payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXXII RES. 03-31-202

EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0101 Period: From 01/01/2019 Parts I-III

		6/29/2020	3: 14 pm
PART I - COST	REPORT STATUS		
Provi der	1. [X] Electronically prepared cost report	Date: 6/29/2020 Time	: 3:14 pm
use only	2. [] Manually prepared cost report		
	3. [0] If this is an amended report enter the number of 4. [F] Medicare Utilization. Enter "F" for full or "L" $$		
Contractor use only	5. [1] Cost Report Status (1) As Submitted 7. Contractor No. (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. [N] Initial Report for the properties of the contraction of the	10. NPR Date: 11. Contractor's Vendor Code: 12. [0] If line 5, column 1 is 4 number of times reopened	

PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WHITLEY MEMORIAL HOSPITAL (15-0101) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[X]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the Legally binding equivalent of my original signature.

(Signed) JEANNÉ WICKENS
Officer or Administrator of Provider(s)

SVP/CF0

Title

(Dated when report is electronically signed.)

12/31/2019 Date/Time Prepared:

Date

			Title XVIII				
	Cost Center Description	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	-60, 903	-32, 038	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	o	0		0	7. 00
200.00	Total	0	-60, 903	-32, 038	0	0	200. 00

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

Health Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0101 Peri od: Worksheet S-2 From 01/01/2019 Part I 12/31/2019 Date/Time Prepared: 6/29/2020 3:14 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 1.00 Street: 1260 E STATE ROAD 205 PO Box: State: IN Zip Code: 46725-9492 County: WHITLEY 2.00 City: COLUMBIA CITY 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)

/ XVIII XIX Туре Certi fi ed Number Number 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 WHITLEY MEMORIAL 150101 23060 07/01/1966 N 3.00 HOSPI TAI Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2019 12/31/2019 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 Υ Υ 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1.

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

Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) 22.02 22.02 N N Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 N Ν N rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 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. Which method is used to determine Medicaid days on lines 24 and/or 25 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	IN TOT TIO						
	In-State	In-State	Out-of	Out-of	Medi cai d	0ther	
	Medi cai d	Medi cai d	State	State	HMO days	Medicaid	
	pai d 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	
4.00 If this provider is an IPPS hospital, enter the	131	457	0	11	50	54 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.							

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 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/29/2020 3:14 pm In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days unpai d paid days eligible days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 25.00 If this provider is an IRF, enter the in-state 25, 00 \cap 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 26. 00 cost reporting period. Enter "1" for urban or "2" for rural. 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. If this is a sole community hospital (SCH), enter the number of periods SCH status in 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 36 00 of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 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 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see 37 01 37 01 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 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 Ν Ν 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 Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. Ν Ν Ν 47.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 N Ν 48.00 Ν Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? 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), MA Ν 56.00 GME payment reduction? Enter "Y" for yes or "N" for no in column 2. If line 56 is yes, is this the first cost reporting period during which residents in approved 57.00 N 57.00 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 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. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as 58.00 Ν defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, 59.00 Pt. NAHE 413.85 Worksheet A Pass-Through Y/N Line # Oual i fi cati on Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 any programs that meet the criteria under 42 CFR 413.85? (see 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 adjustement? Enter "Y" for yes or "N" for no in column 2.

In Lieu of Form CMS-2552-10 Health Financial Systems WHITLEY MEMORIAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0101 Peri od: Worksheet S-2 From 01/01/2019 Part I 12/31/2019 Date/Time Prepared: 6/29/2020 3:14 pm Y/N IME Direct GME IME Direct GME 1.00 2.00 3. 00 4.00 5.00 0.00 0.00 61.00 61.00 Did your hospital receive FTE slots under ACA 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)

	care or general surgery. (see instructions)					
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2. 00	3. 00	4.00	
61 10	Of the FTEs in line 61.05, specify each new program	1.00	2.00	0.00		61, 10
01.10	specialty, if any, and the number of FTE residents			0.00	0.00	01.10
	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 Sei	rvices Administration	(HRSA)			
62.00	Enter the number of FTE residents that your hospital		reporting peri	od for which	0.00	62.00
	your hospital received HRSA PCRE funding (see instruc					
62. 01	Enter the number of FTE residents that rotated from a			your hospital	0.00	62. 01
	during in this cost reporting period of HRSA THC prog		ns)			
63 00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se		et reporting r	pari od? Entar	N	63. 00
03.00	"Y" for yes or "N" for no in column 1. If yes, comple				IN IN	03.00
			Unwei ghted	Unwei ghted	Ratio (col. 1/	
			FTEs	FTEs in	(col. 1 + col.	
			Nonprovi der	Hospi tal	2))	
			Si te	2.00	2.00	
	Section 5504 of the ACA Base Year FTE Residents in No	onnrovider Settings]	1.00	2.00	3.00	
	period that begins on or after July 1, 2009 and before		illi s base year	13 your cost i	epor tring	
64.00	Enter in column 1, if line 63 is yes, or your facilit		0.00	0.00	0. 000000	64. 00
	in the base year period, the number of unweighted nor					
	resident FTEs attributable to rotations occurring in					
	settings. Enter in column 2 the number of unweighted					
	resident FTEs that trained in your hospital. Enter in					
	of (column 1 divided by (column 1 + column 2)). (see	instructions)				

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0101 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/29/2020 3:14 pm Ratio (col. 3/ Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0. 00 0. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ahted Unwei ghted Ratio (col. 3/ Program Code FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	CN: 15-0101	Peri od: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Pre 6/29/2020 3:	epared:
				1. 00	
Long Term Care Hospital PPS 0.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 1.00 Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no.			ng period? Enter	N N	80. 00 81. 00
TEFRA Providers 5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 6.00 Did this facility establish a new Other subprovider (excluded §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 00 86. 00
7.00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	cl assi fi ed u	under section	1	N	87. 00
			V	XIX	
Title V and XIX Services			1. 00	2. 00	_
0.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	servi ces? Er	nter "Y" for	N	Y	90.00
1.00 Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the appli			N	N	91.00
2.00 Are title XIX NF patients occupying title XVIII SNF beds (dualinstructions) Enter "Y" for yes or "N" for no in the applicate	al certificati	on)? (see		N	92. 00
3.00 Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column.		d XIX? Enter	N	N	93.00
4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, a applicable column.	and "N" for no	in the	N	N	94.00
5.00 If line 94 is "Y", enter the reduction percentage in the appl 6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			0. 00 N	0. 00 N	95. 00 96. 00
7.00 If line 96 is "Y", enter the reduction percentage in the appl			0.00	0.00	97. 00
8.00 Does title V or XIX follow Medicare (title XVIII) for the int stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" fo column 1 for title V, and in column 2 for title XIX.	N	Y	98.00		
8.01 Does title V or XIX follow Medicare (title XVIII) for the rep C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for tit title XIX.				Y	98. 01
8.02 Does title V or XIX follow Medicare (title XVIII) for the cal bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or for title V, and in column 2 for title XIX.			N	Y	98. 02
8.03 Does title V or XIX follow Medicare (title XVIII) for a criti- reimbursed 101% of inpatient services cost? Enter "Y" for yes for title V, and in column 2 for title XIX.				N	98. 03
8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH routpatient services cost? Enter "Y" for yes or "N" for no in			N	N	98. 04
in column 2 for title XIX. 8.05 Does title V or XIX follow Medicare (title XVIII) and add bac Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX				Y	98. 05
column 2 for title XIX. 8.06 Does title V or XIX follow Medicare (title XVIII) when cost r Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.	reimbursed fon 1 for title \	Wkst. D, /, and in	N	Y	98. 06
Rural Providers 05.00 Does this hospital qualify as a CAH? 06.00 If this facility qualifies as a CAH, has it elected the all-i	nclusive meth	nod of paymer	N		105. 00 106. 00
for outpatient services? (see instructions) 07.00 Column 1: If line 105 is Y, is this facility eligible for costraining programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do y approved medical education program in the CAH's excluded IPF	1. (see inst you train I&Rs and/or IRF u	tructions) s in an			107. 00
Enter "Y" for yes or "N" for no in column 2. (see instruction 08.00 Is this a rural hospital qualifying for an exception to the CCFR Section §412.113(c). Enter "Y" for yes or "N" for no.		dul e? See 42	2 N		108. 00
DIN Section 9412. 113(c). Eilter 1 101 yes of N 101 No.	Physi cal	Occupationa	<u> </u>	Respiratory	
09.00 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.	1.00 N	2.00	3.00	4.00	109.00
			•		_
				1. 00	-

Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.

ealth Financial Systems WHITLEY MEMORIA OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	AL HOSPITAL Provider CO	N. 1E 0101	In Lie	worksheet S-	
USPITAL AND HUSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	JN. 15-0101	From 01/01/2019 To 12/31/2019	Part I	
				6/29/2020 3:	14 pm
			1. 00	2. 00	
11.00 f this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this community for yes or "N" for no in column 1. If the response to collintegration prong of the FCHIP demo in which this CAH is participated all that apply: "A" for Ambulance services; "B" for additional for tele-health services.	st reporting p lumn 1 is Y, e ticipating in	period? Enter enter the column 2.	. N		111.0
		1. 00	2.00	3.00	+
12.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting particle "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cease participation in the demonstration, if applicable.	peri od? "Y", enter e	N N	2.00	3.00	112. 0
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93" for short term hospital or "98" percent for long term care (in psychiatric, rehabilitation and long term hospitals providers the definition in CMS Pub. 15-1, chapter 22, §2208.1.	, or E only) 3" percent includes	N			0115.0
16.00 is this facility classified as a referral center? Enter "Y" i "N" for no.	for yes or	N			116. 0
17.00 is this facility legally-required to carry malpractice insura "Y" for yes or "N" for no.	ance? Enter	Y			117.0
18.00 is the malpractice insurance a claims-made or occurrence polifithe policy is claim-made. Enter 2 if the policy is occurre			1		118. 0
		Premi ums	Losses	Insurance	
		1. 00	2. 00	3.00	
18.01 List amounts of malpractice premiums and paid losses:		88, 7	95 2, 098	211, 91	1118. (
			1. 00	2.00	
18.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduland amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Hold Harmless provision in ACA §3121 and applicable amendments	ule listing co Harmless prov column 1, "Y' alifies for th	ost centers vision in ACA " for yes or he Outpatient		N	118. (119. (120. (
Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implan		•	Υ		121.
patients? Enter "Y" for yes or "N" for no. 22.00Does the cost report contain healthcare related taxes as defi	ined in §1903	(w)(3) of the	· N		122. (
Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information	is "Y", enter	r in column 2	!		
25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	•		N		125.
in column 1 and termination date, if applicable, in column 2. 7.00 f this is a Medicare certified heart transplant center, ento	er the certifi				127.
in column 1 and termination date, if applicable, in column 2. 28.00 f this is a Medicare certified liver transplant center, ent	er the certifi	ication date			128.
in column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.		cation date i	n		129.
		ti fi cati on			130.
					131.
date in column 1 and termination date, if applicable, in colu	, enter the ce	ertification			
date in column 1 and termination date, if applicable, in column 31.00 lf this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 32.00 lf this is a Medicare certified islet transplant center, ento in column 1 and termination date, if applicable, in column 2.	, enter the ce umn 2. er the certifi				132. (
31.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colu 32.00 If this is a Medicare certified islet transplant center, ento	, enter the co umn 2. er the certifi	ication date			132. (133. (134. (

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 01/01/2019 Part I 12/31/2019 Date/Time Prepared: To 6/29/2020 3:14 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

Name: PARKVIEW HEALTH SYSTEM, INC. | Contractor's Name: WISCONSIN PHYSICIANS Contractor's Number: 08101 141 00 Name: 141 00 SERVI CE 142.00 Street: 10501 CORPORATE DRIVE PO Box: PO BOX 5600 142.00 46895-5600 143.00 City: FORT WAYNE State: Zip Code: 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 2.00 1.00 145.00|| f costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is 145.00 no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? N 146, 00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147.00 N 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2 00 3.00 4 00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν Ν Ν N 155.00 156.00 Subprovi der - IPF 156. 00 Ν Ν Ν Ν 157.00 Subprovi der - IRF Ν Ν Ν N 157 00 158. 00 SUBPROVI DER 158.00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY Ν Ν Ν Ν 160.00 161.00 CMHC Ν Ν Ν 161.00 1.00 Mul ti campus 165.00|Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Ν 165.00 Enter "Y" for yes or "N" for no. FTE/Campus State | Zip Code Name County **CBSA** 3.00 0 1.00 2.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment		1. 00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment		1 00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment		1.00	
	Act		
167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167. 00
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"),	enter the	İ	168. 00
reasonable cost incurred for the HIT assets (see instructions)		İ	
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a	a hardshi p	İ	168. 01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	•	İ	
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N	N"), enter the	9.	99 169.00
transition factor. (see instructions)			
	Begi nni ng	Endi ng	
	1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting			170. 00
period respectively (mm/dd/yyyy)			
	1. 00	2.00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in	N		0 171. 00
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter		İ	
"Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section		İ	
I For yes and in for no fir cordinit is it cordinit its yes, enter the number of section			l l

	Financial Systems WHITLEY MEMOR		011 45 5		u of Form CMS-		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0101	Peri od: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Pre 6/29/2020 3:1	epared:	
				Y/N	Date		
	General Instruction: Enter Y for all YES responses. Enter N	I for all NO ro	sponsos Ent	1.00	2. 00		
	mm/dd/yyyy format.	TOT ATT NO TE	эропзез. Епте		TIC		
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation						
. 00	Has the provider changed ownership immediately prior to the			N		1.00	
	reporting period? If yes, enter the date of the change in c	column 2. (see	Y/N) Date	V/I		
			1.00	2. 00	3. 00		
2. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for	N			2.00	
3. 00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provice officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	Y			3.00	
			Y/N	Type	Date		
	Financial Data and Reports		1.00	2. 00	3. 00		
4. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	for Compiled, ailable in	Y	A	03/27/2020	4.00	
5. 00	Are the cost report total expenses and total revenues differenthose on the filed financial statements? If yes, submit reconstructions are the cost report total expenses and total revenues differenthing to the cost report total expenses and total revenues differenthing to the cost report total expenses and total revenues differenthing total revenues differenthing to the cost report total expenses and total revenues differenthing total revenues differenthing to the cost report total expenses and total revenues differenthing differenthing differenthing differenthing differenthing differenthing differenthing differenthing		IN IN			5. 00	
				Y/N	Legal Oper.		
	Approved Educational Activities			1. 00	2. 00		
5. 00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is N the legal operator of the program?						
7. 00 3. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the	N N		7. 00 8. 00	
0.00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction						
0. 00	Was an approved Intern and Resident GME program initiated of cost reporting period? If yes, see instructions.		the current	N		10.00	
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	\/ /NI	11. 00	
					Y/N 1. 00		
	Bad Debts						
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	Y N	12. 00	
4. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	yes, see ins	structi ons.	N	14.00	
5. 00	Did total beds available change from the prior cost reporti	, , , , , , , , , , , , , , , , , , , ,	yes, see ins ⁻	tructions.	Υ + R	15. 00	
		Y/N	Date	Y/N	Date		
	leave a	1.00	2.00	3. 00	4. 00		
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	N		N		16. 00	
7. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/30/2020	Y	04/30/2020	17. 00	
8. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Y		Y		18.00	
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19. 00	

HOSPI T	Financial Systems WHITLEY MEMORITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der Co	CN: 15-0101	Peri od:	u of Form CMS Worksheet S-	
				From 01/01/2019 To 12/31/2019	Part II Date/Time Pr	
		Descri	nti on	Y/N	6/29/2020 3: Y/N	14 pm
		(1. 00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00
	report data for other: beserve the other day astillents.	Y/N	Date	Y/N	Date	
		1.00	2. 00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEP	PT CHILDRENS H	OSPI TALS)		1.00	
	Capital Related Cost			T		
22. 00	Have assets been relifed for Medicare purposes? If yes, see		ala mada dumi	ing the cost		22. 0
3. 00	Have changes occurred in the Medicare depreciation expense of reporting period? If yes, see instructions.	due to apprais	ais made dur	ing the cost		23. 0
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	d into during	this cost re	porting period?		24. 00
5. 00	Have there been new capitalized leases entered into during	the cost repor	ting period?	If yes, see		25. 0
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during the	e cost renorti	na period? L	f ves. see		26. 0
	instructions.	·	3 1	,		
7. 00	Has the provider's capitalization policy changed during the copy.	cost reportin	g period? If	yes, submit		27. 0
8. 00	Unterest Expense Were new Loans, mortgage agreements or Letters of credit en	tered into dur	ing the cost	reporting		28.0
0. 00	period? If yes, see instructions.	torea rinto dar	ing the cost	reporting		20.0
9. 00	Did the provider have a funded depreciation account and/or I treated as a funded depreciation account? If yes, see instru		bt Service R	eserve Fund)		29. 0
0. 00	Has existing debt been replaced prior to its scheduled maturinstructions.	rity with new	debt? If yes	, see		30. 0
1. 00	Has debt been recalled before scheduled maturity without is: instructions.	suance of new	debt? If yes	, see		31. 0
32. 00	Purchased Services Have changes or new agreements occurred in patient care serv	vices furnishe	d through co	ntractual		32. 0
	arrangements with suppliers of services? If yes, see instruc	ctions.	-			
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 appl no, see instructions.	lied pertainin	g to competi	tive bidding? If		33. 0
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facility under an arilf yes, see instructions.	rangement with	provi der-ba	sed physi ci ans?	Υ	34.0
5. 00	If line 34 is yes, were there new agreements or amended exis		ts with the	provi der-based		35. 0
	physicians during the cost reporting period? If yes, see ins	structions.		Y/N	Date	_
				1. 00	2. 00	
	Home Office Costs					
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pro	epared by the	home office?	Y		36. 00 37. 00
88. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home offi					38. 0
0.00	the provider? If yes, enter in column 2 the fiscal year end			IN I		36.0
9. 00	If line 36 is yes, did the provider render services to other see instructions.	r chain compon	ents? If yes	, N		39. 0
0. 00	If line 36 is yes, did the provider render services to the linstructions.	home office?	If yes, see	N		40. 0
	Cost Report Preparer Contact Information	1.	UU	2.	00	
11 00		ERI C		NI CKESON		41. 0
11.00	respectively.					
		DADKU	II CVCTEN	2		10 0
11. 00 12. 00 13. 00	1 '	PARKVIEW HEALT	H SYSTEM, INC	C. REI MBURSEMENT@F		42. 0

Heal th Fi	inancial Systems WHITI	LEY MEMORIA	AL HOSPIT	AL		In Lie	u of Form CMS-	2552-10
HOSPI TAL	AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONI	NAI RE	Provi c	ler CCN: 15-01		eri od:	Worksheet S-2	<u>)</u>
					To	rom 01/01/2019	Part II Date/Time Pre	nared:
						12/31/2019	6/29/2020 3:	4 pm
				3. 00				
Co	ost Report Preparer Contact Information							
	inter the first name, last name and the title/posi		I RECTOR,	REI MBURSEMEN	JT			41. 00
	eld by the cost report preparer in columns 1, 2,	and 3,						
	especti vel y.							
42. 00 Ei	inter the employer/company name of the cost report	t						42. 00
	reparer.							
	nter the telephone number and email address of th	ne cost						43. 00
re	eport preparer in columns 1 and 2, respectively.							

| Peri od: | Worksheet S-3 | From 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared: | All Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Par

					10	12/31/2019	6/29/2020 3:14	
							I/P Days / 0/P	трііі
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1.00		2.00	3. 00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		30	10, 950	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4.00	HMO IRF Subprovider							4.00
5.00	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	0	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	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	SUBPROVI DER - I PF							16.00
17. 00	SUBPROVI DER - I RF							17.00
18.00	SUBPROVI DER							18.00
19.00	SKILLED NURSING FACILITY	44. 00		0	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								31.00
32.00	Labor & delivery days (see instructions)			O	0			32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33.00
33. 01	LTCH site neutral days and discharges							33. 01

| Peri od: | Worksheet S-3 | From 01/01/2019 | Part I | To 12/31/2019 | Date/Time Prepared:

				'	0 12/31/2019	6/29/2020 3: 1	
		I/P Days	/ O/P Visits	/ Trips	Full Time I		, p
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	odiiiporierre	I tro xviii	TI CI O XIX	Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2	1, 080	78	4, 416			1. 00
2. 00	for the portion of LDP room available beds) HMO and other (see instructions)	1, 398	988				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	o	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	o	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		O	0			6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 080	78	4, 416			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		47	730			13.00
14.00	Total (see instructions)	1, 080	125	5, 146	0.00	257. 00	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						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	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			0			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	257. 00	27. 00
28. 00	Observation Bed Days		158	1, 870			28. 00
29. 00	Ambul ance Trips	0					29. 00
30.00	Employee discount days (see instruction)			44			30.00
31. 00	Employee discount days - IRF			0			31. 00
32.00	Labor & delivery days (see instructions)	0	50	105			32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32. 01
33. 00	LTCH non-covered days	0					33. 00
	LTCH site neutral days and discharges	o					33. 01

| Peri od: | Worksheet S-3 | From 01/01/2019 | Part I | To 12/31/2019 | Date/Time Prepared:

					3 12/31/2019	6/29/2020 3: 1	
		Full Time	•	Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11.00	12. 00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		0			1, 879	1.00
2.00	HMO and other (see instructions)			519	292		2.00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO I RF Subprovi der				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation 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	408	33	1, 879	14. 00
15.00	CAH visits						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						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 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)						32.00
32. 01	Total ancillary labor & delivery room	1					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

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0101

					11	0 12/31/2019	Date/lime Pre 6/29/2020 3:1	
		Wkst. A Line Number		Reclassificati on of Salaries (from Wkst.	Salaries (col.2 ± col.	Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	A-6) 3. 00	3) 4.00	<u>col . 4</u> 5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200. 00	18, 615, 558	6, 469, 066	25, 084, 624	716, 639. 00	35. 00	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0		0.00		
3. 00	A Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3. 00
4. 00	B Physician-Part A -		83, 111	0	83, 111	592. 00	140. 39	4. 00
4. 01 5. 00	Administrative Physicians - Part A - Teaching Physician and Non		0	0	0 0	0. 00 0. 00	l e	
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0.00	6. 00
7. 00	services Interns & residents (in an	21. 00	0	0	0	0. 00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved		0	0	0	0.00	0.00	7. 01
8.00	programs) Home office and/or related organization personnel		6, 469, 066	0	6, 469, 066	165, 603. 00	39. 06	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 1, 703, 083	0 17, 957	0 1, 721, 040	0. 00 80, 315. 00		
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient		0	0	0	0.00	0.00	11. 00
12. 00	Care Contract labor: Top level management and other management and administrative		0	0	0	0.00	0.00	12. 00
13. 00	services Contract Labor: Physician-Part		0	0	0	0. 00	0. 00	13. 00
14. 00	A - Administrative Home office and/or related organization salaries and		0	0	0	0. 00	0. 00	14. 00
	wage-related costs							
14. 01 14. 02	Home office salaries Related organization salaries		6, 469, 066 0	0	6, 469, 066	165, 603. 00 0. 00		14. 01 14. 02
15. 00	Home office: Physician Part A		0	0	ő	0.00		1
16. 00	- Administrative Home office and Contract		0	0	0	0.00	0. 00	16. 00
16. 01	Physicians Part A - Teaching Home office Physicians Part A		0	0	0	0. 00	0. 00	16. 01
16. 02	- Teaching Home office contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		7, 315, 934	0	7, 315, 934			17. 00
18. 00	instructions) Wage-related costs (other)							18. 00
19. 00 20. 00	(see instructions) Excluded areas Non-physician anesthetist Part		739, 853 0	0	739, 853			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	0			21. 00
22. 00	Physician Part A - Administrative		0	0	0			22. 00
22. 01	Physician Part A - Teaching		0	0	0			22. 01
23. 00 24. 00 25. 00	Physician Part B Wage-related costs (RHC/FQHC) Interns & residents (in an		0 0 0	0 0 0	0 0			23. 00 24. 00 25. 00
25. 50	approved program) Home office wage-related		1, 983, 108	_				25. 50
25. 51	(core) Related organization		0	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative -		0	0	0			25. 52
	wage-related (core)							

						rom 01/01/2019	Part II	
					T	o 12/31/2019		
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Pai d Hours	6/29/2020 3:12 Average Hourly	+ piii
		Number		on of Salaries			Wage (col. 4 ÷	
		Number	Reported	(from Wkst.	(col.2 ± col.	Salaries in	col. 5)	
				A-6)	3)	col . 4	(01. 3)	
		1.00	2.00	3.00	4, 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0.00	0	0.00	0.00	25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARII	S						
26.00	Employee Benefits Department	4. 00	1, 866, 538	-1, 866, 538	0	0.00	0.00	26.00
27. 00	Administrative & General	5. 00	1, 460, 975	6, 649, 669	8, 110, 644	14, 811. 00	547. 61	27.00
28.00	Administrative & General under		0	0	0	0.00	0.00	28.00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7. 00	398, 585	49, 272	447, 857	17, 477. 00	25. 63	30.00
31.00	Laundry & Linen Service	8. 00	0	0	0	0.00	0.00	31.00
32.00	Housekeepi ng	9. 00	471, 605	58, 299	529, 904	34, 785. 00	15. 23	32.00
33.00	Housekeeping under contract		0	0	0	0.00	0.00	33.00
	(see instructions)							
34.00	Di etary	10.00	502, 051	-250, 807	251, 244	14, 249. 00	17. 63	34.00
35.00	Di etary under contract (see		0	0	0	0.00	0.00	35.00
	instructions)							
36.00	Cafeteri a	11. 00	0	301, 504	301, 504	18, 286. 00	16. 49	36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37.00
38. 00	Nursing Administration	13. 00	475, 460	58, 775	534, 235	9, 219. 00	57. 95	38.00
39.00	Central Services and Supply	14. 00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15. 00	673, 624	83, 272	756, 896	13, 575. 00	55. 76	40.00
41.00	Medical Records & Medical	16. 00	0	0	0	0.00	0.00	41.00
	Records Library							
42.00	Social Service	17. 00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

| Peri od: | Worksheet S-3 | From 01/01/2019 | Part III | To 12/31/2019 | Date/Time Prepared:

					''	0 12/31/2019	6/29/2020 3: 1	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	$(col.2 \pm col.$	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						l
1.00	Net salaries (see		12, 146, 492	6, 469, 066	18, 615, 558	551, 036. 00	33. 78	1. 00
	instructions)							
2.00	Excluded area salaries (see		1, 703, 083	17, 957	1, 721, 040	80, 315. 00	21. 43	2. 00
	instructions)							1
3.00	Subtotal salaries (line 1		10, 443, 409	6, 451, 109	16, 894, 518	470, 721. 00	35. 89	3. 00
	minus line 2)							1
4.00	Subtotal other wages & related		6, 469, 066	0	6, 469, 066	165, 603. 00	39. 06	4. 00
	costs (see inst.)							1
5.00	Subtotal wage-related costs		9, 299, 042	0	9, 299, 042	0.00	55. 04	5. 00
	(see inst.)							1
6.00	Total (sum of lines 3 thru 5)		26, 211, 517	6, 451, 109	32, 662, 626	636, 324. 00	51. 33	6. 00
7.00	Total overhead cost (see		5, 848, 838	5, 083, 446	10, 932, 284	122, 402. 00	89. 31	7. 00
	instructions)							l

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0101	Peri od: Worksheet S-3
		From 01/01/2019 Part IV

	To 12/31/2019	Date/Time Prep 6/29/2020 3:14	
		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	420, 669	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1, 457, 965	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	2, 117	6. 00
7.00	Employee Managed Care Program Administration Fees	62, 588	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, 183, 888	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)	61, 195	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)	85, 167	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	24, 788	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		l
17.00	FICA-Employers Portion Only	1, 636, 082	17. 00
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		l
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	47, 208	21. 00
	instructions))		l
	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	74, 119	
24.00	Total Wage Related cost (Sum of lines 1 -23)	8, 055, 786	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 Li€	eu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-010	From 01/01/2019	Worksheet S-3 Part V Date/Time Prepared: 6/29/2020 3:14 pm

		12/31/2017	6/29/2020 3: 1	
	Cost Center Description	Contract 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	8, 055, 786	1. 00
2.00	Hospi tal	0	8, 055, 786	2. 00
3.00	Subprovi der - I PF			3. 00
4.00	Subprovi der - I RF			4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF	0	0	8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA			11. 00
12.00	Separately Certified ASC			12. 00
13.00	Hospi tal -Based Hospi ce			13. 00
14.00	Hospital-Based Health Clinic RHC			14. 00
15.00	Hospital-Based Health Clinic FQHC			15. 00
16.00	Hospi tal -Based-CMHC			16. 00
17. 00	Renal Di al ysi s			17. 00
18. 00	Other	0	0	18. 00

	AL UNCOMPENSATED AND INDIGENT CARE DATA Pro	ovider CC	N: 15-0101	Peri od:	Worksheet S-10	0
				From 01/01/2019 To 12/31/2019	Date/Time Pre	naroc
				10 12/31/2019	6/29/2020 3: 1	
					1. 00	
	Uncompensated and indigent care cost computation					
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by lir	ne 202 column	1 8)	0. 217684	1.
00	Medicaid (see instructions for each line) Net revenue from Medicaid				1, 543, 312	2.
00	Did you receive DSH or supplemental payments from Medicaid?				Υ	3.
00	If line 3 is yes, does line 2 include all DSH and/or supplemental	l payments	from Medica	ni d?	Ϋ́	4.
00	If line 4 is no, then enter DSH and/or supplemental payments from	m Medicaio	I		0	5.
00	Medicaid charges				18, 316, 051	6.
00	Medicaid cost (line 1 times line 6)		6.1.	0 15 16	3, 987, 111	
00	Difference between net revenue and costs for Medicaid program (li < zero then enter zero)	ine / minu	IS SUM OT III	nes 2 and 5; IT	2, 443, 799	8.
	Children's Health Insurance Program (CHIP) (see instructions for	each line	:)			
00	Net revenue from stand-alone CHIP		,		17, 995	9.
0. 00	Stand-alone CHIP charges				5, 714	
1.00	Stand-alone CHIP cost (line 1 times line 10)				1, 244	
2. 00	Difference between net revenue and costs for stand-alone CHIP (li enter zero)	ine 11 mir	nus line 9; i	f < zero then	0	12.
	Other state or local government indigent care program (see instru	uctions fo	or each line)			
. 00	Net revenue from state or local indigent care program (Not includ				2, 756, 549	13.
. 00	Charges for patients covered under state or local indigent care p	program (N	lot included	in lines 6 or	24, 257, 104	14.
	10)					
00	State or local indigent care program cost (line 1 times line 14)	~~~+ ~~~~	nnogram (lir	no 15 minuo lino	5, 280, 383	
o. 00	Difference between net revenue and costs for state or local indig 13; if < zero then enter zero)	gent care	program (111	ie is minus iinė	2, 523, 834	10.
	Grants, donations and total unreimbursed cost for Medicaid, CHIP	and state	/local indig	jent care program	ns (see	
	instructions for each line)					
	Private grants, donations, or endowment income restricted to fund	-	-		0	
8. 00	Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos	spital ope	erations	c (sum of lines	0	18.
3. 00	Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid , CHIP and state and local i	spital ope	erations	s (sum of lines	0	
3. 00	Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos	spital ope	erations	s (sum of lines	0 0 4, 967, 633 Total (col. 1	18.
3. 00	Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid , CHIP and state and local i	spital ope	erations care programs Uninsured patients	I nsured pati ents	0 0 4, 967, 633 Total (col. 1 + col. 2)	18.
3. 00	Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid , CHIP and state and local i 8, 12 and 16)	spital ope	erations care programs Uninsured	Insured	0 0 4, 967, 633 Total (col. 1	18.
s. 00 9. 00	Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid , CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line)	spital ope	erations care programs Uninsured patients 1.00	I nsured pati ents 2.00	0 0 4, 967, 633 Total (col. 1 + col. 2) 3.00	18. 19.
3. 00 9. 00	Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid , CHIP and state and local i 8, 12 and 16)	spital ope	erations care programs Uninsured patients	I nsured pati ents 2.00	0 0 4, 967, 633 Total (col. 1 + col. 2) 3.00	18. 19.
3. 00 0. 00 0. 00	Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount	spital ope indigent o	erations care programs Uninsured patients 1.00	I nsured pati ents 2.00	0 0 4, 967, 633 Total (col. 1 + col. 2) 3.00	18. 19.
0. 00	Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unrelimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions)	spital ope indigent o	Uni nsured patients 1.00 2,730,80	I nsured patients 2.00 923,895 923,895	0 0 4, 967, 633 Total (col. 1 + col. 2) 3. 00 3, 654, 701 1, 518, 348	18. 19. 20. 21.
0. 00	Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of	spital ope indigent o	Uninsured patients 1.00 2,730,80	I nsured patients 2.00 923,895 923,895	0 0 4, 967, 633 Total (col. 1 + col. 2) 3. 00 3, 654, 701	18. 19. 20. 21.
0.00	Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care	spital ope indigent o	Uninsured patients 1.00 2,730,80 594,48	I nsured pati ents 2.00 06 923,895 923,895 748	0 0 4, 967, 633 Total (col. 1 + col. 2) 3. 00 3, 654, 701 1, 518, 348	18. 19. 20. 21. 22.
0.00	Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of	spital ope indigent o	Uni nsured patients 1.00 2,730,80	I nsured pati ents 2.00 06 923,895 923,895 748	0 0 4, 967, 633 Total (col. 1 + col. 2) 3. 00 3, 654, 701 1, 518, 348 1, 269	18. 19. 20. 21. 22.
0.00	Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unrelimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22)	spital ope indigent o	Uninsured patients 1.00 2,730,80 594,48 52 593,93	I nsured pati ents 2.00 06 923,895 63 923,895 748 32 923,147	0 0 4, 967, 633 Total (col. 1 + col. 2) 3. 00 3, 654, 701 1, 518, 348 1, 269 1, 517, 079	20. 21. 22. 23.
0.00	Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unrelimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22)	lity ts (see	Uninsured patients 1.00 2,730,80 594,48 52 593,93	I nsured pati ents 2.00 06 923,895 63 923,895 748 32 923,147	0 0 4, 967, 633 Total (col. 1 + col. 2) 3. 00 3, 654, 701 1, 518, 348 1, 269 1, 517, 079	18. 19. 20. 21. 22.
. 00	Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unrelimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount 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 pr If line 24 is yes, enter the charges for patient days beyond the	lity ts (see ff as days beyor	Uninsured patients 1.00 2,730,80 594,49 50 2,730,90	Insured patients 2.00 923,895 63 923,895 748 82 923,147 of stay limit	0 0 4, 967, 633 Total (col. 1 + col. 2) 3. 00 3, 654, 701 1, 518, 348 1, 269 1, 517, 079	20. 21. 22. 23.
1. 00 1. 00 1. 00 1. 00 1. 00 1. 00	Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount 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 pr If line 24 is yes, enter the charges for patient days beyond the stay limit	lity ts (see ff as days beyorogram? indigent	Uninsured patients 1.00 2,730,80 594,49 50 2,730,90	Insured patients 2.00 923,895 63 923,895 748 82 923,147 of stay limit	0 0 4, 967, 633 Total (col. 1 + col. 2) 3. 00 3, 654, 701 1, 518, 348 1, 269 1, 517, 079 1. 00 N	20. 21. 22. 23.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unrelimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount 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 pr If line 24 is yes, enter the charges for patient days beyond the	spital oper indigent of indigent of indigent of indigent of indigent operations indigent operations indigent operations indigent operations indigent operations indigent operations indigent operations indigent operations indigent operations indigent operations indigent operations in indigent operat	Uninsured patients 1.00 2,730,80 594,49 52 and a length care program	Insured patients 2.00 923,895 63 923,895 748 82 923,147 of stay limit	0 0 4, 967, 633 Total (col. 1 + col. 2) 3.00 3, 654, 701 1, 518, 348 1, 269 1, 517, 079 1.00 N	20. 21. 22. 23. 24. 25.
3. 00 0. 00 0. 00 0. 00 0. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00	Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unrelimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount 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 pr If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see instructions)	lity ts (see days beyorogram? indigent ructions) (see instr	Uninsured patients 1.00 2,730,80 594,49 cond a length care program	Insured patients 2.00 923,895 63 923,895 748 82 923,147 of stay limit	0 0 4, 967, 633 Total (col. 1 + col. 2) 3. 00 3, 654, 701 1, 518, 348 1, 269 1, 517, 079 1. 00 N 0	20. 21. 22. 23. 24. 25. 26. 27.
33.00 9.00 1.00	Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount 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 instructions) Medicare allowable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	days beyorogram? indigent cutions) (see instruct	Uninsured patients 1.00 2,730,80 594,45 593,95 and a length care program	Insured patients 2.00 23,895 33 923,895 748 32 923,147 of stay limit of slength of	0 0 0 4, 967, 633 Total (col. 1 + col. 2) 3. 00 3, 654, 701 1, 518, 348 1, 269 1, 517, 079 1. 00 N 0 13, 662, 600 45, 347 69, 765 13, 592, 835	20. 21. 22. 23. 24. 25. 26. 27. 27. 28.
5. 00 6. 00 7. 00 7. 01 8. 00 9. 00	Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount 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 instructions) Medicare ellowable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt expense.	days beyorogram? indigent cutions) (see instruct	Uninsured patients 1.00 2,730,80 594,45 593,95 and a length care program	Insured patients 2.00 23,895 33 923,895 748 32 923,147 of stay limit of slength of	0 0 4, 967, 633 Total (col. 1 + col. 2) 3. 00 3, 654, 701 1, 518, 348 1, 269 1, 517, 079 1. 00 N 0 13, 662, 600 45, 347 69, 765 13, 592, 835 2, 983, 361	20. 21. 22. 23. 24. 25. 26. 27. 27. 28. 29.
3. 00 2. 00 3. 00 3. 00 4. 00 5. 00 6. 00 7. 00 7. 00 7. 00 7. 00 8. 00 9. 00 9. 00	Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount 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 instructions) Medicare allowable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	days beyorogram? indigent of the control of the con	Uninsured patients 1.00 2,730,80 594,45 593,95 and a length care program	Insured patients 2.00 23,895 33 923,895 748 32 923,147 of stay limit of slength of	0 0 0 4, 967, 633 Total (col. 1 + col. 2) 3. 00 3, 654, 701 1, 518, 348 1, 269 1, 517, 079 1. 00 N 0 13, 662, 600 45, 347 69, 765 13, 592, 835	20. 21. 22. 23. 24. 25. 26. 27. 27. 28. 29. 30.

Heal th	Financial Systems	WHITLEY MEMORIA	_ HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der CO		Peri od:	Worksheet A	
					From 01/01/2019 To 12/31/2019	Date/Time Pre	pared·
					10 12/31/201/	6/29/2020 3: 1	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	2.00	2.00	4.00	col . 4)	
	GENERAL SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT		5, 274, 983	5, 274, 98	3 -1, 438, 555	3, 836, 428	1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		0		0 2, 201, 616		
3.00	00300 OTHER CAP REL COSTS		97, 000	97, 00		0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 866, 538	6, 531, 573	8, 398, 11	1 -1, 866, 538	6, 531, 573	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	1, 460, 975	26, 606, 111	28, 067, 08	6 -385, 307	27, 681, 779	5. 00
6. 00	00600 MAI NTENANCE & REPAI RS	0	0		0 0	0	6. 00
7.00	00700 OPERATION OF PLANT	398, 585	1, 291, 979			1, 632, 249	7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	471, 605	280, 751 178, 773	280, 75 650, 37		280, 751 706, 809	8. 00 9. 00
10. 00	01000 DI ETARY	502, 051	278, 398			358, 244	ł
11. 00	01100 CAFETERI A	0	270, 370	700, 44	0 472, 567	472, 567	1
12. 00	01200 MAINTENANCE OF PERSONNEL	l o	0		0 0	0	12.00
13.00	01300 NURSING ADMINISTRATION	475, 460	151	475, 61	1 58, 775	534, 386	1
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0		0 0	0	14. 00
15.00	01500 PHARMACY	673, 624	104, 619	778, 24	3 81, 211	859, 454	1
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0	'	0	0	16.00
17.00	01700 SOCIAL SERVICE	0	0		0	0	
19. 00 20. 00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL		0			0	19. 00 20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV		0			0	21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV		0		0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	o	0		0 0	0	ı
	INPATIENT ROUTINE SERVICE COST CENTERS				-		
30.00	03000 ADULTS & PEDIATRICS	3, 392, 482	540, 470	3, 932, 95	2 -341, 832	3, 591, 120	30.00
43.00	04300 NURSERY	0	0		0 309, 052	309, 052	1
44. 00	04400 SKILLED NURSING FACILITY	0	0		0 0	0	44. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	1, 018, 529	630, 337	1, 648, 86	6 123, 474	1, 772, 340	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	89, 005	1, 250			948, 950	
53. 00	05300 ANESTHESI OLOGY	0	911, 980	911, 98		911, 980	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 865, 853	1, 356, 460	3, 222, 31	3 228, 288	3, 450, 601	54. 00
60.00	06000 LABORATORY	0	3, 272, 504	3, 272, 50	4 0	3, 272, 504	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	770.04	0 0	0	62. 30
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	588, 599 1, 294, 132	191, 243 327, 755	779, 84. 1, 621, 88		769, 751 906, 045	1
67. 00	06700 OCCUPATI ONAL THERAPY	1, 2, 4, 132	327, 733	1, 021, 00	0 575, 069		1
68. 00	06800 SPEECH PATHOLOGY		0		0 16, 207	16, 207	1
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 654, 183	1, 654, 18			71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 607, 699		1
	07300 DRUGS CHARGED TO PATIENTS	0	3, 553, 429	3, 553, 42			
	O7697 CARDI AC REHABI LI TATI ON O7698 HYPERBARI C OXYGEN THERAPY	0	248	24	0 8 -248	0	76. 97 76. 98
76. 79			0	27	0 0	0	1
	OUTPATIENT SERVICE COST CENTERS	-	-				
90.00	09000 CLI NI C	0	0		0 0	0	90. 00
	09001 INTENSIVE OUT PATIENT PROGRAM	0	0		0	0	
	09100 EMERGENCY	2, 815, 037	1, 811, 073	4, 626, 11	0 342, 907	4, 969, 017	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95 00	09500 AMBULANCE SERVICES	1, 649, 753	409, 065	2, 058, 81	8 -1, 661	2, 057, 157	95. 00
70.00	SPECIAL PURPOSE COST CENTERS	1,017,700	1077 000	2,000,01	.,	2/00//10/	70.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	18, 562, 228	55, 304, 335	73, 866, 56	3 -13, 302	73, 853, 261	118. 00
	NONREI MBURSABLE COST CENTERS	1					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	35, 878				190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 OCCUPATIONAL HEALTH	24, 450	501, 722	526, 17	2 10, 182	536, 354	194. 00
	07951 PAIN CLINIC		0				194. 00
	07952 OAK POINTE		0		0 0		194. 02
	07953 FOUNDATION	0	160, 697	160, 69	7 0	160, 697	
	07954 COMMUNITY & VOLUNTEER SERVICES	28, 880	142, 532	171, 41	2 3, 120		
	07955 VACANT SPACE	0	0	'	0		194. 05
194. 06 200. 00	07956 TELEHEALTH MEDICINE TOTAL (SUM OF LINES 118 through 199)	0 18, 615, 558	0 56, 145, 164	74, 760, 72	0 0		194.06
200. UC	TIOTAL (SOW OF LINES TTO HILDUGH 199)	10, 015, 550	50, 145, 104	14,700,72	۷	14, 100, 122	1200.00

Peri od: From 01/01/2019 To 12/31/2019 Date/Ti me Prepared: 6/29/2020 3:14 pm

			6/29/2020 3:14 pm
Cost Center Description	Adjustments	Net Expenses	
		or Allocation	
	6.00	7.00	
GENERAL SERVI CE COST CENTERS	,		
1.00 O0100 CAP REL COSTS-BLDG & FLXT	-2, 138, 512	1, 697, 916	1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP	-185	2, 201, 431	2. 00
3.00 00300 OTHER CAP REL COSTS	0	0	3.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-3, 176, 208	3, 355, 365	4.00
5.00 00500 ADMINISTRATIVE & GENERAL	-8, 982, 216	18, 699, 563	5. 00
6.00 00600 MAINTENANCE & REPAIRS	0	0	6. 00
7.00 OO700 OPERATION OF PLANT	-107, 625	1, 524, 624	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	280, 751	8.00
9. 00 00900 HOUSEKEEPI NG	o	706, 809	9.00
10. 00 01000 DI ETARY	ol	358, 244	10.00
11. 00 01100 CAFETERI A	-293, 717	178, 850	11.00
12. 00 01200 MAI NTENANCE OF PERSONNEL	0	0	12.00
13. 00 01300 NURSI NG ADMINI STRATI ON	o	534, 386	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	ا	001,000	14.00
15. 00 01500 PHARMACY	-165, 640	693, 814	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	-105, 040	075, 014	16. 00
17. 00 01700 SOCIAL SERVICE		0	17.00
· · · · · · · · · · · · · · · · · · ·		0	
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	0	0	19. 00
20. 00 02000 NURSI NG SCHOOL	0	0	20.00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	21. 00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22. 00
23.00 O2300 PARAMED ED PRGM-(SPECIFY)	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	,		
30. 00 03000 ADULTS & PEDI ATRI CS	-372, 080	3, 219, 040	30.00
43. 00 04300 NURSERY	0	309, 052	43.00
44.00 O4400 SKILLED NURSING FACILITY	0	0	44. 00
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	-4, 680	1, 767, 660	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	948, 950	52. 00
53. 00 05300 ANESTHESI OLOGY	-911, 980	o	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-12, 407	3, 438, 194	54.00
60. 00 06000 LABORATORY	0	3, 272, 504	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	-83, 219	686, 532	65. 00
66. 00 06600 PHYSI CAL THERAPY	-361, 480	544, 565	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	575, 069	67. 00
68. 00 06800 SPEECH PATHOLOGY	0		68.00
		16, 207	
69. 00 06900 ELECTROCARDI OLOGY	0	0	69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 046, 484	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	607, 699	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	3, 553, 429	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS			
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	-995, 108	3, 973, 909	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART			92. 00
OTHER REIMBURSABLE COST CENTERS			
95. 00 09500 AMBULANCE SERVI CES	-3, 553	2, 053, 604	95. 00
SPECIAL PURPOSE COST CENTERS	·		
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-17, 608, 610	56, 244, 651	118. 00
NONREI MBURSABLE COST CENTERS	,,	00, = 1.1, 00.1	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	35, 878	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	-254, 682	281, 672	192.00
194. 00 07950 OCCUPATI ONAL HEALTH	234,002	281, 072	194. 00
194. 01 07950 OCCOPATIONAL HEALTH		0	194. 00 194. 01
	1	0	
194. 02 07952 OAK POI NTE	0	1/0/07	194. 02
194. 03 07953 FOUNDATION	0	160, 697	194. 03
194. 04 07954 COMMUNITY & VOLUNTEER SERVICES	-18	174, 514	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)	-17, 863, 310	56, 897, 412	200. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0101

Cost Center	1.00
2.00 3.00 4.00 5.00 A - CAFETERIA RECLASS 1.00 CAFETERIA 111.00 301,504 171,063 0 301,504 171,063 B - OB RECLASS 1.00 NURSERY 43.00 236,573 72,479 2.00 DELI VERY ROOM & LABOR ROOM 52.00 648,891 198,801 0 885,464 271,280 E - BUI LDI NG AND EQUI P LEASE 1.00 CAP REL COSTS-BLDG & FIXT 1.00 0 524,288 2.00 CAP REL COSTS-MVBLE EQUI P 2.00 0 52,978 3.00 0.00 0 0	1.00
A - CAFETERI A RECLASS 1. 00	1.00
1. 00 CAFETERI A 11. 00 301, 504 171, 063 0 301, 504 171, 063 0 301, 504 171, 063 0 301, 504 171, 063 0 301, 504 171, 063 0 301, 504 171, 063 0 301, 504 171, 063 0 301, 504 171, 063 0 301, 504 171, 063 0 301, 504 171, 063 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00
0 301, 504 171, 063 B - OB RECLASS 1. 00 NURSERY 43. 00 236, 573 72, 479 2. 00 DELI VERY ROOM & LABOR ROOM 52. 00 648, 891 198, 801 0 885, 464 271, 280 E - BUI LDI NG AND EQUI P LEASE 1. 00 CAP REL COSTS-BLDG & FIXT 1. 00 0 524, 288 2. 00 CAP REL COSTS-MVBLE EQUI P 2. 00 0 52, 978 3. 00 0 0 0 0	1.00
B - OB RECLASS 1. 00 NURSERY 2. 00 DELI VERY ROOM & LABOR ROOM 52. 00 648, 891 198, 801 0 885, 464 271, 280 E - BUILDI NG AND EQUI P LEASE 1. 00 CAP REL COSTS-BLDG & FIXT 1. 00 0 524, 288 2. 00 CAP REL COSTS-MVBLE EQUI P 2. 00 0 52, 978 3. 00 0 0 0 0 0	4
1. 00 NURSERY 43. 00 236, 573 72, 479 2. 00 DELI VERY ROOM & LABOR ROOM 52. 00 648, 891 198, 801 885, 464 271, 280 E - BUI LDI NG AND EQUI P LEASE 1. 00 CAP REL COSTS-BLDG & FIXT 1. 00 0 524, 288 2. 00 CAP REL COSTS-MVBLE EQUI P 2. 00 0 52, 978 3. 00 0. 00 0 0 0	4
2. 00 DELI VERY ROOM & LABOR ROOM 52. 00 648, 891 198, 801 885, 464 271, 280 E - BUI LDI NG AND EQUI P LEASE 1. 00 CAP REL COSTS-BLDG & FIXT 1.00 0 524, 288 2.00 CAP REL COSTS-MVBLE EQUI P 2. 00 0 52, 978 3. 00 0.00 0 0	4
0 885, 464 271, 280 E - BUI LDI NG AND EQUI P LEASE 1. 00 CAP REL COSTS-BLDG & FI XT 1. 00 0 524, 288 2. 00 CAP REL COSTS-MVBLE EQUI P 2. 00 0 52, 978 3. 00 0. 00 0 0	2.00
E - BUILDING AND EQUIP LEASE 1. 00	
1.00 CAP REL COSTS-BLDG & FIXT 1.00 0 524, 288 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 0 52, 978 3.00 0.00 0 0	
2. 00 CAP REL COSTS-MVBLE EQUI P 2. 00 0 52, 978 0. 00 0 0	
3.00 0.00 0	1.00
	2.00
	3.00
4.00 0.00 0	4.00
5.00 0.00 0 0	5. 00
6.00 0.00 0	6. 00
7. 00 0. 00 0 0	7. 00
8.00 0.00 0	8.00
9.00	9. 00
10.00	10.00
11.00	11. 00
12.00	12. 00
13.00	13. 00
14.00	14. 00
15. 00	15. 00
16. 00 0 0 0	15.00
17.00	17. 00
18. 00 0 0 0	18.00
19.000	19. 00
0 0 577, 266	
G - INSURANCE RECLASS	
1.00 CAP REL COSTS-BLDG & FIXT 1.00 0 36,802	1.00
2. 00 CAP REL COSTS-MVBLE EQUI P 2. 00 0 51, 993	2.00
0 0 88,795	
H - DEPRECIATION RECLASS	
1. 00 CAP REL COSTS-MVBLE EQUI P 2. 00 0 2, 096, 645	1.00
0 2,096,645	
K - SALARY RECLASS	
1.00 ADMINISTRATIVE & GENERAL 5.00 6,469,066 0	1.00
0 6,469,066	
L - REHAB THERAPY DEPT RECLASS	
1. 00 OCCUPATI ONAL THERAPY 67. 00 556, 488 18, 581	1.00
2.00 SPEECH PATHOLOGY 68.00 15, 684 523	2.00
0 572, 172 19, 104	
N - PTO ACCRUAL RECLASS	
1.00 ADMINISTRATIVE & GENERAL 5.00 180,603 0	1.00
2. 00 OPERATION OF PLANT 7. 00 49, 272 0	2.00
3. 00 HOUSEKEEPING 9. 00 58, 299 0	3.00
	1
	4.00
	5.00
6. 00 PHARMACY 15. 00 83, 272 0	6. 00
6. 00 PHARMACY 15. 00 83, 272 0 7. 00 ADULTS & PEDIATRICS 30. 00 419, 371 0	7. 00
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6. 00 PHARMACY 7. 00 ADULTS & PEDI ATRI CS 9. 00 OPERATI NG ROOM 9. 00 OPERATI NG ROOM 10. 00 DELI VERY ROOM & LABOR ROOM 11. 00 RADI OLOGY-DI AGNOSTI C 12. 00 RESPIRATORY THERAPY 12. 00 RESPIRATORY THERAPY 13. 00 PHYSI CAL THERAPY 14. 00 EMERGENCY 15. 00 T2. 761 16. 00 EMERGENCY 17. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 T2. 761 18. 00 COMMUNITY & VOLUNTEER 194. 04 T3. 570 0 T1. 866, 538 1. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 T1. 866, 538 1. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 T1. 866, 538 1. 00 O- CLI NI C DI ETI CI AN RECLASS 1. 00 PHYSI CI ANS' PRI VATE OFFI CES 1 11. 365 0 T2. 00 T1. 365 0 T2. 00 T2. 761 1. 00 PHYSI CI ANS' PRI VATE OFFI CES 1 192. 00 T1. 365 0 T2. 00 T2. 761 1. 00 O- CLI NI C DI ETI CI AN RECLASS 1. 00 O- CLI	7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 16. 00 17. 00 18. 00
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Heal th	Financial Systems	WHITLEY MEMOR	I AL HOSPI TAL		In Lieu of Form CMS-2552-10			
RECLASS	SIFICATIONS			Provi der (CCN: 15-0101	Peri od:	Worksheet A-	5
					From 01/01/2019 To 12/31/2019	Date/Time Pro 6/29/2020 3:		
		Increases						
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3. 00	4. 00	5. 00				
	U - RECLASS FOUNDATION SALARI	ES TO OTHER						
1.00		0.00	0					1. 00
	0		0	C)			
500.00	Grand Total: Increases		10, 106, 109	4, 329, 734	ļ.			500.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0101 Peri od: Worksheet A-6 From 01/01/2019 To 12/31/2019 Date/Time Prepared:

					1	20 3:14 pm
		Decreases				
	Cost Center	Li ne #	Salary		Wkst. A-7 Ref.	
٨	6. 00 CAFETERI A RECLASS	7. 00	8. 00	9. 00	10. 00	
	I ETARY	10.00	301, 504	171, 063	0	1.
0	TETAKI		301, 504	171, 063		1 '
В	- OB RECLASS		221,7221,	,	1	
	DULTS & PEDIATRICS	30.00	885, 464	271, 280	0	1.
o		0.00	o	0	0	2
0			885, 464	271, 280		
	- BUILDING AND EQUIP LEASE					
	DMI NI STRATI VE & GENERAL	5. 00	0	59, 755	10	1
	PERATION OF PLANT	7.00	0	107, 271	10	2
	ESPIRATORY THERAPY HYSICAL THERAPY	65.00	0	77, 102	0	3
	DMINISTRATIVE & GENERAL	66. 00 5. 00	0	280, 160	0	5
	PERATION OF PLANT	7. 00	O O	16, 478 316	0	6
	OUSEKEEPI NG	9.00		1, 868	0	7
	I ETARY	10.00	0	335	o	8
	HARMACY	15. 00	o	2, 061	0	9
	DULTS & PEDIATRICS	30.00	0	5, 341	0	10
	PERATING ROOM	50. 00	o	2, 434	0	11
	ADI OLOGY-DI AGNOSTI C	54.00	Ö	2, 365	0	12
00 RE	ESPI RATORY THERAPY	65.00	0	5, 750	0	13
00 PH	HYSICAL THERAPY	66.00	0	4, 384	0	14
00 EN	MERGENCY	91.00	0	5, 082	0	15
00 AN	MBULANCE SERVICES	95.00	0	1, 661	0	16
	HYSICIANS' PRIVATE OFFICES	192. 00	0	4, 205	0	17
	OMMUNITY & VOLUNTEER	194. 04	0	450	0	18
	ERVICES		_		_	
00 H	YPERBARI C OXYGEN THERAPY	<u>76.</u> 98		248	0	19
0	I NCHDANCE DECLACE		0	577, 266		
	- INSURANCE RECLASS DMINISTRATIVE & GENERAL	5. 00	0	88, 795	12	1
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	+			<u> 0</u> 88, 795	— — ¹²	-
Н	- DEPRECIATION RECLASS		9	00, 173		
	AP REL COSTS-BLDG & FIXT	1.00	0	2, 096, 645	9	1
0				2, 096, 645		
K	- SALARY RECLASS					
0 <u>A</u> [DMI NI STRATI VE & GENERAL			<u>6, 469, 0</u> 66	0	1
0	DELIAR THERARY DERT REGUACO		0	6, 469, 066		
	- REHAB THERAPY DEPT RECLASS		F70 470	10 104	0	
0 PH 0	HYSI CAL THERAPY	66. 00 0. 00	572, 172	19, 104	0	1 2
			572, 172			-
N	- PTO ACCRUAL RECLASS		372, 172	17, 104	1	
	MPLOYEE BENEFITS DEPARTMENT	4.00	1, 866, 538	0	0	1
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00		0.00	0	0	0	16
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00	+		001, 866, 538	0	9	18
0	- CLINIC DIETICIAN RECLASS		1, 000, 000	U		
	I ETARY	10.00	11, 365	0	0	1
0			11, 365		— — —	'
R	- IMPLANTABLE MEDICAL SUPPLI	ES	, 222			_
	EDICAL SUPPLIES CHARGED TO	71. 00	0	607, 699	0	1
	ATI ENT					
0			0	607, 699		
	- INTEREST EXPENSE					
0	THER CAP REL COSTS	3.00	0	97, 000	14	1
0			0	97, 000		
IT.	- RECLASS HOSPITALISTS TO AD				=1	-
	DMINICEDATIVE A ACTUENT					
	DMI NI STRATI VE & GENERAL			40 <u>0,</u> 882 400, 882	9	1

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101 Peri od: Worksheet A-6 From 01/01/2019 To 12/31/2019 Date/Time Prepared: 6/29/2020 3:14 pm Decreases Wkst. A-7 Ref. 10.00 Cost Center Li ne # Sal ary 0ther 6. 00 8.00 9.00 7.00 U - RECLASS FOUNDATION SALARIES TO OTHER 0.00 1.00 1.00

3, 637, 043

10, 798, 800

500.00

500.00 Grand Total: Decreases

				T	o 12/31/2019	Date/Time Prep 6/29/2020 3:14	pared: 4 pm
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	260, 483	0	0	0	0	1. 00
2.00	Land Improvements	2, 492, 826	-3, 787	0	-3, 787	0	2. 00
3.00	Buildings and Fixtures	14, 752, 566	61, 047	0	61, 047	0	3. 00
4.00	Building Improvements	48, 824	0	C	0	0	4. 00
5.00	Fixed Equipment	6, 277, 315	30, 825	C	30, 825	0	5. 00
6.00	Movable Equipment	15, 905, 159	3, 695, 984	C	3, 695, 984	2, 902, 719	6. 00
7.00	HIT designated Assets	3, 759, 797	155, 122	C	155, 122	0	7. 00
8.00	Subtotal (sum of lines 1-7)	43, 496, 970	3, 939, 191	C	3, 939, 191	2, 902, 719	8. 00
9.00	Reconciling Items	1, 714, 580	1, 576, 190	C	1, 576, 190	0	9. 00
10.00	Total (line 8 minus line 9)	41, 782, 390	2, 363, 001	C	2, 363, 001	2, 902, 719	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	260, 483	0			l	1. 00
2.00	Land Improvements	2, 489, 039	44, 862			l	2. 00
3.00	Buildings and Fixtures	14, 813, 613	238, 565			ļ	3. 00
4.00	Building Improvements	48, 824	48, 824			ļ	4. 00
5.00	Fixed Equipment	6, 308, 140	57, 045			l	5. 00
6.00	Movable Equipment	16, 698, 424	6, 013, 048			ļ	6. 00
7.00	HIT designated Assets	3, 914, 919	0			ļ	7. 00
8.00	Subtotal (sum of lines 1-7)	44, 533, 442	6, 402, 344				8. 00
9.00	Reconciling Items	3, 290, 770	0			ļ	9. 00
10. 00	Total (line 8 minus line 9)	41, 242, 672	6, 402, 344				10. 00

Heal th	Financial Systems	WHITLEY MEMORI	IAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-0101	Peri od:	Worksheet A-7	
					From 01/01/2019		
					To 12/31/2019	Date/Time Prep 6/29/2020 3:14	
			SI	JMMARY OF CAP	I TAI	0/27/2020 3. 1	4 piii
			00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1 1712		
	Cost Center Description		Lease	Interest	Insurance (see	Taxes (see	
	·				instructions)	instructions)	
		9. 00	10.00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	IN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	5, 274, 983	0		0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2. 00
3.00	Total (sum of lines 1-2)	5, 274, 983	0		0 0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Relate					
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM					
1.00	CAP REL COSTS-BLDG & FLXT	0	5, 274, 983			l	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0			ļ	2. 00
0 00							

0 0

5, 274, 983

1. 00 2. 00 3. 00

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

Heal th	n Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lieu of Form CMS-2552-10			
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2019 To 12/31/2019	Worksheet A-7 Part III Date/Time Prep		
					10 12/31/2017	6/29/2020 3: 14		
		COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance		
			Leases	for Ratio	instructions)			
				(col. 1 - col.				
		4.00	0.00	2)	4.00	F 00		
	PART III - RECONCILIATION OF CAPITAL COSTS CI	1. 00	2.00	3. 00	4. 00	5. 00		
1. 00	CAP REL COSTS-BLDG & FIXT	25, 634, 679	Ιο	25, 634, 679	0. 583213	0	1. 00	
2. 00	CAP REL COSTS-BLDG & FIXT	18, 898, 763				0	2. 00	
3.00	Total (sum of lines 1-2)	44, 533, 442					3. 00	
3.00	(Sum of Tries 1 2)		TION OF OTHER O			F CAPITAL	3.00	
		, ALLOON	THOM OF OTHER C	57 (I I I I I I	JONINI II C	. OALTTALE		
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease		
	·		Capi tal -Relate	col s. 5	·			
			d Costs	through 7)				
		6. 00	7. 00	8. 00	9. 00	10. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS	1					
1.00	CAP REL COSTS-BLDG & FIXT	0	0	(1, 039, 826	524, 288	1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2, 096, 460		2. 00	
3.00	Total (sum of lines 1-2)	0	0	(3, 136, 286	577, 266	3. 00	
		SUMMARY OF CAPITAL						
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum		
			instructions)	instructions)	Capi tal -Rel ate			
					d Costs (see	through 14)		
					instructions)			
	DADT III DECONCILIATION OF CARLTAL COCTO OF	11. 00	12.00	13. 00	14. 00	15. 00		
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CI		24 000	1	07.000	1 (07 01)	1 00	
1.00	CAP REL COSTS-BLDG & FLXT CAP REL COSTS-MVBLE EQUIP	0			97, 000		1. 00 2. 00	
2. 00 3. 00	Total (sum of lines 1-2)	0			0 97,000	2, 201, 431 3, 899, 347		
3.00	Total (Suil Of Titles 1-2)	1	00, 795	1	91,000	3, 077, 34/	3.00	

Peri od: Workshee From 01/01/2019 Date/Tir Provider CCN: 15-0101

				T	o 12/31/2019		
				Expense Classification on		6/29/2020 3: 14	4 pm
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00 1. 00	5. 00 0	1.00
	COSTS-BLDG & FIXT (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 (chapter 2)		0		0.00	0	3. 00
4.00	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
<i>(</i> 00	expenses (chapter 8)		0		0.00	0	4 00
6. 00	Rental of provider space by suppliers (chapter 8)		U		0.00	U	6. 00
7. 00	Telephone services (pay stations excluded) (chapter		0		0. 00	0	7. 00
	21)					_	
8. 00	Television and radio service (chapter 21)	A	-354	OPERATION OF PLANT	7. 00	0	8. 00
9.00	Parking Lot (chapter 21) Provider-based physician	4.0.2	0		0.00	0	9.00
10. 00	adjustment	A-8-2	-2, 311, 523			U	10. 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12. 00	Related organization	A-8-1	-8, 450, 394			0	12. 00
13. 00	transactions (chapter 10) Laundry and Linen service		0		0. 00	0	13. 00
14.00	Cafeteria-employees and guests Rental of quarters to employee		-214, 201	CAFETERI A	11.00	0	
15. 00	and others		0		0.00	U	
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17.00	patients	В	/ 050	DUADMACV	15.00		17.00
17. 00	Sale of drugs to other than patients	Б	-6, 050	PHARMACY	15. 00	0	17. 00
18. 00	Sale of medical records and abstracts		0		0. 00	0	18. 00
19. 00	Nursing and allied health		0		0.00	0	19. 00
	education (tuition, fees, books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00	0	
21.00	interest, finance or penalty		O		0.00	J	21.00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to						
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
	(chapter 21)						
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
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	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
55. 55	therapy costs in excess of		0	TIEN I	07.00		55. 55
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3		SPEECH PATHOLOGY	68. 00		31. 00
51.00	pathology costs in excess of	A-0-3	U	OLECOLI MINOLOGI	00.00		31.00
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0. 00	0	32. 00
33. 00	Depreciation and Interest		14 141	ADMINISTRATIVE • CENERAL			33. 00
<u></u>	INITEREST EXPENSE	A	- 10, 404	ADMINISTRATIVE & GENERAL	5. 00	ı Ol	J 33. UU

				Tı	0 12/31/2019	Date/Time Pre 6/29/2020 3:1	
				Expense Classification on	Worksheet A		, i
				To/From Which the Amount is	to be Adjusted		
					•		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
33. 01	TELEMETRY ADJUSTMENT	A		ADULTS & PEDIATRICS	30. 00	0	00.01
34.00	MI SC REVENUE	A	-7, 304	ADULTS & PEDIATRICS	30.00	0	34. 00
35.00	POSTURE ASSESSMENTS	В	-81, 320	PHYSI CAL THERAPY	66. 00	0	35. 00
37.00	MI SC REVENUE	В	-12, 407	RADI OLOGY-DI AGNOSTI C	54.00	0	37. 00
38. 00	NON-PATIENT LAB REV.	В	-6, 117	RESPIRATORY THERAPY	65.00	0	38. 00
39. 00	TELEVISION OFFSET	A	-185	CAP REL COSTS-MVBLE EQUIP	2. 00	9	39. 00
40.00	ANSWERING SERVICE	A	-1, 897	ADMINISTRATIVE & GENERAL	5. 00	0	40. 00
41.00	PHYSICIAN RECRUITING	A	-25, 002	ADMINISTRATIVE & GENERAL	5. 00	0	41.00
43.00	VISITOR MEALS	A	-36, 834	CAFETERI A	11. 00	0	43.00
43.01	CAFETERIA - EMPLOYEE	A	-42, 682	CAFETERI A	11. 00	0	43. 01
44.00	PHARMACY SALES	A	-155, 036	PHARMACY	15. 00	0	44. 00
45.00	HAF EXPENSE ADJUSTMENT	A	-2, 717, 868	ADMINISTRATIVE & GENERAL	5. 00	0	45. 00
46.00	SELF INSURANCE	A	-3, 176, 208	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	46. 00
48.00	LOBBY EXPENSE	A	-5, 090	ADMINISTRATIVE & GENERAL	5. 00	0	48. 00
48. 01	LOBBY EXPENSE	A	-18	COMMUNITY & VOLUNTEER	194. 04	0	48. 01
				SERVI CES			
48. 04	INTERUNIT RENT EXPENSE	A	-77, 102	RESPIRATORY THERAPY	65.00	0	48. 04
48. 05	INTERUNIT RENT EXPENSE	A	-280, 160	PHYSI CAL THERAPY	66.00	0	48. 05
48.06	INTERUNIT RENT EXPENSE	A	-59, 755	ADMINISTRATIVE & GENERAL	5. 00	0	48. 06
48. 07	INTERUNIT RENT EXPENSE	A	-107, 271	OPERATION OF PLANT	7.00	0	48. 07
48.08	LI QUOR	A	-706	ADMINISTRATIVE & GENERAL	5. 00	0	48. 08
48. 09	PHYS ADMIN SAL ADD BACK	A	156, 448	ADMINISTRATIVE & GENERAL	5. 00	0	48. 09
49.00	RENT EXPENSE - PHYSICIANS'	A	-254, 682	PHYSICIANS' PRIVATE OFFICES	192.00	0	49. 00
	CLINIC						
49. 01	OPERATING INTEREST	A	-4, 554	PHARMACY	15. 00	0	49. 01
49. 02	OPERATING INTEREST	A	-4, 680	OPERATING ROOM	50.00	0	49. 02
50.00	TOTAL (sum of lines 1 thru 49)		-17, 863, 310				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

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

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

* 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.

 de net been peeted to heritaneet A, cordina i and of 2, the amount arremative character that eated in cordinar i or the parti-								
			Related Organization(s) and/	or Home Office				
Symbol (1)	Name	Percentage of	Name	Percentage of				
		Ownershi p		Ownershi p				
1. 00	2. 00	3. 00	4. 00	5. 00				
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:						

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

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

6.00	В	0. 00 PARKVI EW HEALTH 100. 00	6. 00
7.00		0.00	7. 00
8.00		0.00	8. 00
9.00		0.00	9. 00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

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

line 12.

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

Heal th	Financial Syste	ems		WHITLE	Y MEMORIAL	HUSPI TAL			In Lieu	i of Form C	MS-2552-10
		SERVICES FROM	RELATED (ORGANI ZATI ONS	AND HOME	Provi der	CCN:	15-0101	Period: From 01/01/2019	Worksheet	A-8-1
OFFICE	COSTS								To 12/31/2019		
										6/29/2020	3:14 pm
	Net	Wkst. A-7 Ref.									
	Adjustments										
	(col. 4 minus										
	col. 5)*										
	6. 00	7. 00									
	A. COSTS INCUR	RED AND ADJUST	MENTS REQ	UIRED AS A RES	SULT OF TRA	NSACTI ONS	WI TH	RELATED 0	RGANIZATIONS OR (CLAIMED	
	HOME OFFICE CO	STS:									
1.00	-2, 138, 512	9									1. 00
2.00	-10, 579, 733	0									2. 00
3.00	4, 267, 851	0									3. 00
4.00	0	0									4. 00
5.00	-8, 450, 394										5. 00
4 TI		44611			` '	c					

* 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.

nas not	been posted to worksheet A,	cordinate and the amount arrowable should be murcated in cordinate and this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	FED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	HOME OFFICE	6. 00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
7. 00 8. 00 9. 00 10. 00 100. 00		100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- $\hbox{\it C. Provider has financial interest in corporation, partnership, or other organization.}\\$
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

West. A Line # Cost Center/Physician Identifier Remuneration Professional Component Component RCE Amount Physician rider (proponent Remuneration Component Round Remuneration Component Round Roun							'	0 12/31/2017	6/29/2020 3: 1	
1,00		Wkst. A Line #	Cost	Center/Physician	Total	Professi onal	Provi der	RCE Amount		
1.00				I denti fi er	Remuneration		Component			
1,000		1 00		2 00	3 00	4 00	5 00	6.00		
2.00	1 00		OR A	2. 00						1 00
3,00										
4.00						1			_	
S						400 882				
Composition Continuing Continui			JIK. D		100,002	100,002	0	211,000	ľ	1
					0	١	0	0	0	
8.00 0.00					0	١	0	0	l o	1
9,00					0	١	0	0	l o	1
10.00					0	١	0	0	0	
200.00		1			0	١	0	0	0	
Wkst. A Line # Cost Center/Physician Identifier Unadjusted RCE Limit Servent of Unadjusted RCE Limit Cost of Between the State of Cost of State of Cost of Malpractic Centrol in Unadjusted RCE Limit Cost of Malpractic Centrol in Unadjusted RCE Limit Cost of Malpractic Centrol in Unadjusted RCE Limit Cost of Malpractic Centrol in Unadjusted RCE Limit Cost of Malpractic Centrol in Unadjusted RCE Limit Cost of Malpractic Centrol in Unadjusted RCE Limit Share of col. Physician Cost of Malpractic Centrol in Unadjusted RCE Limit Share of col. Physician Cost of Malpractic Centrol in Unadjusted RCE Limit Share of col. Physician Cost of Malpractic Centrol in Unadjusted RCE Limit Share of col. Physician Indicated Provider Component Share of col. Physician Indicated RCE Physician Indicated		0.00			2 371 821	2 288 710	83 111	0	593	
Identifier		Wkst Aline#	Cost	Center/Physician				Provi der		
1.00			0001							
1.00										
1.00										
2. 00		1. 00		2. 00	8. 00	9. 00	12. 00	13.00	14.00	
3. 00	1.00	91. 00	DR. A		50, 740	2, 537	0	0	0	1. 00
4.00	2.00	53. 00	DR. B		0	0	0	0	0	2. 00
5.00 0.00 0.00 0	3.00				9, 558	478	0	0	0	3. 00
6.00	4.00	30. 00	DR. D		0	0	0	0	0	4. 00
7. 00	5.00	0. 00			0	0	0	0	0	5. 00
8.00 0.	6.00	0. 00			0	0	0	0	0	6. 00
9.00	7.00	0. 00			0	0	0	0	0	7. 00
10.00	8.00	0. 00			0	0	0	0	0	8. 00
New Year Cost Center/Physician Cost Center/Physician Identifier Component Share of col. 14	9.00	0. 00			0	0	0	0	0	9. 00
Wkst. A Line # Cost Center/Physician I dentifier Provider Component Share of col. Li mi t Di sal I owance Adjustment Di sal I owance Di sal	10.00	0. 00			0	0	0	0	0	10.00
Identifier Component Share of col. Li mi t Di sal I owance	200.00							0	0	200.00
Share of col .		Wkst. A Line #	Cost	Center/Physi ci an		Adjusted RCE	RCE	Adjustment		
1.00 2.00 15.00 16.00 17.00 18.00 1.00 91.00 DR. A 0 50,740 19,260 995,108 1.00 2.00 53.00 DR. B 0 0 911,980 2.00 3.00 95.00 DR. C 0 9,558 3,553 3.553 3.00 4.00 30.00 DR. D 0 0 0 400,882 4.00 5.00 0.00 0 0 0 0 5.00 6.00 0.00 0 0 0 0 6.00 7.00 0.00 0 0 0 0 7.00 8.00 0.00 0 0 0 0 0 9.00 9.00 0.00 0 0 0 0 0 9.00 10.00 0 0 0 0 0 0 9.00				l denti fi er		Limit	Di sal I owance			
1.00 2.00 15.00 16.00 17.00 18.00 1.00 91.00 DR. A 0 50,740 19,260 995,108 1.00 2.00 53.00 DR. B 0 0 0 911,980 2.00 3.00 95.00 DR. C 0 9,558 3,553 3,553 3.00 4.00 30.00 DR. D 0 0 0 400,882 4.00 5.00 0.00 0 0 0 0 5.00 6.00 0.00 0 0 0 0 6.00 7.00 0.00 0 0 0 0 7.00 8.00 0.00 0 0 0 0 9.00 9.00 0.00 0 0 0 0 9.00 10.00 0 0 0 0 0 9.00										
1.00 91.00 DR. A 0 50,740 19,260 995,108 1.00 2.00 53.00 DR. B 0 0 0 911,980 2.00 3.00 95.00 DR. C 0 9,558 3,553 3,553 3.00 4.00 30.00 DR. D 0 0 0 400,882 4.00 5.00 0.00 0 0 0 0 5.00 6.00 0.00 0 0 0 0 6.00 7.00 0.00 0 0 0 0 7.00 0 0 0 0 7.00 0										
2. 00 53. 00 DR. B 0 0 0 911, 980 2. 00 3. 00 95. 00 DR. C 0 9, 558 3, 553 3, 553 3. 00 4. 00 30. 00 DR. D 0 0 0 400, 882 4. 00 5. 00 0. 00 0 0 0 0 5. 00 6. 00 0. 00 0 0 0 0 6. 00 7. 00 0. 00 0 0 0 0 7. 00 8. 00 0. 00 0 0 0 0 0 8. 00 9. 00 0. 00 0 0 0 0 0 9. 00 10. 00 0 0 0 0 0 0 10. 00	1 00			2. 00						4 00
3. 00 95. 00 DR. C 0 9,558 3,553 3,553 3.00 4. 00 30. 00 DR. D 0 0 0 400,882 4.00 5. 00 0. 00 0 0 0 0 5.00 6. 00 0. 00 0 0 0 0 6.00 7. 00 0. 00 0 0 0 0 0 6.00 7. 00 0. 00 0 0 0 0 0 8.00 9. 00 0. 00 0 0 0 0 0 9.00 10. 00 0 0 0 0 0 0 10.00						1	-			
4. 00 30. 00 DR. D 0 0 400, 882 4. 00 5. 00 0. 00 0 0 0 0 5. 00 6. 00 0. 00 0 0 0 0 6. 00 7. 00 0. 00 0 0 0 0 0 6. 00 7. 00 0. 00 0 0 0 0 0 7. 00 8. 00 0. 00 0 0 0 0 0 8. 00 9. 00 0. 00 0 0 0 0 0 9. 00 10. 00 0 0 0 0 0 0 10. 00										
5.00 0.00 0 0 0 0 5.00 6.00 0.00 0 0 0 0 6.00 7.00 0.00 0 0 0 0 0 7.00 8.00 0.00 0 0 0 0 0 8.00 9.00 0.00 0 0 0 0 9.00 10.00 0 0 0 0 0 10.00					0	9, 558				1
6.00 0.00 7.00 0.00 8.00 0.00 9.00 0.00 10.00 0.00 0 0 </td <td></td> <td></td> <td>JR. D</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td> <td>1</td>			JR. D		0	0	0			1
7. 00 0. 00 8. 00 0. 00 9. 00 0. 00 10. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 10. 00		1			0	0	0	0		1
8.00 0.00 9.00 0.00 10.00 0.00					0	0	0	0		
9. 00 0. 00 0 0 0 0 9. 00 10. 00 0 0 10. 00					0	0	0	0		1
10.00 0.00 10.00 10.00					0	0	0	0		1
					0	0	0	0		
200.00 0 60,298 22,813 2,311,523 200.00		0.00			1	0	0	0		1
	200.00	l l			1 0	60, 298	22, 813	2, 311, 523	I	200. 00

Health Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0101 Peri od: Worksheet B From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/29/2020 3:14 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1, 697, 916 1 00 00100 CAP REL COSTS-BLDG & FLXT 1, 697, 916 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2, 201, 431 2, 201, 431 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 3, 355, 365 3, 355, 365 4.00 00500 ADMINISTRATIVE & GENERAL 20, 998, 384 5 00 18, 699, 563 528, 591 685, 339 1, 084, 891 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 1, 524, 624 123, 383 159, 972 59, 906 1, 867, 885 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 280, 751 5, 765 7, 475 293, 991 8.00 00900 HOUSEKEEPI NG 788, 755 9 00 706, 809 4, 818 6, 247 70.881 9 00 10.00 01000 DI ETARY 358, 244 20, 656 26, 781 33, 607 439, 288 10.00 01100 CAFETERI A 23, 294 11.00 178, 850 30, 202 40, 330 272, 676 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 1, 404 609, 070 13.00 534, 386 1.820 71, 460 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 16, 678 21,624 38, 302 14.00 01500 PHARMACY 15.00 693, 814 14, 455 18, 742 101, 244 828, 255 15.00 11, 798 01600 MEDICAL RECORDS & LIBRARY 5, 137 16, 00 16,00 0 6,661 0 17 00 01700 SOCIAL SERVICE 0 C 0 0 17 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 19.00 0 20.00 02000 NURSING SCHOOL 0 Ω 0 0 O 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 o 21.00 0 21.00 0 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 r 0 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 391, 440 30.00 3, 219, 040 225, 620 292, 528 4, 128, 628 43.00 04300 NURSERY 309, 052 31, 644 340, 696 43.00 C 04400 SKILLED NURSING FACILITY 44.00 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 767, 660 134, 742 174, 700 153.082 2, 230, 184 50.00 05200 DELIVERY ROOM & LABOR ROOM 1, 049, 124 52.00 948, 950 100, 174 52.00 53.00 05300 ANESTHESI OLOGY 53.00 05400 RADI OLOGY-DI AGNOSTI C 3, 438, 194 181.053 234.745 280, 433 54 00 4, 134, 425 54 00 60.00 06000 LABORATORY 3, 272, 504 31, 558 40, 917 3, 344, 979 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 62.30 06500 RESPIRATORY THERAPY 686, 532 24, 953 32, 353 88, 465 832, 303 65.00 65.00 06600 PHYSI CAL THERAPY 544, 565 147, 389 117, 970 1, 001, 021 66.00 191, 097 66.00 67.00 06700 OCCUPATI ONAL THERAPY 575,069 74, 437 649, 506 67.00 68.00 06800 SPEECH PATHOLOGY 16, 207 0 2,098 18, 305 68.00 06900 ELECTROCARDI OLOGY 0 69 00 Ω 0 69 00 0 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 1, 046, 484 C 0 0 1, 046, 484 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 607, 699 0 0 607, 699 72.00 73.00 0 07300 DRUGS CHARGED TO PATIENTS 3, 553, 429 0 3, 553, 429 73.00 οl 07697 CARDIAC REHABILITATION 76 97 O 76 97 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 76.98 07699 LI THOTRI PSY 76. 99 76.99 0 0 0 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0 Ω 0 0 0 90 00 90.01 09001 INTENSIVE OUT PATIENT PROGRAM 0 Ω 90.01 3, 973, 909 423, 093 91.00 09100 EMERGENCY 165, 141 214, 114 4, 776, 257 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 2, 053, 604 0 0 220, 674 2, 274, 278 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 56<u>, 135,</u> 722 118. 00 118.00 56, 244, 651 1, 654, 637 2, 145, 317 3, 345, 829 NONREI MBURSABLE COST CENTERS 42, 913 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 35.878 3.063 3.972 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 372, 264 192. 00 281, 672 37, 185 48, 212 5. 195 194. 00 07950 OCCUPATIONAL HEALTH 0 194, 00 0 C 0 0 194. 01 07951 PAIN CLINIC 0 0 0 0 194. 01 C 194. 02 07952 OAK POINTE 0 0 0 194. 02 194. 03 07953 FOUNDATI ON 160.697 160, 697 194. 03 0 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 174, 514 3.031 3, 930 4.341 185, 816 194. 04 194. 05 07955 VACANT SPACE 0 194.05 194. 06 07956 TELEHEALTH MEDICINE 0 0 0 0 194.06

56, 897, 412

1, 697, 916

2, 201, 431

3, 355, 365

0 200, 00

0 201.00

56, 897, 412 202. 00

200.00

201.00

202.00

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 01/01/2019 | Part |
| To 12/31/2019 | Date/Time Prepared: 6/29/2020 3:14 pm

				'	0 12/31/2019	6/29/2020 3: 1	
	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL	REPAI RS	PLANT	LINEN SERVICE	0.00	
	GENERAL SERVICE COST CENTERS	5.00	6. 00	7. 00	8. 00	9. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT			I			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	20, 998, 384					5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	0				6. 00
7.00	00700 OPERATION OF PLANT	1, 092, 580	0	2, 960, 465			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	171, 964	0	16, 317			8. 00
9.00	00900 HOUSEKEEPI NG	461, 366	0	13, 638	0	1, 263, 759	9. 00
10.00	01000 DI ETARY	256, 952	0	58, 465	0	25, 213	10.00
11. 00	01100 CAFETERI A	159, 496	0	65, 931	0	28, 432	11. 00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12. 00
13. 00	01300 NURSI NG ADMINISTRATION	356, 263	0	3, 974	0	1, 714	
14. 00	01400 CENTRAL SERVICES & SUPPLY	22, 404	0	47, 206	0	20, 357	1
15.00	01500 PHARMACY	484, 470	0	40, 914	0	17, 644	1
16.00	01600 MEDI CAL RECORDS & LI BRARY	6, 901	0	14, 541	0	6, 271	1
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	1
19.00	01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	1
20. 00 21. 00	02000 NURSI NG SCHOOL 02100 L&R SERVI CES-SALARY & FRI NGES APPRV	0	0	0	0	0	
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0	0	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0	0	
23.00	I NPATIENT ROUTINE SERVICE COST CENTERS	١			J		25.00
30. 00	03000 ADULTS & PEDIATRICS	2, 414, 954	0	638, 600	28, 707	275, 390	30.00
43. 00	04300 NURSERY	199, 283	0		40, 690		1
44.00	04400 SKILLED NURSING FACILITY	0	0	0		0	
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	1, 304, 499	0	381, 378	73, 567	164, 466	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	613, 663	0	0	111, 610	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 418, 345	0	512, 458		220, 993	1
60.00	06000 LABORATORY	1, 956, 575	0	89, 323	87	38, 520	1
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	1
65. 00	06500 RESPI RATORY THERAPY	486, 838	0	70, 628		·	1
66.00	06600 PHYSI CAL THERAPY	585, 526	0	417, 173			1
67.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	379, 915	0	0	14, 398		1
68. 00 69. 00	06900 ELECTROCARDI OLOGY	10, 707	0	0	406	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	612, 119	0	0	0	0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	355, 461	0		0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 078, 504	0	0	0	0	1
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	Ö	0	0	1
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	
	OUTPATIENT SERVICE COST CENTERS	,					1
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	
91.00	09100 EMERGENCY	2, 793, 774	0	467, 420	106, 947	201, 571	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS				.		
95. 00	09500 AMBULANCE SERVI CES	1, 330, 291	0	0	27, 500	0	95. 00
	SPECIAL PURPOSE COST CENTERS	TI		1	I		
118. 00		20, 552, 850	0	2, 837, 966	482, 272	1, 210, 932]118. 00
400.04	NONREI MBURSABLE COST CENTERS	05.404		0 (70		0.700	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	25, 101	0	8, 670			190. 00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 OCCUPATIONAL HEALTH	217, 748	0	105, 249	0		192. 00
	1 07951 PAIN CLINIC	0	0	0	0		194. 00 194. 01
	207952 OAK POINTE	0	0		0		194. 01
	3 07952 OAK POINTE 3 07953 FOUNDATION	93, 996	0				194. 02
	107954 COMMUNITY & VOLUNTEER SERVICES	108, 689	0	8, 580	0		194. 03
	07955 VACANT SPACE	100,007	0	0,300			194. 05
	07956 TELEHEALTH MEDICINE	0	0	١			194. 06
200.00			O			I	200.00
201. 00	, ,	l ol	0	0	o	0	201.00
202.00		20, 998, 384	0	2, 960, 465	482, 272		
							•

					6/29/2020 3:1	4 pm
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF		CENTRAL	
			PERSONNEL	ADMI NI STRATI ON	SERVICES &	
	10.00	44.00	10.00	10.00	SUPPLY	
OFNEDAL CEDILOF COST CENTERS	10.00	11. 00	12. 00	13.00	14. 00	
GENERAL SERVICE COST CENTERS						1 00
1. 00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P						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	779, 918	50/ 50F				10.00
11. 00 01100 CAFETERI A	0	526, 535				11.00
12. 00 01200 MAI NTENANCE OF PERSONNEL	0	10.745		004 7//		12.00
13. 00 O1300 NURSING ADMINISTRATION	0	10, 745	C	981, 766	100.010	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	45 000		0	128, 269	14.00
15. 00 01500 PHARMACY	0	15, 822			1, 714	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	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 SCHOOL	0	0		0	0	20.00
21. 00 02100 L&R SERVI CES-SALARY & FRINGES AF		0		0	0	21.00
22. 00 02200 L&R SERVICES-OTHER PRGM COSTS AF	1	0		0	0	22. 00
23. 00 O2300 PARAMED ED PRGM-(SPECIFY)	0	0		0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS			_			
30. 00 03000 ADULTS & PEDI ATRI CS	779, 918	84, 035	C		1, 432	30.00
43. 00 04300 NURSERY	0	7, 712	C		2, 030	43. 00
44. 00 O4400 SKILLED NURSING FACILITY	0	0	C	0	0	44. 00
ANCILLARY SERVICE COST CENTERS		05 005			10.00/	
50. 00 05000 OPERATI NG ROOM	0	35, 295	C		19, 236	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	21, 154	C		5, 568	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	C	_	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	76, 854	C	0	4, 971	54.00
60. 00 06000 LABORATORY	0	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	24, 411	0	0	3, 939	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	35, 705	0	0	588	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	15, 145		0	454	67.00
68. 00 06800 SPEECH PATHOLOGY	0	376	1	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	C	0	0	69.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI	ENI O	0		0	65, 292	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0			3, 387	73.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	C) 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS				, al		00.00
90. 00 09000 CLINIC	0	0			0	90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0				90. 01
91. 00 09100 EMERGENCY	0	103, 960	C	417, 534	12, 731	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT F	YARI					92. 00
OTHER REIMBURSABLE COST CENTERS		00.005		ا	F 770	05.00
95. 00 09500 AMBULANCE SERVICES	0	83, 985	<u> </u>	0	5, 779	95. 00
SPECIAL PURPOSE COST CENTERS	1 447)	E4E 400		004 7//	407.404	1110 00
118.00 SUBTOTALS (SUM OF LINES 1 through	jh 117) 779, 918	515, 199	C	981, 766	127, 121	1118.00
NONREI MBURSABLE COST CENTERS		_	_			
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANT	1	0				190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	6, 519				192. 00
194. 00 07950 OCCUPATI ONAL HEALTH	0	0	C			194. 00
194. 01 07951 PAIN CLINIC	0	0	C	_		194. 01
194. 02 07952 OAK POLNTE	0	0	C	_		194. 02
194. 03 07953 FOUNDATION	0	3, 488		1 1		194. 03
194. 04 07954 COMMUNITY & VOLUNTEER SERVICES	0	1, 329	ı	_		194. 04
194. 05 07955 VACANT SPACE	0	0	C	_		194. 05
194. 06 07956 TELEHEALTH MEDICINE	0	0	C	이	0	194. 06
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	C			201. 00
202.00 TOTAL (sum lines 118 through 201) 779, 918	526, 535	[C	981, 766	128, 269	202. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 01/01/2019 | Part |
| To 12/31/2019 | Date/Time Prepared: 6/29/2020 3:14 pm

				''	0 12/31/2019	6/29/2020 3:1	
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS	NURSI NG SCHOOL	ļ
		15. 00	16. 00	17. 00	19. 00	20. 00	
	GENERAL SERVICE COST CENTERS			1			
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00 5. 00
6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS						6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10. 00
11. 00	01100 CAFETERI A						11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL						12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVI CES & SUPPLY	1 200 010					14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	1, 388, 819	39, 511				15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	0	39, 311	0			17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0		19. 00
20. 00	02000 NURSI NG SCHOOL	o	0	Ō	_	0	20. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0			23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	66	2, 082		0		
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	387 0	0	0		
44.00	ANCI LLARY SERVICE COST CENTERS	U		0	0		44.00
50. 00	05000 OPERATING ROOM	301	553	0	0	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	Ō	0		52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	390	15, 425	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	0	4 714	0	0	0	
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	506 0	4, 714 1, 249		0	0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	43	1	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	Ö	0	o o	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 381, 463	0	0	0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	1	0	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	
76. 99	07699 LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS	0	0	0	U	0	76. 99
90. 00	09000 CLI NI C	0	0	0	0	0	90.00
	09001 INTENSIVE OUT PATIENT PROGRAM	o	0				
91.00	09100 EMERGENCY	2, 228	15, 058	0	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS			_		_	
95.00	09500 AMBULANCE SERVICES	3, 864	0	0	0	0	95. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	1, 388, 818	39, 511	0	0	0	118. 00
110.00	NONREI MBURSABLE COST CENTERS	1, 300, 010	37, 311	0	0	0	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	1	0		0		192. 00
194.00	07950 OCCUPATI ONAL HEALTH	0	0	0	0	0	194. 00
	07951 PAIN CLINIC	0	0	0	0	0	194. 01
	07952 OAK POINTE	0	0	0	0		194. 02
	07953 FOUNDATION	O	0	0	0		194. 03
	07954 COMMUNITY & VOLUNTEER SERVICES	0	0	0	0		194. 04 194. 05
	07955 VACANT SPACE 07956 TELEHEALTH MEDICINE	0	0		0		194. 05
200.00		٩	Ü		0	l	200. 00
201.00	1 1	o	0	О	0		201. 00
202.00	1 1 0	1, 388, 819	39, 511	•	_		202. 00
	•	·					

| Peri od: | Worksheet B | From 01/01/2019 | Part | | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0101

			Ť	o 12/31/2019	Date/Time Pre 6/29/2020 3:1	
	INTERNS &	RESI DENTS			0/24/2020 3. 1	4 piii
Cost Center Description	SERVI CES-SALAR	SEDVI CES_OTHED	PARAMED ED	Subtotal	Intern &	
cost center bescription	Y & FRINGES	PRGM COSTS	PRGM	Subtotal	Residents Cost	
	APPRV	APPRV			& Post	
					Stepdown Adjustments	
	21.00	22.00	23. 00	24. 00	25. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
6.00 00600 MAI NTENANCE & REPAI RS 7.00 00700 OPERATION OF PLANT						6.00
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A 12. 00 01200 MAI NTENANCE OF PERSONNEL						11. 00 12. 00
13. 00 01300 NURSI NG ADMINI STRATI ON						13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00 O1500 PHARMACY 16. 00 O1600 MEDI CAL RECORDS & LI BRARY						15. 00 16. 00
17. 00 01700 SOCIAL SERVICE						17. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS						19.00
20.00 02000 NURSI NG SCHOOL 21.00 02100 L&R SERVI CES-SALARY & FRI NGES APPRV	0					20. 00 21. 00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV		О				22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)			C			23. 00
30.00 O3000 ADULTS & PEDIATRICS	0	0	C	8, 691, 324	0	30.00
43. 00 04300 NURSERY	0	l .			1	43. 00
44. 00 04400 SKILLED NURSING FACILITY	0	0	C	0	0	44. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	0	0	0	4, 351, 237	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0			1, 886, 081	ő	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	O.	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0	0		7, 440, 668 5, 429, 484	0	54. 00 60. 00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0, 427, 404	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	0	0	C		0	65. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	0	C	2, 243, 816 1, 060, 667	0	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	0			29, 837	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	C	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0	0	O C	1, 723, 895 963, 160	l e	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0			7, 016, 783	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	o c	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY 76. 99 07699 LI THOTRI PSY	0	0		0	0	76. 98 76. 99
OUTPATIENT SERVICE COST CENTERS						70. 77
90. 00 09000 CLI NI C	0	0	C	0	0	90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM 91. 00 09100 EMERGENCY	0	1	C	_	0	90. 01 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		Ĭ		0, 077, 400	Ö	92.00
OTHER REIMBURSABLE COST CENTERS	_	_			_	
95. 00 09500 AMBULANCE SERVI CES SPECI AL PURPOSE COST CENTERS	0	0	<u> </u>	3, 725, 697	0	95. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	C	55, 502, 377	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	l	0	81, 422 747, 289		190. 00 192. 00
194. 00 07950 OCCUPATI ONAL HEALTH	0	1	o c			194. 00
194. 01 07951 PALN CLINIC	0	0	C	0	0	194. 01
194. 02 07952 0AK POLNTE 194. 03 07953 FOUNDATION	0	0		0 258, 181		194. 02 194. 03
194. 04 07954 COMMUNITY & VOLUNTEER SERVICES				308, 143		194. 03
194. 05 07955 VACANT SPACE	0	0	C	0	0	194. 05
194.06 07956 TELEHEALTH MEDICINE 200.00 Cross Foot Adjustments	0	0		0		194. 06 200. 00
201.00 Negative Cost Centers						200.00
202.00 TOTAL (sum lines 118 through 201)	0	0	C	56, 897, 412		202. 00

| Peri od: | Worksheet B | From 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0101

			10 12/31/2019 Date/Time Pr 6/29/2020 3:	
	Cost Center Description	Total	6,2,,2020 0.	, , _p
	<u> </u>	26. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P			2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL			4. 00 5. 00
6. 00	00600 MAI NTENANCE & REPAI RS			6. 00
7. 00	00700 OPERATION OF PLANT			7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE			8. 00
9.00	00900 HOUSEKEEPI NG			9. 00
10.00	01000 DI ETARY			10. 00
11. 00	01100 CAFETERI A			11. 00
12.00	01200 MAINTENANCE OF PERSONNEL			12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON			13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY			14. 00
15. 00	01500 PHARMACY			15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE			16. 00 17. 00
17.00	01900 NONPHYSI CI AN ANESTHETI STS			19.00
20. 00	02000 NURSI NG SCHOOL			20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV			21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV			22. 00
23.00	02300 PARAMED ED PRGM-(SPECIFY)			23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	8, 691, 324		30.00
43.00	04300 NURSERY	590, 798		43. 00
44. 00	04400 SKILLED NURSING FACILITY	0		44. 00
FO 00	ANCILLARY SERVICE COST CENTERS	4 251 227		
50. 00 52. 00	O5000 OPERATING ROOM O5200 DELIVERY ROOM & LABOR ROOM	4, 351, 237 1, 886, 081		50. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	1, 880, 081		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	7, 440, 668		54.00
60.00	06000 LABORATORY	5, 429, 484		60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		62. 30
65.00	06500 RESPI RATORY THERAPY	1, 451, 450		65. 00
66.00	06600 PHYSI CAL THERAPY	2, 243, 816		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 060, 667		67. 00
68. 00	06800 SPEECH PATHOLOGY	29, 837		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0		69. 00
71. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	1, 723, 895		71.00
72. 00 73. 00	07200 DRUCS CHARGED TO PATIENTS	963, 160		72. 00 73. 00
76. 97	07300 DRUGS CHARGED TO PATIENTS 07697 CARDI AC REHABILITATION	7, 016, 783 0		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0		76. 98
76. 99	07699 LI THOTRI PSY	0		76. 99
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLI NI C	0		90. 00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0		90. 01
	09100 EMERGENCY	8, 897, 480		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92. 00
05.00	OTHER REIMBURSABLE COST CENTERS	2 705 (07		05.00
95.00	09500 AMBULANCE SERVICES	3, 725, 697		95. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	55, 502, 377		118. 00
110.00	NONREI MBURSABLE COST CENTERS	33, 302, 377		1118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	81, 422		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	747, 289		192. 00
	07950 OCCUPATI ONAL HEALTH	0		194. 00
	07951 PAIN CLINIC	o		194. 01
	07952 OAK POINTE	0		194. 02
	07953 FOUNDATION	258, 181		194. 03
	07954 COMMUNITY & VOLUNTEER SERVICES	308, 143		194. 04
	07955 VACANT SPACE	0		194. 05
	07956 TELEHEALTH MEDICINE	0		194. 06
200. 00 201. 00		O O		200. 00 201. 00
201.00		56, 897, 412		201.00
202.00	1.01712 (30m 111103 110 till bugir 201)	55, 577, 412		1202.00

| Peri od: | Worksheet B | From 01/01/2019 | Part | I | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0101

					То	12/31/2019	Date/Time Pre 6/29/2020 3:1	
				CAPI TAL REI	ATED COSTS		0/24/2020 3. 1	4 DIII
		Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			Assigned New Capital				DEPARTMENT	
			Related Costs				DEI 7 III TIII EI II	
	T		0	1.00	2.00	2A	4. 00	
1 00		AL SERVICE COST CENTERS						1 00
1. 00 2. 00		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	0	0	О	О	0	4. 00
5.00	00500	ADMINISTRATIVE & GENERAL	3, 858, 057	528, 591	685, 339	5, 071, 987	0	5. 00
6.00		MAINTENANCE & REPAIRS	0	0	0	0	0	6. 00
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	0	123, 383		283, 355	0	7. 00 8. 00
9. 00	1	HOUSEKEEPING	0	5, 765 4, 818		13, 240 11, 065	0	9.00
10.00	1	DI ETARY	o	20, 656		47, 437	0	10.00
11. 00	01100	CAFETERI A	0	23, 294		53, 496	0	11. 00
12.00	1	MAINTENANCE OF PERSONNEL	0	0		0	0	12. 00
13.00	1	NURSI NG ADMI NI STRATI ON	0	1, 404		3, 224	0	13.00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	0	16, 678 14, 455		38, 302 33, 197	0	14. 00 15. 00
16. 00		MEDICAL RECORDS & LIBRARY	ő	5, 137		11, 798	0	16. 00
17. 00	01700	SOCIAL SERVICE	0	0	0	0	0	17. 00
19. 00	1	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20.00	1	NURSING SCHOOL	0	0	0	0	0	20.00
21. 00 22. 00		I&R SERVICES-SALARY & FRINGES APPRV I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	21. 00 22. 00
23. 00		PARAMED ED PRGM-(SPECIFY)	o	0		o	0	23. 00
		IENT ROUTINE SERVICE COST CENTERS	-		· · · · · · · · · · · · · · · · · · ·	- 1		
30. 00	1	ADULTS & PEDIATRICS	0	225, 620	1	518, 148	0	30. 00
43.00		NURSERY	0	0		0	0	43.00
44. 00		SKILLED NURSING FACILITY LARY SERVICE COST CENTERS	0	0	0	0	0	44. 00
50. 00		OPERATING ROOM	0	134, 742	174, 700	309, 442	0	50.00
52.00		DELIVERY ROOM & LABOR ROOM	0	0	1	0	0	52. 00
53.00	1	ANESTHESI OLOGY	0	0		0	0	53. 00
54.00		RADI OLOGY-DI AGNOSTI C	0	181, 053		415, 798	0	54. 00
60. 00 62. 30	1	LABORATORY BLOOD CLOTTING FOR HEMOPHILIACS	0	31, 558 0	40, 917	72, 475	0	60. 00 62. 30
65. 00	1	RESPIRATORY THERAPY	o	24, 953	32, 353	57, 306	0	65.00
66. 00	1	PHYSI CAL THERAPY	0	147, 389		338, 486	0	66. 00
67. 00		OCCUPATIONAL THERAPY	0	0	0	0	0	67. 00
68. 00		SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 71. 00		ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	69. 00 71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	o	0		o	0	72.00
73. 00	1	DRUGS CHARGED TO PATIENTS	0	0	O	o	0	73. 00
76. 97	1	CARDIAC REHABILITATION	0	0	0	0	0	76. 97
76. 98		HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99		LITHOTRIPSY TIENT SERVICE COST CENTERS	l O	0	l o	U _I	0	76. 99
90. 00		CLINIC	0	0	0	o	0	90.00
90. 01		INTENSIVE OUT PATIENT PROGRAM	0	0	O	o	0	
91. 00		EMERGENCY	0	165, 141	214, 114	379, 255	0	91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART				0		92. 00
95. 00		REIMBURSABLE COST CENTERS AMBULANCE SERVICES	O	0	0	0	0	95. 00
75. 00		AL PURPOSE COST CENTERS	ı	U	<u> </u>	<u> </u>		75.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3, 858, 057	1, 654, 637	2, 145, 317	7, 658, 011	0	118. 00
		MBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 063		7, 035		190. 00
		PHYSICIANS' PRIVATE OFFICES OCCUPATIONAL HEALTH	0	37, 185 0	48, 212	85, 397		192. 00 194. 00
		PAIN CLINIC	o	0		Ö		194. 01
	1	OAK POINTE		0	0	o		194. 02
	1	FOUNDATI ON	o	0	0	o		194. 03
	1	COMMUNITY & VOLUNTEER SERVICES	0	3, 031	3, 930	6, 961		194. 04
		VACANT SPACE TELEHEALTH MEDICINE	0	0		0		194. 05 194. 06
200.00		Cross Foot Adjustments		0		0	U	200. 00
201.00		Negative Cost Centers		0	O	Ö		201. 00
202.00)	TOTAL (sum lines 118 through 201)	3, 858, 057	1, 697, 916	2, 201, 431	7, 757, 404	0	202. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2019	Part II
To 12/31/2019	Date/Time Prepared: 6/29/2020 3:14 pm

				'		6/29/2020 3: 1	
	Cost Center Description	ADMI NI STRATI VE		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL	REPAI RS	PLANT	LINEN SERVICE	0.00	
	GENERAL SERVICE COST CENTERS	5. 00	6. 00	7. 00	8. 00	9. 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	5, 071, 987					5. 00
6.00	00600 MAINTENANCE & REPAIRS	o	0				6. 00
7.00	00700 OPERATION OF PLANT	263, 904	0	547, 259			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	41, 537	0	3, 016	57, 793		8. 00
9.00	00900 HOUSEKEEPI NG	111, 439	0	2, 521	0	125, 025	9. 00
10.00	01000 DI ETARY	62, 065	0	10, 808		2, 494	10.00
11.00	01100 CAFETERI A	38, 525	0	12, 188	0	2, 813	•
12.00	01200 MAINTENANCE OF PERSONNEL	0 053	0	0	0	0	12.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	86, 052 5, 411	0	735 8, 726	0	170 2, 014	13. 00 14. 00
15. 00	01500 PHARMACY	117, 020	0	7, 563	0	1, 746	15.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	1, 667	0	2, 688		620	16. 00
17. 00	01700 SOCI AL SERVI CE	0	0	2,000	0	0	17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	o	0	Ö	0	0	19.00
20.00	02000 NURSI NG SCHOOL	o	0	0	0	0	20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	o	0	0	0	0	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	F00 040		440.040	0 440	07.044	1 00 00
30.00	03000 ADULTS & PEDI ATRI CS	583, 313	0	118, 048		27, 244	30.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	48, 135 0	0	0	4, 876	0	43. 00 44. 00
44.00	ANCI LLARY SERVICE COST CENTERS	l ol	U	0	U	0	44.00
50. 00	05000 OPERATI NG ROOM	315, 092	0	70, 500	8, 816	16, 271	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	148, 225	0	0		0	52. 00
53.00	05300 ANESTHESI OLOGY	o	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	584, 132	0	94, 731	6, 807	21, 863	54.00
60.00	06000 LABORATORY	472, 595	0	16, 512	10	3, 811	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	117, 592	0	13, 056		3, 013	65. 00
66.00	06600 PHYSI CAL THERAPY	141, 429	0	77, 117	2, 239	17, 798	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	91, 765	0	0	.,	0	67.00
68. 00	06800 SPEECH PATHOLOGY	2, 586	0	0	49	0	68.00
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	147, 852	0	0	0	0	69. 00 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	85, 859	0		0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	502, 046	0	١	0	0	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	Ö	o	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	o	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 CLINIC	0	0	0		0	90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0 0		0	90. 01
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	674, 810	0	86, 405	12, 816	19, 942	
92. 00	OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00	09500 AMBULANCE SERVICES	321, 321	0	0	3, 295	0	95. 00
70.00	SPECIAL PURPOSE COST CENTERS	02.702.1			0,270		70.00
118.00		4, 964, 372	0	524, 614	57, 793	119, 799	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6, 063	0	1, 603			190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	52, 595	0	19, 456	0		192. 00
	07950 OCCUPATI ONAL HEALTH	0	0	0	0		194. 00
	107951 PAIN CLINIC	0	0	0	0		194. 01
	2 07952 0AK POI NTE 3 07953 FOUNDATI ON	22 704	0	0	0		194. 02 194. 03
	107953 FOUNDATION 107954 COMMUNITY & VOLUNTEER SERVICES	22, 704 26, 253	0	1, 586			194. 03
	07955 VACANT SPACE	20, 253	0	1, 360			194. 04
	07956 TELEHEALTH MEDICINE		0		n		194. 06
200.00			J	ĺ			200. 00
201.00	, ,	0	0	0	o		201. 00
202.00		5, 071, 987	0	547, 259	57, 793	125, 025	202. 00

| Peri od: | Worksheet B | From 01/01/2019 | Part | I | To 12/31/2019 | Date/Time Prepared:

				T	o 12/31/2019	Date/Time Pre 6/29/2020 3:1	
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	T pill
				PERSONNEL	ADMINISTRATION	SERVICES &	
		10.00	11. 00	12.00	13. 00	SUPPLY 14. 00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	10.00	11.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAI NTENANCE & REPAI RS						6.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPING						9. 00
10. 00	01000 DI ETARY	122, 804					10.00
11. 00	01100 CAFETERI A	0	107, 022				11. 00
12.00	01200 MAINTENANCE OF PERSONNEL	o	0	0			12. 00
13.00	01300 NURSING ADMINISTRATION	0	2, 184	0	92, 365		13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	54, 453	1
15. 00	01500 PHARMACY	0	3, 216	0	0	727	15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	16.00
17. 00 19. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00 19. 00
20. 00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL	0	0	0	0	0	20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	Ö	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	l ol	0	Ö	ol	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	o	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	122, 804	17, 081			608	1
43. 00	04300 NURSERY	0	1, 568		_	862	43.00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	0	7, 174	0	13, 337	8, 166	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	4, 300			2, 364	•
53. 00	05300 ANESTHESI OLOGY	o	0	Ö	0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	O	15, 621	Ō	Ö	2, 110	1
60.00	06000 LABORATORY	o	0	0	o	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	0	4, 962	1	0	1, 672	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	7, 257	0	0	250	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY	0	3, 078 77	0	0	193 0	ı
69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0		0	0	68. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	ol ol	27, 718	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	Ō	o	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	0	0	o	1, 438	73. 00
76. 97	07697 CARDIAC REHABILITATION	0	0	0	o	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	O	0	0	ol	0	90. 00
	09001 INTENSIVE OUT PATIENT PROGRAM	0	0		_	0	
	09100 EMERGENCY		21, 129	1	۱ ۹		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		2.7.27		07,202	0, 100	92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVI CES	0	17, 071	0	0	2, 453	95. 00
440.00	SPECIAL PURPOSE COST CENTERS	100 004	101 710	1	00.045	50.0//	
118. 00	7	122, 804	104, 718	0	92, 365	53, 966	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	ام	121	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES		1, 325		_		192. 00
	07950 OCCUPATI ONAL HEALTH	l o	0	0	_		194. 00
	07951 PAIN CLINIC	0	0	0	o		194. 01
194. 02	07952 OAK POINTE	0	0	0	o	0	194. 02
	07953 FOUNDATION	0	709		o		194. 03
	07954 COMMUNITY & VOLUNTEER SERVICES	0	270	0	0		194. 04
	07955 VACANT SPACE	0	0	l ő	0		194. 05
194. 06 200. 00	07956 TELEHEALTH MEDICINE	0	0	0	0	0	194. 06 200. 00
200.00			0	0		0	200.00
201.00		122, 804	107, 022			54, 453	
50			,	'	_,,	, .50	' '-

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0101

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2019	Part II
To 12/31/2019	Date/Time Prepared: 6/29/2020 3:14 pm

COST. CENTER DESCRIPTION					'	0 12/31/2019	6/29/2020 3: 1	
CEMERAL SERVICE COST CENTERS		Cost Center Description	PHARMACY	RECORDS &	SOCIAL SERVICE			
1.00			15. 00		17. 00	19. 00	20. 00	
2. 00. 00200 CAP REL COSTS-MYBLE EQUIP								
4. 00. 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00. 00500 AMN INSTRATIVE & GENERAL 6. 00. 00500 AMN INSTRATIVE & GENERAL 8. 00. 00500 OMN INSTRANCE & REPAIRS 9. 00. 00500 OMN INSTRANCE OF PLANT 10. 00. 00500 OMN INSTRANCE OF PLANT 11. 00. 1100 OMN OWNER AS EMPLOY 11. 00. 1100 OMN OWNER AS EMPLOY 11. 00. 1100 OMN OWNER AS EMPLOY 11. 00. 1100 OMN OWNER AS EMPLOY 11. 00. 1100 OMN OWNER AS EMPLOY 11. 00. 1100 OMN OWNER AS EMPLOY 11. 00. 1100 OMN OWNER AS EMPLOY 11. 00. 1100 OMN OWNER AS EMPLOY 11. 00. 1100 OMNERS AS EMPLOY 11. 00. 00. 00. 00. 00. 00. 00. 00. 00.								1. 00
5. 00 00500 ADMINISTRATIVE & GENERAL 6. 00 00500 MANTENANCE & REPAIRS 6. 00 00500 MANTENANCE & REPAIRS 7. 00 007	1							1
0.000 00000 MAI NTEANACE & REPAIRS								1
7. 00	1	1						
8. 00 00800 LAUMRY & LINEN SERVICE 9. 00 0000 OHOUSKEEPING 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 11	1	•						1
9.00 00900 HOUSEKEEPI NG 10.00	1	1						1
10.00 01000 01000 01000 01000 01000 011000 01000 011000 01000 011000 01000 0110000 0110000 0110000 0110000 0110000 0110000 0110000 0110000 0110000 0110000 0110000 0110000 01100000 01100000 01100000 011000000 01100000000		1						9. 00
12.00 01200 MAINTENANCE OF PERSONNEL 12.00 13.00 13.00 01300 NURS ING ANM IN ISTRATION 14.00 01400 CENTRAL SERVI CES & SUPPLY 163,469 15.00 15.0	1	l .						10.00
13. 00		01100 CAFETERI A						11.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 163, 469 15. 00 15.00 17. 00 0.0 0.0 0.0 0.0 17. 00 17. 00 01.900 0.0								12. 00
15.00 01500 PHARMACY	13.00	01300 NURSING ADMINISTRATION						13. 00
16. 00 01600 NEDICAL RECORDS & LIBRARY 0 16,773 16,00 1700 01700	1	•						14. 00
17.00	1	· ·	· •					15. 00
19. 00 01900 NONDHYSI CI AN AMESTHETI STS 0 0 0 0 0 0 0 0 0	1	· ·	0	16, 773	1			16. 00
20. 00 02000 INRSI NG SCHOOL 0 0 0 0 0 22. 00			0	0				1
21. 00 02100 1 ar SERVI CES-SALARY & FRI NGES APPRV 0 0 0 22. 00 22. 00 02200 1 ar SERVI CES-OTHER PRGM COSTS APPRV 0 0 0 0 23. 00 02300 PARAMED ED PRGM (SPECI FY) 0 0 0 0 23. 00 07300 PARAMED ED PRGM (SPECI FY) 0 0 0 0 23. 00 07300 ADURTS & PEDI ATRI CS 8 884 0 30. 00 30. 00 0300 ADURTS & PEDI ATRI CS 0 164 0 43. 00 44. 00 04400 SKI LLED NURSI NG FACI LI TY 0 0 0 0 44. 00 ANCIL LARY SERVI CE COST CENTERS 50. 00 05000 DEPRATI NG ROOM 35 235 0 50. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 52. 00 53. 00 05300 ANESTHESI OLOGY 0 0 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 46 6.549 0 54. 00 60. 00 06000 LABORATORY 0 0 0 0 60. 00 60. 00 06000 DABORATORY 0 0 0 0 65. 00 61. 00 06000 PHYSI CAL THERAPY 0 0 0 0 65. 00 62. 30 06500 RESPI RATORY THERAPY 0 0 0 0 65. 00 63. 00 06600 PHYSI CAL THERAPY 0 0 0 0 66. 00 64. 00 06600 PHYSI CAL THERAPY 0 0 0 0 67. 00 65. 00 06600 PHYSI CAL THERAPY 0 0 0 0 67. 00 67. 00 06600 PHYSI CAL THERAPY 0 0 0 0 67. 00 68. 00 06600 SPECTH PATHOLOGY 0 18 0 68. 00 69. 00 06600 SPECTH PATHOLOGY 0 0 0 72. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 72. 00 73. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 73. 00 74. 97 07697 CARDI AC REHABI LITATION 0 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76. 97 76. 99 07699 LITHORIUS VE OUT PATI ENTS 0 0 0 0 0 77. 00 07000 EMERGENCY 0 0 0 0 0 77. 00 07100 DEBERRATION DEDS (NON-DISTINCT PART 0 0 0 0 77. 00 07100			0	0		0		1
22.00 02200 AR SERVICES-OTHER PROM COSTS APPRV 0 0 0 0 0 22.00	1	•	0	0			0	
23. 00 02300 PARAMED ED PROM-(SPECIFY) 0 0 0			0	0	1			
INPATIENT ROUTINE SERVICE COST CENTERS 8 884 0 30.00	1		-	0	1			1
30. 00	-	` '	0		1			20.00
43. 00 04300 NURSERY 0 164 0 43. 00 44. 00 0400 SKILLED NURSING FACILITY 0 0 0 0 50. 00 05000 OPERATING ROOM 35 235 0 50. 00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 53. 00 05300 ANESTHESI OLOGY 0 0 0 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 46 6, 549 0 54. 00 60. 00 06000 LABORATORY 0 0 0 0 62. 30 06250 BLOOD CLOTTING FOR HEMOPHI LI ACS 0 0 0 65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 66. 00 06600 RESPIRATORY THERAPY 0 0 0 0 67. 00 06700 OCCUPATIONAL THERAPY 0 530 0 68. 00 06800 SPEECH PATHOLOGY 0 18 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 162,603 0 0 76. 97 07697 CARDIA CREHABI LITATION 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 76. 99 07699 LITHORIP SY 0 0 0 90. 00 09000 CLINIC C 0 0 0 91. 00 09000 CLINIC SUPPLIES COST CENTERS	_		8	884				30.00
ANCI LLARY SERVICE COST CENTERS 50. 00 052000 DELATI ING ROOM								43.00
50. 00 05000 0PERATING ROOM 35 235 0 52. 00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 52. 00 53. 00 05300 ANSTHESI OLGCY 0 0 0 0 0 53. 00 05300 ANSTHESI OLGCY 0 0 0 0 0 0 0 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 46 6,549 0 0 0 0 0 60. 0	44.00	04400 SKILLED NURSING FACILITY	0	0) c			44. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 52. 00 53. 00 05300 ANESTHESI OLOGY 0 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 46 6,549 0 54. 00 60. 00 06000 LABORATORY 0 0 0 0 62. 30 06250 BLOOD CLOTTI NG FOR HEMOPHILI ACS 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 66. 00 06600 RESPI RATORY THERAPY 0 0 0 67. 00 06600 PHYSI CAL THERAPY 0 0 0 68. 00 06600 SPEECH PATHOLOGY 0 18 0 69. 00 06900 SPEECH PATHOLOGY 0 18 0 69. 00 06900 SPEECH PATHOLOGY 0 18 0 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 162,603 0 0 76. 97 07697 CARGED TO PATI ENTS 162,603 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 76. 99 00000 CLI NI C 0 0 79. 00 09000 CLI NI C 0 0 79. 00 09000 DRUGS CHARGEN TO PATI ENT 0 0 79. 00 09000 CLI NI C 0 0 79. 00 09000 CLI NI C 0 0 79. 00 09000 DRUGS CHARGED TO PATI ENT 0 70. 00 09000 DRUGS CHARGED TO PATI ENTS 0 70. 00 09000 DRUGS CHARGED TO PATI ENTS 0 70. 00 09000 DRUGS CHARGED TO PATI ENTS 0 70. 00 09000 DRUGS CHARGED TO PATI ENTS 0 70. 00 09000 DRUGS CHARGED TO PATI ENTS 0 70. 00 09000 DRUGS CHARGED TO PATI ENTS 0 70. 00 09000 DRUGS CHARGED TO PATI ENTS 0 70. 00 09000 DRUGS CHARGED TO PATI ENTS 0 70. 00 09000 DRUGS CHARGED TO PATI ENTS 0 70. 00 09000 DRUGS CHARGED TO PATI ENTS 0 70. 00 09000 DRUGS CHARGED TO PATI ENTS 0 70. 00 09000 DRUGS CHARGED TO PATI ENTS 0 70. 00 09000 DRUGS CHARGED TO PATI ENTS 0 70. 00 09000 DRUGS CHARGED TO PATI ENTS 0 70. 00 09000 DRUGS CHARGED TO PATI ENTS 0 70. 00 09000 DRUGS CHARGED TO PATI ENTS 0 70. 00								1
53. 00	1							50.00
54. 00	1		-	0	1			1
60. 00		1	-	(540	1			1
62. 30	1	1	46	6, 549				1
65. 00	1	•	0	0				1
66. 00 06600 PHYSI CAL THERAPY 60 2, 001 0 667. 00 670. 0 CCUPATI ONAL THERAPY 0 530 0 67. 00 68. 00 06700 OCCUPATI ONAL THERAPY 0 530 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 18 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 77. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 162, 603 0 0 0 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 76. 97 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 76. 99 07699 LI THOTRI PSY 0 0 0 0 0 0 0 76. 99 07699 LI THOTRI PSY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1	1	=	0				1
67. 00	1	•		2. 001	1			66.00
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71. 00		I .	0		1			68. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 162, 603 0 0 0 0 0 73. 00 76. 97 076. 97 076. 97 076. 98 076. 98 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 76. 98 076. 99 LI THOTRI PSY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	69.00	06900 ELECTROCARDI OLOGY	0	0) c			69. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 162,603 0 0 0 73. 00 76. 97 07697 CARDI AC REHABILITATION 0 0 0 0 0 0 76. 97 076. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 0	1	· ·	0	0) C			71. 00
76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 0 0 0 76. 98 07699 LI THOTRI PSY 0 0 0 0 0 0 0 0 0	1	· ·	0	0) C			72. 00
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76. 99 07699 LITHOTRI PSY 0 0 0 0 76. 99 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLI NI C 0 0 0 0 90. 00 90. 01 09001 INTENSI VE OUT PATIENT PROGRAM 0 0 0 0 90. 00 91. 00 09100 EMERGENCY 262 6, 392 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 92. 00 OTHER REIMBURSABLE COST CENTERS			-	0	1			1
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 0 0 0 0 90.00			1	0	1			1
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90. 01 09001 INTENSIVE OUT PATIENT PROGRAM 0 0 0 0 91. 00 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	_		0	0) (90.00
91. 00 09100 EMERGENCY 262 6, 392 0 91. 00 92. 00 92. 00 92. 00 92. 00 94. 00 95. 00			- 1					90. 01
OTHER REIMBURSABLE COST CENTERS			262	6, 392	. c			91.00
	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
95 00 1095001 AMRIII ANCE SERVICES 455 0 0 1 95 00					,			
			455	0) <u> </u>			95. 00
SPECIAL PURPOSE COST CENTERS	_					_	_	
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 163, 469 16, 773 0 0 118.00			163, 469	16, 773	S C	0	0	<u> </u> 118. 00
NONREI MBURSABLE COST CENTERS			٥					100.00
								190.00
			l l	0	1			192. 00 194. 00
			- 1	0	1			194. 00
				0	1			194. 02
		l .	=	0	1			194. 03
			o	0	1			194. 04
			O	0) c			194. 05
			O	0) c			194. 06
200.00 Cross Foot Adjustments 0 0 200.00						0		
201.00 Negative Cost Centers 0 0 0 0 201.00			0	0				
	202.00	TOTAL (sum lines 118 through 201)	163, 469	16, 773	S C	0	1 0	202. 00

Health Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0101 Peri od: Worksheet B From 01/01/2019 Part II Date/Time Prepared: 12/31/2019 6/29/2020 3:14 pm INTERNS & RESIDENTS Cost Center Description SERVI CES-SALAR SERVI CES-OTHER PARAMED ED Subtotal Intern & Y & FRINGES PRGM COSTS Residents Cost PRGM **APPRV APPRV** & Post Stepdown Adjustments 21. 00 22.00 23. 00 24. 00 25. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16, 00 17 00 01700 SOCIAL SERVICE 17 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 20.00 02000 NURSING SCHOOL 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30 00 1, 423, 331 0 43.00 04300 NURSERY 55, 605 0 43.00 04400 SKILLED NURSING FACILITY 44.00 44.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 749.068 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 176, 258 52.00 05300 ANESTHESI OLOGY 53.00 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 1.147.657 54 00 54 00 0 60.00 06000 LABORATORY 565, 403 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 62.30 06500 RESPIRATORY THERAPY 197, 945 65.00 0 65.00 06600 PHYSI CAL THERAPY 66.00 586, 637 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 97, 291 0 67.00 68.00 06800 SPEECH PATHOLOGY 2,730 0 68.00 06900 ELECTROCARDI OLOGY 69 00 0 69 00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 175, 570 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 85, 859 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 666, 087 0 73.00 07697 CARDIAC REHABILITATION 76 97 76 97 0 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 76.98 07699 LI THOTRI PSY 0 76. 99 76.99 0 OUTPATIENT SERVICE COST CENTERS 90 00 90 00 09000 CLI NI C 0 0 90.01 09001 INTENSIVE OUT PATIENT PROGRAM 0 0 90.01 09100 EMERGENCY 91.00 91.00 1, 245, 698 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 344, 595 0 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 118.00 0 0 0 7, 519, 734 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 190. 00 15, 495 163, 314 0 192. 00 194. 00 07950 OCCUPATIONAL HEALTH 0 194.00 0 194. 01 07951 PAIN CLINIC 0 0 194. 01 194. 02 07952 OAK POINTE 0 194. 02 194. 03 07953 FOUNDATI ON 0 194. 03 23.413 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 0 194. 04 35, 448 194. 05 07955 VACANT SPACE 0 194. 05 0 194.06 194. 06 07956 TELEHEALTH MEDICINE 0

0 200, 00

0 201.00

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0

7, 757, 404

0

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200.00

201.00

202.00

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 01/01/2019 | Part II |
| To 12/31/2019 | Date/Time Prepared: 6/29/2020 3:14 pm | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0101

			6/29/2020 3:	
	Cost Center Description	Total		
	CENEDAL SEDVICE COST CENTEDS	26. 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. 00
6. 00	00600 MAINTENANCE & REPAIRS			6. 00
7. 00	00700 OPERATION OF PLANT			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
9.00	00900 HOUSEKEEPI NG			9. 00
10.00	01000 DI ETARY			10. 00
11.00	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			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY			16. 00
17. 00	01700 SOCIAL SERVICE			17. 00
19. 00	01900 NONPHYSI CLAN ANESTHETI STS			19. 00
20.00	02000 NURSI NG SCHOOL			20.00
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRV 02200 &R SERVICES-OTHER PRGM COSTS APPRV			21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)			23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS			23.00
30. 00	03000 ADULTS & PEDIATRICS	1, 423, 331		30.00
43. 00	04300 NURSERY	55, 605		43. 00
44. 00	04400 SKILLED NURSING FACILITY	0		44.00
	ANCILLARY SERVICE COST CENTERS	-1		
50.00	05000 OPERATING ROOM	749, 068		50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	176, 258		52. 00
53.00	05300 ANESTHESI OLOGY	0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 147, 657		54. 00
60.00	06000 LABORATORY	565, 403		60. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		62. 30
65. 00	06500 RESPI RATORY THERAPY	197, 945		65. 00
66.00	06600 PHYSI CAL THERAPY	586, 637		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	97, 291		67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	2, 730		68. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	175, 570		71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	85, 859		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	666, 087		73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	o		76. 98
76. 99	07699 LI THOTRI PSY	0		76. 99
	OUTPATIENT SERVICE COST CENTERS	<u> </u>		
90.00	09000 CLI NI C	0		90. 00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0		90. 01
	09100 EMERGENCY	1, 245, 698		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92. 00
	OTHER REIMBURSABLE COST CENTERS			
95. 00	09500 AMBULANCE SERVI CES	344, 595		95. 00
	SPECIAL PURPOSE COST CENTERS	7 540 704		
118.00		7, 519, 734		118. 00
100.00	NONREI MBURSABLE COST CENTERS	15 405		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	15, 495		190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 OCCUPATIONAL HEALTH	163, 314		192. 00 194. 00
	07950 OCCUPATIONAL HEALTH	0		194. 00
	207951 PATN CETNIC	0		194. 01
	3 O7953 FOUNDATION	23, 413		194. 02
	107954 COMMUNITY & VOLUNTEER SERVICES	35, 448		194. 03
	07955 VACANT SPACE	00, 110		194. 05
	07956 TELEHEALTH MEDICINE	ol		194. 06
200.00		ol		200. 00
201.00		O		201. 00
202.00	TOTAL (sum lines 118 through 201)	7, 757, 404		202. 00

COST	ALLOCATION - STATISTICAL BASIS		Provider CC		Period: From 01/01/2019 To 12/31/2019	Worksheet B-1 Date/Time Pre	
		CAPITAL REL	ATED COSTS		To 12/31/2019	6/29/2020 3:1	
	Cost Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
	JOSEPH OFFICE COOK OFFITTED	1.00	2. 00	4.00	5A	5. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	159, 632					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		159, 632				2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	25, 084, 62		25 000 020	4.00
5. 00 6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	49, 696 0	49, 696 0	8, 110, 64	4 -20, 998, 384 0 0	35, 899, 028 0	1
7. 00	00700 OPERATION OF PLANT	11, 600	11, 600	447, 85	7 0	1, 867, 885	7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	542 453	542 453	529, 90	0	293, 991	1
10.00	01000 DI ETARY	1, 942	453 1, 942			788, 755 439, 288	1
11. 00	01100 CAFETERI A	2, 190	2, 190			272, 676	11. 00
12. 00 13. 00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	0 132	0 132	534, 23	0 0	0 609, 070	
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 568	1, 568		0 0	38, 302	1
15. 00	01500 PHARMACY	1, 359	1, 359	756, 89	6 0	828, 255	15. 00
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY	483	483		0	11, 798	1
	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0		0 0	0	
20.00	02000 NURSI NG SCHOOL	0	0		0 0	0	20. 00
21. 00 22. 00	02100 &R SERVI CES-SALARY & FRINGES APPRV 02200 &R SERVI CES-OTHER PRGM COSTS APPRV	0	0		0 0	0	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0 0	1	1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 43. 00	03000 ADULTS & PEDI ATRI CS 04300 NURSERY	21, 212	21, 212 0	2, 926, 38 236, 57			•
44. 00	04400 SKILLED NURSING FACILITY	0	0		0 0		•
	ANCILLARY SERVICE COST CENTERS						
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	12, 668	12, 668 0	1, 144, 43 748, 89		2, 230, 184 1, 049, 124	1
53. 00	05300 ANESTHESI OLOGY	0	0	740,07	ó	0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	17, 022	17, 022	2, 096, 50	6 0	4, 134, 425	1
60. 00 62. 30	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS	2, 967	2, 967		0	3, 344, 979 0	1
65. 00	06500 RESPIRATORY THERAPY	2, 346	2, 346	661, 36	0 0	832, 303	
66.00	06600 PHYSI CAL THERAPY	13, 857	13, 857	881, 93		1, 001, 021	1
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	556, 48 15, 68		649, 506 18, 305	1
69. 00	06900 ELECTROCARDI OLOGY	0	0	,	o o	0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	1, 046, 484	1
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0			607, 699 3, 553, 429	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	ł	o o	_	1
	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	l	
76. 99	07699 LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	76. 99
90.00	09000 CLI NI C	0	0		0 0	l	
90. 01 91. 00	09001 INTENSIVE OUT PATIENT PROGRAM 09100 EMERGENCY	0 15, 526	0 15, 526		0 6 0	l	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	15, 520	15, 526	3, 163, 02	0	4, 776, 257	92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	O9500 AMBULANCE SERVI CES SPECI AL PURPOSE COST CENTERS	0	0	1, 649, 75	3 0	2, 274, 278	95. 00
118. 00		155, 563	155, 563	25, 013, 33	7 -20, 998, 384	35, 137, 338	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	288 3, 496	288 3, 496		0	1	190.00
	07950 OCCUPATIONAL HEALTH	3, 490	3, 490	36, 63	0 0		194. 00
	07951 PAIN CLINIC	0	0		0 0		194. 01
	07952 OAK POLNTE 07953 FOUNDATION	0	0		0	0 160, 697	194. 02
	07954 COMMUNITY & VOLUNTEER SERVICES	285	285	32, 45	0 0	185, 816	1
194. 05	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	, ,						201. 00
202.00	Cost to be allocated (per Wkst. B,	1, 697, 916	2, 201, 431	3, 355, 36	5	20, 998, 384	1
203.00	Part I) Unit cost multiplier (Wkst. B, Part I)	10. 636439	13. 790662	0. 13376	2	0. 584929	203. 00
	, , , , , , , , , , , , , , , , , , ,		, , , , , , , , , , , , , , , ,	. 5. 15576	ı	0.301727	, 5 . 00

Heal th Finar	ncial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
					From 01/01/2019 Fo 12/31/2019		
		CAPITAL REL	LATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
				(GROSS SALARI ES)		(ACCOM. COST)	
		1. 00	2. 00	4. 00	5A	5. 00	
204. 00	Cost to be allocated (per Wkst. B, Part II)			(D	5, 071, 987	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 00000		0. 141285	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0101

			T	o 12/31/2019	Date/Time Pre 6/29/2020 3:1	
Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	REPAIRS (SQUARE FEET)	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	
	· ·	· ·	LAUNDRY)	0.00	10.00	
GENERAL SERVICE COST CENTERS	6. 00	7. 00	8.00	9. 00	10. 00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT 5.00 O0500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00 00600 MAI NTENANCE & REPAI RS	0					6.00
7.00 O0700 OPERATION OF PLANT	0	98, 336				7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE	0	542	1			8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	0	453 1, 942	1	97, 341 1, 942	13, 569	9.00
11. 00 01100 CAFETERI A		2, 190	1	2, 190	13, 307	11.00
12. 00 01200 MAI NTENANCE OF PERSONNEL	0	0	_	0	0	12. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	132	1	132	0	13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	0	1, 568 1, 359	1	1, 568 1, 359	0	14. 00 15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY		483	1	483	0	16. 00
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	19.00
20. 00 02000 NURSI NG SCHOOL 21. 00 02100 I &R SERVI CES-SALARY & FRI NGES APPRV			0	0	0	20.00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	Ö	Ö	0	0	22. 00
23. 00 O2300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS	0	21 212	15 500	21 212	12 540	30.00
30. 00 03000 ADULTS & PEDI ATRI CS 43. 00 04300 NURSERY		1	15, 500 21, 970	21, 212 0	13, 569 0	43.00
44. 00 O4400 SKILLED NURSING FACILITY	0	1	0	0	0	44. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	12, 668	1	12, 668	0	50. 00 52. 00
53. 00 05300 ANESTHESI OLOGY			60, 262 0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	17, 022	30, 672	17, 022	0	54. 00
60. 00 06000 LABORATORY	0	2, 967	47	2, 967	0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 65. 00 06500 RESPIRATORY THERAPY	0	2, 346	0 1, 551	0 2, 346	0	62. 30
66. 00 06600 PHYSI CAL THERAPY		13, 857	1	13, 857	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	7, 774	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	219	0	0	68. 00
69. 00 06900 ELECTROCARDIOLOGY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0	0	0	69. 00 71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	Ö	ő	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
76. 97 O7697 CARDIAC REHABILITATION	0	0	0	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY 76. 99 07699 LI THOTRI PSY	0		0	0	0	76. 98 76. 99
OUTPATIENT SERVICE COST CENTERS		1		<u> </u>		, , ,
90. 00 09000 CLI NI C	0	η	0	0	0	
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM 91. 00 09100 EMERGENCY	0		0	0 15, 526	0	90. 01 91. 00
92. 00 09100 EMERGENCT 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		15, 520	57, 744	15, 526	U	91.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	0	14, 848	0	0	95.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	94, 267	260, 394	93, 272	13 560	118. 00
NONREI MBURSABLE COST CENTERS		74, 207	200, 374	75, 212	13, 307	1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		1	288		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0		0	3, 496		192. 00
194. 00 07950 OCCUPATI ONAL HEALTH 194. 01 07951 PAIN CLINI C	0	1	0	0		194. 00 194. 01
194. 02 07952 OAK POI NTE	0	Ö	ő	0		194. 02
194. 03 07953 FOUNDATI ON	0	0	0	0		194. 03
194.04 07954 COMMUNITY & VOLUNTEER SERVICES 194.05 07955 VACANT SPACE	0	285	0	285		194. 04 194. 05
194. 05 07955 VACANT SPACE 194. 06 07956 TELEHEALTH MEDICINE	0	0	0	0		194. 05
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers				.		201. 00
202.00 Cost to be allocated (per Wkst. B, Part I)	0	2, 960, 465	482, 272	1, 263, 759	779, 918	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	30. 105607	1. 852086	12. 982803	57. 477928	203. 00
204.00 Cost to be allocated (per Wkst. B,	0	547, 259	1		122, 804	
Part II) Note: The part of th	0.000000	E E4E10E	0.221044	1 204402	9. 050335	205 00
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	5. 565195	0. 221944	1. 284402	7. 000335	200.00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	I .	I .	I .	i	İ	ı

Health Finar	icial Systems	WHITLEY MEMOR	AL HOSPITAL		In Lieu of Form CMS-2552-10		
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2019 o 12/31/2019		narod:
					. 12/31/2019	6/29/2020 3:1	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF			
				LAUNDRY)			
		6. 00	7. 00	8. 00	9. 00	10.00	
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

	Financial Systems	WHITLEY MEMORI		001 45 0404		u or form CMS-	
COST A	LLOCATION - STATISTICAL BASIS		Provi der	1	Period: From 01/01/2019 To 12/31/2019	Worksheet B-1 Date/Time Pre 6/29/2020 3:1	pared:
	Cost Center Description	CAFETERI A (FTES)	MAI NTENANCE PERSONNEL (NUMBER HOUSED)		SUPPLY	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14. 00	15. 00	
·	GENERAL SERVICE COST CENTERS						
13. 00 14. 00 15. 00 16. 00 17. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	451, 760 0 9, 219 0 13, 575 0			0 0 3, 250, 287 0 43, 421 0 0	3, 312, 566 0 0	16. 00 17. 00
19. 00	01900 NONPHYSI CLAN ANESTHETI STS	0		0	0	0	19. 00
21. 00 22. 00	02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	0 0 0		0 0 0	0 0 0	0 0 0 0	
30. 00	03000 ADULTS & PEDI ATRI CS	72, 101		0 72, 10	1 36, 289	158	30.00
43.00	04300 NURSERY	6, 617			51, 436	0	43. 00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0		0	0	0	44. 00
50.00	05000 OPERATING ROOM	30, 283		0 30, 28	487, 433	719	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	18, 150		0 18, 150		0	
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 65, 940		- 1	0 125, 958	0 931	
60. 00	06000 LABORATORY	03, 740			0 123, 730	0	l
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		o i	0	0	1
65. 00	06500 RESPI RATORY THERAPY	20, 944		0	99, 821	0	65. 00
66. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	30, 634		0	14, 911 11, 492	1, 206	1
67. 00 68. 00	06800 SPEECH PATHOLOGY	12, 994 323			11, 492	0	
69. 00	06900 ELECTROCARDI OLOGY	0		o o	o o	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	1, 654, 506	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0		0	0	0	
73. 00 76. 97	07300 DRUGS CHARGED TO PATIENTS 07697 CARDI AC REHABILITATION	0			0 85, 820 0 0	3, 295, 018 0	1
	07698 HYPERBARI C OXYGEN THERAPY	0		-1		0	
	07699 LI THOTRI PSY	0			0	0	
	OUTPATIENT SERVICE COST CENTERS	1					
90. 00 90. 01	09000 CLINIC 09001 INTENSIVE OUT PATIENT PROGRAM	0		- 1		0	
91. 00	09100 EMERGENCY	89, 196		0 89, 19	-	5, 315	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			·	·		92. 00
95. 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES	72, 058		0 0	146, 431	9, 216	95. 00
	SPECIAL PURPOSE COST CENTERS	,		-1			
118. 00	, ,	442, 034		0 209, 730	3, 221, 211	3, 312, 563	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	25, 304	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	5, 593		٠	3, 037		192. 00
194.00	07950 OCCUPATI ONAL HEALTH	0			0		194. 00
	07951 PAIN CLINIC 07952 OAK POINTE	0			0		194. 01 194. 02
	07953 FOUNDATION	2, 993					194. 02
194.04	07954 COMMUNITY & VOLUNTEER SERVICES	1, 140		0	735	0	194. 04
	07955 VACANT SPACE	0		0	0		194. 05
194. 06 200. 00	07956 TELEHEALTH MEDICINE Cross Foot Adjustments	0			0	0	194. 06 200. 00
201.00	1 1						201. 00
202.00	Cost to be allocated (per Wkst. B,	526, 535		0 981, 76	128, 269	1, 388, 819	
202.00	Part I)	1 4/5540	0.0000	4 (0100)	0.000444	0 440050	202 00
203. 00 204. 00	1 1	1. 165519 107, 022	0. 0000	00 4. 68109 0 92, 36		0. 419258 163, 469	

Heal th Finar	ncial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
					From 01/01/2019 To 12/31/2019	Date/Time Pre 6/29/2020 3:1	
	Cost Center Description	*	MAINTENANCE OF		CENTRAL	PHARMACY	
		(FTES)	PERSONNEL	ADMI NI STRATI O	N SERVICES &	(COSTED	
			(NUMBER		SUPPLY	REQUIS.)	
			HOUSED)	(DIRECT NRSIN	G (COSTED		
				HRS)	REQUIS.)		
		11. 00	12.00	13.00	14.00	15. 00	
205. 00	Unit cost multiplier (Wkst. B, Part	0. 236900	0. 000000	0. 44040	0. 016753	0. 049348	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0101

							o 12/31/2019	Date/lime Pre 6/29/2020 3:1	
		Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	(TIM	AL SERVICE ME SPENT)	ANESTHETI STS (ASSI GNED TI ME)	NURSING SCHOOL (ASSIGNED TIME)	I NTERNS & RESI DENTS SERVI CES-SALAR Y & FRI NGES APPRV (ASSI GNED TI ME)	+ piii
	OENED	AL CERVILOE COCT OFFITERS	16. 00		17. 00	19. 00	20. 00	21.00	
1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00	00100 00200 00400 00500 00700 00800 00900 01100 01200 01300 01400 01500 01700 01900	AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS NURSING SCHOOL I&R SERVICES SALARY & FRINGES APPRV	10,000		0 0 0 0 0	C		0	1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRV	0		0			٥	22. 00
23. 00		PARAMED ED PRGM-(SPECIFY)	0		0				23. 00
		IENT ROUTINE SERVICE COST CENTERS				,	_		
30.00		ADULTS & PEDI ATRI CS	527		0				
43. 00 44. 00	1	NURSERY SKILLED NURSING FACILITY	98		0			0	43. 00 44. 00
44.00		LARY SERVICE COST CENTERS					,		1 44. 00
50.00		OPERATING ROOM	140		0	C	0	0	50. 00
52.00	1	DELIVERY ROOM & LABOR ROOM	0		0		0	0	52. 00
53.00	1	ANESTHESI OLOGY	0		0	`	0	0	53. 00
54. 00 60. 00	1	RADI OLOGY-DI AGNOSTI C LABORATORY	3, 904		0			0	54. 00 60. 00
62. 30	1	BLOOD CLOTTING FOR HEMOPHILIACS	Ö		0		Ö	Ö	62. 30
65. 00	1	RESPI RATORY THERAPY	0		0	C	0	0	65. 00
66. 00		PHYSI CAL THERAPY	1, 193		0		0	0	66. 00
67. 00 68. 00	1	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	316 11		0	(0	0 0	67. 00 68. 00
69. 00	1	ELECTROCARDI OLOGY	0		0				69.00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT	Ö		0	Ċ	Ö	Ö	71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0		0	C	0	0	72. 00
73.00		DRUGS CHARGED TO PATIENTS CARDIAC REHABILITATION	0		0	0	0	0	73. 00 76. 97
	1	HYPERBARIC OXYGEN THERAPY	0		0			0	
		LI THOTRI PSY	o		0		_	1	
		TIENT SERVICE COST CENTERS							
90.00		CLINIC	0		0			0	90.00
90. 01 91. 00		INTENSIVE OUT PATIENT PROGRAM EMERGENCY	3, 811		0			0	90. 01 91. 00
		OBSERVATION BEDS (NON-DISTINCT PART	3,011		O		,	Ĭ	92. 00
	OTHER	REIMBURSABLE COST CENTERS							
95. 00		AMBULANCE SERVICES	0		0	(0	0	95. 00
110 00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	10, 000		0		0	0	110 00
118. 00		IMBURSABLE COST CENTERS	10,000		0) 0	0	118. 00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	C	0	0	190. 00
	1	PHYSICIANS' PRIVATE OFFICES	0		0		0		192. 00
		OCCUPATIONAL HEALTH	0		0	1	0		194. 00
		PAIN CLINIC OAK POINTE	0		0		0		194. 01 194. 02
194. 03	07953	FOUNDATI ON	Ö		0		Ö		194. 03
194.04	07954	COMMUNITY & VOLUNTEER SERVICES	0		0	(0	l e	194. 04
	1	VACANT SPACE	0		0		0		194. 05
194. 06 200. 00		TELEHEALTH MEDICINE Cross Foot Adjustments	0		0		0	0	194. 06 200. 00
200.00		Negative Cost Centers							200.00
202.00		Cost to be allocated (per Wkst. B,	39, 511		0	C	0	0	202. 00
000 5		Part I)	0 0544		0.00005			0 0000	000 00
203. 00		Unit cost multiplier (Wkst. B, Part I)	3. 951100		0. 000000	0.000000	0. 000000	0. 000000	203. 00

Heal th Fina	ncial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2019 Fo 12/31/2019		
						I NTERNS & RESI DENTS	
	Cost Center Description		SOCIAL SERVICE		NURSI NG SCHOOL		
		RECORDS &		ANESTHETI STS		Y & FRINGES	
		LI BRARY	(TIME SPENT)	(ASSI GNED	(ASSI GNED	APPRV	
		(TIME SPENT)		TIME)	TIME)	(ASSI GNED	
						TIME)	
		16.00	17. 00	19. 00	20.00	21. 00	
204. 00	Cost to be allocated (per Wkst. B, Part II)	16, 773	0	(0	0	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	1. 677300	0. 000000	0. 00000	0. 000000	0. 000000	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0. 000000		207. 00

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

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0101 From 01/01/2019 12/31/2019 Date/Time Prepared: 6/29/2020 3:14 pm INTERNS & **RESI DENTS** Cost Center Description SERVI CES-OTHER PARAMED ED PRGM COSTS **PRGM** (ASSI GNED **APPRV** (ASSI GNED TIME) TIME) 23.00 22.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16,00 17.00 01700 SOCIAL SERVICE 17 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 20.00 02000 NURSING SCHOOL 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30 00 0 0 43.00 04300 NURSERY 0 0 43.00 04400 SKILLED NURSING FACILITY 0 44.00 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0000000000000000 0 52.00 53.00 05300 ANESTHESI OLOGY 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54 00 54 00 60.00 06000 LABORATORY 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 62.30 06500 RESPIRATORY THERAPY 0 65.00 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 0 69 00 69 00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 73.00 07697 CARDIAC REHABILITATION 76 97 76 97 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 76.98 07699 LI THOTRI PSY 0 76. 99 76.99 0 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0 0 90 00 90.01 09001 INTENSIVE OUT PATIENT PROGRAM 0 0 90.01 0 91.00 09100 EMERGENCY 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 0 0 118.00 118,00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 190.00 0 0 192.00 194. 00 07950 OCCUPATIONAL HEALTH 194. 00 0 194. 01 07951 PAIN CLINIC 0 0 0 0 194.01 194. 02 07952 OAK POINTE 0 194.02 194. 03 07953 FOUNDATI ON 0 194.03 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 0 194.04 194. 05 07955 VACANT SPACE 0 194.05 0 194. 06 07956 TELEHEALTH MEDICINE Ω 194.06 Cross Foot Adjustments 200.00 200. 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 202.00 Part I) 203 00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.000000 203. 00

Health Fina	ncial Systems	WHITLEY MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS			Provi der Co	CN: 15-0101	Peri od: Worksheet B From 01/01/2019		
					To 12/31/2019	Date/Time Pre 6/29/2020 3:1	
		INTERNS &					
		RESI DENTS	DADAMED ED				
	Cost Center Description	SERVI CES-OTHER	PARAMED ED				
		PRGM COSTS	PRGM				
		APPRV	(ASSI GNED				
		(ASSI GNED	TIME)				
		TI ME)					
		22.00	23. 00				
204.00	Cost to be allocated (per Wkst. B,	0	0				204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	0.000000				205. 00
	[1]						
206. 00	NAHE adjustment amount to be allocated		0				206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,		0. 000000				207. 00
	Parts III and IV)						
'		'		'			•

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 From 01/01/2019 Part I To 12/31/2019 Date/Time 6/29/2020	

					10 12/31/2019	6/29/2020 3: 1	
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDI ATRI CS	8, 691, 324		8, 691, 32		8, 691, 324	
	04300 NURSERY	590, 798		590, 79	8 0	590, 798	
44.00	04400 SKILLED NURSING FACILITY	0			0 0	0	44. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	4, 351, 237		4, 351, 23		1,001,207	1
	05200 DELIVERY ROOM & LABOR ROOM	1, 886, 081		1, 886, 08	1 0	1, 886, 081	
	05300 ANESTHESI OLOGY	0			0	0	
	05400 RADI OLOGY-DI AGNOSTI C	7, 440, 668		7, 440, 66		7, 440, 668	1
	06000 LABORATORY	5, 429, 484		5, 429, 48	4 0	5, 429, 484	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	1, 451, 450	0	1, 451, 45		1, 451, 450	1
66.00	06600 PHYSI CAL THERAPY	2, 243, 816	0	2, 243, 81		2, 243, 816	1
	06700 OCCUPATI ONAL THERAPY	1, 060, 667	0	1, 060, 66		1, 060, 667	
	06800 SPEECH PATHOLOGY	29, 837	0	29, 83	7 0	29, 837	
	06900 ELECTROCARDI OLOGY	0			0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 723, 895		1, 723, 89	5 0	1, 723, 895	
	07200 I MPL. DEV. CHARGED TO PATIENTS	963, 160		963, 16		963, 160	1
	07300 DRUGS CHARGED TO PATIENTS	7, 016, 783		7, 016, 78	3 0	7, 016, 783	
76. 97	07697 CARDI AC REHABI LI TATI ON	0			0	0	
	07698 HYPERBARI C OXYGEN THERAPY	0			0	0	1 , 0. , 0
76. 99	07699 LI THOTRI PSY	0			0 0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0			0	0	70.00
	09001 INTENSIVE OUT PATIENT PROGRAM	0			0	0	90. 01
	09100 EMERGENCY	8, 897, 480		8, 897, 48		8, 916, 740	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 585, 556		2, 585, 55	6	2, 585, 556	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES	3, 725, 697		3, 725, 69			
200.00		58, 087, 933	0	,,			1
201.00		2, 585, 556		2, 585, 55		2, 585, 556	
202.00	Total (see instructions)	55, 502, 377	0	55, 502, 37	7 22, 813	55, 525, 190	202.00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0101	Peri od: Worksheet C
		From 01/01/2019 Part I
		T- 10/01/0010 D-+-/T! D

					To 12/31/2019	Date/Time Pre 6/29/2020 3:1	
			Title	XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	11, 706, 592		11, 706, 592			30. 00
43.00	04300 NURSERY	1, 600, 839		1, 600, 839			43. 00
44. 00	04400 SKILLED NURSING FACILITY	0		(44. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	7, 608, 546	25, 680, 516			0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	4, 216, 583	176, 369	4, 392, 952		0. 000000	
53.00	05300 ANESTHESI OLOGY	0	0	1	0. 000000	0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 696, 843	50, 597, 322			0. 000000	
60.00	06000 LABORATORY	5, 047, 210	28, 770, 616	33, 817, 826		0. 000000	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	`	0.00000	0. 000000	
65. 00	06500 RESPI RATORY THERAPY	2, 463, 002	8, 570, 453			0.000000	
66. 00	06600 PHYSI CAL THERAPY	296, 007	5, 262, 825			0.000000	
67.00	06700 OCCUPATI ONAL THERAPY	126, 961	1, 441, 769			0.000000	
68. 00	06800 SPEECH PATHOLOGY	37, 843	75, 173	113, 016	0. 264007	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, 242, 273	3, 266, 956	4, 509, 229	0. 382304	0.000000	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	714, 561	3, 825, 617	4, 540, 178		0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 063, 981	19, 423, 954	24, 487, 935		0.000000	
	07697 CARDI AC REHABI LI TATI ON	0	0	(0.000000	0.000000	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	(0. 000000	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	4, 524, 937	42, 873, 402	47, 398, 339	0. 187717	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	5, 992, 881	5, 992, 881	0. 431438	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	0	10, 663, 527	10, 663, 527	0. 349387	0.000000	95. 00
200.00	Subtotal (see instructions)	48, 346, 178	206, 621, 380	254, 967, 558	3		200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	48, 346, 178	206, 621, 380	254, 967, 558	3		202. 00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0101	Peri od: Worksheet C From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared: 6/29/2020 3:14 pm

					6/29/2020 3: 1	4 pm
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS					30.00
43.00	04300 NURSERY					43. 00
44.00	04400 SKILLED NURSING FACILITY					44. 00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 130711				50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 429343				52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000				53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 137044				54. 00
60.00	06000 LABORATORY	0. 160551				60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000				62. 30
65.00	06500 RESPIRATORY THERAPY	0. 131550				65.00
66.00	06600 PHYSI CAL THERAPY	0. 403649				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 676131				67.00
68.00	06800 SPEECH PATHOLOGY	0. 264007				68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000				69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 382304				71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 212141				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 286540				73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000				76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000				76. 98
76. 99	07699 LI THOTRI PSY	0. 000000				76. 99
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	0. 000000				90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0. 000000				90. 01
91.00	09100 EMERGENCY	0. 188123				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 431438				92. 00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVI CES	0. 349720				95. 00
200.00	Subtotal (see instructions)					200.00
201.00						201. 00
202.00	Total (see instructions)					202. 00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0101	Peri od: Worksheet C From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared: 6/29/2020 3:14 pm

				'	0 12/31/2019	6/29/2020 3:1	
			Ti tl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	8, 691, 324		8, 691, 324		8, 691, 324	
43.00	04300 NURSERY	590, 798		590, 798	0	590, 798	
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	4, 351, 237		4, 351, 237		4, 351, 237	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 886, 081		1, 886, 081	0	1, 886, 081	
53.00	05300 ANESTHESI OLOGY	0		0	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	7, 440, 668		7, 440, 668		7, 440, 668	1
60.00	06000 LABORATORY	5, 429, 484		5, 429, 484	0	5, 429, 484	1
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	
65.00	06500 RESPI RATORY THERAPY	1, 451, 450		1, 451, 450		1, 451, 450	
66. 00	06600 PHYSI CAL THERAPY	2, 243, 816	0	2, 243, 816		2, 243, 816	1
67. 00	06700 OCCUPATI ONAL THERAPY	1, 060, 667	0	1, 060, 667		1, 060, 667	
68. 00	06800 SPEECH PATHOLOGY	29, 837	0	29, 837	0	29, 837	
69. 00	06900 ELECTROCARDI OLOGY	0		0	0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 723, 895		1, 723, 895		1, 723, 895	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	963, 160		963, 160		963, 160	
73.00	07300 DRUGS CHARGED TO PATIENTS	7, 016, 783		7, 016, 783	0	7, 016, 783	
76. 97	07697 CARDI AC REHABI LI TATI ON	0		0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0		0	0	0	1 . 0 0
76. 99	07699 LI THOTRI PSY	0		0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0		0	0	0	1 /0.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0		0	0	0	90. 01
91.00	09100 EMERGENCY	8, 897, 480		8, 897, 480	19, 260	8, 916, 740	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 585, 556		2, 585, 556		2, 585, 556	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES	3, 725, 697		3, 725, 697			
200.00		58, 087, 933	0	58, 087, 933	22, 813	58, 110, 746	200.00
201.00		2, 585, 556		2, 585, 556		2, 585, 556	
202.00	Total (see instructions)	55, 502, 377	0	55, 502, 377	22, 813	55, 525, 190	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		sheet C
		From 01/01/2019 Part	
		To 12/21/2010 Doto	/Tima Dranarad

					To 12/31/2019	Date/Time Pre 6/29/2020 3:1	
			Titl	e XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	11, 706, 592		11, 706, 592			30. 00
43.00	04300 NURSERY	1, 600, 839		1, 600, 839			43. 00
44. 00	04400 SKILLED NURSING FACILITY	0		(44. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	7, 608, 546	25, 680, 516			0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	4, 216, 583	176, 369	4, 392, 952		0. 000000	
53.00	05300 ANESTHESI OLOGY	0	0	1	0. 000000	0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 696, 843	50, 597, 322			0. 000000	
60.00	06000 LABORATORY	5, 047, 210	28, 770, 616	33, 817, 826		0. 000000	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	`	0.00000	0. 000000	
65. 00	06500 RESPI RATORY THERAPY	2, 463, 002	8, 570, 453			0.000000	
66. 00	06600 PHYSI CAL THERAPY	296, 007	5, 262, 825			0.000000	
67. 00	06700 OCCUPATI ONAL THERAPY	126, 961	1, 441, 769	1, 568, 730		0.000000	
68. 00	06800 SPEECH PATHOLOGY	37, 843	75, 173	113, 016	0. 264007	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, 242, 273	3, 266, 956	4, 509, 229	0. 382304	0.000000	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	714, 561	3, 825, 617	4, 540, 178	0. 212141	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 063, 981	19, 423, 954	24, 487, 935	0. 286540	0.000000	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	(0. 000000	0.000000	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	(0. 000000	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	4, 524, 937	42, 873, 402	47, 398, 339	0. 187717	0.000000	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	5, 992, 881	5, 992, 88	0. 431438	0.000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES	0	10, 663, 527	10, 663, 527	0. 349387	0.000000	95. 00
200.00	Subtotal (see instructions)	48, 346, 178	206, 621, 380	254, 967, 558	3		200. 00
201.00							201.00
202.00		48, 346, 178	206, 621, 380	254, 967, 558	3		202. 00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0101	Peri od: Worksheet C From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared: 6/29/2020 3:14 pm

					6/29/2020 3: 1	4 pm
			Title XIX	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS					30.00
43.00	04300 NURSERY					43.00
44.00	04400 SKILLED NURSING FACILITY					44. 00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 130711				50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 429343				52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000				53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 137044				54. 00
60.00	06000 LABORATORY	0. 160551				60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000				62. 30
65.00	06500 RESPIRATORY THERAPY	0. 131550				65.00
66.00	06600 PHYSI CAL THERAPY	0. 403649				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 676131				67.00
68.00	06800 SPEECH PATHOLOGY	0. 264007				68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000				69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 382304				71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 212141				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 286540				73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000				76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000				76. 98
76. 99	07699 LI THOTRI PSY	0. 000000				76. 99
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	0. 000000				90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0. 000000				90. 01
91.00	09100 EMERGENCY	0. 188123				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 431438				92. 00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVI CES	0. 349720				95. 00
200.00	Subtotal (see instructions)					200.00
201.00						201. 00
202.00	Total (see instructions)					202. 00

Health Financial Systems WHITLEY MEM CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | Peri od: | Worksheet C | From 01/01/2019 | Part | I | To 12/31/2019 | Date/Time Prepared: WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101

				''	0 12/31/2019	6/29/2020 3:1	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost		Operating Cost	
				Net of Capital	Reduction	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
				col. 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	4, 351, 237	749, 068			0	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 886, 081	176, 258	1, 709, 823	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	7, 440, 668	1, 147, 657		0	0	54.00
60.00	06000 LABORATORY	5, 429, 484	565, 403	4, 864, 081	0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	1, 451, 450	197, 945	1, 253, 505	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	2, 243, 816	586, 637	1, 657, 179	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 060, 667	97, 291	963, 376	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	29, 837	2, 730	27, 107	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 723, 895	175, 570	1, 548, 325	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	963, 160	85, 859	877, 301	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	7, 016, 783	666, 087	6, 350, 696	0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	O	0	0	0	90. 00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0	90. 01
91.00	09100 EMERGENCY	8, 897, 480	1, 245, 698	7, 651, 782	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 585, 556	423, 424	2, 162, 132	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	3, 725, 697	344, 595	3, 381, 102	0	0	95. 00
200.00	Subtotal (sum of lines 50 thru 199)	48, 805, 811	6, 464, 222	42, 341, 589	0	0	200. 00
201.00	Less Observation Beds	2, 585, 556	423, 424	2, 162, 132	0	0	201. 00
202.00	Total (line 200 minus line 201)	46, 220, 255	6, 040, 798	40, 179, 457	0	0	202. 00

Health 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 Provider CCN: 15-0101 To 12/31/2019 Date/Time Prepared:

				0 12/01/201/	6/29/2020 3: 14	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Total Charges				
			Cost to Charge			
	Operating Cost F	Part I, column	Ratio (col. 6			
	Reduction	8)	/ col. 7)			
	6. 00	7. 00	8. 00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	4, 351, 237	33, 289, 062				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 886, 081	4, 392, 952				52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	7, 440, 668	54, 294, 165	0. 137044			54.00
60. 00 06000 LABORATORY	5, 429, 484	33, 817, 826	0. 160551			60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000			62.30
65. 00 06500 RESPIRATORY THERAPY	1, 451, 450	11, 033, 455	0. 131550			65.00
66. 00 06600 PHYSI CAL THERAPY	2, 243, 816	5, 558, 832	0. 403649			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 060, 667	1, 568, 730	0. 676131			67.00
68. 00 06800 SPEECH PATHOLOGY	29, 837	113, 016	0. 264007			68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.000000			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	I ENT 1, 723, 895	4, 509, 229	0. 382304			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	963, 160	4, 540, 178	0. 212141			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	7, 016, 783	24, 487, 935	0. 286540			73.00
76. 97 07697 CARDIAC REHABILITATION	0	0	0.000000			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	o	0	0.000000			76. 98
76. 99 07699 LI THOTRI PSY	o	0	0.000000			76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0.000000			90.00
90.01 09001 INTENSIVE OUT PATIENT PROGRAM	o	0	0.000000			90. 01
91. 00 09100 EMERGENCY	8, 897, 480	47, 398, 339	0. 187717			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	PART 2, 585, 556	5, 992, 881	0. 431438			92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	3, 725, 697	10, 663, 527	0. 349387			95.00
200.00 Subtotal (sum of lines 50 thru	199) 48, 805, 811	241, 660, 127				200. 00
201.00 Less Observation Beds	2, 585, 556	0				201. 00
202.00 Total (line 200 minus line 201)	46, 220, 255	241, 660, 127			•	202. 00
			•	•	•	

Health Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 01/01/2019		
				To 12/31/2019	Date/Time Pre 6/29/2020 3:1	pared: 4 pm
		Titl∈	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	_	,				
30. 00 ADULTS & PEDI ATRI CS	1, 423, 331		1, 423, 33		l .	
43. 00 NURSERY	55, 605		55, 60	5 730	76. 17	43. 00
44.00 SKILLED NURSING FACILITY	0			0	0.00	44. 00
200.00 Total (lines 30 through 199)	1, 478, 936		1, 478, 93	6 7, 016		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)	1			
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1, 080	244, 544				30.00
43. 00 NURSERY	0	0)			43. 00
44.00 SKILLED NURSING FACILITY	0	0)			44. 00
200.00 Total (lines 30 through 199)	1, 080	244, 544	.[200. 00

Health Financial Systems	WHITLEY MEMORIA	L HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SER	VICE CAPITAL COSTS	Provi der CCN: 15-0101	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Prepared: 6/29/2020 3:14 pm
		Title XVIII	Hospi tal	PPS

					To 12/31/2019	Date/Time Pre 6/29/2020 3:1	
			Title	xVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpatient	Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,			. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	NCILLARY SERVICE COST CENTERS		T			T	
	5000 OPERATING ROOM	749, 068				18, 727	50. 00
	5200 DELIVERY ROOM & LABOR ROOM	176, 258	4, 392, 952	•		l	52. 00
	5300 ANESTHESI OLOGY	0	0	0. 00000		0	53. 00
	5400 RADI OLOGY-DI AGNOSTI C	1, 147, 657	54, 294, 165			22, 510	54. 00
	6000 LABORATORY	565, 403	33, 817, 826			23, 146	
	6250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000		0	62. 30
	6500 RESPI RATORY THERAPY	197, 945	11, 033, 455				65. 00
	6600 PHYSI CAL THERAPY	586, 637	5, 558, 832	0. 10553	2 82, 777	8, 736	66. 00
67.00 0	6700 OCCUPATI ONAL THERAPY	97, 291	1, 568, 730	0. 06201	9 46, 180	2, 864	67.00
68.00 0	6800 SPEECH PATHOLOGY	2, 730	113, 016	0. 02415	6 15, 746	380	68. 00
69.00 0	6900 ELECTROCARDI OLOGY	0	0	0.00000	0 0	0	69. 00
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	175, 570	4, 509, 229	0. 03893	6 299, 499	11, 661	71.00
72. 00 0	7200 IMPL. DEV. CHARGED TO PATIENTS	85, 859	4, 540, 178	0. 01891	1 160, 332	3, 032	72.00
73. 00 0	7300 DRUGS CHARGED TO PATIENTS	666, 087	24, 487, 935	0. 02720	1, 215, 083	33, 051	73. 00
76. 97 0	17697 CARDIAC REHABILITATION	0	0	0.00000	0 0	0	76. 97
76. 98 0	17698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000	0 0	0	76. 98
76. 99 0	17699 LI THOTRI PSY	0	0	0.00000	0 0	0	76. 99
OI	UTPATIENT SERVICE COST CENTERS					•	
90.00	9000 CLI NI C	0	0	0.00000	0 0	0	90. 00
90. 01 0	9001 INTENSIVE OUT PATIENT PROGRAM	0	0	0.00000	0 0	0	90. 01
	9100 EMERGENCY	1, 245, 698	47, 398, 339	0. 02628	1, 436, 514	37, 753	91.00
92.00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART	423, 424	5, 992, 881			0	92. 00
0	THER REIMBURSABLE COST CENTERS	•		•	•		
95. 00 0	9500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	6, 119, 627	230, 996, 600		7, 487, 048	179, 112	200. 00

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COST			Period: From 01/01/2019 To 12/31/2019	Worksheet D Part III Date/Time Pre 6/29/2020 3:1	
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
·	Post-Stepdown	ŭ	Post-Stepdown		Medi cal	
	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	0	30.00
43. 00 04300 NURSERY	o	0		0	0	43. 00
44.00 04400 SKILLED NURSING FACILITY	0	0		0		44.00
200.00 Total (lines 30 through 199)	0	0		0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	
, , , , , , , , , , , , , , , , , , ,	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,		,		
		minus col. 4)				
	4.00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>		<u> </u>	<u> </u>		
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	6, 28	6 0.00	1, 080	30.00
43. 00 04300 NURSERY		0	73	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, 01		1, 080	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	o					43.00
44.00 04400 SKILLED NURSING FACILITY	o					44. 00
200.00 Total (lines 30 through 199)	0					200.00
	,					•

H	lealth Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
	APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0101	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared:

					12,01,201,	6/29/2020 3:1	4 pm
				XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
			Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	(0	0	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	(0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54.00
60.00	06000 LABORATORY	0	0	(0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0	0	(0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	(0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	(0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	(0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	(0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	(0	0	90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0	0	(0	0	90. 01
91.00	09100 EMERGENCY	0	0	(0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0)	0	92.00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	0	0	(0	0	200. 00

Не	al th Financial	Systems		WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
AF	PPORTI ONMENT OF	I NPATI ENT/OUTPATI ENT	ANCILLARY SE	RVICE OTHER PASS	Provider C		Peri od:	Worksheet D	
TH	HROUGH COSTS						From 01/01/2019		
						'	To 12/31/2019		pared:
								6/29/2020 3: 1	4 pm
					Title	: XVIII	Hospi tal	PPS	
	Cost	Center Description		All Other	Total Cost	Total	Total Charges	Ratio of Cost	
				Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
				Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
					4)	col s. 2, 3,	8)	7)	
						and 4)		(see	

		Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
			Medi cal	(sum of cols.		(from Wkst. C,		
			Education Cost	1, 2, 3, and	Cost (sum of	·	(col. 5 ÷ col.	
				4)	col s. 2, 3,	8)	7)	
					and 4)		(see	
							instructions)	
			4. 00	5. 00	6. 00	7. 00	8. 00	
		ANCILLARY SERVICE COST CENTERS						
		05000 OPERATING ROOM	0	0	0	33, 289, 062	l .	1
		05200 DELIVERY ROOM & LABOR ROOM	0	0	0	4, 392, 952		
		05300 ANESTHESI OLOGY	0	0	0	0	0.000000	1
54		05400 RADI OLOGY-DI AGNOSTI C	0	0	0	54, 294, 165		
60	0. 00	06000 LABORATORY	0	0	0	33, 817, 826	0.000000	60. 00
62	2. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62. 30
65	5. 00	06500 RESPI RATORY THERAPY	0	0	0	11, 033, 455	0.000000	65. 00
66	5. 00	06600 PHYSI CAL THERAPY	0	0	0	5, 558, 832	0.000000	66. 00
67	7. 00	06700 OCCUPATIONAL THERAPY	0	0	0	1, 568, 730	0.000000	67.00
68	3. 00	06800 SPEECH PATHOLOGY	0	0	0	113, 016	0.000000	68. 00
69	9. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0.000000	69. 00
71	1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4, 509, 229	0.000000	71. 00
72	2. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4, 540, 178	0.000000	72. 00
73	3. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	24, 487, 935	0.000000	73. 00
76	5. 97	07697 CARDIAC REHABILITATION	0	0	0	0	0.000000	76. 97
76	5. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0.000000	76. 98
76	5. 99	07699 LI THOTRI PSY	0	0	0	0	0.000000	76. 99
		OUTPATIENT SERVICE COST CENTERS						
90	0. 00	09000 CLI NI C	0	0	0	0	0.000000	90.00
90	0. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0.000000	90. 01
91	1.00	09100 EMERGENCY	0	0	0	47, 398, 339	0.000000	91.00
92	2. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	5, 992, 881	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95	5. 00	09500 AMBULANCE SERVICES						95. 00
20	00.00	Total (lines 50 through 199)	0	0	0	230, 996, 600		200. 00

Health Financial Systems	WHITLEY MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS				Period: From 01/01/2019 To 12/31/2019	Worksheet D	pared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpatient Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Pass-Through		Outpatient Program Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS		000 001	ı	0 505 740		
50. 00 05000 OPERATING ROOM	0. 000000	832, 231		0 3, 505, 713	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	9, 910		0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0.000000	0		0 450 0/7	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 064, 901		0 9, 459, 367	0	54.00
60. 00 06000 LABORATORY	0.000000	1, 384, 407		0 295, 461	0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	020.440		0 1 050 4/3	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	0.000000	939, 468		0 1, 959, 462	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0.000000	82, 777		0 38, 452	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0.000000	46, 180		0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0.000000	15, 746		0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0. 000000 0. 000000	200 400		0 599, 950	0	69. 00 71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	299, 499 160, 332		0 599, 950	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				0	73.00
76. 97 07697 CARDIAC REHABILITATION	1	1, 215, 083		0 6, 069, 872	0	76. 97
	0.000000	0		0	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY 76. 99 07699 LI THOTRI PSY	0. 000000 0. 000000	0		0	0	76. 98 76. 99
OUTPATIENT SERVICE COST CENTERS	0.000000	0		0 0	U	76.99
90. 00 09000 CLINIC	0. 000000	0			0	90.00
90. 00 09000 CETNIC 90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0. 000000	0		0	0	90.00
91. 00 09100 EMERGENCY	0.000000	1, 436, 514		0 6, 632, 362	0	91.00
02 ON 100200 ORSEDVATION REDS (NON DISTINCT DART	0.000000	1, 430, 314		0, 032, 302		

0.000000

7, 487, 048

0 200. 00

0 92.00 95.00

6, 632, 362 511, 589

29, 687, 463

0 0 0

0

92. 00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS |
95. 00 | 09500 | AMBULANCE SERVICES |
200. 00 | Total (lines 50 through 199)

Health Financial Systems		WHITLEY M	MEMORIAL HOSPITA	L	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES	AND VACCINE C	COST Provi de	r CCN: 15-0101	From 01/01/2019	Worksheet D Part V Date/Time Prepared:

					Γο 12/31/2019	Date/Time Pre 6/29/2020 3:1	
-			Title	xVIII	Hospi tal	PPS	т рііі
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	, , , , , , , , , , , , , , , , , , ,	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	,	
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0. 130711		(0	458, 235	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 429343)	0	0	02.00
53. 00	05300 ANESTHESI OLOGY	0. 000000)	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 137044	9, 459, 367	1	0	1, 296, 349	54. 00
60.00	06000 LABORATORY	0. 160551	295, 461		0	47, 437	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0)	0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0. 131550	1, 959, 462	(0	257, 767	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 403649	38, 452	(0	15, 521	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 676131	0)	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 264007	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. 382304	599, 950)	0	229, 363	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 212141	615, 235	(0	130, 517	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 286540	6, 069, 872	(0	1, 739, 261	73. 00
	07697 CARDI AC REHABI LI TATI ON	0. 000000	0)	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0)	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0. 000000	0)	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0. 000000	0)	0	0	90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0. 000000	0)	0	0	90. 01
91.00	09100 EMERGENCY	0. 187717	6, 632, 362		0	1, 245, 007	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 431438	511, 589)	0	220, 719	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0. 349387		()		95. 00
200.00	Subtotal (see instructions)		29, 687, 463		0	5, 640, 176	200. 00
201.00	Less PBP Clinic Lab. Services-Program				0		201. 00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)		29, 687, 463		0	5, 640, 176	202. 00

Health Financial Systems	WHITLEY MEMOR	RIAL HOSPITAL		In Lie	u of Form CMS-2	552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES	AND VACCINE COST	Provi der C	CN: 15-0101	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prep 6/29/2020 3:14	pared:
		Title	e XVIII	Hospi tal	PPS	
	Cc	sts				
Cost Center Description	Cost	Cost	1			
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	DI 0 C-!	DI 0 C-!				

		Cos	sts	
	Cost Center Description	Cost	Cost	
	·	Rei mbursed	Rei mbursed	
		Servi ces	Servi ces 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 RESPI RATORY THERAPY	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	76. 98
	07699 LI THOTRI PSY	0	0	76, 99
	OUTPATIENT SERVICE COST CENTERS	•		1
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	l l		0	200. 00
201.00				201. 00
	Only Charges			
202.00		0	О	202. 00

Health Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2019 To 12/31/2019		narod:
				10 12/31/2019	6/29/2020 3: 1	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 423, 331	C	1, 423, 33	1 6, 286	226. 43	30. 00
43. 00 NURSERY	55, 605		55, 60	5 730	76. 17	43.00
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	44. 00
200.00 Total (lines 30 through 199)	1, 478, 936		1, 478, 93	6 7, 016		200. 00
Cost Center Description	I npati ent	Inpati ent		•		
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS	_					
30. 00 ADULTS & PEDIATRICS	78	17, 662	2			30. 00
43. 00 NURSERY	47	3, 580			ļ	43.00
44.00 SKILLED NURSING FACILITY	0	l c			I	44.00
200.00 Total (lines 30 through 199)	125	21, 242	2			200. 00

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY	SERVICE CAPITAL COSTS	Provi der CCN: 15-0101	Peri od:	Worksheet D

Health Financial Systems	WHITLEY MEMOR	TAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provi der Co		Peri od:	Worksheet D	
				From 01/01/2019		
				To 12/31/2019		
		Ti +1	e XIX	Hospi tal	6/29/2020 3: 1 PPS	4 piii
Cost Center Description	Capi tal	Total Charges			Capital Costs	
cost center bescription		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.			column 4)	
	Part II, col.	8)	2)	. Charges	COT GIIIIT 4)	
	26)		2)			
	1, 00	2, 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1	=: 00			0.00	
50. 00 05000 OPERATING ROOM	749, 068	33, 289, 062	0. 02250	123, 157	2, 771	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	176, 258	4, 392, 952	0. 04012	155, 639	6, 245	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 147, 657	54, 294, 165	0. 02113	25, 318	535	54. 00
60. 00 06000 LABORATORY	565, 403	33, 817, 826	0. 01671	9 116, 733	1, 952	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	197, 945	11, 033, 455	0. 01794	0 31, 955	573	65. 00
66. 00 06600 PHYSI CAL THERAPY	586, 637	5, 558, 832	0. 10553	2, 253	238	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	97, 291	1, 568, 730		9 1, 193	74	67. 00
68. 00 06800 SPEECH PATHOLOGY	2, 730	113, 016	0. 02415	6 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	175, 570	4, 509, 229	0. 03893	18, 375	715	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	85, 859	4, 540, 178	0. 01891	1 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	666, 087	24, 487, 935	0. 02720	105, 997	2, 883	73. 00
76. 97 07697 CARDIAC REHABILITATION	0	0	0.00000		0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0.00000	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS	•					1
90. 00 09000 CLI NI C	0	0	0.00000	0 0	0	90.00
90.01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0.00000	0 0	0	90. 01
91. 00 09100 EMERGENCY	1, 245, 698	47, 398, 339	0. 02628	64, 389	1, 692	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	423, 424	5, 992, 881	0. 07065	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	6, 119, 627	230, 996, 600		645, 009	17, 678	200. 00
	*	•		*	-	

Health Financial Systems	WHITLEY MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA		Provider CO		Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part III Date/Time Pre 6/29/2020 3:1	pared:
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School N	ursing School	Allied Health	Allied Health	All Other	
	Post-Stepdown		Post-Stepdowr	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0	0	30. 00
43. 00 04300 NURSERY	0	0		0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	O	0		0		44.00
200.00 Total (lines 30 through 199)	o	0		0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment ((sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions) n	ninus col. 4)				
	4. 00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	6, 28		78	30. 00
43. 00 04300 NURSERY		0	73	0.00	47	43.00
44.00 04400 SKILLED NURSING FACILITY		0		0.00	0	44. 00
200.00 Total (lines 30 through 199)		0	7, 01	6	125	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30. 00
43. 00 04300 NURSERY	0					43. 00
44. 00 04400 SKILLED NURSING FACILITY	0					44. 00
200.00 Total (lines 30 through 199)	0					200. 00

Heal	th Financial Systems	WH	ITLEY MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
	ORTIONMENT OF INPATIENT/OUTPATIE DUGH COSTS	NT ANCILLARY SERVIC	E OTHER PASS	Provider CCN: 15-0101	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared:

					12,01,201,	6/29/2020 3:1	4 pm
				e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
		Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	(0	0	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	(0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54. 00
60.00	06000 LABORATORY	0	0		0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	(0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	(0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	(0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	(0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	(0	0	90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0	0	(0	0	90. 01
91.00	09100 EMERGENCY	0	0	(0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	0	0	(0	0	200. 00

Health Financial	Systems	WHITLEY MEMORIAL HOSPITAL In					eu of Form CMS-2	2552-10
	I NPATI ENT/OUTPATI ENT	ANCILLARY SEI	RVICE OTHER PASS	Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Pre 6/29/2020 3:14	
				Ti tl	e XIX	Hospi tal	PPS	
Cost	Center Description		All Other	Total Cost	Total	Total Charges	Ratio of Cost	
			Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
			Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	

			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
	T	4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS		ı	1			
	05000 OPERATING ROOM	0	0	(33, 289, 062		
	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	4, 392, 952		
53.00	05300 ANESTHESI OLOGY	0	0	(0	0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	C	54, 294, 165		
60.00	06000 LABORATORY	0	0	C	33, 817, 826		
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(0	0. 000000	
65.00	06500 RESPI RATORY THERAPY	0	0	(11, 033, 455	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	(5, 558, 832	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	C	1, 568, 730	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	C	113, 016	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	C	0	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	4, 509, 229	0.000000	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		4, 540, 178	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(24, 487, 935	0.000000	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	(0	0.000000	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0.000000	76. 98
76. 99	07699 LI THOTRI PSY	0	0	l	0	0.000000	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	(0	0.000000	90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0	0	l	0	0.000000	90. 01
91.00	09100 EMERGENCY	0	0	l	47, 398, 339	0.000000	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	l	5, 992, 881	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS	•			•		1
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	О .	(230, 996, 600		200. 00

Hoal +b	Financial Systems	WHITLEY MEMORIA	I HOSDITAL		ln lie	u of Form CMS-2	2552 10
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS		Provi der CC		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Pre	pared:
			Titl	e XIX	Hospi tal	6/29/2020 3: 1 PPS	4 piii
	Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col.	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8	Outpatient Program Charges	Outpati ent Program Pass-Through Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS				_1		
50. 00	05000 OPERATI NG ROOM	0. 000000	123, 157		0	0	00.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	155, 639		0	0	52.00
53. 00	05300 ANESTHESI OLOGY	0.000000	05.040		0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	25, 318		0	0	54.00
60.00	06000 LABORATORY	0. 000000	116, 733		0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0	0	62. 30
65. 00	06500 RESPIRATORY THERAPY	0.000000	31, 955		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0.000000	2, 253		0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0.000000	1, 193		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0.000000	0		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	10.075		0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	18, 375		0	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	105, 997		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
76. 99	07699 LI THOTRI PSY	0. 000000	0		0 0	0	76. 99

0. 000000 0. 000000

0.000000

0.000000

64, 389

645, 009

0 0

0

0

0

0

0

90.01 0

95.00

0 200.00

0 90.00

0 91.00

0 92.00

90.00

90. 01

92.00

200.00

95. 00 09500 AMBULANCE SERVICES

91. 00 09100 EMERGENCY

OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 INTENSIVE OUT PATIENT PROGRAM

09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

Total (lines 50 through 199)

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	Peri od:	Worksheet D

From 01/01/2019 | Part V To 12/31/2019 | Date/Time Prepared: 6/29/2020 3:14 pm Title XIX Hospi tal PPS Costs Charges Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Rei mbursed Ratio From Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 130711 226, 993 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0. 429343 0 0 0 0 0 0 0 0 0 0 0 0 0 52.00 05300 ANESTHESI OLOGY 0.000000 53 00 0 O 53 00 0 |05400| RADI OLOGY-DI AGNOSTI C 54.00 0.137044 0 747, 686 0 54.00 60.00 06000 LABORATORY 0. 160551 455, 974 0 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0 62.30 0 06500 RESPIRATORY THERAPY 0 65.00 0.131550 90, 581 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.403649 38, 016 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.676131 6, 451 0 67.00 06800 SPEECH PATHOLOGY 0 264007 1, 961 68 00 68 00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 382304 48, 731 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0. 212141 72.00 0 07300 DRUGS CHARGED TO PATIENTS 303, 494 73 00 0.286540 0 0 73.00 76. 97 07697 CARDIAC REHABILITATION 0.000000 0 0 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.000000 0 76. 98 76. 99 07699 LI THOTRI PSY 0.000000 0 76. 99 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 0 0 0 90.00 09001 INTENSIVE OUT PATIENT PROGRAM 0.000000 0 0 0 0 90.01 90.01 0. 187717 1, 191, 288 0 91.00 91.00 09100 EMERGENCY 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 431438 92.00 92.00 87, 226 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0. 349387 335, 858 95.00 200.00 Subtotal (see instructions) 0 0 200. 00 3, 534, 259 0 Less PBP Clinic Lab. Services-Program 0 201.00 C 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 3, 534, 259 0 202.00

Health Financial Systems		WHITLEY MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND	VACCINE COST	Provider CCN: 15-0101	Peri od: From 01/01/2019	Worksheet D Part V Date/Time Prepared:

				To 12/31/2019	Date/Time Pro 6/29/2020 3:	
		Ti tl	e XIX	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces 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	29, 670	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	102, 466	0				54. 00
60. 00 06000 LABORATORY	73, 207	0				60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62. 30
65. 00 06500 RESPIRATORY THERAPY	11, 916	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	15, 345	0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	4, 362	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	518	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	18, 630	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	86, 963	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						
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	223, 625	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	37, 633	0				92. 00
OTHER REIMBURSABLE COST CENTERS		•				
95. 00 09500 AMBULANCE SERVICES	117, 344					95. 00
200.00 Subtotal (see instructions)	721, 679	0				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	721, 679	0				202. 00
, ,	•	•	•			•

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0101	Peri od: From 01/01/2019	Worksheet D-1	
			Date/Time Pre 6/29/2020 3:1	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				

		Title XVIII	Hospi tal	6/29/2020 3: 1 PPS	4 pm
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
1. 00 2. 00 3. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-bed and observation bed days).	ped and newborn days)	vate room days,	6, 286 6, 286 0	1. 00 2. 00 3. 00
4. 00 5. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private room reporting period		31 of the cost	4, 416 0	4. 00 5. 00
6.00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	9 1 9		1, 080	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct	tions)	,	0	10.00
11. 00 12. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)	nter O on this line)	,	0	11. 00 12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	3	,	0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra	ear, enter O on this line	e)	0	14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
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
19. 00	reporting period Medicald rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	ne cost	0.00	20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ng period (line	8, 691, 324 0	21. 00 22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December $ 7 \times 1 $ ine 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		0 8, 691, 324	26. 00 27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 -	- line 28)		0. 000000	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 mir	nus line 33)(see instruc	tions)	0.00	34.00
35. 00	Average per diem private room cost differential (line 34 x lir	ne 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 a 27 minus line 36)	and private room cost di	fferential (line	8, 691, 324	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 202 (5	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 382. 65	38.00
40. 00	Medically necessary private room cost applicable to the Progra	•		1, 493, 262 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39)			1, 493, 262	

Heal th	h Financial Systems WHITLEY MEMORIAL HOSPITAL	In Lie	eu of Form CMS-2	2552-10
	JTATION OF INPATIENT OPERATING COST Provider CCN: 15-0101	Period: From 01/01/2019	Worksheet D-1	
		Γο 12/31/2019	Date/Time Pre	
	Title XVIII	Hospi tal	6/29/2020 3: 14 PPS	4 pm
	Cost Center Description Total Total Average Per	Program Days	Program Cost	
	Inpatient Cost Inpatient Days Diem (col. 1 - col. 2)	÷	(col. 3 x col. 4)	
	1.00 2.00 3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) 0 0.00 Intensive Care Type Inpatient Hospital Units	0	0	42. 00
43.00				43. 00
44.00				44.00
46. 00	D BURN INTENSIVE CARE UNIT D SURGICAL INTENSIVE CARE UNIT			45. 00 46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)			47. 00
	Cost Center Description		1.00	
48. 00			1, 440, 548	
49. 00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions) PASS THROUGH COST ADJUSTMENTS		2, 933, 810	49. 00
50. 00		of Parts I and	244, 544	50. 00
51. 00		ım of Dorte II	179, 112	51. 00
51.00	and IV)	III OI PAILS II	179, 112	31.00
52.00			423, 656	
53. 00	Total Program inpatient operating cost excluding capital related, non-physician anesthemedical education costs (line 49 minus line 52)	etist, and	2, 510, 154	53. 00
E 4 00	TARGET AMOUNT AND LIMIT COMPUTATION			
54. 00 55. 00	Program discharges Target amount per discharge		0.00	
56.00	Target amount (line 54 x line 55)		0	56. 00
57. 00 58. 00		ine 53)	0	57. 00 58. 00
59. 00		npounded by the		
60. 00	market basket) Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		0.00	60. 00
61. 00		the amount by	0.00	61.00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of amount (line 56), otherwise enter zero (see instructions)	the target		
62. 00	Relief payment (see instructions)		0	62. 00
63. 00	Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST		0	63. 00
64. 00		ng period (See	0	64. 00
65 OO	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting	port od (Soo	0	65. 00
65. 00	instructions) (title XVIII only)	perrou (see		65.00
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII CAH (see instructions)	only). For	0	66. 00
67. 00		orting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost report	sting period	0	68. 00
08.00	(line 13 x line 20)	triig perrou		00.00
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		0	69. 00
70. 00				70. 00
71.00				71.00
72. 00 73. 00	, ,			72. 00 73. 00
74. 00	Total Program general inpatient routine service costs (line 72 + line 73)			74. 00
75. 00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Pa 26, line 45)	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ line 2)			76. 00
77. 00 78. 00	,			77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess costs (from provider records)			79. 00
80. 00 81. 00		ıs line 79)		80. 00 81. 00
82. 00	'			82.00
83.00				83.00
84. 00 85. 00				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85)			86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions)		1, 870	87. 00
88. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		1, 382. 65	88. 00
89.00) Observation bed cost (line 87 x line 88) (see instructions)		2, 585, 556	89.00

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2019 To 12/31/2019		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 423, 331	8, 691, 324	0. 16376	5 2, 585, 556	423, 424	90. 00
91.00 Nursing School cost	0	8, 691, 324	0.00000	2, 585, 556	0	91.00
92.00 Allied health cost	0	8, 691, 324	0.00000	2, 585, 556	0	92.00
93.00 All other Medical Education	0	8, 691, 324	0.00000	2, 585, 556	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 01/01/2019	Worksheet D-1	
			To 12/31/2019	Date/Time Pre 6/29/2020 3:1	
		Title XIX	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					

Dett 1 - ALL PROPIDES COMPONENTS IMPAILENT DAYS IMPAILENT DA			Title XIX	Hospi tal	PPS	· p
INPATITION DAYS INPATITION		Cost Center Description			1. 00	
Impatient days (including private room days and swing-bed days, excluding newborn) 6,286 2.00 Inpatient days (excluding private room days, excluding swing-bed and observation bed days) 7.00 7.0						
Impatient days (including private room days, excluding saing-bed and newborn days) 0,388 2,00	1 00		e eveluding newborn)		6 286	1 00
do not complete this line. 4. 05 Semi-private room days (excluding swing-bed and observation bed days) 7. 00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost period (if calendar year, enter 0 on this line) 8. 00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days after December 31 of the cost period (in calendar year, enter 0 on this line) 10. 00 Swing-bed SMF type inpatient days (applicable to the Program (excluding swing-bed and newborn days) (see instructions) 8. 00 Total inpatient days including private room days after 1 on this line) 10. 00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after 1 on through December 31 of the cost reporting period (see Instruction) 10. 00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after 1 on the XVIII only (including private room days) after 1 on the XVIII only (including private room days) after 1 on the XVIII only (including private room days) after 1 on the XVIII only (including private room days) after 1 on the XVIII only (including private room days) after 1 on the XVIII only (including private room days) after 1 on the XVIII only (including private room days) after 1 on the XVIII only (including private room days) after 1 on the XVIII only (including private room days) after 1 on the XVIII only (including private room days) after 1 on the XVIII only (including private room days) after 1 on the XVIII only (including private room days) after 1 on the XVIII only (
Semi-private room days (excluding swing-bed and observation bod days) through December 31 of the cost of portring period (in the portring period of the portring period of the portring period of the cost of the portring period o	3. 00		ys). If you have only priv	/ate room days,	0	3. 00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	4 00	·	ed days)		4 416	4 00
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x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32. 00 Average private room per diem charge (line 29 + line 3) 33. 00 Average semi-private room per diem charge (line 30 + line 4) 34. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 2, 1) 28. 00 Average per diem private room cost differential (line 3 x line 31) 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	24. 00		31 of the cost reporting	g period (line	0	24. 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ± line 28) Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 ± line 4) Average per diem private room charge differential (line 32 minus line 33) (see instructions) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 691, 324) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions)	25. 00	9 11	31 of the cost reporting p	period (line 8	0	25. 00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) 9.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 691, 324) 37.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 38.00 Program general inpatient routine service cost (line 9 x line 38) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28.00 29.00 29.00 20.00 20.00 20.00 31.00 20.00 32.00 3		, ,	(line 21 minus line 26)			
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 29 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 691, 324) 37.00 PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 29.00 29.00 30.00 30.00 30.00 0.00 30.00 0.00 30.00 0.00 31.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 34.00 0.00 34.00 0.00 0.00 32.00 0.00 34.00 0.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 34.00 0.00 34.00 0.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 0	27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	,			
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 691, 324) Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00			d and observation bed char	ges)		
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 691, 324) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 37.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 0.00 32.00 32.00 0.00 32.00 32.00 0.00 33.00 32.00 0.00 33.00 33.00 0.00 34.00 34.00 0.00 34.00 35.00 0.00 35.00 36.00 0.00 36.00 37.00 Eneral inpatient routine service cost and private room cost differential (line 8, 691, 324) 37.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00						
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 691, 324) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 33.00 34.00 35.00 36.00 37.00 37.00 38.60 37.00 37.00 40.00			- line 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 691, 324) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 382.65 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 00 34.00 35.00 36.00 37.00 37.00 37.00 37.00 37.00 40.00	32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 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 8, 691, 324) 37. 00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 382. 65 39. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00						
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 36.00 8,691,324 37.00				ons)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 8,691,324 37.00 1,382.65 38.00 1,382.65 38.00 107,847 40.00			ne 31)			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 382.65 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 382.65 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37. 00	27 minus line 36)	and private room cost diff	erential (line	8, 691, 324	37. 00
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,382.65 38.00 Program general inpatient routine service cost (line 9 x line 38) 107,847 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			ICTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 107,847 39.00 40.00	20 00				1 202 / 5	20 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , , , , , , , , , , , , , , , , , , ,	•			
		,	•			
		, , , , , , , , , , , , , , , , , , , ,				

	Financial Systems	WHITLEY MEMORI		0011 1		eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 15-0101	Period: From 01/01/2019		
					To 12/31/2019	Date/Time Pre 6/29/2020 3:1	pared: 4 pm
		T		le XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Day	Average Per		Program Cost (col. 3 x col.	
				col . 2)		4)	
42 00	NURSERY (title V & XIX only)	1. 00 590, 798	2.00	3.00	4. 00 31 47	5. 00	42.00
42.00	Intensive Care Type Inpatient Hospital Units	370,770	, , ,	007.	31 47	30, 030	42.00
43.00	INTENSIVE CARE UNIT						43.00
44. 00 45. 00	CORONARY CARE UNIT						44. 00 45. 00
46. 00							46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk					160, 563	
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructi	ons)		306, 448	49. 00
50.00	Pass through costs applicable to Program inp.	atient routine	services (fro	om Wkst. D, sui	m of Parts I and	21, 242	50.00
51. 00		ationt ancillar	su corul cos (t	From Wkst D	sum of Dorts II	17 470	51.00
31.00	and IV)	atrent anciriai	y services (i	TOIII WKSt. D,	Sull Of Parts II	17,070	31.00
52. 00	Total Program excludable cost (sum of lines					38, 920	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		elated, non-ph	nysician anestl	hetist, and	267, 528	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges						54.00
56. 00	Target amount per discharge Target amount (line 54 x line 55)						55. 00 56. 00
57. 00	,	ing cost and ta	arget amount (line 56 minus	line 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting ported	anding 1004	undated and o	ampaundad by the	0	58. 00 59. 00
39.00	market basket	portring perrou	ending 1996,	upuateu anu ci	onipounded by the	0.00	39.00
60.00	Lesser of lines 53/54 or 55 from prior year						60.00
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less than					0	61.00
	amount (line 56), otherwise enter zero (see		.5 (111165 61 7	(00), 01 1% 0	the target		
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ont (soo instru	ictions)			0	
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mstru	ictions)			0	03.00
64. 00	9 1	ts through Dece	ember 31 of th	ne cost report	ing period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	er 31 of the	cost reportin	g period (See	0	65. 00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(TITIE XVI	II only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost re	eporting period	0	67. 00
68 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost rep	orting period	0	68. 00
00.00	(line 13 x line 20)	0 00313 41101 2	recember of or	the cost rep	or tring period		00.00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NI					0	69. 00
70. 00	Skilled nursing facility/other nursing facil)		70. 00
71.00	Adjusted general inpatient routine service c		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)		ı (line 14 x l	ine 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv						74. 00
75. 00	Capital-related cost allocated to inpatient 26. line 45)	routine service	costs (from	Worksheet B, I	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovi der recor	rds)			78. 00 79. 00
	Total Program routine service costs for comp.				nus line 79)		80.00
81.00	Inpatient routine service cost per diem limi						81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (* .				82. 00 83. 00
84.00	Program inpatient ancillary services (see in	structions)					84. 00
85.00	Utilization review - physician compensation						85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ii Jugii oo)				86. 00
87. 00	Total observation bed days (see instructions)	1: 2)				87. 00
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•				1, 382. 65 2, 585, 556	1
57.00	(3e)					2, 303, 330	1 57.00

Health Financial Systems	WHITLEY MEMORI	IAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od: From 01/01/2019	Worksheet D-1	
				To 12/31/2019	Date/Time Pre 6/29/2020 3:1	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 423, 331	8, 691, 324	0. 16376	5 2, 585, 556	423, 424	90.00
91.00 Nursing School cost	0	8, 691, 324	0.00000	0 2, 585, 556	0	91.00
92.00 Allied health cost	0	8, 691, 324	0.00000	0 2, 585, 556	0	92. 00
93.00 All other Medical Education	0	8, 691, 324	0.00000	0 2, 585, 556	0	93.00

NPATI ENT 1	ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0101	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Pre 6/29/2020 3:1	parec
		Title	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges		Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	TIENT ROUTINE SERVICE COST CENTERS					
	OO ADULTS & PEDIATRICS			1, 982, 210		30. (
	OO NURSERY					43.
	LLARY SERVI CE COST CENTERS					
	OO OPERATING ROOM		0. 1307		108, 782	
	DO DELIVERY ROOM & LABOR ROOM		0. 4293		4, 255	
	OO ANESTHESI OLOGY		0.0000		0	1
	DO RADI OLOGY-DI AGNOSTI C		0. 1370		145, 938	
	DO LABORATORY		0. 1605		222, 268	
	50 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000		0	
	OO RESPI RATORY THERAPY		0. 1315		123, 587	
	DO PHYSI CAL THERAPY		0. 4036		33, 413	
	OO OCCUPATI ONAL THERAPY		0. 6761			
	OO SPEECH PATHOLOGY		0. 2640		4, 157	
	DO ELECTROCARDI OLOGY		0.0000		0	
	DO MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3823		· ·	
	OO IMPL. DEV. CHARGED TO PATIENTS		0. 2121	· ·	34, 013	
	DO DRUGS CHARGED TO PATIENTS		0. 2865		348, 170	
	27 CARDI AC REHABI LI TATI ON		0.0000		0	
	98 HYPERBARI C OXYGEN THERAPY		0.0000		0	1 , 0.
	99 LI THOTRI PSY		0.0000	00 0	0	76.
	PATIENT SERVICE COST CENTERS					
0.00			0.0000		0	
	OI INTENSIVE OUT PATIENT PROGRAM		0.0000		0	1
	OO EMERGENCY		0. 1881		270, 241	91.
	OO OBSERVATION BEDS (NON-DISTINCT PART R REIMBURSABLE COST CENTERS		0. 4314	38 0	0	92.
	ON AMBULANCE SERVICES					95.
00.00 095C	Total (sum of lines 50 through 94 and 96 through 98)			7, 487, 048	1, 440, 548	
01.00	Less PBP Clinic Laboratory Services-Program only charc	uos (lino 61)		7, 407, 048		200.
U I . UU	TLESS FOR CITIEC LADOFATORY SERVICES-PROGRAM ONLY CHARG	jes (iine ol)	1	1 0	1	₁ 201.

	ANCILLARY SERVICE COST APPORTIONMENT WHITLEY MEMORIAL	Provi der C	CN: 15-0101	Peri od:	worksheet D-3	
				From 01/01/2019	5 / (7) 5	
				To 12/31/2019	Date/Time Pre 6/29/2020 3:1	pared:
		Ti tl	e XIX	Hospi tal	PPS	. р
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
			1.00	2. 00	2) 3. 00	
LND	ATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	DO ADULTS & PEDIATRICS			148, 850		30.00
	OO NURSERY			71, 288		43. 00
	LLARY SERVICE COST CENTERS		•			
50.00 050	OO OPERATING ROOM		0. 1307	11 123, 157	16, 098	50.00
52. 00 0520	DO DELIVERY ROOM & LABOR ROOM		0. 4293	43 155, 639	66, 823	52.00
53. 00 0530	OO ANESTHESI OLOGY		0.0000	00 0	0	53.00
54.00 0540	DO RADI OLOGY-DI AGNOSTI C		0. 1370			54.00
	DO LABORATORY		0. 1605		18, 742	
1	50 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000		1	1
	00 RESPI RATORY THERAPY		0. 1315			
	DO PHYSI CAL THERAPY		0. 4036			
	OCCUPATI ONAL THERAPY		0. 6761		l e	
	OO SPEECH PATHOLOGY		0. 2640		0	
	DO ELECTROCARDI OLOGY		0.0000		0	
	DO MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3823			
	OO IMPL. DEV. CHARGED TO PATIENTS		0. 2121		0	
	DO DRUGS CHARGED TO PATIENTS		0. 2865			
	97 CARDI AC REHABI LI TATI ON		0.0000		0	
	98 HYPERBARI C OXYGEN THERAPY 99 LI THOTRI PSY		0. 0000 0. 0000		0	
	PATIENT SERVICE COST CENTERS		0.0000	00 0	0	76. 9
90.00 090			0.0000	00 0	0	90.00
	DI INTENSIVE OUT PATIENT PROGRAM		0.0000		0	
	DO EMERGENCY		0. 1881			
	OO OBSERVATION BEDS (NON-DISTINCT PART		0. 4314			
	ER REIMBURSABLE COST CENTERS			, 0		1 /2.00
	DO AMBULANCE SERVI CES					95. 00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			645, 009	160, 563	
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)	. ,		645, 009		202. 00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 15-0101	Peri od: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 6/29/2020 3:14 pm

PART A INPATIENT HOSPITAL SERVICES UNDER IPPS 1.00				10 12/31/2019	Date/IIme Pre 6/29/2020 3:1	
ART A - INATER' HOSPITAL SERVICES WIDER IPPS 0.0			Title XVIII	Hospi tal		
ART A - INATER' HOSPITAL SERVICES WIDER IPPS 0.0						
1.00 NRS Amounts other than outlier payments for discharges occurring prior to October 1 (see 1.688 L23 1.00 1.		DADT A LINDATIENT HOSDITAL SEDVICES LINDED LDDS			1.00	
1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 (see 1.688, 123 1.01 Instructions) 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see 1.688, 123 1.01 1.02 1.03 DRG for Federal specific operating payment for Would 4 BRCI for discharges occurring on or after 0 1.03 1.04 1.05	1. 00				0	1.00
1.0.2 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see 559,802 1.0.2 Instructions) 1.0.3 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring only or after october 1 (see instructions) 1.0.3 Control of the payment for discharges occurring on or after october 1 (see instructions) 2.00 1.0.4 Control of Scharges (see Instructions) 2.00		DRG amounts other than outlier payments for discharges occurri	ing prior to October 1 (see		
1.03 1.03	1. 02	DRG amounts other than outlier payments for discharges occurri	ing on or after October	I (see	559, 862	1. 02
DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 1.04	1.03	DRG for federal specific operating payment for Model 4 BPCI for	or discharges occurring	orior to October	0	1. 03
2.00 Outlier payments for discharges, (see instructions)	1. 04	DRG for federal specific operating payment for Model 4 BPCI for	or discharges occurring	on or after	0	1. 04
2.02 0.0 Utiler payment for discharges for Model 4 BPCI (see instructions) 16,130 2.02 2.03 0.0 Utiler payments for discharges occurring prior to October 1 (see instructions) 16,130 2.03 2.04 0.0 Utiler payments for discharges occurring on or after October 1 (see instructions) 2.455,126 2.455,126 0.0 2.455,126 2.455,126 0.0 0.0 0.0 2.455,126 0.0 0.0 2.455,126 0.0 0.0 2.455,126 0.0 0.0 2.455,126 0.0 0.0 2.455,126 0.0 0.0 2.455,126 0.0 2.455,		Outlier payments for discharges. (see instructions)				2.00
2.03 Outlier payments for discharges occurring prior to October 1 (see instructions) 1.0 30 2.03			i ana)			
2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 2.465, 126						
Managed Car's Simulated Payments						
Bed days available divided by number of days in the cost reporting period (see Instructions) 24.88 4.00		, ,	. (33331 431.33)			
FIE count for all lepathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/19/96, (see instructions)			rting period (see instru	ctions)		1
TTC count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) NAMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(w)(B)(1) 0.00 7.00	5. 00		t recent cost reporting	period ending on	0.00	5.00
new programs in accordance with 42 CFR 413.79(e) 7.00 MAS Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions after the programs for affiliated programs in accordance with 42 CFR 813.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8.01 The amount of increase if the hospit alw as awarded FTE cap slots under \$ 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8.02 The amount of increase if the hospit alw as awarded FTE cap slots under \$ 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8.02 The amount of increase if the hospit alw as awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions) 9.00 Sum of lines \$ 500 of ACA. (see instructions) 9.00 Instructions 10.00 Ins		` '			0.00	
7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(i)(i)(i)(i)(2)(if) the cost report straddles July 1, 2011 then see instructions. 0.00 7.01 8.00 Adjustment (Increase or decrease) to the FIE count for all opathic and osteopathic programs for a filiated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 0.00 8.00 8.01 The amount of increase if the hospital was awarded FIE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 0.00 8.02 9.00 Sun of lines § Dius 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions) 0.00 0.00 10.00 FIE count for allopathic and osteopathic programs in the current year from your records 0.00 10.00 11.00 FIE count for residents in dental and podiatric programs. 0.00 10.00 12.00 12.00 Current year all owable FIE count for the prior year. 0.00 13.00 13.00 15.00 Sun of lines 12 Principle 14 divided by 3. 0.00 15.00 15.00 16.00 Adjustment for residents in initial years of the program of hospital closure 0.00 16.00 16.00 Adjustment for residents in initial		new programs in accordance with 42 CFR 413.79(e)				
Adjustment (Increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.79(c)(2)(iv). 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).						7. 00
affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00			6	0.00	0.00
8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions) 9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions) 9.00 FTE count for residents in dental and podiatric programs in the current year from your records 9.00 10.0	8.00	affiliated programs in accordance with 42 CFR 413.75(b), 413.			0.00	8.00
S. 02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions)	8. 01		ots under § 5503 of the A	ACA. If the cost	0.00	8. 01
Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 0.00 9.00 9.00 10.00 FTE count for all opathic and osteopathic programs in the current year from your records 0.00 10.00 11.00 FTE count for residents in dental and podiatric programs. 0.00 12.00 11.00 12.00 12.00 13.00 10.10 15.00 10.00 10.00 12.00 13.00 10.00 10.00 13.00 14.00 10.00 10.00 14.00 14.00 15.00 15.00 16.00	8. 02		ots from a closed teachi	ng hospital	0.00	8. 02
instructions	9. 00		es (8, 8,01 and 8,02) (see	0.00	9. 00
11.00 FTE count for residents in dental and podiatric programs. 0.00 11.00 12.00 12.00 13.00 1	10 00	instructions)			0.00	10 00
12. 00 Current year allowable FTE (see instructions) 0.00 12. 00 13. 00			ent year from your record	13		
13.00 Total allowable FTE count for the prior year. 0.00 13.00 14.00 15.00 15.00 16.00						
14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero. 15.00 Sum of lines 12 through 14 divided by 3. 0.00 15.00 16.00 Adjustment for residents in initial years of the program 0.00 16.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adjustment for residents displaced by program or hospital closure 0.00 18.00 19.0		, ,				
15. 00 Sum of lines 12 through 14 divided by 3. 0.00 15. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 17. 00 20. 0	14.00	' '	ar ended on or after Sep	tember 30, 1997,	0.00	14. 00
16. 00 Adj ustment for residents displaced by program or hospital closure 0.00 17. 00 17. 00 Adj ustment for residents displaced by program or hospital closure 0.00 17. 00 18. 00 Adj usted rolling average FTE count 0.00 18. 00 19. 00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19. 00 20. 00 Prior year resident to bed ratio (see instructions) 0.000000 20. 00 21. 01 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21. 00 22. 01 IME payment adj ustment (see instructions) 0 22. 00 1 IME payment adj ustment - Managed Care (see instructions) 0 22. 00 1 IME payment adj ustment - Managed Care (see instructions) 0 22. 00 22. 00 IME payment adj ustment - Managed Care (see instructions) 0 22. 00 24. 00 IME payment adj ustment for the Add-on for § 422 of the MMA 0 22. 00 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25. 00 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25. 00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
17. 00						
18. 00 Adjusted rolling average FTE count 0.00 18. 00 19. 00 Current year resident to bed ratio (line 18 divided by line 4). 0.0000000 19. 00 20. 00 Prior year resident to bed ratio (see instructions) 0.000000 20. 00 21. 00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21. 00 22. 01 IME payment adjustment (see instructions) 0.000000 22. 00 1 IME payment adjustment - Managed Care (see instructions) 0.000000 22. 01 1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.000000 23. 00 24. 00 IME FTE Resident Count Over Cap (see instructions) 0.000 24. 00 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0.000000 25. 00 26. 00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26. 00 27. 00 IME payments adjustment factor. (see instructions) 0.000000 27. 00 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0.000000 27. 00 29. 01 Total IME payment (sum of lines 22 and 28) 0.000000 29. 01 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)						
19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.00 20.00		, , , , , , , , , , , , , , , , , , , ,	sure			
20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.00 IME payment adjustment (see instructions) 0 22.00 IME payment adjustment - Managed Care (see instructions) 0 22.00 IME payment adjustment for the Add-on for § 422 of the MMA Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23.00 (f)(1)(v)(C) (f)(1)(iv)(C) (f)(, ,)			
21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.00 IME payment adjustment (see instructions) 0 22.00 1 IME payment adjustment - Managed Care (see instructions) 0 22.00 1 IME payment adjustment - Managed Care (see instructions) 0 22.01 1 IME payment adjustment for the Add-on for § 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23.00 (f)(1)(iv)(C) .		` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` `) ·			
22. 00 IME payment adjustment (see instructions) 0 22. 00 IME payment adjustment - Managed Care (see instructions) 0 22. 01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412. 105 (f)(1)(iv)(C). 24. 00 IME FTE Resident Count Over Cap (see instructions) 0.00 24. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25. 00 instructions) 26. 00 Resident to bed ratio (divide line 25 by line 4) 0.000000 27. 00 IME payments adjustment factor. (see instructions) 0.000000 27. 00 IME payments adjustment amount (see instructions) 0.000000 27. 00 IME add-on adjustment amount (see instructions) 0.000000 27. 00 28. 00 IME add-on adjustment amount - Managed Care (see instructions) 0.000000 28. 00 Total IME payment (sum of lines 22 and 28) 0.00 29. 01 Total IME payment (sum of lines 22 and 28) 0.00 29. 01 Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 21. 96 31. 00 29. 01 31. 00 Sum of lines 30 and 31 24. 65 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 9. 55 33. 00		, , , , , , , , , , , , , , , , , , , ,				
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA	22.00	IME payment adjustment (see instructions)				22. 00
23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412. 105 (f) (1) (iv) (C). 24. 00 IME FTE Resident Count Over Cap (see instructions) 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see	22. 01	IME payment adjustment - Managed Care (see instructions)			0	22. 01
24. 00 IME FTE Resident Count Over Cap (see instructions) 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions) 26. 00 Resident to bed ratio (divide line 25 by line 4) 27. 00 IME payments adjustment factor. (see instructions) 28. 00 IME add-on adjustment amount (see instructions) 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 20. 00 Sum of lines 30 and 31 30. 00 Allowable disproportionate share percentage (see instructions) 9. 55 33.00	23. 00			FR 412. 105	0.00	23. 00
25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 Resident to bed ratio (divide line 25 by line 4) 10.000000 26.00 10.000000 27.00 IME payments adjustment factor. (see instructions) 10.000000 27.00 IME add-on adjustment amount (see instructions) 10.000000 27.00 IME add-on adjustment amount - Managed Care (see instructions) 10.000000 27.00 28.00 IME add-on adjustment amount - Managed Care (see instructions) 10.000000 27.00 28.00 IME add-on adjustment amount - Managed Care (see instructions) 10.000000 27.00 28.00 IME add-on adjustment amount - Managed Care (see instructions) 10.000000 27.00 28.00 IME add-on adjustment amount - Managed Care (see instructions) 10.000000 27.00 28.00 28.00 29.0	24 00				0.00	24 00
instructions		' ' '	lower of line 23 or line	24 (see		
27. 00 IME payments adjustment factor. (see instructions) 0.000000 27. 00 28. 00 IME add-on adjustment amount (see instructions) 0.000000 28. 00 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0.00 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) 0.00 Disproportionate Share Adjustment 29. 01 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 2. 69 30. 00 31. 00 Percentage of Medicaid patient days (see instructions) 21. 96 31. 00 32. 00 Sum of lines 30 and 31 24. 65 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 9. 55 33. 00		instructions)	Tower of Time 23 of Time	24 (566		
28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 32.00 Allowable disproportionate share percentage (see instructions) 33.00 Allowable disproportionate share percentage (see instructions) 34.00 Sum of lines 30 and 31 35.00 Allowable disproportionate share percentage (see instructions) 37.00 Sum of lines 30 and 31 38.00 Allowable disproportionate share percentage (see instructions)						
28. 01 IME add-on adjustment amount - Managed Care (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 32. 01 Allowable disproportionate share percentage (see instructions) 33. 00 Allowable disproportionate share percentage (see instructions) 34. 05 Percentage of Medicaid patient days (see instructions) 35 Percentage of Medicaid patient days (see instructions) 36 Percentage of Medicaid patient days (see instructions) 37 Percentage of Medicaid patient days (see instructions) 38 Percentage of Medicaid patient days (see instructions) 39 Percentage of Medicaid patient days (see instructions)		, , , , , , , , , , , , , , , , , , , ,				1
29.00 Total IME payment (sum of lines 22 and 28) 0 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 2.69 30.00 31.00 Percentage of Medicaid patient days (see instructions) 21.96 31.00 32.00 Sum of lines 30 and 31 24.65 32.00 33.00 Allowable disproportionate share percentage (see instructions) 9.55 33.00		1	`			1
29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 20. 00 Percentage of Medicaid patient days (see instructions) 21. 96 31. 00 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 29. 01 29. 01 29. 01 29. 01 29. 01 20. 02 30. 00 31. 00 31. 00 32. 00 33. 00 34. 00 35. 00)			
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 2.69 30.00 31.00 Percentage of Medicaid patient days (see instructions) 21.96 31.00 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 9.55 33.00		Total IME payment - Managed Care (sum of lines 22.01 and 28.0	1)			
31.00Percentage of Medicaid patient days (see instructions)21.9631.0032.00Sum of lines 30 and 3124.6532.0033.00Allowable disproportionate share percentage (see instructions)9.5533.00	30.00		atient days (see instruc	tions)	2 69	30 00
32.00 Sum of lines 30 and 31 24.65 32.00 33.00 Allowable disproportionate share percentage (see instructions) 9.55 33.00			att days (see Fristi de	5115)		
33.00 Allowable disproportionate share percentage (see instructions) 9.55 33.00						
34.00 Disproportionate share adjustment (see instructions) 53,671 34.00)			
	34. 00	Disproportionate share adjustment (see instructions)			53, 671	34.00

	Financial Systems WHITLEY MEMORI			u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0101	Peri od: From 01/01/2019	Worksheet E Part A	
			To 12/31/2019	Date/Time Pre 6/29/2020 3:1	pared: 4 nm
		Title XVIII	Hospi tal	PPS	piii
			Prior to 10/1		
	Uncompensated Care Adjustment		1. 00	2. 00	
35. 00	Total uncompensated care amount (see instructions)		8, 272, 872, 447		
35. 01	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, en	stor zoro on this line) (so	0. 000073133	0.000088549	
35. 02	instructions)	iter zero on this ithe) (se	e 605, 020	739, 436	35. 02
35. 03	Pro rata share of the hospital uncompensated care payment a		452, 522	185, 869	1
36. 00	Total uncompensated care (sum of columns 1 and 2 on line 35 Additional payment for high percentage of ESRD beneficiary		638, 391		36.00
40. 00	Total Medicare discharges on Worksheet S-3, Part I excludin		0		40. 00
	652, 682, 683, 684 and 685 (see instructions)				
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	683, 684 an 685. (see	0		41. 00
41. 01	1	IS-DRGs 652, 682, 683, 684	0		41. 01
40.00	an 685. (see instructions)	1:6.6	0.00		40.00
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not qua Total Medicare ESRD inpatient days excluding MS-DRGs 652,	, , , , , , , , , , , , , , , , , , ,	0.00		42. 00 43. 00
	instructions)	•			
44. 00	Ratio of average length of stay to one week (line 43 divide days)	ed by line 41 divided by 7	0. 000000		44. 00
45. 00	Average weekly cost for dialysis treatments (see instruction	ons)	0.00		45. 00
46. 00	Total additional payment (line 45 times line 44 times line	41.01)	0		46. 00
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH,	emall rural hospitals	2, 956, 177		47. 00 48. 00
40.00	only. (see instructions)	silari Turai Nospi tars	0		40.00
				Amount	
49. 00	Total payment for inpatient operating costs (see instruction	(enc		1. 00 2, 956, 177	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I	•		185, 077	
51.00	Exception payment for inpatient program capital (Wkst. L, P			0	51.00
52. 00 53. 00	Direct graduate medical education payment (from Wkst. E-4, 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			0	54. 00
54. 01	Islet isolation add-on payment	(0)		0	54. 01
55. 00 56. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see in	•		0	55. 00 56. 00
57. 00	Routine service other pass through costs (from Wkst. D, Pt.		hrough 35).	0	57. 00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt	. IV, col. 11 line 200)		0	58. 00
59. 00 60. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments			3, 141, 254 14, 780	1
61. 00	3 3 3	nus line 60)		3, 126, 474	1
62. 00	Deductibles billed to program beneficiaries			414, 147	
63.00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			0 20, 328	
65. 00	Adjusted reimbursable bad debts (see instructions)			13, 213	1
66. 00	Allowable bad debts for dual eligible beneficiaries (see in	structions)		6, 188	66. 00
67. 00 68. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	or applicable to MS DDCs (s	oo instructions)	2, 725, 540 0	1
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96		,	0	
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		•	0	70. 00
70. 50 70. 87	Rural Community Hospital Demonstration Project (§410A Demon	, ,	instructions)	0	1
70. 87	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)			0	
70. 89	Pioneer ACO demonstration payment adjustment amount (see in	structions)			70. 89
70. 90	HSP bonus payment HPP adjustment amount (see instructions)			0	
70. 91	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	
70. 92				34, 342	1
70. 93	HVBP payment adjustment amount (see instructions)			•	
70. 93 70. 94	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions) Recovery of accelerated depreciation			-6, 288 0	70. 94

Health Financial Systems WHITLEY	MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0101	Peri od: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Pre 6/29/2020 3:14	
	Title XVIII	Hospi tal	PPS	

				To 12/31/2019	Date/Time Pre 6/29/2020 3:1	
		Title	e XVIII	Hospi tal	PPS	4 piii
		11 61 6		(уууу)	Amount	
				0	1.00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)	column 0		2019	381, 988	70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or aft		:	2020	117, 983	70. 97
70. 98	Low Volume Payment-3				0	70. 98
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	9 & 70)			3, 253, 565	71. 00
71. 01	Sequestration adjustment (see instructions)				65, 071	71. 01
	Demonstration payment adjustment amount after sequestration				0	
	Sequestration adjustment-PARHM pass-throughs					71. 03
	Interim payments				3, 249, 397	
	Interim payments-PARHM					72. 01
	Tentative settlement (for contractor use only)				0	
73. 01 74. 00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (line 71 minus lines 71.01, 71.02) 72 and			-60, 903	73. 01 74. 00
74.00	73)	z, 72, and			-00, 903	74.00
74. 01	Balance due provider/program-PARHM (see instructions)					74. 01
75. 00	Protested amounts (nonallowable cost report items) in accordan	nce with			53, 059	
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		,			
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	of 2.03			0	90. 00
01 00	plus 2.04 (see instructions)				0	01 00
91.00	Capital outlier from Wkst. L, Pt. I, line 2	iati ana)			0	
	Operating outlier reconciliation adjustment amount (see instruction) capital outlier reconciliation adjustment amount (see instruction).				0	92. 00 93. 00
	The rate used to calculate the time value of money (see instruct				0.00	1
95. 00	Time value of money for operating expenses (see instructions)	icti ons)			0.00	1
96. 00	Time value of money for capital related expenses (see instruct	i ons)			0	1
			,	Prior to 10/1	On/After 10/1	
				1. 00	2. 00	
400.00	HSP Bonus Payment Amount			1		
100.00	HSP bonus amount (see instructions)			0	0	100. 00
101 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)			1. 0162646287	1. 0162004405	101 00
	HVBP adjustment amount for HSP bonus payment (see instructions)	:)		1.0102040287		101.00
102.00	HRR Adjustment for HSP Bonus Payment	• /		<u> </u>		102.00
103.00	HRR adjustment factor (see instructions)			0. 9985	0. 9930	103. 00
	HRR adjustment amount for HSP bonus payment (see instructions)	1		0		104.00
	Rural Community Hospital Demonstration Project (§410A Demonstr	ation) Adju	stment			
200.00	Is this the first year of the current 5-year demonstration per	iod under t	he 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.					
004 00	Cost Reimbursement	40)				004 00
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	9 49)				201. 00 202. 00
	Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)					202.00
203.00	Computation of Demonstration Target Amount Limitation (N/A in	first year	of the currer	nt 5-vear demonst		203.00
	peri od)	iiist year	or the curren	re o year demonst	1 4 1 1 0 1 1	
204.00	Medicare target amount					204. 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					
	Program reimbursement under the §410A Demonstration (see instr					207. 00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	line 59)				208. 00
	Adjustment to Medicare IPPS payments (see instructions) Reserved for future use					209. 00 210. 00
	Total adjustment to Medicare IPPS payments (see instructions)					211.00
211.00	Comparision of PPS versus Cost Reimbursement					12 1 1 . 00
212. 00	Total adjustment to Medicare Part A IPPS payments (from line 2	211)				212. 00
	Low-volume adjustment (see instructions)	,				213. 00
	Net Medicare Part A IPPS adjustment (difference between PPS ar	nd cost reim	nbursement)			218. 00
	(line 212 minus line 213) (see instructions)					

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu of F	orm CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0101	From 01/01/2019 Part To 12/31/2019 Date	

		6/29/2020 3: 1	4 pm
	Title XVIII Hospital	PPS	
		1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
1.00	Medical and other services (see instructions)	0	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)	5, 640, 176	2. 00
3.00	OPPS payments	3, 914, 233	3. 00
4.00	Outlier payment (see instructions)	22, 887	4. 00
4. 01 5. 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instructions)	0.000	4. 01 5. 00
6.00	Line 2 times line 5	0.000	6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7. 00
8.00	Transitional corridor payment (see instructions)	0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9. 00
10.00	Organ acqui si ti ons	0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)	0	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		
12. 00	Reasonable charges Ancillary service charges	0	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13. 00
14. 00		0	
	Customary charges	•	
15. 00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16. 00
47.00	had such payment been made in accordance with 42 CFR §413.13(e)	0.000000	47.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	
18. 00 19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	0 0	18. 00 19. 00
17.00	instructions)		17.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20. 00
	instructions)		
	Lesser of cost or charges (see instructions)	0	21. 00
	Interns and residents (see instructions)	0	22. 00
	Cost of physicians' services in a teaching hospital (see instructions)	2 027 120	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT	3, 937, 120	24. 00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	809, 356	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	3, 127, 764	27. 00
	instructions)		
28. 00	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	29. 00
30.00	Subtotal (sum of lines 27 through 29) Primary payer payments	3, 127, 764 588	
	Subtotal (line 30 minus line 31)	3, 127, 176	
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	0,12,,170	02.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33. 00
34.00	Allowable bad debts (see instructions)	49, 437	34.00
	Adjusted reimbursable bad debts (see instructions)	32, 134	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	42, 540	
37. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R	3, 159, 310	37. 00 38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)		39. 50
39. 97	Demonstration payment adjustment amount before sequestration	0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	0	39. 99
	Subtotal (see instructions)	3, 159, 310	
40. 01	Sequestration adjustment (see instructions)	63, 186	
40. 02	Demonstration payment adjustment amount after sequestration	0	40. 02
	Sequestration adjustment-PARHM pass-throughs Interim payments	2 120 142	40. 03
	Interim payments Interim payments-PARHM	3, 128, 162	41. 00 41. 01
42. 00	Tentative settlement (for contractors use only)	0	42. 00
	Tentative settlement-PARHM (for contractor use only)		42. 00
43. 00	Balance due provider/program (see instructions)	-32, 038	
43. 01	Balance due provider/program-PARHM (see instructions)		43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	44. 00
	\$115. 2		
00.00	TO BE COMPLETED BY CONTRACTOR	1 ^	00.00
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)	0 0	
91.00	The rate used to calculate the Time Value of Money	0.00	
93. 00		0.00	
	Total (sum of lines 91 and 93)		94. 00
		•	•

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

					6/29/2020 3: 14	4 pm
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	⁻t 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, 249, 39	7	3, 128, 162	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
2 00	write "NONE" or enter a zero					2 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3. 00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			O	0	3. 01
3.02				O	0	3. 02
3.03				O	0	3. 03
3.04				O	0	3. 04
3.05			(O	0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			O	0	3. 50
3. 51				O	0	3. 51
3.52				0	0	3. 52
3.53				O	0	3. 53
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 54 3. 99
3. 99	3. 50-3. 98)		·			3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 249, 39	7	3, 128, 162	4. 00
00	(transfer to Wkst. E or Wkst. E-3, line and column as		0,21,,0,		0, 120, 102	00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
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		1	ol	1 0	г 01
5. 01 5. 02	TENTATIVE TO PROVIDER			0		5. 01 5. 02
5. 02				0		5. 02
5.05	Provider to Program		<u> </u>	J	0	5. 03
5.50	TENTATI VE TO PROGRAM			o	0	5. 50
5. 51				o	0	5. 51
5. 52				O O	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			O	0	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 PROVI DER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		60, 90		32, 038	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 188, 49		3, 096, 124	7. 00
				Contractor	NPR Date	
		1)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		<i></i>	1.00	2.00	8. 00
0.00	Tham 3. Softer do to			I	1 1	0.00

Heal th	Financial Systems WHITLEY MEMORIA	L HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0101	Peri od: From 01/01/2019	Worksheet E-1	
			To 12/31/2019	Date/Time Pro 6/29/2020 3:	
		Title XVIII	Hospi tal	PPS	
				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	The state of the s	e 14		1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,	8-12			2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12			4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
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	line 31) (see instruction	ns)		32. 00

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

Provider CCN: 15-0101 Peri From

Peri od: From 01/01/2019 To 12/31/2019 Date/Time Prepared: 6/29/2020 3:14 pm

oni y)				12/01/201/	6/29/2020 3: 1	4 pm
		General Fund	Specific	Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	84, 780	l .	0	0	1
2. 00 3. 00	Temporary investments Notes receivable	0	C	-	0	
4. 00	Accounts receivable	27, 798, 166	1	,	0	
5. 00	Other recei vabl e	0	d	0	Ō	
6.00	Allowances for uncollectible notes and accounts receivable	-15, 223, 726	c	0	0	
7. 00	Inventory	596, 017		0	0	
8.00	Prepai d expenses	13, 048, 429		0	0	
9. 00 10. 00	Other current assets Due from other funds	0		1	0	
11. 00	Total current assets (sum of lines 1-10)	26, 303, 666		-	1	1
	FI XED ASSETS				_	1
12.00	Land	260, 483	1			1
13. 00	Land improvements	2, 489, 039	1	-		
14.00	Accumulated depreciation	-794, 343	1	-	0	1
15. 00 16. 00	Buildings Accumulated depreciation	14, 813, 613 -2, 358, 531		1	0	
17. 00	Leasehold improvements	48, 824		-	l ő	
18. 00	Accumulated depreciation	-48, 824	d	0	0	
19. 00	Fi xed equi pment	102, 346	c	0	0	
20. 00	Accumulated depreciation	-70, 654	1	0	0	
21. 00	Automobiles and trucks	863, 181	C	1	0	
22. 00 23. 00	Accumulated depreciation Major movable equipment	-441, 770 15, 774, 258	1	1	0	
24. 00	Accumulated depreciation	-11, 422, 184		1	0	
25. 00	Mi nor equi pment depreci abl e	6, 845, 974	1	1	Ö	
26.00	Accumulated depreciation	-2, 277, 231	[c	0	0	26. 00
27. 00	HIT designated Assets	0	C	0	0	
28. 00	Accumulated depreciation	0	C	1	0	
29. 00 30. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	23, 784, 181		1	0	
30.00	OTHER ASSETS	23, 704, 101		,		30.00
31.00	Investments	59, 581, 236	C	0	0	31. 00
32.00	Deposits on Leases	0	C	0		
33. 00	Due from owners/officers	0	C	1	0	1
34. 00	Other assets	44, 954		-	0	
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	59, 626, 190 109, 714, 037	1	,	0	
30. 00	CURRENT LIABILITIES	107, 714, 037		,, ,		30.00
37. 00	Accounts payable	1, 418, 051	C	0	0	37. 00
38. 00	Salaries, wages, and fees payable	1, 103, 723	C	0	l ~	
39. 00	Payroll taxes payable	0	C	0	0	1
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	0		0	0	
42.00	Accel erated payments			,	0	42.00
43. 00	Due to other funds	Ö	C	0	0	1
44.00	Other current liabilities	111, 851	c	0	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	2, 633, 625	C	0	0	45. 00
47.00	LONG TERM LIABILITIES	I 0				1,, 00
46. 00 47. 00	Mortgage payable Notes payable	0	C	,	0	
48. 00	Unsecured Loans			-	l .	1
49. 00	Other long term liabilities	9, 724, 064	-	1	· ·	
50.00	Total long term liabilities (sum of lines 46 thru 49)	9, 724, 064	l .	0	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	12, 357, 689	d c	0	0	51.00
	CAPI TAL ACCOUNTS	07.05/.040	1			
52. 00 53. 00	General fund balance Specific purpose fund	97, 356, 348	C			52. 00 53. 00
54. 00	Donor created - endowment fund balance - restricted			΄		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	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	97, 356, 348	c		0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	109, 714, 037		0	0	
	59)					

Provi der CCN: 15-0101

					То	12/31/2019	Date/Time Prep 6/29/2020 3:14	
		General	Fund	Speci al	Purp	ose Fund	Endowment Fund	•
		1.00	2. 00	3. 00		4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)		80, 665, 210 15, 676, 684 96, 341, 894		0	0	0	1. 00 2. 00 3. 00 4. 00
5. 00 6. 00 7. 00 8. 00	NONALLOWABLE HOME OFFICE INT EXPENSE	822, 915 0 0 0			0 0 0		0 0	5. 00 6. 00 7. 00 8. 00
9. 00 10. 00 11. 00 12. 00 13. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) ASSET TRANSFERS	0 0 -191, 539	822, 915 97, 164, 809		0	0	0	9. 00 10. 00 11. 00 12. 00 13. 00
14. 00 15. 00 16. 00 17. 00	AUGET TIMINGTERS	0 0			0 0 0		0 0	
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)		-191, 539 97, 356, 348			0		18. 00 19. 00
		Endowment Fund	PI ant	Fund				
		6.00	7. 00	8. 00				
1.00 2.00 3.00 4.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0		0			1. 00 2. 00 3. 00 4. 00
5. 00 6. 00 7. 00 8. 00 9. 00	NONALLOWABLE HOME OFFICE INT EXPENSE		0 0 0 0					5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) ASSET TRANSFERS	0	0 0 0 0 0		0			10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0			0			18. 00 19. 00

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

		[1	o 12/31/2019	Date/Time Pre 6/29/2020 3:1	
	Cost Center Description	Inpatient	Outpati ent	Total	T PIII
		1.00	2. 00	3.00	
	PART I - PATIENT REVENUES	•			
	General Inpatient Routine Services				
1.00	Hospi tal	8, 630, 385	5	8, 630, 385	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF			0	5. 00
6.00	Swing bed - NF			0	6. 00
7.00	SKILLED NURSING FACILITY			0	7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	8, 630, 385	5	8, 630, 385	10. 00
	Intensive Care Type Inpatient Hospital Services	1			
11.00	INTENSIVE CARE UNIT				11. 00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)			0	15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines		'	0	16. 00
17. 00	11-15) Total inpatient routine care services (sum of lines 10 and 16)	8, 630, 385		8, 630, 385	17. 00
18. 00	Ancillary services	37, 438, 939		37, 438, 939	18.00
19. 00	Outpatient services	37, 430, 73		203, 996, 451	
20. 00	RURAL HEALTH CLINIC			203, 990, 431	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		-	0	21. 00
22. 00	HOME HEALTH AGENCY		ή – "	O	22. 00
23. 00	AMBULANCE SERVICES		10, 740, 402	10, 740, 402	23. 00
24. 00	CMHC	1	10,7,10,102	10/ / 10/ 102	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26. 00
27. 00	OTHER (SPECIFY)		ol ol	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	46, 069, 324	214, 736, 853	260, 806, 177	28. 00
	G-3, line 1)		,		
	PART II - OPERATING EXPENSES	•			
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		74, 760, 722		29. 00
30.00	PROVISION FOR BAD DEBT	13, 521, 551			30.00
31.00	HOME OFFICE INTEREST EXPENSE	822, 915	5		31. 00
32.00					32. 00
33. 00					33. 00
34.00					34. 00
35. 00					35. 00
36. 00	Total additions (sum of lines 30-35)		14, 344, 466		36. 00
37. 00	DEDUCT (SPECIFY)		1		37. 00
38. 00					38. 00
39. 00]		39. 00
40.00			<u> </u>		40.00
41. 00	T) 		41.00
42. 00	Total deductions (sum of lines 37-41)		00 105 100		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		89, 105, 188		43. 00
	to Wkst. G-3, line 4)	1	1		l

111 +1-	Figure 1 - L. Contains	DDI AL JIOGDI TAL	la lia	£ F OMC (DEED 40
	Financial Systems WHITLEY MEMO MENT OF REVENUES AND EXPENSES	Provider CCN: 15-0101	Peri od:	u of Form CMS-2 Worksheet G-3	
			From 01/01/2019 To 12/31/2019	Date/Time Prep 6/29/2020 3:14	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3,			260, 806, 177	1.00
2.00	Less contractual allowances and discounts on patients' ac	counts		164, 548, 749	
3.00	Net patient revenues (line 1 minus line 2)			96, 257, 428	
4.00	Less total operating expenses (from Wkst. G-2, Part II, I			89, 105, 188	
5.00	Net income from service to patients (line 3 minus line 4)			7, 152, 240	5. 00
6. 00	OTHER INCOME Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			1, 165, 961	
8. 00	Revenues from telephone and other miscellaneous communica	tion sorvices		1, 105, 901	
9. 00	Revenue from television and radio service	ition services		0	
10. 00	Purchase di scounts			0	
					11. 00
12. 00	Parking Lot receipts				12. 00
	Revenue from Laundry and Linen service			0	13. 00
14. 00	Revenue from meals sold to employees and quests			246, 808	
	Revenue from rental of living quarters				15. 00
16. 00	9 1	er than patients			16. 00
	Revenue from sale of drugs to other than patients			ō	
18. 00	Revenue from sale of medical records and abstracts			ol	
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21.00	Rental of vending machines			0	21.00
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
24.00	REALIZED AND UNREALIZED GAINS ON INV			5, 418, 874	24. 00
24. 01	GAIN/LOSS ON SALE OF CAPITAL ASSETS			-37, 821	24. 01
24. 02	EMS SUBSI DY			250, 000	24. 02
24. 03	OTHER REVENUE			1, 480, 622	24. 03
25.00	Total other income (sum of lines 6-24)			8, 524, 444	25. 00
26.00	Total (line 5 plus line 25)			15, 676, 684	26. 00
27. 00	OTHER EXPENSES (SPECIFY)			0	
28. 00	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 2	8)		15, 676, 684	29. 00

Heal th	Financial Systems WHITLEY MEMORIA	J HOSPITAI	In lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0101	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III	pared:
		Title XVIII	Hospi tal	PPS	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			179, 750	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			5, 327	2.00
2.01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost re	eporting period (see inst	ructions)	12. 51	3. 00
4.00	Number of interns & residents (see instructions)			0.00	
5. 00	Indirect medical education percentage (see instructions)			0.00	
6. 00	Indirect medical education adjustment (multiply line 5 by the 1.01) (see instructions)			0	
7. 00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)		, part A line	0. 00	
8.00	Percentage of Medicaid patient days to total days (see instr	uctions)		0.00	
9.00	Sum of lines 7 and 8			0.00	
10.00	Allowable disproportionate share percentage (see instruction	s)		0.00	
11.00	Disproporti onate share adjustment (see instructions)			105.077	
12.00	Total prospective capital payments (see instructions)			185, 077	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1. 00
2.00	Program inpatient ancillary capital cost (see instructions)			0	
3. 00	Total inpatient program capital cost (line 1 plus line 2)			0	
4.00	Capital cost payment factor (see instructions)			0	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)	(:+:)		0	
2. 00 3. 00	Program inpatient capital costs for extraordinary circumstan Net program inpatient capital costs (line 1 minus line 2)	ces (see mstructions)		0	
4. 00	Applicable exception percentage (see instructions)			0.00	
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0.00	
6.00	Percentage adjustment for extraordinary circumstances (see i	nstructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary	y circumstances (line 2 >	(line 6)	0	7. 00
8.00	Capital minimum payment level (line 5 plus line 7)			0	8. 00
9.00	Current year capital payments (from Part I, line 12, as appl			0	
10.00	Current year comparison of capital minimum payment level to			0	
11. 00	Carryover of accumulated capital minimum payment level over	capital payment (from pri	or year	0	11. 00
12. 00	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital p.	avments (line 10 nlus lin	no 11)	0	12. 00
13. 00	Current year exception payment (if line 12 is positive, ente			0	
14. 00	Carryover of accumulated capital minimum payment level over			0	
	(if line 12 is negative, enter the amount on this line)	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	3 11		
15. 00		structi ons)		0	
	Current year operating and capital costs (see instructions)			0	
	Current year exception offset amount (see instructions)			0	17. 00