliated programs in accordance with 42 CFR 413.75(b), 413.11998), and 67 FR 50069 (August 1, 2002).			0. 00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slopeport straddles July 1, 2011, see instructions.	ots under § 5503 of the	ACA. If the cost	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slounder § 5506 of ACA. (see instructions)	ots from a closed teachi	ng hospital	0. 00	8. 02
9. 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
10. 00 11. 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	ds	0.00	10. 00 11. 00
12. 00	Current year allowable FTE (see instructions)				12.00
13. 00	Total allowable FTE count for the prior year.			0.00	
14. 00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	ar ended on or after Sep	tember 30, 1997,	0. 00	14. 00
15. 00	Sum of lines 12 through 14 divided by 3.			0. 00	15. 00
16. 00	Adjustment for residents in initial years of the program				16.00
17.00	Adjustment for residents displaced by program or hospital clos	sure			17. 00
18.00	Adjusted rolling average FTE count			0.00	18. 00
19.00	Current year resident to bed ratio (line 18 divided by line 4)).		0.000000	19. 00
20.00	Prior year resident to bed ratio (see instructions)			0.000000	20. 00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21. 00
22.00	IME payment adjustment (see instructions)			0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422	2 of the MMA		0	22. 01
23. 00	Number of additional allopathic and osteopathic IME FTE reside $(f)(1)(iv)(C)$.	ent cap slots under 42 C	FR 412. 105	0. 00	23. 00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the linstructions)	ower of line 23 or line	24 (see	0. 00	25. 00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26. 00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27. 00
28.00	IME add-on adjustment amount (see instructions)		0	28. 00	
28. 01	IME add-on adjustment amount - Managed Care (see instructions)		0	28. 01	
29.00	Total IME payment (sum of lines 22 and 28)			0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			0	29. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instruc	tions)	2. 44	30. 00
31. 00	Percentage of Medicaid patient days (see instructions)	J (1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.	<i>,</i>	22. 28	
32. 00	Sum of lines 30 and 31			24. 72	32.00
33. 00	Allowable disproportionate share percentage (see instructions))		9. 61	
	Di sproporti onate share adjustment (see instructions)			53, 772	
	· · · · · · · · · · · · · · · · · · ·				=

Health Francial Systems	Hoal th	Einancial Systems WILLTLEY MEMODIA	I HOSDITAL	In Lie	of Form CMS 1	2552 10
Proceedings Proceedings Procedure						2332-10
Title XVIII	CALCUL	ATTON OF RETWIDORSEMENT SETTLEMENT	Trovider Con. 13-0101			
				To 12/31/2018		
Incorporated Care Adjustment			Title XVIII	Hospi tal		<u> 24 am</u>
Incompensated Care Adjustment		· · · · · · · · · · · · · · · · · · ·	THE XVIII			
15.00 Total uncompensated care amount (see instructions)						
Section Sect						
Despital uncompensated care payment (IF IIne 34 is zero, enter zero on this line) (see 30, 304 605,020 35,02 Instructions) 262,008 122,408 35,03 35,03 36,00 Total uncompensated care (sum of columns 1 and 2 on line 35,03) 262,008 414,508 36,00 Total uncompensated care (sum of columns 1 and 2 on line 35,03) 262,008 414,508 36,00 Total uncompensated care (sum of columns 1 and 2 on line 35,03) 262,008 414,508 36,00 262,622,633,644 36,00 262,633,644 36,00 262,633,644 36,00 262,633,644 36,00 262,633,644 36,00 262,633,644 36,00 262,633,644 36,00 262,633,644 36,00 262,633,644 36,00 262,633,644 36,00 262,633,644 36,00 262,633,644 36,00 262,633,644 36,00 262,633,644 363,00 262,633,644 363,00 262,633,644 363,00 262,633,644 363,00 262,633,644 363,00 262,633,644 363,00 262,633,644 363,00 262,633,644 363,00 262,633,644 363,00 262,633,644 363,00 262,633,644 363,00 262,633,00 262,633,644 363,00 262,633,00 262,633,644 363,00 262,633,00 262,633,644 363,00 262,633,00 262,633,644 363,00 263,00						
Instructions 15.03 Pror trait share of the hospital uncorpensated care payment amount (see instructions) 262,008 152,408 35.03 36.00 Additional payment for high percentage of ESSN beneficiary of idehanges (lines 40 through 46) 40.00 Total Medicare discharges on Worksheet 5-3. Part 1 excluding discharges (lines 40 through 46) 40.00 Total Medicare discharges and Worksheet 5-3. Part 1 excluding discharges (lines 40 through 46) 41.00 Instructions 42.00 Instructions 42.00 Instructions 42.00 Instructions 43.00 Instructions 44.00		,	+-: - :> (l e	1
35.03 Pro rata share of the hospital uncompensated care payment amount (see instructions) 262,008 152,498 35.03 36.00 Total uncompensated care (sum of columns 1 and 2 on line 35.03) 414,506 40.00 414,506 40.00 40.0	35. 02		er zero on this line) (se	350, 304	605, 020	35.02
Total uncompensated care (sum of columns 1 and 2 on line 35.03)	35 03		ount (see instructions)	262 008	152 498	35 03
Additional payment for high percentage of ESRO beneficiary discharges (lines 40 through 46) 40.00 Total Ranges on Worksheet S-3, Part excluding discharges for WS-DRGS 0 41.00 1.					l	
622. 682. 683, 684 and 685 (see Instructions) 41.00 Total ESRO Medicare covered and paid discharges excluding MS-DRGs 652. 682, 683, 684 an 685. (see 10 instructions) 41.01 Total ESRO Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 0 an 685. (see instructions) 42.00 Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 0.00 42.00 Instructions) 43.00 Total Medicare ESRO inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see 0 43.00 Instructions) 44.00 Ratto of average length of stay to one week (line 43 divided by line 41 divided by 7 0.000000 44.00 Ratto of average length of stay to one week (line 43 divided by line 41 divided by 7 0.000000 44.00 Ratto of average length of stay to one week (line 43 divided by line 41 divided by 7 0.000000 45.00 Average weekly cost for dialysis treatments (see instructions) 0.00 45.00 Average weekly cost for dialysis treatments (see instructions) 0.00 45.00 Ratto of average length of stay to one week (line 43 divided by line 41 divided by 7 0.000000 45.00 Payment for inpatient program (line 45 times line 44 times line 41.01) 0.00 46.00 Payment for inpatient program (line 45 times line 44 times line 41.01) 0.00 46.00 Payment for inpatient program capital (from Wsst. L. Pt. III, see instructions) 1.00 48.00 Payment for inpatient program capital (from Wsst. L. Pt. III, see instructions) 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.0				gh 46)		
41.00 Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see 0 1.0	40.00		discharges for MS-DRGs	0		40. 00
Instructions 1				_		
1. Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 0 0 0.065 (see instructions) 0.00	41. 00		683, 684 an 685. (see	0		41.00
an 685. (see instructions) 42. 00 Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 43. 00 Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see 0 1 43. 00 Instructions) 44. 00 Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 0.000000 days) 45. 00 Average weekly cost for dialysis treatments (see instructions) 45. 00 Average weekly cost for dialysis treatments (see instructions) 47. 00 Subtotal (see instructions) 48. 00 Hospital additional payment (line 45 times line 44 times line 41.01) 49. 00 Subtotal (see instructions) 49. 00 Total payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions) 49. 00 Total payment for inpatient operating costs (see instructions) 49. 00 Total payment for inpatient program capital (from Wst. L. Pt. 1 and Pt. II., as applicable) 49. 00 Total payment for inpatient program capital (from Wst. L. Pt. 1 in 49 see instructions) 49. 00 Direct graduate medical education payment (from Wst. L. Pt. 1 in 49 see instructions) 50. 00 Direct graduate medical education payment (from Wst. L. Pt. 1 in 69) 50. 00 Direct graduate medical education payment (from Wst. L. Pt. 1 in 69) 50. 00 Direct graduate medical education payment (from Wst. D. Pt. III., column 9, lines 30 through 35). 50. 00 Direct graduate medical education payment (from Wst. D. Pt. III., column 9, lines 30 through 35). 50. 00 Direct graduate medical education payment (from Wst. D. Pt. III., column 9, lines 30 through 35). 50. 00 Direct graduate medical education payment (from Wst. D. Pt. III., column 9, lines 30 through 35). 50. 00 Direct graduate medical education payment (from Wst. D. Pt. III., column 9, lines 30 through 35). 50. 00 Direct graduate medical education payment (from Wst. D. Pt. III., column 9, lines 30 through 35). 50. 00 Direct graduate from payment payment (from Wst. D. Pt. III., column 9, lines 30 through 35). 50. 00 Direct graduate from payment payment (from Wst. D. Pt. III., column 9, lin	/1 ∩1		_NPCc 650 680 683 684	0		41 01
42.00 Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 0.00 42.00 43.00 Total Medicare ESRB inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685, see 0 instructions) 44.00 Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 0.000000 44.00 Attio of average weekly cost for dialysis treatments (see instructions) 0.00 45.00 46.00 Total additional payment (line 45 times line 44 times line 41.01) 0 46.00 46.00 46.00 47.00 46.00 47.00	41.01		-0103 032, 002, 003, 004			41.01
Instructions	42.00		ify for adjustment)	0.00		42. 00
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Hospital specific payments (to be completed by SCH and MDH, small rural hospitals 0		, , ,	,	2, 721, 426		
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1.00		only. (see instructions)				
19,00 Total payment for inpatient operating costs (see instructions) 2,721,426 49,00 2,000						
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Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0	From 01/01/2018	Worksheet E Part A Date/Time Prepared: 5/28/2019 10: 24 am

				From 01/01/2018 To 12/31/2018	Part A Date/Time Pre 5/28/2019 10:	
		Title	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)	n column 0	2	2018	344, 047	70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or after the corresponding federal year for the period ending on or after the corresponding federal year for the period ending on or after the corresponding federal year for the period ending on or after the corresponding federal year for the period ending on or after the corresponding federal federal fiscal year (yyyy) (Enter in the corresponding federal fiscal year (yyyy)) (Enter in the corresponding federal federal fiscal year (yyyy)) (Enter in the corresponding federal f		2	2019	129, 811	70. 97
70. 98	Low Volume Payment-3	ter 10/1)			0	70. 98
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	59 & 70)			2, 969, 620	•
71. 01	Sequestration adjustment (see instructions)	37 & 70)			59, 392	
71. 02	Demonstration payment adjustment amount after sequestration				07, 372	1
72. 00	Interim payments				3, 032, 023	•
73. 00	Tentative settlement (for contractor use only)				0,002,020	73.00
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02	2, 72, and			-121, 795	
75. 00	73) Protested amounts (nonallowable cost report items) in accordar	nce with			57, 007	75. 00
70.00	CMS Pub. 15-2, chapter 1, §115.2				0,,00,	70.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum oplus 2.04 (see instructions)	of 2.03			0	90. 00
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instru	uctions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instruction)				0	93.00
94.00	The rate used to calculate the time value of money (see instru	,			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)	ŕ			0	95. 00
96.00	Time value of money for capital related expenses (see instruction	tions)			0	96. 00
		•		Prior to 10/1	On/After 10/1	
	luco o			1. 00	2. 00	
100.00	HSP Bonus Payment Amount					
					Λ.	100 00
100.00	HSP bonus amount (see instructions)			0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment					
101. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)	2)		1. 0142088081	1. 0162646287	101. 00
101. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions	s)			1. 0162646287	
101. 00 102. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment	s)		1. 0142088081	1. 0162646287 0	101. 00 102. 00
101. 00 102. 00 103. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)			1. 0142088081 0 0. 9985	1. 0162646287 0 0. 9985	101. 00 102. 00 103. 00
101. 00 102. 00 103. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions))	istment	1. 0142088081	1. 0162646287 0 0. 9985	101. 00 102. 00
101. 00 102. 00 103. 00 104. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr) ration) Adju		1. 0142088081 0 0. 9985	1. 0162646287 0 0. 9985 0	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.) ration) Adju		1. 0142088081 0 0. 9985	1. 0162646287 0 0. 9985 0	101. 00 102. 00 103. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement) ration) Adju riod under t		1. 0142088081 0 0. 9985	1. 0162646287 0 0. 9985 0	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line) ration) Adju riod under t		1. 0142088081 0 0. 9985	1. 0162646287 0 0. 9985 0	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions)) ration) Adju riod under t		1. 0142088081 0 0. 9985	1. 0162646287 0 0. 9985 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	ration) Adjuriod under t	the 21st	1. 0142088081 0 0. 9985 0	1. 0162646287 0 0. 9985 0	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	ration) Adjuriod under t	the 21st	1. 0142088081 0 0. 9985 0	1. 0162646287 0 0. 9985 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)	ration) Adjuriod under t	the 21st	1. 0142088081 0 0. 9985 0	1. 0162646287 0 0. 9985 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount	ration) Adjuriod under t	the 21st	1. 0142088081 0 0. 9985 0	1. 0162646287 0 0. 9985 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	ration) Adjuriod under t	the 21st	1. 0142088081 0 0. 9985 0	1. 0162646287 0 0. 9985 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	ration) Adjuriod under t	the 21st	1. 0142088081 0 0. 9985 0	1. 0162646287 0 0. 9985 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	ration) Adju riod under t e 49) first year	the 21st	1. 0142088081 0 0. 9985 0	1. 0162646287 0 0. 9985 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	ration) Adjuriod under te 49) first year	the 21st	1. 0142088081 0 0. 9985 0	1. 0162646287 0 0. 9985 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions)	ration) Adjuriod under te 49) first year	the 21st	1. 0142088081 0 0. 9985 0	1. 0162646287 0 0. 9985 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	ration) Adjuriod under te 49) first year	the 21st	1. 0142088081 0 0. 9985 0	1. 0162646287 0 0. 9985 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)	ration) Adjuriod under te 49) first year	the 21st	1. 0142088081 0 0. 9985 0	1. 0162646287 0 0. 9985 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use	ration) Adjuriod under te 49) first year	the 21st	1. 0142088081 0 0. 9985 0	1. 0162646287 0 0. 9985 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	first year	the 21st	1. 0142088081 0 0. 9985 0	1. 0162646287 0 0. 9985 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	first year	the 21st	1. 0142088081 0 0. 9985 0	1. 0162646287 0 0. 9985 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 211. 00 213. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 205)	ration) Adjuriod under to the 49) first year ructions) line 59)	of the currer	1. 0142088081 0 0. 9985 0	1. 0162646287 0 0. 9985 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 211. 00 213. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 2 Low-volume adjustment (see instructions)	ration) Adjuriod under to the 49) first year ructions) line 59)	of the currer	1. 0142088081 0 0. 9985 0	1. 0162646287 0 0. 9985 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00

| In Lieu of Form CMS-2552-10 | Period: Worksheet E | From 01/01/2018 | Part A Exhibit 4 | To 12/31/2018 | Date/Time Prepared: 5/28/2019 10: 24 am Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0101

						0 12/31/2010	5/28/2019 10:	
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line 0	E, Part A) 1.00	Entitlement 2.00	to 10/01 3.00	0n/After 10/01 4.00	through 4) 5.00	
1. 00	DRG amounts other than outlier	1, 00	1.00	2.00	3.00		5.00	1. 00
1.00	payments	1.00		J			J	1.00
1. 01	DRG amounts other than outlier payments for discharges	1. 01	1, 638, 149	0	1, 638, 149		1, 638, 149	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges	1. 02	599, 996	0		599, 996	599, 996	1. 02
1. 03	occurring on or after October 1 DRG for Federal specific operating payment for Model 4	1. 03	0	0	C		0	1. 03
1 04	BPCI occurring prior to October 1	1 04						1 04
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2. 00	15, 003	0	11, 221	3, 782	15, 003	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	(0	0	2. 01
3. 00	Operating outlier reconciliation	2. 01	0	0	(O	0	3. 00
4. 00	Managed care simulated payments	3. 00	0	0	(0	0	4. 00
	Indirect Medical Education Adju							
5. 00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	0	0	C	0	0	6. 00
6. 01	instructions) IME payment adjustment for	22. 01	0	0	C	0	0	6. 01
	managed care (see instructions) Indirect Medical Education Adju	votmont for the	Add on for Co	otion 100 of t	ho MMA			
7. 00	IME payment adjustment factor	27. 00	0. 000000	0.000000	0. 000000	0. 000000		7. 00
	(see instructions)			0.000000				
8. 00	IME adjustment (see instructions)	28. 00	0	U	(0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	0	(0	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	(0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	C	0	0	9. 01
	Di sproporti onate Share Adjustmo	ent						
10. 00	Allowable disproportionate	33. 00	0. 0961	0. 0961	0. 0961	0. 0961		10. 00
11 00	share percentage (see instructions)	24.00	E0 770	2	20. 25	1 1 1 1 1	E0 770	11 00
11.00	Disproportionate share adjustment (see instructions)	34.00	53, 772	0	39, 357		53, 772	
11. 01	Uncompensated care payments Additional payment for high per	36.00	414,506 D beneficiary	0 di scharges	262, 008	152, 498	414, 506	11.01
12. 00	Total ESRD additional payment	46. 00	0	ui scriai ges 0	C	0	0	12. 00
13. 00	(see instructions) Subtotal (see instructions)	47. 00	2, 721, 426	0	1, 950, 735	770, 691	2, 721, 426	13 00
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	48. 00	2, 721, 420	0	(0	2, 721, 420	14. 00
15. 00	(see instructions) Total payment for inpatient operating costs (see	49. 00	2, 721, 426	0	1, 950, 735	770, 691	2, 721, 426	15. 00
16. 00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I,	50. 00	185, 732	0	138, 917	46, 815	185, 732	16. 00
17. 00	if applicable) Special add-on payments for	54. 00	0	0	C	o	0	17. 00
17. 01 17. 02	new technologies Net organ aquisition cost Credits received from manufacturers for replaced	68. 00	0	0	C	0	0	17. 01 17. 02
	devices for applicable MS-DRGs							

From 01/01/2018 Part A Exhibit 4 12/31/2018 Date/Time Prepared: 5/28/2019 10: 24 am Title XVIII Hospi tal PPS W/S E, Part A Amounts (from Pre/Post Period Prior Total (Col 2 Peri od to 10/01 E, Part A) Entitlement On/After 10/01 through 4) line 4 00 Ω 1 00 2 00 3 00 5 00 18.00 Capital outlier reconciliation 93.00 18.00 adjustment amount (see instructions) 19.00 SUBTOTAL 2, 089, 652 817, 506 2, 907, 158 19. 00 W/S L, line (Amounts from L) 0 1.00 2.00 3.00 4. 00 5.00 20.00 Capital DRG other than outlier 1.00 179, 847 136, 814 43, 033 179, 847 20.00 Model 4 BPCI Capital DRG other 20. 01 1.01 20.01 than outlier Capital DRG outlier payments 2 00 21 00 5, 885 21.00 5,885 C 2, 103 3, 782 21.01 Model 4 BPCI Capital DRG 2.01 21.01 outlier payments 22.00 Indirect medical education 5.00 0.0000 0.0000 0.0000 0.0000 22.00 percentage (see instructions) 23.00 Indirect medical education 6.00 23.00 0 0 0 adjustment (see instructions) 24.00 Allowable disproportionate 10.00 0.0000 0.0000 0.0000 0.0000 24.00 share percentage (see instructions) Di sproporti onate share 11.00 25.00 25.00 0 C 0 0 adjustment (see instructions) 138, 917 26.00 Total prospective capital 12.00 185, 732 46, 815 185, 732 26.00 payments (see instructions) W/S E, Part A (Amounts to E, line Part A) 2.00 3.00 4. 00 1.00 5. 00 0 27.00 Low volume adjustment factor 27 00 0.164643 0 158789 28.00 Low volume adjustment 70.96 344, 047 344, 047 28.00 (transfer amount to Wkst. E, Pt. A, line) 29.00 Low volume adjustment 70. 97 129, 811 29. 00 129, 811 (transfer amount to Wkst. E, Pt. A, line) 100.00 Transfer low volume 100.00 adjustments to Wkst. E, Pt. A.

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 15-0101		Worksheet E Part B Date/Time Prepared: 5/28/2019 10:24 am

			5/28/2019 10:	24 am
		Title XVIII Hospital	PPS	2
			1. 00	
4 00	PART B - MEDICAL AND OTHER HEALTH SERVICES		1	
1.00	Medical and other services (see instructions)	ti ana)	0	
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruction OPPS payments	LI OIIS)	4, 408, 592 3, 424, 581	1
4. 00	Outlier payment (see instructions)		12, 333	•
4. 01	Outlier reconciliation amount (see instructions)		12, 333	1
5. 00	Enter the hospital specific payment to cost ratio (see instruc	ctions)	0.000	1
6.00	Line 2 times line 5	,	0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7. 00
8.00	Transitional corridor payment (see instructions)		0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200	0	
10.00	Organ acquisitions		0	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)		0	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges			
12. 00	Ancillary service charges		1	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)	0	•
14. 00	Total reasonable charges (sum of lines 12 and 13)		0	
	Customary charges		•	
15. 00	Aggregate amount actually collected from patients liable for p	payment for services on a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for	. ,	0	16. 00
47.00	had such payment been made in accordance with 42 CFR §413.13(6	e)		47.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	1
18. 00 19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only	vifling 10 avegads ling 11) (see	0 0	18. 00 19. 00
19.00	instructions)	y II IIIle 18 exceeds IIIle II) (see		19.00
20. 00	Excess of reasonable cost over customary charges (complete onl	vifline 11 exceeds line 18) (see	0	20. 00
	instructions)			
21. 00	Lesser of cost or charges (see instructions)		0	21. 00
22. 00	Interns and residents (see instructions)		0	
23. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		3, 436, 914	24. 00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions	-)	724, 563	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line		724, 303	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p		2, 712, 351	•
	instructions)		, , , , , ,	
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)	0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	
30.00	Subtotal (sum of lines 27 through 29)		2, 712, 351	1
31.00	Primary payer payments		112	ı
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE)	`FS)	2, 712, 239	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0	33. 00
34. 00	Allowable bad debts (see instructions)		108, 440	1
35.00	Adjusted reimbursable bad debts (see instructions)		70, 486	35. 00
36. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	90, 819	
	Subtotal (see instructions)		2, 782, 725	•
38. 00	MSP-LCC reconciliation amount from PS&R		0	•
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	•
39. 50 39. 97	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration	5)	0	39. 50 39. 97
39. 97	Partial or full credits received from manufacturers for replacements	red devices (see instructions)	0	39. 97
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	sed devices (see Thati detrons)	0	39. 99
40. 00	Subtotal (see instructions)		2, 782, 725	1
40. 01	Sequestration adjustment (see instructions)		55, 655	
40. 02	Demonstration payment adjustment amount after sequestration		0	40. 02
41.00	Interim payments		2, 701, 895	1
42. 00	Tentative settlement (for contractors use only)		0	•
43.00	Balance due provider/program (see instructions)	' I ONO D I 45 O I I 4	25, 175	1
44. 00	Protested amounts (nonallowable cost report items) in accordand	nce with CMS Pub. 15-2, chapter 1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR			
90. 00	Original outlier amount (see instructions)		0	90. 00
91. 00	Outlier reconciliation adjustment amount (see instructions)		0	1
92.00	The rate used to calculate the Time Value of Money		0.00	
93. 00	Time Value of Money (see instructions)		0	1
94. 00	Total (sum of lines 91 and 93)		0	94. 00

Health Financial Systems WHIT ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0101

					5/28/2019 10: 2	24 am
		Ti tl e	XVIII	Hospi tal	PPS	
		Inpatier	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		3, 032, 02		2, 701, 895	1. 00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for			0	0	2. 00
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					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. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02				0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3. 04
3.05				0	0	3. 05
	Provi der to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				0	0	3. 51
3. 52				0	0	3. 52
3.53				0	0	3. 53
3.54				0	0	3. 54
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)		3, 032, 02	22	2. 701. 895	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		3, 032, 02	23	2, 701, 693	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	o	5. 02
5.03				0	0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52				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
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			0	25, 175	6. 01
6. 02	SETTLEMENT TO PROGRAM		121, 79	95	23, 173	6. 02
7. 00	Total Medicare program liability (see instructions)		2, 910, 22		2, 727, 070	7. 00
7.00	program radii raji		2,7.0,22	Contractor	NPR Date	7. 50
)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor			1.00	2.00	8. 00
0.00	Name of Contractor			I	ı J	0.00

Heal th	Financial Systems WHITLEY MEMORIA	L HOSPITAL	In Lie	u of Form CMS-	2552-10	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0101	Peri od:	Worksheet E-1 Part II		
	From 01/01/2018 Pa To 12/31/2018 Da					
	5.					
		Title XVIII	Hospi tal	PPS		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				4	
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	2 14		1. 00	
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	3-12			2. 00	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12			4. 00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6. 00	
7.00	CAH only - The reasonable cost incurred for the purchase of c	certified HIT technology	Wkst. S-2, Pt. I		7. 00	
	line 168	63				
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00	
9.00	Sequestration adjustment amount (see instructions)				9. 00	
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				1	
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00	
	Other Adjustment (specify)				31.00	
	On Delang dual provide (Specify)					

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

30. 00 31. 00 32. 00

Health Financial Systems WHITLEY MEN
BALANCE SHEET (If you are nonproprietary and do not maintain
fund-type accounting records, complete the General Fund column
only)

Provider CCN: 15-0101 | Period: From 01/01/2

Peri od: Worksheet G From 01/01/2018 To 12/31/2018 Date/Time Prepared:

onl y)			'	0 12/31/2016	5/28/2019 10:	
		General Fund	Specific Purpose Fund	Endowment Fund		
		1.00	2.00	3. 00	4. 00	
4 00	CURRENT ASSETS	455 700	J			1 00
1. 00 2. 00	Cash on hand in banks	155, 780		0	0	1. 00 2. 00
3.00	Temporary investments Notes receivable			-	0	3. 00
4. 00	Accounts receivable	25, 965, 034	1	0	0	4. 00
5. 00	Other recei vabl e	20,700,001		Ö	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-15, 299, 033	s c	0	0	6. 00
7.00	Inventory	783, 796	o C	0	0	7. 00
8.00	Prepaid expenses	2, 529, 110	0	0	0	
9.00	Other current assets	0	0	0	0	
10.00	Due from other funds	14 124 (07	0		0	10.00
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	14, 134, 687	' <u> </u>	0	0	11. 00
12. 00	Land	260, 483		0	0	12.00
13. 00	Land improvements	2, 492, 826	1	-	0	13. 00
14. 00	Accumul ated depreciation	-605, 559	1		0	14. 00
15.00	Bui I di ngs	14, 801, 390) c	0	0	15. 00
16.00	Accumulated depreciation	-1, 920, 515	5 C	0	0	16. 00
17. 00	Leasehold improvements	0	0	0	0	17. 00
18.00	Accumulated depreciation	-48, 824	•		0	18.00
19.00	Fixed equipment	87, 962		-	0	19.00
20. 00 21. 00	Accumulated depreciation Automobiles and trucks	-67, 249 753, 752		0	0	20.00
22. 00	Accumulated depreciation	-298, 840		0	0	22. 00
23. 00	Major movable equipment	15, 043, 487	•	Ö	Ö	23. 00
24.00	Accumulated depreciation	-10, 948, 427	1	0	0	24. 00
25.00	Mi nor equipment depreciable	6, 876, 467	· c	0	0	25. 00
26.00	Accumulated depreciation	-1, 819, 754		-	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0		0	0	28. 00
29. 00 30. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	24, 607, 199		-	0	29. 00 30. 00
30.00	OTHER ASSETS	24, 007, 199	1	U U	0	30.00
31.00	Investments	52, 989, 068	S C	0	0	31. 00
32.00	Deposits on Leases	O	O	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33. 00
34.00	Other assets	1, 466, 022	1	-	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	54, 455, 090	1		0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	93, 196, 976) C	0	0	36. 00
37. 00	Accounts payable	1, 603, 498	s c	O	0	37. 00
38. 00	Salaries, wages, and fees payable	956, 218	1	0	Ö	38. 00
39. 00	Payroll taxes payable	0	Ö	0	0	39. 00
40.00	Notes and Loans payable (short term)	0) c	0	0	40.00
41.00	Deferred income	0	0	0	0	41. 00
42.00	Accel erated payments	0	_	_	_	42. 00
43.00	Due to other funds	0	0	0	0	1
44. 00 45. 00	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	146, 135 2, 705, 851			0	
43.00	LONG TERM LIABILITIES	2, 700, 601	1	U U	0	45.00
46. 00	Mortgage payable	0) C	0	0	46. 00
47. 00	Notes payable	O	Ö	0	0	
48.00	Unsecured Loans	0) c	0	0	48. 00
49.00	Other long term liabilities	9, 835, 915	5 C	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9, 835, 915			0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	12, 541, 766) C	0	0	51.00
52. 00	CAPITAL ACCOUNTS General fund balance	80, 655, 210	1			52. 00
53. 00	Specific purpose fund	00, 033, 210	΄ Ι			53.00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			o		55. 00
56.00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant		1		0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
E0 00	replacement, and expansion	00 455 010	,		_	E0 00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	80, 655, 210 93, 196, 976			0	
00.00	59)	73, 170, 970]			55.55
	•	•	•	. '		•

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0101

Period: Worksheet G-1 From 01/01/2018

16.00

17.00

18.00

19.00

0

0

12/31/2018 Date/Time Prepared: 5/28/2019 10: 24 am General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 81, 782, 324 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 5, 893, 515 2.00 Total (sum of line 1 and line 2) 3.00 87, 675, 839 0 3.00 4.00 Additions (credit adjustments) (specify) 0 0 4.00 5.00 NONALLOWABLE HOME OFFICE INT EXPENSE 784, 696 0 5.00 6.00 6.00 0 0 7.00 0 7.00 0 8.00 0 8.00 0 0 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 784, 696 10.00 Subtotal (line 3 plus line 10) 11.00 88, 460, 535 0 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 13.00 ASSET TRANSFERS 7, 805, 325 13.00 14.00 0 0 14.00 0 0 15.00 0 15.00 0 16.00 0 16.00 17.00 17.00 7, 805, 325 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 19.00 80, 655, 210 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 3.00 Total (sum of line 1 and line 2) 0 0 3.00 Additions (credit adjustments) (specify) 4.00 4.00 5.00 NONALLOWABLE HOME OFFICE INT EXPENSE 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 11.00 0 Subtotal (line 3 plus line 10) 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 ASSET TRANSFERS 13.00 13.00 14.00 0 14.00 0 15.00 15.00

0

16.00

17.00

18.00

19.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

Health Financial Systems VSTATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0101

			10 12/31/2018	Date/IIme Prep 5/28/2019 10:2	
	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	8, 018, 97	9	8, 018, 979	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF		0	0	5.00
6.00	Swing bed - NF		0	0	6.00
7.00	SKILLED NURSING FACILITY		0	0	7. 00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	8, 018, 97	9	8, 018, 979	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT				11. 00
12. 00					12. 00
13. 00					13.00
14. 00					14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00		nes	0	0	16. 00
	11-15)		_		
17. 00		8, 018, 97		8, 018, 979	17. 00
18.00		32, 995, 01		32, 995, 018	18.00
19.00			0 183, 690, 410	183, 690, 410	19. 00
20.00			0	0	20. 00
21. 00			0 0	0	21.00
22. 00			7 05/ 000	7 05/ 000	22. 00
23. 00			0 7, 956, 238	7, 956, 238	23. 00
24. 00					24. 00
25. 00 26. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE				25. 00 26. 00
26.00				0	27. 00
28. 00		Wkst. 41, 013, 99	7 191, 646, 648	232, 660, 645	28. 00
26.00	G-3, line 1)	WKS1. 41, 013, 99	191, 040, 040	232, 000, 043	26.00
	PART II - OPERATING EXPENSES				
29. 00			68, 303, 836		29. 00
30.00		13, 279, 38			30.00
31. 00	HOME OFFICE INTEREST EXPENSE	784, 69			31. 00
32. 00	THOME STATES EN ENGE				32. 00
33. 00			o I		33. 00
34. 00			0		34. 00
35. 00			o I		35. 00
36. 00	Total additions (sum of lines 30-35)		14, 064, 077		36.00
37. 00			0		37.00
38. 00			ol		38.00
39. 00			ol		39. 00
40.00			0		40.00
41.00			0		41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00		transfer	82, 367, 913		43.00
	to Wkst. G-3, line 4)				

Heal th	Financial Systems WH	HITLEY MEMORIAL H	NSPI TAI	Inlie	u of Form CMS-2	2552-10
	ENT OF REVENUES AND EXPENSES		rovi der CCN: 15-0101	Peri od:	Worksheet G-3	1002 10
				From 01/01/2018 To 12/31/2018	Date/Time Prep 5/28/2019 10:	
	I=				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I,		28)		232, 660, 645	
2.00	Less contractual allowances and discounts on pa	atients' accounts			145, 454, 624	
3.00	Net patient revenues (line 1 minus line 2)	D			87, 206, 021	
4.00	Less total operating expenses (from Wkst. G-2,)		82, 367, 913	
5. 00	Net income from service to patients (line 3 min OTHER INCOME	nus irne 4)			4, 838, 108	5. 00
6. 00	Contributions, donations, bequests, etc				0	6. 00
7. 00	Income from investments				1, 005, 821	
8.00	Revenues from telephone and other miscellaneous	s communication se	ervi ces		0	
9. 00	Revenue from television and radio service	5 00111110111 00 01 011	3. 7. 000		0	
10.00	Purchase di scounts				0	
11. 00	Rebates and refunds of expenses				0	11. 00
12. 00	Parking lot receipts				0	12. 00
13.00	Revenue from Laundry and Linen service				0	13. 00
14.00	Revenue from meals sold to employees and guests	5			223, 961	14. 00
15.00	Revenue from rental of living quarters				0	15. 00
16.00	Revenue from sale of medical and surgical suppl	ies to other than	n patients		0	16. 00
17.00	Revenue from sale of drugs to other than patien	nts			0	17. 00
18.00	Revenue from sale of medical records and abstra	acts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc	c.)			0	19. 00
	Revenue from gifts, flowers, coffee shops, and	canteen			0	20.00
21. 00	Rental of vending machines				0	21. 00
22. 00	Rental of hospital space				0	22. 00
23.00	Governmental appropriations				0	20.00
24.00	OTHER (SPECIFY)				0	24.00
24. 01	GAIN/LOSS ON SALE OF CAPITAL ASSETS				-2, 354, 405	24. 01
24. 02	EMS SUBSIDY				250, 000	
24. 03	OTHER REVENUE				1, 930, 030	
	Total other income (sum of lines 6-24)				1, 055, 407	
	Total (line 5 plus line 25)				5, 893, 515	
	OTHER EXPENSES (SPECIFY)				0	
28 00	Total other evenences (sum of line 27 and subscr	rinte)			Λ	28 00

0 28.00 5, 893, 515 29.00

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0101	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Pre	narod:
			10 12/31/2016	5/28/2019 10:	
	Title XVIII Hospital			PPS	
	DART I FILLY PROSPECTIVE HETUR			1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
00	CAPITAL FEDERAL AMOUNT Capital DRG other than outlier				1.0
. 00 . 01	Model 4 BPCI Capital DRG other than outlier			179, 847 0	1.0
2. 00	Capital DRG outlier payments			5, 885	
2. 01	Model 4 BPCI Capital DRG outlier payments			0, 000	1
3. 00	Total inpatient days divided by number of days in the cost reporting period (see instructions)			12. 37	3.0
1.00	Number of interns & residents (see instructions)			0.00	4.0
5. 00	Indirect medical education percentage (see instructions)			0.00	5.0
. 00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)			0	6. 0
. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)			0.00	
3. 00	Percentage of Medicaid patient days to total days (see instructions)			0. 00	
00	Sum of lines 7 and 8			0.00	
0.00	Allowable disproportionate share percentage (see instruction	ons)		0. 00	
1. 00 2. 00	1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1			0 185, 732	1
2.00	Total prospective capital payments (see mistructions)			100, 732	12.0
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
. 00	Program inpatient routine capital cost (see instructions)			0	1.0
. 00	Program inpatient ancillary capital cost (see instructions)			0	2. 0
3. 00	Total inpatient program capital cost (line 1 plus line 2)			0	
1.00	Capital cost payment factor (see instructions)			0	4. 0
. 00	Total inpatient program capital cost (line 3 x line 4)			0	5.0
				1. 00	
00	PART III - COMPUTATION OF EXCEPTION PAYMENTS			0	1,
. 00 . 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta	ancos (soo instructions)		0	1. C
. 00	Net program inpatient capital costs for extraordinary circumstal values program inpatient capital costs (line 1 minus line 2)	inces (see Histructions)		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 (see	instructions)		0.00	
00	Adjustment to capital minimum payment level for extraordina		x line 6)	0	1
. 00	Capital minimum payment level (line 5 plus line 7)	, 004000 (0 2)		0	
. 00	Current year capital payments (from Part I, line 12, as app	ol i cabl e)		0	
0. 00	Current year comparison of capital minimum payment level to		less line 9)	0	10.0
1. 00	Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	capital payment (from pri	or year	0	11. 0
2. 00				0	12. 0
3.00			′	0	1
	Carryover of accumulated capital minimum payment level over	capital payment for the t	following period	0	14. (
4. 00	(if line 12 is negative, enter the amount on this line)		ļ		
4. 005. 00				0	15. (16. (