This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0101 Worksheet S Peri od: From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/15/2023 4:07 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/15/2023 4: 07 pm Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(5) Amended

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 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 01/01/2022 and ending 12/31/2022 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.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SIGNATURE STATEMENT	
1	Jeanne Wickens		l t	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Jeanne Wickens			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	160, 857	7, 796	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	TOTAL	0	160, 857	7, 796	0	0	200.00
The ob	sous amounts represent "due to" or "due from"	the engliceble	program for t	he element of	+ h a abauca aama	lov indinotod	

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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/15/2023 4:07 pm 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 Provi der Component Name CCN CBSA Date Payment System (P, T, 0, or N)
V | XVIII | XIX Certi fi ed Number Number Type 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 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 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) 01/01/2022 12/31/2022 20.00 21.00 Type of Control (see instructions) 2 21.00 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 UCPs, including supplemental UCPs, for 22.01 this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October

1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires a final UCP to be Ν Ν 22.02 determined at cost report settlement? (see instructions) 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 Ν Ν Ν 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) 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. 22.04 Did this hospital receive a geographic reclassification from urban to 22 04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? 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) 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.

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 3 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

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 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/15/2023 4:07 pm In-State In-State Out-of Out-of Medi cai d Medi cai d Medi cai d State State HMO days Medi cai d paid days eligible Medi cai d Medi cai d days unpai d pai d 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 58 52 957 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. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 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. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in 0 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 36 00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 0 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν N 40.00 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX V 1. 00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N N N 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N 47.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 Ν N Ν 48.00 Teachi ng Hospi tal s Is this a hospital involved in training residents in approved GME programs? For cost reporting Ν Ν 56.00 periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, Ν 57.00 is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or

"N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.

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 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/15/2023 4:07 pm | XVIII | XIX 1. 00 2.00 3.00 58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. Ν 58.00 Pt. I Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qualification Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 N instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. IME Direct GME IME Direct GME 1. 00 2.00 3. 00 4. 00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 0.00 61.00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 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 Name Program Code Unwei ghted Unwei ghted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 0.00 61.10 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 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) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 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 0.00 62.01 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 63.00

"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

Health Financial Systems	WHI TLEY	MEMORIAL HOSPITAL		In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP				eriod: com 01/01/2022	Worksheet S-2 Part I	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2. 00	3. 00	
Section 5504 of the ACA Base Yea	nr FTE Residents in N	onprovider Settings				
period that begins on or after 2 64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to resettings. Enter in column 2 the resident FTEs that trained in year.	yes, or your facili ber of unweighted no stations occurring in number of unweighte our hospital. Enter in	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64.00
of (column 1 divided by (column	Program Name	Program Code	Unweighted	Unwei ahted	Ratio (col.	
	Program Name	Program code	FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	3/ (col. 3 + col. 4))	
	1. 00	2. 00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0. 00		65. 00
			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
			Nonprovi der	Hospi tal	col. 2))	
			Si te			
			1. 00	2. 00	3. 00	
Section 5504 of the ACA Current		n Nonprovider Setting	ysEffective f	or cost report	ing periods	
beginning on or after July 1, 20 66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primal occurring in all nonpo unweighted non-primal al. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0.000000 Ratio (col.	66.00
	Ü	Ü	FTEs Nonprovider Site	FTEs in Hospital	3/ (col. 3 + col. 4))	
(7.00   5.1	1. 00	2. 00	3.00	4. 00	5. 00	(7.00
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents.  Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0. 00	0.000000	67.00

Provide CRE 13-0101   Period 2077/2022   Period 2	Health Financial Systems WHITLEY MEMORIAL HO	SPI TAL	In Li	eu of Form CMS-	2552-10
Direct ONE in Accordance with the FY 2003 IPPS Final Rule. 87 FR 40065-49972 (Account 10, 2022)  80 CO For a coak reporting period beginning prior to Ecocord 1, 2002, did you obtain period so from your (Account 10, 2002)  Impatient Systematric Facility PPS  20 OI is this facility on inpatient Expellity (IPP). or doos it contain an IPP subprovider?  10 OI is this facility on inpatient Expellity (IPP). or doos it contain an IPP subprovider?  10 OI is this facility on inpatient Expellity (IPP). Or doos it contain an IPP subprovider?  10 OI is this facility on inpatient Expellity (IPP). Or doos it contain an IPP subprovider?  10 OI is this facility on inpatient Expellity (IPP). Or doos it contain an IPP subprovider?  10 OI is this facility on inpatient Expellity (IPP). Or doos it contain an IPP subprovider?  11 OI IT line 70 is yes. Column 1. Did there is thoroster in the IPP for yes or "F for min (yes) 42 CPR 424 424(4)(1)(1)(2)(2) Oldama 2. Did this facility in rine rishering in accordance with 42 CPR 412-424 (4)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)			Peri od:	Worksheet S-2	
Birract (Biff in Accordance with the FV 2023 IPPS Final Bule, B) F8 4905-49072 (August 10, 2023)  80.00 For a cost reporting period beginning prior to October 1, 2022 oil you obtain permission from your MAC to apply the new Bule. Formula in accordance with the FV 2023 IPPS Final Rule, 87 FR 4905-49072 (August 10, 2023)  10.00 Is this Facility an inpatient Psychiatric Facility (PF), or does it contain an IPP subprovider? No. 2 oo 3.00  17.00 If file of D is yet, Column 1; Did the facility from residents in a new feeding program in the most recent cast report file on on before November 15, 2002 Fater **Y For yes or **N For on See 147 CSR 419 434(0)(1)(1)(2)) Column 2; Bul 11st Kncility from residents in a new feeding period (See Instructions). If old on Facility period (See Instructions). If old on Facility period (See Instructions).  75.00 If file of D is yet, Column 1: Did the facility have an approved QME teaching program in the most recent cost reporting benefit of the program year began during this cost it contain an IBM subprovider? Enter **Y For yes and **N For no.  87.00 If file of D is yet, Column 1: Did the facility have an approved QME teaching program in the most recent cost reporting period ending on or before November 15, 2004 Parter **Y For yes or **N For yet in the facility period (See Instructions).  88.00 If it is not is a Licet co-located within another November 15, 2004 Parter **Y For yes or **N For m.  88.00 Is shis a Licet co-located within another Negatial For part or all of the cost reporting period Enter R.  88.00 Is shis a licet co-located within another Negatial For part or all of the cost reporting period Enter R.  88.00 Is shis a new hospital under 42 CFR Section \$415.80(r(Y)(1)(1) TERRAY Enter *Y* For yes or **N* For no.  88.00 Is shis a new hospital under 42 CFR Section \$415.80(r(Y)(1)(1) TERRAY Enter **Y* For yes or **N* For no.  88.00 Is shis hospital an extended mospital Section of the non-thine Section Parter **Y* For yes or **N* For no.  88.00 Is shis hospital an extended negat				2 Date/Time Pre	
Birect ONE in Accordance with the PY 2003 IPPS Final Boll 8.1 FR 49056-49072 (August 10, 2012)   Color of the Color of t				5/15/2023 4:0	)/ pm
68.00 Mor to apply the new Bird Foreign in a prior to October 1, 2022, did you obtain permission from your (Mor to apply the new Bird Foreign in a concranace with the FY 2023 IPPS Final Rule, BY FR 4906-49072 N. (Mouset 10, 2027)  The provided of the pro	Direct CME in Accordance with the EV 2023 LDDS Final Dule 87 FD	49065_49072 (August	10 2022)	1. 00	
Impattion   Psychiatric   Facility   Psychia	68.00 For a cost reporting period beginning prior to October 1, 2022,	lid you obtain permis	sion from your	N	68. 00
Impation   Deportuatric   Excititive PPS   1.00   2.00   3.00   2		IPPS Final Rule, 87	FR 49065-49072		
The second content of the second content o	(X. agas - v. v cont.)				
Finite **Y** for yes or **I** for no.  Trick of 1 is yes: Out on 1: Did the facility have an approved OVE teaching program in the most recent cost report filled on or before November 15, 2007 inter **Y** for yes or **N** for no. (see program in accordance with 14 of 26 At 24 (d.) (1) (ii) (1) (0)? Etter **Y** for yes or **N** for no. (see program in accordance with 14 of 26 At 24 (d.) (1) (iii) (1) (0)? Etter **Y** for yes or **N** for no. (oce) instructions).  75. 00 (Jum 3: If column 2 is Y*, indicate which program year began during this cost reporting period. (See instructions).  76. 00 (Jif ine 75 is yes: Column 1: Did the facility have an approved OVE teaching program in the most recent cast reporting period anding on or before November 15, 2004 (June **) **Y** for yes or **N** for no. Column 2: Did this facility train residents in a nex teaching program in accordance with 42 indicate which program year began during this cost reporting period. (see instructions).  Leng Term Care Mopilat IPS  80. 00 (Is this a long term care hospitat (J10)? Inter **Y** for yea and **N** for no.  10 (Is this a long term care hospitat (J10)? Inter **Y** for yea and **N** for no.  11 (Is this a new hospital IPS)  12 (Is this a new long that IPS)  13 (Is this a new long that IPS)  14 (Is this a new long that IPS)  15 (Is this a new long that IPS)  16 (Is this a new long that IPS)  17 (Is this inter this period within another hospital for part or all of the cost reporting period? Enter **Y** for yea and **N** for no.  18 (Is this a new long that IPS)  18 (Is this a new long that IPS)  18 (Is this a new long that IPS)  19 (Is this a new long that IPS)  10 (Is this a new long that IPS)  10 (Is this a new long that IPS)  10 (Is this a new long that IPS)  11 (Is this hospital an extended neeplastic disease care hospital classified under section in the language of the care that the lang	Inpatient Psychiatric Facility PPS		1.	00   2.00   3.00	
17.00   f		s it contain an IPF s	ubprovi der? N	I	70. 00
42 CFR 412 424 (q(1)(111)(2) Column 2: Did this Facility train residents in a new teaching program in accordance with 42 CFR 41244 (q(1)(111)(D)? Enter "" for yes or "N" for no. Column 3: If column 2 is V. indicate which program year began during this cost reporting period.  75.00 Jis this Facility an Inpatient Rehabilitation Facility (IRP), or does it contain an IRF No. 1 Inpatient Rehabilities on the Facility have an approved GME teaching program in the most record cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no record cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no record cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no record cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no record cost reporting period cost in the state of the cost reporting period. (See instructions)  1.00	71.00 If line 70 is yes: Column 1: Did the facility have an approved G			0	71. 00
program in accordance with 42 CFR 412-424 (Q1)(11)(D)? Enter "Y" for yes or "N" for no.					
Cose Instructions	program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter '	Y" for yes or "N" fo	r no.		
Inspire of Rehabit Facility or Inspire of Rehabit Facility (IRF), or does it contain an IRF   N   75,00		ing this cost report	ing period.		
supprovider? Enter "Y" for yes and "N" for no.  No. 10   Filin 75 is yes: Column 1: Bid the facility have an approved GME teaching program in the most recent cost reporting period ending on on before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Bid this facility train residents in a new teaching program in accordance with 42 cFR 412.424 (g)(1)(ii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is X, Indicate which program year began during this cost reporting period. (See Instructions)    1.00	Inpatient Rehabilitation Facility PPS		_		1
76. 00   if i ine 75 is yes: Column 1: Did the facility have an approved GBF teaching program in the most recent cost reporting period ending on or before Novembor 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 412-42 (d)(1)(ii)(ii)(0)? Enter "Y" for yes or "N" for no. Column 2: Enter the program year began during this cost reporting period. (see Instructions)    1.00		loes it contain an IR	F   N	1	75.00
no. Column 2: bid this facility train residents in a new teaching program in accordance with 42				0	76. 00
Indicate which program year began during this cost reporting period. (see instructions)					
Long Term Care Hospital PPS   1.00					
Long Term Care Hospital PPS   80.00   Sthis a long term care hospital (LTCII)? Enter "Y" for yes and "N" for no.   81.00   Sthis a long term care hospital (LTCII)? Enter "Y" for yes and "N" for no.   81.00   "Y" for yes or "N" for no   10.00   "Y" for yes or "N"	indicate which program year began during this cost reporting peri	od. (See Mistruction:	5)		
80.00   Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.   N   80.00	Long Term Care Hospital PPS			1. 00	
### For yes and "N" for no. ### TEFRA Providers ### 15	80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and				
TEFRA Providers   St. 00   St his a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 85.00   St his a new hospital water subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(1)(2)? Enter "Y" for yes and "N" for no. 1886.00   St his hospital an extended neoplastic disease care hospital classified under section   N   87.00   1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.   Approved for Permanent Adjustment (Y/N)   Adjustments   N   N   Permanent (Y/N)   Adjustments   N   N   N   N   N   N   N   N   N		of the cost reporti	ng period? Ente	r N	81.00
86. 00   bid this facility establish a new other subprovider (excluded unit) under 42 CFR Section   S413.40(f(7)(1)(1))? Enter "Y" for yes and "N" for no.   N   87.00	TEFRA Provi ders				
81.00   Sthis hospital an extended neoplastic disease care hospital classified under section   N   87.00   Sthis hospital an extended neoplastic disease care hospital classified under section   N   87.00   1886(d) (1) (B) (vi )? Enter "Y" for yes or "N" for no.   Approved for Permanent Adjustment (Y/N)   Adjustment				. N	
R86(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.   Approved for Permanent Adj ustment (Adj ustment (Y/N))   Approved Approved Register (Y/N)   Approved Register (Y/N)   Reg	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	,			
Remainent Adjustment Adjustment (Y/N)   Adjustments   Adjustment   A		issified under section	n	N	87.00
88.00   Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 39. (see instructions)   Column 2: Enter the number of approved permanent adjustments.   Wkst. A Line   Effective Date   Approved Permanent Adjustment Amount Per Discharge					
88.00   Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions)   Column 2: Enter the number of approved permanent adjustments.   Wkst. A Line Date   Date   Permanent Adjustment					
Section   Sect					-
See instructions   Column 2: Enter the number of approved permanent adjustments.   Wilst. A Line No.   Date   Approved Permanent Adjustment A				_	88. 00
Column 2: Enter the number of approved permanent adjustments.		omplete col. 2 and li	ne		
89.00   Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.    V					
89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number 0.00 3.00 0 89.00 on which the per discharge permanent adjustment approval was based.  Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge.  Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.  V XIX 1.00 2.00  Title V and XIX Services  90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.  91.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.  92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.  93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.  94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.  95.00 If line 94 is "Y", enter the reduction percentage in the applicable column.  N N 96.00 applicable column.				_ ' '	
89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge.  Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.  V XIX 1.00 2.00  Title V and XIX Services  90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.  91.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.  92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.  93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.  94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the paplicable column.  95.00 If line 94 is "Y", enter the reduction percentage in the applicable column.  N N 96.00 applicable column.					
89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number					
on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge.  Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.  V XIX 1.00 2.00  Title V and XIX Services  90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.  91.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.  92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.  93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.  94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the policable column.  95.00 If line 94 is "Y", enter the reduction percentage in the applicable column.  N N 96.00 applicable column.	90.00 Column 1. If line 90 column 1 is V enter the Worksheet A line				90.00
beginning date) for the permanent adjustment to the TEFRA target amount per discharge.  Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.    V	on which the per discharge permanent adjustment approval was base	ed.			, 07.00
per discharge. Column 3: Enter the amount of the approved permanent adjustment to the  TEFRA target amount per discharge.  V XIX  1.00 2.00  Title V and XIX Services  90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.  91.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.  92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.  93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.  94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.  95.00 If line 94 is "Y", enter the reduction percentage in the applicable column.  N N 96.00 applicable column.	, , ,	I			
Title V and XIX Services  90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.  91.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.  92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.  93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter N N 93.00 "Y" for yes or "N" for no in the applicable column.  94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the Applicable column.  95.00 If line 94 is "Y", enter the reduction percentage in the applicable column.  96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the Applicable column.  N N 96.00 applicable column.	per di scharge.				
Title V and XIX Services  90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.  91.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in N N 91.00 full or in part? Enter "Y" for yes or "N" for no in the applicable column.  92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.  93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter N N 93.00 "Y" for yes or "N" for no in the applicable column.  94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the N N 94.00 applicable column.  95.00 If line 94 is "Y", enter the reduction percentage in the applicable column.  N N 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the N N N 96.00		to the			
Title V and XIX Services  90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.  91.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in N N 91.00 full or in part? Enter "Y" for yes or "N" for no in the applicable column.  92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.  93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter N N 93.00 "Y" for yes or "N" for no in the applicable column.  94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the N N 94.00 applicable column.  95.00 If line 94 is "Y", enter the reduction percentage in the applicable column.  96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the N N 96.00 applicable column.		'			
yes or "N" for no in the applicable column.  91.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.  92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.  93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.  94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.  95.00 If line 94 is "Y", enter the reduction percentage in the applicable column.  96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.  N N 96.00 Policy Type Policy P	Title V and XIX Services		1.00	2.00	
91.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.  92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.  93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.  94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.  95.00 If line 94 is "Y", enter the reduction percentage in the applicable column.  96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.  N N 91.00 O 0.00 O.00 O.00 O.00 O.00 O.00 O.0		rvices? Enter "Y" for	N	Y	90.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.  93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.  94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.  95.00 If line 94 is "Y", enter the reduction percentage in the applicable column.  96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.  N N 92.00 N 94.00 N 94.00 N 94.00 N 95.00 N 96.00 N 96.00	91.00 Is this hospital reimbursed for title V and/or XIX through the co		N	N	91.00
instructions) Enter "Y" for yes or "N" for no in the applicable column.  93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.  94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.  95.00 If line 94 is "Y", enter the reduction percentage in the applicable column.  96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.  N N 94.00 Ones title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	, , , , , , , , , , , , , , , , , , , ,			N	92.00
"Y" for yes or "N" for no in the applicable column.  94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.  95.00 If line 94 is "Y", enter the reduction percentage in the applicable column.  96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.  N N 96.00 Possible column.	instructions) Enter "Y" for yes or "N" for no in the applicable of	col umn.			
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.  95.00 If line 94 is "Y", enter the reduction percentage in the applicable column.  96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.  N 94.00 Occurrence N 94.00 Occurrence N 96.00 Occurrence N N 96.00 Occurrence N N N N N N N N N N N N N N N N N N N		τιε V and XIX? Enter	N	N	93.00
95.00   If line 94 is "Y", enter the reduction percentage in the applicable column. 0.00   95.00   96.00   Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.   N   N   96.00   96.00   N   N   N   N   N   N   N   N   N	94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "	N" for no in the	N	N	94.00
applicable column.	95.00 If line 94 is "Y", enter the reduction percentage in the applical		0.00	0.00	95. 00
		N" for no in the	N	N	96.00
		ole column.	0.00	0.00	97. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CO	N 45 045: 1		u of Form CMS	
11011001		Period: From 01/01/2022 To 12/31/2022	Date/Time Pr 5/15/2023 4:	epared:
		V	XI X	_
98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and restepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N"		1. 00 N	2. 00 Y	98.00
<pre>column 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of ch. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in title XIX.</pre>			Y	98. 0
98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no for title V, and in column 2 for title XIX.		N	Y	98. 02
98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hereimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for title V, and in column 2 for title XIX.	no in column	N 1	N	98. 03
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 10 outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for in column 2 for title XIX.		N	N	98.04
98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE di: Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for t column 2 for title XIX.	itle V, and i	n N	Y	98. 0
98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title ' column 2 for title XIX.		N	Y	98.00
Rural Providers  105.00 Does this hospital qualify as a CAH?		N		105. 0
106.00 If this facility qualifies as a CAH, has it elected the all-inclusive methor outpatient services? (see instructions)				106. 0
107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursementraining programs? Enter "Y" for yes or "N" for no in column 1. (see instance Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&R: approved medical education program in the CAH's excluded LPF and/or LRF Enter "Y" for yes or "N" for no in column 2. (see instructions)	tructions) s in an unit(s)?			107. 0
108.00 Is this a rural hospital qualifying for an exception to the CRNA fee sche   CFR Section §412.113(c). Enter "Y" for yes or "N" for no.   Physical	dul e? See 42  Occupational		Respi ratory	108.0
1.00	2. 00	3. 00	4. 00	
109.00  f 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.	N	N	N	109. 0
			1.00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration Demonstration) for the current cost reporting period? Enter "Y" for yes or complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lapplicable.	"N" for no.	lf yes,	1. 00 N	110. 0
Demonstration) for the current cost reporting period? Enter "Y" for yes or complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, I	"N" for no.	If yes, ugh 215, as	N	110.00
Demonstration) for the current cost reporting period? Enter "Y" for yes or complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lapplicable.	"N" for no. i nes 200 thro ommunity period? Enter enter the column 2.	If yes, ugh 215, as 1.00		110.00
Demonstration) for the current cost reporting period? Enter "Y" for yes or complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lapplicable.  111.00 If this facility qualifies as a CAH, did it participate in the Frontier Complete 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 in Enter all that apply: "A" for Ambulance services; "B" for additional beds	"N" for no. i nes 200 thro ommunity period? Enter enter the column 2.	If yes, ugh 215, as 1.00	N 2. 00	
Demonstration) for the current cost reporting period? Enter "Y" for yes or complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lapplicable.  111.00 If this facility qualifies as a CAH, did it participate in the Frontier CHE 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 in Enter all that apply: "A" for Ambulance services; "B" for additional beds for tele-health services.  112.00 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	"N" for no. ines 200 thro ommunity period? Enter enter the column 2.; and/or "C"	If yes, ugh 215, as	2. 00 N	111.00
Demonstration) for the current cost reporting period? Enter "Y" for yes or complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lapplicable.  In 11.00 If this facility qualifies as a CAH, did it participate in the Frontier CAHealth 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 in Enter all that apply: "A" for Ambulance services; "B" for additional beds for tele-health services.  In 12.00 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.  In 2.00 Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no.	ommunity period? Enter enter the column 2.; and/or "C"	If yes, ugh 215, as	2. 00 N	111.0
Demonstration) for the current cost reporting period? Enter "Y" for yes or complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lapplicable.  111.00 If this facility qualifies as a CAH, did it participate in the Frontier CA 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 in Enter all that apply: "A" for Ambulance services; "B" for additional beds for tele-health services.  112.00 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.  113.00 Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no.  Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on	ommunity period? Enter enter the column 2.; and/or "C"	If yes, ugh 215, as	2. 00 N	111.00
complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lapplicable.  111.00 If this facility qualifies as a CAH, did it participate in the Frontier Complete 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 demoin which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds for tele-health services.  112.00 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.  113.00 Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no.  Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes)	"N" for no. i nes 200 thro ommuni ty peri od? Enter enter the column 2.; and/or "C"	If yes, ugh 215, as	2. 00 N	

yes, enter the approval date (mm/dd/yyyy) in column 2.

Health Financial Systems	WHITLEY MEMORI	IAL HOSPITAL			In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE		Provi der CC	CN: 15-0101			Worksheet S- Part I	2 repared:
						1.00	
147.00 Was there a change in the statist	ical basis? Enter "Y" for	ves or "N" for	no no			1.00 N	147. 00
148.00 Was there a change in the order o						N	148. 00
149.00 Was there a change to the simplif				for no.		N	149.00
		Part A	Part B	3 T	itle V	Title XIX	
		1. 00	2. 00		3. 00	4. 00	
Does this facility contain a prov or charges? Enter "Y" for yes or							
155.00 Hospi tal		N	N		N	N	155. 00
156.00 Subprovi der - IPF		N	N		N	N	156. 00
157.00 Subprovi der - IRF		N	N		N	N	157.00
158. 00 SUBPROVI DER 159. 00 SNF		N.	,		N	N.	158. 00 159. 00
160.00 HOME HEALTH AGENCY		N N	N N		N N	N N	160.00
161. 00 CMHC		IN	N N		N	N N	161. 00
101.00 SMITO					14		- 101.00
Mul ti campus						1. 00	
165.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has or	ne or more camp	uses in di	fferent C	BSAs?	N	165. 00
Efficiency of the following the first state of the	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2.00	3.00	4.00	5. 00	
166.00  f   line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.0	00 166. 00
					'	1. 00	
Health Information Technology (HI	T) incentive in the Americ	can Recovery ar	nd Reinvest	ment Act		1.00	
167.00 s this provider a meaningful use						Υ	167. 00
168.00 If this provider is a CAH (line 1	05 is "Y") and is a meanir	ngful user (lin	e 167 is "	Y"), ente	r the		168. 00
reasonable cost incurred for the 168.01 If this provider is a CAH and is			er qualify	for a har	dshi p		168. 01
exception under §413.70(a)(6)(ii)	? Enter "Y" for yes or "N"	for no. (see	instructio	ns)			
169.00 If this provider is a meaningful transition factor. (see instructi	user (line 167 is "Y") and				enter the	9. 9	99169.00
	,			Be	gi nni ng	Endi ng	
					1.00	2. 00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and ending	date for the r	reporti ng				170. 00
					1. 00	2.00	_
171.00  If line 167 is "Y", does this pro section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (	reported on Wkst. S-3, Pt. umn 1. If column 1 is yes,	I, line 2, co	ol. 6? Ente	r	N		0171.00

Health Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0101 Peri od: Worksheet S-2 From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/15/2023 4:07 pm Y/N Date 1.00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If N 2 00 yes, enter in column 2 the date of termination and in column  $\hat{\textbf{3}},$  "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Α 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from 5.00 Ν those on the filed financial statements? If yes, submit reconciliation Legal Oper. Y/N 1.00 2.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7 00 7 00 N 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 N 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved 11.00 Ν Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions Υ 15.00 Part A Part B Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? N N 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for 05/01/2022 05/01/2022 17.00 Υ 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R 18.00 18.00 Υ Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R 19.00 Ν Ν Report data for corrections of other PS&R Report information? If yes, 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	Provi der C	CN: 15-0101	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S- Part II	2 epared:		
			i pti on	Y/N	Y/N	·		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20.00		
20.00	Report data for Other? Describe the other adjustments:			IN IN	IV	20.00		
		Y/N	Date	Y/N	Date			
04.00	lw	1.00	2. 00	3.00	4. 00			
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00		
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS	HOSPI TALS)					
22.00	Capital Related Cost	a i notrusti ono				1 22 00		
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, se Have changes occurred in the Medicare depreciation expense			ing the cost		22. 00 23. 00		
20.00	reporting period? If yes, see instructions.	due to apprai	sar s made dar	The cost		20.00		
24. 00	Were new leases and/or amendments to existing leases enter If yes, see instructions	ed into during	this cost re	porting period?		24. 00		
25. 00	Have there been new capitalized leases entered into during	the cost repo	rting period?	'If yes, see		25. 00		
26. 00	instructions. 6.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see 26							
20.00	instructions.	ne cost report	ing period. I	1 303, 300				
27. 00	Has the provider's capitalization policy changed during th copy.	e cost reporti	ng period? If	yes, submit		27. 00		
28. 00	Interest Expense Were new Loans, mortgage agreements or letters of credit e	ntered into du	ring the cost	reporting		28. 00		
20.00	period? If yes, see instructions.		-l-+ C! F	)		20.00		
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		ebt Service R	reserve Fund)		29. 00		
30. 00	Has existing debt been replaced prior to its scheduled mat linstructions.		debt? If yes	s, see		30.00		
31. 00	Has debt been recalled before scheduled maturity without instructions.	ssuance of new	debt? If yes	s, see		31. 00		
32. 00	Purchased Services Have changes or new agreements occurred in patient care se		ed through co	ntractual		32.00		
33. 00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap		ng to competi	tive bidding? If		33.00		
	no, see instructions. Provider-Based Physicians							
34.00	Were services furnished at the provider facility under an	arrangement wi	th provider-b	ased physicians?	Υ	34.00		
25 00	If yes, see instructions.	datina aanaama	n+c	provider bood		25.00		
35.00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		nts with the	provider-based		35. 00		
				Y/N	Date			
	Homo Offi co Costs			1.00	2. 00			
36 00	Home Office Costs Were home office costs claimed on the cost report?			Y		36.00		
	If line 36 is yes, has a home office cost statement been p If yes, see instructions.	repared by the	home office?			37. 00		
38. 00	If line 36 is yes , was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en			N		38. 00		
39. 00				s, 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			
41. 00	Cost Report Preparer Contact Information	SHANNON		ECENBARGER		41.00		
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SI (AININUIV		LUENDAKUEK		41.00		
42. 00	Enter the employer/company name of the cost report preparer.	PARKVI EW HEALT	H SYSTEM, INC	C.		42.00		
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(260) 373-8457	•	REI MBURSEMENT@I	PARKVI EW. COM	43.00		

Health Financial Systems	WHITLEY MEMORIA	L HOSPI TAI	=	In Lieu	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QU	UESTI ONNAI RE	Provi de	r CCN: 15-0101	riod: om 01/01/2022 12/31/2022	Worksheet S-2 Part II Date/Time Pre 5/15/2023 4:0	pared:
	_		3. 00			
Cost Report Preparer Contact Information						
41.00 Enter the first name, last name and the tit		I RECTOR, R	EIMBURSEMENT			41. 00
held by the cost report preparer in columns	s 1, 2, and 3,					
respecti vel y.						
42.00 Enter the employer/company name of the cost	report					42.00
preparer.						
43.00 Enter the telephone number and email address						43.00
report preparer in columns 1 and 2, respect	ti vel y.					

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: Heal th Fi nancial SystemsWHI TLEYHOSPI TAL AND HOSPI TAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-0101

				T	o 12/31/2022	Date/Time Pre 5/15/2023 4:0	
						I/P Days /	7 (2111
						0/P Visits /	
						Tri ps	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Li ne No.	2.00	Avai I abl e	4.00	F 00	
	DADT I CTATICTICAL DATA	1. 00	2.00	3. 00	4. 00	5. 00	
1. 00	PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	30	10, 950	0.00	0	1.00
1.00	8 exclude Swing Bed, Observation Bed and	30.00	30	10, 950	0.00	U	1.00
	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	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6. 00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7. 00	Total Adults and Peds. (exclude observation		30	10, 950	0.00		7. 00
7.00	beds) (see instructions)			10, 700	0.00	o l	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	13.00
14.00	Total (see instructions)		30	10, 950	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVI DER - I RF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY	44. 00	0	0		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						24.00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)		30			_	27. 00
28. 00	Observation Bed Days					0	28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32. 01	Total ancillary labor & delivery room						32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days						33. 00
33. 00	LTCH non-covered days  LTCH site neutral days and discharges						33.00
	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00
54.00	Transportary Expansion Covid 17 The Acute Care	30.00	١	1		0	04.00

Heal th Fi nancial SystemsWHITLEYHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: Provi der CCN: 15-0101

				1	0 12/31/2022	5/15/2023 4: 0	
		I /D Davis	/ O/P Visits	/ Trins	Full Time	Equi val ents	) piii
		1/F Days	/ U/F VISITS	/ 111 ps	Turi irille	Lqui vai ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	Component	I II LI G XVIII	II ti o xi x	Patients	& Residents	Payrol I	
		6. 00	7. 00	8.00	9. 00	10.00	
	PART I - STATISTICAL DATA	0.00	7.00	0.00	7. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 093	40	5, 044			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)	1, 080	971				2.00
3.00	HMO IPF Subprovider	ol	0				3.00
4.00	HMO IRF Subprovider	ol	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	ol	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation	1, 093	40	5, 044			7.00
	beds) (see instructions)			·			
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		15	532			13.00
14.00	Total (see instructions)	1, 093	55	5, 576	0.00	272.00	14.00
15.00	CAH visits	o	0	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	0	0	0	0.00	0.00	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							24.00
24. 10	HOSPICE (non-distinct part)			109			24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	272. 00	27. 00
28.00	Observation Bed Days		31	1, 463			28. 00
29. 00	The state of the s	0					29. 00
30.00				56			30.00
31.00	1 ' 3			0			31.00
32.00	,	0	42	97			32.00
32. 01				0			32. 01
	outpatient days (see instructions)						
	LTCH non-covered days	0					33.00
33. 01		0					33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

Heal th Fi nancial SystemsWHI TLEYHOSPI TAL AND HOSPI TAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-0101

				To	12/31/2022	Date/Time Pre 5/15/2023 4:0	
		Full Time		Di sch	arges	07 107 2020 1. 0	, Dill
		Equi val ents			_		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
	DADT I OTATIOTICAL DATA	11. 00	12. 00	13. 00	14. 00	15. 00	
4 00	PART I - STATISTICAL DATA			200	20	4 047	4 00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	338	20	1, 917	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2. 00	for the portion of LDP room available beds)	ł		302	338		2. 00
3. 00	HMO and other (see instructions) HMO IPF Subprovider			302	338		2. 00 3. 00
4. 00	HMO IRF Subprovider	+			0		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	1			٩		5.00
6. 00	Hospital Adults & Peds. Swing Bed SNF						6. 00
7. 00	Total Adults and Peds. (exclude observation	1					7. 00
7.00	beds) (see instructions)						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						13.00
14. 00	Total (see instructions)	0.00	0	338	20	1, 917	14. 00
15. 00	CAH visits	0.00	O	330	20	1, 717	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	0.00					19. 00
20. 00	NURSING FACILITY	0.00					20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges			0			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0101

					Ť	o 12/31/2022	Date/Time Pre 5/15/2023 4:0	pared: 7 pm
		Wkst. A Line	Amount	Reclassi fi cat	Adj usted	Paid Hours	Average	ļ
		Number	Reported	i on of Sal ari es	Sal ari es (col. 2 ± col.	Related to Salaries in	Hourly Wage (col. 4 ÷	
				(from Wkst.	3)	col. 4	col . 5)	
		1. 00	2. 00	A-6) 3. 00	4.00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1. 00	Total salaries (see	200.00	22, 633, 346	5, 817, 989	28, 451, 335	689, 534. 00	41. 26	1.00
2 00	instructions)					0.00	0.00	2 00
2. 00	Non-physician anesthetist Part A		0	0	C	0. 00	0. 00	2.00
3.00	Non-physician anesthetist Part		0	0	C	0. 00	0. 00	3.00
4. 00	Physician-Part A - Administrative		95, 430	0	95, 430	564. 00	169. 20	4.00
4. 01	Physicians - Part A - Teaching		0	0	· ·		0. 00	
5. 00	Physician and Non Physician-Part B		0	0	C	0. 00	0. 00	5.00
6. 00	Non-physician-Part B for hospital-based RHC and FQHC		0	0	d	0. 00	0. 00	6.00
7. 00	services Interns & residents (in an	21. 00	0	0	0	0. 00	0. 00	7.00
	approved program)							
7. 01	Contracted interns and residents (in an approved programs)		0	0	C	0.00	0. 00	7.01
8. 00	Home office and/or related organization personnel		5, 817, 989	0	5, 817, 989	122, 942. 00	47. 32	8.00
9.00	SNF	44. 00	0	0	0		0. 00	
10. 00	Excluded area salaries (see instructions)		2, 080, 669	15, 907	2, 096, 576	82, 031. 00	25. 56	10.00
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		0	0		0.00	0.00	11.00
	Care							
12. 00	Contract labor: Top level management and other		0	0	C	0.00	0. 00	12.00
	management and administrative							
13. 00	services Contract Labor: Physician-Part A - Administrative		0	0	С	0.00	0. 00	13.00
14. 00	Home office and/or related		0	0	О	0. 00	0. 00	14.00
	organization salaries and wage-related costs							
14. 01	Home office salaries		5, 817, 989	0	5, 817, 989			14.01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00	0. 00 0. 00	
	- Administrative		9					
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	O	0. 00	0. 00	16. 00
16. 01	Home office Physicians Part A		0	0	d	0. 00	0. 00	16. 01
16. 02	- Teaching Home office contract		0	0	0	0. 00	0. 00	16. 02
.0.02	Physicians Part A - Teaching					0.00	3. 55	.0.02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		8, 313, 936	0	8, 313, 936			17. 00
10.00	instructions)							10.00
18. 00	Wage-related costs (other) (see instructions)							18.00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		846, 900	0	846, 900			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0				21.00
22. 00	B Physician Part A -		0	0	1 0			22.00
	Administrative		Ü					
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0	0	0			22. 01 23. 00
24. 00	Wage-related costs (RHC/FQHC)		0	0				24.00
25. 00	Interns & residents (in an approved program)		0	0	O			25. 00
25. 50	Home office wage-related		0	0	C			25. 50
25. 51	(core) Rel ated organization		0	_	0			25. 51
	wage-related (core)		0		]			
25. 52	, , , , , , , , , , , , , , , , , , ,		0	0	0			25. 52
	- Administrative -							

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0101 Peri od: Worksheet S-3 From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/15/2023 4:07 pm Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Sal ari es Related to Reported ion of (col. 2 ± col. Sal ari es Salaries in (from Wkst. 3) col. 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 25.53 Home office: Physicians Part A 0 25. 53 - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 2, 156, 016 -2, 156, 016 0.00 0. 00 26.00 141, 943. 00 27.00 Administrative & General 5.00 1, 669, 971 6,013,324 7, 683, 295 54. 13 27.00 28.00 0.00 28.00 Administrative & General under 0 00 0 contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 30.00 Operation of Plant 7.00 532, 519 62, 288 594, 807 19, 257. 00 30. 89 30.00 Laundry & Linen Service 8.00 0.00 31.00 31.00 0.00 32.00 857, 206 38, 084. 00 Housekeepi ng 9.00 767, 439 89, 767 22. 51 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 34.00 Dietary 10.00 485, 236 -187, 524 297, 712 12, 422. 00 23.97 34.00 35.00 Dietary under contract (see 0.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 0 232, 547 232, 547 11, 989. 00 19. 40 36.00 0.00 37.00 Maintenance of Personnel 12.00 0.00 37.00 Nursing Administration 64. 47 38.00 38.00 13.00 539, 517 63, 107 602, 624 9, 348. 00 39.00 Central Services and Supply 14.00 0.00 0.00 39.00 14, 310. 00 59. 79 40.00 Pharmacy 15.00 766, 022 89, 601 855, 623 40.00 Medical Records & Medical Records Library 41.00 16.00 0 C 0 0.00 0.00 41.00

0

0

0

0

0

0

0.00

0.00

0.00 42.00

0.00 43.00

17.00

18.00

42.00

Social Service

43.00 Other General Service

пеан	n Financiai Systems		WHITE!	IAL HUSPITAL		III LI E	u of Form CN3-2	332-10
HOSPI	TAL WAGE INDEX INFORMATION			Provi der C		Period: From 01/01/2022		
						To 12/31/2022	Date/Time Pre 5/15/2023 4:0	
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4.00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		16, 815, 357	5, 817, 989	22, 633, 34	6 566, 592. 00	39. 95	1.00
	instructions)							
2.00	Excluded area salaries (see		2, 080, 669	15, 907	2, 096, 57	6 82, 031. 00	25. 56	2.00
	instructions)							
3.00	Subtotal salaries (line 1		14, 734, 688	5, 802, 082	20, 536, 77	0 484, 561. 00	42. 38	3.00
	minus line 2)							
4.00	Subtotal other wages & related		5, 817, 989	0	5, 817, 98	9 122, 942. 00	47. 32	4.00
							l	

5, 802, 082

4, 207, 094

8, 313, 936

34, 668, 695

11, 123, 814

0.00

607, 503. 00

247, 353. 00

40.48

57. 07

44. 97

5.00

6.00

7.00

8, 313, 936

28, 866, 613

6, 916, 720

costs (see inst.)

instructions)

Subtotal wage-related costs

(see inst.)
Total (sum of lines 3 thru 5)
Total overhead cost (see

5.00

6. 00

7.00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10	
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0101	Period: Worksheet S-3 From 01/01/2022 Part IV	
		To 12/31/2022 Date/Time Prepared:	

	To 12/31/2022	Date/Time Pre	
		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	551, 400	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1, 774, 836	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	4, 025	6.00
7.00	Employee Managed Care Program Administration Fees	504, 568	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)	4, 144, 878	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)	21, 467	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)	84, 885	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	-4, 400	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Noncumul ati ve porti on)		
	TAXES		
17. 00	FICA-Employers Portion Only	1, 978, 298	
18. 00	Medicare Taxes - Employers Portion Only	0	
19. 00	Unempl oyment Insurance	0	
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	68, 718	21.00
	instructions))		
22. 00	Day Care Cost and Allowances	0	
	Tuition Reimbursement	32, 161	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	9, 160, 836	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	1	25. 00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0101	Peri od: Worksheet S-3
		From 01/01/2022   Part V

		To 12/31/2022	Date/Time Pre 5/15/2023 4:0	
	Cost Center Description	Contract	Benefit Cost	
		Labor		
		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	9, 160, 836	1.00
2.00	Hospi tal	0	9, 160, 836	2.00
3.00	SUBPROVI DER - I PF			3.00
4.00	SUBPROVI DER - I RF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY	0	0	8. 00
9.00	NURSING FACILITY			9.00
				10.00
	Hospi tal -Based HHA			11.00
	AMBULATORY SURGICAL CENTER (D. P. ) I			12.00
	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
	RENAL DIALYSIS I			17.00
18. 00	Other	0	0	18. 00

OSPI T	Financial Systems WHITLEY MEMORIAL HOTAL UNCOMPENSATED AND INDIGENT CARE DATA Pr		CCN: 15-	0101	Peri od:	u of Form CMS-2 Worksheet S-1	
USFII	AL UNCOMPLINGATED AND TINDIGENT CARE DATA	Tovidei	CCN. 13-		rom 01/01/2022	WOLKSHEET 3-1	U
					o 12/31/2022	Date/Time Pre 5/15/2023 4:0	
							,, piii
	Uncomponented and indigent care cost computation					1.00	
00	Uncompensated and indigent care cost computation  Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	i ded by	line 201	2 column	8)	0. 207456	1.
00	Medicaid (see instructions for each line)	rueu by	11116 202	Z COI UIIIII	- 0)	0.207430	i ''
00	Net revenue from Medicaid					5, 539, 901	2.
00	Did you receive DSH or supplemental payments from Medicaid?					Y	3.
00	If line 3 is yes, does line 2 include all DSH and/or supplementa			m Medica	i d?	Y	4
00	If line 4 is no, then enter DSH and/or supplemental payments from	om Medio	cai d			0	
00	Medicaid charges Medicaid cost (line 1 times line 6)					27, 650, 383 5, 736, 238	
00	Difference between net revenue and costs for Medicaid program (I	line 7 m	ni nus sur	m of lin	es 2 and 5 if	196, 337	1
00	<pre>&lt; zero then enter zero)</pre>	11110 7 1	iii rius sui	01 1111	cs z ana o, m	170,007	0.
	Children's Health Insurance Program (CHIP) (see instructions for	r each I	i ne)				
. 00	Net revenue from stand-alone CHIP					9, 323	
0. 00 1. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)					48, 056 9, 970	
2. 00	Difference between net revenue and costs for stand-alone CHIP (I	line 11	minus li	ine 9∙i	f < zero then	647	
00	enter zero)	11110 11	iii nas m	1110 7, 1	1 ( 2010 (11011	017	'-
	Other state or local government indigent care program (see instr						
3. 00	Net revenue from state or local indigent care program (Not inclu					7, 562, 192	
1. 00	Charges for patients covered under state or local indigent care 10)	progran	n (Not ir	ncl uded	in lines 6 or	40, 964, 276	14.
5. 00	State or local indigent care program cost (line 1 times line 14)	)				8, 498, 285	15.
	Difference between net revenue and costs for state or local indi		are progr	ram (lin	e 15 minus line		
							10.
	13; if < zero then enter zero)						] '0.
	Grants, donations and total unreimbursed cost for Medicaid, CHIF						10.
7. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line)	P and st	rate/loca	al indig			
8. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line) Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of ho	P and st Inding chospital	ate/loca	al indig are ons	ent care progra	o o	17. 18.
8. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line)  Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of hotal unreimbursed cost for Medicaid, CHIP and state and local	P and st Inding chospital	ate/loca	al indig are ons	ent care progra	ams (see	17. 18.
8. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line) Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of ho	P and st Inding chospital	narity ca operation	al indig are ons	ent care progra	o o	17. 18.
3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line)  Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of hotal unreimbursed cost for Medicaid, CHIP and state and local	P and st Inding chospital	narity ca operation nt care p	al indig are ons programs nsured ients	(sum of lines	0 0 1,133,077 Total (col. 1 + col. 2)	17. 18.
3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line)  Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of hotal unreimbursed cost for Medicaid, CHIP and state and Local 8, 12 and 16)	P and st Inding chospital	narity ca operation nt care p	al indig are ons programs	ent care progra	0 0 1,133,077	17. 18.
3. 00 9. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line)  Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of hotal unreimbursed cost for Medicaid, CHIP and state and local	P and st Inding chospital indiger	narity ca operation nt care publication	al indig are ons programs nsured ients	(sum of lines  Insured patients 2.00	0 0 1,133,077 Total (col. 1 + col. 2) 3.00	17. 18. 19.
8. 00 9. 00 0. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line) Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions)	P and st nding ch ospital indiger	cate/loca	al indig are ons programs nsured ients .00	(sum of lines Insured patients 2.00	Total (col. 1 + col. 2) 3.00	17. 18. 19.
8. 00 9. 00 0. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line)  Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire faci (see instructions)  Cost of patients approved for charity care and uninsured discour	P and st nding ch ospital indiger	cate/loca	al indig are ons programs nsured :ients .00	(sum of lines Insured patients 2.00	Total (col. 1 + col. 2) 3.00	17. 18. 19.
3. 00 9. 00 0. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line)  Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of hotal unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire faci (see instructions)  Cost of patients approved for charity care and uninsured discourinstructions)	P and standing choospital indiger	cate/loca	al indig are ons programs nsured ients .00 .,603,093	(sum of lines Insured patients 2.00 1,174,490 1,174,490	Total (col. 1 + col. 2) 3.00  5,777,583 2,129,429	17. 18. 19. 20.
3. 00 9. 00 0. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line)  Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire faci (see instructions)  Cost of patients approved for charity care and uninsured discour instructions)  Payments received from patients for amounts previously written or	P and standing choospital indiger	cate/loca	al indig are ons programs nsured ients .00	(sum of lines Insured patients 2.00 1,174,490 1,174,490	Total (col. 1 + col. 2) 3.00	17. 18. 19. 20.
3. 00 9. 00 0. 00 1. 00 2. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line)  Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire faci (see instructions)  Cost of patients approved for charity care and uninsured discour instructions)  Payments received from patients for amounts previously written charity care	P and standing choospital indiger	cate/loca	al indig are ons programs nsured ients .00 .,603,093	(sum of lines Insured patients 2.00 1,174,490 1,174,490	Total (col. 1 + col. 2) 3.00 5,777,583 2,129,429	17. 18. 19. 20. 21.
3. 00 2. 00 0. 00 1. 00 2. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line)  Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire faci (see instructions)  Cost of patients approved for charity care and uninsured discour instructions)  Payments received from patients for amounts previously written charity care	P and standing chospital indiger	cate/loca	al indig are ons programs nsured dients .00	(sum of lines Insured patients 2.00 1,174,490 1,174,490	Total (col. 1 + col. 2) 3.00  5,777,583 2,129,429	17. 18. 19. 20. 21.
0.00	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line)  Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire faci (see instructions)  Cost of patients approved for charity care and uninsured discourinstructions)  Payments received from patients for amounts previously written charity care  Cost of charity care (line 21 minus line 22)	P and standing choospital indiger	unarity ca operation operation the care pure patents of the care p	al indigare ons programs nsured ients .00 .,603,093	(sum of lines	Total (col. 1 + col. 2) 3.00  5,777,583 2,129,429 2,129,429 1.00	20. 21. 22. 23.
0.00	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line)  Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire faci (see instructions)  Cost of patients approved for charity care and uninsured discourinstructions)  Payments received from patients for amounts previously written of charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patients	P and standing chospital indiger	unarity ca operation operation operation the care punits unit pat 1	al indigare ons programs nsured ients .00 .,603,093	(sum of lines	Total (col. 1 + col. 2) 3.00  5,777,583 2,129,429	20. 21. 22. 23.
3. 00 2. 00 3. 00 3. 00 4. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line)  Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire faci (see instructions)  Cost of patients approved for charity care and uninsured discourinstructions)  Payments received from patients for amounts previously written charity care  Cost of charity care (line 21 minus line 22)	P and standing chospital indiger indiger indiger indiger indiger in the control of the control o	Unir pat	al indig are ons programs nsured dients .00 .,603,093 954,939	(sum of lines  Insured patients 2.00  1,174,490 0,1,174,490 of stay limit	Total (col. 1 + col. 2) 3.00 5,777,583 2,129,429 0 2,129,429	20. 21. 22. 23.
33.00 3.00 3.00 3.00 1.00 2.00 44.00	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line)  Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire faci (see instructions)  Cost of patients approved for charity care and uninsured discour instructions)  Payments received from patients for amounts previously written charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care particular in the second control of the charges for patient days beyond the	P and standing chospital indiger indiger	Unir pat  Unir pat  2  Deeyond a 2 2 ent care	al indig are ons programs nsured dients .00 .,603,093 954,939	(sum of lines  Insured patients 2.00  1,174,490 0,1,174,490 of stay limit	Total (col. 1 + col. 2) 3.00 5,777,583 2,129,429 0 2,129,429	20. 21. 22. 23.
33. 00 30. 00 31. 00 32. 00 44. 00 55. 00 66. 00 77. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line)  Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire faci (see instructions)  Cost of patients approved for charity care and uninsured discour instructions)  Payments received from patients for amounts previously written charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care partially line 24 is yes, enter the charges for patient days beyond the stay limit	P and standing chospital indiger indig	Unir pat  Deeyond a rent care in care	al indig are ons programs nsured ients .00 954,939 0 954,939	(sum of lines  Insured patients 2.00  1,174,490 0,1,174,490 of stay limit	Total (col. 1 + col. 2) 3.00  5,777,583 2,129,429 0 2,129,429 1.00 N	20. 21. 22. 23. 24. 25. 26. 27.
88.00 99.00 11.00 22.00 44.00 45.00 66.00 77.00	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line)  Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire faci (see instructions)  Cost of patients approved for charity care and uninsured discourinstructions)  Payments received from patients for amounts previously written charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care plif line 24 is yes, enter the charges for patient days beyond the stay limit  Total bad debt expense for the entire hospital complex (see instined care reimbursable bad debts for the entire hospital complex (see	P and standing chospital indiger indig	Description of the care property of the care property of the care property of the care of	al indigare ons programs nsured ients .00 .,603,093 954,939 I ength program	(sum of lines  Insured patients 2.00  1,174,490 0,1,174,490 of stay limit	Total (col. 1 + col. 2) 3.00  5,777,583 2,129,429 0 2,129,429 1.00 N 0 7,916,215 76,593 117,834	20. 21. 22. 23. 24. 25. 26. 27. 27.
0. 00 11. 00 12. 00 44. 00 55. 00 77. 00 77. 01 88. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line)  Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire faci (see instructions)  Cost of patients approved for charity care and uninsured discour instructions)  Payments received from patients for amounts previously written of charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care provided in the stay limit total bad debt expense for the entire hospital complex (see inst Medicare allowable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	P and standing chospital indiger indiger indiger indiger indiger indiger indiger indiger indiger instance instance instance instance instance instance instance in stance in sta	Descriptions of the control of the c	al indig are ons programs nsured dients .00 954,939 ( 954,939 I ength program	(sum of lines  Insured patients 2.00  1,174,490 0,1,174,490 of stay limit	0 0 1,133,077 Total (col. 1 + col. 2) 3.00 5,777,583 2,129,429 0 2,129,429 1.00 N 0 7,916,215 76,593 117,834 7,798,381	20. 21. 22. 23. 24. 25. 26. 27. 27. 28.
9. 00 0. 00 1. 00 2. 00 3. 00 4. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line)  Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire faci (see instructions)  Cost of patients approved for charity care and uninsured discourinstructions)  Payments received from patients for amounts previously written charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care plif line 24 is yes, enter the charges for patient days beyond the stay limit  Total bad debt expense for the entire hospital complex (see instined care reimbursable bad debts for the entire hospital complex (see	P and standing chospital indiger indiger indiger indiger indiger indiger indiger indiger indiger instance instance instance instance instance instance instance in stance in sta	Descriptions of the control of the c	al indig are ons programs nsured dients .00 954,939 ( 954,939 I ength program	(sum of lines  Insured patients 2.00  1,174,490 0,1,174,490 of stay limit	Total (col. 1 + col. 2) 3.00  5,777,583 2,129,429 0 2,129,429 1.00 N 0 7,916,215 76,593 117,834	20. 21. 22. 23. 24. 25. 26. 27. 27. 28. 29.

Heal th	Financial Systems	WHITLEY MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der Co	CN: 15-0101	Peri od:	Worksheet A	
					From 01/01/2022 To 12/31/2022		narod:
					10 12/31/2022	5/15/2023 4:0	
	Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
				+ col . 2)	i ons (See	Trial Balance	
					A-6)	(col. 3 +-	
						col. 4)	
	DENERAL DERIVERS DOOT DENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
1 00	GENERAL SERVI CE COST CENTERS		4 715 105	4 715 10	1 057 (05	2 (57 400	1 00
1.00	00100 CAP REL COSTS-BLDG & FLXT		4, 715, 185				1.00
2. 00 3. 00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS		0		1, 890, 554	1, 890, 554 0	2. 00 3. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 156, 016	7, 595, 782	9, 751, 79	-2, 156, 016	7, 595, 782	4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	1, 669, 971	29, 414, 116			30, 680, 322	5.00
6. 00	00600 MAINTENANCE & REPAIRS	1,009,971	27, 414, 110	31,004,00	1 -403, 703	30, 080, 322	6.00
7. 00	00700 OPERATION OF PLANT	532, 519	1, 486, 247	2, 018, 76	5 -52, 204	1, 966, 562	7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	332, 317	326, 721			326, 721	8.00
9. 00	00900 HOUSEKEEPI NG	767, 439	189, 575	1		1, 045, 378	9.00
10. 00	01000 DI ETARY	485, 236	416, 391			508, 801	10.00
11. 00	01100 CAFETERI A	0	0	1	437, 621	437, 621	11.00
12. 00	01200 MAINTENANCE OF PERSONNEL	l ol	0		0	0	12.00
13.00	01300 NURSING ADMINISTRATION	539, 517	2, 460	541, 97	63, 107	605, 084	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	O	0		o	0	14.00
15.00	01500 PHARMACY	766, 022	114, 251	880, 27	87, 496	967, 769	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0	0	16.00
17.00	01700 SOCIAL SERVICE	0	0		0	0	17.00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0		0	0	19. 00
20.00	02000 NURSI NG PROGRAM	0	0	)	0	0	20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	)	0	0	21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	)	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	(	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	4, 152, 495	2, 217, 975	6, 370, 470		6, 035, 905	30.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	0		0 401, 774 0 0	401, 774 0	43. 00 44. 00
44.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>		1	<u> </u>	U	44.00
50. 00	05000 OPERATING ROOM	1, 157, 578	2, 266, 746	3, 424, 324	19, 719	3, 444, 043	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	86, 015	-195			911, 793	52.00
53.00	05300 ANESTHESI OLOGY	0	0		o o	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 251, 821	1, 373, 272	3, 625, 09	259, 519	3, 884, 612	54.00
60.00	06000 LABORATORY	0	3, 869, 935	3, 869, 93	5 0	3, 869, 935	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	)	0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	912, 442	716, 516			1, 654, 912	65.00
66. 00	06600 PHYSI CAL THERAPY	1, 467, 669	331, 750	1, 799, 419		663, 220	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	1	941, 660		67.00
68. 00	06800 SPEECH PATHOLOGY	0	0		66, 953	66, 953	1
69.00	06900 ELECTROCARDI OLOGY	0	1 000 071	1 000 07:	1 (20 007	0	69.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS		1, 083, 971	1, 083, 97	1 -629, 097 629, 097	454, 874	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS		4, 972, 000	4, 972, 000		629, 097 4, 972, 000	
	07697 CARDI AC REHABI LI TATI ON		4, 972, 000	4, 772, 000			76. 97
	07698 HYPERBARI C OXYGEN THERAPY		-2, 614	-2, 61	6, 614		76. 98
76. 99	07699 LI THOTRI PSY		2,014	2,01	0,014	4, 000	76. 99
70.77	OUTPATIENT SERVICE COST CENTERS	<u> </u>			<u> </u>		70.77
90.00	09000 CLI NI C	0	0		0	0	90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	o	0		o	0	90. 01
91.00	09100 EMERGENCY	3, 607, 937	1, 275, 402	4, 883, 339	9 417, 299	5, 300, 638	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVI CES	2, 045, 000	468, 175	2, 513, 17	-4, 409	2, 508, 766	95.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE	00 507 (77	6, 928	1			113.00
118. 00		22, 597, 677	62, 840, 589	85, 438, 26	-12, 000	85, 426, 266	1118.00
100.00	NONREI MBURSABLE COST CENTERS		2 1/2	2.10		2.1/2	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	35, 669	2, 163		1		
	07950 OCCUPATI ONAL HEALTH	35, 669	520, 389	556, 05	12,000		194.00
	107950 OCCOPATIONAL HEALTH		0	]			194.00
	207952 OAK POINTE		0	]			194.01
	307953 FOUNDATION		11, 719	11, 71		11, 719	
	107954 COMMUNITY & VOLUNTEER SERVICES		47, 151		1	47, 151	
	07955 VACANT SPACE	0	.,, .sı	1			194. 05
	07956 TELEHEALTH MEDICINE	l ol	0		ol ol		194.06
200.00		22, 633, 346	63, 422, 011	86, 055, 35	7 0		
		·			·	·	

Provi der CCN: 15-0101

				te/IIme Prepared: 15/2023 4:07 pm
Cost Center Description	Adjustments	Net Expenses		137 2023 4. 07 pin
, and the second	(See A-8)	For		
		Allocation		
OFFICIAL OFFICE COOT OFFITTED	6. 00	7. 00		
GENERAL SERVICE COST CENTERS	2 120 E12	1 510 070		1 00
1. 00   00100   CAP REL COSTS-BLDG & FLXT 2. 00   00200   CAP REL COSTS-MVBLE EQUIP	-2, 138, 512 -100	1, 518, 978 1, 890, 454		1.00
3. 00   00300 OTHER CAP REL COSTS	- 100	1, 670, 434		3.00
4. 00   00400 EMPLOYEE BENEFITS DEPARTMENT	0	7, 595, 782		4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	-10, 786, 198	19, 894, 124		5.00
6. 00 00600 MAINTENANCE & REPAIRS	0	0		6.00
7.00 00700 OPERATION OF PLANT	-114, 734	1, 851, 828		7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	326, 721		8.00
9. 00 00900 HOUSEKEEPI NG	0	1, 045, 378		9. 00
10. 00  01000 DI ETARY	0	508, 801		10.00
11. 00   01100   CAFETERI A	-381, 931	55, 690		11.00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0		12. 00
13. 00 O1300 NURSING ADMINISTRATION	0	605, 084		13.00
14. 00   01400   CENTRAL SERVI CES & SUPPLY	0	0		14.00
15. 00   01500   PHARMACY	-113, 998	853, 771		15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0		16.00
17. 00   01700   SOCI AL SERVI CE 19. 00   01900   NONPHYSI CI AN ANESTHETI STS	0	0		17. 00 19. 00
20. 00   02000   NURSI NG PROGRAM	0	0		20.00
21. 00   02100   1&R SERVICES-SALARY & FRINGES APPRV	0	0		21. 00
22. 00   02200   &R SERVICES-OTHER PRGM COSTS APPRV	0	0		22.00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	o o		23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	<u> </u>		20.00
30. 00 03000 ADULTS & PEDI ATRI CS	-360, 328	5, 675, 577		30.00
43. 00 04300 NURSERY	0	401, 774		43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		44.00
ANCILLARY SERVICE COST CENTERS				
50.00   05000   OPERATING ROOM	-1, 130, 737	2, 313, 306		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	911, 793		52.00
53. 00   05300   ANESTHESI OLOGY	0	0		53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	-679	3, 883, 933		54.00
60. 00   06000   LABORATORY	0	3, 869, 935		60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	77 000	1 577 000		62. 30
65. 00   06500   RESPI RATORY   THERAPY 66. 00   06600   PHYSI CAL   THERAPY	-77, 889 -354, 723	1, 577, 023 308, 497		65. 00 66. 00
67. 00   06700   OCCUPATI ONAL THERAPY	-354, 723	941, 660		67.00
68. 00 06800 SPEECH PATHOLOGY	0	66, 953		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	00, 733		69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	454, 874		71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	629, 097		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	4, 972, 000		73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		76. 97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	4, 000		76. 98
76. 99 07699 LI THOTRI PSY	0	0		76. 99
OUTPATIENT SERVICE COST CENTERS				
90. 00  09000   CLI NI C	0			90.00
90.01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0		90. 01
91. 00   09100   EMERGENCY	-655, 938	4, 644, 700		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
OTHER REIMBURSABLE COST CENTERS	2 520	2 504 227		95. 00
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	-2, 539	2, 506, 227		95.00
113. 00 11300 INTEREST EXPENSE	0	0		113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-16, 118, 306			118.00
NONREI MBURSABLE COST CENTERS	10, 110, 300	07, 307, 700		110.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	2, 163		190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	-251, 681	316, 377		192. 00
194. 00 07950 OCCUPATI ONAL HEALTH	0	0		194.00
194. 01 07951 PAIN CLINIC	0	o		194. 01
194. 02 07952 OAK POINTE	0	o		194. 02
194. 03 07953 FOUNDATI ON	0	11, 719		194. 03
194.04 07954 COMMUNITY & VOLUNTEER SERVICES	0	47, 151		194. 04
194.05 07955 VACANT SPACE	0	0		194. 05
194. 06 07956 TELEHEALTH MEDICINE	0	0		194. 06
200.00   TOTAL (SUM OF LINES 118 through 199)	-16, 369, 987	69, 685, 370		200. 00

Health Financial Systems RECLASSIFICATIONS Period: Worksheet A-6
From 01/01/2022
To 12/31/2022 Date/Time Prepared: 5/15/2023 4:07 pm Provider CCN: 15-0101

					5/15/2023 4	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
4 00	A - CAFETERIA RECLASS	44.00	222 547	205 274		4
1. 00	CAFETERI A	11.00	232, 547	205, 074		1.00
	O D DECLACE		232, 547	205, 074		_
1. 00	B - OB RECLASS NURSERY	43. 00	365, 171	36, 603		1.00
2. 00	DELIVERY ROOM & LABOR ROOM	52.00	741, 579	74, 333		2.00
2.00	O ROOM & LABOR ROOM		1, 106, 750	110, 936		2.00
	E - BUILDING AND EQUIP LEASE		1, 100, 750	110, 730		_
1. 00	CAP REL COSTS-BLDG & FLXT	1. 00	0	552, 482		1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	2. 00	o	151, 853		2.00
3. 00	HYPERBARI C OXYGEN THERAPY	76. 98	o	6, 614		3. 00
4. 00	ITTI ERBARTO OXTOER THERAIT	0.00	0	0, 014		4.00
5. 00		0.00	ő	Ö		5.00
6. 00		0.00	Ö	Ö		6.00
7. 00		0.00	0	Ö		7.00
8. 00		0. 00	0	Ö		8.00
9. 00		0. 00	0	Ö		9.00
10.00		0.00	o	O		10.00
11. 00		0.00	O	0		11.00
12. 00		0.00	o	Ö		12.00
13.00		0.00	o	0		13.00
14.00		0.00	o	0		14.00
15. 00		0.00	o	Ö		15. 00
16. 00		0. 00	o	0		16.00
				710, 949		
	G - INSURANCE RECLASS	<u>'</u>	<u>'</u>			
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	43, 263		1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0	7 <u>8, 8</u> 57		2.00
	0		0	122, 120		
	H - DEPRECIATION RECLASS					
1. 00	CAP REL COSTS-MVBLE EQUIP		0	<u>1, 659, 844</u>		1.00
	0		0	1, 659, 844		_
	K - SALARY RECLASS	5 00	5 047 000			4
1. 00	ADMI NI STRATI VE & GENERAL		<u>5, 817, 989</u>	0		1.00
	U DELIAR THERARY DERT DECLAR	)C	5, 817, 989	U		_
1 00	L - REHAB THERAPY DEPT RECLAS		022 444	10 104		1 00
1.00	OCCUPATI ONAL THERAPY	67. 00	923, 464	18, 196		1.00
2. 00	SPECH PATHOLOGY		6 <u>5, 6</u> 60 989, 124	<u>1, 293</u> 19, 489		2. 00
	N - PTO ACCRUAL RECLASS		909, 124	19, 409		_
1. 00	ADMINISTRATIVE & GENERAL	5. 00	195, 335	0		1.00
2. 00	OPERATION OF PLANT	7. 00	62, 288	Ö		2.00
3. 00	HOUSEKEEPI NG	9. 00	89, 767	Ö		3. 00
4. 00	DI ETARY	10.00	56, 758	Ö		4.00
5. 00	NURSING ADMINISTRATION	13. 00	63, 107	Ö		5. 00
6. 00	PHARMACY	15. 00	89, 601	Ö		6. 00
7. 00	ADULTS & PEDIATRICS	30.00	485, 715	Ö		7. 00
8. 00	OPERATI NG ROOM	50.00	135, 401	0		8.00
9. 00	DELIVERY ROOM & LABOR ROOM	52. 00	10, 061	Ö		9. 00
10.00	RADI OLOGY-DI AGNOSTI C	54. 00	263, 394	Ö		10.00
11. 00	RESPI RATORY THERAPY	65. 00	106, 728	Ō		11.00
12. 00	PHYSI CAL THERAPY	66.00	171, 672	Ö		12.00
13.00	EMERGENCY	91. 00	422, 017	Ō		13. 00
14.00	PHYSICIANS' PRIVATE OFFICES	192.00	4, 172			14.00
	0		2, 156, 016	0		
	O - CLINIC DIETICIAN RECLASS		,			
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	11, 735	0		1.00
	0		11, 735	0		_
	R - IMPLANTABLE MEDICAL SUPPL					
1.00	IMPL. DEV. CHARGED TO	72. 00	0	629, 097		1.00
	PATI ENTS					1
	0		0	629, 097		_
	S - INTEREST EXPENSE		.1			4
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	6, 928		1.00
	U DECLACE HOODETS COTO	ADULTO A DES	0	6, 928		4
1 00	T - RECLASS HOSPITALISTS TO A			404 000		4
1. 00	ADULTS & PEDIATRICS	30.00	<u>_</u>	404,000		1.00
500.00	Grand Total: Increases		10, 314, 161	404, 000 3, 868, 437		500.00
500.00	Jordina Total. Thereases	ı	10, 314, 101	5, 000, 457		1 300.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: | 5/15/2023 4:07 pm Provider CCN: 15-0101

						5/15/2023 4:07 p
	Cook Cooker	Decreases	Callann	0+4	W+ 4 7 D-6	
	Cost Center 6.00	Li ne # 7.00	Sal ary 8. 00	0ther 9.00	Wkst. A-7 Ref. 10.00	
^	- CAFETERI A RECLASS	7.00	8.00	9.00	10.00	
	ETARY	10. 00	232, 547	205, 074	0	1
0			232, 547	205, 074		
B	- OB RECLASS		232, 347	203, 074		
	OULTS & PEDI ATRI CS	30.00	1, 106, 750	110, 936	0	1
ŏ ľ	30210 a 12317(11(103	0. 00	0	0	o	
0	_ — — — — +		1, 106, 750	110, 936	— —  —	
E	- BUILDING AND EQUIP LEASE		17 1007 700	, , , , ,		
	OMINISTRATIVE & GENERAL	5. 00	0	62, 234	10	1
-	PERATION OF PLANT	7. 00	o	114, 216	10	
	ESPI RATORY THERAPY	65. 00	o	80, 774	0	3
	HYSI CAL THERAPY	66. 00	o	299, 258	o	
	OMINISTRATIVE & GENERAL	5. 00	o	10, 746	O	Ę
	PERATION OF PLANT	7. 00	O	276	O	1
	DUSEKEEPI NG	9. 00	o	1, 403	o	1 -
o DI	ETARY	10.00	o	228	o	8
о РН	HARMACY	15. 00	o	2, 105	o	· ·
OO AD	OULTS & PEDIATRICS	30.00	o	6, 594	O	10
00 OP	PERATING ROOM	50.00	o	115, 682	О	11
00 RA	ADI OLOGY-DI AGNOSTI C	54.00	O	3, 875	О	12
OO EN	MERGENCY	91.00	О	4, 718	О	13
OO AN	MBULANCE SERVICES	95. 00	o	4, 409	O	14
00 PH	HYSICIANS' PRIVATE OFFICES	192. 00	o	3, 907	o	15
	AP REL COSTS-BLDG & FLXT	1. 00	o	524	10	16
0				710, 949		
G	- INSURANCE RECLASS					
O AD	OMINISTRATIVE & GENERAL	5. 00	0	122, 120	12	1
0		0.00	o	0	12	2
0	- $    -$		0	122, 120		
Н	- DEPRECIATION RECLASS				·	
O CA	AP REL COSTS-BLDG & FIXT	1. 00	0	1, 659, 844	9	1
0				1, 659, 844		
K	- SALARY RECLASS					
O AD	DMINISTRATIVE & GENERAL	5. 00	0	5, 817, 989	0	1
0			0	5, 817, 989		
L	- REHAB THERAPY DEPT RECLAS	S				
0 PH	HYSI CAL THERAPY	66. 00	989, 124	19, 489	0	1
00		000	0	0	0	2
0			989, 124	19, 489		
	- PTO ACCRUAL RECLASS					
	MPLOYEE BENEFITS DEPARTMENT	4. 00	2, 156, 016	0		1
0		0. 00	0	0	0	2
0		0. 00	0	0	0	3
0		0. 00	0	0	0	4
0		0. 00	0	0	0	
0		0. 00	0	0	0	6
0		0. 00	0	0	0	7
0		0.00	0	0	0	8
0		0. 00	0	0	0	Ç
00		0.00	O	0	0	10
00		0.00	O	0	0	11
00		0.00	O	0	0	12
00		0.00	0	0	O	13
00		000	0	0	0	14
0			2, 156, 016	0		
	- CLINIC DIETICIAN RECLASS					
O DI	ETARY	1000	1 <u>1, 7</u> 35	0	0	1
0			11, 735	0		
	- IMPLANTABLE MEDICAL SUPPL			1		
	EDICAL SUPPLIES CHARGED TO	71. 00	0	629, 097	0	1
PA	ATI ENT					
0			0	629, 097		
	- INTEREST EXPENSE			1		
O IN	NTEREST EXPENSE	1 <u>13.</u> 00	0	6, 928	14	1
0			0	6, 928		
	- RECLASS HOSPITALISTS TO A					
_ [.=	OMINISTRATIVE & GENERAL	500	0	404, 000		1
O AL						1
0	rand Total: Decreases		0 4, 496, 172	404, 000 9, 686, 426		500

Provider CCN: 15-0101

| Peri od: | Worksheet A-7 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared:

				'	0 12/31/2022	5/15/2023 4:0	
			<u> </u>	Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1. 00	Land	260, 483	356, 077	C	356, 077	0	1.00
2.00	Land Improvements	2, 512, 929	0	C	0	0	2.00
3. 00	Buildings and Fixtures	14, 853, 613	65, 191	C	65, 191	0	3.00
4.00	Building Improvements	48, 824	0	C	0	0	4.00
5. 00	Fixed Equipment	6, 515, 388	0	C	0	0	5.00
6.00	Movable Equipment	19, 443, 585	1, 551, 331		1, 551, 331	147, 195	
7. 00	HIT designated Assets	3, 753, 369	88, 138		88, 138		7.00
8. 00	Subtotal (sum of lines 1-7)	47, 388, 191	2, 060, 737		2, 060, 737	147, 195	
9.00	Reconciling Items	-37, 449	-648, 284	C	-648, 284	0	,
10.00	Total (line 8 minus line 9)	47, 425, 640	2, 709, 021	C	2, 709, 021	147, 195	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	616, 560	0				1.00
2.00	Land Improvements	2, 512, 929					2.00
3.00	Buildings and Fixtures	14, 918, 804	217, 885				3. 00
4.00	Building Improvements	48, 824	48, 824				4. 00
5.00	Fi xed Equi pment	6, 515, 388	57, 045				5.00
6.00	Movable Equipment	20, 847, 721	6, 089, 328				6.00
7.00	HIT designated Assets	3, 841, 507	0				7. 00
8.00	Subtotal (sum of lines 1-7)	49, 301, 733	6, 457, 944				8.00
9.00	Reconciling Items	-685, 733	0				9. 00
10. 00	Total (line 8 minus line 9)	49, 987, 466	6, 457, 944				10.00

Heal th	Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0101	Peri od: From 01/01/2022 To 12/31/2022		pared:
			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 WOR	KSHEET A, COLUM	N 2, LINES 1	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	4, 715, 185	0	)	0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	1	0	0	2.00
3.00	Total (sum of lines 1-2)	4, 715, 185	0		0 0	0	3. 00
		SUMMARY OF	F CAPI TAL				
	Cost Center Description	Other	Total (1)				
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	<u> </u>				
1.00	CAP REL COSTS-BLDG & FLXT	0	4, 715, 185				1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	0	0	1			2. 00
3. 00	Total (sum of lines 1-2)	0	4, 715, 185				3.00

Heal th	n Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	1	Period: From 01/01/2022 To 12/31/2022	Worksheet A-7 Part III Date/Time Prep 5/15/2023 4:0	
		COME	PUTATION OF RAT	TIOS	ALLOCATION OF		<i>y</i> piii
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 -			
		1.00	0.00	col . 2)	4.00	F 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	24, 575, 056	0	24, 575, 056	0. 505302	0	1. 00
2. 00	CAP REL COSTS-BEDG & TTXT	24, 638, 539				-	2.00
3. 00	Total (sum of lines 1-2)	49, 213, 595					3.00
0.00	Trotal (Sam of Tribo 1 2)	ALLOCATION OF OTHER CAPITAL			SUMMARY 0		0.00
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at				
			ed Costs	through 7)			
	DART III DECONOLILATION OF CARLTAL COCTO	6. 00	7. 00	8. 00	9. 00	10.00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS C			Ι ,	014 020	EE1 OEO	1 00
1. 00 2. 00	CAP REL COSTS-BLUG & FIXT	0	0	)	916, 829 1, 659, 744		1. 00 2. 00
3. 00	Total (sum of lines 1-2)	0	0	)	2, 576, 573	•	3. 00
3.00	Total (suil of Titles 1-2)	0	SI SI	JMMARY OF CAPI		703, 611	3.00
			00	Juliu 01 07 1	171L		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see	instructions)	Capi tal -Rel at	(sum of cols.	
			instructions)		ed Costs (see	9 through 14)	
					instructions)		
	DART III DECONOLILATION OF CARLEY COOTS	11.00	12. 00	13. 00	14. 00	15. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS C		42.0/2	1 ,	4 000	1 510 070	1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FLXT CAP REL COSTS-MVBLE EQUIP	0	,		6, 928	1, 518, 978 1, 890, 454	1. 00 2. 00
3. 00	Total (sum of lines 1-2)	0		•		3, 409, 432	3. 00
3.00	10tal (30m 01 111163 1-2)	1	1 122, 120	1	0, 720	5, 407, 432	3.00

Peri od: From 01/01/2022 Provider CCN: 15-0101

				Fr   To	rom 01/01/2022 b 12/31/2022	Date/Time Pre	
				Expense Classification on	Worksheet A	5/15/2023 4:0	7 pm
				To/From Which the Amount is			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	cost center bescription	(2)				Ref.	
1. 00	Investment income - CAP REL	1. 00	2. 00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00	5. 00 0	1.00
	COSTS-BLDG & FLXT (chapter 2)						
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	Investment income - other		0		0. 00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0. 00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00
	expenses (chapter 8)		O				
6. 00	Rental of provider space by suppliers (chapter 8)		0		0. 00	0	6. 00
7. 00	Tel ephone servi ces (pay		0		0. 00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service	А	-518	OPERATION OF PLANT	7. 00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0. 00	0	9. 00
10.00	Provi der-based physician adjustment	A-8-2	-2, 169, 570			0	10.00
11. 00	Sale of scrap, waste, etc.		0		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	-9, 194, 503			0	12. 00
	transactions (chapter 10)	-	,		0.00	0	
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	-284, 329	CAFETERI A	0. 00 11. 00	0	13. 00 14. 00
15. 00	Rental of quarters to employee and others		0		0. 00	0	15. 00
16. 00	Sale of medical and surgical		0		0. 00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than	В	-5, 032	PHARMACY	15. 00	0	17. 00
18. 00	patients Sale of medical records and		0		0.00	0	18. 00
10.00	abstracts		0		0.00	0	10.00
19. 00	Nursing and allied health education (tuition, fees,		U		0. 00	U	19. 00
20. 00	books, etc.) Vending machines		0		0. 00	0	20. 00
	Income from imposition of		0		0.00	0	1
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	limitation (chapter 14)		_				
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
27.00	(chapter 21)		0	CAR REL COCTO RIDO & FLYT	1 00	0	27.00
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0 0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
20.00	therapy costs in excess of		O		37.30		-3. 55
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
	instructions)						

					5/15/2023 4:0	/ pill
	Worksheet A					
			To/From Which the Amount is	to be Adiusted		
Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
cost center bescription		AIIIOUITE	Cost Center	LITTE #		
	(2)				Ref.	
	1. 00	2. 00	3. 00	4. 00	5. 00	
31.00 Adjustment for speech	A-8-3	C	SPEECH PATHOLOGY	68. 00		31.00
pathology costs in excess of						
limitation (chapter 14)						
		0		0 00	0	22 00
				0. 00	0	32.00
Depreciation and Interest						
33.00   INTEREST EXPENSE	A	-1, 970	ADMINISTRATIVE & GENERAL	5. 00	0	33.00
33.01 TELEMETRY ADJUSTMENT	A	43, 672	ADULTS & PEDIATRICS	30. 00	0	33. 01
34.00 MISC REVENUE	A		ADULTS & PEDIATRICS	30.00	0	34.00
35. 00 POSTURE ASSESSMENTS	В		PHYSI CAL THERAPY	66. 00	0	35. 00
					· ·	
37.00 MISC REVENUE	В		RADI OLOGY-DI AGNOSTI C	54. 00	0	37.00
38.00 NON-PATIENT LAB REV.	В		RESPI RATORY THERAPY	65. 00	0	38. 00
39.00 TELEVISION OFFSET	A	-100	CAP REL COSTS-MVBLE EQUIP	2. 00	9	39.00
40.00 ANSWERING SERVICE	l A	-1.897	ADMINISTRATIVE & GENERAL	5. 00	0	40.00
41. 00 PHYSI CI AN RECRUITING	A	1	ADMINISTRATIVE & GENERAL	5. 00	0	41. 00
43. 00 VISITOR MEALS	A		CAFETERI A	11. 00	0	43.00
					_	
43.01 CAFETERIA - EMPLOYEE	A	1	CAFETERI A	11. 00	0	43. 01
44.00 PHARMACY SALES	A	-105, 575	PHARMACY	15. 00	0	44.00
45.00 HAF EXPENSE ADJUSTMENT	A	-3, 692, 902	ADMINISTRATIVE & GENERAL	5. 00	0	45.00
46.00 OTHER ADJUSTMENTS (SPECIFY)				0.00	0	46.00
(3)				0.00	ŭ	10.00
48. 00 LOBBY EXPENSE	A	14 /50	ADMINISTRATIVE & GENERAL	5. 00	0	48. 00
	A	-10, 430	ADMINISTRATIVE & GENERAL		-	
48. 01 OTHER ADJUSTMENTS (SPECIFY)				0. 00	0	48. 01
(3)						
48.04 INTERUNIT RENT EXPENSE	A	-77, 853	RESPI RATORY THERAPY	65. 00	0	48. 04
48.05 INTERUNIT RENT EXPENSE	A	-295, 367	PHYSI CAL THERAPY	66. 00	0	48. 05
48. 06 INTERUNIT RENT EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	48. 06
48. 07   INTERUNIT RENT EXPENSE	A		OPERATION OF PLANT	7. 00	0	48. 07
<b>1</b>	•	1	1		_	
48. 08 LI QUOR	A		ADMINISTRATIVE & GENERAL	5. 00	0	48. 08
48.09 PHYS ADMIN SAL ADD BACK	A		ADMINISTRATIVE & GENERAL	5. 00	0	48. 09
49.00 RENT EXPENSE - PHYSICIANS'	A	-251, 681	PHYSICIANS' PRIVATE OFFICES	192. 00	0	49.00
CLINIC						
49. 01 OPERATING INTEREST	A	-3, 391	PHARMACY	15. 00	0	49. 01
49. 02 OPERATING INTEREST	A		OPERATING ROOM	50.00	0	49. 02
	1	1		30.00	U	
50.00 TOTAL (sum of lines 1 thru 49	기	-16, 369, 987				50.00
(Transfer to Worksheet A,						
column 6, line 200.)						
(1) Description - all chapter refere	nces in this co	olumn pertain t	o CMS Pub 15-1			

<sup>(1)</sup> 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.

<sup>(3)</sup> 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	WHI TLEY MEMOR	RLAL HOSPITAL	In Lieu of Form CMS-2552-10			
STATEME OFFI CE	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-0101	Peri od: From 01/01/2022	Worksheet A-8	3-1	
				To 12/31/2022	Date/Time Pre 5/15/2023 4:0		
	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 ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED (	ORGANIZATIONS OF	R CLAIMED HOME		
	OFFICE COSTS:						
1.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	16, 880, 027	14, 124, 730	1.00	
2.00	1.00	CAP REL COSTS-BLDG & FLXT	INTERUNIT RENTAL EXPENSE	0	2, 138, 512	2.00	
3.00	5. 00	ADMINISTRATIVE & GENERAL	SUBSI DY ADJUSTMENT	0	9, 811, 288	3.00	
4.00	0.00			0	0	4.00	
5.00	TOTALS (sum of lines 1-4).			16, 880, 027	26, 074, 530	5.00	
	Transfer column 6, line 5 to						

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.

			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 RELA	FED 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:

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.
- 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
- 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 provi der.

Heal th	Financial Syste	ems	W	HITLEY MEMORIAL	HOSPI TAL		In Lieu	of Form CMS-	2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED ORGANIZAT	TIONS AND HOME	Provi der	CCN: 15-0101	Peri od:	Worksheet A-	8-1
OFFICE	COSTS						From 01/01/2022 To 12/31/2022	Date/Time Pro 5/15/2023 4:	epared: 07 pm
		Wkst. A-7 Ref.							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6. 00	7. 00							
		RED AND ADJUSTI	MENTS REQUIRED AS	A RESULT OF TRA	ANSACTI ONS	WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:								
1.00	2, 755, 297	0							1.00
2.00	-2, 138, 512	9							2.00
3.00	-9, 811, 288	0							3.00
4.00	0	0							4.00
5.00	-9, 194, 503								5.00
* The	amounts on line	es 1-4 (and sub	bscripts as approp	riate) are tran	nsferred i	n detail to Wo	rksheet A, column	6, lines as	
			se cost and negati						t which
			columns 1 and/or						
	Related Orga	ni zati on(s)				'			
	and/or Ho								
Type of Business									
	31								
	6 1	00							

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

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

6.00	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
8. 00 9. 00			9.00
10.00			10.00
10. 00 100. 00		1	100.00

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

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

- 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 organi zati on.
- 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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Peri od: Worksheet A-8-2 From 01/01/2022 To 12/31/2022 Date/Time Prepared: Provider CCN: 15-0101

									То	12/31/2022	Date/Time Pre 5/15/2023 4:0	
	Wkst. A Line #		Cost	Center/Physi ci an	Total	Pro	fessi onal	Provi der		RCE Amount	Physi ci an/Prov	
				l denti fi er	Remuneration	Co	mponent	Component			ider Component	
											Hours	
	1.00			2. 00	3. 00		4.00	5. 00		6. 00	7. 00	
1.00	30.00				404, 000		404,000		0	211, 500	0	1.00
2.00	50.00				1, 107, 093	3	1, 107, 093		0	239, 400	0	2.00
3.00	91. 00				703, 729	)	620, 396	83, 33	3	211, 500	470	3.00
4.00	95.00	DR.	D		12, 097	'	0	12, 09	7	211, 500	94	4.00
5.00	0.00						0		0	0	0	5.00
6.00	0.00				C		0		0	0	0	6.00
7.00	0.00				C		0		0	0	0	7. 00
8. 00	0.00					ol	0		0	0	0	8. 00
9. 00	0.00					ol	0		0	0	0	9. 00
10.00	0.00						0		o	0	0	10.00
200.00					2, 226, 919		2, 131, 489	95, 43	o		564	200.00
	Wkst. A Line #		Cost	Center/Physi ci an	Unadjusted RCE	5 Pe	ercent of	Cost of		Provi der	Physician Cost	
				I denti fi er	Limit	Unadi	usted RCE	Memberships 8	ß.	Component	of Malpractice	
							Limit	Continuing	SI	hare of col.	Insurance	
								Education		12		
	1. 00			2. 00	8. 00		9. 00	12. 00		13. 00	14. 00	
1.00	30.00				C	)	0		0	0	0	1.00
2.00	50.00				C		0		0	0	0	2.00
3.00	91.00				47, 791		2, 390		0	0	0	3.00
4.00	95. 00	DR.	D		9, 558	3	478		0	0	0	4.00
5.00	0.00				C		0		0	0	0	5.00
6.00	0.00				C		0		0	0	0	6.00
7.00	0.00				C		0		0	0	0	7. 00
8.00	0.00				C		0		0	0	0	8. 00
9.00	0.00						0		0	0	0	9. 00
10.00	0.00				C		0		0	0	0	10.00
200.00					57, 349		2, 868		0	0	0	200.00
	Wkst. A Line #		Cost	Center/Physi ci an	Provi der	Adj ı	usted RCE	RCE		Adjustment		
				l denti fi er	Component		Limit	Di sal I owance	:			
					Share of col.							
					14							
	1. 00			2. 00	15. 00		16. 00	17. 00		18. 00		
1.00	30. 00						0		0	404, 000		1.00
2.00	50.00						0		0	1, 107, 093		2.00
3.00	91. 00						47, 791			655, 938		3. 00
4.00	95. 00	4	D				9, 558	2, 53	9	2, 539		4. 00
5.00	0.00						0		0	0		5. 00
6. 00	0.00				C		0		0	0		6. 00
7. 00	0.00				C		0		0	0		7. 00
8.00	0.00				C	)	0		0	0		8.00
9.00	0.00	1			C	P	0		0	0		9. 00
10.00	0.00				C	)	0		0	0		10.00
200.00					( C	)	57, 349	38, 08	1	2, 169, 570		200.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101

				5/15/2023 4:0	/ pili			
				ON TIME REE	_ATED COSTS			
		Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
			for Cost			BENEFITS		
			Allocation (from Wkst A			DEPARTMENT		
			col. 7)					
			0	1. 00	2.00	4. 00	4A	
-		AL SERVICE COST CENTERS						
1.00		CAP REL COSTS-BLDG & FIXT	1, 518, 978					1.00
2. 00 4. 00		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	1, 890, 454 7, 595, 782		1, 890, 454 0	7, 595, 782		2. 00 4. 00
5. 00		ADMINISTRATIVE & GENERAL	19, 894, 124	475, 071		2, 051, 230	23, 011, 676	5.00
6. 00		MAINTENANCE & REPAIRS	0	0	0	0	0	6. 00
7.00		OPERATION OF PLANT	1, 851, 828	110, 380	137, 374	158, 799	2, 258, 381	7.00
8. 00	1	LAUNDRY & LINEN SERVICE	326, 721	5, 157		0	338, 297	8.00
9. 00 10. 00		HOUSEKEEPI NG DI ETARY	1, 045, 378 508, 801	4, 311 18, 479		228, 853 79, 482	1, 283, 907 629, 760	9. 00 10. 00
11. 00		CAFETERI A	55, 690			62, 084	164, 548	11. 00
12. 00		MAINTENANCE OF PERSONNEL	0	0		0	0	12.00
13.00		NURSING ADMINISTRATION	605, 084	1, 256		160, 886	768, 789	13.00
14.00		CENTRAL SERVICES & SUPPLY	0	14, 920		0	33, 489	14.00
15. 00 16. 00		PHARMACY MEDICAL RECORDS & LIBRARY	853, 771	12, 932 4, 596		228, 430	1, 111, 227 10, 316	15. 00 16. 00
17. 00		SOCIAL SERVICE	0	4, 570	3, 720	0	10, 310	17. 00
19. 00	4	NONPHYSI CI AN ANESTHETI STS	0	0	O	0	0	19. 00
20.00		NURSI NG PROGRAM	0	0	0	0	0	20.00
21.00		I &R SERVICES-SALARY & FRINGES 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
23.00	I NPAT	IENT ROUTINE SERVICE COST CENTERS	0	0	<u> </u>	<u>U</u>	U	23.00
30.00		ADULTS & PEDIATRICS	5, 675, 577	201, 843	251, 205	942, 812	7, 071, 437	30.00
43.00		NURSERY	401, 774	0		97, 492	499, 266	43.00
44. 00		SKILLED NURSING FACILITY LARY SERVICE COST CENTERS	0	0	0	0	0	44.00
50.00		OPERATING ROOM	2, 313, 306	120, 542	150, 022	345, 193	2, 929, 063	50.00
52. 00		DELIVERY ROOM & LABOR ROOM	911, 793			223, 633	1, 135, 426	
53.00		ANESTHESI OLOGY	0	0		0	0	53.00
54.00		RADI OLOGY-DI AGNOSTI C	3, 883, 933			671, 500	4, 918, 990	
60. 00 62. 30		LABORATORY BLOOD CLOTTING FOR HEMOPHILIACS	3, 869, 935	28, 232 0		0	3, 933, 304 0	60. 00 62. 30
65. 00		RESPIRATORY THERAPY	1, 577, 023	22, 323		272, 093	1, 899, 222	65. 00
66.00		PHYSI CAL THERAPY	308, 497	131, 856		173, 592	778, 048	
67.00		OCCUPATI ONAL THERAPY	941, 660		-	246, 542	1, 188, 202	67.00
68.00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	66, 953	0	0	17, 530	84, 483	
69. 00 71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	454, 874	)   0	0	0	0 454, 874	69. 00 71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS	629, 097	0	Ö	Ö	629, 097	
73.00		DRUGS CHARGED TO PATIENTS	4, 972, 000	0	0	0	4, 972, 000	
76. 97		CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98 76. 99		HYPERBARI C OXYGEN THERAPY LI THOTRI PSY	4, 000	0	0	0		76. 98 76. 99
70. 77		TIENT SERVICE COST CENTERS		<u> </u>	<u> </u>	<u> </u>	0	70. 77
90.00	09000	CLINIC	0	0	0	0	0	90.00
90. 01		INTENSIVE OUT PATIENT PROGRAM	0	0		0	0	90. 01
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	4, 644, 700	147, 738	183, 868	1, 075, 897	6, 052, 203 0	
<del>9</del> 2.00		REIMBURSABLE COST CENTERS					U	92.00
95.00	09500	AMBULANCE SERVICES	2, 506, 227	0	0	545, 964	3, 052, 191	95.00
	SPECI	AL PURPOSE COST CENTERS	T		ı			
113. 00 118. 00	1	INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	40 207 040	1 402 440	1 944 000	7 502 012	40 212 104	113.00
110.00		IMBURSABLE COST CENTERS	69, 307, 960	1, 482, 448	1, 844, 990	7, 582, 012	69, 212, 196	110.00
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 163	552	687	0	3, 402	190. 00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	316, 377	33, 266	41, 402	13, 770	404, 815	
		OCCUPATIONAL HEALTH	0	0	0	0		194.00
		PAIN CLINIC OAK POINTE	0	) 	0	o n		194. 01 194. 02
194. 03	07953	FOUNDATI ON	11, 719	0		ol	11, 719	
194. 04	07954	COMMUNITY & VOLUNTEER SERVICES	47, 151	2, 712	3, 375	О	53, 238	194. 04
		VACANT SPACE	0	0	0	0		194. 05
200.00		TELEHEALTH MEDICINE Cross Foot Adjustments		0		O		194. 06 200. 00
201.00		Negative Cost Centers		0	О	o		201.00
202.00	1	TOTAL (sum lines 118 through 201)	69, 685, 370	1, 518, 978	1, 890, 454	7, 595, 782	69, 685, 370	202. 00

Provider CCN: 15-0101

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Ti me Prepared: 5/15/2023 4:07 pm

						5/15/2023 4:0	
	Cost Center Description	ADMI NI STRATI V		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		E & GENERAL 5.00	REPAI RS 6. 00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	
	GENERAL SERVICE COST CENTERS	3.00	0.00	7.00	0.00	7. 00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						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	23, 011, 676					5.00
6.00	00600 MAINTENANCE & REPAIRS	1 112 454	0	2 271 027			6.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	1, 113, 456 166, 792	0	3, 371, 837 18, 628			7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	633, 009	0	15, 569		1, 932, 485	1
10.00	01000 DI ETARY	310, 492	0	66, 745		38, 645	1
11. 00	01100 CAFETERI A	81, 128	0	75, 269		43, 580	1
12.00	01200 MAINTENANCE OF PERSONNEL	o	0	0	0	0	12.00
13.00	01300 NURSING ADMINISTRATION	379, 038	0	4, 537	0	2, 627	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	16, 511	0	53, 891	0	31, 203	1
15. 00	01500 PHARMACY	547, 872	0	46, 708	0	27, 044	1
16.00	01600 MEDI CAL RECORDS & LI BRARY	5, 086	0	16, 600	0	9, 612	1
17. 00 19. 00	01700 SOCIAL SERVICE	0	0	0	0	0	1
20.00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG PROGRAM		0	0	0	0	1
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV		0	0	0	0	
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	l ol	0	Ö	0	Ö	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	o	0	0	0	0	1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	3, 486, 456	0	729, 043	222, 477	422, 112	1
43. 00	04300 NURSERY	246, 155	0	0	0	0	1
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	1, 444, 125	0	435, 391	0	252, 090	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	559, 802	0	433, 371	_	232, 070	1
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 425, 224	0	585, 035	0	338, 734	1
60.00	06000 LABORATORY	1, 939, 249	0	101, 974	0	59, 043	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	936, 379	0	80, 630	0	46, 685	1
66.00	06600 PHYSI CAL THERAPY	383, 603	0	476, 256	0	275, 751	1
67.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	585, 823	0	0	0	0	1
68. 00 69. 00	06900 ELECTROCARDI OLOGY	41, 653	0	0	0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	224, 268	0	0	0	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	310, 166	0	Ö	0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 451, 360	0	0	0	0	1
76. 97	07697 CARDI AC REHABI LI TATI ON	o	0	0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	1, 972	0	0	0	0	
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
00.00	OUTPATIENT SERVICE COST CENTERS				0		00.00
90. 00 90. 01	09000 CLINIC 09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0	_	0	
	09100 EMERGENCY	2, 983, 936	0				
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 700, 700	· ·	000,010	001, 210	000, 701	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	1, 504, 831	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE	00 770 00/			500 747	4 05/ 000	113.00
118.00		22, 778, 386	0	3, 239, 894	523, 717	1, 856, 090	]118.00
100 00	NONREIMBURSABLE COST CENTERS   19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 677	0	1, 993	0	1 15/	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	199, 587	0	120, 155			192.00
	07950 OCCUPATI ONAL HEALTH	0	0	0	0		194.00
194. 01	07951 PAIN CLINIC	o	0	0	0	0	194. 01
194. 02	07952 OAK POINTE	0	0	0	0	0	194. 02
	B 07953  FOUNDATI ON	5, 778	0	0	0		194. 03
	07954 COMMUNITY & VOLUNTEER SERVICES	26, 248	0	9, 795	0		194. 04
	07955 VACANT SPACE	0	0	0	0		194.05
194. 06 200. 00	07956 TELEHEALTH MEDICINE Cross Foot Adjustments		0	0	0	0	194. 06 200. 00
200.00			0	_	0	_	200.00
201.00		23, 011, 676	0	3, 371, 837	523, 717		
	,	,,	· ·	2, 3, ., 307	020,.17	1, 752, 760	,

Provider CCN: 15-0101

| Peri od: | Worksheet B | From 01/01/2022 | Part I | To | 12/31/2022 | Date/Time | Prepared: | 5/15/2023 | 4:07 pm |

					5/15/2023 4:0	7 pm
Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	
			OF PERSONNEL	ADMI NI STRATI O	SERVICES &	
	10.00	44.00	10.00	N	SUPPLY	
CENEDAL CEDALCE COCT CENTEDO	10. 00	11. 00	12. 00	13. 00	14. 00	
GENERAL SERVICE COST CENTERS						1 00
1.00 O0100 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
5. 00   00500   ADMI NI STRATI VE & GENERAL						5.00
6. 00 00600 MAI NTENANCE & REPAI RS						6.00
7. 00 00700 OPERATION OF PLANT						7.00
8. 00   00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00   01000   DI ETARY	1, 045, 642					10.00
11. 00  01100  CAFETERI A	0	364, 525				11. 00
12.00 O1200 MAINTENANCE OF PERSONNEL	0	0	C			12. 00
13.00 O1300 NURSING ADMINISTRATION	0	7, 349	C	1, 162, 340		13. 00
14.00   01400   CENTRAL SERVICES & SUPPLY	0	0	C	0	135, 094	14. 00
15. 00   01500   PHARMACY	0	11, 269	C	0	2, 237	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	C	0	0	16. 00
17. 00   01700   SOCI AL   SERVI CE	0	0	C	0	0	17. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	0	0	C	0	0	19. 00
20. 00   02000   NURSI NG PROGRAM	0	0	C	0	0	20.00
21.00   02100   1&R SERVICES-SALARY & FRINGES APPRV	0	0	C	0	0	21. 00
22.00   02200   I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	C	0	0	22. 00
23.00 O2300 PARAMED ED PRGM-(SPECIFY)	0	0	C	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	1, 045, 642	57, 488	C		2, 037	30.00
43. 00   04300   NURSERY	0	6, 696	C		4, 373	
44.00 O4400 SKILLED NURSING FACILITY	0	0	C	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATING ROOM	0	22, 211	C		29, 604	1
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	13, 719	C		8, 883	
53. 00   05300   ANESTHESI OLOGY	0	0	C	1 1	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	54, 548	C		7, 447	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	19, 925	C	0	7, 411	65.00
66. 00   06600   PHYSI CAL THERAPY	0	17, 475	C	0	282	1
67. 00 06700 OCCUPATI ONAL THERAPY	0	16, 332	C	0	545	1
68. 00 06800 SPEECH PATHOLOGY	0	980	C	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	43, 606	1
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	3, 036	1
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	C	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	C	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	C	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS		_	_		_	
90. 00   09000   CLI NI C	0	0	C		0	
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0	_		_	
91. 00   09100   EMERGENCY	0	72, 349	C	507, 099	17, 406	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS		50.404			0.0/4	05.00
95. 00 09500 AMBULANCE SERVI CES	0	59, 121	C	0	8, 064	95.00
SPECIAL PURPOSE COST CENTERS						110 00
113. 00 11300 INTEREST EXPENSE	4 045 (40	250 4/0		4 4 (0 0 40	404.004	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 045, 642	359, 462	C	1, 162, 340	134, 931	1118.00
NONREI MBURSABLE COST CENTERS	ما					100 00
190. 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C			190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	5, 063	C			192.00
194. 00 07950 OCCUPATI ONAL HEALTH	0	0	C	1		194.00
194. 01 07951 PAIN CLINIC	0	0	C	-		194. 01
194. 02 07952 OAK POINTE	0	0	C	1 1		194. 02
194. 03 07953 FOUNDATION	0	0	C	<u>[</u>		194. 03
194. 04 07954 COMMUNITY & VOLUNTEER SERVICES	0	0				194.04
194. 05 07955 VACANT SPACE	0	0	C	-		194.05
194. 06 07956 TELEHEALTH MEDICINE	0	O	C	ارا ال	0	194.06
200.00 Cross Foot Adjustments	_	_	_	_	_	200.00
201.00 Negative Cost Centers	0 045 (40)	0	C			201.00
202.00   TOTAL (sum lines 118 through 201)	1, 045, 642	364, 525	[ C	1, 162, 340	135, 094	ZUZ. UU

| Peri od: | Worksheet B | From 01/01/2022 | Part I | To 12/31/2022 | Date/Time Prepared:

			To	12/31/2022	Date/Time Pre 5/15/2023 4:0	
Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	NURSI NG PROGRAM	ļ
	15. 00	16. 00	17. 00	19. 00	20.00	
GENERAL SERVICE COST CENTERS  1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00   00200   CAP REL COSTS-MVBLE EQUIP 4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT 5. 00   00500   ADMINISTRATIVE & GENERAL 6. 00   00600   MAINTENANCE & REPAIRS 7. 00   00700   OPERATION OF PLANT 8. 00   00800   LAUNDRY & LINEN SERVICE						2. 00 4. 00 5. 00 6. 00 7. 00 8. 00
9. 00   00900   HOUSEKEEPI NG   10. 00   01000   DI ETARY   11. 00   01100   CAFETERI A   12. 00   01200   MAI NTENANCE OF PERSONNEL   13. 00   01300   NURSI NG ADMI NI STRATI ON   14. 00   01400   CENTRAL SERVI CES & SUPPLY						9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
15. 00   01500   PHARMACY 16. 00   01500   MEDI CAL RECORDS & LI BRARY 17. 00   01700   SOCI AL SERVI CE	1, 746, 357 0 0	41, 614 O	O			15. 00 16. 00 17. 00
19. 00   01900   NONPHYSICIAN ANESTHETISTS 20. 00   02000   NURSING PROGRAM 21. 00   02100   I&R SERVICES-SALARY & FRINGES APPRV 22. 00   02200   I&R SERVICES-OTHER PRGM COSTS APPRV	0 0 0 0	0 0 0 0	0 0 0	0	0	19. 00 20. 00 21. 00 22. 00
23.00 O2300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0			23. 00
30. 00 03000 ADULTS & PEDIATRICS	0	7, 515	0	0	0	
43.00   04300   NURSERY 44.00   04400   SKILLED NURSING FACILITY	0	1, 028 0	0 0	0 0	0	
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	l ol	891	0	ol	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	Ö	O	0	Ö	0	52.00
53. 00   05300  ANESTHESI OLOGY 54. 00   05400  RADI OLOGY-DI AGNOSTI C	0 3	0 9, 051	0	0	0	
60.00 06000 LABORATORY 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	o	0	
62. 30   06250   BLOOD CLOTTING FOR HEMOPHILIACS 65. 00   06500   RESPIRATORY THERAPY	0	0	0	0	0	
66. 00   06600 PHYSI CAL THERAPY 67. 00   06700 OCCUPATI ONAL THERAPY	0	3, 221 995	0	0	0	
68.00 06800 SPEECH PATHOLOGY	0	92	0	ő	0	68. 00
69.00   06900   ELECTROCARDI OLOGY 71.00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	0	0	69. 00 71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS 76. 97 O7697 CARDIAC REHABILITATION	1, 746, 354 0	0	0	0	0	
76. 98 O7698 HYPERBARI C OXYGEN THERAPY 76. 99 O7699 LI THOTRI PSY	o	0	0	o	0	
76. 99 O7699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS			U <sub>1</sub>	0	0	76. 99
90.00   09000   CLINIC 90.01   09001   INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0	
91. 00   09100   EMERGENCY	Ö	18, 821	0	o	0	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	95.00
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS  190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 746, 357	41, 614 Ol	0	0		118. 00 190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	Ö	0	0	ō	0	192. 00
194. 00 07950 0CCUPATI ONAL HEALTH 194. 01 07951 PAI N CLI NI C	0	0	0	0		194. 00 194. 01
194. 02 07952 OAK POINTE	0	0	0	0		194. 02
194.03 07953 FOUNDATION 194.04 07954 COMMUNITY & VOLUNTEER SERVICES	0	0	0	0		194. 03 194. 04
194. 05 07955 VACANT SPACE	0	0	0	O		194.05
194.06 07956 TELEHEALTH MEDICINE 200.00  Cross Foot Adjustments		0	0	0	0	194. 06 200. 00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	0 1, 746, 357	0 41, 614	0	0	0	201. 00 202. 00
202.00   TOTAL (Sum Times The through 201)	1, 140, 337	71,014	O	Ч	O	1-02.00

Heal th Financial Systems

WHITLEY MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0101
Period:
From 01/01/2022
To 12/31/2022
Part I
Date/Time Prepared:
5/15/2023 4: 07 pm

INTERNS & RESIDENTS

Cost Center Description

SERVICES-SALA SERVICES-OTHE PARAMED ED Subtotal Intern &

						5/15/2023 4:0	7 pm
		INTERNS &	RESI DENTS				
	Cost Center Description	SEDVICES SALA	SERVI CES-OTHE	PARAMED ED	Subtotal	Intern &	
	cost center bescription	RY & FRINGES	R PRGM COSTS	PRGM	Subtotal	Resi dents	
		APPRV	APPRV	FRGW		Cost & Post	
		7	7			Stepdown	
						Adjustments	
		21. 00	22. 00	23.00	24. 00	25.00	
	ERAL SERVICE COST CENTERS						
	00 CAP REL COSTS-BLDG & FIXT						1.00
	COO CAP REL COSTS-MVBLE EQUIP						2.00
1	OO EMPLOYEE BENEFITS DEPARTMENT OO ADMINISTRATIVE & GENERAL						4. 00 5. 00
1	OO MAINTENANCE & REPAIRS			•			6.00
	OO OPERATION OF PLANT						7.00
	OO LAUNDRY & LINEN SERVICE						8.00
9.00 009	000 HOUSEKEEPI NG						9. 00
	000 DI ETARY						10.00
	00 CAFETERI A						11.00
1	MAINTENANCE OF PERSONNEL						12.00
1	OO NURSING ADMINISTRATION OO CENTRAL SERVICES & SUPPLY						13. 00 14. 00
	OO PHARMACY						15.00
	00 MEDICAL RECORDS & LIBRARY						16.00
	OO SOCIAL SERVICE						17. 00
19. 00 019	NONPHYSICIAN ANESTHETISTS						19.00
20. 00 020	OOO NURSING PROGRAM						20.00
	00 I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
	100 I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
	OO PARAMED ED PRGM-(SPECIFY)			] 0			23. 00
	PATIENT ROUTINE SERVICE COST CENTERS  OOO ADULTS & PEDIATRICS	1 0	0	0	13, 447, 344	0	30.00
	NURSERY			1		l .	1
	00 SKILLED NURSING FACILITY	0	0	0		l	1
	ILLARY SERVICE COST CENTERS		1				
	OOO OPERATING ROOM	0	0		5, 269, 388	l e	
	200 DELIVERY ROOM & LABOR ROOM 200 ANESTHESIOLOGY	0	0	0	1, 813, 921 0	0	
1	OO RADI OLOGY-DI AGNOSTI C			1	-		1
	OO LABORATORY			0	6, 033, 570		60.00
	50 BLOOD CLOTTING FOR HEMOPHILIACS	0	Ö	Ō	0	Ö	1
65. 00 065	000 RESPI RATORY THERAPY	0	0	0	2, 990, 252	0	65.00
	000 PHYSI CAL THERAPY	0	0	0	1, 934, 636	0	66.00
	OO OCCUPATI ONAL THERAPY	0	0	0	1, 791, 897	0	67.00
1	SOO SPEECH PATHOLOGY	0	0	0	127, 208	l	68.00
1	OO ELECTROCARDI OLOGY OO MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0		0	0 722, 748	0	
	100 IMPL. DEV. CHARGED TO PATIENTS			0	939, 263	l .	
	OO DRUGS CHARGED TO PATIENTS			Ö	9, 172, 750	ĺ	1
	97 CARDIAC REHABILITATION	0	0	0	0	0	76. 97
	98 HYPERBARIC OXYGEN THERAPY	0	0	0	5, 972	0	
	99 LI THOTRI PSY	0	0	0	0	0	76. 99
90. 00 090	PATIENT SERVICE COST CENTERS		0	0	0	0	90.00
	001 INTENSIVE OUT PATIENT PROGRAM				-		1
1	OO EMERGENCY			_			1
	OO OBSERVATION BEDS (NON-DISTINCT PART		-		., .,	0	1
	ER REIMBURSABLE COST CENTERS						
	OO AMBULANCE SERVICES	0	0	0	4, 624, 207	0	95.00
	CIAL PURPOSE COST CENTERS OO INTEREST EXPENSE	1	I	I			113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	o	0	68, 765, 342	0	118.00
	REIMBURSABLE COST CENTERS				00/ / 00/ 0 12		1.10.00
190. 00 190	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190. 00
	200 PHYSICIANS' PRIVATE OFFICES	0	0	0	799, 335		192.00
	50 OCCUPATI ONAL HEALTH	0	0	0	0		194.00
	PAIN CLINIC	0	0	0	0		194. 01
	152 OAK POI NTE 153 FOUNDATI ON				0 17, 497	l	194. 02 194. 03
	1954 COMMUNITY & VOLUNTEER SERVICES			0	94, 970	l .	194. 03
	755 VACANT SPACE	0	0	l o	,4, ,70	l .	194. 05
	756 TELEHEALTH MEDICINE		0	Ö	0		194. 06
200. 00	Cross Foot Adjustments	0	0	0	0		200. 00
201.00	Negative Cost Centers	0	0				201.00
202. 00	TOTAL (sum lines 118 through 201)	0	0	0	69, 685, 370	1 0	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

| Peri od: | Worksheet B | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: Provider CCN: 15-0101

				10 12/31/2022   Date/Time Pre	
		Cost Center Description	Total	, , , , , , , , , , , , , , , , , , , ,	
			26. 00		
4 00		AL SERVICE COST CENTERS			4 00
1. 00 2. 00	1	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP			1. 00 2. 00
4. 00	1	EMPLOYEE BENEFITS DEPARTMENT			4.00
5. 00	1	ADMINISTRATIVE & GENERAL			5.00
6. 00	1	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00		LAUNDRY & LINEN SERVICE			8. 00
9.00		HOUSEKEEPI NG			9.00
10.00	1	DI ETARY			10.00
11. 00 12. 00		CAFETERIA MAINTENANCE OF PERSONNEL			11. 00 12. 00
13. 00	1	NURSI NG ADMI NI STRATI ON			13.00
14. 00	1	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16. 00	01600	MEDICAL RECORDS & LIBRARY			16.00
17. 00	1	SOCIAL SERVICE			17.00
19. 00	1	NONPHYSI CI AN ANESTHETI STS			19.00
20.00		NURSING PROGRAM I&R SERVICES-SALARY & FRINGES APPRV			20. 00 21. 00
21. 00 22. 00	1	I&R SERVICES-SALART & FRINGES APPRV			22.00
23. 00		PARAMED ED PRGM-(SPECIFY)			23. 00
		IENT ROUTINE SERVICE COST CENTERS			
30.00		ADULTS & PEDIATRICS	13, 447, 344		30.00
43.00	1	NURSERY	757, 518		43.00
44. 00		SKILLED NURSING FACILITY	0		44.00
FO 00		LARY SERVICE COST CENTERS	F 2/0 200		F0 00
50. 00 52. 00		OPERATING ROOM DELIVERY ROOM & LABOR ROOM	5, 269, 388 1, 813, 921		50.00 52.00
53.00		ANESTHESI OLOGY	1, 013, 721		53.00
54. 00	1	RADI OLOGY-DI AGNOSTI C	8, 339, 032		54.00
60.00	1	LABORATORY	6, 033, 570		60.00
62. 30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		62. 30
65.00	1	RESPI RATORY THERAPY	2, 990, 252		65.00
66.00	1	PHYSI CAL THERAPY	1, 934, 636		66.00
67.00	1	OCCUPATIONAL THERAPY	1, 791, 897		67.00
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	127, 208		68. 00 69. 00
71.00	1	MEDICAL SUPPLIES CHARGED TO PATIENT	722, 748		71.00
72. 00	1	IMPL. DEV. CHARGED TO PATIENTS	939, 263		72.00
73.00	1	DRUGS CHARGED TO PATIENTS	9, 172, 750		73.00
76. 97	1	CARDIAC REHABILITATION	0		76. 97
76. 98	1	HYPERBARI C OXYGEN THERAPY	5, 972		76. 98
76. 99	_	LI THOTRI PSY	0		76. 99
90. 00		TIENT SERVICE COST CENTERS	0		90.00
90. 01		INTENSIVE OUT PATIENT PROGRAM	Ö		90.01
91. 00	1	EMERGENCY	10, 795, 636		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
	OTHER	REIMBURSABLE COST CENTERS			
95. 00		AMBULANCE SERVICES	4, 624, 207		95.00
112 00		AL PURPOSE COST CENTERS			112 00
118.00		INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	68, 765, 342		113. 00 118. 00
110.00		IMBURSABLE COST CENTERS	00, 703, 342		1110.00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	8, 226		190. 00
		PHYSICIANS' PRIVATE OFFICES	799, 335		192.00
		OCCUPATI ONAL HEALTH	О		194. 00
		PAIN CLINIC	0		194. 01
		OAK POINTE	17 407		194. 02
		FOUNDATION COMMUNITY & VOLUNTEER SERVICES	17, 497 94, 970		194. 03 194. 04
		VACANT SPACE	74, 7/0 N		194. 04
		TELEHEALTH MEDICINE	0		194.06
200.00		Cross Foot Adjustments	o		200.00
201.00		Negative Cost Centers	o		201. 00
202.00	)	TOTAL (sum lines 118 through 201)	69, 685, 370		202.00

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

			То	12/31/2022	Date/Time Pre 5/15/2023 4:0	
		CAPI TAL REI	LATED COSTS		7 7 7 7 2 0 2 3 4 . 0	, piii
Cook Cooking Doors, at lan	D:+1	DIDC & FLVT	M/DLE FOULD	Ch. + - + - I	EMPL OVEE	
Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
	Capi tal				DEPARTMENT	
	Related Costs					
OFNEDAL CEDILOF OCCT OFNITEDO	0	1. 00	2.00	2A	4. 00	
GENERAL SERVICE COST CENTERS  1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 O0200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	О	0	4.00
5.00 00500 ADMINISTRATIVE & GENERAL	4, 355, 189	475, 071	591, 251	5, 421, 511	0	5.00
6.00 00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6. 00
7. 00 00700 OPERATION OF PLANT	0	110, 380		247, 754	0	7.00
8. 00   00800   LAUNDRY & LI NEN SERVI CE 9. 00   00900   HOUSEKEEPI NG	0	5, 157 4, 311	6, 419 5, 365	11, 576 9, 676	0	8. 00 9. 00
10. 00   01000 DI ETARY	0	18, 479		41, 477	0	10.00
11. 00 01100 CAFETERI A	0	20, 839		46, 774	0	11.00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	0	o	0	12.00
13.00 O1300 NURSING ADMINISTRATION	0	1, 256		2, 819	0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	14, 920		33, 489	0	14.00
15. 00   01500   PHARMACY 16. 00   01600   MEDI CAL RECORDS & LI BRARY	0	12, 932		29, 026	0	15. 00 16. 00
17. 00   01700   SOCIAL SERVICE	0	4, 596 0	5, 720	10, 316 0	0	17.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0		ő	0	19.00
20. 00   02000   NURSI NG   PROGRAM	0	0	Ö	ō	0	20.00
21.00 02100 & SERVICES-SALARY & FRINGES APPRV	0	0	0	o	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 03000 ADULTS & PEDIATRICS	0	201, 843	251, 205	453, 048	0	30.00
43. 00   04300   NURSERY	0	201, 843	· ·	453, 046	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		ō	0	44.00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATING ROOM	0	120, 542	150, 022	270, 564	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	161, 973	201, 584	363, 557	0	53. 00 54. 00
60. 00   06000   LABORATORY	0	28, 232		63, 369	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0	22, 323	27, 783	50, 106	0	65.00
66. 00   06600   PHYSI CAL THERAPY	0	131, 856	164, 103	295, 959	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00   06800   SPEECH PATHOLOGY 69. 00   06900   ELECTROCARDI OLOGY	0	0	0	0	0	68. 00 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	Ö	ō	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	o	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99 07699 LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS	0	0	l o	U	0	76. 99
90. 00 09000 CLINIC	0	0	0	ol	0	90.00
90.01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0	o	0	90. 01
91. 00   09100   EMERGENCY	0	147, 738	183, 868	331, 606	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVICES	1 0	0		ما	0	05.00
SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	95. 00
113. 00 11300   NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	4, 355, 189	1, 482, 448	1, 844, 990	7, 682, 627	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	552		1, 239		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	33, 266	41, 402	74, 668		192.00
194. 00 07950 OCCUPATI ONAL HEALTH 194. 01 07951 PAIN CLINIC	0	0	0	0		194. 00 194. 01
194. 02 07952  OAK POINTE	0	0		O O		194. 01
194. 03 07953 FOUNDATI ON		0		ől		194. 02
194. 04 07954 COMMUNITY & VOLUNTEER SERVICES	0	2, 712	3, 375	6, 087		194. 04
194. 05 07955 VACANT SPACE	0	0	0	0		194. 05
194. 06 07956 TELEHEALTH MEDICINE	0	0	0	0	0	194.06
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	1	_		0	0	200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	4, 355, 189	1, 518, 978	1, 890, 454	7, 764, 621		201.00
, , , , , , , , , , , , , , , , , , ,	, , , , , , , , , , , , , , , , , , , ,	, , , , , , , , ,	, , , , , , , , , , , , ,	,,	Ţ.	

						5/15/2023 4:0	7 pm
	Cost Center Description	ADMI NI STRATI V		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		E & GENERAL	REPAI RS	PLANT	LINEN SERVICE	0.00	
	CENEDAL CEDVICE COCT CENTEDO	5. 00	6. 00	7. 00	8. 00	9. 00	_
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	•		•			2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	•					4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	5, 421, 511					5.00
6. 00	00600 MAINTENANCE & REPAIRS	3, 421, 311	0				6.00
7. 00	00700 OPERATION OF PLANT	262, 329		510, 083			7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	1		1			8.00
9. 00	00900 HOUSEKEEPI NG	39, 296		2, 818		141 147	1
10.00	01000 DI ETARY	149, 136		2, 355 10, 097	0	161, 167	1
11. 00	01100 CAFETERI A	73, 152			0	3, 223	
12.00	01200 MAINTENANCE OF PERSONNEL	19, 114		11, 386 0	0	3, 635 0	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	89, 301		686	0	219	
14. 00		1		1			1
15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	3, 890		8, 153		2, 602	1
		129, 078		7, 066	0	2, 255	1
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 198		1 2,0	0	802	1
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0		0	0	
20.00	02000 NURSI NG PROGRAM	0	U		0	0	
21. 00	02100   &R SERVICES-SALARY & FRINGES APPRV	0	0		0	0	
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0		1 0	0	0	23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	001 201		110 207	22,000	25 205	20.00
30.00	03000 ADULTS & PEDIATRICS	821, 391	0	1	22, 808	35, 205	1
43. 00	04300 NURSERY	57, 994	0		0	0	1
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
F0 00	ANCILLARY SERVICE COST CENTERS	0.40.004		1			
50.00	05000 OPERATING ROOM	340, 234	0		0	21, 024	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	131, 889	0	0	0	0	
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	571, 380	0	88, 503		28, 250	1
60.00	06000 LABORATORY	456, 885	0	15, 426	0	4, 924	1
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	
65. 00	06500 RESPI RATORY THERAPY	220, 610	0	12, 198	0	3, 893	1
66. 00	06600 PHYSI CAL THERAPY	90, 376	0	72, 047	0	22, 997	1
67. 00	06700 OCCUPATI ONAL THERAPY	138, 019	0	0	0	0	
68. 00	06800 SPEECH PATHOLOGY	9, 813	0	0	0	0	
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	52, 837	0	0	0	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	73, 075	0	0	0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	577, 538	0	0	0	0	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	465	0	0	0	0	
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0	0	0	
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0	_	0	
91. 00	09100 EMERGENCY	703, 012	0	80, 724	30, 882	25, 767	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	354, 536	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	5, 366, 548	0	490, 122	53, 690	154, 796	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	395	0			96	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	47, 023	0	18, 177	0	5, 802	192.00
194.00	07950 OCCUPATI ONAL HEALTH	0	0			0	194.00
194. 0°	07951 PAIN CLINIC	0	0	0	0	0	194. 01
194. 02	07952 OAK POINTE	0	0	0	0	0	194. 02
194. 03	07953 FOUNDATI ON	1, 361	0	0	0	0	194. 03
	1 07954 COMMUNITY & VOLUNTEER SERVICES	6, 184	0	1, 482	0	473	194. 04
	07955 VACANT SPACE	0	0	0	0		194.05
	07956 TELEHEALTH MEDICINE	0		Ō	0		194.06
200.00						]	200.00
201.00	, ,	0	o	0	O	o	201.00
202.00		5, 421, 511	_		53, 690		
0	,		,	1 2.2,300			

					5/15/2023 4:0	7 pm
Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	
			OF PERSONNEL	ADMI NI STRATI O	SERVICES &	
				N	SUPPLY	
	10. 00	11. 00	12. 00	13. 00	14. 00	
GENERAL SERVICE COST CENTERS			T	1		
1.00 O0100 CAP REL COSTS-BLDG & FIXT					I	1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP					I	2.00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT					I	4.00
5.00   00500   ADMINISTRATIVE & GENERAL					I	5.00
6.00 00600 MAINTENANCE & REPAIRS					I	6.00
7.00 00700 OPERATION OF PLANT					I	7.00
8.00   00800 LAUNDRY & LINEN SERVICE					I	8.00
9. 00 00900 HOUSEKEEPI NG					I	9. 00
10. 00   01000 DI ETARY	127, 949				I	10.00
11. 00 01100 CAFETERI A	127,717	80, 909			I	11.00
12. 00 01200 MAI NTENANCE OF PERSONNEL	o o	00, 707	<u></u>		I	12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	1, 631	٥	94, 656	I	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	1, 031		74, 030	48, 134	
1	0	2 501				1
15. 00 01500 PHARMACY	0	2, 501	0		797	15.00
16. 00   01600   MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	16.00
17. 00   01700   SOCI AL SERVI CE	0	0	0	0	0	17.00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	19. 00
20. 00   02000   NURSI NG   PROGRAM	0	0	0	0	0	20.00
21.00  02100 1&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22.00   02200   1 &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00   03000   ADULTS & PEDIATRICS	127, 949	12, 760	0	32, 830	726	30.00
43. 00   04300   NURSERY	0	1, 486	0	0	1, 558	43.00
44.00 04400 SKILLED NURSING FACILITY	O	o	0	o	0	44.00
ANCILLARY SERVICE COST CENTERS	<u>'</u>					
50. 00 05000 OPERATING ROOM	0	4, 930	C	12, 705	10, 548	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	3, 045	l o	1	3, 165	ı
53. 00   05300   ANESTHESI OLOGY	0	0, 1.1	0	l ' '	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	12, 107		0	2, 653	1
60. 00   06000   LABORATORY	0	.2, .0,	ĺ	1	0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	٥		Ö	62. 30
65. 00   06500   RESPI RATORY   THERAPY	0	4, 422			2, 640	1
66. 00   06600 PHYSI CAL THERAPY	0	3, 879			101	66.00
	0			0		1
67. 00   06700   OCCUPATI ONAL THERAPY	0	3, 625	0		194	1
68. 00   06800   SPEECH PATHOLOGY	0	217	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	0	15, 537	1
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	1, 082	
76. 97   07697   CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98   07698   HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00   09000   CLI NI C	0	0	0	0	0	90.00
90.01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0	90. 01
91. 00 09100 EMERGENCY	O	16, 060	0	41, 296	6, 201	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	13, 122	О	0	2, 873	95.00
SPECIAL PURPOSE COST CENTERS	-1	-,	-	-		
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	127, 949	79, 785	l o	94, 656	48 075	118.00
NONREI MBURSABLE COST CENTERS	12,7,7,7	7,7,700		7 17 000	10,070	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	С	0	0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	Ö	1, 124	l o	1		192.00
194. 00 07950  OCCUPATI ONAL HEALTH	0	1, 124		-		194. 00
194. 01 07950 OCCOPATIONAL HEALTH	Š	0		1		194.00
	0	0	_	-		
194. 02 07952 OAK POLNTE	0	0	0			194. 02
194. 03 07953 FOUNDATION	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	C	0	0	194. 06
200.00 Cross Foot Adjustments					I	200. 00
201.00 Negative Cost Centers	0	0	0			201. 00
202.00   TOTAL (sum lines 118 through 201)	127, 949	80, 909	0	94, 656	48, 134	202.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | T

				10 12/31/2022	5/15/2023 4:0	
Cost Center Description	PHARMACY	MEDI CAL RECORDS &	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	NURSI NG PROGRAM	рііі
	15. 00	16. 00	17. 00	19. 00	20.00	
GENERAL SERVICE COST CENTERS	10.00	10.00	17.00	17.00	20.00	
1.00 O0100 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
5. 00   00500 ADMI NI STRATI VE & GENERAL						5.00
6. 00   00600   MAI NTENANCE & REPAI RS						6.00
7. 00   00700   OPERATION OF PLANT 8. 00   00800   LAUNDRY & LINEN SERVICE						7. 00 8. 00
8. 00   00800   LAUNDRY & LI NEN SERVI CE 9. 00   00900   HOUSEKEEPI NG						9.00
10. 00   01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11.00
12. 00 01200 MAINTENANCE OF PERSONNEL						12.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00   01500   PHARMACY	170, 723					15. 00
16. 00   01600   MEDI CAL RECORDS & LI BRARY	0	14, 827				16.00
17. 00   01700   SOCI AL SERVI CE 19. 00   01900   NONPHYSI CI AN ANESTHETI STS	0	0	9			17.00
20. 00   02000   NURSI NG   PROGRAM	0	0		0	0	19.00 20.00
21. 00   02100   L&R SERVICES-SALARY & FRINGES APPRV	0	0			٥	21.00
22. 00   02200   L&R SERVICES-OTHER PRGM COSTS APPRV	l o	0				22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0				23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	0	2, 678				30.00
43. 00   04300   NURSERY	0	366				43.00
44. 00 O4400 SKILLED NURSING FACILITY	0	0	(	)		44. 00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	0	317		7		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	1			52.00
53. 00   05300   ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	O	3, 225				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	1, 148	(			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	354				67.00
68. 00   06800   SPEECH PATHOLOGY 69. 00   06900   ELECTROCARDI OLOGY	0	33 0				68. 00 69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	170, 723	0				73.00
76. 97   07697   CARDIAC REHABILITATION	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		0	1 ,			90.00
90.00   09000   CLINIC 90.01   09001   INTENSIVE OUT PATIENT PROGRAM	0	0	•			90.00
91. 00   09100   EMERGENCY	0	6, 706				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0,700	Ì			92.00
OTHER REIMBURSABLE COST CENTERS	•					
95. 00 09500 AMBULANCE SERVICES	0	0	(			95. 00
SPECIAL PURPOSE COST CENTERS	T T		ı	T		
113. 00 11300 INTEREST EXPENSE	470 700	44.007				113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	170, 723	14, 827		0		118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	o	0	•			192.00
194. 00 07950 OCCUPATI ONAL HEALTH	o	0				194. 00
194. 01 07951 PAIN CLINIC	0	0				194. 01
194. 02 07952 OAK POINTE	0	0	(			194. 02
194. 03 07953 FOUNDATI ON	0	0	(			194. 03
194. 04 07954 COMMUNITY & VOLUNTEER SERVICES	0	0	(			194. 04
194. 05 07955 VACANT SPACE	0	0	]	ال		194. 05
194.06 07956 TELEHEALTH MEDICINE 200.00 Cross Foot Adjustments		0		0	_	194. 06 200. 00
201.00   Negative Cost Centers		0				200.00
202.00 TOTAL (sum lines 118 through 201)	170, 723	14, 827				202.00
· · · · · · · · · · · · · · · · · · ·	, ==1	.,	•			

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Worksheet B Part II Date/Time Prepared: 5/15/2023 4:07 pm Provider CCN: 15-0101 Peri od: From 01/01/2022 To 12/31/2022 INTERNS & RESIDENTS SERVI CES-SALA SERVI CES-OTHE PARAMED ED Cost Center Description Subtotal Intern &

	cost center bescription	RY & FRINGES APPRV	R PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Residents Cost & Post Stepdown Adjustments	
	OFNEDAL CERVILOE COST OFNEDO	21. 00	22. 00	23. 00	24. 00	25. 00	
1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS-BLDG & FIXT  00200 CAP REL COSTS-BLDG & FIXT  00400 EMPLOYEE BENEFITS DEPARTMENT  00500 ADMINISTRATIVE & GENERAL  00600 MAINTENANCE & REPAIRS  00700 OPERATION OF PLANT  00800 LAUNDRY & LINEN SERVICE  00900 HOUSEKEEPING  01100 CAFETERIA  01200 MAINTENANCE OF PERSONNEL  01300 NURSING ADMINISTRATION						1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00 23. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM 02100 L&R SERVICES-SALARY & FRINGES APPRV 02200 L&R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY) I NPATIENT ROUTINE SERVICE COST CENTERS	0	0	0			14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00 23. 00
	03000 ADULTS & PEDI ATRI CS 04300 NURSERY				1, 619, 682 61, 404	0	1
	04400 SKILLED NURSING FACILITY				01, 404		1
50. 00 52. 00 53. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC				726, 187 145, 924 0 1, 069, 675	0 0 0 0	52. 00 53. 00
62. 30 65. 00 66. 00	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY				540, 604 0 293, 869 486, 507 142, 192	0 0 0 0	62. 30 65. 00 66. 00
68. 00 69. 00 71. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS				10, 063 0 68, 374 73, 075	0 0 0	68. 00 69. 00 71. 00
76. 97 76. 98 76. 99	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 0UTPATIENT SERVICE COST CENTERS				749, 343 0 465 0	0	76. 97 76. 98
90. 00 90. 01 91. 00 92. 00	09000 CLINIC 09001 INTENSIVE OUT PATIENT PROGRAM 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS				0 0 1, 242, 254	0	90. 01
	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS				370, 531	0	95.00
113. 00 118. 00	11300  INTEREST EXPENSE   SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	7, 600, 149	0	113. 00 118. 00
190. 00 192. 00 194. 00 194. 01 194. 02 194. 03 194. 04	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 OCCUPATIONAL HEALTH 07951 PAIN CLINIC 07952 OAK POINTE 07953 FOUNDATION 07954 COMMUNITY & VOLUNTEER SERVICES				2, 032 146, 846 0 0 0 0 1, 361 14, 233	0 0 0 0 0 0	190. 00 192. 00 194. 00 194. 01 194. 02 194. 03 194. 04
	07955 VACANT SPACE 07956 TELEHEALTH MEDICINE Cross Foot Adjustments Negative Cost Centers TOTAL (sum lines 118 through 201)	000000000000000000000000000000000000000	0 0	0	0 0 0 0 7, 764, 621	0 0 0	194. 05 194. 06 200. 00 201. 00 202. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2022 | Part II | Date/Time Prepared: | 5/15/2023 | 4:07 pm | Provider CCN: 15-0101

			23 4:07 pm
	Cost Center Description	Total	
		26. 00	
	GENERAL SERVICE COST CENTERS		
	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
	00500 ADMINI STRATI VE & GENERAL		5.00
6. 00 7. 00	OO6OO  MAINTENANCE & REPAIRS   OO7OO  OPERATION OF PLANT		6. 00 7. 00
	00800 LAUNDRY & LINEN SERVICE		8.00
	00900 HOUSEKEEPI NG		9.00
	01000 DI ETARY		10.00
	01100 CAFETERI A		11.00
	01200 MAINTENANCE OF PERSONNEL		12.00
	01300 NURSING ADMINISTRATION		13.00
	01400 CENTRAL SERVICES & SUPPLY		14.00
	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
	01700 SOCIAL SERVICE		17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000 NURSI NG PROGRAM		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
	INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000 ADULTS & PEDIATRICS	1, 619, 682	30.00
	04300 NURSERY	61, 404	43.00
44.00	04400 SKILLED NURSING FACILITY	0	44. 00
	ANCILLARY SERVICE COST CENTERS		
	05000 OPERATING ROOM	726, 187	50.00
	05200 DELIVERY ROOM & LABOR ROOM	145, 924	52.00
	05300 ANESTHESI OLOGY	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	1, 069, 675	54.00
	06000 LABORATORY	540, 604	60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	202 0(0	62. 30
	06500 RESPIRATORY THERAPY	293, 869	65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	486, 507	66. 00 67. 00
	06800 SPEECH PATHOLOGY	142, 192 10, 063	68.00
	06900 ELECTROCARDI OLOGY	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	68, 374	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	73, 075	72.00
	07300 DRUGS CHARGED TO PATIENTS	749, 343	73.00
	07697 CARDI AC REHABI LI TATI ON	0	76. 97
	07698 HYPERBARIC OXYGEN THERAPY	465	76. 98
76. 99	07699 LI THOTRI PSY	o	76. 99
	OUTPATIENT SERVICE COST CENTERS	<u> </u>	
90.00	09000 CLI NI C	0	90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	О	90. 01
	09100 EMERGENCY	1, 242, 254	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		 92.00
	OTHER REIMBURSABLE COST CENTERS		
95.00	09500 AMBULANCE SERVI CES	370, 531	95.00
	SPECIAL PURPOSE COST CENTERS		
	11300   NTEREST EXPENSE		113. 00
118. 00		7, 600, 149	118. 00
40	NONREI MBURSABLE COST CENTERS		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 032	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	146, 846	192.00
	07950 OCCUPATI ONAL HEALTH	0	194.00
	07951 PAIN CLINIC	0	194. 01
	07952 OAK POLNTE	0	194. 02
	07953 FOUNDATION	1, 361	194. 03
	07954 COMMUNITY & VOLUNTEER SERVICES	14, 233	194. 04 194. 05
	07955 VACANT SPACE 07956 TELEHEALTH MEDICINE	0	194.05
200.00		0	200.00
200.00		0	200.00
201.00		7, 764, 621	202.00
202.00	1.31/12 (34m 111103 110 till odgil 201)	,,,04,021	1202.00

	Financial Systems	WHITLEY MEMOR		011 45 0404 5		U OT FORM CMS	
COST	NLLOCATION - STATISTICAL BASIS		Provi der C	F	Period: From 01/01/2022 To 12/31/2022	Worksheet B-1 Date/Time Pre	
		CAPITAL REI	ATED COSTS	'	12/31/2022	5/15/2023 4: 0	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
		1. 00	2.00	4.00	5A	5. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 4. 00 5. 00 6. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	159, 632 0 49, 926	159, 632 0	28, 451, 335		46, 673, 694	1.00 2.00 4.00 5.00 6.00
7. 00 8. 00 9. 00 10. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	11, 600 542 453	542 453	857, 206	0 0	2, 258, 381 338, 297 1, 283, 907	7. 00 8. 00 9. 00
11. 00 12. 00 13. 00	01000 DI ETARY 01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMINI STRATI ON	1, 942 2, 190 0 132	2, 190 0 132	232, 547 C 602, 624	0 0	629, 760 164, 548 0 768, 789	11. 00 12. 00 13. 00
14. 00 15. 00 16. 00 17. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	1, 568 1, 359 483 0	1, 359	855, 623	0	33, 489 1, 111, 227 10, 316 0	15. 00 16. 00 17. 00
19. 00 20. 00 21. 00 22. 00	01900   NONPHYSICIAN ANESTHETISTS   02000   NURSING PROGRAM   02100   L&R SERVICES-SALARY & FRINGES APPRV   02200   L&R SERVICES-OTHER PRGM COSTS APPRV	0 0 0 0	o			0 0 0 0	19. 00 20. 00 21. 00 22. 00
23. 00	02300   PARAMED ED PRGM-(SPECIFY)     INPATIENT ROUTINE SERVICE COST CENTERS	0	0	C	0	0	23.00
30. 00 43. 00 44. 00	03000 ADULTS & PEDIATRICS 04300 NURSERY 04400 SKILLED NURSING FACILITY	21, 212 0 0	0	1	0	499, 266	43.00
50. 00 52. 00	ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM  05200 DELIVERY ROOM & LABOR ROOM	12, 668				, , , , , , , , , , , , , , , , , , , ,	1
53. 00 54. 00 60. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0 17, 022 2, 967	0 17, 022 2, 967		0 0	0 4, 918, 990 3, 933, 304	54.00
62. 30 65. 00	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY	0 2, 346	0 2, 346	1, 019, 170	0	0 1, 899, 222	62. 30 65. 00
66. 00 67. 00 68. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	13, 857 0 0	13, 857 0 0	650, 217 923, 464 65, 660	0	778, 048 1, 188, 202 84, 483	67. 00 68. 00
	06900   ELECTROCARDIOLOGY   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   07200   IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0 0	0 454, 874 629, 097	71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY	0 0		1		4, 972, 000 0 4, 000	76. 97
76. 99	07699 LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS	0	0	C	0	0	
90. 00 90. 01 91. 00 92. 00	09000 CLINIC 09001 INTENSIVE OUT PATIENT PROGRAM 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0 0 15, 526	0	Č	0	0	90. 01
95. 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	0	2, 045, 000	0	3, 052, 191	95.00
113. 00 118. 00	3 /	155, 793	155, 793	28, 399, 759	-23, 011, 676	46, 200, 520	113. 00 118. 00
192. 00 194. 00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 OCCUPATI ONAL HEALTH 07951 PAIN CLINI C	58 3, 496 0			0	404, 815 0	190. 00 192. 00 194. 00 194. 01
194. 02 194. 03 194. 04	07952 OAK POINTE 07953 FOUNDATION 07954 COMMUNITY & VOLUNTEER SERVICES	0 0 285		0	0 0	0 11, 719 53, 238	194. 02 194. 03 194. 04
194. 06 200. 00	, ,	0	0	C	0 0		194. 05 194. 06 200. 00
201. 00 202. 00	Cost to be allocated (per Wkst. B,	1, 518, 978	1, 890, 454	7, 595, 782		23, 011, 676	201. 00 202. 00
203.00	Part I)   Unit cost multiplier (Wkst. B, Part I)	9. 515498	11. 842575	0. 266975	;	0. 493033	203. 00

Heal th Fi	inancial Systems	WHITLEY MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2022 Fo 12/31/2022		
		CAPITAL REI	LATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS	Reconciliatio n	ADMINISTRATIV E & GENERAL	
				DEPARTMENT (GROSS SALARI ES)		(ACCUM. COST)	
		1. 00	2.00	4. 00	5A	5. 00	
204.00	Cost to be allocated (per Wkst. B, Part II)			(	D	5, 421, 511	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000000		0. 116158	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

Heal th Financial Systems

WHITLEY MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 15-0101 | Period: From 01/01/2022 To 12/31/2022 | Provider CCN: 15-0101 | Period: From 01/01/2022 To 12/31/2022 | Provider CCN: 15-0101 | Period: From 01/01/2022 To 12/31/2022 | Provider CCN: 15-0101 | Period: From 01/01/2022 To 12/31/2022 | Provider CCN: 15-0101 | Period: From 01/01/2022 To 12/31/2022 | Provider CCN: 15-0101 | Period: From 01/01/2022 To 12/31/2022 | Provider CCN: 15-0101 | Period: From 01/01/2022 To 12/31/2022 | Provider CCN: 15-0101 | Period: From 01/01/2022 To 12/31/2022 | Provider CCN: 15-0101 | Period: From 01/01/2022 To 12/31/2022 | Provider CCN: 15-0101 | Period: From 01/01/2022 To 12/31/2022 | Provider CCN: 15-0101 | Period: From 01/01/2022 To 12/31/2022 | Provider CCN: 15-0101 | Period: From 01/01/2022 To 12/31/2022 | Provider CCN: 15-0101 | Period: From 01/01/2022 To 12/31/2022 | Provider CCN: 15-0101 | Period: From 01/01/2022 To 12/31/2022 | Provider CCN: 15-0101 | Period: From 01/01/2022 To 12/31/2022 | Provider CCN: 15-0101 | Period: From 01/01/2022 To 12/31/2022 | Provider CCN: 15-0101 | Period: From 01/01/2022 To 12/31/2022 | Provider CCN: 15-0101 | Period: From 01/01/2022 To 12/31/2022 | Provider CCN: 15-0101 | Period: From 01/01/2022 To 12/31/2022 | Provider CCN: 15-0101 | Period: From 01/01/2022 To 12/31/2022 | Provider CCN: 15-0101 | Period: From 01/01/2022 | Provider CCN: 15-0101 | Provider CCN: 15-0101

							5/15/2023 4: 0	7 pm
		Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS	
				(SQUARE FEET)	(POUNDS OF	(======================================	SERVED)	
			6. 00	7. 00	LAUNDRY) 8.00	9. 00	10.00	
		AL SERVICE COST CENTERS						
1.00	1	CAP REL COSTS-BLDG & FIXT						1.00
2.00	1	CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 00		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00		MAINTENANCE & REPAIRS	0					6.00
7. 00		OPERATION OF PLANT	0	98, 106				7. 00
8.00		LAUNDRY & LINEN SERVICE	0	542				8. 00
9. 00		HOUSEKEEPI NG	0	453	•	97, 111		9. 00
10.00		DIETARY	0	1, 942		1, 942	15, 918	
11. 00 12. 00	1	CAFETERIA MAINTENANCE OF PERSONNEL	0	2, 190 0	1	2, 190 0	0	1
13. 00	1	NURSING ADMINISTRATION	0	132		132	0	1
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1, 568		1, 568	0	14.00
15. 00		PHARMACY	0	1, 359		1, 359	0	
16.00		MEDICAL RECORDS & LIBRARY	0	483	0	483	0	16.00
17. 00 19. 00		SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	17. 00 19. 00
20.00		NURSING PROGRAM	0	0	0	0	0	20.00
21. 00	1	I&R SERVICES-SALARY & FRINGES APPRV	0	Ö	0	o	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	O	0	22. 00
23. 00		PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
20.00		I ENT ROUTINE SERVICE COST CENTERS	1	04.040	I 00 400	04.040	45.040	00.00
30. 00 43. 00		ADULTS & PEDI ATRI CS NURSERY	0	21, 212		21, 212	15, 918 0	30. 00 43. 00
44. 00		SKILLED NURSING FACILITY				0	0	1
		LARY SERVICE COST CENTERS				<u> </u>		1 00
50.00	05000	OPERATING ROOM	0	12, 668	0	12, 668	0	50.00
52.00		DELIVERY ROOM & LABOR ROOM	0	0		0	0	
53.00	1	ANESTHESI OLOGY	0	17 000		0	0	
54. 00 60. 00		RADI OLOGY-DI AGNOSTI C LABORATORY	0	17, 022 2, 967		17, 022 2, 967	0	54. 00 60. 00
62. 30		BLOOD CLOTTING FOR HEMOPHILIACS	0	2, 707	1	2, 707	0	62. 30
65. 00		RESPI RATORY THERAPY	0	2, 346		2, 346	0	65.00
66.00	06600	PHYSI CAL THERAPY	0	13, 857	0	13, 857	0	66.00
67. 00		OCCUPATI ONAL 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	0	0	71.00
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	Ö	0	o	0	ı
73.00		DRUGS CHARGED TO PATIENTS	0	0	0	O	0	73.00
76. 97		CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98	1	HYPERBARI C OXYGEN THERAPY	0	0		0	0	76. 98
76. 99		LITHOTRIPSY TIENT SERVICE COST CENTERS	0	0	0	0	0	76. 99
90.00		CLINIC	0	0	0	0	0	90.00
90. 01		INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0	1
91. 00	1	EMERGENCY	0	15, 526	124, 745	15, 526	0	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART						92.00
95. 00		REIMBURSABLE COST CENTERS AMBULANCE SERVICES	0	0	0	ol	0	95. 00
93.00		AL PURPOSE COST CENTERS	0	0	0	ι	0	75.00
113.00		INTEREST EXPENSE						113.00
118.00	)	SUBTOTALS (SUM OF LINES 1 through 117)	0	94, 267	216, 874	93, 272	15, 918	118.00
	NONRE	IMBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			58		190.00
	1	PHYSICIANS' PRIVATE OFFICES OCCUPATIONAL HEALTH	0	3, 496	0	3, 496		192. 00 194. 00
		PAIN CLINIC	0		0			194. 00
		OAK POINTE	0	Ö	Ö	o		194. 02
		FOUNDATI ON	0	0	0	O		194. 03
		COMMUNITY & VOLUNTEER SERVICES	0	285	1	285		194. 04
		VACANT SPACE	0	0	1	0		194.05
194.06		TELEHEALTH MEDICINE Cross Foot Adjustments		0			0	194. 06 200. 00
200.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B,	0	3, 371, 837	523, 717	1, 932, 485	1, 045, 642	
		Part I)						
203.00	1	Unit cost multiplier (Wkst. B, Part I)	0. 000000			I I	65. 689283	1
204.00	,	Cost to be allocated (per Wkst. B, Part II)		510, 083	53, 690	161, 167	127, 949	204.00
	I	11 at 117	I	I	I	ı I		I

Health Financial Systems	WHITLEY MEMORI	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
			_	rom 01/01/2022 o 12/31/2022	Date/Time Pre 5/15/2023 4:0	
Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS	
	(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF		SERVED)	
			LAUNDRY)			
	6. 00	7. 00	8. 00	9. 00	10.00	
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	5. 199305	0. 247563	1. 659616	8. 038007	205. 00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COST ALLOCA	TION - STATISTICAL BASIS		Provi der C		eri od:	Worksheet B-1	
				T <sub>0</sub>	rom 01/01/2022 o 12/31/2022	Date/Time Pre 5/15/2023 4:0	
	Cost Center Description	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	PHARMACY	, piii
		(FTES)	OF PERSONNEL (NUMBER	ADMI NI STRATI O N	SERVI CES & SUPPLY	(COSTED REQUIS.)	
			HOUSED)	(DI RECT	(COSTED	KEQUIU. )	
		11. 00	12. 00	NRSI NG HRS) 13.00	REQUIS.) 14.00	15. 00	
GENEF	RAL SERVICE COST CENTERS	11.00	12.00	13.00	14.00	15.00	
	CAP REL COSTS-BLDG & FIXT						1.00
	CAP REL COSTS-MVBLE EQUIP  EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5.00 00500	ADMINISTRATIVE & GENERAL						5.00
	MAINTENANCE & REPAIRS OPERATION OF PLANT						6. 00 7. 00
	LAUNDRY & LINEN SERVICE						8.00
9.00 00900	HOUSEKEEPI NG						9. 00
	DI ETARY CAFETERI A	2, 232					10.00 11.00
	MAINTENANCE OF PERSONNEL	2, 232	0				12.00
13.00 01300	NURSING ADMINISTRATION	45	0	211, 938			13.00
	CENTRAL SERVICES & SUPPLY PHARMACY	0 69	0	0	3, 360, 745 55, 650	489, 904, 277	14. 00 15. 00
	MEDICAL RECORDS & LIBRARY	0	0	0	0	407, 704, 277	
	SOCIAL SERVICE	0	0	0	0	0	17. 00
	NONPHYSICIAN ANESTHETISTS NURSING PROGRAM	0	0	0	0	0	19. 00 20. 00
	I &R SERVICES-SALARY & FRINGES APPRV	0	0	ő	0	0	21.00
l l	O I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
	PARAMED ED PRGM-(SPECIFY) FIENT ROUTINE SERVICE COST CENTERS	0	0	0	O	0	23.00
30.00 03000	ADULTS & PEDIATRICS	352	0	73, 507	50, 680	0	
	NURSERY SKILLED NURSING FACILITY	41 0	0			0	
	LLARY SERVICE COST CENTERS	J	0		٥		1 44.00
	OPERATING ROOM	136	0			0	
l l	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	84 0	0	17, 521 0	220, 980 0	0	
54.00 05400	RADI OLOGY-DI AGNOSTI C	334	0	0	185, 254	831	54.00
	LABORATORY BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	60. 00 62. 30
	RESPIRATORY THERAPY	122	0	0	184, 350	0	65.00
	PHYSI CAL THERAPY	107	0	0	7, 021	0	66.00
	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	100	0	0	13, 547 0	0	67. 00 68. 00
69.00 06900	ELECTROCARDI OLOGY	0	Ö	o o	Ö	0	69.00
	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1, 084, 798	0	71.00
	IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0	0	75, 526	0 489, 903, 446	72. 00 73. 00
76. 97 07697	CARDIAC REHABILITATION	0	0	0	0	0	76. 97
	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	
	ATIENT SERVICE COST CENTERS	U	0	0	U		70.99
	CLINIC	0	0	0	0	0	
90.01 09001	INTENSIVE OUT PATIENT PROGRAM	0 443	0	92, 463	432, 999	0	
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART		_	1_,	,		92.00
	R REIMBURSABLE COST CENTERS  AMBULANCE SERVICES	362	0	0	200, 619	0	95.00
	AL PURPOSE COST CENTERS	302	0	0	200, 017	0	73.00
	INTEREST EXPENSE	2 201	0	211 020	2 25/ /77	400 004 077	113.00
118. 00 NONRE	SUBTOTALS (SUM OF LINES 1 through 117)   EIMBURSABLE COST CENTERS	2, 201	0	211, 938	3, 356, 677	489, 904, 277	]118.00
190. 00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	- 1		190. 00
	PHYSICIANS' PRIVATE OFFICES OCCUPATIONAL HEALTH	31	0		3, 613		192. 00 194. 00
	PAIN CLINIC	0	0	0	0		194.00
	OAK POINTE	0	0	0	0		194. 02
	FOUNDATION COMMUNITY & VOLUNTEER SERVICES	0	0	0	0 455		194. 03 194. 04
	VACANT SPACE	0	0	ő	0		194. 05
	5 TELEHEALTH MEDICINE	0	0	0	0	0	194.06
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
202. 00	Cost to be allocated (per Wkst. B,	364, 525	0	1, 162, 340	135, 094	1, 746, 357	
203. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	163. 317652	0. 000000	5. 484340	0. 040198	0. 003565	203. 00
204. 00	Cost to be allocated (per Wkst. B,	80, 909	0	94, 656		170, 723	1
	Part II)						

Heal th Fina	ncial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der C		Peri od: From 01/01/2022	Worksheet B-1	
					To 12/31/2022	Date/Time Pre 5/15/2023 4:0	
	Cost Center Description	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	PHARMACY	
		(FTES)	OF PERSONNEL	ADMI NI STRATI	O SERVICES &	(COSTED	
			(NUMBER	N	SUPPLY	REQUIS.)	
			HOUSED)	(DI RECT	(COSTED		
				NRSI NG HRS)	REQUIS.)		
		11. 00	12. 00	13. 00	14.00	15. 00	
205. 00	Unit cost multiplier (Wkst. B, Part	36. 249552	0. 000000	0. 44662	0. 014322	0. 000348	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

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0101 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/15/2023 4:07 pm INTERNS & **RESI DENTS** Cost Center Description MEDI CAL SOCI AL NONPHYSI CI AN NURSI NG SERVI CES-SALA RY & FRINGES RECORDS & SERVI CE **ANESTHETISTS PROGRAM** (ASSI GNED LI BRARY (TIME SPENT) **APPRV** (ASSI GNED (TIME SPENT) TIME) TIME) (ASSI GNED TIME) 16. 00 17. 00 19.00 20.00 21.00 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 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12 00 12 00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 10,000 16.00 16.00 17.00 01700 SOCIAL SERVICE 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 0 19.00 02000 NURSI NG PROGRAM 20 00 0 0 0 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22.00 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1,806 0 0 0 0 30.00 04300 NURSERY 0 0 0 0 43.00 43.00 247 04400 SKILLED NURSING FACILITY 44.00 0 0 0 0 44.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 214 0 0 0 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 0 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 2.175 0 0 54 00 06000 LABORATORY 60.00 60.00 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0 0 0 62.30 06500 RESPIRATORY THERAPY 0 65.00 0 0 65.00 0 66.00 06600 PHYSI CAL THERAPY 774 0 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 239 0 67.00 06800 SPEECH PATHOLOGY 68.00 22 0 68.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 C 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 0 0 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 73.00 0 07697 CARDIAC REHABILITATION 0 76.97 C 0 76.97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 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 0 0 0 0 90.00 09001 INTENSIVE OUT PATIENT PROGRAM 0 0 90.01 0 0 0 90.01 0 91.00 91.00 09100 EMERGENCY 4.523 C 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 0 0 0 0 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 10,000 0 0 0 0 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 0 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 C 0 0 192.00 194.00 07950 OCCUPATIONAL HEALTH 0 0 0 0 194.00 0 0 0 194. 01 07951 PAIN CLINIC 0 0 0 194. 01 194. 02 07952 OAK POINTE 0 0 194 02 0 0 o 194. 03 07953 FOUNDATI ON 0 0 0 194. 03 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 0 0 0 0 194.04 194. 05 07955 VACANT SPACE 0 0 0 o 0 194.05 194. 06 07956 TELEHEALTH MEDICINE 0 0 0 0 194, 06 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 0 202.00 Cost to be allocated (per Wkst. B, 0 202.00 41, 614 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 4. 161400 0.000000 0.000000 0.000000 0.000000 203.00

Heal th Finar	ncial Systems	WHITLEY MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2022 To 12/31/2022		
						I NTERNS & RESI DENTS	
	Cost Center Description	MEDI CAL	SOCI AL	NONPHYSI CI AN		SERVI CES-SALA	
		RECORDS &	SERVI CE	ANESTHETI STS		RY & 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)	14, 827	0		0 0	0	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	1. 482700	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

Provider CCN: 15-0101 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/15/2023 4:07 pm INTERNS & **RESI DENTS** Cost Center Description SERVI CES-OTHE PARAMED ED R PRGM COSTS PRGM (ASSI GNED **APPRV** (ASSI GNED TIME) TIME) 22. 00 23. 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 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12 00 12 00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 17.00 01700 SOCIAL SERVICE 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 02000 NURSING PROGRAM 20 00 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 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 0 30.00 04300 NURSERY 0 43.00 0 43.00 04400 SKILLED NURSING FACILITY 44.00 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 52.00 53.00 05300 ANESTHESI OLOGY 0000000000000 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 54 00 06000 LABORATORY 0 60.00 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 62.30 06500 RESPIRATORY THERAPY 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 07697 CARDIAC REHABILITATION 76.97 0 76.97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 76.98 76. 99 07699 LI THOTRI PSY 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 09001 INTENSIVE OUT PATIENT PROGRAM 0 90.01 0 90.01 0 91.00 09100 EMERGENCY 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 0 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 0 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192.00 194.00 07950 OCCUPATIONAL HEALTH 0 0 194.00 194. 01 07951 PAIN CLINIC 0 0 0 0 194.01 194. 02 07952 OAK POINTE 194 02 0 194. 03 07953 FOUNDATI ON 0 194.03 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 194.04 0 0 194. 05 07955 VACANT SPACE 0 194. 05 194. 06 07956 TELEHEALTH MEDICINE 0 C 194.06 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 0 0 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.000000 203.00

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS	-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider Co	CN: 15-0101	Peri od: From 01/01/2022 To 12/31/2022	Worksheet B- Date/Time Pr 5/15/2023 4:	epared:
Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHE R PRGM COSTS APPRV (ASSI GNED TI ME) 22.00	PARAMED ED PRGM (ASSI GNED TIME)				
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	HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0101	Peri od: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/15/2023 4:0	
		Title	: XVIII	Hospi tal	PPS	

				7	To 12/31/2022	Date/Time Pre 5/15/2023 4:0	pared:
			Title	XVIII	Hospi tal	PPS	7 рііі
			11 (10	,,,,,,	Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	, , , , , , , , , , , , , , , , , , ,	(from Wkst.	Adj .		Di sal I owance		
		B, Part I,	•				
		col. 26)					
		1. 00	2. 00	3.00	4. 00	5. 00	
	ATIENT ROUTINE SERVICE COST CENTERS						
	00 ADULTS & PEDIATRICS	13, 447, 344		13, 447, 344	1 0	13, 447, 344	30.00
	00 NURSERY	757, 518		757, 518	0	757, 518	
	OO SKILLED NURSING FACILITY	0		(	0	0	44.00
	LLARY SERVICE COST CENTERS						
	OO OPERATING ROOM	5, 269, 388		5, 269, 388		5, 269, 388	
	OO DELIVERY ROOM & LABOR ROOM	1, 813, 921		1, 813, 921	0	1, 813, 921	52.00
	00 ANESTHESI OLOGY	0		(	0	0	
	00 RADI OLOGY-DI AGNOSTI C	8, 339, 032		8, 339, 032		8, 339, 032	
	00 LABORATORY	6, 033, 570		6, 033, 570	0	6, 033, 570	
	50 BLOOD CLOTTING FOR HEMOPHILIACS	0		(	0	0	
	00 RESPI RATORY THERAPY	2, 990, 252	0	2, 990, 252		2, 990, 252	
	00 PHYSI CAL THERAPY	1, 934, 636	0	1, 934, 636		1, 934, 636	
	00 OCCUPATI ONAL THERAPY	1, 791, 897	0	1, 791, 897		1, 791, 897	
	00 SPEECH PATHOLOGY	127, 208	0	127, 208	3 0	127, 208	
	00 ELECTROCARDI OLOGY	0		(	0	0	
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	722, 748		722, 748		722, 748	
	00 IMPL. DEV. CHARGED TO PATIENTS	939, 263		939, 263		939, 263	
	DO DRUGS CHARGED TO PATIENTS	9, 172, 750		9, 172, 750	0	9, 172, 750	
	97 CARDIAC REHABILITATION	0		(	0	0	
	98 HYPERBARIC OXYGEN THERAPY	5, 972		5, 972		5, 972	
	99 LI THOTRI PSY	0		(	0	0	76. 99
	PATIENT SERVICE COST CENTERS						
	00 CLI NI C	0		(	0	0	
	01 INTENSIVE OUT PATIENT PROGRAM	0		(	0	0	90. 01
	00 EMERGENCY	10, 795, 636		10, 795, 636	· ·	10, 831, 178	
	OO OBSERVATION BEDS (NON-DISTINCT PART	3, 023, 436		3, 023, 436		3, 023, 436	92.00
	ER REIMBURSABLE COST CENTERS					4 (0) 74(	05.00
	00 AMBULANCE SERVICES	4, 624, 207		4, 624, 20	2, 539	4, 626, 746	95.00
	CLAL PURPOSE COST CENTERS						440.00
	OO INTEREST EXPENSE	71 700 770	0	71 700 77	20 001	71 007 050	113.00
200.00	Subtotal (see instructions)	71, 788, 778	0	,		71, 826, 859	
201. 00	Less Observation Beds	3, 023, 436	0	3, 023, 436		3, 023, 436	
202. 00	Total (see instructions)	68, 765, 342	0	68, 765, 342	2 38, 081	68, 803, 423	1202.00

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	Period: Worksheet C From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

				Т	o 12/31/2022	Date/Time Pre 5/15/2023 4:0	
			Title	XVIII	Hospi tal	PPS	
			Charges	<u> </u>			
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	14, 536, 072		14, 536, 072			30.00
	04300 NURSERY	1, 670, 978		1, 670, 978	3		43.00
44.00	04400 SKILLED NURSING FACILITY	0		(	)		44.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	6, 685, 137	28, 409, 525			0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	4, 342, 166	197, 778	4, 539, 944		0.000000	
	05300 ANESTHESI OLOGY	0	0	·	0.00000	0. 000000	
54.00	05400   RADI OLOGY-DI AGNOSTI C	4, 627, 293	58, 784, 044	63, 411, 337	0. 131507	0.000000	
60.00	06000 LABORATORY	6, 630, 380	43, 039, 653	49, 670, 033		0.000000	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(		0.000000	
65.00	06500 RESPI RATORY THERAPY	3, 207, 171	11, 672, 411	14, 879, 582	0. 200963	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	412, 685	7, 076, 364	7, 489, 049	0. 258329	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	357, 171	1, 823, 727	2, 180, 898	0. 821633	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	139, 996	227, 035	367, 031	0. 346587	0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	C	0. 000000	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 140, 593	3, 841, 111	4, 981, 704	0. 145080	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	220, 547	3, 553, 474	3, 774, 021	0. 248876	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	6, 509, 669	31, 291, 079	37, 800, 748	0. 242661	0.000000	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	C	0. 000000	0.000000	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	13, 775	10, 625	24, 400	0. 244754	0.000000	76. 98
76. 99	07699 LI THOTRI PSY	0	0	C	0. 000000	0.000000	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	C	0. 000000	0.000000	90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0	0	C	0. 000000	0.000000	90. 01
91.00	09100 EMERGENCY	6, 124, 399	65, 845, 998	71, 970, 397	0. 150001	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	5, 763, 055	5, 763, 055	0. 524624	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	13, 315, 606	13, 315, 606	0. 347277	0. 000000	95.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
200.00		56, 618, 032	274, 851, 485	331, 469, 517	'		200.00
201.00							201.00
202.00	Total (see instructions)	56, 618, 032	274, 851, 485	331, 469, 517	'		202. 00

Health Financial Systems	WHITLEY MEMORIAL HOSPIT	AL	In Lieu of	Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provio		01/01/2022 Par 12/31/2022 Dat	rksheet C rt I te/Time Prepared: 15/2023 4:07 pm

					5/15/2023 4:07 pm
			Title XVIII	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS				30.0
13.00	04300 NURSERY				43.0
14.00	04400 SKILLED NURSING FACILITY				44. 0
	ANCILLARY SERVICE COST CENTERS				
0.00	05000 OPERATING ROOM	0. 150148			50.0
2.00	05200 DELIVERY ROOM & LABOR ROOM	0. 399547			52.0
53.00	05300 ANESTHESI OLOGY	0. 000000			53.0
4. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 131507			54.0
0.00	06000 LABORATORY	0. 121473			60.0
2. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 3
5.00	06500 RESPI RATORY THERAPY	0. 200963			65.0
6.00	06600 PHYSI CAL THERAPY	0. 258329			66.0
7. 00	06700 OCCUPATI ONAL THERAPY	0. 821633			67.0
8. 00	06800 SPEECH PATHOLOGY	0. 346587			68. 0
9. 00	06900 ELECTROCARDI OLOGY	0. 000000			69. 0
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 145080			71.0
2. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 248876			72.0
3. 00	07300 DRUGS CHARGED TO PATIENTS	0. 242661			73.0
6. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 9
6. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 244754			76. 9
6. 99	07699 LI THOTRI PSY	0. 000000			76. 9
	OUTPATIENT SERVICE COST CENTERS				
0.00	09000 CLI NI C	0. 000000			90.0
0. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0. 000000			90.0
1.00	09100 EMERGENCY	0. 150495			91.0
2. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 524624			92.0
	OTHER REIMBURSABLE COST CENTERS				
5. 00	09500 AMBULANCE SERVICES	0. 347468			95. 0
	SPECIAL PURPOSE COST CENTERS				
13.00	11300 I NTEREST EXPENSE				113. 0
200.00					200. 0
201.00					201. 0
202.00					202. 0

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		Worksheet C Part I Date/Time Prepared: 5/15/2023 4:07 pm

				1	To 12/31/2022	Date/Time Pre 5/15/2023 4:0	pared:
			Ti tl	e XIX	Hospi tal	PPS	7 рііі
				,	Costs	1.0	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,	.,				
		col . 26)					
		1. 00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	13, 447, 344		13, 447, 344	1 0	13, 447, 344	30.00
43.00	04300 NURSERY	757, 518		757, 518	0	757, 518	43.00
44.00	04400 SKILLED NURSING FACILITY	0		(	0	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	5, 269, 388		5, 269, 388	0	5, 269, 388	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 813, 921		1, 813, 921	0	1, 813, 921	52.00
53. 00	05300 ANESTHESI OLOGY	0		(	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 339, 032		8, 339, 032	0	8, 339, 032	54.00
	06000 LABORATORY	6, 033, 570		6, 033, 570	0	6, 033, 570	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		(	0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	2, 990, 252	0	2, 990, 252	0	2, 990, 252	65.00
66. 00	06600 PHYSI CAL THERAPY	1, 934, 636	0	1, 934, 636	0	1, 934, 636	66.00
	06700 OCCUPATI ONAL THERAPY	1, 791, 897	0	1, 791, 897	0	1, 791, 897	67.00
68. 00	06800 SPEECH PATHOLOGY	127, 208	0	127, 208	0	127, 208	
69. 00	06900 ELECTROCARDI OLOGY	0		(	0	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	722, 748		722, 748		722, 748	
	07200 IMPL. DEV. CHARGED TO PATIENTS	939, 263		939, 263	0	939, 263	
	07300 DRUGS CHARGED TO PATIENTS	9, 172, 750		9, 172, 750	0	9, 172, 750	
	07697 CARDI AC REHABI LI TATI ON	0		(	0	0	
	07698 HYPERBARIC OXYGEN THERAPY	5, 972		5, 972	0	5, 972	76. 98
	07699 LI THOTRI PSY	0		(	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0		(	0	0	
	09001 INTENSIVE OUT PATIENT PROGRAM	0		(	0	0	90. 01
	09100 EMERGENCY	10, 795, 636		10, 795, 636	· ·		
	09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 023, 436		3, 023, 436	5	3, 023, 436	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES	4, 624, 207		4, 624, 207	2, 539	4, 626, 746	95.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE	74 700	_	74 700		74 00/	113.00
200.00	Subtotal (see instructions)	71, 788, 778	0			71, 826, 859	
201.00	Less Observation Beds	3, 023, 436	_	3, 023, 436		3, 023, 436	
202. 00	Total (see instructions)	68, 765, 342	0	68, 765, 342	38, 081	68, 803, 423	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	Period: Worksheet C From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

				רן	o 12/31/2022	Date/Time Pre 5/15/2023 4:0	pared:
			Ti tl	e XIX	Hospi tal	PPS	у рии
			Charges				
	Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	•	'	·	+ col. 7)	Ratio	I npati ent	
				ŕ		Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	14, 536, 072		14, 536, 072	2		30.00
	04300 NURSERY	1, 670, 978		1, 670, 978	3		43.00
44.00	04400 SKILLED NURSING FACILITY	0		(			44.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	6, 685, 137	28, 409, 525	35, 094, 662		0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	4, 342, 166	197, 778	4, 539, 944	0. 399547	0.000000	52.00
	05300 ANESTHESI OLOGY	0	0	(	0. 000000	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 627, 293	58, 784, 044	63, 411, 337	0. 131507	0.000000	54.00
60.00	06000 LABORATORY	6, 630, 380	43, 039, 653	49, 670, 033	0. 121473	0.000000	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(	0. 000000	0.000000	62. 30
65.00	06500 RESPI RATORY THERAPY	3, 207, 171	11, 672, 411	14, 879, 582	0. 200963	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	412, 685	7, 076, 364	7, 489, 049	0. 258329	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	357, 171	1, 823, 727	2, 180, 898	0. 821633	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	139, 996	227, 035	367, 031	0. 346587	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	(	0. 000000	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 140, 593	3, 841, 111	4, 981, 704	0. 145080	0.000000	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	220, 547	3, 553, 474	3, 774, 021	0. 248876	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	6, 509, 669	31, 291, 079	37, 800, 748	0. 242661	0.000000	73.00
76. 97	07697 CARDIAC REHABILITATION	0	0	(	0. 000000	0.000000	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	13, 775	10, 625	24, 400	0. 244754	0.000000	76. 98
76. 99	07699 LI THOTRI PSY	0	0	(	0. 000000	0.000000	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	(	0. 000000	0.000000	90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0	0	(	0. 000000	0.000000	90. 01
91.00	09100 EMERGENCY	6, 124, 399	65, 845, 998	71, 970, 397	0. 150001	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	5, 763, 055	5, 763, 055	0. 524624	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	13, 315, 606	13, 315, 606	0. 347277	0. 000000	95.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
200.00		56, 618, 032	274, 851, 485	331, 469, 517	'		200.00
201.00							201.00
202.00	Total (see instructions)	56, 618, 032	274, 851, 485	331, 469, 517	'		202. 00

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0101	From 01/01/2022	Worksheet C Part I Date/Time Prepared: 5/15/2023 4:07 pm

				5/15/2023 4:07 pm
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDIATRICS				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. 150148			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 399547			52.00
53. 00   05300   ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 131507			54.00
60. 00   06000   LABORATORY	0. 121473			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 200963			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 258329			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 821633			67.00
68.00 06800 SPEECH PATHOLOGY	0. 346587			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
71.00  07100 MEDICAL SUPPLIES CHARGED TO PATIEN	T 0. 145080			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 248876			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 242661			73.00
76. 97 07697 CARDIAC REHABILITATION	0. 000000			76. 97
76. 98 07698 HYPERBARIC OXYGEN THERAPY	0. 244754			76. 98
76. 99 07699 LI THOTRI PSY	0. 000000			76. 99
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLINIC	0. 000000			90.00
90.01 09001 INTENSIVE OUT PATIENT PROGRAM	0. 000000			90.01
91. 00 09100 EMERGENCY	0. 150495			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	T 0. 524624			92.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 347468			95.00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113.00
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	HOSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST REDUCTIONS FOR MEDICAID ONLY	TO CHARGE RATIOS NET OF	Provi der CCN: 15-0101	From 01/01/2022	Worksheet C Part II Date/Time Prepared:

					To 12/31/2022	Date/Time Pre 5/15/2023 4:0	
			Ti tl	e XIX	Hospi tal	PPS	,, p
	Cost Center Description	Total Cost	Capital Cost	Operating	Capi tal	Operati ng	
		(Wkst. B,	(Wkst. B,	Cost Net of	Reducti on	Cost	
		Part I, col.	Part II col.	Capital Cost		Reduction	
		26)	26)	(col. 1 -		Amount	
				col. 2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	LLARY SERVICE COST CENTERS			,			
	OO OPERATING ROOM	5, 269, 388	· ·			0	
	DO DELIVERY ROOM & LABOR ROOM	1, 813, 921	145, 924	1, 667, 99	7 0	0	
	OO ANESTHESI OLOGY	0	0	1	0	0	
	OO RADI OLOGY-DI AGNOSTI C	8, 339, 032				0	
	OO LABORATORY	6, 033, 570	540, 604	5, 492, 96	6 0	0	00.00
	60 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0	62. 30
	00 RESPI RATORY THERAPY	2, 990, 252	293, 869	2, 696, 38	3 0	0	65.00
66.00 0660	OO PHYSI CAL THERAPY	1, 934, 636	486, 507	1, 448, 12	9 0	0	66.00
67.00 0670	OCCUPATIONAL THERAPY	1, 791, 897	142, 192	1, 649, 70	5 0	0	67.00
68.00 0680	OO SPEECH PATHOLOGY	127, 208	10, 063	117, 14	5 0	0	68. 00
69.00 0690	00 ELECTROCARDI OLOGY	0	0		0	0	69.00
71.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENT	722, 748	68, 374	654, 37	4 0	0	71.00
72.00 0720	OO IMPL. DEV. CHARGED TO PATIENTS	939, 263	73, 075	866, 18	8 0	0	72.00
73.00 0730	DO DRUGS CHARGED TO PATIENTS	9, 172, 750	749, 343	8, 423, 40	7 0	0	73.00
76. 97 0769	77 CARDIAC REHABILITATION	0	0		0 0	0	76. 97
76. 98 0769	98 HYPERBARIC OXYGEN THERAPY	5, 972	465	5, 50	7 0	0	76. 98
76. 99 0769	99 LI THOTRI PSY	0	0		0 0	0	76. 99
OUTP	PATIENT SERVICE COST CENTERS						
90.00 0900	OO CLI NI C	0	0		0 0	0	90.00
90. 01 0900	1 INTENSIVE OUT PATIENT PROGRAM	0	0		0	0	90. 01
91.00 0910	OO EMERGENCY	10, 795, 636	1, 242, 254	9, 553, 38	2 0	0	91.00
92.00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART	3, 023, 436	364, 161	2, 659, 27	5 0	0	92.00
OTHE	R REIMBURSABLE COST CENTERS						
	OO AMBULANCE SERVICES	4, 624, 207	370, 531	4, 253, 67	6 0	0	95. 00
	CLAL PURPOSE COST CENTERS						
	OO INTEREST EXPENSE						113.00
200. 00	Subtotal (sum of lines 50 thru 199)	57, 583, 916					200.00
201. 00	Less Observation Beds	3, 023, 436	· ·				201.00
202.00	Total (line 200 minus line 201)	54, 560, 480	5, 919, 063	48, 641, 41	7 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 Provider CCN: 15-0101 Provider CCN: 15-0101 From 01/01/2022 To 12/31/2022 Date/Time Prepared:

Title XIX					10 12/31/2022	5/15/2023 4:07 pm
Capital and Operating Cost to Part II, column 8)			Ti tl	e XIX	Hospi tal	PPS
Operating Cost Reduction   Cost Reduction   Cost Reduction   Cost   Cool umn 8    Cool umn 8    Cool umn 8   Cool umn 8    Cool umn 8    Cool umn 8   Cool umn 8    Cool umn	Cost Center Description	Cost Net of	Total Charges			
ANCILLARY SERVICE COST CENTERS   Col umn 8		Capital and	(Worksheet C,	Cost to		
Reduction   Col. 7)   Col. 7    Co		Operati ng	Part I,	Charge Ratio		
ANCI LLARY SERVI CE COST CENTERS   50.00   7.00   8.00		Cost	column 8)	(col. 6 /		
ANCI LLARY SERVICE COST CENTERS   50.00		Reducti on				
50.00		6. 00	7. 00	8. 00		
52.00   05200   DELIVERY ROOM & LABOR ROOM   1, 813, 921   4, 539, 944   0. 399547   52.00   53.00   05300   ANESTHESI OLOGY   0   0   0   0   0.000000   53.00   05400   RADII OLOGY-DI AGNOSTI C   8, 339, 032   63, 411, 337   0. 131507   54.00   06000   06000   LABORATORY   6.033, 570   49, 670, 033   0. 121473   60.00   62.30   06250   BLODD CLOTTI ING FOR HEMOPHI LI ACS   0   0   0   0.000000   62.30   06500   RESPI RATORY THERAPY   2, 990, 252   14, 879, 582   0. 200963   65.00   06600   PHYSI CAL THERAPY   1, 791, 897   2, 180, 898   0. 821633   67, 000   06700   0CCUPATI ONAL THERAPY   1, 791, 897   2, 180, 898   0. 821633   67, 000   06700   0CCUPATI ONAL THERAPY   1, 791, 897   2, 180, 898   0. 821633   67, 000   06900   ELECTROCARDI OLOGY   0   0   0   0.000000   69, 000   06900   ELECTROCARDI OLOGY   0   0   0   0.000000   69, 000   000000   000000   000000   000000						
53. 00   05300   ANESTHESI OLOGY   0   0   0   0   0   0   0   0   0		5, 269, 388	35, 094, 662	0. 15014	18	
54. 00   05400   RADI OLOGY-DI AGNOSTI C   8, 339, 032   63, 411, 337   0.131507   54. 00   60. 00   06000   LABORATORY   6, 033, 570   49, 670, 033   0.121473   60. 00   62. 30   65. 00   06500   RESPI RATORY THERAPY   2, 990, 252   14, 879, 582   0. 200963   65. 00   66. 00   06600   PHYSI CAL THERAPY   1, 934, 636   7, 489, 049   0. 258329   66. 00   66. 00   06000   CHOTTI ORAL THERAPY   1, 791, 897   2, 180, 898   0. 821633   67. 00   6700   OCCUPATI ORAL THERAPY   1, 791, 897   2, 180, 898   0. 821633   67. 00   68. 00   06800   SPEECH PATHOLOGY   127, 208   367, 031   0. 346587   68. 00   69. 00   0. 000000   69. 00   0. 000000   69. 00   0. 0000000   69. 00   0. 0000000   69. 00   0. 0000000   69. 00   0. 0000000   69. 00   0. 0000000   69. 00   0. 0000000   72. 00   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   939, 263   3, 774, 021   0. 248876   72. 00   73. 00   0. 000500   CHARGED TO PATI ENTS   9, 172, 750   37, 800, 748   0. 242661   73. 00   76. 97   76.97   CARDI AC REHABI LI TATI ON   0   0   0. 000000   76. 97   76. 98   07699   LI THOTRI PSY   0   0   0. 000000   0. 000000   76. 99   0. 000000   0. 0		1, 813, 921	4, 539, 944	0. 39954	17	
60. 00   06000   LABORATORY   6, 033, 570   49, 670, 033   0. 121473   0. 006250   0. 000000   62. 30   06500   0. 000000   62. 30   06500   0. 00500   0. 000000   065. 00   0. 00500   0. 000000   065. 00   0. 00500   0. 0000000   0. 0000000   0. 0000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00		0	0	0. 00000	00	
62. 30		8, 339, 032	63, 411, 337	0. 13150	)7	
65. 00		6, 033, 570	49, 670, 033	0. 12147	73	
66. 00 06600 PHYSI CAL THERAPY 1, 934, 636 7, 489, 049 0. 258329 66. 00 6700 0CCUPATI ONAL THERAPY 1, 791, 897 2, 180, 898 0. 821633 67. 00 6800 SPECH PATHOLOGY 12, 708 367, 031 0. 346587 68. 00 6800 SPECH PATHOLOGY 0 0. 0. 000000 69. 00 0. 0000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 0000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 0		0	0	0. 00000	00	62. 30
67. 00 06700 OCCUPATI ONAL THERAPY 1, 791, 897 2, 180, 898 0. 821633 67. 00 68. 00 68800 SPEECH PATHOLOGY 127, 208 367, 031 0. 346587 68. 00 6900 ELECTROCARDI OLOGY 0 0 0. 000000 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 722, 748 4, 981, 704 0. 145080 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 939, 263 3, 774, 021 0. 248876 72. 00 07300 DRUGS CHARGED TO PATI ENTS 939, 263 3, 774, 021 0. 248876 72. 00 07300 DRUGS CHARGED TO PATI ENTS 9, 172, 750 37, 800, 748 0. 242661 73. 00 07697 CARDI AC REHABI LI TATI ON 0 0 0. 000000 76. 98 07698 HYPERBARI C OXYGEN THERAPY 5, 972 24, 400 0. 244754 76. 98 07699 LI THOTRI PSY 0 0 0. 000000 76. 99 0000 CLI NI C 0 0. 000000 76. 99 0000 CLI NI C 0 0. 000000 90. 01 00000 1 NTENSI VE OUT PATI ENT PROGRAM 0 0 0. 000000 90. 01 09001 INTENSI VE OUT PATI ENT PROGRAM 0 0 0. 000000 90. 01 09000 CMBCREGENCY 10, 795, 636 71, 970, 397 0. 150001 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 3, 023, 436 5, 763, 055 0. 524624 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 3, 023, 436 5, 763, 055 0. 524624 92. 00 09200 OBSERVATI ON BEDS COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 11300 INTEREST EXPENSE 113. 00 Less Observati on Beds 3, 023, 436 0 0 00 0000 0000 0000 0000 0000 000	65. 00 06500 RESPI RATORY THERAPY	2, 990, 252	14, 879, 582	0. 20096	53	65. 00
68.00 06800 SPEECH PATHOLOGY 127, 208 367, 031 0.346587 68.00 69.00 69.00 ELECTROCARDI OLOGY 0 0 0.000000 69.00 71.00 7100 MEDI CAL SUPPLIES CHARGED TO PATIENT 722, 748 4, 981, 704 0.145080 71.00 7200 IMPL. DEV. CHARGED TO PATIENTS 939, 263 3, 774, 021 0.248876 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 9, 172, 750 37, 800, 748 0.242661 73.00 76.97 CARDI AC REHABILITATION 0 0 0.000000 76.97 CARDI AC REHABILITATION 0 0.244754 76.98 76.99 07699 HYPERBARI C 0XYGEN THERAPY 5, 972 24, 400 0.244754 76.98 07699 LI THOTRI PSY 0 0 0.000000 76.99 UI THOTRI PSY 0 0 0.000000 76.99 UI THOTRI PSY 0 0 0.000000 90.00 90.01 09001 INTENSI VE OUT PATIENT PROGRAM 0 0 0.000000 90.01 09001 INTENSI VE OUT PATIENT PROGRAM 0 0 0.000000 90.01 09000 EMERGENCY 10, 795, 636 71, 970, 397 0.150001 91.00 92.00 08SERVATION BEDS (NON-DISTINCT PART 3, 023, 436 5, 763, 055 0.524624 92.00 07500 AMBULANCE SERVI CES 4, 624, 207 13, 315, 606 0.347277 95.00 09500 AMBULANCE SERVI CES 4, 624, 207 13, 315, 606 0.347277 95.00 09500 AMBULANCE SERVI CES 3, 023, 436 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	66. 00 06600 PHYSI CAL THERAPY	1, 934, 636	7, 489, 049	0. 25832	29	66.00
69. 00		1, 791, 897	2, 180, 898	0. 82163	33	67. 00
71. 00	68.00 06800 SPEECH PATHOLOGY	127, 208	367, 031	0. 34658	37	68. 00
72. 00	69. 00 06900 ELECTROCARDI OLOGY	0	0	0. 00000	00	69.00
73. 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	722, 748	4, 981, 704	0. 14508	30	71.00
76. 97 76. 98 76. 98 76. 98 76. 99 76	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	939, 263	3, 774, 021	0. 24887	76	72.00
76. 98	73.00 07300 DRUGS CHARGED TO PATIENTS	9, 172, 750	37, 800, 748	0. 24266	51	73.00
76. 99 07699 LITHOTRI PSY 0 0 0.000000 76. 99 00TPATI ENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 0 0 0.000000 90. 01 09001 INTENSI VE OUT PATI ENT PROGRAM 0 0 0.000000 90. 01 91. 00 09100 EMERGENCY 10, 795, 636 71, 970, 397 0.150001 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 3, 023, 436 5, 763, 055 0.524624 92. 00 07400 AMBULANCE SERVI CES 4, 624, 207 13, 315, 606 0.347277 95. 00 09500 AMBULANCE SERVI CES 4, 624, 207 13, 315, 606 0.347277 95. 00 09500 AMBULANCE SERVI CES 5 0.000 AMBULANCE SERVI CES 5 0.0000 AMBULANCE SERVI CES 5	76. 97 07697 CARDIAC REHABILITATION	0	0	0. 00000	00	76. 97
OUTPATIENT SERVICE COST CENTERS   O	76. 98 07698 HYPERBARI C OXYGEN THERAPY	5, 972	24, 400	0. 24475	54	76. 98
90. 00   09000   CLINIC   0   0   0.000000   90. 01   90. 00   0.000000   90. 01   9	76. 99 07699 LI THOTRI PSY	0	0	0. 00000	00	76. 99
90. 01   09001   INTENSIVE OUT PATIENT PROGRAM   0   0   0.0000000   90. 01   91. 00   91. 00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART   3, 023, 436   5, 763, 055   0.524624   92. 00   09500   AMBURANCE SERVICES   4, 624, 207   13, 315, 606   0.347277   95. 00   09500   AMBURANCE SERVICES   4, 624, 207   13, 315, 606   0.347277   95. 00   09500   AMBURANCE SERVICES   4, 624, 207   13, 315, 606   0.347277   95. 00   09500   AMBURANCE SERVICES   13. 00   11300   INTEREST EXPENSE   113. 00   200. 00   201. 00	OUTPATIENT SERVICE COST CENTERS					
91. 00	90. 00 09000 CLI NI C	0	0	0.00000	00	90.00
92. 00	90.01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0. 00000	00	90. 01
07HER REIMBURSABLE COST CENTERS 095.00   O9500   AMBULANCE SERVICES   4, 624, 207   13, 315, 606   0. 347277   95.00   SPECIAL PURPOSE COST CENTERS 113.00   11300   INTEREST EXPENSE   113.00   200.00   Subtotal (sum of lines 50 thru 199)   57, 583, 916   315, 262, 467   200.00   201.00   Less Observation Beds   3, 023, 436   0   201.00	91. 00 09100 EMERGENCY	10, 795, 636	71, 970, 397	0. 15000	)1	91.00
95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 023, 436	5, 763, 055	0. 52462	24	92.00
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   200.00   Subtotal (sum of lines 50 thru 199)   57,583,916   315,262,467   200.00   201.00   Less Observation Beds   3,023,436   0   201.00	OTHER REIMBURSABLE COST CENTERS					
113. 00   200. 00   201. 00   Subtotal (sum of lines 50 thru 199)   Less Observation Beds   57, 583, 916   315, 262, 467   200. 00   201. 00   201. 00   3, 023, 436   0   201. 00	95. 00 09500 AMBULANCE SERVICES	4, 624, 207	13, 315, 606	0. 34727	77	95.00
200.00 Subtotal (sum of lines 50 thru 199) 57,583,916 315,262,467 201.00 Less Observation Beds 3,023,436 0 201.00	SPECIAL PURPOSE COST CENTERS					
201.00 Less Observation Beds 3,023,436 0 201.00	113. 00 11300   I NTEREST EXPENSE					113.00
201.00 Less Observation Beds 3,023,436 0 201.00	200.00 Subtotal (sum of lines 50 thru 199)	57, 583, 916	315, 262, 467			200. 00
202.00   Total (line 200 minus line 201)   54,560,480   315,262,467   202.00	201.00 Less Observation Beds	3, 023, 436				201.00
	202.00   Total (line 200 minus line 201)	54, 560, 480	315, 262, 467			202. 00

Health Financial Systems	WHITLEY MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Period: From 01/01/2022		
			-	Го 12/31/2022	Date/Time Pre 5/15/2023 4:0	
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient		
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			T			
30. 00 ADULTS & PEDIATRICS	1, 619, 682	0	1, 619, 68		248. 91	30.00
43. 00 NURSERY	61, 404		61, 40	532	115. 42	
44.00 SKILLED NURSING FACILITY	0			0	0.00	
200.00 Total (lines 30 through 199)	1, 681, 086		1, 681, 08	7, 039		200.00
Cost Center Description	Inpatient	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
	/ 00	col . 6)	-			
INDATIENT DOUTINE CEDVICE COCT CENTEDO	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	1 000	272.050	I			20.00
30. 00 ADULTS & PEDIATRICS	1, 093	272, 059				30.00
43. 00 NURSERY	0	0				43.00
44.00 SKILLED NURSING FACILITY	1 000	0 272 050				44.00
200.00 Total (lines 30 through 199)	1, 093	272, 059	I			200. 00

Health Financial Systems	WHITLEY MEMORIAL H	HOSPI TAL	In Lieu	of Form CMS-2552-10
ADDODTIONMENT OF INDATIENT ANCILLARY	SEDVICE CADITAL COSTS I	Provider CCN: 15-0101	Pari ad:	Workshoot D

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der Co		Period: From 01/01/2022		
				To 12/31/2022	Date/Time Pre 5/15/2023 4:0	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpati ent	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS			,			
50.00   05000   OPERATING ROOM	726, 187				•	1
52.00   05200   DELIVERY ROOM & LABOR ROOM	145, 924	4, 539, 944			333	
53. 00   05300   ANESTHESI OLOGY	0	0	0. 00000		0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 069, 675					
60. 00   06000   LABORATORY	540, 604	49, 670, 033			14, 985	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0. 00000		0	
65. 00 06500 RESPI RATORY THERAPY	293, 869				15, 501	65.00
66. 00   06600 PHYSI CAL THERAPY	486, 507	7, 489, 049		.,	•	1
67. 00 06700 OCCUPATI ONAL THERAPY	142, 192			·	•	1
68. 00   06800   SPEECH PATHOLOGY	10, 063	367, 031		·	1, 242	
69. 00   06900   ELECTROCARDI OLOGY	0	0	0. 00000		0	07.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	68, 374			·	2, 984	
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS	73, 075	3, 774, 021	0. 01936	3 28, 739	556	72.00
73.00   07300   DRUGS CHARGED TO PATIENTS	749, 343	37, 800, 748	0. 01982	3 1, 353, 059	26, 822	73.00
76. 97   07697   CARDI AC REHABI LI TATI ON	0	0	0.00000	0 0	0	76. 97
76.98 07698 HYPERBARIC OXYGEN THERAPY	465	24, 400	0. 01905	7 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0. 00000	0 0	0	76. 99
OUTPAȚI ENT SERVI CE COST CENTERS						
90. 00  09000   CLI NI C	0	0	0. 00000		0	70.00
90.01 09001 NTENSIVE OUT PATIENT PROGRAM	0	0	0. 00000		0	90. 01
91. 00   09100   EMERGENCY	1, 242, 254				28, 406	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	364, 161	5, 763, 055	0. 06318	9 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES					ı	95.00
200.00   Total (lines 50 through 199)	5, 912, 693	301, 946, 861		7, 130, 598	130, 589	200.00

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS		<u> </u>	Period: From 01/01/2022 Fo 12/31/2022	Worksheet D Part III Date/Time Pre 5/15/2023 4:0	
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments		_		Cost	
	1A	1. 00	2A	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	(	0	0	30.00
43. 00   04300 NURSERY	0	0		0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		o		44.00
200.00 Total (lines 30 through 199)	0	0		o	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem	I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col . 6)		
	instructions)	minus col. 4)		·		
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	6, 50	0.00	1, 093	30.00
43. 00   04300 NURSERY		0	532	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	7, 039	9	1, 093	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 Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0101	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2022	Part IV

THROOC				1	o 12/31/2022	Date/Time Pre 5/15/2023 4:0	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING 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
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	(	0	0	73.00
	07697 CARDI AC REHABI LI TATI ON	0	0	(	0	0	76. 97
	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	70.00
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						1
	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	0	0	(	0	0	200.00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS   Provider CCN: 15-0	
		From 01/01/2022   Dorst 11/

From 01/01/2022 | Part IV To 12/31/2022 | Date/Time Prepared: THROUGH COSTS 5/15/2023 4:07 pm Title XVIII Hospi tal Cost Center Description All Other Total Cost Ratio of Cost Total Total Charges to Charges Medi cal (sum of cols. Outpati ent (from Wkst. 1, 2, 3, and 4) C, Part I, (col. 5 ÷ Educati on Cost (sum of Cost col s. 2, 3, col. 8) col. 7) and 4) (see instructions) 7. 00 4. 00 5.00 6.00 8. 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 35, 094, 662 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 4, 539, 944 0.000000 52.00 52.00 0 0 0 0 0 0 0 0 0 0 0 0 0 05300 ANESTHESI OLOGY 0 0.000000 53.00 53.00 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 63, 411, 337 0.000000 54.00 60.00 06000 LABORATORY 0 0 49, 670, 033 0.000000 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0.000000 62.30 06500 RESPIRATORY THERAPY 0 14, 879, 582 0.000000 65.00 0 65.00 0 66.00 06600 PHYSI CAL THERAPY 0 7, 489, 049 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 2, 180, 898 0.000000 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 367, 031 0.000000 68.00 0 06900 ELECTROCARDI OLOGY 0 0.000000 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 4, 981, 704 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 3, 774, 021 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 37, 800, 748 0.000000 73 00 73 00 0 07697 CARDIAC REHABILITATION 76. 97 0 0.000000 76.97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 24, 400 0.000000 76.98 07699 LI THOTRI PSY 0 76.99 0 0.000000 76.99 0 OUTPATIENT SERVICE COST CENTERS 90.00 0.000000 90.00 09000 CLI NI C 0 0 0 0 0 90.01 09001 INTENSIVE OUT PATIENT PROGRAM 0 0 0.000000 90.01 0 0 71, 970, 397 91.00 09100 EMERGENCY 0 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 5, 763, 055 0.000000 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00 0 0 Total (lines 50 through 199) 0 301, 946, 861 200.00 200.00

Health Financial Systems		WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OTHROUGH COSTS	OUTPATIENT ANCILLARY	SERVICE OTHER PASS	S Provider C		Period: From 01/01/2022 To 12/31/2022		
			Title	xVIII	Hospi tal	PPS	, p
Cost Center Des	cri pti on	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷		Costs (col. 8	3	Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	

					3/ 13/ 2023 4.0	, biii
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷	-	Costs (col. 8	-	Costs (col. 9	
	col. 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	400, 972	0	2, 640, 716	0	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000	10, 364	0	10, 364	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0	0	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	1, 058, 238	0	9, 043, 197	0	54.00
60. 00   06000   LABORATORY	0. 000000	1, 376, 779	0	1, 523, 555	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	0	0	0	62.30
65. 00 06500 RESPIRATORY THERAPY	0. 000000	784, 837	0	2, 606, 262	0	65.00
66. 00   06600 PHYSI CAL THERAPY	0. 000000	114, 150	0	114, 150	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	95, 044	0	96, 062	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	45, 294	0	45, 294	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	217, 431	0	508, 705	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	28, 739	0	266, 876	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 353, 059	0	12, 164, 011	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	7, 868	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0	0	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS			·	-		
90. 00 09000 CLI NI C	0. 000000	0	0	0	0	90.00
90.01 09001 INTENSIVE OUT PATIENT PROGRAM	0. 000000	0	o	0	0	90. 01
91. 00 09100 EMERGENCY	0. 000000	1, 645, 691	o	10, 511, 912	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	o	1, 061, 056	0	92.00
OTHER REIMBURSABLE COST CENTERS		-	-1	, ,		
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)		7, 130, 598	0	40, 600, 028	0	200.00

Health Financial Systems	WHITLEY MEMORIAL	_ HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-0101	From 01/01/2022	Worksheet D Part V Date/Time Prepared: 5/15/2023 4:07 pm
		T1 11 \0.0111		000

					To 12/31/2022	Date/Time Pre 5/15/2023 4:0	
			Title	: XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	·	Charge Ratio	Reimbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	0. 150148		(	0	396, 498	1
	O DELIVERY ROOM & LABOR ROOM	0. 399547		(	0	4, 141	
	O ANESTHESI OLOGY	0. 000000		(	0	0	
	O RADI OLOGY-DI AGNOSTI C	0. 131507	9, 043, 197	(	0	1, 189, 244	
60.00 0600	O LABORATORY	0. 121473		(	0	185, 071	60.00
62. 30 0625	O BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	(	0	0	62. 30
65. 00 0650	O RESPI RATORY THERAPY	0. 200963	2, 606, 262	(	0	523, 762	65.00
66. 00 0660	O PHYSI CAL THERAPY	0. 258329	114, 150	(	0	29, 488	66.00
67. 00 0670	O OCCUPATIONAL THERAPY	0. 821633	96, 062	(	0	78, 928	67.00
68. 00 0680	O SPEECH PATHOLOGY	0. 346587	45, 294	(	0	15, 698	68. 00
69. 00 0690	O ELECTROCARDI OLOGY	0. 000000	0	(	0	0	69.00
71. 00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENT	0. 145080	508, 705	(	0	73, 803	71.00
72. 00 0720	O IMPL. DEV. CHARGED TO PATIENTS	0. 248876	266, 876	(	0	66, 419	72.00
73. 00 0730	O DRUGS CHARGED TO PATIENTS	0. 242661	12, 164, 011	(	0	2, 951, 731	73.00
76. 97 0769	7 CARDIAC REHABILITATION	0. 000000	0	(	0	0	76. 97
76. 98 0769	8 HYPERBARIC OXYGEN THERAPY	0. 244754	7, 868	(	0	1, 926	76. 98
76. 99 0769	9 LI THOTRI PSY	0. 000000	0	(	0	0	76. 99
OUTP.	ATIENT SERVICE COST CENTERS						1
90.00 0900	O CLI NI C	0. 000000	0	(	0	0	90.00
90. 01 0900	1 INTENSIVE OUT PATIENT PROGRAM	0. 000000	0	(	0	0	90. 01
91.00 0910	O EMERGENCY	0. 150001	10, 511, 912		0	1, 576, 797	91.00
92.00 0920	O OBSERVATION BEDS (NON-DISTINCT PART	0. 524624	1, 061, 056		0	556, 655	
OTHE	R REIMBURSABLE COST CENTERS						1
95. 00 0950	O AMBULANCE SERVICES	0. 347277		(			95. 00
200.00	Subtotal (see instructions)		40, 600, 028	(	0	7, 650, 161	200.00
201. 00	Less PBP Clinic Lab. Services-Program				0		201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		40, 600, 028	(	0	7, 650, 161	202. 00

Health Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lieu	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provider C	CN: 15-0101	Peri od: From 01/01/2022	Worksheet D	pared:
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				

					5/15/2023 4:0	)7 pm
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
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						
50.00   05000   OPERATING ROOM	0	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00   05300   ANESTHESI OLOGY	0	0				53.00
54. 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 RESPIRATORY 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
76. 97 07697 CARDIAC REHABILITATION	0	0	)			76. 97
76. 98 07698 HYPERBARIC OXYGEN THERAPY	0	0	)			76. 98
76. 99   07699 LI THOTRI PSY	0	0				76. 99
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
91. 00   09100   EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0					95.00
200.00 Subtotal (see instructions)	0	0	)			200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00   Net Charges (line 200 - line 201)	0	0				202. 00

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2022		
				To 12/31/2022	Date/Time Pre 5/15/2023 4:0	pared: 7 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1, 619, 682	0	1, 619, 68		248. 91	30.00
43. 00 NURSERY	61, 404		61, 40	4 532	115. 42	
44.00   SKILLED NURSING FACILITY	0			0	0.00	1
200.00 Total (lines 30 through 199)	1, 681, 086		1, 681, 08	5 7, 039		200.00
Cost Center Description	Inpatient	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col . 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS			ı			
30. 00 ADULTS & PEDIATRICS	40	9, 956	•			30.00
43. 00 NURSERY	15	1, 731				43.00
44.00 SKILLED NURSING FACILITY	0	0				44.00
200.00 Total (lines 30 through 199)	55	11, 687				200. 00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu o	of Form CMS-2552-10
ADDODTIONMENT OF INDATIENT ANCILLAE	V SERVICE CARLEAL COSTS   Drovi don	CCN: 15 0101 Port od: W	orkshoot D

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2022 To 12/31/2022	Part II	narad.
				10 12/31/2022	Date/Time Pre 5/15/2023 4:0	pareu: 7 pm
		Ti tl	e XIX	Hospi tal	PPS	, p
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	726, 187				•	
52.00 05200 DELIVERY ROOM & LABOR ROOM	145, 924	4, 539, 944			2, 040	
53. 00   05300   ANESTHESI OLOGY	0	0	0. 00000		0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 069, 675		1			54.00
60. 00   06000   LABORATORY	540, 604	49, 670, 033			843	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0. 00000		0	62. 30
65. 00 06500 RESPIRATORY THERAPY	293, 869		1		449	65.00
66. 00 06600 PHYSI CAL THERAPY	486, 507	7, 489, 049			64	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	142, 192				50	67.00
68.00 06800 SPEECH PATHOLOGY	10, 063	367, 031			0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000		0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	68, 374		1	•	253	71.00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS	73, 075	3, 774, 021	0. 01936		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	749, 343	37, 800, 748			1, 143	
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0	0. 00000		0	76. 97
76. 98   07698   HYPERBARI C OXYGEN THERAPY	465	24, 400			0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0.00000	00	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	00	0	90. 01
91. 00   09100   EMERGENCY	1, 242, 254	71, 970, 397	0. 01726	53, 853	930	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	364, 161	5, 763, 055	0. 06318	89 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00   Total (lines 50 through 199)	5, 912, 693	301, 946, 861	[	521, 565	10, 321	200. 00

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P.	ASS THROUGH COS	TS Provider C		Period: From 01/01/2022 Fo 12/31/2022	Worksheet D Part III Date/Time Pre 5/15/2023 4:0	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng Program	Nursi ng Program	Allied Health Post-Stepdown	Allied Health Cost	All Other Medical	
	Post-Stepdown Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDI ATRI CS	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		o	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem	I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col . 6)		
		minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	0,00		40	
43. 00   04300   NURSERY		0	532			
44.00 04400 SKILLED NURSING FACILITY		0	(	0.00	0	
200.00 Total (lines 30 through 199)		0	7, 039	9	55	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	9.00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
43. 00   04300   NURSERY	0					43.00
44. 00   04400   SKILLED NURSING FACILITY						44.00
200.00 Total (lines 30 through 199)	0					200.00
200.00   10tal (111163 30 till ough 177)	١					1200.00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS   Provider CCN: 15-0101	Peri od: Worksheet D
THROUGH COSTS		From 01/01/2022 Part IV

THROUG	in C0515				To 12/31/2022	Date/Time Pre 5/15/2023 4:0	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	1	0	0	00.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	1	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0	0	54.00
60.00	06000 LABORATORY	0	0	1	0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	1	0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0	0	1	0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0	0	1	0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	1	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	1	0	0	68. 00
	06900 ELECTROCARDI OLOGY	0	0	1	0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1	0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	1	0	0	73.00
	07697   CARDI AC REHABI LI TATI ON	0	0	1	0	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	0	1	0	0	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	1	0	0	90.00
	09001 INTENSIVE OUT PATIENT PROGRAM	0	0	1	0	0	90. 01
	09100 EMERGENCY	0	0	1	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		(	)	0	92.00
	OTHER REIMBURSABLE COST CENTERS						1
	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	0	0	1	0	0	200.00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS   Provider CCN:	: 15-0101 Peri od:	Worksheet D

From 01/01/2022 Part IV To 12/31/2022 Date/Time Prepared: THROUGH COSTS 5/15/2023 4:07 pm Title XIX Hospi tal All Other Total Cost Total Charges Ratio of Cost Cost Center Description Total to Charges Medi cal (sum of cols. Outpati ent (from Wkst. 1, 2, 3, and 4) C, Part I, Educati on Cost (sum of (col. 5 ÷ Cost col s. 2, 3, col. 8) col. 7) and 4) (see instructions) 7. 00 4. 00 5.00 6.00 8. 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 35, 094, 662 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 4, 539, 944 0.000000 52.00 52.00 0 0 0 0 0 0 0 0 0 0 0 0 0 05300 ANESTHESI OLOGY 0 0.000000 53.00 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 63, 411, 337 0.000000 54.00 60.00 06000 LABORATORY 0 0 49, 670, 033 0.000000 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0.000000 62.30 0 14, 879, 582 65.00 06500 RESPIRATORY THERAPY 0 0.000000 65.00 0 66.00 06600 PHYSI CAL THERAPY 0 7, 489, 049 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 2, 180, 898 0.000000 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 367, 031 0.000000 68.00 0 06900 ELECTROCARDI OLOGY 0.000000 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 4, 981, 704 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 3, 774, 021 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 37, 800, 748 0.000000 73 00 Ω 73 00 0 76. 97 07697 CARDIAC REHABILITATION 0 0.000000 76.97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 24, 400 0.000000 76.98 07699 LI THOTRI PSY 0 76.99 0 0.000000 76.99 0 OUTPATIENT SERVICE COST CENTERS 90.00 0.000000 90.00 09000 CLI NI C 0 0 0 0 0 90.01 09001 INTENSIVE OUT PATIENT PROGRAM 0 0.000000 90.01 0 0 71, 970, 397 91.00 09100 EMERGENCY 0 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 5, 763, 055 0.000000 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00

0

0

0

301, 946, 861

200.00

Total (lines 50 through 199)

200.00

Heal th Financial	Systems		WHIT	LEY MEMOR	AL HOSPI	TAL		In Lieu	u of Form C	MS-2552-10
APPORTIONMENT OF THROUGH COSTS	I NPATI ENT/OUTPATI ENT	ANCI LLARY	SERVI CE	OTHER PAS	3 Provi	der CCN	N: 15-0101	od: 01/01/2022 12/31/2022		Prepared:

THROUG	H COSTS				Fo 12/31/2022	Date/Time Pre	
			T	VI V		5/15/2023 4: 0	7 pm
	0	0.1		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 ÷		Costs (col. 8		Costs (col. 9	
		col . 7)		x col. 10)		x col . 12)	
	ANOLLI ADV. CEDVI OF COCT. CENTERS	9. 00	10. 00	11. 00	12. 00	13. 00	
F0 00	ANCILLARY SERVICE COST CENTERS	0.000000	101.05/				
	05000 OPERATING ROOM	0. 000000	191, 856		0	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	63, 457	(	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0	(	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	34, 303		0	0	54.00
60.00	06000 LABORATORY	0. 000000	77, 487	(	0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	(	0	0	62.30
65. 00	06500 RESPI RATORY THERAPY	0. 000000	22, 755		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	992	(	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	763	(	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	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. 000000	18, 443		0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	57, 656		0	0	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0	0	76. 98
	07699 LI THOTRI PSY	0. 000000	0		0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS	0.00000			-		
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
	09100 EMERGENCY	0. 000000	53, 853		0	O	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95.00
200.00			521, 565	(	0	0	200.00
	· · · · · · · · · · · · · · · · · · ·	•		•	•	'	•

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu of Fo	orm CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 1	5-0101 Peri od: Works	

To 12/31/2022 Date/Time Prepared: 5/15/2023 4:07 pm Title XIX Hospi tal PPS Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Part I, col. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0. 150148 361, 935 05200 DELIVERY ROOM & LABOR ROOM 0. 399547 0 52.00 0 52.00 0 05300 ANESTHESI OLOGY 0.000000 0 53.00 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.131507 0 0 677, 684 54.00 60.00 06000 LABORATORY 0. 121473 0 522, 298 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0.000000 0 0 0 62.30 06500 RESPIRATORY THERAPY 0 65.00 0. 200963 0 94, 939 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 258329 51, 416 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.821633 0 8, 502 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 0.346587 68.00 5,007 0 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.145080 48, 762 71.00 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 248876 0 72.00 72 00 40 836 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0. 242661 0 106, 425 0 73.00 76. 97 07697 CARDIAC REHABILITATION 0.000000 0 0 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 76. 98 0. 244754 0 0 0 07699 LI THOTRI PSY 0.000000 0 76. 99 76. 99 0 Ω 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 0 90.00 0 90.01 09001 INTENSIVE OUT PATIENT PROGRAM 0.000000 0 ol 0 90.01 0 91 00 09100 EMERGENCY 0.150001 0 1, 274, 758 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0.524624 0 52, 839 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0. 347277 255, 213 95.00 Subtotal (see instructions) 0 200.00 200.00 Ω 3, 245, 401 255, 213 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges 0 202.00 202.00 Net Charges (line 200 - line 201) 255, 213 3, 245, 401

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0101	Period: From 01/01/2022	Worksheet D Part V Date/Time Prepared:

				To 12/31/2022	Date/Time Pro 5/15/2023 4:0	
-		Ti tl	e XIX	Hospi tal	PPS	от рііі
	Cos	sts				
Cost Center Description	Cost	Cost				
· ·	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	54, 344				50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00   05300   ANESTHESI OLOGY	0	0				53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	89, 120				54.00
60. 00   06000   LABORATORY	0	63, 445				60.00
62.30   06250   BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62. 30
65. 00 06500 RESPIRATORY THERAPY	0	19, 079				65.00
66. 00 06600 PHYSI CAL THERAPY	0	13, 282				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	6, 986				67.00
68. 00 06800 SPEECH PATHOLOGY	0	1, 735				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	7, 074				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	10, 163				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	25, 825				73.00
76. 97   07697   CARDI AC   REHABI LI TATI ON	0	0				76. 97
76. 98 07698 HYPERBARIC OXYGEN THERAPY	0	0				76. 98
76. 99 07699 LI THOTRI PSY	0	0				76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0				90.00
90.01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0	1			90. 01
91. 00   09100   EMERGENCY	0					91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0	27, 721				92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00   09500   AMBULANCE SERVI CES	88, 630					95.00
200.00 Subtotal (see instructions)	88, 630	509, 989				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00   Net Charges (line 200 - line 201)	88, 630	509, 989				202. 00

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0101	Peri od: From 01/01/2022	Worksheet D-1	
			To 12/31/2022	Date/Time Pre 5/15/2023 4:0	pared: 7 pm
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					

		Title XVIII	Hospi tal	PPS	<u>, biii </u>
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day	s, excluding newborn)		6, 507	1.00
2.00	Inpatient days (including private room days, excluding swing-			6, 507	2.00
3. 00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	ivate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ed days)		5, 044	4.00
5. 00	Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost	0	5.00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private 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 roo	m days) through December	31 of the cost	0	7. 00
7.00	reporting period	iii days) tiii dagii beeciiibei	01 01 110 0031	Ü	7.00
8.00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	a the Dragram (avaluding	owing had and	1, 093	9. 00
9. 00	Total inpatient days including private room days applicable t newborn days) (see instructions)	o the Program (excruding	Swing-bed and	1, 093	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	oom days)	0	10.00
44.00	through December 31 of the cost reporting period (see instruc				44.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		oom days) after	0	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI		e room davs)	0	12.00
	through December 31 of the cost reporting period	3 .	,		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14.00
15. 00	Total nursery days (title V or XIX only)	am (excluding swing-bed	uays)	0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0. 00	19. 00
20 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0.00	20.00
20.00	reporting period	S di tel Becember 51 61 t	110 0031	0.00	20.00
21. 00	,			13, 447, 344	1
22. 00	Swing-bed cost applicable to SNF type services through Decemb $5 \times 1$ line 17)	er 31 of the cost report	ing period (line	0	22. 00
23. 00	,	31 of the cost reportin	a period (line 6	0	23. 00
	x line 18)		]		
24.00		r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	neriod (line 8	0	25. 00
23.00	x line 20)	or the cost reporting	perrod (Trile o	O	23.00
26.00	, ,			0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		13, 447, 344	27. 00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation had ch	arnes)	0	28. 00
	Private room charges (excluding swing-bed charges)	d and observation bed ch	lai ges)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	1
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	1
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0. 00 0. 00	1
35. 00	Average per diem private room cost differential (line 34 x li			0. 00	1
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	13, 447, 344	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see	instructions)		2, 066. 60	1
	Program general inpatient routine service cost (line 9 x line			2, 258, 794	1
40. 00 41. 00	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39			0 2, 258, 794	
	, , , , , , , , , , , , , , , , , , , ,		1	,	

	Financial Systems TION OF INPATIENT OPERATING COST	WHITLEY MEMORIA		CCN: 15-0101	Period:	u of Form CMS-2 Worksheet D-1	
					From 01/01/2022 To 12/31/2022		
						5/15/2023 4:0	
	Cost Center Description	Total	Ti t	le XVIII  Average Per	Hospital Program Days	PPS Program Cost	
	cost center bescription	Inpatient	Inpatient	Di em (col.		(col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
2 00	NUDSERV (+i+lo V º VIV only)	1. 00	2. 00	0 0.	4. 00 00 0	5. 00	42.
	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units			oj o.	00  0	0	42.
3. 00	INTENSIVE CARE UNIT						43.
	CORONARY CARE UNIT						44.
1	BURN INTENSIVE CARE UNIT						45. 46.
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description						17.
3. 00	Program inpatient ancillary service cost (Wk	est D 2 col 2	Line 200)			1. 00 1, 266, 453	10
3. 01	Program inpatient cellular therapy acquisiti	on cost (Worksh	, 1111e 200) eet D-6. Par	t III. line 10	), column 1)	1, 200, 433	
00	Total Program inpatient costs (sum of lines	41 through 48.0	1)(see instr	uctions)	-,,	3, 525, 247	
_	PASS THROUGH COST ADJUSTMENTS						
	Pass through costs applicable to Program inp III)	atient routine	services (fr	om Wkst. D, su	um of Parts I and	272, 059	50.
	nn) Pass through costs applicable to Program inp	atient ancillar	v services (	from Wkst. D.	sum of Parts II	130, 589	51.
	and IV)		\				
	Total Program excludable cost (sum of lines			ales est est est est est		402, 648	
	Total Program inpatient operating cost exclu medical education costs (line 49 minus line		ιατeα, non-p	nysician anesi	rnetist, and	3, 122, 599	53
	TARGET AMOUNT AND LIMIT COMPUTATION	32)					1
	Program di scharges						54
	Target amount per discharge					0.00	
	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	uco only)				0. 00 0. 00	
	Target amount (line 54 x sum of lines 55, 55					0.00	1
	Difference between adjusted inpatient operat		rget amount	(line 56 minus	s line 53)	ő	
.00	Bonus payment (see instructions)	9		•	•	0	58
	Trended costs (lesser of line 53 ÷ line 54,		the cost re	porting period	d ending 1996,	0. 00	59
	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,		m nrior vear	· cost renort	undated by the	0.00	60
	market basket)	01 11110 00 110	piroi yeai	cost report,	apacited by the	0.00	
	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x	ser of 50% of t	he amount by	/ which operati	ng costs (line	0	61
	enter zero. (see instructions)						/ ,
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	62
	PROGRAM INPATIENT ROUTINE SWING BED COST	(555 111511 4	01.0)				"
	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of t	he cost report	ting period (See	0	64
	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	or 31 of the	cost reporti	na neriod (See	0	65
	instructions)(title XVIII only)	its arter becomb	ci 3i di tile	. cost reportir	ig perrou (see		03
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	<pre>II only); for</pre>	0	66
	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	no costs through	Docombox 21	of the cost :	conorting paris-	_	67
	(line 12 x line 19)	ie costs through	December 31	or the cost r	eporting period	0	0/
. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 c	of the cost rep	oorting period	0	68
	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routing costs (	lino 47 . li	20 (0)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER N					0	1 09
. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	tine service	cost (line 37	7)		70
1	Adjusted general inpatient routine service o		ine 70 ÷ lir	ie 2)			71
	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 v	line 35)			72
	medically necessary private room cost appile Total Program general inpatient routine serv		•				74
	Capital-related cost allocated to inpatient				Part II, column		75
	26, line 45)	0)					
	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76
	Inpatient routine service costs (line 9 x line Inpatient routine service cost (line 74 minu						78
	Aggregate charges to beneficiaries for exces		rovider reco	ords)			79
00	Total Program routine service costs for comp	parison to the c			nus line 79)		80
	Inpatient routine service cost per diem limi						81
1	Inpatient routine service cost limitation (I		•				82
	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in		5)				83
	Utilization review – physician compensation		ns)				85
1	Total Program inpatient operating costs (sum						86
F	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					1, 463	
. 00							

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/15/2023 4:0	pared: 7 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions	)			3, 023, 436	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	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, 619, 682	13, 447, 344	0. 12044	6 3, 023, 436	364, 161	90.00
91.00 Nursing Program cost	0	13, 447, 344	0. 00000	3, 023, 436	0	91.00
92.00 Allied health cost	0	13, 447, 344	0. 00000	3, 023, 436	0	92.00
93.00 All other Medical Education	0	13, 447, 344	0. 00000	00 3, 023, 436	0	93.00

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0101	Peri od: From 01/01/2022	Worksheet D-1	
			To 12/31/2022	Date/Time Pre 5/15/2023 4:0	pared: 7 pm
		Title XIX	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					

		Title XIX	Hospi tal	PPS	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1. 00 2. 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			6, 507 6, 507	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed days)		ivate room days	0, 507	3.00
	do not complete this line.	у-у		_	
4. 00	Semi-private room days (excluding swing-bed and observation b			5, 044	4.00
5. 00	Total swing-bed SNF type inpatient days (including private reporting period	om days) through Decembe	er 31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	3 .			
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roo	m days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	dayo, arto. boodbo.		· ·	0.00
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	40	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instruc		oom days)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11. 00
12.00	December 31 of the cost reporting period (if calendar year, e		o maam daysa)	0	12.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	x only (including privat	e room days)	U	12.00
13.00		X only (including privat	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y			_	
14. 00 15. 00		am (excluding swing-bed	days)	0 532	14. 00 15. 00
	Nursery days (title V or XIX only)			15	
	SWI NG BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	of the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
10.00	reporting period	es arter becomber 51 or	the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period	s after December 21 of t	ho cost	0. 00	20. 00
20.00	Medicaid rate for swing-bed NF services applicable to service reporting period	s arter becember 31 or t	THE COST	0.00	20.00
21. 00	Total general inpatient routine service cost (see instruction			13, 447, 344	21. 00
22. 00	] 3	er 31 of the cost report	ing period (line	. 0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	na neriod (line A	0	23. 00
20.00	x line 18)	or or the cost reporting	ig perrod (Trile o		20.00
24. 00		r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	21 of the cost reporting	noried (line 9	0	25. 00
25.00	x line 20)	31 of the cost reporting	perrou (Trie 6	U	25.00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00		(line 21 minus line 26)		13, 447, 344	27. 00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation hed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	a and observation bea on	lai ges)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	,	÷ line 28)		0.000000	•
32. 00 33. 00				0. 00 0. 00	•
34. 00		nus line 33)(see instruc	tions)	0. 00	•
35. 00		ne 31)		0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35)	and private room cost di	fforontial (line	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	rrerentiai (IINe	13, 447, 344	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00 -	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
38. 00 39. 00		•		2, 066. 60 82, 664	38. 00 39. 00
40. 00				82, 664	40.00
	Total Program general inpatient routine service cost (line 39			82, 664	

	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24. 00
25. 00		0	25. 00
26.00	Total swing-bed cost (see instructions)	0	26.00
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	13, 447, 344	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		1
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Pri vate room charges (excluding swing-bed charges)	0	29.00
30.00	Semi -pri vate room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
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)	0. 00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	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 and private room cost differential (line	13, 447, 344	37.00
	27 minus line 36)		1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		1
	Program general inpatient routine service cost (line 9 x line 38)	82, 664	39.00
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	82, 664	41.00

COMI CIATION OF TWIATI	ENT OPERATING COST		Provi der C		Peri od:	Worksheet D-1	2552-10
					From 01/01/2022 To 12/31/2022	Date/Time Pre	
			Ti tl	e XIX	Hospi tal	5/15/2023 4: 0 PPS	и ріп
Cost Cent	er Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42 00 NUDCEDY (+:+1-	W 0 MIN and o	1. 00	2.00	3.00	4. 00	5. 00	42.00
42.00 NURSERY (title	Type Inpatient Hospital Units	757, 518	532	1, 423. 91	15	21, 359	42.00
43. 00 INTENSIVE CARE							43.00
44.00 CORONARY CARE							44.00
45. 00 BURN INTENSIVE							45.00
46. 00 SURGI CAL INTEN 47. 00 OTHER SPECIAL							46. 00 47. 00
	er Description						47.00
48.00 Program inpati	ent ancillary service cost (Wk	ct D 2 col 3	2 Line 200)			1. 00 98, 313	48. 00
	ent cellular therapy acquisiti			III. line 10.	column 1)	90, 313	1
	inpatient costs (sum of lines					202, 336	
	OST ADJUSTMENTS						
50.00 Pass through c	osts applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	11, 687	50.00
1 1	osts applicable to Program inp	atient ancillar	y services (f	rom Wkst. D, s	um of Parts II	10, 321	51.00
and IV)			•				
	excludable cost (sum of lines		alated non	veleion anacth	otict and	22, 008	1
Ŭ.	inpatient operating cost exclu- ion costs (line 49 minus line	0 .	erated, non-ph	ysician anestn	etist, and	180, 328	53.00
	AND LIMIT COMPUTATION	02)					
54.00 Program di scha	9					0	
55.00 Target amount   55.01 Permanent adju	ber discharge stment amount per discharge					0. 00 0. 00	
1	unt per discharge (contractor	use onlv)				0.00	1
1 3	(line 54 x sum of lines 55, 55	<b>J</b> ,	)			0	1
1	ween adjusted inpatient operat	ing cost and ta	arget amount (	line 56 minus	line 53)	0	
	(see instructions) (lesser of line 53 ÷ line 54,	or line 55 from	the cost ron	orting ported	onding 1006	0 0. 00	58. 00 59. 00
	mpounded by the market basket)	or title 55 from	ii the cost rep	or tring perrou	ending 1990,	0.00	39.00
60.00 Expected costs						0. 00	60.00
market basket) 61.00 Continuous imp	rovement bonus payment (if lin	e 53 ÷ line 54	is less than	the lowest of	lines 55 plus	0	61.00
53) are less t	59, or line 60, enter the les nan expected costs (lines 54 x ee instructions)						
	(see instructions)					0	
	tient cost plus incentive paym	ent (see instru	uctions)			0	63.00
	ENT ROUTINE SWING BED COST -bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost reporti	na period (See	0	64.00
i nstructi ons) (	title XVIII only)	o o		·			" " "
	-bed SNF inpatient routine cos	ts after Decemb	per 31 of the	cost reporting	period (See	0	65.00
	title XVIII only) swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	l only); for	0	66.00
CAH, see instr		•	·		3,		
67.00 Title V or XIX	swing-bed NF inpatient routing	e costs through	n December 31	of the cost re	porting period	0	67.00
	swing-bed NF inpatient routin	e costs after [	December 31 of	the cost repo	rting period	0	68. 00
(line 13 x line 69.00 Total title V	e 20) or XIX swing-bed NF inpatient	routine costs (	line 67 + line	e 68)		0	69.00
	LED NURSING FACILITY, OTHER N						37.00
	g facility/other nursing facil						70.00
	al inpatient routine service c e service cost (line 9 x line		ine /U ÷ line	2)			71.00
9	ssary private room cost applic		n (line 14 x l	ine 35)			73.00
74.00 Total Program	general inpatient routine serv	ice costs (line	e 72 + line 73	)			74.00
75.00 Capital -relate 26, line 45)	d cost allocated to inpatient	routine service	e costs (from	Worksheet B, P	art II, column		75.00
1 .	al-related costs (line 75 ÷ li	ne 2)					76. 00
77.00 Program capi ta	-related costs (line 9 x line	76)					77. 00
	ine service cost (line 74 minu			-1->			78.00
	ges to beneficiaries for exces routine service costs for comp				us line 79)		79. 00 80. 00
3	ne service cost per diem limi			( 70 mm			81.00
	ne service cost limitation (I						82.00
	atient routine service costs (		ns)				83.00
, , ,	ent ancillary services (see in view - physician compensation	,	ons)				84. 00 85. 00
	inpatient operating costs (sum						86.00
PART IV - COMPL	JTATION OF OBSERVATION BED PASS	S THROUGH COST					
	on bed days (see instructions	`				1, 463	

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO	Provider CCN: 15-0101		Worksheet D-1	
				From 01/01/2022 To 12/31/2022		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions	)			3, 023, 436	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	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, 619, 682	13, 447, 344	0. 12044	6 3, 023, 436	364, 161	90.00
91.00 Nursing Program cost	0	13, 447, 344	0.00000	00 3, 023, 436	0	91.00
92.00 Allied health cost	0	13, 447, 344	0. 00000	00 3, 023, 436	0	92.00
93.00 All other Medical Education	0	13, 447, 344	0. 00000	00 3, 023, 436	0	93.00

INPATIENT AN	NCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0101	Peri od:	Worksheet D-3	
				From 01/01/2022 To 12/31/2022	Date/Time Pre	norod.
				10 12/31/2022	5/15/2023 4:0	pareu. 17 pm
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges		Program Costs	
				Charges	(col . 1 x	
			1 00	0.00	col . 2)	
LAIDAT	LENT DOUTING CEDVICE COCT CENTEDS		1.00	2. 00	3. 00	
	I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS		1	2 407 720		30.00
	NURSERY			2, 407, 739		43.00
	LARY SERVICE COST CENTERS					43.00
	OPERATING ROOM		0. 1501	48 400, 972	60, 205	50.00
	DELIVERY ROOM & LABOR ROOM		0. 1301		4, 141	
	ANESTHESI OLOGY		0.0000		4, 141	
	RADI OLOGY-DI AGNOSTI C		0. 1315		139, 166	
	LABORATORY		0. 1214		167, 241	
	BLOOD CLOTTING FOR HEMOPHILIACS		0.0000		0	
	RESPI RATORY THERAPY		0. 2009		157, 723	
	PHYSI CAL THERAPY		0. 2583		29, 488	
67. 00 06700	OCCUPATI ONAL THERAPY		0. 8216		78, 091	67.0
68.00 06800	SPEECH PATHOLOGY		0. 3465	87 45, 294	15, 698	68.0
69.00 06900	ELECTROCARDI OLOGY		0.0000	00 0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1450	80 217, 431	31, 545	71.0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS		0. 2488	76 28, 739	7, 152	
	DRUGS CHARGED TO PATIENTS		0. 2426	61 1, 353, 059	328, 335	
	CARDI AC REHABI LI TATI ON		0.0000		0	
	HYPERBARIC OXYGEN THERAPY		0. 2447		0	
	LI THOTRI PSY		0.0000	00 0	0	76. 99
	TIENT SERVICE COST CENTERS					
90. 00 09000			0.0000		0	
	INTENSIVE OUT PATIENT PROGRAM		0.0000		0	
	EMERGENCY		0. 1504		247, 668	
	OBSERVATION BEDS (NON-DISTINCT PART		0. 5246	24 0	0	92.00
	REI MBURSABLE COST CENTERS					05 0
4	AMBULANCE SERVICES			7 120 500	1 2// 452	95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)	. (line (1)		7, 130, 598		
201.00	Less PBP Clinic Laboratory Services-Program only charges	s (Tine 61)		7 120 500		201.00
202. 00	Net charges (line 200 minus line 201)		1	7, 130, 598		202. 0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT							
NPATLENT ROUTI NE SERVICE COST CENTERS   Ratio of Cost   Inpatient   Program Cost   Col. 1 x   Col. 2)							
To 12/31/2022   Date/Time Prepared: 5/15/2023 4:07 pm	INPATIENT ANCILLA	RY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0101		Worksheet D-3	3
Title XIX						Date/Time Pre	nared.
Title XIX					10 12/31/2022		
NPATIENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3.			Ti tl	e XIX	Hospi tal		
NAME	Cost	Center Description		Ratio of Cos	t Inpatient	I npati ent	
NPATI ENT ROUTI NE SERVI CE COST CENTERS				To Charges	Program		
INPATI ENT ROUTINE SERVICE COST CENTERS   91,868   30.00					Charges		
INPATI ENT ROUTI NE SERVICE COST CENTERS   91, 868   30. 00   300. 00   300. ADULTS & PEDIATRI CS   91, 868   43. 00   43.00							
30.00				1.00	2. 00	3. 00	
43.00							
ANCILLARY SERVICE COST CENTERS   50.00							
50. 00   05000   0PERATI NG ROOM   0.150148   191,856   28,807   50.00   52.00   05200   DELIVERY ROOM & LABOR ROOM   0.399547   63,457   25,354   52.00   05300   ANESTHESI OLOGY   0.000000   0   0.53.00   0.399547   63,457   25,354   52.00   05300   ANESTHESI OLOGY   0.000000   0   0.53.00   0.000000   0   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000					26, 096		43.00
52.00   05200   DELIVERY ROOM & LABOR ROOM   0.399547   63,457   25,354   52.00   53.00   05300   ARESTHESI OLOGY   0.000000   0   53.00   0.000000   0   0.000000   0   0.000000   0				0.4504	101 057	20.007	
53.00       05300 ANESTHESI OLOGY       0.000000       0       0       53.00         54.00       05400 RADI OLOGY-DI AGNOSTI C       0.131507       34,303       4,511       54.00         60.00       06000 LABORATORY       0.121473       77,487       9,413       60.00         62.30       06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS       0.000000       0       0       62.30         65.00       06500 RESPI RATORY THERAPY       0.20963       22,755       4,573       65.00         66.00       06600 PHYSI CAL THERAPY       0.258329       992       256       66.00         67.00       06600 DROCCUPATI ONAL THERAPY       0.821633       763       627       67.00         68.00       06800 SPEECH PATHOLOGY       0.346587       0       0       68.00         69.00       06900 ELECTROCARDI OLOGY       0.000000       0       0       69.00         71.00       07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.145080       18,443       2,676       71.00         72.00       07200 IMPL. DEV. CHARGED TO PATI ENTS       0.248876       0       0       72.00         73.00       07300 DRUGS CHARGED TO PATI ENTS       0.242661       57,656       13,991       73.00							
54. 00   05400   RADI OLOGY-DI AGNOSTI C   0. 131507   34, 303   4, 511   54. 00   60. 00   05000   LABORATORY   9, 413   60. 00   62. 30   06250   BLOOD CLOTTI NG FOR HEMOPHI LI ACS   0. 0000000   0   0   62. 30   6250   BLOOD CLOTTI NG FOR HEMOPHI LI ACS   0. 0000000   0   0   62. 30   65. 00   06500   RESPI RATORY THERAPY   0. 200963   22, 755   4, 573   65. 00   06600   PHYSI CAL THERAPY   0. 823629   992   256   66. 00   06600   PHYSI CAL THERAPY   0. 823629   992   256   66. 00   06700   0000PATI ONAL THERAPY   0. 821633   763   627   67. 00   06700   0000PATI ONAL THERAPY   0. 346587   0   0   68. 00   06900   ELECTROCARDI OLOGY   0. 000000   0   0   69. 00   071. 00   071. 00   071. 00   071. 00   071. 00   071. 00   071. 00   071. 00   071. 00   071. 00   071. 00   071. 00   071. 00   071. 00   071. 00   072. 00							
60. 00   06000   LABORATORY   0. 121473   77, 487   9, 413   60. 00   62. 30   6250   BLOOD CLOTTING FOR HEMOPHILIACS   0. 000000   0   0   62. 30   62. 30   6250   BLOOD CLOTTING FOR HEMOPHILIACS   0. 000000   0   0   62. 30							
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0 0 62. 30 65. 00 6500 RESPIRATORY THERAPY 0.200963 22,755 4,573 65. 00 66. 00 06600 PHYSICAL THERAPY 0.258329 992 256 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.821633 763 627 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.346587 0 0 68. 00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 69. 00 071. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.145080 18,443 2,676 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.248876 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0.248876 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0.242661 57,656 13,991 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.244754 0 0 76. 97 76. 98 07699 HYPERBARI C OXYGEN THERAPY 0.244754 0 0 76. 98 07699 LI THOTRI ENSY 0.000000 0 0 0 76. 99 0000000 0 0 0 0 76. 99 0000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0				•			
65. 00 06500 RESPIRATORY THERAPY				•		· ·	
66. 00 06600 PHYSICAL THERAPY 0. 258329 992 256 66. 00 67. 00 06700 0CCUPATIONAL THERAPY 0. 821633 763 627 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 346587 0 0 68. 00 06900 ELECTROCARDI OLOGY 0. 0. 000000 0 0 0 68. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0. 145080 18, 443 2, 676 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 248876 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 242661 57, 656 13, 991 73. 00 76. 97 07697 CARDI AC REHABILITATION 0. 000000 0 0 0 76. 97 07697 CARDI AC REHABILITATION 0. 000000 0 0 0 76. 98 076.99 ULI THOTRI PSY 0. 000000 0 0 0 0 76. 99 0000 0000 CLI NI C 0. 000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
67. 00	1 1			•		· ·	
68. 00				•			
69. 00							
71. 00							
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 248876   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 242661   57, 656   13, 991   73. 00   76. 97   07697   CARDIA C REHABILITATION   0. 000000   0   0   0   76. 97   07698   HYPERBARI C OXYGEN THERAPY   0. 244754   0   0   0   76. 98   0. 000000   0   0   0   0   0   0   0	1 1			•		_	
73. 00							
76. 97						_	
76. 98				•			
76. 99 07699 LITHOTRI PSY 0.000000 0 0 76. 99 00TPATI ENT SERVI CE COST CENTERS  90. 00 09000 CLINI C 0.000000 0 0 0 90. 00 90. 01 090. 01 1NTENSI VE OUT PATI ENT PROGRAM 0.000000 0 0 0 90. 01 91. 00 091. 00 18MERGENCY 0.150495 53, 853 8, 105 91. 00 92. 00 08SERVATI ON BEDS (NON-DISTINCT PART 0.524624 0 0 92. 00 0716R REIMBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVI CES 95. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 521, 565 98, 313 200. 00 201. 00							
OUTPATIENT SERVICE COST CENTERS   O. 000000   O. 0   O. 0000000   O. 0   O. 00000000   O. 0   O. 00000000   O. 0   O. 000000000   O. 0   O. 00000000   O. 0   O. 000000000   O. 0   O. 0000000000						0	76. 99
90. 01   09001   INTENSIVE OUT PATIENT PROGRAM   0.000000   0   90. 01   91. 00   91. 00   92. 00   92. 00   92. 00   92. 00   92. 00   93. 00   94. 00   94. 00   95				•			
91. 00   09100   EMERGENCY   0. 150495   53, 853   8, 105   91. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART   0. 524624   0   0   92. 00   00   0THER REIMBURSABLE COST CENTERS   95. 00   200. 00   201. 00   Cless PBP Clinic Laboratory Services-Program only charges (line 61)   0   201. 00   201. 00   0. 150495   53, 853   8, 105   91. 00   92. 00   92. 00   92. 00   92. 00   92. 00   93. 00   94. 00   95. 00	90. 00 09000 CLI NI	C		0.00000	00 0	0	90.00
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART   0. 524624   0   0   92. 00   0THER REIMBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVICES   95. 00   201. 00   Less PBP Clinic Laboratory Services-Program only charges (line 61)   0   201. 00   201. 00   0. 524624   0   0   92. 00   92. 00   92. 00   92. 00   92. 00   93. 00   94. 00   95.	90. 01 09001 I NTEN	ISIVE OUT PATIENT PROGRAM		0.00000	00	0	90. 01
OTHER REIMBURSABLE COST CENTERS           95.00         09500 AMBULANCE SERVICES         95.00           200.00         Total (sum of lines 50 through 94 and 96 through 98)         521,565         98,313 200.00           201.00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         201.00	91.00 09100 EMERG	SENCY		0. 15049	95 53, 853	8, 105	91.00
95. 00	92. 00 09200 OBSER	RVATION BEDS (NON-DISTINCT PART		0. 52462	24 0	0	92.00
200.00       Total (sum of lines 50 through 94 and 96 through 98)       521,565       98,313 200.00         201.00       Less PBP Clinic Laboratory Services-Program only charges (line 61)       0       201.00	OTHER REIME	BURSABLE COST CENTERS					
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00	95. 00 09500 AMBUL	ANCE SERVICES					95.00
					521, 565	98, 313	
202.00   Net charges (line 200 minus line 201)   521,565    202.00			y charges (line 61)		_		
	202.00   Net c	charges (line 200 minus line 201)			521, 565		202.00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0101	Peri od: Worksheet E From 01/01/2022 Part A Date/Time Prepared: 5/15/2023 4:07 pm

	Title XVIII	'	Hospi tal	5/15/2023 4: 0 PPS	
			nospi tai	1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			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 instructions)				1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after 0 instructions)	october 1	(see	600, 888	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occi 1 (see instructions)	curring p	rior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occuped to the contraction of the	curri ng o	n or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2. 00 2. 01
2. 02 2. 03	Outlier payment for discharges for Model 4 BPCI (see instructions) Outlier payments for discharges occurring prior to October 1 (see instructions)	;)		0	2. 02 2. 03
2.04	Outlier payments for discharges occurring on or after October 1 (see instruction			0	2. 04
3. 00 4. 00	Managed Care Simulated Payments  Bed days available divided by number of days in the cost reporting period (see	e instruc	ti ons)	0 25. 69	3. 00 4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most recent cost rep	ortina n	oriod anding of	0.00	5. 00
	or before 12/31/1996. (see instructions)	0 .			
5. 01 6. 00	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see ins FTE count for allopathic and osteopathic programs that meet the criteria for allow programs in accordance with 42 CFR 413.79(e)			0. 00 0. 00	5. 01 6. 00
6. 26	Rural track program FTE cap limitation adjustment after the cap-building windown the CAA 2021 (see instructions)	w closed	under §127 of	0. 00	6. 26
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(			0. 00 0. 00	7. 00 7. 01
7. 02	cost report straddles July 1, 2011 then see instructions.  Adjustment (increase or decrease) to the hospital's rural track program FTE literack programs with a rural track for Medicare GME affiliated programs in acco	mi tati on	(s) for rural	0. 00	7. 02
8. 00	and 87 FR 49075 (August 10, 2022) (see instructions) Adjustment (increase or decrease) to the FTE count for allopathic and osteopatl affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64	hic prog	rams for	0. 00	8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots under § 5503			0. 00	8. 01
8. 02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots from a closed	l teaching	g hospi tal	0.00	8. 02
8. 21	under § 5506 of ACA. (see instructions) The amount of increase if the hospital was awarded FTE cap slots under §126 of	the CAA	2021 (see	0.00	8. 21
9. 00	Instructions) Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines		7.01, plus or	0.00	9. 00
10. 00	minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instruct FTE count for allopathic and osteopathic programs in the current year from you		5	0.00	
11. 00 12. 00	FTE count for residents in dental and podiatric programs.  Current year allowable FTE (see instructions)				11. 00 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 ended on or af otherwise enter zero.	ter Septe	ember 30, 1997,	0. 00	
15. 00 16. 00	Sum of lines 12 through 14 divided by 3.  Adjustment for residents in initial years of the program (see instructions)				15. 00 16. 00
17. 00	Adjustment for residents displaced by program or hospital closure				17. 00
18.00	Adjusted rolling average FTE count				18.00
19. 00 20. 00	Current year resident to bed ratio (line 18 divided by line 4).  Prior year resident to bed ratio (see instructions)			0. 000000 0. 000000	19. 00 20. 00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	21.00
22. 00 22. 01	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)			0	22. 00 22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  Number of additional allopathic and osteopathic IME FTE resident cap slots und-	lar 12 CEI	2 412 105	0.00	23. 00
	(f)(1)(iv)(C).	161 42 CI I	( 412. 103		
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the lower of line 23	or line :	24 (see	0. 00 0. 00	
26. 00	Instructions) Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27. 00 28. 00	IME payments adjustment factor. (see instructions)  IME add-on adjustment amount (see instructions)			0.000000	27. 00 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 patient days (see	instruct	ons)	4. 98	30.00
31. 00 32. 00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31			18. 64 23. 62	31. 00 32. 00
	Allowable disproportionate share percentage (see instructions)				33.00

	Financial Systems WHITLEY MEMORIA ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0101	Peri od: From 01/01/2022 To 12/31/2022	u of Form CMS-2 Worksheet E Part A Date/Time Pre	
		Title XVIII	Hospi tal	PPS	
				1. 00	
34.00	Disproportionate share adjustment (see instructions)			50, 718	34.00
			Pri or to 10/1 1.00	0n/After 10/1 2.00	
	Uncompensated Care Payment Adjustment		1.00	2.00	
35. 00	Total uncompensated care amount (see instructions)			6, 874, 403, 459	1
35. 01 35. 02	Factor 3 (see instructions) Hospital UCP, including supplemental UCP (If line 34 is zero	o. enter zero on this line	0. 000121008 870, 287	0. 000129634 891, 160	1
	(see instructions)		,		
35. 03	1	UCP (see instructions)	650, 927	224, 621	35. 03
30.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03) Additional payment for high percentage of ESRD beneficiary of	discharges (lines 40 throu	875, 548 ah 46)		36.00
40.00	Total Medicare discharges (see instructions)		0		40.00
41. 00 41. 01	Total ESRD Medicare discharges (see instructions) Total ESRD Medicare covered and paid discharges (see instruc	ctions)	0		41. 00 41. 01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qual		0. 00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)		0		43.00
44. 00	Ratio of average length of stay to one week (line 43 divided	d by line 41 divided by 7	0. 000000		44.00
45. 00	days) Average weekly cost for dialysis treatments (see instruction	ns)	0. 00		45.00
46. 00	Total additional payment (line 45 times line 44 times line 4	41. 01)	0		46.00
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH,	cmall rural bosnitals	3, 258, 136 0		47. 00 48. 00
46.00	only. (see instructions)	siliari Turai Hospi tars			40.00
				Amount	
49. 00	Total payment for inpatient operating costs (see instruction	ns)		1. 00 3, 258, 136	49 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I a			173, 312	1
51.00	Exception payment for inpatient program capital (Wkst. L, Pi			0	51.00
52. 00 53. 00	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment	line 49 see instructions).		0	52. 00 53. 00
54.00	Special add-on payments for new technologies			19, 675	ı
54. 01	Islet isolation add-on payment	(0)		0	54.01
55. 00 55. 01	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cellular therapy acquisition cost (see instructions)	69)		0	55. 00 55. 01
56. 00	Cost of physicians' services in a teaching hospital (see int	tructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt.		hrough 35).	0	57.00
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58)	. IV, COI. II II Ne 200)		0 3, 451, 123	58. 00 59. 00
60.00	,			3, 449	•
61.00	Total amount payable for program beneficiaries (line 59 minu	us line 60)		3, 447, 674	•
62. 00 63. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			384, 780 0	1
	Allowable bad debts (see instructions)			38, 484	1
65.00	1 3	-+		25, 015	
// 00	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63)	structions)		25, 313 3, 087, 909	
66. 00 67. 00		r applicable to MS-DRGs (s	ee instructions)	0	68.00
66. 00 67. 00 68. 00	Credits received from manufacturers for replaced devices for			Λ.	69.00
67. 00 68. 00 69. 00	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96)		s)	0	70 00
67. 00 68. 00 69. 00 70. 00	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	).(For SCH see instruction	,	0	70.00 70.50
67. 00 68. 00 69. 00 70. 00 70. 50 70. 75	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons N95 respirator payment adjustment amount (see instructions)	).(For SCH see instruction stration) adjustment (see	,	0 0 0	70. 50 70. 75
67. 00 68. 00 69. 00 70. 00 70. 50 70. 75 70. 87	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration	).(For SCH see instruction stration) adjustment (see	,	0 0 0	70. 50 70. 75 70. 87
67. 00 68. 00 69. 00 70. 00 70. 50 70. 75	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	).(For SCH see instruction stration) adjustment (see n	,	0 0 0	70. 50 70. 75 70. 87 70. 88
67. 00 68. 00 69. 00 70. 00 70. 50 70. 75 70. 87 70. 88 70. 89 70. 90	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions)	).(For SCH see instruction stration) adjustment (see n	,	0 0 0 0 0	70. 50 70. 75 70. 87 70. 88 70. 89 70. 90
67. 00 68. 00 69. 00 70. 00 70. 50 70. 75 70. 87 70. 88 70. 89 70. 90 70. 91	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions)	).(For SCH see instruction stration) adjustment (see n	,	0 0 0 0 0	70. 50 70. 75 70. 87 70. 88 70. 89 70. 90 70. 91
67. 00 68. 00 69. 00 70. 00 70. 50 70. 75 70. 87 70. 88 70. 89 70. 90 70. 91 70. 92	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	).(For SCH see instruction stration) adjustment (see n	,	0 0 0 0 0	70. 50 70. 75 70. 87 70. 88 70. 89 70. 90 70. 91 70. 92
67. 00 68. 00 69. 00 70. 00 70. 50 70. 75 70. 87 70. 88 70. 89 70. 90 70. 91 70. 92 70. 93 70. 94	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)	).(For SCH see instruction stration) adjustment (see n	,	0 0 0 0 0 0 0 0 -11, 319	70. 50 70. 75 70. 87 70. 88 70. 89 70. 90 70. 91 70. 92 70. 93

Heal th	Financial Systems WHITE	_EY MEMORIAL	HOSPI TAL		In Lieu	ı of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT		Provi der Co	CN: 15-0101	Peri od:	Worksheet E	
					From 01/01/2022	Part A	
					To 12/31/2022	Date/Time Pre	
			Ti +Lo	· XVIII	Hooni tal	5/15/2023 4: 0 PPS	7 pm
			l little		Hospi tal (yyyy)	Amount	
				111	0	1. 00	
70.96	Low volume adjustment for federal fiscal year (yy	vv) (Enter i	n column O		2022	369, 764	70. 96
70.70	the corresponding federal year for the period prior		ii cor allii o		2022	007,701	70.70
70. 97	Low volume adjustment for federal fiscal year (yy		n column 0		2023	103, 867	70. 97
	the corresponding federal year for the period end					,	
70. 98	Low Volume Payment-3	J	ŕ			0	70. 98
70. 99	HAC adjustment amount (see instructions)					0	70. 99
	Amount due provider (line 67 minus lines 68 plus/	minus lines	69 & 70)			3, 550, 221	71.00
71. 01	Sequestration adjustment (see instructions)					44, 733	71. 01
71. 02	Demonstration payment adjustment amount after sequ	uestration				0	71. 02
71. 03	Sequestration adjustment-PARHM or CHART pass-through	ughs					71.03
	Interim payments					3, 344, 631	
	Interim payments-PARHM or CHART						72. 01
	Tentative settlement (for contractor use only)					0	
	Tentative settlement-PARHM or CHART (for contract						73. 01
74. 00	Balance due provider/program (line 71 minus lines	71.01, 71.0	2, 72, and			160, 857	74.00
74. 01	73) Balance due provider/program-PARHM or CHART (see		`				74. 01
	Protested amounts (nonallowable cost report items					74, 141	
73.00	CMS Pub. 15-2, chapter 1, §115.2	) III accorda	nce with			74, 141	75.00
	TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96	5)		1			_
90.00	Operating outlier amount from Wkst. E, Pt. A, line		of 2.03			0	90.00
	plus 2.04 (see instructions)	, -:				_	
91. 00	Capital outlier from Wkst. L, Pt. I, line 2					0	91.00
92.00	Operating outlier reconciliation adjustment amoun	t (see instr	uctions)			0	92.00
93. 00	Capital outlier reconciliation adjustment amount	(see instruc	tions)			0	93.00
	The rate used to calculate the time value of money		uctions)			0. 00	
	Time value of money for operating expenses (see i	,				0	
96. 00	Time value of money for capital related expenses	(see instruc	tions)			0	96.00
					Prior to 10/1 1.00		
	HSP Bonus Payment Amount				1.00	2. 00	
	HSP bonus amount (see instructions)				0	0	100.00
	HVBP Adjustment for HSP Bonus Payment				<u> </u>		100.00
	HVBP adjustment factor (see instructions)				0. 0000000000	0. 0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see	instruction	s)		0	0	102.00
	HRR Adjustment for HSP Bonus Payment				<del>.</del>		
103.00	HRR adjustment factor (see instructions)				0.0000	0.0000	103. 00
104.00	HRR adjustment amount for HSP bonus payment (see				0	0	104. 00
	Rural Community Hospital Demonstration Project (§4						
200. 00	Is this the first year of the current 5-year demon		riod under	the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no	O					
204 22	Cost Reimbursement	D+ 11 11	- 40)				001 00
	Medicare inpatient service costs (from Wkst. D-1,	PT. II, lin	e 49)				201.00
	Medicare discharges (see instructions)						202.00
203.00	Case-mix adjustment factor (see instructions)	tion (NI/A '	fi not	of the	n+ E 1/00:= -l		203. 00
	Computation of Demonstration Target Amount Limitate period)	LION (N/A IN	irrst year	or the curre	ent 5-year demons	tration	
	Modicare target amount						204 00

71.00 The rate asea to carearate the trine varies of money (see that actions)		0.00	71.00
95.00 Time value of money for operating expenses (see instructions)		0	95.00
96.00 Time value of money for capital related expenses (see instructions)		0	96.00
	Prior to 10/1	On/After 10/1	
	1. 00	2. 00	
HSP Bonus Payment Amount			
100.00 HSP bonus amount (see instructions)	0	0	100.00
HVBP Adjustment for HSP Bonus Payment			
101.00 HVBP adjustment factor (see instructions)	0. 0000000000	0. 0000000000	101.00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
HRR Adjustment for HSP Bonus Payment			
103.00 HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00 Is this the first year of the current 5-year demonstration period under the 21st			200.00
Century Cures Act? Enter "Y" for yes or "N" for no.			
Cost Reimbursement			
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)		l	201. 00
202.00 Medicare discharges (see instructions)			202. 00
203.00 Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the curr	ent 5-year demons	strati on	
peri od)			
204.00 Medicare target amount		l	204.00
205.00 Case-mix adjusted target amount (line 203 times line 204)			205. 00
206.00 Medicare inpatient routine cost cap (line 202 times line 205)			206. 00
Adjustment to Medicare Part A Inpatient Reimbursement			
207.00 Program reimbursement under the §410A Demonstration (see instructions)		l .	207. 00
208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)		l .	208. 00
209.00 Adjustment to Medicare IPPS payments (see instructions)		l .	209. 00
210.00 Reserved for future use			210. 00
211.00 Total adjustment to Medicare IPPS payments (see instructions)			211. 00
Comparision of PPS versus Cost Reimbursement			
212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)		1	212. 00
213.00 Low-volume adjustment (see instructions)			213. 00
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)			218. 00
(line 212 minus line 213) (see instructions)		ĺ	

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL		In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 15-0101		Worksheet E Part B Date/Time Prepared: 5/15/2023 4:07 pm

		10 12/31/2022	5/15/2023 4: 0	
	Title XVIII	Hospi tal	PPS	
			1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		0	
2. 00	Medical and other services reimbursed under OPPS (see instructions)		7, 650, 161	2.00
3. 00	OPPS payments		4, 743, 209	3.00
4. 00	Outlier payment (see instructions)	13, 730		
4. 01	Outlier reconciliation amount (see instructions)		0	
5. 00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	1
6.00	Line 2 times line 5		0	
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	1
8. 00 9. 00	Transitional corridor payment (see instructions)  Ancillary service other pass through costs from Wkst. D, Pt. IV, 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		0	111.00
	Reasonable charges			1
12. 00	Ancillary service charges		0	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	
	Total reasonable charges (sum of lines 12 and 13)		0	
00	Customary charges			1 00
15.00	Aggregate amount actually collected from patients liable for payment for services on a	charge basis	0	15.00
	Amounts that would have been realized from patients liable for payment for services or	9	0	1
	had such payment been made in accordance with 42 CFR §413.13(e)	3		
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17. 00
	Total customary charges (see instructions)		0	18. 00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds lir	ne 11) (see	0	19.00
	instructions)			
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds lir	ne 18) (see	0	20.00
	instructions)			
	Lesser of cost or charges (see instructions)		0	
	Interns and residents (see instructions)		0	
	Cost of physicians' services in a teaching hospital (see instructions)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		4, 756, 939	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	+!)	988, 489	1
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instru		0 7/0 450	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22	and 23] (see	3, 768, 450	27. 00
20 00	instructions) Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	1
	Subtotal (sum of lines 27 through 29)		3, 768, 450	1
	Primary payer payments		3, 700, 430	1
	Subtotal (line 30 minus line 31)		3, 768, 450	1
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		27 / 227 / 222	
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
	Allowable bad debts (see instructions)		79, 350	
35.00	Adjusted reimbursable bad debts (see instructions)		51, 578	35. 00
	Allowable bad debts for dual eligible beneficiaries (see instructions)		45, 141	36.00
37.00	Subtotal (see instructions)		3, 820, 028	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			39. 50
	N95 respirator payment adjustment amount (see instructions)		0	
39. 97	Demonstration payment adjustment amount before sequestration		0	
39. 98	Partial or full credits received from manufacturers for replaced devices (see instruct	ti ons)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION		0	
	Subtotal (see instructions)		3, 820, 028	1
40. 01	Sequestration adjustment (see instructions)		48, 132	
40. 02	Demonstration payment adjustment amount after sequestration		0	
	Sequestration adjustment-PARHM or CHART pass-throughs		2 7/4 100	40.03
	Interim payments Interim payments PAPHM or CHAPT		3, 764, 100	1
41.01	Interim payments-PARHM or CHART Tentative settlement (for contractors use only)		0	41. 01 42. 00
42. 00	Tentative settlement (for contractors use only) Tentative settlement-PARHM or CHART (for contractor use only)		U	42.00
42.01	Balance due provider/program (see instructions)		7, 796	1
43. 01	Balance due provider/program-PARHM (see instructions)		7, 770	43.00
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, c	chapter 1	0	1
17.00	§115. 2	ap (0) 1,	O	17.00
	TO BE COMPLETED BY CONTRACTOR			1
90.00	Original outlier amount (see instructions)		0	90.00
	Outlier reconciliation adjustment amount (see instructions)		0	1
	The rate used to calculate the Time Value of Money		0.00	
	Time Value of Money (see instructions)		0	
94.00	Total (sum of lines 91 and 93)		0	94.00
		·		

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lieu	of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0101	Peri od:	Worksheet E	
			From 01/01/2022		
			To 12/31/2022		
				5/15/2023 4:	07 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				(	200.00

Health Financial Systems WHITE ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1 From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared: 5/15/2023 4:07 pm Provider CCN: 15-0101

					5/15/2023 4:0	7 pm
		Title	: XVIII	Hospi tal	PPS	
		Inpatien	it 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, 344, 631		3, 764, 100	1.00
2.00	Interim payments payable on individual bills, either				0	2.00
	submitted or to be submitted to the contractor for					
	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		1	.T	_	
3. 01	ADJUSTMENTS TO PROVIDER		(		0	
3. 02			(		0	3. 02
3. 03			(	1	0	3. 03
3. 04			(		0	3.04
3. 05			(	)	0	3. 05
2 50	Provi der to Program		1	\		2 50
3.50	ADJUSTMENTS TO PROGRAM		(		0	3.50
3. 51 3. 52						3. 51 3. 52
3. 52 3. 53						3.52
3. 53				1		3.53
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines					3. 99
3. 99	3. 50-3. 98)			,		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 344, 631		3, 764, 100	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		T	T		
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
F 01	Program to Provider TENTATIVE TO PROVIDER			\	0	F 01
5. 01 5. 02	TENTATIVE TO PROVIDER					5. 01 5. 02
5. 02						
5.05	Provider to Program			7	0	3.03
5. 50	TENTATI VE TO PROGRAM				0	5.50
5. 51						5.51
5. 52					0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				l ol	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		160, 857	7	7, 796	6. 01
6.02	SETTLEMENT TO PROGRAM		(		0	6. 02
7.00	Total Medicare program liability (see instructions)		3, 505, 488	3	3, 771, 896	7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	14. 60.4		)	1. 00	2. 00	0.0-
8.00	Name of Contractor			1	ı	8. 00

Health Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of				u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT  Provider CCN: 15-0101   Period:   From 01/01/2022   To 12/31/2022   For 12/31/2022   From 01/01/2022   From 12/31/2022   From			Worksheet E-Part II Date/Time Pro 5/15/2023 4:0	epared:	
		Title XVIII	Hospi tal	PPS	or pili
	· · · · · · · · · · · · · · · · · · ·				
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 lin	ie 14		1. 00 2. 00
	2.00 Medicare days (see instructions)				
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4. 00	Total inpatient days (see instructions)				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				6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of cline 168	certified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ns)		32.00

Heal th	Financial Systems WHITLEY MEMOR	AL HOSPITAL	In Lie	u of Form CMS-2	552-10
OUTLI E	R RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0101	Peri od:	Worksheet E-5	
			From 01/01/2022 To 12/31/2022	Date/Time Prep 5/15/2023 4:07	
		Title XVIII		PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or s	um of 2.03 plus 2.04 (see	instructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00	Operating outlier reconciliation adjustment amount (see in	structions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see inst	ructions)		0	4.00
5.00 The rate used to calculate the time value of money (see instructions)				0.00	5.00
6.00	Time value of money for operating expenses (see instruction	ns)		0	6.00
7.00 Time value of money for capital related expenses (see instructions)				0	7.00

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

Provider CCN: 15-0101

Peri od: From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/15/2023 4:07 pm

OH y)					5/15/2023 4:0	7 pm
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	0.00	1.00	
1.00	Cash on hand in banks	3, 448	0	0	0	1.00
2.00	Temporary investments	0	0	0		2.00
3. 00	Notes recei vable	0	0	0		3.00
4.00	Accounts receivable	33, 465, 127	0	0	0	4.00
5.00	Other receivable	0 7/2 00/	0	0	0	5.00
6. 00 7. 00	Allowances for uncollectible notes and accounts receivable	-21, 763, 996 386, 123		0	0	6. 00 7. 00
8. 00	Inventory Prepai d expenses	9, 963, 899		0	0	8.00
9. 00	Other current assets	7, 703, 077		0	ő	9.00
10.00	Due from other funds	Ö	Ö	0	ő	10.00
11.00	Total current assets (sum of lines 1-10)	22, 054, 601	0	0		11.00
	FIXED ASSETS					
12.00	Land	616, 560	0	0	0	12.00
13.00	Land improvements	2, 512, 929	1	0		13.00
14. 00	Accumulated depreciation	-1, 364, 267	1	0	_	14.00
15.00	Bui I di ngs	41, 959, 419	1	0		15.00
16.00	Accumulated depreciation	-6, 639, 718	l I	0	0	16.00
17. 00 18. 00	Leasehold improvements	48, 824 -48, 824		0	0	17.00
19.00	Accumulated depreciation Fixed equipment	102, 346	1	0	0	18. 00 19. 00
20.00	Accumulated depreciation	-80, 859	1	0	0	20.00
21. 00	Automobiles and trucks	1, 160, 122	1	0	0	21.00
22. 00	Accumulated depreciation	-843, 317	1	0	ő	22.00
23. 00	Major movable equipment	15, 919, 336		0	Ö	23.00
24. 00	Accumulated depreciation	-13, 281, 371	0	0	0	24.00
25.00	Mi nor equi pment depreci abl e	6, 499, 428	0	0	0	25. 00
26.00	Accumulated depreciation	-66, 717	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	_	29.00
30. 00	Total fixed assets (sum of lines 12-29)	46, 493, 891	0	0	0	30.00
21 00	OTHER ASSETS Investments	(4 OE1 704	0	0		21 00
31. 00 32. 00	Deposits on Leases	64, 851, 724		0	_	31. 00 32. 00
33. 00	Due from owners/officers			0	0	33.00
34. 00	Other assets	688, 331	_	0	ő	34.00
35. 00	Total other assets (sum of lines 31-34)	65, 540, 055	1	0		35.00
36.00	Total assets (sum of lines 11, 30, and 35)	134, 088, 547	1	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	6, 688, 007	1	0		37.00
38. 00	Salaries, wages, and fees payable	1, 156, 247	0	0	_	38. 00
39. 00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and Loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42. 00 43. 00	Accel erated payments Due to other funds			0	0	42.00
44. 00	Other current liabilities	2, 763, 420		0	0	43. 00 44. 00
45. 00	Total current liabilities (sum of lines 37 thru 44)	10, 607, 674	1	0		45.00
10.00	LONG TERM LIABILITIES	10,007,071	٦			10.00
46. 00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	0	0	0		47.00
48.00	Unsecured Loans	0	0	0	0	48. 00
49.00	Other long term liabilities	481, 593	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	481, 593	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	11, 089, 267	0	0	0	51.00
	CAPITAL ACCOUNTS				1	
52.00	General fund balance	122, 999, 280	1			52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance		•	0		56.00
57. 00 58. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0 0	57. 00 58. 00
50.00	replacement, and expansion					30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	122, 999, 280	n	Ω	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	134, 088, 547	1	0	Ö	60.00
	59)					

Provider CCN: 15-0101

					To 12/31/2022	Date/Time Pre 5/15/2023 4:0	
		General	Fund	Special P	urpose Fund	Endowment	, ,
				·		Fund	
		1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	Fund balances at beginning of period		135, 810, 732	•	0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1, 588, 098				2.00
3.00	Total (sum of line 1 and line 2)		134, 222, 634	1	0	0	3.00
4. 00 5. 00	Additions (credit adjustments) (specify) ADD-BACK NONALLOWABLE INTEREST	754 044			0	0	4. 00 5. 00
6. 00	ADD-BACK NONALLOWABLE INTEREST	754, 046			0	0	
7. 00		0		1	0	0	
8. 00					0	0	
9. 00		0				0	
10.00	Total additions (sum of line 4-9)		754, 046	1	0	Ü	10.00
11. 00	Subtotal (line 3 plus line 10)		134, 976, 680	•	o		11.00
12.00	Deductions (debit adjustments) (specify)	o		1	ol	0	12.00
13.00	TRANSFERS	11, 977, 400			0	0	13.00
14.00		0			0	0	14.00
15. 00		0			0	0	
16. 00		0		1	0	0	16.00
17. 00		0			0	0	
18. 00	Total deductions (sum of lines 12-17)		11, 977, 400		0		18.00
19. 00	Fund balance at end of period per balance		122, 999, 280	)	0		19.00
	sheet (line 11 minus line 18)	Endowment	DI ont	L Fund			
		Fund	Prant	. Funa			
		runa					
		6. 00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1.00
2. 00	Net income (loss) (from Wkst. G-3, line 29)	_					2.00
3.00	Total (sum of line 1 and line 2)	0			0		3.00
4. 00	Additions (credit adjustments) (specify)		0	)			4.00
5. 00 6. 00	ADD-BACK NONALLOWABLE INTEREST		0				5. 00 6. 00
7. 00			0				7.00
8. 00			0				8.00
9. 00			0				9.00
10. 00	Total additions (sum of line 4-9)	0	O	Ί ,	o		10.00
11. 00	Subtotal (line 3 plus line 10)	0		l	0		11.00
12. 00	Deductions (debit adjustments) (specify)		0				12.00
13.00	TRANSFERS		0				13.00
14.00			0				14.00
15.00			0	)			15.00
16.00			0				16.00
17. 00			0	)			17. 00
18. 00	Total deductions (sum of lines 12-17)	0			0		18.00
19. 00	Fund balance at end of period per balance	0			0		19. 00
	sheet (line 11 minus line 18)						I

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

			To 12/31/2022	Date/Time Pre 5/15/2023 4:0	
	Cost Center Description	I npati ent	Outpati ent	Total	/ pili
	oust defited bescription	1.00	2.00	3. 00	
	PART I - PATIENT REVENUES	11.00	2.00	0.00	
	General Inpatient Routine Services				
1.00	Hospi tal	11, 184, 89	18	11, 184, 898	1.00
2.00	SUBPROVIDER - IPF			, ,	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF		o	0	5.00
6.00	Swing bed - NF		o	0	6.00
7.00	SKILLED NURSING FACILITY		o	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)	11, 184, 89	8	11, 184, 898	10.00
	Intensive Care Type Inpatient Hospital Services		'		
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines		0	0	16.00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11, 184, 89	98	11, 184, 898	17.00
18.00	Ancillary services	42, 484, 29	0	42, 484, 295	18.00
19. 00	Outpati ent servi ces		0 264, 474, 133	264, 474, 133	19.00
20.00	RURAL HEALTH CLINIC		0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21.00
22. 00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES		0 13, 315, 606	13, 315, 606	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )				25.00
26.00	HOSPI CE				26.00
27. 00	OTHER (SPECIFY)		0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	53, 669, 19	277, 789, 739	331, 458, 932	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES		0, 055 057		
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		86, 055, 357		29.00
30.00	ADD (SPECIFY)	754.0	0		30.00
31.00	HOME OFFICE INTEREST EXPENSE	754, 04			31.00
32.00			0		32.00
33.00			0		33.00
34.00			0		34.00
35. 00	T-1-1 - 11'11' ( C 1' 20 25')		0		35.00
36.00	Total additions (sum of lines 30-35)		754, 046		36.00
37. 00	DEDUCT (SPECIFY)		0		37.00
38. 00			0		38.00
39.00					39.00
40.00			0		40.00
41.00	Total deductions (our of Lines 27 41)		را		41.00
42. 00 43. 00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(trans	For	96 900 403		42. 00 43. 00
43.00	to Wkst. G-3, line 4)	1 61	86, 809, 403		43.00
	10 WK31. 0-3, 11116 4)	1	1		1

Heal th	Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES			Provider CCN: 15-0101	Peri od:	Worksheet G-3	
				From 01/01/2022 To 12/31/2022	Date/Time Pre	nared·
				10 12/01/2022	5/15/2023 4:0	
					1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)				331, 458, 932	
2. 00	Less contractual allowances and discounts on patients' accounts				243, 687, 956	
3. 00	Net patient revenues (line 1 minus line 2)				87, 770, 976	1
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			86, 809, 403	1	
5. 00					961, 573	5.00
/ 00	OTHER I NCOME				0	/ 00
6.00	Contributions, donations, bequests, etc				-	
7. 00 8. 00	Income from investments				917, 788 0	1
9. 00					0	
10.00					0	1
11. 00					-	11.00
12.00					0	ı
13. 00	,				0	
	Revenue from meals sold to employees and qu	osts			277, 577	
		ests			277, 377	
	Revenue from rental of living quarters			0		
	Revenue from sale of medical and surgical supplies to other than patients Revenue from sale of drugs to other than patients			0	ı	
	00 Revenue from sale of medical records and abstracts			-	18.00	
	00 Tuition (fees, sale of textbooks, uniforms, etc.)				19.00	
	Revenue from gifts, flowers, coffee shops,	,			0	1
	Rental of vending machines			0	1	
22. 00				0	•	
23. 00	Governmental appropriations				0	1
24. 00	OTHER REVENUE				2, 492, 869	
24. 01	GAIN/(LOSS) ON SALE OF CAPITAL ASSET				-6, 487, 905	
	EMS SUBSIDY				250, 000	
	COVI D-19 PHE Fundi ng				230, 000	1
	Total other income (sum of lines 6-24)				-2, 549, 671	
	Total (line 5 plus line 25)				-1, 588, 098	
	OTHER EXPENSES (SPECIFY)				0	1
	Total other expenses (sum of line 27 and su	bscripts)			0	1

0 28.00 -1,588,098 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		Figure 1 - Control - Contr	U LIOCOL TAL		. C. E OHC. (	2550 40			
PART I - FULLY PROSPECTIVE METHOD			2552-10						
PART I - FILITY PROSPECTIVE METHOD   Title XVIII   Hospital   PROSPECTIVE METHOD	CALCUL	ATTON OF CAPITAL PAYMENT	Provider CCN: 15-0101						
Title XVIII   Hospital   PPS						narod:			
PART I - FULLY PROSPECTIVE METHOD				10 12/31/2022					
PART 1 - FULLY PROSPECTIVE WETHOD			, p						
PART I - FULLY PROSPECTIVE METHOD									
CAPITAL FEDERAL AMOUNT   1.00					1. 00				
1.00									
1.01   Model 4 BPCI Capital DRG outlier payments   0   2.01									
2.00									
Model 4 BPCI Capital DRG outlier payments   0 2.01									
Total inpatient days divided by number of days in the cost reporting period (see instructions)   1.4 24   3.00									
Number of Interns & residents (see instructions)   0.00   4.00		1 1 3	-						
Indirect medical education percentage (see instructions)			tructions)						
Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01 (see instructions)   Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see Instructions)   0.00   7.00	4.00	Number of interns & residents (see instructions)							
1.01) (see instructions)   0.00   7									
Part     Comparison   Part	6.00		ne sum of lines 1 and 1.0	1, columns 1 and	0	6. 00			
30) (see instructions)   8.00   9.00   5.0									
R. 00   Percentage of Medicaid patient days to total days (see instructions)   0.00   8.00   0.00	7. 00		patient days (Worksheet	E, part A line	0. 00	7. 00			
Q. 00   Sum of   I'nes 7 and 8   0.00   9.00   10.00	0.00					0.00			
10.00   Allowable disproportionate share percentage (see instructions)   0.00   10.00   11.0			ructions)						
11.00 Disproportionate share adjustment (see instructions) 12.00 Total prospective capital payments (see instructions) 173, 312 12.00    PART II - PAYMENT UNDER REASONABLE COST									
173, 312   12.00			ns)						
PART II - PAYMENT UNDER REASONABLE COST  1.00 Program inpatient routine capital cost (see instructions) 2.00 Program inpatient program capital cost (see instructions) 3.00 Total inpatient program capital cost (line 1 plus line 2) 4.00 Capital cost payment factor (see instructions) 5.00 Total inpatient program capital cost (line 3 x line 4)  PART III - COMPUTATION OF EXCEPTION PAYMENTS  1.00  POrgram inpatient capital costs (see instructions)  1.00  Algorithm in the payment of the payment line 2 (see instructions)  1.00  Algorithm in the payment level for extraordinary circumstances (see instructions)  2.00  3.00  Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)  3.00  4.00									
PART III - PAYMENT UNDER REASONABLE COST  1.00 Program inpatient routine capit al cost (see instructions) 2.00 Program inpatient ancillary capital cost (see instructions) 3.00 Total inpatient program capital cost (line 1 plus line 2) 4.00 Capital cost payment factor (see instructions) 5.00 Total inpatient program capital cost (line 3 x line 4)  PART III - COMPUTATION OF EXCEPTION PAYMENTS  1.00 Program inpatient capital costs (see instructions) 2.00 Program inpatient capital costs (see instructions) 3.00 Net program inpatient capital costs (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 6.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 11.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level to capital payments (from prior year Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (from prior year Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (from prior year Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (from prior year Worksheet L, Part III, line 14) 12.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 14.00 Current year payment (if line 12 is positive, enter the amount on this line) 15.00 Current year payment in and capital costs (see instructions) 16.00 Current year opperating and capital costs (see instructions) 17.00 Cu	12.00	lotal prospective capital payments (see instructions)	1/3, 312	12.00					
PART III - PAYMENT UNDER REASONABLE COST  1.00 Program inpatient routine capit al cost (see instructions) 2.00 Program inpatient ancillary capital cost (see instructions) 3.00 Total inpatient program capital cost (line 1 plus line 2) 4.00 Capital cost payment factor (see instructions) 5.00 Total inpatient program capital cost (line 3 x line 4)  PART III - COMPUTATION OF EXCEPTION PAYMENTS  1.00 Program inpatient capital costs (see instructions) 2.00 Program inpatient capital costs (see instructions) 3.00 Net program inpatient capital costs (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 6.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 11.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level to capital payments (from prior year Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (from prior year Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (from prior year Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (from prior year Worksheet L, Part III, line 14) 12.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 14.00 Current year payment (if line 12 is positive, enter the amount on this line) 15.00 Current year payment in and capital costs (see instructions) 16.00 Current year opperating and capital costs (see instructions) 17.00 Cu					1 00				
1.00 Program inpatient routine capital cost (see instructions) 2.00 Program inpatient ancillary capital cost (see instructions) 3.00 Total inpatient program capital cost (line 1 plus line 2) 4.00 Capital cost payment factor (see instructions) 5.00 Total inpatient program capital cost (line 3 x line 4)  PART III - COMPUTATION OF EXCEPTION PAYMENTS  1.00 Program inpatient capital costs (see instructions)  1.00 Program inpatient capital costs (see instructions) 2.00 Program inpatient capital costs (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 6.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 8 less line 9) 7.00 Current year capital payments (from Part I, line 12, as applicable) 7.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 7.00 Carryover of accumulated capital minimum payment level over capital payments (line 10 plus line 11) 7.00 Net comparison of capital minimum payment level over capital payments (line 10 plus line 11) 7.00 Net comparison of capital minimum payment level over capital payments (line 10 plus line 11) 7.00 Net comparison of capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 7.00 Current year exception payment level to capital payment for the following period (if line 12 is negative, enter the amount on this line) 7.00 Current year operating and capital payment (see instructions) 7.00 Current year operating and capital payment (see instructions) 7.00 Current year operating and capital costs (see instructions) 7.00 Current year operating and capital costs (see instructions) 7.00 Current year operating		DADT LL DAVMENT LINDED DEASONABLE COST	1.00						
2.00 Program inpatient ancillary capital cost (see instructions) 3.00 Total inpatient program capital cost (line 1 plus line 2) 4.00 Carryover of accumulated capital minimum payment level to capital payments (line 8 less line 9) 6.00 Carryover of accumulated capital minimum payment level to capital payments (line 1 plus line 1) 6.00 Current year exception payment level to capital payments (line 1 line 10) 6.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 6.00 Current year allowable operating and capital costs (see instructions) 7.00 Current year allowable operating and capital payment (see instructions) 7.00 Current year capoparating and capital minimum payment (see instructions) 7.00 Current year capital minimum payment level over capital payments (line 1 plus line 2) 7.00 Current year capital minimum payment level over capital payments (for period capital minimum payment level over capital payments (for period capital minimum payment level over capital payments (for period capital minimum payment level over capital payment (for period capital minimum payment level over capital payment (for the following period (if line 12 is negative, enter the amount on this line) 7.00 Current year operating and capital mayment (see instructions) 7.00 Current year operating and capital payment (see instructions) 7.00 Current year operating and capital payment (see instructions) 7.00 Current year operating and capital payment (see instructions) 7.00 Current year operating and capital costs (see instructions) 8.00 Current year operating and capital costs (see instructions) 8.00 Current year operating and capital costs (see instructions) 8.00 Current year operating and capital costs (see instructions) 8.00 Current year operating and capital costs (see instructions) 8.00 Current year operating and capital costs (see instructions) 8.00 Current year operating and capital costs (see instructions) 8.00 Current year operati	1 00			0	1 00				
3.00   Total inpatient program capital cost (line 1 plus line 2)									
2.00 Capital cost payment factor (see instructions)  DART III - COMPUTATION OF EXCEPTION PAYMENTS  Program inpatient capital costs (see instructions)  Program inpatient capital costs (see instructions)  Net program inpatient capital costs (line 1 minus line 2)  Applicable exception percentage (see instructions)  Capital cost for comparison to payments (line 3 x line 4)  Capital minum payment level (line 5 plus line 7)  Capital minum payment level (line 5 plus line 7)  Current year capital payments (from Part I, line 12, as applicable)  Carryover of accumulated capital minimum payment level over capital payments (from prior year Worksheet L, Part III, line 14)  Carryover of accumulated capital minimum payment level to capital payments (from prior year capital payment in linum payment level over capital payments (from prior year capital payment level to capital payments (from prior year capital payment level to capital payments (from prior year capital payment level to capital payments (from prior year capital payment level to capital payments (from prior year capital payment level to capital payments (from prior year capital payment level to capital payments (from prior year capital payment level to capital payments (from prior year capital payment level to capital payments (from prior year capital payment level to capital payments (from prior year capital payment level to capital payments (line 10 plus line 11)  Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)  Carrent year allowable operating and capital payment (see instructions)  0 15.00 Current year operating and capital costs (see instructions)  0 16.00 Current year operating and capital costs (see instructions)									
PART III - COMPUTATION OF EXCEPTION PAYMENTS  1.00 Program inpatient capital costs (see instructions) 2.00 Program inpatient capital costs (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 9.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 9.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 9.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 9.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 9.00 Current year comparison of capital minimum payment level to capital payments (line 10 plus line 11) 9.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 9.12.00 Net comparison of capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 9.50 Current year allowable operating and capital payment (see instructions) 9.15.00 Current year operating and capital posses (see instructions) 9.15.00 Current year operating and capital costs (see instructions) 9.16.00 Current year operating and capital costs (see instructions) 9.50 On 16.00 Current year operating and capital costs (see instructions) 9.50 On 16.00 Current year operating and capital costs (see instructions) 9.50 On 16.00 Current year operating and capital costs (see instructions) 9.50 On 16.00 Current year operating and capital costs (see instructions)									
PART III - COMPUTATION OF EXCEPTION PAYMENTS  1.00 Program inpatient capital costs (see instructions) 2.00 Program inpatient capital costs for extraordinary circumstances (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year 11.00 Net comparison of capital minimum payment level over capital payment (from prior year 11.00 Net comparison of capital minimum payment level over capital payment (from prior year 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year 11.00 Carryover of accumulated capital minimum payment level over capital payment for the following period 12.00 Carryover of accumulated capital minimum payment level over capital payment for the following period 13.00 Current year exception payment in the manunt on this line) 15.00 Current year allowable operating and capital payment (see instructions) 16.00 Current year operating and capital costs (see instructions) 17.00 On 18.00 Current year operating and capital costs (see instructions) 18.00 Current year operating and capital costs (see instructions)		, , , , , , , , , , , , , , , , , , , ,			_				
PART III - COMPUTATION OF EXCEPTION PAYMENTS  1. 00 Program inpatient capital costs (see instructions) 2. 00 Program inpatient capital costs for extraordinary circumstances (see instructions) 3. 00 Net program inpatient capital costs (line 1 minus line 2) 4. 00 Applicable exception percentage (see instructions) 5. 00 Capital cost for comparison to payments (line 3 x line 4) 6. 00 Percentage adjustment for extraordinary circumstances (see instructions) 7. 00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8. 00 Capital minimum payment level (line 5 plus line 7) 9. 00 Current year capital payments (from Part I, line 12, as applicable) 10. 00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11. 00 Carryover of accumulated capital minimum payment level over capital payment (from prior year 0 11. 00 Worksheet L, Part III, line 14) 12. 00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) 12. 00 Current year exception payment (if line 12 is positive, enter the amount on this line) 14. 00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 15. 00 Current year allowable operating and capital payment (see instructions) 16. 00 Current year operating and capital payment (see instructions) 16. 00 Current year operating and capital costs (see instructions) 17. 00 Current year operating and capital costs (see instructions) 18. 00 Current year operating and capital payment (see instructions) 19. 10 Current year operating and capital costs (see instructions) 19. 10 Current year operating and capital costs (see instructions)	3.00	Total Tripatient program capital cost (Title 3 x Title 4)			0	3.00			
Program inpatient capital costs (see instructions)  2.00 Program inpatient capital costs for extraordinary circumstances (see instructions)  3.00 Net program inpatient capital costs (line 1 minus line 2)  4.00 Applicable exception percentage (see instructions)  5.00 Capital cost for comparison to payments (line 3 x line 4)  6.00 Percentage adjustment for extraordinary circumstances (see instructions)  7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)  8.00 Capital minimum payment level (line 5 plus line 7)  9.00 Current year capital payments (from Part I, line 12, as applicable)  10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)  11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year  Worksheet L, Part III, line 14)  12.00 Current year exception payment (if line 12 is positive, enter the amount on this line)  14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)  15.00 Current year allowable operating and capital payment (see instructions)  0 15.00 Current year operating and capital costs (see instructions)  0 15.00 Current year operating and capital payment (see instructions)					1. 00				
2.00 Program inpatient capital costs for extraordinary circumstances (see instructions)  3.00 Net program inpatient capital costs (line 1 minus line 2)  4.00 Applicable exception percentage (see instructions)  5.00 Capital cost for comparison to payments (line 3 x line 4)  6.00 Percentage adjustment for extraordinary circumstances (see instructions)  7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)  8.00 Capital minimum payment level (line 5 plus line 7)  9.00 Current year capital payments (from Part I, line 12, as applicable)  10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)  11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)  12.00 Net comparison of capital minimum payment level over capital payments (line 10 plus line 11)  13.00 Current year exception payment (if line 12 is positive, enter the amount on this line)  14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)  15.00 Current year allowable operating and capital payment (see instructions)  0 2.00  3.00  3.00  4.00  5.00  6.00  6.00  7.00  8.00  7.00  8.00  6.00  7.00  8.00  7.00  8.00  9.00  10.00		PART III - COMPUTATION OF EXCEPTION PAYMENTS							
3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level over capital payment (from prior year of accumulated capital minimum payment level over capital payments (line 10 plus line 11) 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions) 0 15.00 16.00 Current year operating and capital payment (see instructions) 0 16.00	1.00	Program inpatient capital costs (see instructions)			0	1. 00			
4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year 11.00 Net comparison of capital minimum payment level over capital payment (from prior year 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions) 16.00 Current year operating and capital costs (see instructions) 17.00 Adjustment for extraordinary circumstances (line 2 x line 6) 18.00 Current year allowable operating and capital payments (line 10 plus line 11) 19.00 Current year allowable operating and capital payment (see instructions) 19.00 Current year operating and capital costs (see instructions) 19.00 Current year operating and capital costs (see instructions)			nces (see instructions)						
Capital cost for comparison to payments (line 3 x line 4)  6.00 Percentage adjustment for extraordinary circumstances (see instructions)  7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)  8.00 Capital minimum payment level (line 5 plus line 7)  9.00 Current year capital payments (from Part I, line 12, as applicable)  10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)  11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year  12.00 Net comparison of capital minimum payment level over capital payment (line 10 plus line 11)  12.00 Carryover of accumulated capital minimum payment level over capital payments (line 10 plus line 11)  13.00 Current year exception payment (if line 12 is positive, enter the amount on this line)  14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)  15.00 Current year allowable operating and capital payment (see instructions)  0 15.00  16.00 Current year operating and capital costs (see instructions)	3.00	Net program inpatient capital costs (line 1 minus line 2)							
6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions)  0.00 6.00 7.00 8.00 7.00 8.00 9.00 1.00 1.00 1.00 1.00 1.00 1.00 1	4.00				0. 00				
7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level over capital payments (line 10 plus line 11) 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions)  0 7.00 8.00 7.00 8.00 9.00 10.00 11.00 11.00 12.00 11.00 12.00 13.00 14.00 15.00 16.00 16.00	5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5.00			
8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions)  0 8.00 9.00 10.00 11.00 12.00 11.00 12.00 15.00 15.00 16.00 16.00	6.00	Percentage adjustment for extraordinary circumstances (see instructions)			0.00	6. 00			
9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions)  0 9.00 10.00 11.00 12.00 11.00 12.00 15.00 15.00 16.00 17.00	7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)			0	7. 00			
10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year  Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions)  0 10.00 11.00 12.00 12.00 13.00 14.00 15.00 16.00 16.00	8.00	Capital minimum payment level (line 5 plus line 7)			0	8. 00			
11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)  12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)  13.00 Current year exception payment (if line 12 is positive, enter the amount on this line)  14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)  15.00 Current year allowable operating and capital payment (see instructions)  0 15.00  16.00 Current year operating and capital costs (see instructions)  0 16.00	9.00	Current year capital payments (from Part I, line 12, as applicable)				9. 00			
Worksheet L, Part III, line 14)  12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)  13.00 Current year exception payment (if line 12 is positive, enter the amount on this line)  14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)  15.00 Current year allowable operating and capital payment (see instructions)  16.00 Current year operating and capital costs (see instructions)  0 15.00	10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)				10.00			
12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)  13.00 Current year exception payment (if line 12 is positive, enter the amount on this line)  14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)  15.00 Current year allowable operating and capital payment (see instructions)  16.00 Current year operating and capital costs (see instructions)  17.00 Current year operating and capital costs (see instructions)  18.00 Current year operating and capital costs (see instructions)	11.00					11.00			
13.00 Current year exception payment (if line 12 is positive, enter the amount on this line)  14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)  15.00 Current year allowable operating and capital payment (see instructions)  16.00 Current year operating and capital costs (see instructions)  17.00 Current year operating and capital costs (see instructions)  18.00 13.00 14.00 15.00 16.00	40 -					40			
14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)  15.00 Current year allowable operating and capital payment (see instructions)  16.00 Current year operating and capital costs (see instructions)  16.00 Current year operating and capital costs (see instructions)					-				
(if line 12 is negative, enter the amount on this line)  15.00 Current year allowable operating and capital payment (see instructions)  16.00 Current year operating and capital costs (see instructions)  0 15.00 16.00					-				
15.00 Current year allowable operating and capital payment (see instructions)  0 15.00 Current year operating and capital costs (see instructions)  0 16.00	14. 00		capital payment for the	following period	0	14.00			
16.00 Current year operating and capital costs (see instructions) 0 16.00	4- 6-				_	45.00			
					-				
17.00   current year exception ortset amount (see instructions)   0  17.00					-				
	17.00	current year exception offset amount (see instructions)		l	0	17.00			