PART II - CERTIFICATION

(3) Settled with Audit

(4) Reopened (5) Amended

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

CERTIFICATION BY 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 01/01/2016 and ending 12/31/2016 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.

> (Si aned) Officer or Administrator of Provider(s) Title

number of times reopened = 0-9.

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	-70, 384	81, 314	0	0	1. 00
2.00	Subprovi der - IPF	0	0	0		0	2. 00
3.00	Subprovi der - I RF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
200.00	Total	0	-70, 384	81, 314	0	0	200. 00
The ob	ave amounts represent "due to" or "due fram"	the engliceble	program for th	a alamant of t	ha abayıa aamal	ov indiaa+ad	

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 01/01/2016 Part I 12/31/2016 Date/Time Prepared: 3/30/2017 9:09 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 1260 E STATE ROAD 205 PO Box: 1.00 State: IN Zip Code: 46725-9492 County: WHITLEY 2.00 City: COLUMBIA CITY 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)

/ XVIII XIX Туре Certi fi ed Number Number 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal 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 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 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 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2016 12/31/2016 Type of Control (see instructions) 21.00 21.00 2 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for disproportionate γ N 22.00 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 cost reporting Υ Υ 22.01 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) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν N 22 03 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 below? In column 23 00 3 N 23 00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

		In-State	In-State	Out-of	Out-of	Medicaid	0ther	
		Medicaid	Medi cai d	State	State	HMO days	Medi cai d	
		paid days	eligible	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	
24. 00	If this provider is an IPPS hospital, enter the	270	615	0	0	683	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.							
	If this provider is an IRF, enter the in-state	0	0	0	0	0		25. 00
	Medicaid paid days in column 1, the in-state					Ĭ		20.00
	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.			l			I	

	inancial Systems L AND HOSPITAL HEALTH CARE COMPL			AL HOSPITAL Provider CC		eri od:	u of Form CMS-2 Worksheet S-2	
					Fr	om 01/01/2016 0 12/31/2016		
			Y/N	I ME	Direct GME	I ME	Direct GME	, diii
(1.0/ 5			1.00	2.00	3. 00	4. 00	5. 00	(1.0)
u	nter the amount of ACA §5503 aw sed for cap relief and/or FTEs are or general surgery. (see in	that are nonprimary		0.00	0.00			61. 06
·			Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1. 00	2. 00	3. 00	4. 00	1
si fi ci p ui	f the FTEs in line 61.05, speci pecialty, if any, and the numbe or each new program. (see instrolumn 1, the program name, ente rogram code, enter in column 3, nweighted count and enter in co TE unweighted count.	r of FTE residents uctions) Enter in r in column 2, the the IME FTE				0. 00	0. 00	61. 10
p r i e 3	f the FTEs in line 61.05, speci rogram specialty, if any, and t esidents for each expanded prog nstructions) Enter in column 1, nter in column 2, the program c , the IME FTE unweighted count , direct GME FTE unweighted cou	ne number of FTE ram. (see the program name, ode, enter in column and enter in column				0. 00	0. 00	61. 20
							1.00	-
	CA Provisions Affecting the Hea							
y	nter the number of FTE resident our hospital received HRSA PCRE nter the number of FTE resident	funding (see instruc	tions)					62.00
d	uring in this cost reporting pe	riod of HRSA THC prog	ıram. (s	<u>ee instruction</u>			0.00	2.0.
63. 00 H	eaching Hospitals that Claim Re as your facility trained reside Y" for yes or "N" for no in col	nts in nonprovider se	ettings	during this co		eriod? Enter	N	63. 00
					Unwei ghted FTEs Nonprovi der	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	,
					Si te 1. 00	2.00	3.00	-
	ection 5504 of the ACA Base Yea				his base year	is your cost r	eporting	
64. 00 Ei	eriod that begins on or after J nter in column 1, if line 63 is n the base year period, the num esident FTEs attributable to ro ettings. Enter in column 2 the esident FTEs that trained in yo f (column 1 divided by (column	yes, or your facilit per of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir	y trair n-primar all nor I non-pr n columr	ed residents by care provider imary care 3 the ratio	0.00	0. 00	0. 000000	64.00
		Program Name	Pro	ogram Code	Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00		2. 00	Si te 3. 00	4. 00	5. 00	
i: t yy a: p p r t: c: u: r r n c: u: Y 5	nter in column 1, if line 63 s yes, or your facility rained residents in the base ear period, the program name ssociated with primary care TEs for each primary care rogram in which you trained esidents. Enter in column 2, he program code, enter in olumn 3, the number of nweighted primary care FTE esidents attributable to otations occurring in all on-provider settings. Enter in olumn 4, the number of nweighted primary care esident FTEs that trained in our hospital. Enter in column , the ratio of (column 3 ivided by (column 3 + column)). (see instructions)	1.00			0.00			65. 00

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 01/01/2016 Part I Date/Time Prepared: 12/31/2016 3/30/2017 9:09 am Unwei ghted Unwei ghted Ratio (col. (col. 1 + col FTEs FTEs in 2)) Nonprovi der Hospi tal 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 66.00 0.000000 66.00 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 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 Code Ratio (col. 3/ Program Name Unwei ghted Unwei ahted 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 0.00 0.00 0.000000 67.00 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? Enter "Y" for yes or "N" for no. 70.00 70.00 Ν If line 70 yes. Column 1: Did the facility have an approved GME teaching program in the most 71.00 0 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 Ν 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 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) 1.00 Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N 81.00 Y" for yes and "N" for no. TEFRA Provi ders 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. N 85.00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 \$413.40(f)(i)(i)? Enter "Y" for yes and "N" for no.
Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" Ν 87.00 for yes or "N" for no. ٧/ XIX 1.00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for Ν 90.00 yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in Ν Ν 91.00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 92.00 92.00 N Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 93 00 N N 93 00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the N 94.00 Ν applicable column.

F	eri od:		CMS-2552-10
	rom 01/01/20 o 12/31/20	016 Date/Time	Prepared:
	V	3/30/2017 XI X	9:09 am
umn.	1. 00	2.00	95, 00
no in the	N	N	96. 00
umn.	0.00	0.00	97. 00
nethod of payment	N		105. 00 106. 00
nstructions) If			107. 00
	N		108. 00
	Speech 3 00	Respirato	ory
2.00	3.00	1.00	109. 00
		1.00	
ition project (410	DA Demo)for	N	110. 00
		1 00 2 00 2	. 00
	· ·		
2 is "E", enter i term care (includ	n column des	N	0 115.00
"N" for no.		N	116. 00
,		Y	117. 00
			118. 00
Premi ums	Losses	Insuranc	ce
1. 00	2.00	3.00	
93, 729	9 188,	774 21	, 039 118. 01
	1. 00	2.00	
	N		118. 02
"Y" for yes or the Outpatient	N	N	119. 00 120. 00
ces charged to	Y		121. 00
	N		122. 00
'N" for no 15	A.I		125 00
	IN IN		125. 00 126. 00
tification date			127. 00
			128. 00
tification date			1
ification date			129. 00
fication date in			129. 00 130. 00 131. 00
	2.00 ation project (410 o in column 1. If 2 is "E", enter i term care (inclue the definition i "N" for no. "Y" for yes or ' 1 if the policy i Premiums 1.00	umn. nethod of payment ment for I&R structions) If program is cost chedule? See 42 N Occupational Speech 2.00 3.00 ation project (410A Demo) for provision in CMS The program is cost chedule? See 42 N ation project (410A Demo) for The program is cost chedule? See 42 N The program is	method of payment ment for I&R structions) If program is cost chedule? See 42 N Occupational Speech Respirate 2.00 3.00 4.00

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	WHITLEY MEMORI	Provi der CC	N: 15-0101			J of Form CMS Worksheet S- Part I Date/Time Pr 3/30/2017 9:	2 repared:
					1. 00	2. 00	-
I33.00 If this is a Medicare certified oth in column 1 and termination date, i	f applicable, in column	2.		9			133. 00
34.00 If this is an organ procurement organd termination date, if applicable	anization (OPO), enter t , in column 2.	he OPO number i	n column 1				134. 00
40.00 Are there any related organization chapter 10? Enter "Y" for yes or "N are claimed, enter in column 2 the	" for no in column 1. If	yes, and home	office cost	ts	Υ	15H032	140. 00
1.00	2. 0	00			3. 00		
If this facility is part of a chain				name an	d address	of the	
home office and enter the home offi 11.00 Name: PARKVIEW HEALTH SYSTEM, INC.	Contractor's Name: WI			ctor's Nu	umber: 0810	1	141. 00
12.00 Street: 10501 CORPORATE DRIVE	•	D BOX 5600					142. 0
43.00 City: FORT WAYNE	State: I N	N	Zi p Coo	de:	4689	5-5600	143. 00
						1.00	-
4.00 Are provider based physicians' cost	s included in Worksheet	A?				1.00 Y	144. 0
·······						·	
To a second seco					1. 00	2.00	
45. 00 If costs for renal services are cla inpatient services only? Enter "Y" no, does the dialysis facility incl period? Enter "Y" for yes or "N" f	for yes or "N" for no in ude Medicare utilization	column 1. If o	column 1 is		N		145. 00
46.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/dd	changed from the previocolumn 1. (See CMS Pub.			f	N		146. 0
						1.00	+
47.00 Was there a change in the statistic	al basis? Enter "Y" for	yes or "N" for	no.			N	147. 0
48.00 Was there a change in the order of						N	148. 0
49.00 Was there a change to the simplifie	d cost finding method? E	nter "Y" for ye	es or "N" fo		itle V	N Title XIX	149. 0
		1. 00	2.00		3.00	4. 00	\dashv
Does this facility contain a provid			n the appli		f the lowe	r of costs	
or charges? Enter "Y" for yes or "N 55.00 Hospi tal	" for no for each compon	nent for Part A N	and Part B N	. (See 4	2 CFR §413 N	. 13) N	155. 00
56. 00 Subprovi der – TPF		N N	N N		N	N	156. 00
57. 00 Subprovi der – I RF		N	N		N	N	157. 0
58. 00 SUBPROVI DER							158. 0
59. 00 SNF		N	N		N	N	159. 00
O. OO HOME HEALTH AGENCY		N	N		N	N	160. 0
61. 00 CMHC			N N		N	N	161. 00
						1.00	
Multicampus 65.00 s this hospital part of a Multicam	pus hospital that has on	e or more campu	ıses in dift	ferent C	3SAs?	N	165. 00
Enter "Y" for yes or "N" for no.	Name	County		Zip Code		FTE/Campus	
66.00 fline 165 is yes, for each	0	1. 00	2. 00	3. 00	4. 00	5.00	00 166. 00
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in						0. 0	70 100. 00
column 5 (see instructions)						1.00	
Health Information Technology (HIT)	incentive in the Americ	can Recovery and	d Reinvestm	ent Act		1.00	
57.00 s this provider a meaningful user 58.00 f this provider is a CAH (line 105 reasonable cost incurred for the HI	under §1886(n)? Enter " is "Y") and is a meanin	Y" for yes or " gful user (line	N" for no.		the	N	167. 00 0168. 00
68.01 If this provider is a CAH and is no exception under §413.70(a)(6)(ii)?	t a meaningful user, doe	s this provider			dshi p		168. 0 ²
69.00 If this provider is a meaningful us transition factor. (see instruction	er (line 167 is "Y") and				enter the	0.0	00169. 0

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTI	FICATION DATA	Provider CCN: 15-0101	Peri od:	Worksheet S-2	!
			From 01/01/2016		
			To 12/31/2016		pared:
			3/30/2017 9:0	19 am	
	Begi nni ng	Endi ng			
			1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	10/01/2015	09/30/2016	170. 00		
			1. 00	2.00	
171.00 If line 167 is "Y", does this provider ha	ve any days for indiv	iduals enrolled in	N	0	171. 00
section 1876 Medicare cost plans reported					
"Y" for yes and "N" for no in column 1. I	n				
1876 Medicare days in column 2. (see inst	ructions)			İ	

	Financial Systems WHITLEY MEMOR AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 1E 0101	Period:	workshoot S	
HUSPI I	AL AND HUSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		From 01/01/2016 To 12/31/2016	Date/Time Pro	epared:
				Y/N	3/30/2017 9:0 Date	J9 am
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter M	l for all NO re	sponses. Ente			
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation Has the provider changed ownership immediately prior to the	, boginning of	the cost	N	I	1 00
1. 00	reporting period? If yes, enter the date of the change in a	column 2 (see	instructions)			1.00
	reporting period. It yes, enter the date of the enange in t	20. 4 21 (000	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.		N			2.00
3. 00	contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the providual officers, medical staff, management personnel, or members of directors through ownership, control, or family and other	provider involved in business transactions, including management cts, with individuals or entities (e.g., chain home offices, drug ical supply companies) that are related to the provider or its rs, medical staff, management personnel, or members of the board ectors through ownership, control, or family and other similar onships? (see instructions)				
	(see matruetrons)		Y/N	Туре	Date	
			1.00	2.00	3. 00	
	Financial Data and Reports	. 6. 1 5	1			
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,	Y	A		4.00
5. 00	Are the cost report total expenses and total revenues diffe	erent from	N			5. 00
	those on the filed financial statements? If yes, submit rec	conciliation.		V (0)		
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
5. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is th	ne provider is	N		6. 00
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.		during the	N N		7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	N		9. 00
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.			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	V/AI	11. 00
					1. 00	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			st reporting	Y N	12. 00 13. 00
	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	yes, see ins	tructi ons.	N	14. 00
	Bed Complement Did total beds available change from the prior cost reporti	ng period? If	yes, see inst	ructi ons.	Υ	15. 00
	<u> </u>		rt A		t B	
		Y/N	Date	Y/N	Date	
	DC4D D-+-	1.00	2. 00	3. 00	4. 00	
	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	N		N		16. 00
17. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/30/2016	Y	04/30/2015	17. 00
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Y		Y		18. 00
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19. 00

Heal th	Financial Systems WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	-2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CC	CN: 15-0101	Peri od: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Pro 3/30/2017 9:0	epared:		
		Descri	pti on	Y/N	Y/N	1		
		C		1. 00	3. 00			
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00		
	insper tradition of the street and actiments.	Y/N	Date	Y/N	Date			
21. 00	Was the cost report prepared only using the provider's	1. 00 N	2. 00	3. 00 N	4. 00	21. 00		
21.00	records? If yes, see instructions.	IN		IN IN		21.00		
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	OSPI TALS)					
	Capital Related Cost							
22. 00	Have assets been relifed for Medicare purposes? If yes, see					22. 00		
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	ing the cost		23. 00				
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during	this cost re	porting period?		24. 00		
25. 00	Have there been new capitalized leases entered into during linstructions.	the cost repor	ting period?	If yes, see		25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th	ne cost reporti	ng period? I	f yes, see		26. 00		
27. 00	instructions. Has the provider's capitalization policy changed during the	cost reportin	g period? If	yes, submit		27. 00		
	Interest Expense							
28. 00	Were new loans, mortgage agreements or letters of credit en period? If yes, see instructions.		28. 00					
29. 00								
30. 00	Has existing debt been replaced prior to its scheduled matu instructions.	irity with new	debt? If yes	, see		30. 00		
31. 00	Has debt been recalled before scheduled maturity without is instructions.	suance of new	debt? If yes	, see		31. 00		
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser		d through co	ntractual		32. 00		
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		g to competi	tive bidding? If		33. 00		
	Provi der-Based Physi ci ans							
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with	provi der-ba	sed physicians?	Υ	34. 00		
35. 00	If line 34 is yes, were there new agreements or amended exi		ts with the	provi der-based		35. 00		
	physicians during the cost reporting period? If yes, see in	ISTI UCTI ONS.		Y/N	Date			
				1.00	2. 00			
	Home Office Costs				00			
36.00	Were home office costs claimed on the cost report?			Υ		36. 00		
	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	repared by the	home office?			37. 00		
38. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			N		38. 00		
39. 00	If line 36 is yes, did the provider render services to othe			, N		39. 00		
40. 00	see instructions. If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00		
	Cost Poport Propagor Contact Information	1.	00					
41. 00	held by the cost report preparer in columns 1, 2, and 3,	ERI C		NI CKESON		41. 00		
42. 00		PARKVIEW HEALTI	H SYSTEM, IN	C.		42. 00		
43. 00		(260) 373-8406		ERI C. NI CKESON@F	PARKVIEW. COM	43. 00		
	report preparer in columns 1 and 2, respectively.							

Heal th	Financial Systems W	HITLEY MEMORIA	L HOSPITAL			In Lie	u of Form C	MS-2	552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUEST	I ONNAI RE	Provi der	CCN: 15-0101	Peri From To	od: n 01/01/2016 12/31/2016		Prep	oared:
		-		3. 00					
	Cost Report Preparer Contact Information								
41. 00	Enter the first name, last name and the title/pheld by the cost report preparer in columns 1, respectively.	'	I RECTOR, RE	I MBURSEMENT					41. 00
42. 00	Enter the employer/company name of the cost reports preparer.	port							42. 00
43. 00	Enter the telephone number and email address of report preparer in columns 1 and 2, respectivel								43. 00

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared:
3/30/2017 9:09 am

						3/30/2017 9:09	9 am
						I/P Days / O/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1.00	2.00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	30		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, 980	0. 00	o o	7. 00
7.00	beds) (see instructions)		30	10, 900	0.00	O	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							11. 00
	SURGICAL INTENSIVE CARE UNIT						12.00
12.00	OTHER SPECIAL CARE (SPECIFY)	42.00				0	
13.00	NURSERY	43. 00	20	40.000	0.00	0	13.00
14.00	Total (see instructions)		30	10, 980	0. 00	0	14.00
15.00	CAH visits					0	15. 00
16. 00	SUBPROVIDER - I PF						16. 00
17. 00	SUBPROVIDER - IRF						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 Trips						29. 00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)		0	0			32. 00
32. 01	Total ancillary labor & delivery room						32. 01
JZ. U1	outpatient days (see instructions)						JZ. U1
33. 00	LTCH non-covered days						33. 00
55. 50	2. S IS SSVOI ou days	I	l	I			55. 55

Peri od: Worksheet S-3
From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared: 3/30/2017 9:09 am

						3/30/2017 9:0	9 am
		I/P Days	s / O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
		6. 00	7. 00	Pati ents 8, 00	& Residents 9.00	Payrol I 10. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 159	7.00	3, 790		10.00	1. 00
1.00	8 exclude Swing Bed, Observation Bed and	1, 159	132	3, 790			1.00
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds) HMO and other (see instructions)	1, 037	1, 236				2. 00
2. 00 3. 00	HMO IPF Subprovider	1,037	1, 230				3.00
4. 00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	_			5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF	U	0				6.00
7. 00	Total Adults and Peds. (exclude observation	1, 159	132	3, 790			7.00
7.00	beds) (see instructions)	1, 137	132	3, 770			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		123	882			13. 00
14.00	Total (see instructions)	1, 159	255	4, 672	0.00	263. 30	14.00
15.00	CAH visits	0	0	C			15. 00
16.00	SUBPROVI DER - I PF						16. 00
17.00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	0	0	C	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	0	C			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C			
27. 00	Total (sum of lines 14-26)		004	4 040	0.00	263. 30	
28. 00	Observation Bed Days		281	1, 340			28. 00
29. 00	Ambul ance Trips	0		0.2			29. 00
30.00	Employee discount days (see instruction)			93 0			30.00
31.00	Employee discount days - IRF	0	77	-			
32. 00	Labor & delivery days (see instructions)		77	131			32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)			C			32. 01
33 00	LTCH non-covered days	0					33. 00
55.00	121011 Holl Covered days	ı Y		Ĭ	I	I	1 33.00

| Peri od: | Worksheet S-3 | From 01/01/2016 | Part I | To 12/31/2016 | Date/Time Prepared:

				10) 12/31/2010	3/30/2017 9:09	
		Full Time		Di sch	arges	0,00,201, ,10	, GIII
		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		0	347	225	1, 574	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)			357	108		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				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						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						13. 00
14. 00	Total (see instructions)	0. 00	0	347	225	1, 574	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	,	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						32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days				J		33. 00

							0 12/31/2016	Date/lime Pre 3/30/2017 9:0	9 am
PART II - WAGE DATA					on of Salaries (from	Sal ari es (col. 2 ± col.	Related to Salaries in		
1. 00 Internal sal art is (See 200.00 16,388,743 3,475,379 20,364,122 588,112,49 36,49 1.0			1. 00	2. 00				6. 00	
Total salaries (See 200.00 16.388,743 3.975,379 20,164,122 588,112 49 36.49 1.0									1
2.00 Ann-physic clain Anestheritist Part	1.00	Total salaries (see	200. 00	16, 388, 743	3, 975, 379	20, 364, 122	558, 112. 49	36. 49	1. 00
4. 00 Physician-Part A - A - A - A - A - A - A - A - A - A	2. 00			0	0	0	0. 00	0. 00	2. 00
4. Admin is trative 4 - Teaching 7. O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3. 00
4.01 Physicians - Part A - Teaching 0 0 0 0 0.00 0.00 0.00 5.00 Physician and flow physician - Part B 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4. 00	, ,		84, 406	0	84, 406	545. 00	154. 87	4. 00
Mon-physic ian-Part B Form		Physicians - Part A - Teaching		-	0	1		l e	
Interest & residents (in an approved program)	6. 00	Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0. 00	0. 00	6. 00
Contracted interins and residents (in an approved programs) 8.00 Home office and/or related programs 8.00 Home	7. 00	Interns & residents (in an	21. 00	0	0	0	0. 00	0. 00	7. 00
Nome office and/or related organization personnel 44.00 0 0 0 0 0 0 0 0 0	7. 01	Contracted interns and residents (in an approved		0	0	0	0.00	0.00	7. 01
10.00 Excluded area salaries (see 1,485,117 135,897 1,621,014 74,543.59 21.75 10.0	8. 00	Home office and/or related		5, 078, 116	0	5, 078, 116	119, 673. 00	42. 43	8. 00
OTHER WAGES & RELATED COSTS		Excluded area salaries (see	44. 00	0 1, 485, 117	0 135, 897	0 1, 621, 014		•	
11.00 Contract Labor: Direct Patient Care C									1
12.00 Contract labor: Top level management and other management and administrative services 13.00 Contract labor: Physician-Part 14.00 Management and administrative 14.00 Management and admi	11. 00	Contract Labor: Direct Patient		0	0	0	0. 00	0. 00	11. 00
13.00 Contract labor: Physician=Part 0 0 0 0 0.00 0.00 0.00 13.0 14.00 Home office and/or related orgalization salaries and wage-related costs 3,975,379 0 3,975,379 119,673.00 33.22 14.0 14.01 Home office salaries 3,975,379 0 3,975,379 119,673.00 33.22 14.0 15.00 Home office: Physician Part A 0 0 0 0 0.00 0.00 14.0 15.00 Home office and Contract 0 0 0 0 0 0.00 0.00 15.0 16.00 Home office and Contract 0 0 0 0 0 0.00 0.00 15.0 16.00 Home office and Costs (core) (see instructions) 4,688,292 0 4,688,292 17.0 17.00 Wage-related costs (core) (see instructions) 467,177 0 467,177 19.0 19.00 Excluded areas 467,177 0 467,177 19.0 10.00 Non-physician anesthetist Part 0 0 0 0 0 10.00 Non-physician Part A 4 40,0 1,633,823 -1,457,130 176,693 5,831.45 30.30 26.0 10.00 Wage-related costs (RHC/FOHC) 0 0 0 0 10.00 0 0 0 0 10.00 0 0 0 10.00 0 0 0 10.00 0 0 0 10.00 0 0	12. 00	Contract labor: Top level management and other management and administrative		0	0	0	0. 00	0. 00	12. 00
14.00 Home office and/or related organization sal aries and wage-related costs 14.01 Home office sal aries and wage-related costs 14.02 Related organization sal aries 3,975,379 0 3,975,379 119,673.00 33.22 14.0 15.00 Home office sharies 0 0 0 0 0 0 0 16.00 Home office Physician Part A 0 0 0 0 0 0 16.00 Home office and Contract 0 0 0 0 0 0 0 16.00 Physicians Part A - Teaching 0 0 0 0 0 0 18.00 Wage-related costs (core) (see instructions) 0 0 0 0 0 19.00 Experience of the same states of the same	13. 00	Contract Labor: Physician-Part		0	0	0	0. 00	0. 00	13. 00
14.01 Home office salaries	14. 00	Home office and/or related orgainzation salaries and		0	0	0	0.00	0.00	14. 00
15.00 Home office: Physician Part A		Home office salaries		3, 975, 379	0	3, 975, 379			
Home office and Contract		Home office: Physician Part A		0	0	0			
17. 00 Wage-rel ated costs (core) (see instructions) 18. 00 Wage-rel ated costs (other) 0 0 0 0 0 18. 00 0 0 0 0 0 0 0 0 0	16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16. 00
18. 00 Wage-related costs (other) (see instructions) 18. 00 0 0 0 0 0 0 0 0 0	17. 00	Wage-related costs (core) (see		4, 688, 292	0	4, 688, 292			17. 00
19. 00	18. 00	Wage-related costs (other)		0	0	0			18. 00
B		Excluded areas		467, 177 0	0	467, 177 0			19. 00 20. 00
Administrative	21. 00	A Non-physician anesthetist Part		0	0	0			21. 00
22. 01 Physician Part A - Teaching	22. 00			0	0	0			22. 00
24.00 Wage-related costs (RHC/FQHC) 0 0 0 0 24.00 25.00 Interns & residents (in an approved program) 0 0 0 0 0 0 25.00 25.50 Home office wage-related 1,102,737 0 1,102,737 25.5		Physician Part A - Teaching		0	О	О			22. 01
25. 00				0	0	0			23. 00
25. 50 Home office wage-related		Interns & residents (in an			1	0			25. 00
wage-related Home office: Physician Part A		Home office wage-related		1, 102, 737 0	0	1, 102, 737 0			25. 50 25. 51
wage-related Home office & Contract O O O O	25. 52	wage-related Home office: Physician Part A		0	О	0			25. 52
Physicians Part A - Teaching - wage-related OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department	25 52	wage-rel ated		_	_				25 52
26.00 Employee Benefits Department 4.00 1,633,823 -1,457,130 176,693 5,831.45 30.30 26.00	∠3. 53	Physicians Part A - Teaching - wage-related							∠5. 53
	26 00			1 622 022	_1 /57 120	174 402	5 921 AE	20.20	26 00
						l			

| Peri od: | Worksheet S-3 | From 01/01/2016 | Part II | To 12/31/2016 | Date/Time Prepared:

					'	0 12/31/2010	3/30/2017 9:0	
		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 ± col.	Salaries in	col . 5)	
				Worksheet A-6)		col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		0	0	0	0.00	0. 00	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00		0	0	0.00		29. 00
30.00	Operation of Plant	7. 00	· ·	31, 154	451, 178	,		30.00
31. 00	Laundry & Linen Service	8. 00		0	0	0.00		
32.00	Housekeepi ng	9. 00	390, 976	28, 999	419, 975	33, 259. 51	12. 63	32.00
33.00	Housekeeping under contract		0	0	0	0.00	0. 00	33.00
	(see instructions)							
34.00	Di etary	10. 00	405, 123	-314, 800	90, 323	8, 659. 46	10. 43	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	334, 683	334, 683	22, 505. 94	14. 87	36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13. 00	214, 521	15, 911	230, 432	6, 616. 11	34. 83	38.00
39.00	Central Services and Supply	14. 00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15. 00	523, 460	38, 826	562, 286	12, 233. 93	45. 96	40.00
41.00	Medical Records & Medical	16. 00	0	0	0	0.00	0.00	41.00
	Records Li brary							
42.00	Soci al Servi ce	17. 00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

| Peri od: | Worksheet S-3 | From 01/01/2016 | Part III | To 12/31/2016 | Date/Time Prepared: Provider CCN: 15-0101

					1'	0 12/31/2010	3/30/2017 9:0	
		Worksheet A	Amount	Reclassi fi cati	Adjusted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2.00	3.00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		11, 310, 627	3, 975, 379	15, 286, 006	438, 439. 49	34. 86	1.00
	instructions)							
2.00	Excluded area salaries (see		1, 485, 117	135, 897	1, 621, 014	74, 543. 59	21. 75	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		9, 825, 510	3, 839, 482	13, 664, 992	363, 895. 90	37. 55	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		3, 975, 379	0	3, 975, 379	119, 673. 00	33. 22	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		5, 791, 029	0	5, 791, 029	0. 00	42. 38	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		19, 591, 918			·		
7.00	Total overhead cost (see		5, 197, 446	3, 035, 232	8, 232, 678	129, 988. 36	63. 33	7. 00
	instructions)							

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 01/01/2016 Part IV

	To 12/31/2016	Date/Time Prep 3/30/2017 9:00	
		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	286, 984	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	632, 577	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	0	6. 00
7.00	Employee Managed Care Program Administration Fees	66, 513	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	2, 880, 207	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)	0	8. 02
8. 03	Heal th Insurance (Purchased)	0	8. 03
9. 00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	28, 178	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)	76, 000	13. 00
14. 00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00	'Workers' Compensation Insurance	20, 831	15. 00
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	20,001	16. 00
10.00	Non cumulative portion)	Ö	10.00
	TAXES		
17. 00	FICA-Employers Portion Only	1, 159, 373	17. 00
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	Unempl oyment Insurance	0	19. 00
	State or Federal Unemployment Taxes	0	20. 00
20.00	OTHER	-	20.00
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	47, 285	21. 00
21.00	instructions))	17, 200	21.00
22. 00	Day Care Cost and Allowances	0	22. 00
23. 00	Tui ti on Rei mbursement	41, 569	23. 00
	Total Wage Related cost (Sum of lines 1 -23)	5, 239, 517	24. 00
_ 1. 00	Part B - Other than Core Related Cost	0, 20, 017	_ 1. 00
25 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00
25.00	John Midd Red Teb Good (Great I)	O ₁	20.00

Heal th F	inancial Systems	WHITLEY MEMORIAL HOSPI	TAL		In Lie	u of Form CMS-2	2552-10
HOSPI TAL	CONTRACT LABOR AND BENEFIT COST	Provi	ider CCN:	1	From 01/01/2016	Worksheet S-3 Part V Date/Time Prep 3/30/2017 9:09	pared:
	Cost Center Description				Contract Labor	Benefit Cost	
					1. 00	2. 00	
P	ART V - Contract Labor and Benefit Cost						
H	ospital and Hospital-Based Component Identifi	cati on:					
1.00 T	otal facility's contract labor and benefit co	ost			0	5, 239, 517	1.00

			3/30/201/ 9.0	7 aiii
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	5, 239, 517	1. 00
2.00	Hospi tal	0	5, 239, 517	2. 00
3.00	Subprovi der - IPF			3. 00
4.00	Subprovi der - I RF			4.00
5.00	Subprovi der - (0ther)	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 Dialysis			17. 00
18. 00	Other	0	0	18. 00

111-4-	Figure 1 Contains	WILL THEY MEMORIAL	HOCDLTAL		1 - 11 -	£ F OMC 3	NEED 10	
	Financial Systems FAL UNCOMPENSATED AND INDIGENT CARE DATA	WHITLEY MEMORIAL		N 15 0101		u of Form CMS-2		
HOSPI I	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CO	JN: 15-0101	Peri od: From 01/01/2016	Worksheet S-10	J	
					To 12/31/2016	Date/Time Pre	nared:	
					10 12/31/2010	3/30/2017 9:09		
						1. 00		
	Uncompensated and indigent care cost comput							
1.00								
	Medicaid (see instructions for each line)							
2.00	Net revenue from Medicaid					1, 409, 848	2. 00	
3.00	Did you receive DSH or supplemental payment			6 W II .	10	Y	3. 00	
4.00	If line 3 is "yes", does line 2 include all			rrom Medical	1?	N 577 515	4. 00	
5. 00 6. 00	If line 4 is "no", then enter DSH or supple Medicaid charges	ementai payments fro	om wedicald			576, 515 17, 355, 373	5. 00 6. 00	
7. 00	Medicaid charges Medicaid cost (line 1 times line 6)					4, 254, 583	7. 00	
8. 00	Difference between net revenue and costs for	or Modicald program	(lino 7 min	us sum of Liv	oc 2 and 5: if	2, 268, 220	8. 00	
0.00	< zero then enter zero)	or medicard program	(TITIE / IIITT	us sum or iri	ies 2 and 5, 11	2, 200, 220	0.00	
	Children's Health Insurance Program (CHIP)	(see instructions 1	or each lin	e)				
9.00	Net revenue from stand-alone CHIP	•				0	9. 00	
10.00	Stand-alone CHIP charges					0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10	0)				0	11.00	
12.00	Difference between net revenue and costs for	or stand-alone CHIP	(line 11 mi	nus line 9; i	f < zero then	0	12.00	
	enter zero)							
40.00	Other state or local government indigent ca					0.004.050		
13.00	Net revenue from state or local indigent ca	1 5 1			,	2, 921, 059		
14. 00	Charges for patients covered under state or	r rocar indigent car	re program (Not included	in lines 6 or	21, 017, 821	14. 00	
15. 00	10) 5.00 State or local indigent care program cost (line 1 times line 14)							
16. 00	Difference between net revenue and costs for			nrogram (Liu	ne 15 minus line	5, 152, 414 2, 231, 355	15. 00 16. 00	
10.00	13; if < zero then enter zero)	or state or rocal ri	iai gent care	program (TT	ic 15 iii iids i i iic	2, 231, 333	10.00	
	Uncompensated care (see instructions for ea	ach line)						
17. 00	Private grants, donations, or endowment ind	come restricted to	fundi ng char	ity care		0	17.00	
18. 00	Government grants, appropriations or transf	fers for support of	hospital op	erati ons		0	18. 00	
19. 00	Total unreimbursed cost for Medicaid , CHIF	and state and loca	al indigent	care programs	s (sum of lines	4, 499, 575	19.00	
	8, 12 and 16)					T		
				Uni nsured	Insured	Total (col. 1		
				patients 1.00	pati ents 2.00	+ col . 2) 3.00		
20. 00	Charity care charges for the entire facilit	ty (see instructions	=)	225, 0		2, 076, 642	20. 00	
21. 00	Cost of patients approved for charity care			55, 1		509, 079		
22. 00	Partial payment by patients approved for ch		20)		32 638	770		
	Cost of charity care (line 21 minus line 22			55, 0		508, 309		
	, , , , , , , , , , , , , , , , , , , ,							
						1. 00		
24.00	N	24. 00						
	imposed on patients covered by Medicaid or other indigent care program?							
25. 00								
	26.00 Total bad debt expense for the entire hospital complex (see instructions)							
27. 00	Medicare bad debts for the entire hospital			071		88, 333		
28. 00	Non-Medicare and non-reimbursable Medicare				- 20)	9, 492, 724		
29. 00	Cost of non-Medicare and non-reimbursable M		kpense (IIne	i times line	28)	2, 327, 094		
30.00	Cost of uncompensated care (line 23 column Total unreimbursed and uncompensated care of		ino 20)			2, 835, 403 7, 334, 978		
31.00	Trotal uniterimonised and uncompensated care of	rost (Title 14 bins 1	1116 30)			1, 334, 9/8	31.00	

Heal th	Financial Systems	WHITLEY MEMORIAL	L HOSPITAL		In Lie	u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der Co	CN: 15-0101	Peri od:	Worksheet A	
					From 01/01/2016 To 12/31/2016	Date/Time Pre	pared:
						3/30/2017 9:0	
	Cost Center Description	Sal ari es	0ther		Reclassificati	Reclassi fied	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +- col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		3, 490, 268	3, 490, 26	8 -350, 267	3, 140, 001	
2.00	00200 CAP REL COSTS-MVBLE EQUIP		753, 386			1, 837, 306	
3.00	00300 OTHER CAP REL COSTS	1 (22 022	97, 000			5 200 020	
4. 00 5. 00	OO400	1, 633, 823 1, 609, 519	5, 213, 336 15, 009, 842			5, 390, 029 16, 575, 254	1
6. 00	00600 MAINTENANCE & REPAIRS	1,007,317	13, 007, 042	10, 019, 30	0	10, 373, 234	6. 00
7. 00	00700 OPERATION OF PLANT	420, 024	1, 072, 714	1, 492, 73	8 -67, 239	1, 425, 499	1
8.00	00800 LAUNDRY & LINEN SERVICE	0	213, 377	213, 37	7 0	213, 377	8. 00
9.00	00900 HOUSEKEEPI NG	390, 976	171, 349			590, 322	
10.00	01000 DI ETARY	405, 123	277, 255	682, 37		147, 824	1
11. 00 12. 00	O1100 CAFETERI A O1200 MAI NTENANCE OF PERSONNEL	0	0		0 553, 015	553, 015	11. 00 12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	214, 521	1, 965	216, 48	6 15, 911	232, 397	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0) 2.0, .0	0 0	0	14. 00
15.00	01500 PHARMACY	523, 460	2, 966, 778	3, 490, 23	8 -1, 794, 018	1, 696, 220	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	
17. 00	01700 SOCIAL SERVICE	0	0	2	0	0	
19. 00 20. 00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0	0		0	0	19. 00 20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV		0		0 0	0	21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV		0		o o	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0	0	1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	1	2, 713, 092	426, 968			2, 284, 802	1
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	0	1	0 241, 537 0 0	241, 537 0	1
44.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>	0	<u>'l</u>	<u>U</u>	0	44.00
50.00	05000 OPERATI NG ROOM	923, 978	418, 902	1, 342, 88	0 66, 476	1, 409, 356	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	79, 779	988	80, 76	7 888, 839	969, 606	
53. 00	05300 ANESTHESI OLOGY	0	661, 623			661, 623	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	1, 686, 216	617, 617			2, 397, 394	1
60. 00 62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		2, 574, 981	2, 574, 98	1 -453	2, 574, 528 0	60.00
65. 00	06500 RESPI RATORY THERAPY	446, 459	154, 946	601, 40	5 -39, 096	562, 309	1
66.00	06600 PHYSI CAL THERAPY	1, 224, 245	336, 268			682, 808	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 580, 295	580, 295	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0)	0 119, 860	119, 860	
69. 00 71. 00	06900 ELECTROCARDI OLOGY	102	051 351	951, 54	0 9, 694	9, 694 628, 636	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	192	951, 351	931, 34	3 -322, 907 0 322, 716	322, 716	
	07300 DRUGS CHARGED TO PATIENTS		0		0 1, 825, 520		1
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0		76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	0	1	0 0	0	
76. 99		0	0)	0 0	0	76. 99
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	90, 485	18, 411	108, 89	6 16, 877	125, 773	90.00
	1	70, 483	10, 411	100, 07	0 10, 077	123, 773	1
	09100 EMERGENCY	2, 541, 734	2, 923, 957	5, 465, 69	1 158, 366	5, 624, 057	
92.00							92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES	1, 413, 266	261, 505	1, 674, 77	1 103, 413	1, 778, 184	95. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	16, 316, 892	38, 614, 787	54, 931, 67	9 -331, 737	54, 599, 942	118 00
	NONREI MBURSABLE COST CENTERS	10/010/072	00/01///07	1 01,701,07	2017707	01,077,712	1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21, 326				190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	16, 645	903, 354				1
	07950 OCCUPATI ONAL HEALTH	0	-59, 410				194. 00
	07951		0		0 0		194. 01 194. 02
	07952 OAK POINTE	5	95, 004	95, 00	9 249, 537	344, 546	
194.04	07954 COMMUNITY & VOLUNTEER SERVICES	55, 201	231, 149				
	07955 VACANT SPACE	0	0		0 0		194. 05
200.00	TOTAL (SUM OF LINES 118-199)	16, 388, 743	39, 806, 210	56, 194, 95	3 0	56, 194, 953	200. 00

Health Financial Systems	WHITLEY MEMOR		In Lieu of Form CM	
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CCN: 15-	0101 Peri od: Worksheet A	Ą
			To 12/31/2016 Date/Time F 3/30/2017	Prepared:
Cost Center Description	Adjustments	Net Expenses	07 007 20 17	7.07 4111
	(See A-8) 6.00	For Allocation 7.00		
GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00 O0100 CAP REL COSTS-BLDG & FIXT	-2, 096, 580			1. 00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP	-45, 406	1, 791, 900		2.00
3.00 00300 OTHER CAP REL COSTS 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-2, 224, 226	3, 165, 803		3. 00 4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	-2, 224, 220			5. 00
6. 00 00600 MAI NTENANCE & REPAI RS	0			6. 00
7.00 00700 OPERATION OF PLANT	-97, 452	1, 328, 047		7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE	0			8. 00
9. 00 00900 HOUSEKEEPI NG	20.801	590, 322		9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	-20, 801 -52, 016	127, 023 500, 999		10.00
12. 00 01200 MAI NTENANCE OF PERSONNEL	32,010	0		12. 00
13.00 01300 NURSING ADMINISTRATION	0	232, 397		13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	1 "		14. 00
15. 00 01500 PHARMACY	-927, 795	768, 425		15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCIAL SERVICE	0			16. 00 17. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	0	0		19.00
20. 00 02000 NURSI NG SCHOOL	o o	o o		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			22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	0		23. 00
I NPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS	25, 083	2, 309, 885		30.00
43. 00 04300 NURSERY	25,003			43. 00
44.00 04400 SKILLED NURSING FACILITY	0			44. 00
ANCILLARY SERVICE COST CENTERS	_			
50. 00 05000 OPERATING ROOM	0			50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	-643, 942			52. 00 53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	043, 742			54.00
60. 00 06000 LABORATORY	0			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62. 30
65. 00 06500 RESPI RATORY THERAPY	-73, 771	488, 538		65. 00
66. 00 06600 PHYSI CAL THERAPY	-324, 942			66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	580, 295 119, 860		67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	0			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0			73. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON 76. 98 O7698 HYPERBARI C OXYGEN THERAPY	0	1 -1		76. 97 76. 98
76. 99 07699 LI THOTRI PSY	Ö	1		76. 99
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0	125, 773		90.00
90. 01 09001 INTENSI VE OUT PATI ENT PROGRAM	20.57/			90. 01
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	-30, 576	5, 593, 481		91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS				72.00
95. 00 09500 AMBULANCE SERVICES	0	1, 778, 184		95. 00
SPECIAL PURPOSE COST CENTERS				
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	-8, 632, 791	45, 967, 151		118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21, 326		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	-318, 216	600, 403		192. 00
194. 00 07950 OCCUPATI ONAL HEALTH	0	0		194. 00
194. 01 07951 PALN CLINIC	0	0		194. 01
194. 02 07952 0AK POLNTE 194. 03 07953 FOUNDATI ON	0	344, 546		194. 02 194. 03
194. 04 07954 COMMUNITY & VOLUNTEER SERVICES		310, 520		194. 03
194. 05 07955 VACANT SPACE	0	0		194. 05
200.00 TOTAL (SUM OF LINES 118-199)	-8, 951, 007	47, 243, 946		200. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0101

Cycl Center 11 to P						3/30/2017 9: 0	
CAPTERIA RECIASS			Increases				
A CAPTERIA POLOSS 1.00 DETERIA 11.00 311.573 218.332 11.00 1.00 NBSPC 25.5							
0.00 0.00			3. 00	4. 00	5. 00		
STILLON STIL							
B - 08 RECLASS 189, 197 318, 307 2, 00	1. 00	CAFETERI A	<u>11.</u> 00				1.00
DOC MUNISHEY 1.00		0		311, 573	218, 332		
Description	1 00		42.00	100 107	20 207		1 00
BUILDING AND EQUIP LEASE							1
Both Company	2.00	DELI VERT ROOM & LABOR ROOM					2.00
1,00		E - RIII DING AND FOULD LEASE		000, 773	170, 330		
2.00	1 00		1 00	O	474 864		1 00
3.00 4.00 5.00 0.00 0.00 0.00 0.00 0.00 0			l l	1			1
4.00		NEE 303.3 m.73EE E43.1	l l	i i			1
5.00				ı	-		1
0.00					0		1
7, 00 0, 00 0, 00 0 0 0 0 0			l l	ı	0		1
8. 00 9. 00 10. 00 9. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 11. 00 12. 00 12. 00 13. 00 14. 00 15. 00 15. 00 16. 00 17. 00 18. 00 18. 00 19. 0			l l	o	0		1
9.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 11.00 1				ı	0		
11.00			0.00	o	0		9. 00
12.00	10.00		0.00	О	0		10.00
13.00	11.00		0.00	О	0		11. 00
14.00	12.00		0. 00	O	0		12.00
15, 00	13.00		0.00	0	0		13. 00
16. 00	14.00		0. 00	0	0		14.00
17. 00	15.00		0. 00	0	0		15. 00
18.00	16.00		0. 00	0	0		16. 00
C	17.00		0.00	0	0		17. 00
1.00 CAP REL COSTS-MYBLE EQUIP 2.00 0 45,023 2.00 45,023	18.00		000		0		18. 00
1.00		0		0	552, 738		
2.00 CAP REL COSTS-MVBLE FOULP 2.00 0 45,023 0 0 0 0 0 0 0 0 0							4
1.00 0 83,915							1
H - DEPRECIATION RECLASS	2.00						2.00
1.00				0	83, 915		
1.00	4 00		0.00	ما	050 (0)		4 00
1.00 CAP REL_COSTS-MUSLE_EQUIP 2.00 0 1.327 0 0 1.327 0 0 1.327 0 0 1.327 0 0 0 1.327 0 0 0 1.327 0 0 0 0 0 0 0 0 0	1.00	CAP REL COSTS-MARTE EGOLD					1.00
1.00		U TAVES DECLASS		U	959, 696		-
1.00 ADMINISTRATIVE & GENERAL 5.00 3.975,379 0 0 0 0 0 0 0 0 0	1 00		2 00	٥	1 327		1 00
1.00 ADMINISTRATI VE & GENERAL 5.00 3,975,379 0 0 0 0 0 0 0 0 0	1.00	n KEE COSTS-WVBEE EQUIT					1.00
1.00		K - SALARY RECLASS		<u> </u>	1, 327		ł
C	1 00		5 00	3 975 379	0		1 00
Comparison Com	1.00	0					1.00
1.00		L - REHAB THERAPY DEPT RECLAS	S	0, ,,0,0,,	5		1
2.00 SPECH PATHOLOGY 68.00 105.314 6.735 0 0 0 0 0 0 0 0 0	1.00			517, 107	33, 080		1.00
1.00 DRUGS CHARGED TO PATIENT RECLASS 1.00			l l				1
N - DRUGS CHARGED TO PATIENT RECLASS 1.00 0 1,827,325 0 0 1,827,325 0 0 1,827,325 0 0 1,827,325 0 0 1,827,325 0 0 1,827,325 0 0 1,827,325 0 0 1,827,325 0 0 1,827,325 0 0 1,827,325 0 0 0 1,827,325 0 0 0 0 0 0 0 0 0		0					
N - PTO ACCRUAL RECLASS N - PTO ACCRUAL RECLASS		M - DRUGS CHARGED TO PATIENT	RECLASS				1
1. 00 ADMI NI STRATI VE & GENERAL 5. 00 412, 047 0 2. 00 31, 154 0 2. 00 32, 00 4. 00 DELATION OF PLANT 7. 00 31, 154 0 2. 00 3. 00 4. 00 DI ETARY 10. 00 6, 237 0 4. 00 5. 00 MURSI NG ADMI NI STRATI ON 13. 00 15, 911 0 5. 00 6. 00 PHARMACY 15. 00 38, 826 0 6. 00 7. 00 ADULTS & PEDI ATRI CS 30. 00 210, 077 0 7. 00 ADULTS & PEDI ATRI CS 30. 00 210, 077 0 7. 00 ADULTS & PEDI ATRI CS 30. 00 210, 077 0 7. 00 7. 00 OPERATI NG ROOM 50. 00 68, 533 0 9. 00 0. 00	1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	1, 827, 325		1.00
1. 00 ADMINISTRATIVE & GENERAL 5. 00 412, 047 0 2. 00 OPERATION OF PLANT 7. 00 31, 154 0 3. 00 HOUSEKEEPING 9. 00 28, 999 0 4. 00 DI ETARY 10. 00 6, 237 0 4. 00 5. 00 NURSING ADMINISTRATION 13. 00 15, 911 0 5. 00 6. 00 PHARMACY 15. 00 38, 826 0 6. 00 7. 00 ADULTS & PEDIATRICS 30. 00 210, 077 0 7. 00 8. 00 NURSERY 43. 00 14, 033 0 9. 00 OPERATING ROOM 50. 00 68, 533 0 9. 00 OPERATING ROOM 50. 00 68, 533 0 9. 00 OPERATING ROOM 50. 00 68, 533 0 9. 00 OPERATING ROOM 50. 00 57, 214 0 10. 00 RADI OLOGY-DI AGNOSTI C 54. 00 125, 070 0 11. 00 RADI OLOGY-DI AGNOSTI C 54. 00 125, 070 0 11. 00 12. 00 RESPIRATORY THERAPY 65. 00 33, 115 0 12. 00 13. 00 PHYSI CAL THERAPY 66. 00 44, 639 0 12. 00 SPEECH PATHOLOGY 68. 00 7, 811 0 15. 00 15. 00 SPEECH PATHOLOGY 68. 00 7, 811 0 15. 00 16. 00 CLI NI C 90. 00 7, 413 0 15. 00 17. 00 DEMERGENCY 91. 00 188, 526 0 17. 00 18. 00 AMBULANCE SERVI CES 95. 00 10, 4825 0 19. 00 OPHYSI CI ANS' PRI VATE OFFICES 192. 00 1, 457, 130 0 OPHYSI CI ANS' PRI VATE OFFICES 192. 00 1, 457, 130 0 OCAFETERI A 10 CALL NI CALL		0		0	1, 827, 325		
2. 00 OPERATION OF PLANT 7. 00 31, 154 0 3. 00 HOUSEKEEPI NG 9. 00 28, 999 0 3. 00 4. 00 DI ETARY 10. 00 6, 237 0 4. 00 5. 00 NURSI NG ADMINISTRATION 13. 00 15, 911 0 5. 00 6. 00 PHARMACY 15. 00 38, 826 0 6. 00 7. 00 ADULTS & PEDIATRICS 30. 00 210, 077 0 7. 00 ADULTS & PEDIATRICS 30. 00 14, 033 0 7. 00 OPERATING ROOM 50. 00 68, 533 0 9. 00 OPERATING ROOM 50. 00 68, 533 0 9. 00 OPERATING ROOM 50. 00 68, 533 0 9. 00 OPERATING ROOM 50. 00 68, 533 0 9. 00 OPERATING ROOM 50. 00 57, 214 0 10. 00 11. 00 The Company of		N - PTO ACCRUAL RECLASS					
3. 00 HOUSEKEEPING 9. 00 28, 999 0 4. 00 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1.00						1.00
4.00 DI ETARY 10.00 6, 237 0 10.00 5.00 NURSI NG ADMI NI STRATI ON 13.00 15, 911 0 5.00 6.00 PHARMACY 15.00 38, 826 0 6.00 PHARMACY 15.00 38, 826 0 7.00 ADULTS & PEDI ATRI CS 30.00 210, 077 0 7.00 8.00 NURSERY 43.00 14, 033 0 8.00 9.00 OPERATI NG ROOM 50.00 68, 533 0 9.00 10.00 DELI VERY ROOM & LABOR ROOM 52.00 57, 214 0 10.00 11.00 RADI OLOGY-DI AGNOSTI C 54.00 125, 070 0 11.00 RESPI RATORY THERAPY 65.00 33, 115 0 122.00 RESPI RATORY THERAPY 66.00 44, 639 0 12.00 PHYSI CAL THERAPY 66.00 44, 639 0 13.00 PHYSI CAL THERAPY 67.00 38, 355 0 14.00 OCCUPATI ONAL THERAPY 67.00 38, 355 0 14.00 15.00 SPEECH PATHOLOGY 68.00 7, 811 0 15.00 SPEECH PATHOLOGY 68.00 7, 811 0 15.00 CLI NI C 90.00 7, 413 0 16.00 CLI NI C DI ETI CI AN RECLASS		•			-		1
5. 00 NURSI NG ADMI NI STRATI ON 13. 00 15, 911 0 5. 00 6. 00 PHARMACY 15. 00 38, 826 0 6. 00 7. 00 ADULTS & PEDI ATRI CS 30. 00 210, 077 0 7. 00 8. 00 NURSERY 43. 00 14, 033 0 8. 00 9. 00 OPERATI NG ROOM 50. 00 68, 533 0 9. 00 10. 00 DELI VERY ROOM & LABOR ROOM 52. 00 57, 214 0 10. 00 11. 00 RADI D LOGY-DI AGNOSTI C 54. 00 125, 070 0 11. 00 12. 00 RESPI RATORY THERAPY 65. 00 33, 115 0 12. 00 13. 00 PHYSI CAL THERAPY 66. 00 44, 639 0 13. 00 14. 00 OCCUPATI ONAL THERAPY 67. 00 38, 355 0 14. 00 15. 00 SPEECH PATHOLOGY 68. 00 7, 811 0 15. 00 16. 00 CLI NI C 90. 00 7, 413 0 16. 00 18. 00 AMBULANCE SERVI CES 95. 00 104, 825 0 19.		•					1
6.00 PHARMACY 15.00 38,826 0 6.00 7.00 ADULTS & PEDIATRICS 30.00 210,077 0 7.00 8.00 NURSERY 43.00 14,033 0 9.00 9.00 OPERATING ROOM 50.00 68,533 0 9.00 10.00 DELIVERY ROOM & LABOR ROOM 52.00 57,214 0 10.00 11.00 RADIOLOGY-DIAGNOSTIC 54.00 125,070 0 11.00 12.00 RESPIRATORY THERAPY 65.00 33,115 0 12.00 13.00 PHYSICAL THERAPY 66.00 44,639 0 13.00 14.00 OCCUPATIONAL THERAPY 67.00 38,355 0 14.00 15.00 SPEECH PATHOLOGY 68.00 7,811 0 15.00 16.00 CLINIC 90.00 7,413 0 16.00 17.00 EMERGENCY 91.00 188,526 0 17.00 18.00 AMBULANCE SERVICES 95.00 104,825 0 18.00 19.00 PHYSICIANS' PRIVATE OFFICES 192.00 1,235 0 19.00 0 - CLINIC DIETICIAN RECLASS		•			-		1
7. 00 ADULTS & PEDIATRICS 30. 00 210, 077 0 8. 00 NURSERY 43. 00 14, 033 0 9. 00 PERATI NG ROOM 50. 00 68, 533 0 9. 00 10. 00 DELI VERY ROOM & LABOR ROOM 52. 00 57, 214 0 11. 00 RADI OLOGY-DI AGNOSTI C 54. 00 125, 070 0 11. 00 12. 00 RESPIRATORY THERAPY 65. 00 33, 115 0 12. 00 13. 00 PHYSI CAL THERAPY 66. 00 44, 639 0 13. 00 14. 00 OCCUPATI ONAL THERAPY 67. 00 38, 355 0 14. 00 15. 00 SPEECH PATHOLOGY 68. 00 7, 811 0 15. 00 16. 00 CLI NI C 90. 00 7, 413 0 15. 00 17. 00 EMERGENCY 91. 00 188, 526 0 17. 00 18. 00 19. 00 PHYSI CI ANS' PRI VATE OFFI CES 95. 00 104, 825 0 19. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 1, 235 0 19. 00 0 - CLI NI C DI ETI CI AN RECLASS		1	l l				1
8.00 NURSERY 43.00 14,033 0 9.00 OPERATI NG ROOM 50.00 68,533 0 9.00 10.00 DELI VERY ROOM & LABOR ROOM 52.00 57, 214 0 10.00 11.00 RADI OLOGY-DI AGNOSTI C 54.00 125,070 0 11.00 RESPI RATORY THERAPY 65.00 33,115 0 12.00 13.00 PHYSI CAL THERAPY 66.00 44,639 0 12.00 OCCUPATI ONAL THERAPY 67.00 38,355 0 14.00 OCCUPATI ONAL THERAPY 67.00 38,355 0 14.00 SPEECH PATHOLOGY 68.00 7,811 0 15.00 SPEECH PATHOLOGY 68.00 7,811 0 15.00 16.00 CLI NI C 90.00 7,413 0 16.00 17.00 EMERGENCY 91.00 188,526 0 17.00 AMBULANCE SERVI CES 95.00 104,825 0 18.00 19.00 CAFETERI A 90.00 1,235 0 19.00 CAFETERI A 11.00 23,110 0 0 0 - CLI NI C DI ETI CI AN RECLASS					-		1
9. 00 OPERATI NG ROOM 50. 00 68, 533 0 10. 00 DELI VERY ROOM & LABOR ROOM 52. 00 57, 214 0 110. 00 111. 00 RADI OLOGY-DI AGNOSTI C 54. 00 125, 070 0 111. 00 RESPIRATORY THERAPY 65. 00 33, 115 0 12. 00 13. 00 PHYSI CAL THERAPY 66. 00 44, 639 0 13. 00 OCCUPATI ONAL THERAPY 67. 00 38, 355 0 14. 00 OCCUPATI ONAL THERAPY 68. 00 7, 811 0 15. 00 SPEECH PATHOLOGY 68. 00 7, 811 0 15. 00 16. 00 CLI NI C 90. 00 7, 413 0 16. 00 17. 00 EMERGENCY 91. 00 188, 526 0 17. 00 18. 00 PHYSI CI ANS' PRI VATE OFFI CES 95. 00 104, 825 0 18. 00 OCCUPATI ONAL THE OFFI CES 192. 00 1, 235 0 19. 00 O- CLI NI C 11. 00 23, 110 0 0 0 - CLI NI C DI ETI CI AN RECLASS					-		1
10. 00 DELI VERY ROOM & LABOR ROOM 52. 00 57, 214 0 10. 00		•			-		1
11. 00 RADI OLOGY-DI AGNOSTI C 54. 00 125, 070 0 12. 00 RESPI RATORY THERAPY 65. 00 33, 115 0 13. 00 PHYSI CAL THERAPY 66. 00 44, 639 0 14. 00 OCCUPATI ONAL THERAPY 67. 00 38, 355 0 15. 00 SPEECH PATHOLOGY 68. 00 7, 811 0 16. 00 CLINI C 90. 00 7, 413 0 15. 00 17. 00 EMERGENCY 91. 00 188, 526 0 17. 00 18. 00 AMBULANCE SERVI CES 95. 00 104, 825 0 18. 00 19. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 1, 235 0 19. 00 20. 00 CAFETERI A 11. 00 23, 110 0 0 - CLINIC DI ETI CI AN RECLASS		•			-		1
12. 00 RESPIRATORY THERAPY 65. 00 33, 115 0 12. 00 13. 00 PHYSI CAL THERAPY 66. 00 44, 639 0 13. 00 14. 00 OCCUPATI ONAL THERAPY 67. 00 38, 355 0 14. 00 15. 00 SPEECH PATHOLOGY 68. 00 7, 811 0 15. 00 16. 00 CLINIC 90. 00 7, 413 0 15. 00 17. 00 EMERGENCY 91. 00 188, 526 0 17. 00 18. 00 AMBULANCE SERVI CES 95. 00 104, 825 0 18. 00 19. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 1, 235 0 19. 00 0 - CLINIC DIETICIAN RECLASS		•			-		1
13. 00 PHYSI CAL THERAPY 66. 00 44, 639 0 14. 00 OCCUPATI ONAL THERAPY 67. 00 38, 355 0 15. 00 SPEECH PATHOLOGY 68. 00 7, 811 0 16. 00 CLI NI C 90. 00 7, 413 0 17. 00 EMERGENCY 91. 00 188, 526 0 18. 00 AMBULANCE SERVI CES 95. 00 104, 825 0 19. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 1, 235 0 20. 00 CAFETERI A 11. 00 23, 110 0 0 11. 00 23, 110 0 0 0 1, 457, 130 0		•	l l		-		1
14. 00 OCCUPATI ONAL THERAPY 67. 00 38, 355 0 15. 00 SPEECH PATHOLOGY 68. 00 7, 811 0 16. 00 CLINIC 90. 00 7, 413 0 17. 00 EMERGENCY 91. 00 188, 526 0 18. 00 AMBULANCE SERVICES 95. 00 104, 825 0 19. 00 PHYSI CI ANS' PRI VATE OFFICES 192. 00 1, 235 0 20. 00 CAFETERIA 11. 00 23, 110 0 0 1, 457, 130 0		•			-		1
15. 00 SPEECH PATHOLOGY 68. 00 7, 811 0 15. 00 16. 00 CLINIC 90. 00 7, 413 0 16. 00 17. 00 EMERGENCY 91. 00 188, 526 0 17. 00 18. 00 AMBULANCE SERVICES 95. 00 104, 825 0 19. 00 PHYSICIANS' PRIVATE OFFICES 192. 00 1, 235 0 20. 00 CAFETERIA 0 11. 00 23, 110 0 0 - CLINIC DIETICIAN RECLASS 0 0 0 - CLINIC DIETICIAN RECLASS		•			0		1
16. 00 CLINIC 90. 00 7, 413 0 16. 00 17. 00 EMERGENCY 91. 00 188, 526 0 17. 00 18. 00 AMBULANCE SERVICES 95. 00 18. 00 19. 00 PHYSICIANS' PRIVATE OFFICES 192. 00 1, 235 0 19. 00 CAFETERIA 1. 00 23, 110 0 0 - CLINIC DIETICIAN RECLASS		•			0		
17. 00 EMERGENCY 91. 00 188, 526 0 17. 00 18. 00 18. 00 19.		•			0		1
18. 00 AMBULANCE SERVICES 95. 00 104, 825 0 18. 00 19.		•			0		1
19. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 1, 235 0 20. 00 CAFETERI A 11. 00 23, 110 0 20. 00 0 - CLI NI C DI ETI CI AN RECLASS		•			-		
20. 00 CAFETERIA 0 11. 00 23, 110 0 20. 00 0 - CLINIC DIETICIAN RECLASS					-		
0 1, 457, 130 0 0 - CLINIC DIETICIAN RECLASS					-		1
O - CLINIC DIETICIAN RECLASS	20.00	0	— — ····				20.00
		O - CLINIC DIETICIAN RECLASS		,,	5		1
0 7,464 0	1.00		90.00	9, 464	0		1.00
			+		o		
		·		·	·		

Heal th Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 RECLASSIFICATIONS Provider CCN: 15-0101 Period: From 01/01/2016 Worksheet A-6

					To 12/31/2016 Date/Time Pr 3/30/2017 9:	epared: 09 am
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4.00	5. 00		
	P - CORPORATE DIRECT ALLOC RE	CLASS				
1.00	FOUNDATI ON	194. 03	27, 198	222, 339		1. 00
2.00	COMMUNITY & VOLUNTEER	194.04	2, 639	21, 569		2. 00
	SERVICES					
	0		29, 837	243, 908		
	Q - OCCUPATIONAL HEALTH RECLA	ISS				
1.00	OCCUPATI ONAL HEALTH	194.00	0	59, 410		1. 00
2.00	ELECTROCARDI OLOGY	69.00	0	10, 000		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	O	0		9. 00
10.00		0.00	O	0		10.00
	0 — — — — —			69, 410		
	R - IMPLANTABLE MEDICAL SUPPL	.I ES				1
1.00	IMPL. DEV. CHARGED TO	72.00	0	322, 716		1. 00
	PATI ENTS					
	0			322, 716		
	S - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	97, 000		1. 00
	TOTALS			97, 000		
500.00	Grand Total: Increases		7, 286, 597	4, 594, 518		500.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0101

						3/30/	2017 9:09 am
		Decreases					
	Cost Center	Li ne #	Salary	Other 0.00	Wkst. A-7 Ref.		
	6. 00 A - CAFETERI A RECLASS	7. 00	8. 00	9. 00	10. 00		
1. 00	DI ETARY	10.00	311, 573	218, 332	. 0		1.00
	0		311, 573	218, 332			
	B - OB RECLASS						
1.00	ADULTS & PEDIATRICS	30. 00	880, 793	178, 336			1. 00
2.00			0	0			2. 00
	E - BUILDING AND EQUIP LEASE		880, 793	178, 336			
1. 00	ADMINISTRATIVE & GENERAL	5. 00	O	54, 122	10		1. 00
2. 00	OPERATION OF PLANT	7. 00	o	97, 158			2. 00
3.00	RESPI RATORY THERAPY	65.00	О	69, 834	. 0		3. 00
4.00	PHYSI CAL THERAPY	66.00	0	253, 749			4. 00
5. 00	ADMINISTRATIVE & GENERAL	5. 00	0	44, 372			5. 00
6.00	OPERATION OF PLANT	7.00	0	1, 235			6. 00
7. 00 8. 00	HOUSEKEEPI NG DI ETARY	9. 00 10. 00	0	1, 002 1, 422	1		7. 00 8. 00
9. 00	PHARMACY	15. 00	0	5, 519	1		9. 00
10. 00	ADULTS & PEDIATRICS	30.00	Ö	6, 206			10.00
11. 00	OPERATING ROOM	50.00	o	1, 898	1		11. 00
12.00	RADI OLOGY-DI AGNOSTI C	54.00	o	2, 779			12. 00
13.00	RESPI RATORY THERAPY	65.00	0	2, 363	0		13. 00
14. 00	PHYSI CAL THERAPY	66.00	0	3, 615			14. 00
15. 00	EMERGENCY	91.00	0	3, 399	1		15. 00
16.00	AMBULANCE SERVICES	95.00	0	1, 412			16.00
17. 00 18. 00	PHYSICIANS' PRIVATE OFFICES COMMUNITY & VOLUNTEER	192. 00 194. 04	0	2, 615 38			17. 00 18. 00
16.00	SERVICES	194.04	٩	30			16.00
	0	+		552, 738			
	G - INSURANCE RECLASS		<u>'</u>		'		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	83, 915			1. 00
2.00		0.00	•	0	12		2. 00
	0		0	83, 915			
1 00	H - DEPRECIATION RECLASS CAP REL COSTS-BLDG & FIXT	1.00	O	959, 696	9		1.00
1. 00	CAP REL COSTS-BLDG & FIXT		_ — — }	95 <u>9, 6</u> 96			1.00
	J - TAXES RECLASS		<u> </u>	737, 070	1		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 327	13		1. 00
	0			1, 327			
	K - SALARY RECLASS						
1. 00	ADMI NI STRATI VE & GENERAL		0	<u>3, 975, 379</u>			1. 00
	L - REHAB THERAPY DEPT RECLAS	<u> </u>	0	3, 975, 379			
1. 00	PHYSI CAL THERAPY	66.00	622, 421	39, 815	0		1.00
2. 00		0.00	0	07, 01.0	1		2. 00
	0		622, 421	39, 815			
	M - DRUGS CHARGED TO PATIENT						
1. 00	PHARMACY	1500	0	<u>1, 827, 325</u> 1, 827, 325			1.00
	N - PTO ACCRUAL RECLASS		U _I	1,027,320			
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1, 457, 130	C	0		1. 00
2.00		0.00	0	C			2. 00
3.00		0.00	o	C	0		3. 00
4.00		0.00	0	C			4. 00
5. 00		0.00	0	C			5. 00
6.00		0.00	0	0			6.00
7. 00 8. 00		0. 00 0. 00	0	0			7. 00 8. 00
9. 00		0.00	0	0			9. 00
10. 00		0.00	Ö	Ö			10.00
11. 00		0.00	Ö	C	1		11. 00
12.00		0.00	o	C	o		12. 00
13.00		0.00	O	C	0		13. 00
14. 00		0. 00	0	C			14. 00
15. 00		0.00	0	0	1		15.00
16.00		0.00	0	0			16.00
17. 00 18. 00	•	0. 00 0. 00	0	0	- 1		17. 00 18. 00
19. 00		0.00	o	0			19. 00
20. 00		0.00	ŏl	Ö	1		20. 00
	0		1, 457, 130				
	O - CLINIC DIETICIAN RECLASS	-		•			
1.00	DI ETARY	<u>10.</u> 00	9, 464	0	0		1. 00
	lo		9, 464	C	y I		

Health Financial Systems RECLASSIFICATIONS WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0101

Peri od: Worksheet A-6 From 01/01/2016 To 12/31/2016 Date/Time Prepared:

					'	3/30/2017 9:	
		Decreases		<u> </u>			
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
<u>[</u>]	P - CORPORATE DIRECT ALLOC RE	CLASS					
	ADMINISTRATIVE & GENERAL	5. 00	29, 837	243, 908	0		1. 00
2.00		0.00	0_	0	0		2. 00
Į(0		29, 837	243, 908			
[0	Q - OCCUPATIONAL HEALTH RECLA	SS					
	RADI OLOGY-DI AGNOSTI C	54.00	0	28, 730			1. 00
2. 00 I	LABORATORY	60.00	0	453			2. 00
3.00	PHYSI CAL THERAPY	66.00	0	2, 744	0		3. 00
4.00	OCCUPATI ONAL THERAPY	67.00	0	8, 247	0		4. 00
5.00	ELECTROCARDI OLOGY	69.00	0	306	0		5. 00
	MEDICAL SUPPLIES CHARGED TO	71.00	0	191	0		6. 00
	PATI ENT						
7.00	DRUGS CHARGED TO PATIENTS	73.00	0	1, 805	0		7. 00
8.00	EMERGENCY	91.00	0	26, 761	0		8. 00
9.00	OPERATING ROOM	50.00	0	159	0		9. 00
10. 00 E	RESPIRATORY_THERAPY	<u>65.</u> 00	0_	14	0		10.00
Į(0		0	69, 410			
<u>[</u>	R - IMPLANTABLE MEDICAL SUPPĻ	I ES					
	MEDICAL SUPPLIES CHARGED TO	71.00	0	322, 716	0		1. 00
Į.	PATI ENT	↓					
Į(0		0	322, 716			
	S - INTEREST EXPENSE						
	OTHER CAP REL COSTS	3.00	0_	9 <u>7, 0</u> 00			1. 00
	TOTALS		0	97, 000			
500.00	Grand Total: Decreases		3, 311, 218	8, 569, 897			500.00

					o 12/31/2016	Date/Time Prep 3/30/2017 9:09	pared:
				Acqui si ti ons		373072017 7.0	7 CIIII
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
1.00	Land	260, 976	0	(0	0	1.00
2.00	Land Improvements	279, 913	2, 189, 539	(2, 189, 539	0	2. 00
3.00	Buildings and Fixtures	1, 119, 257	13, 473, 808	(13, 473, 808	5, 000	3. 00
4.00	Building Improvements	48, 824	0	(0	0	4.00
5.00	Fixed Equipment	618, 063	5, 645, 898	(5, 645, 898		5. 00
6.00	Movable Equipment	10, 783, 840	4, 492, 587	(4, 492, 587	722, 813	6. 00
7.00	HIT designated Assets	3, 410, 808	0	(0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	16, 521, 681	25, 801, 832	(25, 801, 832		8. 00
9.00	Reconciling Items	-3, 314, 772	1, 363, 894	(1, 363, 894	0	9. 00
10.00	Total (line 8 minus line 9)	19, 836, 453	24, 437, 938	(24, 437, 938	727, 813	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		al				
1.00	Land	260, 976	0				1. 00
2.00	Land Improvements	2, 469, 452	44, 862				2. 00
3.00	Buildings and Fixtures	14, 588, 065	237, 338				3. 00
4.00	Building Improvements	48, 824	48, 824				4. 00
5.00	Fi xed Equipment	6, 263, 961	53, 545				5. 00
6.00	Movable Equipment	14, 553, 614	5, 792, 193				6. 00
7.00	HIT designated Assets	3, 410, 808	0				7. 00
8.00	Subtotal (sum of lines 1-7)	41, 595, 700	6, 176, 762				8. 00
9.00	Reconciling Items	-1, 950, 878	0				9. 00
10. 00	Total (line 8 minus line 9)	43, 546, 578	6, 176, 762				10. 00

Heal th	Financial Systems	WHITLEY MEMORI	IAI HOSPITAI		In lie	u of Form CMS-2	2552-10		
	CILIATION OF CAPITAL COSTS CENTERS	WITTEET WEWORT	Provider CO	CN: 15-0101	Peri od: From 01/01/2016 To 12/31/2016	Worksheet A-7 Part II	pared:		
			SUMMARY OF CAPITAL						
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)				
		9. 00	10.00	11.00	12.00	13. 00			
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	IN 2, LINES 1 a	nd 2					
1.00	CAP REL COSTS-BLDG & FIXT	3, 490, 268	0		0 0	0	1. 00		
2.00	CAP REL COSTS-MVBLE EQUIP	722, 309	31, 077		0 0	0	2.00		
3.00	Total (sum of lines 1-2)	4, 212, 577	31, 077		0 0	0	3. 00		
		SUMMARY 0	F CAPITAL						
	Cost Center Description	Other	Total (1) (sum						
	·	Capi tal -Relate	of cols. 9						
		d Costs (see	through 14)						
		instructions)							
		14. 00	15. 00						
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	IN 2, LINES 1 a	nd 2					
1.00	CAP REL COSTS-BLDG & FIXT	0	3, 490, 268				1. 00		
2.00	CAP REL COSTS-MVBLE EQUIP	0	753, 386				2. 00		
	1	1 .		I .					

0 0 0

3, 490, 268 753, 386 4, 243, 654

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)

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0101 Period: From 01/01/2016 To 12/31/2016 COMPUTATION OF RATIOS Cost Center Description Cost Center Description Cost Center Description Reconciliation of CAPITAL Costs Center A-7 Part III Date/Time Prepare 3/30/2017 9:09 and AlloCation of Other Capital Cost Center Description Gross Assets Capitalized Cost Center Description Co	
Cost Center Description Cost Center Descripti	
Cost Center Description Gross Assets Capitalized Gross Assets Ratio (see Insurance Leases for Ratio instructions)	
Leases for Ratio instructions)	
1.00 2.00 3.00 4.00 5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS	
	. 00
	. 00
	. 00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL	
Cost Center Description Taxes Other Total (sum of Depreciation Lease	
Capi tal -Rel ate col s. 5	
d Costs through 7)	
6.00 7.00 8.00 9.00 10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS	
	. 00
	. 00
	. 00
SUMMARY OF CAPITAL	
Cost Center Description Interest Insurance (see Taxes (see Other Total (2) (sum	
instructions) instructions) Capital -Relate of cols. 9	
d Costs (see through 14)	
i nstructi ons)	
11.00 12.00 13.00 14.00 15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS	
	. 00
	. 00
3.00 Total (sum of lines 1-2) 0 83,915 0 97,000 2,835,321 3.	. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 WHITLEY MEMORIAL HOSPITAL Provider CCN: 15-0101 Peri od: Worksheet A-8 From 01/01/2016 To 12/31/2016 Date/Time Prepared:

					To 12/31/2016	Date/Time Prep 3/30/2017 9:09	
				Expense Classification or	Worksheet A	373072017 7.03	7 alli
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3. 00	4. 00	5. 00	
1. 00	Investment income - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	o	2. 00
2.00	COSTS-MVBLE EQUIP (chapter 2)		0	CAI REE COSTS-WVBEE EQUIT	2.00	l I	2.00
3.00	Investment income - other		0		0.00	o	3. 00
	(chapter 2)						
4. 00	Trade, quantity, and time		0		0.00	0	4. 00
5. 00	di scounts (chapter 8) Refunds and rebates of		0		0.00	o	5. 00
0.00	expenses (chapter 8)		· ·		0.00	ı	0.00
6.00	Rental of provider space by		0		0.00	o	6. 00
	suppliers (chapter 8)						
7. 00	Tel ephone servi ces (pay		0		0.00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service	A	-294	OPERATION OF PLANT	7.00	o	8. 00
	(chapter 21)						
9.00	Parking Lot (chapter 21)		0		0.00		
10. 00	Provi der-based physician	A-8-2	-36, 953			0	10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0.00	o	11. 00
	(chapter 23)		3		0.00		
12.00	Related organization	A-8-1	-4, 117, 379			o	12. 00
	transactions (chapter 10)						
13.00	Laundry and linen service	, n	10.225	CAFETERIA	0.00	l .	
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		- 18, 225 0	CAFETERI A	11. 00 0. 00	l	14. 00 15. 00
13.00	and others		0		0.00	l I	13.00
16.00	Sale of medical and surgical		0		0.00	o	16. 00
	supplies to other than						
17. 00	patients Sale of drugs to other than		0		0.00	o	17. 00
17.00	patients		0		0.00	l "	17.00
18. 00	Sale of medical records and		0		0.00	o	18. 00
	abstracts						
19. 00	Nursing school (tuition, fees,		0		0.00	0	19. 00
20. 00	books, etc.) Vending machines		0		0.00	o	20. 00
21.00	Income from imposition of		0		0.00		21. 00
	interest, finance or penalty						
	charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of						
0.4	limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
	limitation (chapter 14)						
25. 00	Utilization review -		0	*** Cost Center Deleted ***	114.00		25. 00
	physicians' compensation						
04 00	(chapter 21)		_	045 551 00070 5150 5 5117		_	0, 05
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	o	27. 00
. 50	COSTS-MVBLE EQUIP		9			l I	
28. 00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19. 00	l :	28. 00
29. 00	Physicians' assistant		0		0.00	1	29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)						
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0.00	o	32. 00
	Depreciation and Interest		9		3.00	l I	==. 55
22 00	MI SCELLANEOUS REVENUE	В	-3, 962	ADMINISTRATIVE & GENERAL	5. 00	o	33. 00
	TELEMETRY ADJUSTMENT	l A		ADULTS & PEDIATRICS	30.00	,	33. 01

From 01/01/2016 | WUI NOTICE LA-0

To 12/31/2016 | Date/Time Prepared:

				To	o 12/31/2016	Date/Time Pre 3/30/2017 9:0	
				Expense Classification on	Worksheet A	373072017 7.0	7 CIIII
				To/From Which the Amount is			
				Top 1 1 dim min dir tild 7 mildare 1 d	to bo haj dotod		
	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	
35. 00	POSTURE ASSESSMENTS	В	-71, 193	PHYSI CAL THERAPY	66.00	0	35. 00
36.00	ANESTHESIA PROFESSIONAL FEES	A	-637, 565	ANESTHESI OLOGY	53.00	0	36. 00
38.00	NON-PATIENT LAB REV.	В	-3, 937	RESPIRATORY THERAPY	65.00	0	38. 00
39.00	TELEVISION OFFSET	A	-45, 406	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, 000	ADMINISTRATIVE & GENERAL	5. 00	0	41.00
42.00	MEALS ON WHEELS	A	-20, 801	DI ETARY	10.00	0	42. 00
43.00	VI SI TOR MEALS	A	-33, 791	CAFETERI A	11. 00	0	43.00
44.00	PHARMACY SALES	A	-920, 277	PHARMACY	15. 00	0	44.00
45.00	COMMUNITY HEALTH & VOLUNTEER	A	-10, 835	ADMINISTRATIVE & GENERAL	5. 00	0	45. 00
	SV						
46.00	SELF INSURANCE	A	-2, 224, 226	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	46. 00
48.00	LOBBY EXPENSE	A	-3, 752	ADMINISTRATIVE & GENERAL	5. 00	0	48. 00
48. 01	INTERUNIT RENT EXPENSE	A	-69, 834	RESPIRATORY THERAPY	65.00	0	48. 01
48. 02	INTERUNIT RENT EXPENSE	A	-253, 749	PHYSI CAL THERAPY	66.00	0	48. 02
48. 03	INTERUNIT RENT EXPENSE	A	-54, 122	ADMINISTRATIVE & GENERAL	5. 00	0	48. 03
48. 04	INTERUNIT RENT EXPENSE	A	-97, 158	OPERATION OF PLANT	7. 00	0	48. 04
49.00	OPERATING INTEREST	A	-7, 518	PHARMACY	15. 00	0	49. 00
49. 02	RENT EXPENSE - PHYSICIANS'	A	-318, 216	PHYSICIANS' PRIVATE OFFICES	192. 00	0	49. 02
	CLINIC						
49. 07			0		0.00	0	49. 07
49. 10			0		0.00	0	49. 10
50.00	TOTAL (sum of lines 1 thru 49)		-8, 951, 007	'			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.

			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	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:	-		

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

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

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

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

Worksheet A-8, column 2,

line 12.

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- 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		WHITLEY MEMORIAL	HOSPI TAL		In Lie	u of Form CN	IS-2552-10
STATEME OFFI CE		SERVICES FROM	RELATED ORGA	NIZATIONS AND HOME	Provider CCN	: 15-0101	Peri od: From 01/01/2016 To 12/31/2016	Worksheet /	
							10 12/31/2010	3/30/2017	
	Net	Wkst. A-7 Ref.							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6. 00	7. 00							
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRE	ED AS A RESULT OF TRA	ANSACTIONS WIT	H RELATED (ORGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:							
1.00	-2, 096, 580	9							1. 00
2.00	-4, 674, 018	0							2.00
3.00	2, 653, 219	0							3. 00
4.00	0	0							4.00
5.00	-4, 117, 379								5. 00
* The	amounts on lin	es 1-4 (and sub	scripts as a	ppropriate) are tran	sferred in det	tail to Wor	ksheet A, column	6, lines as	
				egative amounts decr					
has not	heen nosted to	o Worksheet A	columns 1 an	d/or 2 the amount a	Llowable shoul	d ha indic	ated in column 4	of this nar	t

Related Organization(s)
and/or Home Office

Type of Business

6.00

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

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

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

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0101

								10 12/31/2016	3/30/2017 9:0	
	Wkst. A Line #		Cost	Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
				I denti fi er	Remuneration	Component	Component		ider Component	
									Hours	
	1. 00			2. 00	3.00	4.00	5. 00	6. 00	7. 00	
1.00	91. 00	DR.	Α		60, 406	C	60, 406	171, 400	362	1. 00
2.00	53. 00	DR.	В		24, 000	C	24, 000	200, 300	183	2. 00
3.00	0.00)			0	C	0	0	0	3. 00
4.00	0. 00				0	C	0	0	0	4. 00
5.00	0.00				0	C	0	0	0	5. 00
6.00	0.00				0	C	0	0	0	6. 00
7.00	0. 00				0	C	0	0	0	7. 00
8.00	0. 00)			0	C	0	0	0	8. 00
9.00	0.00				0	C	0	0	0	9. 00
10.00	0.00				0	C	0	0	0	
200.00					84, 406		84, 406)	545	
	Wkst. A Line #		Cost	Center/Physi ci an	Unadjusted RCE		Cost of	Provi der	Physician Cost	
				l denti fi er	Limit		Memberships &	Component	of Malpractice	
						Limit	Conti nui ng	Share of col.	Insurance	
							Educati on	12	44.00	
1 00	1.00	-		2. 00	8.00	9. 00	12. 00	13. 00	14.00	1.00
1.00	91.00				29, 830					1
2.00	53. 00	4	В		17, 623	1		-	0	
3.00	0.00				0	1	_		0	
4.00	0.00	1			0	C			0	
5.00	0. 00 0. 00				0				0	
6.00	0.00				0				0	
7. 00 8. 00	0.00				0					
9. 00	0.00				0					
10. 00	0.00									
200.00	0.00	1			47, 453	2, 373	3		1	
	Wkst. A Line #		Cost	Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	WKSt. A LITTE #		COST	I denti fi er	Component	Limit	Di sal I owance	Auj us tillerit		
				ruentiffei	Share of col.	LIIIII	Di Sai i Owance			
					14					
	1. 00			2.00	15. 00	16. 00	17. 00	18. 00		
1. 00	91. 00	DR.	Α		0					1. 00
2. 00	53. 00				0	1				2. 00
3.00	0.00				0			1	1	3. 00
4.00	0. 00	,			0		0	0		4. 00
5. 00	0. 00)			0		0	0		5. 00
6. 00	0. 00				0					6. 00
7. 00	0. 00				1 0	l		0		7. 00
8. 00	0. 00				1 0	l d		0		8. 00
9. 00	0. 00				0		0	0		9. 00
10.00	0.00				0	d	0	0		10.00
200.00		1			0	47, 453	36, 953	36, 953	:	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 01/01/2016 Part I Date/Time Prepared: 12/31/2016 3/30/2017 9:09 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT All ocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1,043,421 1, 043, 421 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 1, 791, 900 1, 791, 900 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 3, 165, 803 3, 165, 803 4.00 00500 ADMINISTRATIVE & GENERAL 16, 256, 337 5 00 14, 454, 887 318, 584 547, 109 935, 757 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 1, 328, 047 78, 103 134, 129 70, 754 1, 611, 033 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 213, 377 3, 649 223, 293 8.00 6. 267 00900 HOUSEKEEPI NG 9 00 590, 322 3.050 5. 238 65.861 664, 471 9 00 10.00 01000 DI ETARY 127, 023 13,076 22, 455 14, 165 176, 719 10.00 01100 CAFETERI A 500, 999 14, 745 25, 323 593, 552 11.00 52, 485 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 270, 949 13.00 232, 397 889 1.526 36, 137 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 10, 557 18, 131 28, 688 14.00 01500 PHARMACY 15, 714 15.00 768, 425 9, 150 88, 178 881, 467 15.00 01600 MEDICAL RECORDS & LIBRARY 3, 252 5, 585 8, 837 16.00 0 0 16,00 17 00 01700 SOCIAL SERVICE 0 0 0 Ω 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 19.00 0 20.00 02000 NURSING SCHOOL 0 0 0 0 0 20.00 0 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 21.00 0 0 21.00 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 O 22.00 C 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 309, 885 3, 018, 265 30.00 142.821 245, 272 320, 287 43.00 04300 NURSERY 241, 537 0 31, 871 273, 408 43.00 04400 SKILLED NURSING FACILITY 44.00 0 44.00 ANCILLARY SERVICE COST CENTERS <u>1, 796, 7</u>76 50.00 05000 OPERATING ROOM 1, 409, 356 85. 294 146, 479 155, 647 50.00 05200 DELIVERY ROOM & LABOR ROOM 969, 606 1, 099, 546 52.00 129, 940 52.00 53.00 05300 ANESTHESI OLOGY 17, 681 17, 681 53.00 05400 RADI OLOGY-DI AGNOSTI C 2.397.394 104, 551 179, 548 2.965.541 54 00 284, 048 54 00 60.00 06000 LABORATORY 2, 574, 528 31, 315 53, 779 2, 659, 622 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 62.30 06500 RESPIRATORY THERAPY 488, 538 15, 796 27, 127 75, 207 606, 668 65.00 65.00 06600 PHYSI CAL THERAPY 101, 379 686, 499 66.00 357, 866 83, 631 143, 623 66.00 67.00 06700 OCCUPATIONAL THERAPY 580, 295 C 87, 108 667, 403 67.00 68.00 06800 SPEECH PATHOLOGY 119,860 0 17, 740 137,600 68.00 9, 694 69 00 06900 ELECTROCARDI OLOGY 0 9 694 Ω 69 00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 628, 636 0 30 628, 666 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 322, 716 0 322, 716 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 1,825,520 0 1, 825, 520 73.00 07697 CARDIAC REHABILITATION 0 76 97 76.97 Ωl

76. 98 07	7698 HYPERBARIC OXYGEN THERAPY	O	0	0	O	0	76. 98	
76. 99 07	7699 LI THOTRI PSY	0	0	0	0	0	76. 99	
OU	OUTPATIENT SERVICE COST CENTERS							
90.00 09	POOO CLI NI C	125, 773	24, 151	41, 476	16, 837	208, 237	90.00	
90. 01 09	2001 INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0	90. 01	
	P100 EMERGENCY	5, 593, 481	96, 949	166, 494	428, 162	6, 285, 086	91.00	
	2200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00	
	HER REIMBURSABLE COST CENTERS							
	9500 AMBULANCE SERVICES	1, 778, 184	0	0	238, 069	2, 016, 253	95.00	
SP	PECIAL PURPOSE COST CENTERS							
118. 00	SUBTOTALS (SUM OF LINES 1-117)	45, 967, 151	1, 039, 563	1, 785, 275	3, 149, 662	45, 940, 527 1	18. 00	
	NREIMBURSABLE COST CENTERS							
4	2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	21, 326	1, 939	3, 330	0	26, 595 1		
- 1	P200 PHYSICIANS' PRIVATE OFFICES	600, 403	0	0	2, 804	603, 207 1		
	7950 OCCUPATI ONAL HEALTH	0	0	0	0		94. 00	
4	7951 PAIN CLINIC	0	0	0	0		94. 01	
	7952 OAK POINTE	0	0	0	0		94. 02	
194. 03 07	7953 FOUNDATI ON	344, 546	0	0	4, 266	348, 812 1		
4	7954 COMMUNITY & VOLUNTEER SERVICES	310, 520	1, 919	3, 295	9, 071	324, 805 1		
194. 05 07	7955 VACANT SPACE	0	0	0	0	•	94. 05	
200.00	Cross Foot Adjustments					0 2	00.00	
201.00	Negative Cost Centers		0	0	0	0 2	01.00	
202.00	TOTAL (sum lines 118-201)	47, 243, 946	1, 043, 421	1, 791, 900	3, 165, 803	47, 243, 946 2	02.00	

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2016 | Part I | To 12/31/2016 | Date/Time Prepared: | 3/30/2017 9:09 am

						3/30/2017 9:0	9 am
	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	16, 256, 337					5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	0				6. 00
7. 00	00700 OPERATION OF PLANT	845, 161	l o	2, 456, 194			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	117, 141	0	13, 859			8. 00
9.00	00900 HOUSEKEEPI NG	348, 587	0	11, 584		1, 024, 642	9. 00
10.00	01000 DI ETARY	92, 708	0	49, 659		20, 933	10.00
11. 00	01100 CAFETERI A	311, 382	0	56, 000	0	23, 606	11. 00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12. 00
13.00	01300 NURSING ADMINISTRATION	142, 142	0	3, 375	0	1, 423	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	15, 050	0	40, 095	0	16, 901	14. 00
15.00	01500 PHARMACY	462, 425	0	34, 751	0	14, 649	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	4, 636	0	12, 351	0	5, 206	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20.00	02000 NURSI NG SCHOOL	0	0	0	0	0	20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	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
	I NPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	1, 583, 406	i e			228, 645	1
43. 00	04300 NURSERY	143, 432	0		20, 706		43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
	ANCILLARY SERVICE COST CENTERS	1 040 400				10/ 5/0	
50.00	05000 OPERATING ROOM	942, 603	0	323, 933		1	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	576, 831	0	0	75, 999	l	52.00
53. 00	05300 ANESTHESI OLOGY	9, 276	0	0 7 0 7	50.005	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 555, 747	0	397, 066		l	54.00
60.00	06000 LABORATORY	1, 395, 259	0	118, 931	310	50, 133	60.00
62. 30 65. 00	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY	210 242	0	59, 989	1, 974	0	62. 30 65. 00
66.00	06600 PHYSI CAL THERAPY	318, 263 360, 143	0	317, 617			66.00
67. 00	06700 OCCUPATIONAL THERAPY	350, 125	0	317,017	11, 426 12, 178		67.00
68. 00	06800 SPEECH PATHOLOGY	72, 186			3, 160	l	68. 00
69. 00	06900 ELECTROCARDI OLOGY	5, 086	0		3, 100		69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	329, 803			0	0	71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	169, 299			0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	957, 682			0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	757,002			0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY			0	0	Ö	76. 98
76. 99		0		0	0	o o	76. 99
70. 77	OUTPATIENT SERVICE COST CENTERS				<u> </u>		70.77
90. 00	09000 CLI NI C	109, 243	0	91, 723	2, 759	38, 664	90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0	ł .	0	0	0	90. 01
	09100 EMERGENCY	3, 297, 195	Ö	368, 196	79, 073		
92. 00		-,,	_		,	1	92.00
	OTHER REIMBURSABLE COST CENTERS	1	l				
95. 00	09500 AMBULANCE SERVI CES	1, 057, 742	0	0	15, 620	0	95. 00
	SPECIAL PURPOSE COST CENTERS	, , , , ,					
118.00	SUBTOTALS (SUM OF LINES 1-117)	15, 572, 553	0	2, 441, 542	354, 293	1, 018, 466	118. 00
	NONREI MBURSABLE COST CENTERS		•		<u> </u>		
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	13, 952	0	7, 364	0	3, 104	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	316, 447	0	0	0	0	192. 00
194.00	07950 OCCUPATIONAL HEALTH	0	0	0	0	0	194. 00
194.0	1 07951 PAIN CLINIC	0	0	0	0	0	194. 01
194. 02	2 07952 OAK POINTE	0	0	0	0	0	194. 02
194.03	3 07953 FOUNDATI ON	182, 990	0	0	O	0	194. 03
194.0	4 07954 COMMUNITY & VOLUNTEER SERVICES	170, 395	0	7, 288	0	3, 072	194. 04
	07955 VACANT SPACE	0	0	0	0	0	194. 05
200.00	, ,					l	200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	16, 256, 337	0	2, 456, 194	354, 293	1, 024, 642	202. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet B	
From 01/01/2016	Part	
To 12/31/2016	Date/Time Prepared:	3/30/2017 9:09 am

			'	0 12/31/2010	3/30/2017 9:0	
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF		CENTRAL	
			PERSONNEL	ADMI NI STRATI ON	SERVICES &	
	10.00	11. 00	12.00	13.00	SUPPLY 14. 00	
GENERAL SERVI CE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
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 MAINTENANCE & REPAIRS						6. 00
7. 00 00700 0PERATI ON OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG	240.010					9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	340, 019	004 E40				10. 00 11. 00
12. 00 01200 MAI NTENANCE OF PERSONNEL		984, 540	0			12.00
13. 00 01300 NURSI NG ADMINI STRATI ON		14, 242	0	432, 131		13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY		14, 242	0	432, 131	100, 734	14. 00
15. 00 01500 PHARMACY	o	26, 646	Ö	o	5, 379	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	o	0	0	0	0	16. 00
17. 00 01700 SOCIAL SERVICE	o	0	0	0	0	17. 00
19.00 01900 NONPHYSICIAN ANESTHETISTS	o	0	0	0	0	19. 00
20. 00 02000 NURSI NG SCH00L	0	0	0	0	0	20. 00
21.00 02100 1 &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22.00 02200 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
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	240.010	144 250		120 074	1 /74	1 20 00
30. 00 03000 ADULTS & PEDI ATRI CS 43. 00 04300 NURSERY	340, 019	144, 258			1, 674	30.00
43. 00 04300 NURSERY 44. 00 04400 SKI LLED NURSI NG FACI LI TY	0	12, 864 0	0		1, 733 0	43. 00 44. 00
ANCI LLARY SERVI CE COST CENTERS	ı o	0		U U	0	44.00
50. 00 05000 OPERATING ROOM	0	73. 967	0	67, 155	15, 028	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	o	50, 996			6, 337	52.00
53. 00 05300 ANESTHESI OLOGY	o	0	0	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	142, 880	0	0	3, 302	54.00
60. 00 06000 LABORATORY	o	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	38, 132	0	0	3, 621	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	77, 642		0	711	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	21, 593		0	611	67.00
68. 00 06800 SPEECH PATHOLOGY	0	5, 513	0	0	124	68. 00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	0	22 447	69. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0	0	0	32, 667 15, 185	ı
73. 00 07300 DRUGS CHARGED TO PATIENTS		0	0	0	15, 105	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON		0	0	Ö	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	o	0	Ö	O	0	76. 98
76. 99 07699 LI THOTRI PSY	o	0	0	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	7, 810	0	0	691	90. 00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0			0	
91. 00 09100 EMERGENCY	0	206, 740	0	187, 702	6, 485	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS		140, 202			F 007	05 00
95. 00 O9500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	148, 393	0	0	5, 927	95. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	340, 019	971, 676	0	432, 131	00 175	118. 00
NONREI MBURSABLE COST CENTERS	340,017	771,070		432, 131	77, 473	1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	1. 085	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	o	3, 216				192. 00
194. 00 07950 OCCUPATI ONAL HEALTH	o	0		0	0	194. 00
194. 01 07951 PAIN CLINIC	O	0	0	0	0	194. 01
194. 02 07952 OAK POINTE	0	0	0	0		194. 02
194. 03 07953 FOUNDATI ON	0	4, 594		0		194. 03
194. 04 07954 COMMUNITY & VOLUNTEER SERVICES	0	5, 054		0		194. 04
194. 05 07955 VACANT SPACE	0	0	0	이	0	194. 05
200.00 Cross Foot Adjustments		^	_		0	200. 00 201. 00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118-201)	340, 019	984, 540	0		100, 734	
202.00 TOTAL (Suil TITIES TIO-201)	340,019	704, 540	1	432, 131	100, 734	1202. UU

In Lieu of Form CMS-2552-10

Period:	Worksheet B	
From 01/01/2016	Part	
To 12/31/2016	Date/Time Prepared:	3/30/2017 9:09 am

				'	0 12/31/2010	3/30/2017 9:0	
	Cost Center Description	PHARMACY	RECORDS &	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS	NURSING SCHOOL	
		15. 00	16. 00	17. 00	19. 00	20. 00	
GENE	ERAL SERVICE COST CENTERS						
1.00 0010	OO CAP REL COSTS-BLDG & FIXT						1. 00
	OO CAP REL COSTS-MVBLE EQUIP						2. 00
	DO EMPLOYEE BENEFITS DEPARTMENT						4. 00
	DO ADMINISTRATIVE & GENERAL						5. 00
	DO MAI NTENANCE & REPAI RS						6. 00
	OO OPERATION OF PLANT						7.00
	DO LAUNDRY & LINEN SERVICE DO HOUSEKEEPING						8. 00 9. 00
•	DOLDI ETARY						10.00
	DOLCAFETERI A						11. 00
	DO MAINTENANCE OF PERSONNEL						12. 00
1	DO NURSI NG ADMI NI STRATI ON						13. 00
	DO CENTRAL SERVICES & SUPPLY						14. 00
1	DO PHARMACY	1, 425, 317					15. 00
16. 00 0160	DO MEDICAL RECORDS & LIBRARY	o	31, 030				16. 00
	DO SOCIAL SERVICE	0	0	0			17. 00
	DO NONPHYSICIAN ANESTHETISTS	0	0	0	0		19. 00
	00 NURSI NG SCHOOL	0	0	0		0	20. 00
	00 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0			21. 00
	00 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22. 00
	DO PARAMED ED PRGM-(SPECIFY)	0	0	0			23. 00
	ATIENT ROUTINE SERVICE COST CENTERS	F	2 554				20.00
	DO ADULTS & PEDI ATRI CS DO NURSERY	5 0	2, 554				30. 00 43. 00
	DO SKILLED NURSING FACILITY	0	528 0			1	44. 00
	LLARY SERVICE COST CENTERS	<u> </u>	0		0	0	1 44.00
	DO OPERATING ROOM	82	596	0	0	0	50.00
	DO DELIVERY ROOM & LABOR ROOM	0	0	l o	0	1	52. 00
	DO ANESTHESI OLOGY	o	0	Ö	0	0	53. 00
	DO RADI OLOGY-DI AGNOSTI C	427	13, 050	0	0	0	54.00
	DO LABORATORY	0	0	0	0	0	60.00
62. 30 0625	50 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
•	DO RESPI RATORY THERAPY	0	0	0	0	0	65. 00
	DO PHYSI CAL THERAPY	981	3, 230		0	0	66. 00
	OO OCCUPATIONAL THERAPY	0	1, 142		0	0	67. 00
1	OO SPEECH PATHOLOGY	0	419	1	0	0	68. 00
1	DO ELECTROCARDI OLOGY	0	0	0	0	0	69.00
1	DO MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
	DO IMPL. DEV. CHARGED TO PATIENTS DO DRUGS CHARGED TO PATIENTS	1, 417, 670	0		0		72. 00 73. 00
	97 CARDI AC REHABILITATION	1, 417, 670	0		0	0	76. 97
	98 HYPERBARI C OXYGEN THERAPY	o	0		0	0	76. 98
	99 LI THOTRI PSY	Ö	0	0	0	Ö	76. 99
	PATIENT SERVICE COST CENTERS		-	-			
90.00 0900	DO CLI NI C	4	0	0	0	0	90. 00
90. 01 0900	D1 INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0	90. 01
	DO EMERGENCY	3, 097	9, 511	0	0	0	1
92. 00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART					1	92. 00
	ER REIMBURSABLE COST CENTERS						
	OO AMBULANCE SERVI CES	3, 051	0	0	0	0	95. 00
	CIAL PURPOSE COST CENTERS	1 405 017	21 020			0	110 00
118. 00	SUBTOTALS (SUM OF LINES 1-117) REIMBURSABLE COST CENTERS	1, 425, 317	31, 030	0	0	0	118. 00
	DO GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	0	0	0	0	190. 00
	DO PHYSI CLANS' PRI VATE OFFI CES	ol ol	0			l	190.00
	50 OCCUPATI ONAL HEALTH	0	0		_		194. 00
	51 PAIN CLINIC	0	0	٥	_		194. 01
	52 OAK POINTE	ol ol	0	Ö			194. 02
	53 FOUNDATION	ol	0	Ö	_		194. 03
	54 COMMUNITY & VOLUNTEER SERVICES	o	0	0	0		194. 04
	55 VACANT SPACE	O	0	0	0		194. 05
200. 00	Cross Foot Adjustments				0		200. 00
201.00	Negative Cost Centers	0	0	0			201. 00
202.00	TOTAL (sum lines 118-201)	1, 425, 317	31, 030	0	0	, 0	202. 00

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

			Ė	o 12/31/2016		
	INTERNS &	RESI DENTS			3/30/2017 9:0	alli
Cost Center Description	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost	
	APPRV	APPRV	FRGW		& Post	
					Stepdown	
	24.00	00.00	00.00	04.00	Adjustments	
GENERAL SERVICE COST CENTERS	21.00	22. 00	23. 00	24. 00	25. 00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00 OO200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5. 00
6.00 00600 MAI NTENANCE & REPAI RS 7.00 00700 OPERATION OF PLANT						6. 00 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 12. 00 01200 MAI NTENANCE OF PERSONNEL						11. 00 12. 00
13. 00 01200 MATNITENANCE OF PERSONNEL 13. 00 01300 NURSI NG ADMI NI STRATI ON			•			13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00 01500 PHARMACY						15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY						16.00
17. 00 01700 SOCIAL SERVICE 19. 00 01900 NONPHYSICIAN ANESTHETISTS						17. 00 19. 00
20. 00 02000 NURSI NG SCHOOL						20. 00
21.00 02100 &R SERVICES-SALARY & FRINGES APPRV	0					21.00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV		0				22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY) I NPATIENT ROUTINE SERVICE COST CENTERS)		23. 00
30. 00 03000 ADULTS & PEDIATRICS	0	0		6, 011, 767	0	30. 00
43. 00 04300 NURSERY	0	0			0	43. 00
44.00 O4400 SKILLED NURSING FACILITY	0	0		0	0	44.00
ANCILLARY SERVICE COST CENTERS		2		0 445 000	0	F0 00
50.00 05000 0PERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			0	50. 00 52. 00
53. 00 05300 ANESTHESI OLOGY	0	0			0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	· C		0	54.00
60. 00 06000 LABORATORY	0	0	(.,,	0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 65. 00 06500 RESPIRATORY THERAPY	0	0		,	0	62. 30 65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0			0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	i c	1, 053, 052	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0	0		219, 002	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(14, 780	0	69. 00
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS	0	0		991, 136 507, 200	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0			Ö	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	(0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	(0	0	76. 98
76. 99 O7699 LITHOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0	0	() 0	0	76. 99
90. 00 09000 CLINIC	0	0		459, 131	0	90. 00
90.01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0		0	0	90. 01
91. 00 09100 EMERGENCY	0	0	(10, 598, 292		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92. 00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES	0	0		3, 246, 986	0	95. 00
SPECIAL PURPOSE COST CENTERS				0,210,700	0	70.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	0	(45, 221, 792	0	118. 00
NONREI MBURSABLE COST CENTERS			1	50.400		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		52, 100 923, 044		190. 00 192. 00
194. 00 07950 OCCUPATI ONAL HEALTH	0	0		0		194. 00
194. 01 07951 PAIN CLINIC	0	0		o o	0	194. 01
194. 02 07952 OAK POINTE	0	0		0		194. 02
194. 03 07953 FOUNDATION 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES	0	0		536, 396		194. 03 194. 04
194.04 07954 COMMUNITY & VOLUNTEER SERVICES 194.05 07955 VACANT SPACE		0		510, 614		194. 04 194. 05
200.00 Cross Foot Adjustments		Ö		o o		200. 00
201.00 Negative Cost Centers	0	0		-		201. 00
202.00 TOTAL (sum lines 118-201)	0	0	il c	47, 243, 946	0	202. 00

		10 12/31/2016 Date/11me Pro	
Cost Center Description	Total	373072017 7.0	J dill
	26.00		
GENERAL SERVICE COST CENTERS	<u>'</u>		
1.00 O0100 CAP REL COSTS-BLDG & FLXT			1. 00
2.00 00200 CAP REL COSTS-MVBLE EQUIP			2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5.00 00500 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 O1200 MAINTENANCE OF PERSONNEL			12. 00
13.00 O1300 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 NONPHYSICIAN ANESTHETISTS			19. 00
20. 00 02000 NURSI NG SCHOOL			20. 00
21. 00 02100 1 &R SERVICES-SALARY & FRINGES APPRV			21. 00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV			22. 00
23. 00 02300 PARAMED ED PRGM- (SPECIFY)			23. 00
INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00 03000 ADULTS & PEDI ATRI CS	6, 011, 767		30.00
43. 00 04300 NURSERY	452, 671		43. 00
44. 00 04400 SKILLED NURSING FACILITY	0		44. 00
ANCILLARY SERVICE COST CENTERS	2 415 000		
50. 00 05000 OPERATING ROOM	3, 415, 888		50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 856, 009		52.00
53. 00 05300 ANESTHESI OLOGY	26, 957		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 297, 724		54.00
60. 00 06000 LABORATORY	4, 224, 255 0		60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 65. 00 06500 RESPIRATORY THERAPY	-		62. 30 65. 00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	1, 053, 935		66.00
67. 00 06700 OCCUPATIONAL THERAPY	1, 592, 135 1, 053, 052		67. 00
68. 00 06800 SPEECH PATHOLOGY	219, 002		68.00
69. 00 06900 SELECT FATHOLOGY	14, 780		69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	991, 136		71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	507, 200		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	4, 200, 872		73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	4, 200, 872		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	<u> </u>		1 /0: //
90. 00 09000 CLINIC	459, 131		90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0		90. 01
91. 00 09100 EMERGENCY	10, 598, 292		91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS	<u>'</u>		
95. 00 09500 AMBULANCE SERVI CES	3, 246, 986		95. 00
SPECIAL PURPOSE COST CENTERS			
118.00 SUBTOTALS (SUM OF LINES 1-117)	45, 221, 792		118. 00
NONREI MBURSABLE COST CENTERS	<u> </u>		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	52, 100		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	923, 044		192. 00
194. 00 07950 OCCUPATI ONAL HEALTH	O		194. 00
194. 01 07951 PAIN CLINIC	0		194. 01
194. 02 07952 OAK POINTE	0		194. 02
194. 03 07953 FOUNDATI ON	536, 396		194. 03
194.04 07954 COMMUNITY & VOLUNTEER SERVICES	510, 614		194. 04
194. 05 07955 VACANT SPACE	0		194. 05
200.00 Cross Foot Adjustments	0		200.00
201.00 Negative Cost Centers	0		201.00
202.00 TOTAL (sum lines 118-201)	47, 243, 946		202. 00
	· '		-

| Period: | Worksheet B | From 01/01/2016 | Part II | To | 12/31/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0101

					To	12/31/2016	Date/Time Pre	
				CAPI TAL REI	ATED COSTS		3/30/2017 9:0	9 am
		Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs	1 00	2.00	2.4	4.00	
	GENER	AL SERVICE COST CENTERS	0	1. 00	2. 00	2A	4. 00	
1.00		CAP REL COSTS-BLDG & FIXT						1.00
2.00		CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 5. 00	1	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	0 3, 528, 279	0 318, 584	0 547, 109	0 4, 393, 972	0	4. 00 5. 00
6. 00		MAINTENANCE & REPAIRS	3, 326, 279	316, 364	347, 109	4, 393, 972	0	6.00
7. 00		OPERATION OF PLANT	0	78, 103	134, 129	212, 232	0	7. 00
8.00		LAUNDRY & LINEN SERVICE	0	3, 649		9, 916	0	8. 00
9. 00 10. 00		HOUSEKEEPI NG DI ETARY	0	3, 050 13, 076		8, 288 35, 531	0	9. 00 10. 00
11. 00	1	CAFETERI A	0	14, 745		40, 068	0	11.00
12. 00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12. 00
13.00	1	NURSI NG ADMI NI STRATI ON	0	889		2, 415	0	13.00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	0	10, 557 9, 150	18, 131 15, 714	28, 688 24, 864	0	14. 00 15. 00
16. 00		MEDICAL RECORDS & LIBRARY	0	3, 252		8, 837	0	16.00
17. 00		SOCIAL SERVICE	0	0	0	o	0	17. 00
19. 00	1	NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.00
20. 00 21. 00	1	NURSING SCHOOL I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	O O	0	20. 00 21. 00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	Ö	o	0	22. 00
23. 00		PARAMED ED PRGM-(SPECIFY)	0	0	0	o	0	23. 00
20.00		ADULTS & PEDIATRICS	0	142 021	245 272	200 002	0	20.00
30. 00 43. 00	1	NURSERY	0	142, 821 0	245, 272 0	388, 093 0	0	30. 00 43. 00
44. 00		SKILLED NURSING FACILITY	0	0		Ö	0	44. 00
		LARY SERVICE COST CENTERS	_					
50. 00 52. 00		OPERATING ROOM DELIVERY ROOM & LABOR ROOM	0	85, 294 0	1	231, 773 0	0	50. 00 52. 00
53. 00		ANESTHESI OLOGY	0	0		o	0	53.00
54.00	05400	RADI OLOGY-DI AGNOSTI C	0	104, 551	179, 548	284, 099	0	54. 00
60.00		LABORATORY	0	31, 315	53, 779	85, 094	0	60.00
62. 30 65. 00		BLOOD CLOTTING FOR HEMOPHILIACS RESPIRATORY THERAPY	0	15, 796	0 27, 127	42, 923	0	62. 30 65. 00
66. 00		PHYSI CAL THERAPY	0	83, 631	143, 623	227, 254	0	66.00
67. 00	1	OCCUPATIONAL THERAPY	0	0	0	O	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	Ö	0	Ö	o	0	72.00
73. 00		DRUGS CHARGED TO PATIENTS	0	0	0	o	0	73. 00
76. 97 76. 98	1	CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76. 97 76. 98
	1	LITHOTRI PSY	0	0	0	0		
	OUTPA	TIENT SERVICE COST CENTERS						
90.00		CLINIC	0	24, 151	1	65, 627	0	
90. 01 91. 00		INTENSIVE OUT PATIENT PROGRAM EMERGENCY	0	0 96, 949		0 263, 443	0	•
92. 00		OBSERVATION BEDS (NON-DISTINCT PART	0	70, 747	100, 474	203, 443	O	92.00
	OTHER	REIMBURSABLE COST CENTERS						
95. 00		AMBULANCE SERVICES	0	0	0	0	0	95. 00
118. 00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	3, 528, 279	1, 039, 563	1, 785, 275	6, 353, 117	0	118. 00
		IMBURSABLE COST CENTERS	0,020,277	1,7007,7000	1,700,270	0,000,117		
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1, 939		5, 269		190. 00
		PHYSI CI ANS' PRI VATE OFFI CES OCCUPATI ONAL HEALTH	0	0	0	0		192. 00 194. 00
		PAIN CLINIC		0		ol		194. 00
194. 02	07952	OAK POINTE	O	0	o	ō	0	194. 02
		FOUNDATION	0	0	0	0		194. 03
	1	COMMUNITY & VOLUNTEER SERVICES VACANT SPACE	0	1, 919 0	3, 295	5, 214 0		194. 04 194. 05
200.00		Cross Foot Adjustments				o		200. 00
201.00	1	Negative Cost Centers		0	0	0		201. 00
202. 00	ון	TOTAL (sum lines 118-201)	3, 528, 279	1, 043, 421	1, 791, 900	6, 363, 600	0	202. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2016	Part II
To 12/31/2016	Date/Time Prepared: 3/30/2017 9:09 am

				'		3/30/2017 9:0	
	Cost Center Description	ADMI NI STRATI VE		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL 5.00	REPAI RS 6. 00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	
	GENERAL SERVICE COST CENTERS	5.00	0.00	7.00	8.00	9.00	
1.00	00100 CAP REL COSTS-BLDG & 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	4, 393, 972					5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	0				6. 00
7. 00	00700 OPERATION OF PLANT	228, 441	0	440, 673			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	31, 663	0	2, 487		404 507	8. 00
9.00	00900 HOUSEKEEPI NG	94, 221	0	2, 078	-	104, 587	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	25, 058	0	8, 909 10, 047	0	2, 137	10.00
12. 00	01200 MAINTENANCE OF PERSONNEL	84, 164	0	10, 047 0	0	2, 410 0	11. 00 12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	38, 420	0	606	0	145	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	4, 068	0	7, 194		1, 725	14. 00
15. 00	01500 PHARMACY	124, 990	0	6, 235		1, 495	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 253	0	2, 216		531	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20.00	02000 NURSI NG SCHOOL	0	0	0	0	0	20. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	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
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	427, 984	0	97, 314	2, 432	23, 338	30.00
43. 00	04300 NURSERY	38, 769	0	97, 314	2, 432	23, 336	43.00
44. 00	04400 SKILLED NURSING FACILITY	30, 707	0	0		0	44. 00
	ANCI LLARY SERVI CE COST CENTERS	<u> </u>					
50.00	05000 OPERATING ROOM	254, 779	0	58, 118	7, 363	13, 938	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	155, 913	0	0	9, 453	0	52.00
53.00	05300 ANESTHESI OLOGY	2, 507	0	0	0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	420, 508	0	71, 239		17, 084	54.00
60.00	06000 LABORATORY	377, 129	0	21, 338		5, 117	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	86, 024	0	10, 763 56, 985		2, 581	65.00
66. 00 67. 00	06700 OCCUPATIONAL THERAPY	97, 344 94, 636	0	56, 985 0	1, 421 1, 515	13, 666 0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	19, 511	0	0	393	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	1, 375	0	0	373	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	89, 144	0	0	0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	45, 760	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	258, 855	0	0	0	0	73. 00
76. 97	07697 CARDIAC REHABILITATION	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	00.500		4, 45,	0.40	0.047	
90. 00 90. 01	09000 CLINIC	29, 528	0	16, 456		3, 947	90. 00 90. 01
	09001 INTENSIVE OUT PATIENT PROGRAM 09100 EMERGENCY	0	0	0 44 0E0	-	0 15, 842	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	891, 204	U	66, 059	9, 034	10, 642	91.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95. 00	09500 AMBULANCE SERVICES	285, 901	0	0	1, 943	0	95. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		4, 209, 149	0	438, 044	44, 066	103, 956	118. 00
	NONREI MBURSABLE COST CENTERS		_		_		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 771	0	1, 321	0		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	85, 534	0	0	0		192.00
	07950 OCCUPATIONAL HEALTH	0	0	0	0		194. 00 194. 01
	07951		0	0	0		194. 01
	3 O7953 FOUNDATION	49, 461	0	0			194. 02
	107954 COMMUNITY & VOLUNTEER SERVICES	46, 057	0	1, 308	0		194. 04
	07955 VACANT SPACE	0	0	., 300	o o		194. 05
200.00]					200. 00
201.00	Negative Cost Centers	0	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	4, 393, 972	0	440, 673	44, 066	104, 587	202. 00

| Peri od: | Worksheet B | From 01/01/2016 | Part | I | To | 12/31/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0101

				Т	o 12/31/2016	Date/Time Pre 3/30/2017 9:0	
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	/ dill
				PERSONNEL	ADMI NI STRATI ON		
		10.00	11. 00	12.00	13. 00	SUPPLY 14.00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 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 MAINTENANCE & REPAIRS						6. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	71, 635					10. 00
11.00	01100 CAFETERI A	0	136, 689				11.00
12. 00 13. 00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	0	0 1, 977	1			12. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	o	0	Ö		41, 675	1
15. 00	01500 PHARMACY	0	3, 699			2, 225	1
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	0	0	0	0	
19. 00	01900 NONPHYSI CI AN ANESTHETI STS		0		0	0	1
20. 00	02000 NURSI NG SCHOOL	o	0	0	O	0	
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRV	0	0	0		0	
22. 00 23. 00	02200 1 & R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0		0	
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0		<u> </u>	0	23.00
30. 00	03000 ADULTS & PEDI ATRI CS	71, 635	20, 028			692	30. 00
43.00	04300 NURSERY	0	1, 786			717	43.00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	44. 00
50.00	05000 OPERATING ROOM	0	10, 269	0	6, 770	6, 217	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	7, 080		.,	2, 622	1
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	10 927	0		1 244	
60.00	06000 LABORATORY	0	19, 837 0	1		1, 366 0	1
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	o	0	Ö		0	1
65. 00	06500 RESPI RATORY THERAPY	0	5, 294		_	1, 498	1
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	10, 779 2, 998		_	294 253	1
68. 00	06800 SPEECH PATHOLOGY	l o	765		_	51	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0			0	
71. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	_	13, 516	1
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	_	6, 282 0	1
76. 97	07697 CARDI AC REHABI LI TATI ON	o o	0	Ö		0	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0		0	
76. 99	07699 LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	76. 99
90. 00	09000 CLINIC	O	1, 084	0	0	286	90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	O	0	0		0	1
	09100 EMERGENCY	0	28, 705	0	18, 923	2, 683	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00	09500 AMBULANCE SERVI CES	0	20, 602	0	0	2, 452	95. 00
	SPECIAL PURPOSE COST CENTERS			_			
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	71, 635	134, 903	0	43, 563	41, 154	118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	o	0	0	ol	449	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	O	446			72	192. 00
	07950 OCCUPATI ONAL HEALTH	0	0				194. 00
	07951		0	·			194. 01 194. 02
	07953 FOUNDATION		638		_		194. 02
194. 04	07954 COMMUNITY & VOLUNTEER SERVICES	0	702	0			194. 04
194. 05 200. 00	O7955 VACANT SPACE Cross Foot Adjustments	0	0	0	0	0	194. 05 200. 00
200.00		0	0	0	0	0	200.00
202.00		71, 635	136, 689				202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2016 | Part II | To 12/31/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0101

			1	0 12/31/2016	3/30/2017 9:0	
Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS	NURSI NG SCHOOL	, um
	15. 00	16.00	17. 00	19. 00	20.00	
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 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
6.00 00600 MAINTENANCE & REPAIRS						6. 00
7.00 O0700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10. 00
11. 00 01100 CAFETERI A						11. 00
12.00 01200 MAINTENANCE OF PERSONNEL						12. 00
13.00 O1300 NURSING ADMINISTRATION						13. 00
14. 00 O1400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00 01500 PHARMACY	163, 508					15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	12, 837	'			16. 00
17. 00 01700 SOCIAL SERVICE	0	0	0			17. 00
19.00 O1900 NONPHYSICIAN ANESTHETISTS	0	0	0	0		19. 00
20. 00 02000 NURSI NG SCHOOL	0	0	0		0	
21.00 02100 1 &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 O2300 PARAMED ED PRGM-(SPECIFY)	0	0) 0			23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	1	1, 056	1			30. 00
43. 00 04300 NURSERY	0	218	1			43. 00
44.00 O4400 SKILLED NURSING FACILITY	0	0) 0			44. 00
ANCILLARY SERVICE COST CENTERS				·		4
50.00 05000 OPERATING ROOM	9	246				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	1			52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	49	5, 401	0			54. 00
60. 00 06000 LABORATORY	0	0	0			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62. 30
65. 00 06500 RESPI RATORY THERAPY	0	0	0			65. 00
66. 00 06600 PHYSI CAL THERAPY	112	1, 336	1			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	472	1			67. 00
68. 00 06800 SPEECH PATHOLOGY	0	173	1			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0			69. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0			71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	162, 632	0	0			73. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0	0			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0			76. 98
76. 99 07699 LI THOTRI PSY	0	0) 0			76. 99
OUTPATIENT SERVICE COST CENTERS			J 0		1	00.00
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	355	3, 935	5 0			91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS	250		J 0			05 00
95. 00 09500 AMBULANCE SERVI CES	350	0) 0			95. 00
SPECIAL PURPOSE COST CENTERS	1/2 500	12 027	, ,		1	110 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	163, 508	12, 837	' 0	0	0	118. 00
NONREI MBURSABLE COST CENTERS						100 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	1			192. 00
194. 00 07950 OCCUPATI ONAL HEALTH	0	0	0			194. 00
194. 01 07951 PAIN CLINIC	0	0	0			194. 01
194. 02 07952 OAK POI NTE	0	0	0		1	194. 02
194. 03 07953 FOUNDATION	0	0	0		1	194. 03
194. 04 07954 COMMUNITY & VOLUNTEER SERVICES	0	0	J 0		1	194. 04
194. 05 07955 VACANT SPACE		0	0 ار	_] _	194. 05
200. 00 Cross Foot Adjustments		-	_	0		200. 00
201.00 Negative Cost Centers	1/0 500	10.007	0			201. 00
202.00 TOTAL (sum lines 118-201)	163, 508	12, 837	' O	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 01/01/2016 Part II Date/Time Prepared: 12/31/2016 3/30/2017 9:09 am INTERNS & RESIDENTS Cost Center Description SERVI CES-SALAR SERVI CES-OTHER PARAMED ED Subtotal Intern & Y & FRINGES PRGM COSTS Residents Cost PRGM **APPRV APPRV** & Post Stepdown Adjustments 21. 00 22.00 23.00 24. 00 25. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16, 00 16.00 17 00 01700 SOCIAL SERVICE 17 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 20.00 02000 NURSING SCHOOL 20.00 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 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30 00 1,045,776 0 43.00 04300 NURSERY 44,065 0 43.00 04400 SKILLED NURSING FACILITY 44.00 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 589, 482 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 179, 735 52.00 53.00 05300 ANESTHESI OLOGY 2,507 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54 00 826, 092 0 54 00 60.00 06000 LABORATORY 488, 717 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 62.30 06500 RESPIRATORY THERAPY 149, 329 65.00 65.00 06600 PHYSI CAL THERAPY 409, 191 66.00 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 99,874 0 67.00 68.00 06800 SPEECH PATHOLOGY 20, 893 68.00 06900 ELECTROCARDI OLOGY 69 00 1 375 0 69 00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 102, 660 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 52, 042 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 421, 487 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 117, 271 0 90.01 09001 INTENSIVE OUT PATIENT PROGRAM 0 90.01 91.00 91.00 09100 EMERGENCY 1, 300, 983 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 311, 248 0 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 118.00 0 0 0 6, 162, 727 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 190. 00 11, 127 0 192. 00 86,052 194. 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 50.099 0 194. 03 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 0 194. 04 53.595 194. 05 07955 VACANT SPACE 0 194. 05 200.00 Cross Foot Adjustments 0 0 200. 00

0

0

0

6, 363, 600

0 201.00

0 202. 00

Negative Cost Centers

TOTAL (sum lines 118-201)

201.00

202.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2016 | Part II | To 12/31/2016 | Date/Time Prepared: Provider CCN: 15-0101

			10 12/31/2016 Date/11 me Pro	
	Cost Center Description	Total	070072017 710	, G.III
	·	26. 00		
	ENERAL SERVICE COST CENTERS			
1	00100 CAP REL COSTS-BLDG & FIXT			1.00
1	00200 CAP REL COSTS-MVBLE EQUIP			2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
1	00500 ADMINISTRATIVE & GENERAL			5. 00
1	00600 MAINTENANCE & REPAIRS			6.00
	00700 OPERATION OF PLANT			7.00
1	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING			8. 00 9. 00
	01000 DI ETARY			10.00
1	01100 CAFETERI A			11.00
	01200 MAI NTENANCE OF PERSONNEL			12. 00
1	01300 NURSI NG ADMINI STRATI ON			13. 00
	01400 CENTRAL SERVICES & SUPPLY			14.00
1	01500 PHARMACY			15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY			16. 00
17.00	01700 SOCIAL SERVICE			17. 00
	01900 NONPHYSICIAN ANESTHETISTS			19. 00
1	02000 NURSI NG SCHOOL			20. 00
1	02100 I&R SERVICES-SALARY & FRINGES APPRV			21. 00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV			22. 00
_	2300 PARAMED ED PRGM-(SPECIFY)			23. 00
_	NPATIENT ROUTINE SERVICE COST CENTERS	4 045 77/		
	03000 ADULTS & PEDIATRICS	1, 045, 776		30.00
	04300 NURSERY	44, 065		43. 00
	04400 SKILLED NURSING FACILITY NOCILLARY SERVICE COST CENTERS	0		44. 00
	05000 OPERATING ROOM	589, 482		50.00
1	05200 DELIVERY ROOM & LABOR ROOM	179, 735		52. 00
	05300 ANESTHESI OLOGY	2, 507		53. 00
	05400 RADI OLOGY-DI AGNOSTI C	826, 092		54. 00
	06000 LABORATORY	488, 717		60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		62. 30
65.00	06500 RESPI RATORY THERAPY	149, 329		65. 00
66.00	06600 PHYSI CAL THERAPY	409, 191		66. 00
	06700 OCCUPATI ONAL THERAPY	99, 874		67. 00
	06800 SPEECH PATHOLOGY	20, 893		68. 00
	06900 ELECTROCARDI OLOGY	1, 375		69. 00
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	102, 660		71. 00
1	07200 IMPL. DEV. CHARGED TO PATIENTS	52, 042		72. 00
	07300 DRUGS CHARGED TO PATIENTS	421, 487		73. 00
	07697 CARDI AC REHABI LI TATI ON	0		76. 97
1	07698 HYPERBARI C OXYGEN THERAPY 07699 LITHOTRIPSY	0		76. 98 76. 99
_	OUTPATIENT SERVICE COST CENTERS	U		70. 99
	09000 CLINIC	117, 271		90.00
	09001 INTENSIVE OUT PATIENT PROGRAM	0		90. 01
	09100 EMERGENCY	1, 300, 983		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART			92.00
0	THER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	311, 248		95. 00
S	SPECIAL PURPOSE COST CENTERS			
118. 00	SUBTOTALS (SUM OF LINES 1-117)	6, 162, 727		118. 00
	IONREI MBURSABLE COST CENTERS			
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	11, 127		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	86, 052		192. 00
194.000	07950 OCCUPATI ONAL HEALTH	0		194. 00
	07951 PALN CLINIC 07952 OAK POINTE	0		194. 01 194. 02
	07952 OAK POINTE 07953 FOUNDATION	50, 099		194. 02
	07953 FOUNDATION 07954 COMMUNITY & VOLUNTEER SERVICES	53, 595		194. 03
	07955 VACANT SPACE	55, 595		194. 04
200.00	Cross Foot Adjustments	0		200. 00
201.00	Negative Cost Centers	o		201. 00
202.00	TOTAL (sum lines 118-201)	6, 363, 600		202. 00
'				

Cost Control Description			ICI AI SYSTEMS	WHITLEY MEMORI		011 45 0404		U OF FORM CMS	
Cost Center Description	COST A	LLOCA	ITON - STATISTICAL BASIS		Provider C			Worksheet B-1	
COST Center Description									
Business								3/30/2017 9:0	9 am
Compared				CAPITAL REL	LATED COSTS				
Compared			Cost Contor Doscription	DIDC 0 FLVT	MVDLE FOLLD	EMDLOVEE	Doconci Li ati on	ADMINI CTDATI VE	
PARTICLE STRYLET COST CENTESS 1.00 2.00 5.0			cost center bescription				RECONCITIATION		
CAMPS STANIES STANIE				(SQUARE TEET)	(SQUARE FEET)				
								(ACCOM: COST)	
SERREAL SERVICE COST CRITTERS 1.00 2.00 4.00 5A 5.00									
1.00				1.00	2.00		5A	5. 00	
2.00		GENER	AL SERVICE COST CENTERS						
0.00 0.00 DEPLOYEE BEREFITS DEPARTMENT 0		1		154, 970					
5.00 DOSCOM MATEMANES REPAIRS 47,316 47,316 5,97,108 -16,256,337 30,987,09 5,00 7.00 DOSCOM MATEMANES REPAIRS 1,60 11,600 451,178 0 1,511,333 7,00 7.00 DOSCOM METAMANES HERRIST 1,600 11,007 451,178 0 1,511,333 7,00 7.00 DOSCOM MATEMANES REPAIRS 1,602 453 473 479,75 0 0 664,471 7.00 DOSCOM MATEMANES REPAIRS 1,942 1,942 90,323 0 176,719 10,00 7.00 DOSCOM MATEMANES REPAIRS 1,942 1,942 90,323 0 176,719 10,00 7.00 DOSCOM MATEMANES OF FERSIONES 1,942 1,942 90,323 0 176,719 10,00 7.00 DOSCOM MATEMANES OF FERSIONES 1,500 1,500 2,600 0 2,700 1,00 7.00 DOSCOM MATEMANES OF FERSIONES 1,500 1,500 0 0 0 0 0 0 0 7.00 DOSCOM MATEMANES OF FERSIONES 1,500 1,500 1,500 0 0 0 0 0 0 0 0 7.00 DOSCOM MATEMANES OF FERSIONES 1,500 1,500 0 0 0 0 0 0 0 0 0		1	l e e e e e e e e e e e e e e e e e e e		154, 970				
0.00 0.00				0	0				
0.0000 0.00000 0.00000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000		1	l e e e e e e e e e e e e e e e e e e e	47, 316	47, 316	5, 967, 10	-16, 256, 337		
8.00 00800 LANDRY & LINEN SERVICE				11 (00	11 (00	451 17			
0.000 0.00000 0.00000 0.00000 0.00000 0.00000000							0		
10.00 01000 DETARY 1.942 1.942 90.323 0 176, 179 10.00 1700 CAFELRIA 2.190 2.190 334, 683 693, 525 11.00 1700 CAFELRIA 2.190 2.190 334, 683 693, 525 11.00 1700 CAFELRIA 2.190 2.190 2.30, 632 0 2.200 2.200 2.100 2.100 2.100 CAFELRIA 2.190 2.100 2.100 2.100 2.100 2.100 CAFELRIA 2.100 2.100 2.100 2.100 CAFELRIA 2.100 2.100 CAFELRIA 2.100 2.100 CAFELRIA 2.100 2.100 CAFELRIA 2		1	l e e e e e e e e e e e e e e e e e e e						
11.00 01100 CAFETERIA 2.190 2.190 3.34.683 0 593.552 11.00 12.00 12.00 13.00 MIRSHAG ADMINISTRATION 13.2 13.2 230.432 0 270.740 13.00 13.00 CAFETERIA 13.00 13.00 CAFETERIA 13.00 13.00 CAFETERIA 13.00 13.00 CAFETERIA 13.00 C							1		
12.00 01200 MAINTENANCE OF PERSONNÉE 0 0 0 0 12.00		1	l e e e e e e e e e e e e e e e e e e e				1		
13.00 01300 RIBESTRO, ADMINISTRATION 13.2 13.2 230, 432 0 277,0 949 13.00 15.00 01500 PHABRIACY 1,556 1,559 1,359 562, 286 0 881, 467 15.00 17.00 01500 PHABRIACY 1,359 1,359 562, 286 0 881, 467 15.00 17.00 01700 SICHAL SERVICE 0 0 0 0 0 0 0 0 0		1	l e e e e e e e e e e e e e e e e e e e		0	.,	1		
15.00 01500 PHARMACY 1,359 1,359 562,286 0 881,467 15.00 17.00 017000 01700 01700 01700 01700				132	132	230, 43	2 0	270, 949	13. 00
16.00 16.00 MEDI CAL RECORDS & LIBRARY 483 483 0 0 8,837 16.70 17.00 17.	14. 00	01400	CENTRAL SERVICES & SUPPLY	1, 568	1, 568		o	28, 688	14. 00
17.00 01700 MORPHYSICIAN AMESTHETISTS 0 0 0 0 0 17.9				1, 359	1, 359	562, 28	6 0	881, 467	15. 00
19.00 0900 MORPHYSICI AN AMESTHETISTS 0 0 0 0 0 0 0 0 0		1	l .	483	483		0	8, 837	16. 00
0.000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000				0	0		- 1	_	
21.00				0	0	(0	_	
22.00 02200 RAS ERRY (CES-OTHER PROM COSTS APPRY 0 0 0 0 0 0 23.00				0	0	(0	· ·	
23.00				0	0	1	0	_	1
INPATI ENT ROUTH NE SERVICE COST CENTERS 30.00 30.00 30.00 30.00 30.00 30.01 3				0	0			_	
30.00 03000 ADULTS & PEDIATRICS 21,212 21,212 2,042,376 0 3,018,265 30.00 44.00 04000 NIRSERY 0 0 0 0 0 0 0 0 0	23.00			0		1) ()	U	23.00
43.00 04300 NURSERY 0 0 203,230 0 273,408 43.00 44.00 44.00 AUCULARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0	30 00			21 212	21 212	2 0/2 37	5	3 018 265	30 00
44, 00 04400 SKILLED NURSING FACILITY 0 0 0 0 0 0 44, 00							1		1
ANCILLARY SERVICE COST CENTERS 1, 2668 12, 668 12, 668 92, 511 0 1, 796, 776 50, 00 52, 00 05200 DELIATIN FOROM 12, 668 12, 668 12, 668 992, 511 0 1, 796, 776 50, 00 52, 00 05200 DELIATIN FOROM & LABOR ROOM 0 0 0 0 0 0 0 0 0				_					1
50.00							٥,		1 00
52.00 05200 05200 05200 05200 05200 05200 05400 0 0 0 0 0 0 0 0 0				12, 668	12, 668	992, 51	1 0	1, 796, 776	50.00
54.00 05400 RADIO LOGY-DI ASNOSTIC 15.528 1.528 1.811, 286 0 2.965, 541 54.00 0 0 0 0 0 0 0 2.656, 541 54.00 0 2.656, 541 54.00 0 0 0 0 0 0 0 0 0	52. 00	05200	DELIVERY ROOM & LABOR ROOM				1		1
60.00	53. 00	05300	ANESTHESI OLOGY	0	0		0	17, 681	53. 00
Color Colo	54. 00	05400	RADI OLOGY-DI AGNOSTI C	15, 528	15, 528	1, 811, 28	6 0	2, 965, 541	54.00
65 00 0.6500 RESPI RATORY THERAPY 2, 346 2, 346 479, 574 0 606, 668 65. 00				4, 651	4, 651		0	2, 659, 622	60.00
66.00 06600 PHYSICAL THERAPY 12, 421 12, 421 446, 463 0 686, 499 66.00 67.00 67.00 06700 0555, 462 0 667, 403 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 0		1	l e e e e e e e e e e e e e e e e e e e	0	0	(- 1		
67. 00 06700 06CUPATIONAL THERAPY 0 0 555, 462 0 667, 403 67. 00 68. 00 06800 06900 06900 0 113, 125 0 137, 600 68. 00 69. 00 06900 06900 06900 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 192 0 628, 666 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 322, 716 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 322, 716 72. 00 74. 97 07697 CARD LAG REHABILITATION 0 0 0 0 0 0 0 76. 97 75. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 76. 98 76. 99 07699 07699 LTHORTI PSY 0 0 0 0 0 0 0 0 76. 90 07699 LTHORTI PSY 0 0 0 0 0 0 0 76. 90 07699 LTHORTI PSY 0 0 0 0 0 0 0 76. 90 07699 LTHORTI PSY 0 0 0 0 0 0 76. 90 07699 LTHORTI SERVICE COST CENTERS 79. 00 09000 LUNES UP AND LINES OF A CONTROL OF A								· ·	
68. 00 06900 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 9,694 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 0 0 9,694 69. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 322,716 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 322,716 72. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					12, 421				
69-00 0900				0	0				
17.1 00				0	0	113, 12			
172.00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 3.22,716 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 1.825,520 73.00 73.00 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 76.97 76.98 07697 CARDIA C. REHABILITATION 0 0 0 0 0 0 0 76.97 76.99 07697 CARDIA C. REHABILITATION 0 0 0 0 0 0 0 0 0				0	0	10:			
73.00 07300 DRUGS CHARGED TO PATLENTS 0 0 0 0 0 1,825,520 73.00 76.97 07697 CARDI AC REHABILITATION 0 0 0 0 0 0 0 76.98 76.99 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 76.99 76.99 07699 LITHOTRI PSY 0 0 0 0 0 0 0 0 0				0			1		
76. 97 07697 (ARDI AC REHABILITATION 0 0 0 0 0 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 76. 99 0000 (LINI C) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0					1
76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 0 0 0 0 90. 00 09000 CLI NI C 0 0 0 0 0 0 0 90. 01 09000 CLI NI C 0 0 0 0 0 0 91. 00 09100 EMERGENCY 14. 399 14. 399 2. 730, 260 0 6. 285, 086 91. 00 92. 00 09200 08SERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 0 0 95. 00 09500 AMBULANCE SERVI CES 0 0 1.518, 091 0 2. 016, 253 95. 00 SPECI AL PURPOSE COST CENTERS 0 0 1. 518, 091 0 2. 016, 253 118. 00 NONREI MBURSABLE COST CENTERS 0 0 0 1. 80 119. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 288 288 0 0 26, 595 190. 00 194. 00 07950 OCCUPATI ONAL HEALTH 0 0 0 0 0 194. 00 194. 01 07951 PAIN CLI NIC 0 0 0 0 0 0 194. 02 07952 OXFORD AND CLINES 0 0 0 0 0 0 194. 03 07953 FOUNDATION 0 0 0 0 0 0 194. 04 07954 COMMUNITY & VOLUNTEER SERVI CES 285 285 57, 840 0 348, 812 194. 03 199. 00 00 00 0 0 0 0 0 0				0	0				
76. 99 07699 LITHOTRI PSY 00 0 0 0 0 0 0 0 0 0 76. 99 0000 O9000 CLINI C				0	0		o	0	1
90. 00 09000 CLINIC 3,587 3,587 107,362 0 208,237 90. 00 90. 01 09001 INTENSIVE OUT PATIENT PROGRAM 0 0 0 0 0 0 90. 01 91. 00 09100 EMERGENCY 14,399 14,399 2,730,260 0 6,285,086 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 1,518,091 0 2,016,253 95. 00 09500 AMBULANCE SERVI CES 0 0 0 1,518,091 0 2,016,253 95. 00 09500 AMBULANCE SERVI CES 0 0 0 1,518,091 0 2,016,253 95. 00 09500 AMBULANCE SERVI CES 0 0 0 1,518,091 0 2,016,253 95. 00 09500 AMBULANCE SERVI CES 0 0 0 1,518,091 0 2,016,253 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0,000 0 0 0 0 0				0	0		ol ol	0	76. 99
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM 0 0 0 0 0 0 0 0 0		OUTPA	TIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY 14, 399 14, 399 2, 730, 260 0 6, 285, 086 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 92. 00 07				3, 587	3, 587	107, 36	2 0	208, 237	
92. 00 OP200 OBSERVATI ON BEDS (NON-DI STINCT PART OTHER REI MBURSABLE COST CENTERS 95. 00 OP500 AMBULANCE SERVI CES O O O I, 518, 091 O 2, 016, 253 P5. 00 SPECI AL PURPOSE COST CENTERS 118. 00 SPECI AL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LI NES 1-117) I54, 397 I54, 397 20, 084, 506 -16, 256, 337 29, 684, 190 I18. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 288 288 0 0 26, 595 190. 00 192. 00 19200 PHYSI CI ANS* PRI VATE OFFI CES 0 0 17, 880 0 603, 207 192. 00 194. 00 07950 OCCUPATI ONAL HEALTH 0 0 0 0 0 0 0 194. 00 194. 01 194. 01 07951 PAIN CLI NIC 0 0 0 0 0 0 194. 01 194. 01 07951 PAIN CLI NIC 0 0 0 0 0 0 194. 01 194. 01 07952 OAK POI NITE 0 0 0 0 0 0 348, 812 194. 03 194. 04 07954 COMMUNI TY & VOLUNTEER SERVI CES 285 285 57, 840 0 324, 805 194. 04 194. 05 07955 VACANT SPACE 0 0 0 0 0 0 0 194. 02 200. 00 Cross Foot Adjustments 200. 00 Cost to be allocated (per Wkst. B, 1, 043, 421 1, 791, 900 3, 165, 803 16, 256, 337 202. 00 204. 00 Cost to be allocated (per Wkst. B, Part I) 6. 733052 11. 562883 0. 156821 0 0. 524608 203. 00 204. 00 Cost to be allocated (per Wkst. B, Part I) 6. 733052 11. 562883 0. 156821 0 0. 524608 203. 00 204. 00 Cost to be allocated (per Wkst. B, Part I)				0	0				
OTHER REIMBURSABLE COST CENTERS 0 0 0 1,518,091 0 2,016,253 95.00				14, 399	14, 399	2, 730, 26	0	6, 285, 086	1
95. 00 09500 AMBULANCE SERVI CES 0 0 1,518,091 0 2,016,253 95. 00 SPECI AL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1-117) 154,397 154,397 20,084,506 -16,256,337 29,684,190 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 288 288 0 0 26,595 190. 00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 17,880 0 603,207 192. 00 194. 01 194. 01 07951 PAI N CLI NIC 0 0 0 0 0 194. 01 194. 02 07952 OAK POI NTE 0 0 0 0 0 0 194. 02 194. 03 07953 FOUNDATION 0 0 0 0 27,203 0 348,812 194. 03 194. 04 07954 COMMUNI TY & VOLUNTEER SERVI CES 285 285 57,840 0 324,805 194. 04 194. 05 07955 VACANT SPACE 0 0 0 0 0 0 0 0 0									92.00
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 154,397 154,397 20,084,506 -16,256,337 29,684,190 118.00	05 00	OTHER	REIMBURSABLE COST CENTERS			1 510 00	1 0	2.01/ 252	05 00
18. 00 SUBTOTALS (SUM OF LINES 1-117) 154, 397 154, 397 20, 084, 506 -16, 256, 337 29, 684, 190 18. 00				0	0	1, 518, 09	1 0	2, 016, 253	95.00
NONRE MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 288 288 0 0 26, 595 190. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 194. 00 0 0 0 0 0 0 194. 00 194. 00 194. 01 07950 OCCUPATI ONAL HEALTH 0 0 0 0 0 0 0 194. 00 194. 01 194. 01 07951 PAIN CLINIC 0 0 0 0 0 0 0 194. 02 194. 02 07952 OAK POI NTE 0 0 0 0 0 0 0 194. 02 194. 03 07953 FOUNDATI ON 0 0 0 27, 203 0 348, 812 194. 03 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 285 285 57, 840 0 324, 805 194. 04 194. 05 07955 VACANT SPACE 0 0 0 0 0 0 194. 05 07955 VACANT SPACE 0 0 0 0 0 0 194. 05 07955 079				154 207	154 207	20 004 50	14 254 227	20 494 100	110 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 288 288 0 0 0 26, 595 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 17, 880 0 603, 207 192. 00 194. 00 07950 OCCUPATI ONAL HEALTH 0 0 0 0 0 0 0 194. 00 194. 01 07951 PAI N CLI NI C 0 0 0 0 0 0 0 0 194. 01 194. 02 07952 OAK POI NTE 0 0 0 0 0 0 0 0 194. 01 194. 02 07952 OAK POI NTE 0 0 0 0 0 0 348, 812 194. 03 194. 04 07954 COMMUNI TY & VOLUNTEER SERVI CES 285 285 57, 840 0 324, 805 194. 04 194. 05 07955 VACANT SPACE 0 0 0 0 0 0 0 0 194. 05 200. 00 Cross Foot Adjustments 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	116.00			104, 397	154, 597	20, 064, 300	-10, 230, 337	29, 004, 190	1110.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 17,880 0 603,207 192.00 194.00 07950 OCCUPATIONAL HEALTH 0 0 0 0 0 0 194.00 194.01 07951 PAIN CLINIC 0 0 0 0 0 0 194.01 194.01 194.02 07952 OAK POINTE 0 0 0 0 0 0 194.02 194.03 07953 FOUNDATION 0 0 0 27,203 0 348,812 194.03 194.04 07954 COMMUNITY & VOLUNTEER SERVICES 285 285 57,840 0 324,805 194.04 194.05 07955 VACANT SPACE 0 0 0 0 0 0 194.05 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 6.733052 11.562883 0.156821 0.524608 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 6.733052 11.562883 0.156821 0.524608 203.00 204.00	190 00			288	288	1		26 595	190 00
194. 00 07950 OCCUPATI ONAL HEALTH 0 0 0 0 0 0 0 194. 00 194. 01 07951 PAI N CLINI C 0 0 0 0 0 0 194. 01 194. 01 194. 02 07952 OAK POI NTE 0 0 0 0 0 0 0 194. 02 194. 02 194. 03 07953 FOUNDATI ON 0 0 0 27, 203 0 348, 812 194. 03 194. 04 07954 COMMUNI TY & VOLUNTEER SERVI CES 285 285 57, 840 0 324, 805 194. 04 194. 05 07955 VACANT SPACE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	192 00	19200	PHYSICIANS' PRIVATE OFFICES						
194. 01 07951 PAIN CLINIC 0 0 0 0 0 0 194. 01 194. 02 194. 02 07952 OAK POINTE 0 0 0 0 0 0 194. 02 194. 03 07953 FOUNDATION 0 0 0 27, 203 0 348, 812 194. 03 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 285 285 57, 840 0 324, 805 194. 04 194. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	Ö	,			
194. 03 07953 FOUNDATION 0 0 27, 203 0 348, 812 194. 03 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 285 285 57, 840 0 324, 805 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 285 57, 840 0 324, 805 194. 04 07955 VACANT SPACE 0 0 0 0 0 194. 05 200. 00 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 203. 00 Unit cost multiplier (Wkst. B, Part I) 6. 733052 11. 562883 0. 156821 0. 524608 203. 00 204. 00 Cost to be allocated (per Wkst. B, Part I) 4, 393, 972 204. 00				0	0		o o	0	194. 01
194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 285 57, 840 0 324, 805 194. 04 194. 05 07955 VACANT SPACE 0 0 0 0 0 194. 05 200. 00 Cross Foot Adjustments 200. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 4. 043, 421 1, 791, 900 3, 165, 803 16, 256, 337 202. 00 204. 00 Unit cost multiplier (Wkst. B, Part I) 6. 733052 11. 562883 0. 156821 0. 524608 203. 00 204. 00 Cost to be allocated (per Wkst. B, Part I) 4, 393, 972 204. 00	194. 02	07952	OAK POINTE	0	0		o o	0	194. 02
194. 05 07955 VACANT SPACE 0 0 0 0 0 0 194. 05 200. 00 201. 00 0 0 201. 00 201. 00 202. 00 Cost to be allocated (per Wkst. B, Part I) 203. 00 Unit cost multiplier (Wkst. B, Part I) 6. 733052 11. 562883 0. 156821 0. 524608 203. 00 204. 00 Cost to be allocated (per Wkst. B, Part I) 0. 524608 203. 00 204. 00 Cost to be allocated (per Wkst. B, Part I) 0. 524608 203. 00 4, 393, 972 204. 00	194. 03	07953	FOUNDATI ON	0	0	27, 20	3 0	348, 812	194. 03
200. 00 Cross Foot Adjustments 200. 00 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 1,043,421 1,791,900 3,165,803 16,256,337 202. 00 203. 00 Unit cost multiplier (Wkst. B, Part I) 6.733052 11.562883 0.156821 0.524608 203. 00 204. 00 Cost to be allocated (per Wkst. B, 0 4,393,972 204. 00				285	285	57, 840	0		
201.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, Part I) 1,791,900 3,165,803 16,256,337 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 6.733052 11.562883 0.156821 0.524608 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 0.43,421 1,791,900 3,165,803 16,256,337 202.00 203.00 204.00				0	0	(이	0	
202. 00 Cost to be allocated (per Wkst. B, Part I) 1,043,421 1,791,900 3,165,803 16,256,337 202.00 203. 00 Unit cost multiplier (Wkst. B, Part I) 6.733052 11.562883 0.156821 0.524608 203.00 204. 00 Cost to be allocated (per Wkst. B, 0 4,393,972 204.00		1							
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, Part I) 6.733052 11.562883 0.156821 0.524608 203.00 4,393,972 204.00		1		1 040 401	4 704 000	0.445.00		1/ 05/ 007	
203.00 Unit cost multiplier (Wkst. B, Part I) 6.733052 11.562883 0.156821 0.524608 203.00 204.00 Cost to be allocated (per Wkst. B, 0 4,393,972 204.00	202.00			1, 043, 421	1, 791, 900	3, 165, 80	ا	16, 256, 337	202.00
204.00 Cost to be allocated (per Wkst. B, 0 4,393,972 204.00	203 00			6 733052	11 562883	0 15682	1	0 524609	203 00
				0. 733032	11. 302003	0. 13002			
	_500							., 5.5, ,72	55
				•	•	*	· ·	•	-

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
				From 01/01/2016 To 12/31/2016		
	CAPITAL REL	ATED COSTS				
Cost Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
	1. 00	2.00	4.00	5A	5. 00	
205.00 Unit cost multiplier (Wkst. B, Part			0. 000000		0. 141798	205. 00

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

Peri od: Wo From 01/01/2016

					o 12/31/2016	Date/Time Pre 3/30/2017 9:0	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	7 alli
		REPAIRS (SQUARE FEET)	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	
		(SQUARE FEET)	(SQUARE FEET)	LAUNDRY)			
	1	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		I	1		I	1.00
2. 00	00200 CAP REL COSTS-BLDG & FTXT						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0	96, 054				6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	542	1			8.00
9.00	00900 HOUSEKEEPI NG	0	453		95, 059		9. 00
10.00	01000 DI ETARY	0	1, 942	1	1, 942		1
11. 00 12. 00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL	0	2, 190	1	2, 190 0	0	11. 00 12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	1	1	132	l .	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	.,		1,000		14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	1, 359 483		1, 359 483	0	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	0	0		0	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	o	0	0	0	19. 00
20.00	02000 NURSI NG SCHOOL	0	0	O C	0	0	20.00
21. 00 22. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0			0	0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	1		Ö	Ö	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 43. 00	03000 ADULTS & PEDI ATRI CS 04300 NURSERY	0				11, 820 0	30. 00 43. 00
44. 00	04400 SKI LLED NURSING FACILITY						44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	12, 668				50.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0		48, 504		0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	15, 528	1	_		54.00
60.00	06000 LABORATORY	0	4, 651	198	4, 651	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	1 2/0	_	0	62. 30
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	2, 346 12, 421			0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	7, 772		0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	2, 017	0	0	68. 00
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0			0	0	69. 00 71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	Ö		0	Ö	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
76. 97 76. 98	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	76. 97 76. 98
76. 99	07699 LI THOTRI PSY				0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0				0	
90. 01 91. 00	09001 INTENSIVE OUT PATIENT PROGRAM 09100 EMERGENCY	0		0 50, 465	_	0	90. 01 91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		14, 377	30, 403	14, 377		92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	O9500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	0	9, 969	0	0	95.00
118. 00		0	95, 481	226, 116	94, 486	11, 820	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		•			190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 OCCUPATIONAL HEALTH	0	ł .				192. 00 194. 00
	07735 GCCCI ATTONAL TIEAETT	0	Ö		0		194. 01
	2 07952 OAK POINTE	0	0) c	0		194. 02
	3 07953 FOUNDATION 1 07954 COMMUNITY & VOLUNTEER SERVICES	0	285		0 285	l .	194. 03 194. 04
	07954 COMMONITY & VOLUNTEER SERVICES	0	285		285		194. 04
200.00	Cross Foot Adjustments]				200. 00
201.00					4 05 1 1	245 -	201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	2, 456, 194	354, 293	1, 024, 642	340, 019	202.00
203.00		0. 000000	25. 570970	1. 566864	10. 779011	28. 766413	203. 00
204.00	Cost to be allocated (per Wkst. B,	0	440, 673	•			204. 00
205.00	Part II) Unit cost multiplier (Wkst. B, Part	0. 000000	4. 587763	0. 194882	1. 100232	6. 060491	205 00
200.00		0.000000	4. 307703	0. 174002	1. 100232	0.000491	200.00

	Financial Systems	WHITLEY MEMORI.			In Lie	u of Form CMS-	
COST AL	LOCATION - STATISTICAL BASIS		Provi der		eriod: com 01/01/2016 o 12/31/2016	Worksheet B-1 Date/Time Pre 3/30/2017 9:0	pared:
	Cost Center Description	CAFETERIA (FTES)	MAI NTENANCE PERSONNEL (NUMBER HOUSED)	OF NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVI CES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11. 00	12.00	13. 00	14. 00	15. 00	
	ENERAL SERVICE COST CENTERS				1		
2. 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 DIETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 01000 NURSING SCHOOL 012100 I&R SERVICES-SALARY & FRINGES APPRV 012200 I&R SERVICES-OTHER PRGM COSTS APPRV 012300 PARAMED ED PRGM-(SPECIFY) 01901 NPATIENT ROUTINE SERVICE COST CENTERS	2, 143 0 31 0 58 0 0 0 0		0 0 1,036 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 057, 480 109, 869 0 0 0 0 0 0	1, 883, 878 0 0 0 0 0 0 0	16. 00 17. 00 19. 00
	3000 ADULTS & PEDIATRICS	314		0 314	34, 185	6	30.00
	04300 NURSERY	28		0 0	35, 398	0	
	04400 SKILLED NURSING FACILITY NCILLARY SERVICE COST CENTERS	0		0 0	0	0	44. 00
	05000 OPERATING ROOM	161		0 161	306, 943	109	50.00
	05200 DELIVERY ROOM & LABOR ROOM	111		0 111	129, 436	0	52. 00
	5300 ANESTHESI OLOGY	0		0 0	o	0	53. 00
1	D5400 RADI OLOGY-DI AGNOSTI C	311		0 0	67, 451	565	1
- 1	06000 LABORATORY	0		0 0	0	0	60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0 0	72.047	0	62. 30
4	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	83 169		0 0	73, 967	0 1, 296	65.00
4	06700 OCCUPATIONAL THERAPY	47		0 0	14, 520 12, 476	1, 296	66. 00 67. 00
	06800 SPEECH PATHOLOGY	12			2, 540	0	68. 00
	06900 ELECTROCARDI OLOGY	0		0 0	0	0	69. 00
71.00	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		0 0	667, 196	0	71. 00
4	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0 0	310, 160	0	
	07300 DRUGS CHARGED TO PATIENTS	0		0 0	0	1, 873, 771	•
1	07697 CARDI AC REHABI LI TATI ON	0		0 0	0		76. 97
	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	0		0 0	0 0	0	
-	OUTPATIENT SERVICE COST CENTERS	1 9		0	<u> </u>		70.77
90.00	99000 CLI NI C	17		0 0	14, 119	5	90. 00
	99001 INTENSIVE OUT PATIENT PROGRAM	0		0 0	0	0	90. 01
	09100 EMERGENCY	450		0 450	132, 465	4, 094	
	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
	9500 AMBULANCE SERVICES	323		0 0	121, 056	4, 032	95. 00
S	PECIAL PURPOSE COST CENTERS				. 1		
	SUBTOTALS (SUM OF LINES 1-117) ONREIMBURSABLE COST CENTERS	2, 115		0 1, 036	2, 031, 781	1, 883, 878	
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0 0	22, 151		190.00
	9200 PHYSICIANS' PRIVATE OFFICES 07950 OCCUPATIONAL HEALTH	/ 0		0 0	3, 548 0		192. 00 194. 00
4	07951 PAIN CLINIC				0		194. 01
	07952 OAK POINTE	o		0 0	Ö		194. 02
194. 03	7953 FOUNDATION	10		0 0	О		194. 03
	07954 COMMUNITY & VOLUNTEER SERVICES	11		0 0	0		194. 04
194. 05 C 200. 00	07955 VACANT SPACE Cross Foot Adjustments	0		0	O	0	194. 05 200. 00
200.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	984, 540		0 432, 131	100, 734	1, 425, 317	ı
	Part I)					,	
203. 00	Unit cost multiplier (Wkst. B, Part I)	459. 421372	0. 0000		0. 048960	0. 756587	
204. 00	Cost to be allocated (per Wkst. B,	136, 689		0 43, 563	41, 675	163, 508	204. 00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part	63. 783948	0. 0000	00 42.049228	0. 020255	0. 086793	205 00
200.00	II)	03. 703740	0.0000	42.047220	0. 020235	0.000793	200.00
		· '		,	<u>'</u>		•

Health Financial Systems In Lieu of Form CMS-2552-10 WHITLEY MEMORIAL HOSPITAL COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0101 Peri od: Worksheet B-1 From 01/01/2016 12/31/2016 Date/Time Prepared: 3/30/2017 9:09 am INTERNS & **RESI DENTS** MEDI CAL SOCIAL SERVICE NONPHYSICIAN NURSING SCHOOL SERVICES-SALAR Cost Center Description Y & FRINGES RECORDS & **ANESTHETISTS** LI BRARY (TIME SPENT) (ASSI GNED **APPRV** (ASSI GNED (TIME SPENT) TIME) TIME) (ASSI GNED TIME) 16.00 17. 00 19.00 20.00 21.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 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 00800 LAUNDRY & LINEN SERVICE 8.00 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 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 10,000 16.00 16,00 17 00 01700 SOCIAL SERVICE 17 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 20.00 02000 NURSING SCHOOL 0 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 21.00 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 Ω 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 823 0 0 0 0 0 43.00 04300 NURSERY 170 C 0 0 43.00 04400 SKILLED NURSING FACILITY 0 0 44.00 0 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 192 0 0 0 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 52.00 0 52.00 0 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54 00 4, 206 0 54 00 0 60.00 06000 LABORATORY 0 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0 0 0 62.30 06500 RESPIRATORY THERAPY 0 65.00 65.00 0 0 0 06600 PHYSI CAL THERAPY 0 66.00 1,041 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 368 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 135 0 68.00 06900 ELECTROCARDI OLOGY 0 69 00 0 Ω 0 69 00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0 C 0 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 72.00 73.00 0 0 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 07697 CARDIAC REHABILITATION 76 97 0 0 76 97 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 0 76.98 07699 LI THOTRI PSY 0 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 0 0 0 0 90.01 0 0 91.00 09100 EMERGENCY 3,065 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 0 0 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 10,000 0 0 0 0 118.00 118.00 NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 192.00 0 0 0 0 194.00 194. 00 07950 OCCUPATIONAL HEALTH 0 0 194. 01 07951 PAIN CLINIC 0 0 0 194. 01 194. 02 07952 OAK POINTE 0 0 194. 02 0 0 0 194. 03 07953 FOUNDATI ON 0 0 194. 03 0 194.04 07954 COMMUNITY & VOLUNTEER SERVICES 0 0 C 0 0 194.04 194. 05 07955 VACANT SPACE 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, 31,030 0 0 202.00

3. 103000

12.837

0.000000

0.000000

0.000000

0.000000 203.00 0 204.00

Part II)

Unit cost multiplier (Wkst. B, Part I)

Cost to be allocated (per Wkst. B,

203.00

204 00

Health Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
				From 01/01/2016 To 12/31/2016		
					I NTERNS & RESI DENTS	
Cost Center Description	MEDICAL RECORDS &	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS	NURSING SCHOOL	SERVICES-SALAR 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	
205.00 Unit cost multiplier (Wkst. B, Part	1. 283700	0. 000000	0. 000000	0.000000	0. 000000	205. 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

From 01/01/2016 12/31/2016 Date/Time Prepared: 3/30/2017 9:09 am INTERNS & **RESI DENTS** Cost Center Description SERVI CES-OTHER PARAMED ED PRGM COSTS **PRGM APPRV** (ASSI GNED (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 69 00 06900 ELECTROCARDI OLOGY 0 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 1-117) 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 0 190.00 0 0 192.00 194. 00 07950 OCCUPATIONAL HEALTH 194. 00 0 0 194. 01 07951 PAIN CLINIC 0 194.01 194. 02 07952 OAK POINTE 0 194.02 0 194. 03 07953 FOUNDATI ON 194.03 0 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 0 194.04 194. 05 07955 VACANT SPACE 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, O 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.000000 203.00 204. 00 204.00 Cost to be allocated (per Wkst. B, Part II)

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CO	CN: 15-0101	Peri od:	Worksheet B-1	
				From 01/01/2016 To 12/31/2016	Date/Time Pre 3/30/2017 9:0	pared:
	INTERNS &					
	RESI DENTS	DADAMED ED				
Cost Center Description	SERVI CES-OTHER	PARAMED ED				
	PRGM COSTS	PRGM				
	APPRV	(ASSI GNED				
	(ASSI GNED	TIME)				
	TIME)					
	22.00	23. 00				
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000				205. 00

Health Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 15-0101	Peri od: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 3/30/2017 9:0	pared: 9 am
		Ti tl e	e XVIII	Hospi tal	PPS	
·				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	

						37 307 2017 7.0	7 aiii
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	'	(from Wkst. B,	Áďj.		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
30. 00	03000 ADULTS & PEDIATRICS	6, 011, 767		6, 011, 767	٥	6, 011, 767	30.00
43. 00	04300 NURSERY	452, 671		452, 671	0	452, 671	43. 00
	04400 SKILLED NURSING FACILITY	132,071		432, 071	0	432, 671	1
44.00	ANCI LLARY SERVI CE COST CENTERS	1 0		0	U O	0	1 44.00
50. 00		3, 415, 888		3, 415, 888	٥	3, 415, 888	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 856, 009		1, 856, 009		1, 856, 009	
53.00	05300 ANESTHESI OLOGY	26, 957		26, 957		33, 334	
54.00	05400 RADI OLOGY - DI AGNOSTI C	5, 297, 724	l e	5, 297, 724		5, 297, 724	1
60.00	06000 LABORATORY	4, 224, 255		4, 224, 255	0	4, 224, 255	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	_	0	0	0	
65. 00	06500 RESPI RATORY THERAPY	1, 053, 935		1, 053, 935		1, 053, 935	
66. 00	06600 PHYSI CAL THERAPY	1, 592, 135		1, 592, 135		1, 592, 135	
67. 00	06700 OCCUPATI ONAL THERAPY	1, 053, 052		1, 053, 052		1, 053, 052	
68. 00	06800 SPEECH PATHOLOGY	219, 002		219, 002		219, 002	
69. 00	06900 ELECTROCARDI OLOGY	14, 780		14, 780		14, 780	
71. 00		991, 136		991, 136	0	991, 136	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	507, 200		507, 200	0	507, 200	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 200, 872		4, 200, 872	0	4, 200, 872	73. 00
76. 97	07697 CARDIAC REHABILITATION	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	<u>'</u>					
90.00	09000 CLI NI C	459, 131		459, 131	0	459, 131	90. 00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0		0	o	0	1
91. 00	09100 EMERGENCY	10, 598, 292		10, 598, 292	30, 576	10, 628, 868	
92.00		1, 570, 319		1, 570, 319		1, 570, 319	
00	OTHER REIMBURSABLE COST CENTERS	.,0,0,0,7		., 0, 0, 01,		., 5, 6, 61,	1
95. 00	09500 AMBULANCE SERVI CES	3, 246, 986		3, 246, 986	n	3, 246, 986	95. 00
200.00	l l	46, 792, 111					
201.00		1, 570, 319		1, 570, 319		1, 570, 319	
202.00		45, 221, 792					
202.00	Total (See Histi dell'ons)	1 75, 221, 772	1	75, 221, 772	30, 733	75, 256, 745	1202.00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-010	1 Period: Worksheet C From 01/01/2016 Part I To 12/31/2016 Date/Time Prepared:

				Т	o 12/31/2016	Date/Time Pre 3/30/2017 9:0	
-			Title	XVIII	Hospi tal	PPS	7 dili
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpati ent Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	5, 744, 699		5, 744, 699			30.00
	04300 NURSERY	1, 674, 072		1, 674, 072		1	43.00
	04400 SKILLED NURSING FACILITY	O		0		1	44.00
	ANCILLARY SERVICE COST CENTERS				'		
50. 00	05000 OPERATING ROOM	4, 697, 212	18, 169, 799	22, 867, 011	0. 149381	0.000000	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	8, 058, 769	221, 698	8, 280, 467	0. 224143	0.000000	52. 00
53. 00	05300 ANESTHESI OLOGY	449, 668	2, 293, 080	2, 742, 748	0. 009828	0.000000	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 215, 181	50, 163, 587	53, 378, 768	0. 099248	0.000000	54.00
60. 00	06000 LABORATORY	2, 811, 671	16, 781, 428	19, 593, 099	0. 215599	0.000000	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	O	0	0	0.000000	0.000000	62. 30
65. 00	06500 RESPI RATORY THERAPY	899, 245	3, 063, 087	3, 962, 332	0. 265989	0.000000	65. 00
66. 00	06600 PHYSI CAL THERAPY	236, 877	3, 678, 687	3, 915, 564	0. 406617	0.000000	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	123, 721	1, 025, 426	1, 149, 147	0. 916377	0.000000	67.00
68. 00	06800 SPEECH PATHOLOGY	14, 709	313, 876	328, 585	0. 666500	0.000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	828, 478	2, 180, 849	3, 009, 327	0. 004911	0.000000	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	990, 903	3, 075, 149	4, 066, 052	0. 243759	0.000000	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	482, 139	611, 060	1, 093, 199	0. 463959	0.000000	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 212, 123	10, 529, 923	14, 742, 046	0. 284959	0.000000	73.00
76. 97	07697 CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76. 97
76. 98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76. 98
	07699 LI THOTRI PSY	0	0	0	0. 000000	0.000000	76. 99
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	1, 365	205, 768	207, 133	2. 216600	0.000000	90. 00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0	0.000000	0.000000	90. 01
91. 00	09100 EMERGENCY	2, 297, 110	27, 356, 562	29, 653, 672	0. 357402	0.000000	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2, 964, 776	2, 964, 776	0. 529659	0.000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES	0	5, 096, 938	5, 096, 938	0. 637046	0. 000000	95. 00
200. 00	Subtotal (see instructions)	36, 737, 942	147, 731, 693	184, 469, 635		ı	200. 00
201.00	Less Observation Beds					i	201. 00
202. 00	Total (see instructions)	36, 737, 942	147, 731, 693	184, 469, 635			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 From 01/01/2016 Part I To 12/31/2016 Date/Ti me 3/30/2017	e Prepared:

				3/30/2017 9:0	<u>)9 am</u>
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
43. 00 04300 NURSERY					43. 00
44.00 04400 SKILLED NURSING FACILITY					44. 00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 149381				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 224143				52. 00
53. 00 05300 ANESTHESI OLOGY	0. 012154				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 099248				54.00
60. 00 06000 LABORATORY	0. 215599				60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000				62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 265989				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 406617				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 916377				67.00
68.00 06800 SPEECH PATHOLOGY	0. 666500				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 004911				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 243759				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 463959				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 284959				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					1
90. 00 09000 CLI NI C	2. 216600				90.00
90.01 09001 INTENSIVE OUT PATIENT PROGRAM	0. 000000				90. 01
91. 00 09100 EMERGENCY	0. 358433				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 529659				92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0. 637046				95. 00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202. 00
	'				

Health Financial Systems	WHITLEY MEMORI	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 3/30/2017 9:0	
		Ti tl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	

			T: 11	VIV		37 307 2017 7. 0	7 am
			IITI	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 & PEDIATRICS	6, 011, 767		6, 011, 767	0	6, 011, 767	30.00
43.00	04300 NURSERY	452, 671		452, 671	0	452, 671	43.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
	ANCILLARY SERVICE COST CENTERS	•		<u>'</u>			1
50.00	05000 OPERATI NG ROOM	3, 415, 888		3, 415, 888	0	3, 415, 888	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 856, 009		1, 856, 009		1, 856, 009	
53.00	05300 ANESTHESI OLOGY	26, 957		26, 957		33, 334	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 297, 724		5, 297, 724	0	5, 297, 724	54.00
60.00	06000 LABORATORY	4, 224, 255		4, 224, 255		4, 224, 255	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	1
65. 00	06500 RESPI RATORY THERAPY	1, 053, 935	0	1, 053, 935	0	1, 053, 935	1
66. 00	06600 PHYSI CAL THERAPY	1, 592, 135		1, 592, 135		1, 592, 135	1
67. 00	06700 OCCUPATI ONAL THERAPY	1, 053, 052		1, 053, 052		1, 053, 052	
68. 00	06800 SPEECH PATHOLOGY	219, 002		219, 002		219, 002	
69. 00	06900 ELECTROCARDI OLOGY	14, 780		14, 780		14, 780	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	991, 136		991, 136		991, 136	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	507, 200		507, 200		507, 200	
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 200, 872		4, 200, 872		4, 200, 872	
76. 97	07697 CARDI AC REHABI LI TATI ON	1,200,072		1, 200, 0, 2	0	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY			0	0	0	76. 98
76. 79	07699 LI THOTRI PSY	0		0	0	0	
70. 77	OUTPATIENT SERVICE COST CENTERS				<u> </u>	0	70. 77
90. 00		459, 131		459, 131	0	459, 131	90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	457, 151		437, 131	0	457, 131	1
91. 00	09100 EMERGENCY	10, 598, 292		10, 598, 292	۱	10, 628, 868	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 570, 319		1, 570, 319		1, 570, 319	
72.00	OTHER REIMBURSABLE COST CENTERS	1, 370, 319		1, 570, 519		1, 370, 317	72.00
95. 00		3, 246, 986		3, 246, 986	0	3, 246, 986	05.00
200.00		46, 792, 111	l e				
200.00			ł			1, 570, 319	
	· ·	1, 570, 319		1, 570, 319			
202.00	of total (see mistructions)	45, 221, 792	0	45, 221, 792	36, 953	45, 258, 745	1202.00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0101	Period: Worksheet C From 01/01/2016 Part I
		To 12/31/2016 Date/Time Prepared

					To 12/31/2016	Date/Time Pre 3/30/2017 9:0	
			Titl	e XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	Inpatient	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient	
				1 001. 7)	Ratio	Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	5, 744, 699		5, 744, 69	9		30. 00
43.00	04300 NURSERY	1, 674, 072		1, 674, 07	2	I	43.00
44.00	04400 SKILLED NURSING FACILITY	0				I	44. 00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	4, 697, 212	18, 169, 799	22, 867, 01	0. 149381	0. 000000	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	8, 058, 769	221, 698	8, 280, 46	7 0. 224143	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	449, 668	2, 293, 080	2, 742, 74	0. 009828	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 215, 181	50, 163, 587	53, 378, 76	0. 099248	0.000000	54.00
60.00	06000 LABORATORY	2, 811, 671	16, 781, 428	19, 593, 09 ⁹	9 0. 215599	0.000000	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0.000000	0.000000	62. 30
65.00	06500 RESPI RATORY THERAPY	899, 245	3, 063, 087	3, 962, 33	0. 265989	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	236, 877	3, 678, 687	3, 915, 56	0. 406617	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	123, 721	1, 025, 426	1, 149, 14	0. 916377	0.000000	67.00
68. 00	06800 SPEECH PATHOLOGY	14, 709	313, 876	328, 58	0. 666500	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	828, 478	2, 180, 849	3, 009, 32	0. 004911	0.000000	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	990, 903	3, 075, 149	4, 066, 05	0. 243759	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	482, 139	611, 060	1, 093, 19	0. 463959	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 212, 123	10, 529, 923	14, 742, 04	0. 284959	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						
	09000 CLI NI C	1, 365	205, 768	207, 13		0. 000000	90. 00
	09001 INTENSIVE OUT PATIENT PROGRAM	0	0		0.000000	0.000000	90. 01
	09100 EMERGENCY	2, 297, 110	27, 356, 562	29, 653, 67	0. 357402	0.000000	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2, 964, 776	2, 964, 77	0. 529659	0.000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	5, 096, 938	5, 096, 93	0. 637046	0.000000	95. 00
200.00		36, 737, 942	147, 731, 693	184, 469, 63	ō		200. 00
201.00							201. 00
202.00	Total (see instructions)	36, 737, 942	147, 731, 693	184, 469, 63	ō	I	202. 00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu o	f Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0101	From 01/01/2016 Pa To 12/31/2016 Da	orksheet C ort I ort I orte/Time Prepared: (30/2017 9:09 am

				3/30/2017 9:09 am
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
43. 00 04300 NURSERY				43. 00
44.00 04400 SKILLED NURSING FACILITY				44. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 149381			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 224143			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 012154			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 099248			54. 00
60. 00 06000 LABORATORY	0. 215599			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 265989			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 406617			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 916377			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 666500			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 004911			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 243759			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 463959			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 284959			73. 00
76. 97 07697 CARDIAC REHABILITATION	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	2. 216600			90.00
90.01 09001 INTENSIVE OUT PATIENT PROGRAM	0. 000000			90. 01
91. 00 09100 EMERGENCY	0. 358433			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 529659			92. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 637046			95. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
	1			1

Health Financial Systems		WHITLEY MEMORIA	_ HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE	COST TO CHARGE	RATIOS NET OF	Provider CCN: 15-0101	Peri od:	Worksheet C
REDUCTIONS FOR MEDICALD ONLY				From 01/01/2016	Part II

12/31/2016 Date/Time Prepared: To 3/30/2017 9:09 am Title XIX Hospi tal PPS Operating Cost Capital Cost Operating Cost Cost Center Description Total Cost Capi tal (Wkst. B, Part (Wkst. B, Part Net of Capital Reducti on Reducti on I, col. 26) Cost (col. 1 Amount II col. 26) col. 2) 1.00 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 3, 415, 888 589, 482 2, 826, 406 50.00 50.00 0 0 0 0 0 0 0 0 0 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 179, 735 1, 676, 274 52.00 1, 856, 009 0 52.00 53.00 05300 ANESTHESI OLOGY 26, 957 2,507 24, 450 53.00 05400 RADI OLOGY-DI AGNOSTI C 5, 297, 724 826, 092 4, 471, 632 54.00 0 54.00 06000 LABORATORY 60.00 4, 224, 255 488, 717 3, 735, 538 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 62.30 65.00 06500 RESPIRATORY THERAPY 1,053,935 149, 329 904, 606 0 65.00 66.00 06600 PHYSI CAL THERAPY 1, 592, 135 409, 191 1, 182, 944 66.00 06700 OCCUPATIONAL THERAPY 67.00 1,053,052 99, 874 953, 178 0 67.00 68.00 06800 SPEECH PATHOLOGY 219,002 20, 893 198, 109 0 68.00 69.00 06900 ELECTROCARDI OLOGY 14, 780 1, 375 13, 405 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 991, 136 102, 660 888, 476 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 507, 200 455, 158 72.00 72.00 52, 042 0 73.00 07300 DRUGS CHARGED TO PATIENTS 4, 200, 872 421, 487 3, 779, 385 0 73.00 07697 CARDIAC REHABILITATION 76. 97 76. 97 0 0 0 0 07698 HYPERBARI C OXYGEN THERAPY 76. 98 76 98 0 O 0 07699 LI THOTRI PSY 76. 99 0 0 76. 99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 459, 131 117, 271 341, 860 0 0 90.00 09001 INTENSIVE OUT PATIENT PROGRAM 0 Ω 90.01 90.01 91.00 09100 EMERGENCY 10, 598, 292 1, 300, 983 9, 297, 309 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 273, 165 92.00 92.00 1,570,319 1, 297, 154 0 0 OTHER REIMBURSABLE COST CENTERS 95.00 95. 00 09500 AMBULANCE SERVICES 3, 246, 986 311, 248 2, 935, 738 0 200.00 Subtotal (sum of lines 50 thru 199) 40, 327, 673 5, 346, 051 34, 981, 622 0 0 200.00 0 273, 165 1, 297, 154 0 201. 00 201.00 Less Observation Beds 1,570,319 0 202.00 Total (line 200 minus line 201)

38, 757, 354

5, 072, 886

33, 684, 468

202.00

Health Financial Systems	WHITLEY ME	EMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST REDUCTIONS FOR MEDICALD ONLY	TO CHARGE RATIOS NET OF	F Provi der CCN: 15-0101	Peri od: From 01/01/2016 To 12/31/2016	Worksheet C Part II Date/Time Prepared:

						3/30/2017 9:0	9 am
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
			(Worksheet C,				
		Operating Cost	Part I, column	Ratio (col.	6		
		Reduction	8)	/ col. 7)			
		6. 00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3, 415, 888	22, 867, 011	0. 14938	31		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 856, 009	8, 280, 467	0. 22414	13		52.00
53.00	05300 ANESTHESI OLOGY	26, 957	2, 742, 748	0. 00982	28		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 297, 724	53, 378, 768	0. 09924	18		54.00
60.00	06000 LABORATORY	4, 224, 255	19, 593, 099	0. 21559	9		60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	00		62. 30
65.00	06500 RESPI RATORY THERAPY	1, 053, 935	3, 962, 332	0. 26598	39		65. 00
66.00	06600 PHYSI CAL THERAPY	1, 592, 135	3, 915, 564	0. 40661	7		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 053, 052	1, 149, 147	0. 91637	77		67. 00
68. 00	06800 SPEECH PATHOLOGY	219, 002	328, 585	0. 66650	00		68. 00
69.00	06900 ELECTROCARDI OLOGY	14, 780	3, 009, 327	0. 00491	1		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	991, 136	4, 066, 052	0. 24375	59		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	507, 200	1, 093, 199	0. 46395	59		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 200, 872	14, 742, 046	0. 28495	59		73. 00
76. 97	07697 CARDIAC REHABILITATION	O	0	0.00000	00		76. 97
76. 98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.00000	00		76. 98
76. 99	07699 LI THOTRI PSY	0	0	0.00000	00		76. 99
Ī	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	459, 131	207, 133	2. 21660	00		90. 00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0.00000	00		90. 01
91.00	09100 EMERGENCY	10, 598, 292	29, 653, 672	0. 35740)2		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 570, 319			59		92. 00
Ī	OTHER REIMBURSABLE COST CENTERS				<u>'</u>		
95. 00	09500 AMBULANCE SERVICES	3, 246, 986	5, 096, 938	0. 63704	16		95. 00
200.00	Subtotal (sum of lines 50 thru 199)	40, 327, 673					200.00
201.00	Less Observation Beds	1, 570, 319					201. 00
202.00	Total (line 200 minus line 201)	38, 757, 354					202.00
1				1	Į.		

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 01/01/2016 To 12/31/2016		pared: 9 am	
			XVIII	Hospi tal	PPS		
Cost Center Description	Capi tal	Swi ng 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 & PEDI ATRI CS	1, 045, 776	0	1, 045, 77	6 5, 130	203. 85	30.00	
43. 00 NURSERY	44, 065		44, 06	5 882	49. 96	43.00	
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	44.00	
200.00 Total (lines 30-199)	1, 089, 841		1, 089, 84	1 6, 012		200. 00	
Cost Center Description	I npati ent	I npati ent					
	Program days	Program					
		Capital Cost					
		(col. 5 x col.					
		6)					
	6.00	7. 00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDIATRICS	1, 159	236, 262	1			30.00	
43. 00 NURSERY	0	0				43.00	
44.00 SKILLED NURSING FACILITY	0	0				44.00	
200.00 Total (lines 30-199)	1, 159	236, 262	1			200. 00	

Heal th	Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Period: From 01/01/2016 To 12/31/2016		pared: 9 am
				XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
			(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	· ·		. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS		T			T	
50.00	05000 OPERATING ROOM	589, 482					
52. 00	05200 DELIVERY ROOM & LABOR ROOM	179, 735				l e	52. 00
53.00	05300 ANESTHESI OLOGY	2, 507				l	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	826, 092					
60.00	06000 LABORATORY	488, 717	19, 593, 099	l .		22, 116	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000		0	62. 30
65.00	06500 RESPI RATORY THERAPY	149, 329					65. 00
66. 00	06600 PHYSI CAL THERAPY	409, 191	3, 915, 564	0. 10450	107, 360	11, 220	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	99, 874	1, 149, 147	0. 08691	1 59, 582	5, 178	67. 00
68. 00	06800 SPEECH PATHOLOGY	20, 893	328, 585	0. 06358	6, 764	430	68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 375	3, 009, 327	0.00045	57 252, 102	115	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	102, 660	4, 066, 052	0. 02524	176, 080	4, 446	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	52, 042	1, 093, 199	0. 04760	180, 227	8, 580	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	421, 487	14, 742, 046	0. 02859	1, 057, 712	30, 241	73.00
76. 97	07697 CARDIAC REHABILITATION	0	0	0.00000	0 0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0. 00000	0 0	0	76. 98
7/ 00	07/00 LITUOTRI DEV		l	0 00000	nol 0	1 ^	7/ 00

117, 271

273, 165

1, 300, 983

5, 034, 803

0.000000

0. 566163

0.000000

0.043873

0.092137

207, 133

29, 653, 672

171, 953, 926

2, 964, 776

0 76. 99

90.00

90. 01

91.00

0 92.00

95.00

379

39, 020

0

170, 368 200. 00

670

889, 387

5, 964, 387

76. 99

90.00

90. 01

92.00

200.00

07699 LI THOTRI PSY

95. 00 09500 AMBULANCE SERVICES

91. 00 09100 EMERGENCY

OUTPATIENT SERVICE COST CENTERS
09000 CLINIC
09001 INTENSIVE OUT PATIENT PROGRAM

Total (lines 50-199)

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

Health Financial Systems	WHITLEY MEMOR	IAL F	IOSPI TAL		In Li€	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS F	Provi der CO		Period: From 01/01/2016 To 12/31/2016		pared: 9 am
			Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Alli	Cost	All Other Medical Education Cos		Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1.00		2.00	3.00	4. 00	5. 00	
30.00 03000 ADULTS & PEDIATRICS 043.00 04300 NURSERY 044.00 200.00 Other Total (lines 30-199) Cost Center Description	Total Patient Days		0 0 0	Inpatient Program Days	0 0 0 Inpatient	0 0 0 0	30. 00 43. 00 44. 00 200. 00
INPATIENT ROUTINE SERVICE COST CENTERS	0.00		7.00	0.00	7.00		
30. 00 03000 ADULTS & PEDIATRICS 43. 00 04300 NURSERY 44. 00 04400 SKI LLED NURSI NG FACI LI TY 200. 00 Total (li nes 30-199)	5, 130 882 0 6, 012		0. 00 0. 00 0. 00	,	0 0		30. 00 43. 00 44. 00 200. 00

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0101	Peri od: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 3/30/2017 9:09 am
		T' 11 \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	11 1 1	DDC

				'	0 12/31/2010	3/30/2017 9:0	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician Nu	ursing School	Allied Health	All Other	Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS		_	_	-1		
	05000 OPERATI NG ROOM	0	0	0	0	0	50. 00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	이	0	52. 00
	05300 ANESTHESI OLOGY	0	0	C	이	0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	0	C	이	0	54. 00
	06000 LABORATORY	0	0	0	0	0	60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
	06500 RESPI RATORY THERAPY	0	0	0	0	0	65. 00
	06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	C	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	C	0	0	76. 98
	07699 LI THOTRI PSY	0	0	C	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0	0	0	0	, , , , , ,
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0	90. 01
91. 00	09100 EMERGENCY	0	0	C	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	C	0	. 0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES					1	95. 00
200.00	Total (lines 50-199)	0	0	[C	o o	0	200. 00

Heal th	ealth Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10							
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS				Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV	pared:	
				XVIII	Hospi tal	PPS		
	Cost Center Description	Total	Total Charges			Inpati ent		
			(from Wkst. C,		Ratio of Cost	Program		
		Cost (sum of		(col. 5 ÷ col		Charges		
		col. 2, 3 and	8)	7)	(col. 6 ÷ col.			
		4)			7)			
	I	6. 00	7. 00	8. 00	9. 00	10. 00		
	ANCILLARY SERVICE COST CENTERS	1				(10.0(0		
50.00	05000 OPERATI NG ROOM	0	22, 867, 011	1		618, 960		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	8, 280, 467			•	52.00	
53.00	05300 ANESTHESI OLOGY	0	2, 742, 748			-	1	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	53, 378, 768			1, 333, 415		
60.00	06000 LABORATORY	0	19, 593, 099	1		886, 666	60.00	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0 0 0 0 0 0 0	0.00000		0	62. 30	
65. 00	06500 RESPI RATORY THERAPY	0	3, 962, 332			313, 695	65.00	
66.00	06600 PHYSI CAL THERAPY	0	3, 915, 564	1		107, 360	66.00	
67. 00	06700 OCCUPATI ONAL THERAPY	0	1, 149, 147			· ·	67. 00	
68. 00	06800 SPEECH PATHOLOGY	0	328, 585				68. 00	
69. 00	06900 ELECTROCARDI OLOGY	0	3, 009, 327	1			69.00	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	4, 066, 052				1	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	1, 093, 199				72.00	
	07300 DRUGS CHARGED TO PATIENTS	0	14, 742, 046	1		1, 057, 712	1	
	07697 CARDI AC REHABI LI TATI ON	0	0	0.00000		0	76. 97	
	07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000		0	76. 98	
76. 99	07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0	0	0.00000	0.000000	0	76. 99	
90. 00	09000 CLINIC		207 122	0.00000	0. 000000	670	90.00	
90.00	09000 CLINIC 09001 INTENSIVE OUT PATIENT PROGRAM		207, 133	0.00000		670	90.00	
90.01	09100 EMERGENCY	0	29, 653, 672	1		889, 387	90.01	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	29, 653, 672	1		0 889, 387	91.00	
72. UU	U7200 OBSERVATION BEDS (NON-DISTINCT PART		2, 904, 770	0.00000	0.00000		72.00	

171, 953, 926

92.00 95.00

5, 964, 387 200. 00

92. 00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS | 095.00 | 09500 | AMBULANCE SERVICES | 200.00 | Total (lines 50-199)

Health 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 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared:

				To	12/31/2016	Date/Time Pr 3/30/2017 9:	
			Title	xVIII	Hospi tal	PPS	<u> </u>
	Cost Center Description	I npati ent	Outpati ent	Outpati ent	· · · · · · · · · · · · · · · · · · ·		
	'	Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8		Costs (col. 9			
		x col. 10)		x col. 12)			
		11. 00	12.00	13. 00			
	ANCILLARY SERVICE COST CENTERS						
50.00	O5000 OPERATI NG ROOM	0	2, 560, 349	0			50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0			52. 00
53.00	05300 ANESTHESI OLOGY	0	313, 683	0			53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	8, 077, 990	0			54. 00
60.00	06000 LABORATORY	0	182, 381	0			60. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62. 30
65.00	06500 RESPI RATORY THERAPY	0	499, 658	0			65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	0			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0			67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	0			68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	617, 554	0			69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	281, 256	0			71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	114, 672	0			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	3, 442, 261	0			73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	o	0	o			76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	o	0	o			76. 98
76. 99	07699 LI THOTRI PSY	o	0	o			76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	138, 121	0			90. 00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	o	0	0			90. 01
91.00	09100 EMERGENCY	o	4, 095, 153	o			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	o	482, 632	0			92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50-199)	o	20, 805, 710	0			200.00

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC	CN: 15-0101	Peri od: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Pre 3/30/2017 9:0	
		Title	XVIII	Hospi tal	PPS	
		·	Charges		Costs	
Cost Center Description	Cost to Charge Ratio From Worksheet C,	PPS Reimbursed Services (see inst.)		Cost Rei mbursed Servi ces Not	PPS Services (see inst.)	

					3/30/2017 9:0	19 am
		Ti tl e	Title XVIII Hospital		PPS	
		Charges		Costs		
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	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						
50. 00 05000 OPERATING ROOM	0. 149381	2, 560, 349		0	382, 467	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 224143	0)	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 009828	313, 683		0	3, 083	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 099248	8, 077, 990	1	0	801, 724	54.00
60. 00 06000 LABORATORY	0. 215599	182, 381		0	39, 321	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0)	0 0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 265989	499, 658		0 0	132, 904	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 406617	0)	0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 916377	0)	0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 666500	0	1	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 004911	617, 554		0	3, 033	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 243759	281, 256	,	0	68, 559	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 463959	114, 672		0	53, 203	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 284959	3, 442, 261		0	980, 903	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0	1	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0	1	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0	1	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS				*		
90. 00 09000 CLI NI C	2. 216600	138, 121		0 0	306, 159	90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0. 000000)	0 0	0	90. 01
91. 00 09100 EMERGENCY	0. 357402	4, 095, 153		0 0	1, 463, 616	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 529659			0 0	255, 630	
OTHER REIMBURSABLE COST CENTERS	•		,	·		
95. 00 09500 AMBULANCE SERVICES	0. 637046			0		95. 00
200.00 Subtotal (see instructions)		20, 805, 710		ol o	4, 490, 602	200.00
201.00 Less PBP Clinic Lab. Services-Program				ol o		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		20, 805, 710		0	4, 490, 602	202. 00
, , , , , , , , , , , , , , , , , , , ,	•	•	•	•	•	•

Health Financial Systems	WHITLEY MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVIC	ES AND VACCINE COST	Provi der Co	CN: 15-0101		Worksheet D Part V Date/Time Pre 3/30/2017 9:0	
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7.00				
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54 OO O5400 RADLOLOGY-DLAGNOSTLC	0	1				54 00

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider Co	Provider CCN: 15-0101		Worksheet D Part I Date/Time Prepared 3/30/2017 9:09 am		
			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 & PEDI ATRI CS	1, 045, 776	0	1, 045, 77	6 5, 130	203. 85	30.00	
43. 00 NURSERY	44, 065		44, 06	5 882	49. 96	43.00	
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	44.00	
200.00 Total (lines 30-199)	1, 089, 841		1, 089, 84	1 6, 012		200. 00	
Cost Center Description	I npati ent	I npati ent					
	Program days	Program					
		Capital Cost					
		(col. 5 x col.					
		6)					
	6.00	7. 00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDIATRICS	132	26, 908				30.00	
43. 00 NURSERY	123	6, 145				43.00	
44.00 SKILLED NURSING FACILITY	0	0				44.00	
200.00 Total (lines 30-199)	255	33, 053				200. 00	

Health Financial Systems	WHITLEY MEMOR	IAI HOSPITAI		In lie	u of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II	pared:
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Total Charges (from Wkst. C, Part I, col. 8)	to Charges	Program	Capital Costs (column 3 x column 4)	
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS				-		
50. 00 05000 OPERATI NG ROOM	589, 482	22, 867, 011	0. 02577	9 1, 549, 075	39, 934	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	179, 735	8, 280, 467	0. 02170	1, 486, 797	32, 272	52. 00
53. 00 05300 ANESTHESI OLOGY	2, 507	2, 742, 748	0. 00091	4 212, 429	194	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	826, 092	53, 378, 768	0. 01547	6 368, 435	5, 702	54.00
60. 00 06000 LABORATORY	488, 717	19, 593, 099	0. 02494	3 590, 023	14, 717	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	0 0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	149, 329	3, 962, 332	0. 03768	7 135, 808	5, 118	65. 00
66. 00 06600 PHYSI CAL THERAPY	409, 191	3, 915, 564	0. 10450	9, 403	983	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	99, 874	1, 149, 147	0. 08691	1 2, 281	198	67. 00
68. 00 06800 SPEECH PATHOLOGY	20, 893	328, 585	0. 06358	5 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 375	3, 009, 327	0. 00045	7 81, 176	37	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	102, 660	4, 066, 052	0. 02524	8 238, 721	6, 027	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	52, 042	1, 093, 199	0. 04760	10, 265	489	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	421, 487	14, 742, 046	0. 02859	1 809, 217	23, 136	73. 00
76. 97 07697 CARDIAC REHABILITATION	0	0	0.00000	0 0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000	0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0. 00000	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	117, 271	207, 133	0. 56616	337	191	90.00
90.01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0.00000	0	0	90. 01
91. 00 09100 EMERGENCY	1, 300, 983	29, 653, 672	0. 04387	3 248, 120	10, 886	91.00
02 00 00200 OBSEDVATION PEDS (NON DISTINCT DART	272 165	2 064 776	0 00212	7 0	l n	02 00

273, 165

5, 034, 803

0.092137

5, 742, 087

139, 884 200. 00

92.00 95.00

171, 953, 926

2, 964, 776

Health Financial Systems	WHITLEY MEMORI	IAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	TS Provider C		Peri od:	Worksheet D	
				From 01/01/2016 To 12/31/2016		pared:
					3/30/2017 9:0	
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health		Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
					minus col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0)	0	0	
43. 00 04300 NURSERY	0	0)	0	0	
44.00 04400 SKILLED NURSING FACILITY	0	0)		0	44. 00
200.00 Total (lines 30-199)	0	0)	0	0	200. 00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6. 00	7. 00	8. 00	9. 00		
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	5, 130		1			30. 00
43. 00 04300 NURSERY	882	0.00	12	3 0		43. 00
44.00 04400 SKILLED NURSING FACILITY	0	0.00		0		44. 00
200.00 Total (lines 30-199)	6, 012		25	5 0		200. 00

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS		Peri od: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 3/30/2017 9:09 am
		Title XIX	Hospi tal	PPS
Cost Center Description	Non Physician	Mursing School Allied Healt	h All Other	Total Cost

			'	0 12/31/2010	3/30/2017 9:0	
			e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician Nu	ursing School	Allied Health		Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS				ا		
50. 00 05000 OPERATI NG ROOM	0	0	Ü	0	0	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0	Ü	0	01	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	Ü	0	01	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	Ü	0	01	54.00
60. 00 06000 LABORATORY	0	0	Ü	0	01	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	Ü	0	01	62. 30
65. 00 06500 RESPI RATORY THERAPY	0	0	U	0	01	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	U	0	01	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	U	0	01	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	U	0	01	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	U	0	01	69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	U	0	01	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	U	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	Ü	0	01	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	01	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	Ü	0	01	76. 98
76. 99 07699 LITHOTRIPSY	l U	U	U	ıl U	0	76. 99
OUTPATIENT SERVICE COST CENTERS 90. 00 O9000 CLINIC		٥		ا	0	90.00
90. 00 09000 CLINIC 90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0		0	90.00
91. 00 09100 EMERGENCY	0	0			0	91.00
	0	0	0		0	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	UU	U	U	y U	U	92.00
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)		0	_			200.00
200.00 10tal (11165 50-199)	l ol	U	l	ų ų	U	₁ 200.00

	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	WHITLEY MEMOR		°N: 15_0101	Peri od:	u of Form CMS-2 Worksheet D	2332-10
	H COSTS	WICE UTILK FAS	Flovide		From 01/01/2016		
TTIKOOG	11 (0313				To 12/31/2016	Date/Time Pre	pared:
						3/30/2017 9:0	9 am
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total	Total Charges			I npati ent	
			(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of	Part I, col.			Charges	
		col. 2, 3 and	8)	7)	(col . 6 ÷ col .		
		4)			7)		
	I	6. 00	7. 00	8. 00	9. 00	10. 00	
	ANCILLARY SERVICE COST CENTERS	_				4 540 075	
50.00	05000 OPERATI NG ROOM	0	22, 867, 011				
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	8, 280, 467				
53. 00	05300 ANESTHESI OLOGY	0	2, 742, 748	l .		212, 429	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	53, 378, 768				
60.00	06000 LABORATORY	0	19, 593, 099			590, 023	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0. 00000		0	62. 30
65. 00	06500 RESPI RATORY THERAPY	0	3, 962, 332			135, 808	65. 00
66.00	06600 PHYSI CAL THERAPY	0	3, 915, 564			9, 403	
67.00	06700 OCCUPATI ONAL THERAPY	0	1, 149, 147			2, 281	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	328, 585				68. 00
69. 00		0	3, 009, 327				69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	4, 066, 052			238, 721	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 093, 199			10, 265	ı
73.00	07300 DRUGS CHARGED TO PATIENTS	0	14, 742, 046			809, 217	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0.00000		0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000		0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0.00000	0. 000000	0	76. 99
	OUTPAȚI ENT SERVI CE COST CENTERS						
90.00	09000 CLI NI C	0	207, 133	0.00000	0. 000000	337	90.00
	09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0.00000		0	90. 01
	09100 EMERGENCY	0	29, 653, 672			248, 120	
02 00	00200 OBSEDVATION BEDS (NON DISTINCT DADT	1	2 0/4 77/	0 00000	0 000000	0	02 00

0 0 0

171, 953, 926

2, 964, 776

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0.000000

0 92.00 95.00

5, 742, 087 200. 00

Health 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 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared:

				0 12/31/2016	3/30/2017 9:0	epareu: 09 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9			
	x col. 10)		x col. 12)			
	11. 00	12. 00	13. 00			
ANCILLARY SERVICE COST CENTERS			1 -	T.		4
50. 00 05000 OPERATI NG ROOM	0	0)		50. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0)		52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	C)		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	C)		54. 00
60. 00 06000 LABORATORY	0	0)		60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIA	CS 0	0)		62. 30
65. 00 06500 RESPI RATORY THERAPY	0	0	C)		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	C			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	C)		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0)		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	C)		69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO P.		0	C)		71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	S 0	0	C)		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C			73. 00
76. 97 07697 CARDIAC REHABILITATION	0	0	C			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	C)		76. 98
76. 99 07699 LI THOTRI PSY		0	C			76. 99
OUTPATIENT SERVICE COST CENTERS			-			
90. 00 09000 CLINI C	0	0	C			90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0	C			90. 01
91. 00 09100 EMERGENCY	0	0	C)		91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINC	I PARI O	0	0			92. 00
OTHER REIMBURSABLE COST CENTERS			1	1		
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	0	0	(C	1		200. 00

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

From 01/01/2016 To 12/31/2016 Part V Date/Time Prepared: 3/30/2017 9:09 am Title XIX Hospi tal PPS Costs Charges Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Rei mbursed Ratio From Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) 3.00 (see inst.) 1. 00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 149381 3, 712, 538 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0. 224143 0 3,645 52.00 05300 ANESTHESI OLOGY 0.009828 0 0 425, 524 53 00 53 00 0 |05400| RADI OLOGY-DI AGNOSTI C 0 54.00 0.099248 0 5, 661, 470 0 54.00 60.00 06000 LABORATORY 0. 215599 1, 861, 469 0 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0 0 62.30 0 06500 RESPIRATORY THERAPY 0 0 394, 233 65.00 0.265989 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 406617 462, 643 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 0.916377 142, 663 0 67.00 06800 SPEECH PATHOLOGY 0.666500 196, 819 68 00 68 00 69.00 06900 ELECTROCARDI OLOGY 0.004911 404, 398 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 243759 514, 092 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.463959 377, 688 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 0 1, 221, 997 73 00 0.284959 0 73.00 76. 97 07697 CARDIAC REHABILITATION 0.000000 0 0 0 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.000000 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0.000000 0 76. 99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 2. 216600 0 0 18, 587 0 90.00 09001 INTENSIVE OUT PATIENT PROGRAM 0.000000 0 0 0 90.01 90.01 4, 993, 601 0. 357402 0 91.00 91.00 09100 EMERGENCY 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 529659 528, 567 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0. 637046 716, 991 95.00 716, 991 200.00 Subtotal (see instructions) 0 20, 919, 934 0 200. 00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 +/- line 201) 716, 991 20, 919, 934 0 202.00

Health Financial Systems					WHI TLEY	MEMORI AL	HOSPI TAL				In Lieu	of Form CMS-2552	-10
APPORTI ONMENT OF MEDICAL	OTHER	HEALTH	SERVI CES	AND	VACCI NE	COST	Provi der	CCN:	15-0101	From	01/01/2016 12/31/2016	Worksheet D Part V Date/Time Prepare	

				To 12/31/2016	Date/Time Prepa 3/30/2017 9:09	
		Ti tl	e XIX	Hospi tal	PPS	
	Cos	sts		<u> </u>		
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCI LLARY SERVI CE COST CENTERS	1	T == . ===	ı			
50. 00 05000 OPERATI NG ROOM	0	554, 583			•	50. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0.7				52. 00
53. 00 05300 ANESTHESI OLOGY	0	4, 182				53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	561, 890				54. 00
60. 00 06000 LABORATORY	0	401, 331			l l	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62. 30
65. 00 06500 RESPIRATORY THERAPY	0	104, 862	•			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	188, 119	•			66. 00
67. 00 06700 OCCUPATIONAL THERAPY	0	130, 733	•			67. 00
68. 00 06800 SPEECH PATHOLOGY	0	131, 180				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 986				69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	125, 315				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	175, 232	•			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	348, 219	i			73.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0				76. 97 76. 98
76. 98 07698 HYPERBARI C OXYGEN THERAPY 76. 99 07699 LI THOTRI PSY	0	_	1			76. 98 76. 99
OUTPATIENT SERVICE COST CENTERS	1 0	0				76. 99
90. 00 09000 CLINIC	1 0	41, 200				90. 00
90. 01 09000 CETNIC 90. 01 09001 INTENSIVE OUT PATIENT PROGRAM			1		•	90. 00 90. 01
91. 00 09100 EMERGENCY	0	1, 784, 723				91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		•		•	92. 00
OTHER REIMBURSABLE COST CENTERS		217, 700	L			72.00
95. 00 09500 AMBULANCE SERVICES	456, 756					95. 00
200.00 Subtotal (see instructions)	456, 756	l .				00.00
201.00 Less PBP Clinic Lab. Services-Program	0					01. 00
Only Charges					-`	
202.00 Net Charges (line 200 +/- line 201)	456, 756	4, 834, 332			20	02. 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 01/01/2016	Worksheet D-1	
			Date/Time Pre	
	Title XVIII	Hospi tal	3/30/2017 9: 0	9 am
Cost Center Description	THE XVIII	nospi tai	113	

PART 1 ALL PROVIDER COMPONENTS PART 1 ALL PROVIDER COMPONENTS 1.00			Title XVIII	Hospi tal	3/30/2017 9: 0 PPS	9 am
PART 1 - ALL PROVIDER COMPONENTS 1.00		Cost Center Description	IT LITE AVITT	110Spi tai	FF3	
IMPARTENT DAYS		·			1. 00	
1.00 Inpatient days (including private room days and swing-bed days, excluding newborn) 5.130 1.00						
Impattent days (including private room days, excluding saring-bed and nebborn days) 17 you have not yet vate room days, (excluding saring-bed and observation bed days). 17 you have not yet vate room days, (excluding saring-bed and observation bed days). 17 you have not yet vate room days. 3,740 4,00	1 00		s excluding newborn)		5 130	1 00
Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line. 4.00 Somi-private room days (excluding swing-bed and observation bed days). 5.00 Total swing-bed SW type inpatient days (including private room days) through December 31 of the cost of control period (including private room days). 6.00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (including period for its line). 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (including period for its line). 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost of the cost reporting period (including period for its line). 9.00 Total swing-bed NF type inpatient days applicable to the Program (excluding swing-bed and neoborn days). 10.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if real endar year, enter 0 on this line). 11.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if real endar year, enter 0 on this line). 12.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if real endar year, enter 0 on this line). 13.00 Swing-bed SWF type inpatient days applicable to titles V or XIX only (including private room days). 13.00 Total swing-bed SWF type inpatient days applicable to titles V or XIX only (including private room days). 13.00 Total swing-bed SWF type inpatient days applicable to services after December 31 of the cost. 13.00 Total swing-bed SWF type inpatient days applicable to services after December 31 of the cost. 13.00 Total swing-bed SWF type inpatient days applicable to services after December 31 of the					•	
Semi-private room days (excluding swing-bed and observation bed days) 1,700 5.00 Total swing-bed SRF type inpatient days (including private room days) after December 31 of the cost 0,500 Total swing-bed SRF type inpatient days (including private room days) after December 31 of the cost 0,500 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 0,700 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 0,700 Poper ting period (including private room days) after December 31 of the cost 0,800 Poper ting period (including private room days) after December 31 of the cost 0,800 Poper ting period (including private room days) Poper ting period (including period (including private room days) Poper ting period (including period (including private room days) Poper ting period (including period (including private room days) Poper ting period (including period (including private room days) Poper ting period (including period (including private room days) Poper ting period (including period (including private room days) Poper ting period (including period period Poper ting				vate room days,		
1 Total Swing-bed SNE Type Inpatient days (including private room days) after December 31 of the cost reporting period of Total swing-bed SNE Type Inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this I line) 7.00 Total swing-bed NE Type Inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this I line) 9.00 Total swing-bed NE Type Inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this I line) 10.00 Industrial swing-bed NE Type Inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this I line) 10.00 Swing-bed SNE Type Inpatient days applicable to the Program (excluding swing-bed and n. 1,159 9.00 newborn days) 11.00 Swing-bed SNE Type Inpatient days applicable to the Type Inpatient days applicable to SNE Type Inpatient days applicable to the SNE Type Inpatient days applicable to the SNE Type Inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this I line) 12.00 Swing-bed NE Type Inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NE Type Inpatient days applicable to the Program (excluding swing-bed days) 14.00 Type Inpatient days applicable to the Program (excluding swing-bed days) 15.00 North of the Cost reporting period (if callendar year, enter 0 on this I line) 16.00 North of the Cost reporting period (if callendar year, enter 0 on this I line) 17.00 Medicane rate for swing-bed SNE services applicable to services through December 31 of the cost reporting period (including swing-bed cost applicable to SNE type services applicable to services through December 31 of the cost reporting period (line 2 x line 1) 18.00 Swing-bed cost applicable to SNE type services after Dece			, , , , , , , , , , , , , , , , , , , ,	, ,		
reporting period (if callendar year, enter 0 on this line) 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.0						
Total saving-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this Line)	5. 00		om days) through Decembe	r 31 of the cost	0	5. 00
reporting period (if calendar year, either 0 on this line) 7.00 Total sing-bed NF type inpatient days (including private room days) through December 31 of the cost 1 of reporting period 1 total inpatient days (including private room days) after December 31 of the cost 1 of 8.00 1 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 1 of 10.00 1 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 1 of the cost reporting period (including private room days) 2 of through December 31 of the cost reporting period (including private room days) after 1 of 11.00 1 December 31 of the cost reporting period (including private room days) 3 of 1 of	6 00		om days) after December	21 of the cost	0	6 00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Record of the cost reporting period (if calendar year, enter 0 on this line) Record of the cost reporting period (if calendar year, enter 0 on this line) Record of the cost reporting period (see instructions) December 31 of the cost reporting period (see instructions) December 31 of the cost reporting period (see instructions) December 31 of the cost reporting period (if calendar year, enter 0 on this line) December 31 of the cost reporting period (if calendar year, enter 0 on this line) December 31 of the cost reporting period (if calendar year, enter 0 on this line) December 31 of the cost reporting period (if calendar year, enter 0 on this line) December 31 of the cost reporting period (if calendar year, enter 0 on this line) December 31 of the cost reporting period (if calendar year, enter 0 on this line) December 31 of the cost reporting period (if calendar year, enter 0 on this line) December 31 of the cost reporting period (if calendar year, enter 0 on this line) December 31 of the cost reporting period (in unresery days (title V or XIX only) December 31 of the cost	0.00		on days) arter becember :	of the cost	0	6.00
1.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if Calendar year, enter 0 on this line) 1.00 1.00	7.00		m days) through December	31 of the cost	0	7. 00
reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10. 00 Swing-bed SRF type inpatient days applicable to title XVIII only (including private room days) 11. 00 Saing-bed SRF type inpatient days applicable to title XVIII only (including private room days) after through becember 31 of the cost reporting period (see instructions) 12. 00 Swing-bed SRF type inpatient days applicable to title XVIII only reflect to this line) 13. 00 Swing-bed SRF type inpatient days applicable to title SV or XIX only (including private room days) after on the suine) 13. 00 Swing-bed SRF type inpatient days applicable to title SV or XIX only (including private room days) 13. 00 Swing-bed SRF type inpatient days applicable to title SV or XIX only (including private room days) 14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 16. 00 Nerestry days (title V or XIX only) 16. 00 Nerestry days (title V or XIX only) 17. 00 SWING-BRF AND SWIN			3 , 0			
10.00 Swings-bed SNF type inpatient days applicable to title XVIII only (including private room days) 0.00	8.00		m days) after December 3	1 of the cost	0	8. 00
newborn days 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 10.00 10.	0.00		the Dregree (evaluding	owing had and	1 150	0 00
10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 0 10.00	9.00		the Program (excluding	Swing-bed and	1, 159	9.00
through December 31 of the cost reporting period (see instructions) 1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.01 of SNF through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.02 of SNF through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.03 of SNF through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.04 of SNF through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.05 of SNF through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.06 of SNF through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.07 of SNF through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.08 of SNF through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.09 of SNF through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 of SNF through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 of SNF through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 of SNF through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 of SNF through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 of SNF through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 of SNF through December 31 of the cost reporting period (if calendar year) 1.00 of SNF through December 31 of the cost reporting per	10.00	1	nly (including private r	oom days)	0	10. 00
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through December 31 of the cost reporting period 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 18.00 Nurser of rowing-bed SNF services applicable to services after December 31 of the cost 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Ning-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 20.01 Ning-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 29) 20.02 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 29) 20.03 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 29) 20.04 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	12.00			a maam daya)	0	12 00
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 14.00 14.00 16.00	12.00		confy (including private	e room days)	0	12.00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14,00 Motically necessary private room days applicable to the Program (excluding swing-bed days) 0 14,00 15,00 16,00 1	13. 00		only (including private	e room davs)	0	13. 00
15.00 Total nursery days (title V or XIX only) 0 15.00 16.00 16.00 17.00 17.00 18.00						
16. 00 Nursery days (title V or XIX only) 16. 00 16. 00 17. 00 17. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 19. 00			am (excluding swing-bed	days)	_	
SWING BED ADJUSTMENT 18.00 1					_	
17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 18. 00 Perporting period 18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19. 00 Medicald rate for swing-bed NF services applicable to services through December 31 of the cost 19. 00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Program period 19. 00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Program period 19. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 19. 10 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 19. 10 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 19. 10 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 19. 10 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 19. 10 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 19. 10 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 19. 10 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 20. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 20. 00 Total swing-bed cost (see instructions)	16.00				0	16.00
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44.00 COSOMARY CARE UNIT	Heal th	Financial Systems	WHITLEY MEMORI	AL_HOSPITAL		In Li€	eu of Form CMS-2	<u> 2552-10</u>
Coat Center Description	COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 15-0101			
Total Program injusticent costs (sum of lines 50 and 51) Program injusticent costs (sum of lines 50 and 51) Program injusticent costs (sum of lines 50 and 51) Program injusticent lines 50 and 51 and 52 and							Date/Time Pre	
Total Program Days Program Day				Ti +I	e XVIII	Hosni tal		9 am
1.00 NURSERY (1111 or 9 x1X only)		Cost Center Description	Total			<u> </u>	+	
1.00 2.00 3.00 4.00 5.00 0.00		'	Inpatient Cost	Inpatient Day	/sDiem (col. 1		(col. 3 x col.	
MINISTRY (TITE V A XIX anly)			1.00	2.00		4.00		
Internsive Cure Type Impartient Rospital Units	42. 00	NURSERY (title V & XIX only)						42. 00
44.00 CORONARY CARE UNIT		Intensive Care Type Inpatient Hospital Units						
								43.00
44.00 OHER SPICIAL CAME (SPICIAL) A A A A A A A A A								
Cost Center Description								46. 00
1.00	47. 00							47. 00
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3 and 17	51. 00		atient ancillar	y services (f	from Wkst. D, s	sum of Parts II	170, 368	51.00
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Cline 13 x line 20 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	(0.00	,	t£t D	21 -4	5 ALA			/0.00
69.00 Total title V or XiX swing-bed NF inpatient routine costs (line 67 + line 68) 069.00	68.00	l .	e costs arter b	ecember 31 01	the cost repo	orting period		08.00
70. 00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71. 00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72. 00 Program routine service cost applicable to Program (line 14 x line 35) 73. 00 Total Program general inpatient routine service costs (line 72 + line 73) 75. 00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76. 00 Program capital -related costs (line 75 ÷ line 2) 77. 00 Program capital related costs (line 9 x line 76) 78. 00 Inpatient routine service cost (from provider records) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 79. 01 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 79. 02 Reasonable inpatient routine service costs (see instructions) 79. 00 Program inpatient routine service costs (see instructions) 79. 01 Program inpatient notine service costs (see instructions) 79. 02 Program inpatient notine service costs (see instructions) 79. 03 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 79. 00 Total observation bed days (see instructions) 79. 00 Inpatient routine bed also (see instructions) 79. 00 Total observation bed days (see instructions) 79. 00 Total observation bed observation bed observations (line 27 ÷ line 2) 79. 00 Total observation bed observations (line 27 ÷ line 2) 79. 00 Total observa	69. 00	1 '	routine costs (line 67 + lir	ne 68)		0	69. 00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 77.00 Aggregate charges to beneficiaries for excess costs (from provider records) 78.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 71.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 74.00 74.00 74.00 74.00 74.00 74.00 75.00 74.00 74.00 74.00 74.00 75.0	70.00						T	70.00
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26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)			•		*	Part II column		1
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79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 79. 00 80. 00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81. 00 Inpatient routine service cost per diem limitation 81. 00 Reasonable inpatient routine service costs (see instructions) 82. 00 Utilization review - physician compensation (see instructions) 83. 00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 79. 00 80. 00 81. 00 81. 00 82. 00 81. 00 82. 00 83. 00 84. 00 85. 00 86. 00 87. 00 88. 00 88. 00 89. 00 80		, ,	,					
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Utilization review - physician compensation (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		1 .		rovi der recor	rds)			1
82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 83.00 Reasonable inpatient routine service costs (see instructions) 83.00 84.00 Program inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Rotal observation bed days (see instructions) 1,340 87.00 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,171.88 88.00						nus line 79)		80.00
83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Reasonable inpatient routine service costs (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine services (see instructions) 88.00 Reasonable inpatient routin				`				81.00
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				•				1
85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		•		<u>-,</u>				84. 00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1, 171.88 88.00		Utilization review - physician compensation	(see instructio					85. 00
87.00 Total observation bed days (see instructions) 1,340 87.00 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,171.88 88.00	86. 00			rough 85)				86. 00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,171.88 88.00	87. 00						1. 340	87. 00
89.00 Observation bed cost (line 87 x line 88) (see instructions) 1,570,319 89.00	88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 171. 88	88. 00
	89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				1, 570, 319	89.00

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2016	Worksheet D-1	
				To 12/31/2016	Date/Time Pre 3/30/2017 9:0	pared: 9 am
		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, 045, 776	6, 011, 767	0. 17395	5 1, 570, 319	273, 165	90.00
91.00 Nursing School cost	0	6, 011, 767	0.00000	0 1, 570, 319	0	91.00
92.00 Allied health cost	0	6, 011, 767	0.00000	0 1, 570, 319	0	92.00
93.00 All other Medical Education	0	6, 011, 767	0.00000	0 1, 570, 319	0	93.00

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0101	Peri od: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Pre 3/30/2017 9:0	
		Title XIX	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					1

		Title XIX	Hospi tal	PPS	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			5, 130	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-l Private room days (excluding swing-bed and observation bed day		vato room dave	5, 130 0	2. 00 3. 00
3.00	do not complete this line.	ys). If you have only pir	vate room days,	O	3.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		3, 790	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through December	31 of the cost	0	5. 00
	reporting period		4 6 11		, 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) arter becember 3	or the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private roor	n davs) through December	31 of the cost	0	7. 00
	reporting period	3 / 3			
8.00	Total swing-bed NF type inpatient days (including private roor	n days) after December 31	of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Dreamam (eveluding	swing had and	132	9. 00
9.00	newborn days)	the Program (excruding	Swifig-bed and	132	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	om days)	0	10. 00
	through December 31 of the cost reporting period (see instruc				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		om days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)		room days)	0	12. 00
12.00	through December 31 of the cost reporting period	t only (the daing private	. room days)	Ü	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13.00
44.00	after December 31 of the cost reporting period (if calendar ye				44.00
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed o	iays)	0 882	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			123	16. 00
.0.00	SWING BED ADJUSTMENT			120	
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0. 00	17. 00
40.00	reporting period			0.00	10.00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of t	he cost	0. 00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ie cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	-)		6, 011, 767	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		na period (line	0,011,707	22. 00
22.00	5 x line 17)	or or or the edet report.	ng perreu (rine	· ·	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
24.00	X line 18)	a 21 of the cost reportin	a norical (line	0	24. 00
24. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reportif	ig period (iine	U	24.00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)				
26. 00	Total swing-bed cost (see instructions)	(line 21 minus line 24)		0 011 777	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		6, 011, 767	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	irges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)	- line 28)		0. 000000 0. 00	31. 00 32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34. 00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruct	ions)	0.00	34. 00
35. 00	Average per diem private room cost differential (line 34 x line	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	and private room cost dif	Terential (line	6, 011, 767	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		1, 171. 88	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		154, 688	39. 00
40.00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	•		0 154, 688	40.00
41.00	Trotal Trogram general impatrent routine service cost (TIME 39	+ 1111C 40)	I	134, 088	41.00

Country Coun	<u>Heal</u> th	Financial Systems	WHITLEY MEMORI	AL_HOSPIT	AL		In Lie	eu of Form CMS-2	<u>2552-</u> 10
Date Description	COMPUT	ATION OF INPATIENT OPERATING COST		Provid	ler CO	CN: 15-0101			
Cost Center Description								Date/Time Pre	
Total Decided Program Program Program Program Post Program Post Program Post					Ti +I	e XIX	Hosni tal		9 am
Injury		Cost Center Description	Total	Total	11 (1				
1.00		<u>'</u>	Inpatient Cost	I npati ent	Days	Diem (col. 1		(col. 3 x col.	
			1 00	2.00			4.00		
Interest view Care Type Inpatrient Bioglatal Biolitis 44.00 INTEREST CARE UNIT 44.00 A.	42. 00	NURSERY (title V & XIX onlv)		2.00	882				42. 00
44.00									
45.00 SUBRI INTENSIVE CARE UNIT 46.00 SUBRICAL INTENSIVE CARE UNIT 46.00 47.00 10.01 47.00 47.00 47.00 47.00									l
46.00 SIRGELACIAL INTERSIVE CARE UNIT 46.00 Cost Center Description 1.00 1.00 1.10 1									
Cost Center Description									•
1.00	47. 00			•					47. 00
48.00 Program Inpattlent and Illary service cost (West: D-3, col. 3, 11ne 200) 1, 156, 676 48.00 1016 Program Inpattlent costs (com of Tilnes 4, 11hrough 48) (cost en Instructions) 1, 374, 491 490 1016 Program Inpattlent costs (cost of Tilnes 4, 11hrough 48) (cost en Instructions) 1, 374, 491 490 1016 Program Inpattlent costs (cost in Instructions) 1, 374, 491 490 1016 Program Inpattlent costs (cost in Instructions) 1, 374, 491 490 1016 Program Inpattlent costs (cost in Instructions) 1, 374, 491 490 1016 Program Inpattlent costs (cost in Instructions) 1, 374, 491 490 1016 Program Inpattlent costs (cost in Instructions) 1, 201, 501 1016 Program Inpattlent operating cost excluding capital related, non-physician anesthetist, and in 1, 201, 501 1, 201, 5		Cost Center Description						1.00	
1,374,491 9,00 Pass through costs applicable to Program inpatient routine services (From Wkst. D. sum of Parts I and pass through costs applicable to Program inpatient routine services (From Wkst. D. sum of Parts II and pass through costs applicable to Program inpatient ancillary services (From Wkst. D. sum of Parts II 139,884 51.00 110	48. 00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3	Line 20	0)				48. 00
50.00 Pass through costs applicable to Program inpatient routine services (from Wist. D., sum of Parts II and III) 139,884 51.00 120,000 120,000 130,000		, ,			-	ns)			
1110									
139,884 51.00 and 107 172,787 139,884 51.00 and 107 172,787 139,884 51.00 and 107 172,787 139,884 51.00 172,787 17	50. 00		atient routine	servi ces	(from	Wkst. D, sum	of Parts I and	33, 053	50.00
and IV) 53.00 Total Program excludable cost (sum of lines 50 and 51) 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 1,201,554 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 1,201,554 54.00 Program of scharges 55.00 Target amount (line 54 x line 55) 55.00 Program discharges 56.00 Program of scharges 57.00 Program of scharges 58.00 Program of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 58.00 Program of lines 53/54 or 55 from prior year cost report, updated by the market basket 58.00 Program of lines 53/54 or 55 from prior year cost report, updated by the market basket 58.00 Program of lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 59) are less than expected costs (lines 59 ta 66), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 58.00 Program invalidation of the partient cost plus incentive payment (see instructions) 58.00 Program invalidation of the payment (see instructions) 58.00 Program invalidation of the payment (see instructions) 59.00 Program invalidation of the payment (see instructions) 60.00 Total Program of the patient routine costs (line 64 plus line 65) (little XVIII only). For CAH (see instructions) 61.00 Total Program of the patient of the patient routine costs (line 64 plus line 65) (little XVIII only). For CAH (see instructions) 62.00 Total Program of patient patient routine costs (line 64 plus line 65) (little XVIII only). For C	51. 00		atient ancillar	y service	s (fr	om Wkst. D, s	um of Parts II	139, 884	51.00
Total Program Inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		and IV)							
medical education costs (line 49 minus line 52)				10+04 ==	n nb	cicion anas+5	otict and	l	1
TARCET MOUNT AND LIMIT COMPUTATION 54.00 FORT and discharge 0.54.00 55.00 Target amount per discharge 0.00 55.00 Target amount per discharge 0.00 55.00 56.00 Target amount per discharge 0.00 55.00 56.00 Target amount per discharge 0.00 55.00 56.00 Target amount per discharge 0.00 56.00 56.00 Target amount per discharge 0.00 56.00 Target 0.00 Target 0.00 Target 0.00 56.00 Target 0.00 Target 0.	ეკ. UU			nated, no	ı-pny	sician anesth	erist, and	1, 201, 554	33.00
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81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1, 171.88 88.00							us line 79)		1
Reasonable inpatient routine service costs (see instructions) 83.00 84.00 Program inpatient ancillary services (see instructions) 85.00 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 83.00 84.00 85.00 86.00 87.00 88.00	81. 00	Inpatient routine service cost per diem limi	tati on				•		1
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 84.00 85.00 86.00 Por Computation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Response in patient ancillary services (see instructions) 88.00 Response in patient ancillary services (see instructions) 85.00 Response in patient ancillary services (see instructions) 86.00 Response in patient ancillary services (see instructions) 87.00 Response in patient ancillary s		1 .		* .					1
85. 00 Utilization review - physician compensation (see instructions) 85. 00 Total Program inpatient operating costs (sum of lines 83 through 85) 87. 00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1, 171. 88 88. 00		1		13)					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 7 total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1, 171.88 88.00		, , , , , , , , , , , , , , , , , , , ,		ons)					
87.00 Total observation bed days (see instructions) 1,340 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,171.88 88.00	86. 00			rough 85)					86. 00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,171.88 88.00	87 NO							1 3/10	87 00
89.00 Observation bed cost (line 87 x line 88) (see instructions) 1,570,319 89.00		1	•	line 2)					1
	89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)					1, 570, 319	89. 00

Health Financial Systems	WHITLEY MEMORI	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2016	Worksheet D-1	
				To 12/31/2016	Date/Time Pre 3/30/2017 9:0	
		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	1
				Bed Cost (from	Through Cost	1
				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, 045, 776	6, 011, 767	0. 17395	5 1, 570, 319	273, 165	90.00
91.00 Nursing School cost	0	6, 011, 767	0.00000	1, 570, 319	0	91.00
92.00 Allied health cost	0	6, 011, 767	0.00000	1, 570, 319	0	92. 00
93.00 All other Medical Education	0	6, 011, 767	0.00000	1, 570, 319	0	93.00

NPATI ENT	ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0101	Peri od: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Pre 3/30/2017 9:0	parec
		Titl∈	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS					
0.00 0300	OO ADULTS & PEDIATRICS			1, 632, 018		30. (
3.00 0430	OO NURSERY					43. (
	LLARY SERVICE COST CENTERS					
	OO OPERATING ROOM		0. 1493		92, 461	1
	DO DELIVERY ROOM & LABOR ROOM		0. 2241		1, 663	
	00 ANESTHESI OLOGY		0. 0121		904	
	DO RADI OLOGY-DI AGNOSTI C		0. 0992			
	DO LABORATORY		0. 2155		191, 164	
	50 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000		0	
	00 RESPI RATORY THERAPY		0. 2659		83, 439	
	00 PHYSI CAL THERAPY		0. 4066			
	00 OCCUPATI ONAL THERAPY		0. 9163		54, 600	
	OO SPEECH PATHOLOGY		0. 6665		4, 508	
	00 ELECTROCARDI OLOGY		0.0049		1, 238	
	OO MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2437			
	DO IMPL. DEV. CHARGED TO PATIENTS		0. 4639			
	DO DRUGS CHARGED TO PATIENTS		0. 2849		301, 405	
	OT CARDIAC REHABILITATION		0.0000		0	
	98 HYPERBARI C OXYGEN THERAPY		0.0000		0	1 , 0.
	POLITHOTRI PSY		0.0000	00 0	0	76.
0016	PATIENT SERVICE COST CENTERS		2. 2166	00 670	1, 485	90.
	DOTELTRIC DOTELTRIC		0.0000		1, 485	1
	O EMERGENCY		0. 0000		318, 786	
			0. 5364		310, 700	
	DO OBSERVATION BEDS (NON-DISTINCT PART R REIMBURSABLE COST CENTERS		0. 5290	U 17 U	0	¹ ^{72.}
	ON AMBULANCE SERVICES					95.
00.00	Total (sum of lines 50-94 and 96-98)			5, 964, 387	1, 354, 185	
01.00	Less PBP Clinic Laboratory Services-Program only charges	c (line 61)		0, 704, 307		200.
02.00	Net Charges (line 200 minus line 201)	5 (1116 01)		5, 964, 387		201.

Heal th	Financial Systems WHITLEY MEMORIAL	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0101	Peri od:	Worksheet D-3	
				From 01/01/2016 To 12/31/2016	Date/Time Pre 3/30/2017 9:0	pared: 9 am
		Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	LADATI DALT DOUTLAG CEDAL OF COCT CENTEDS		1.00	2. 00	3. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS			1 15/ 775		20.00
	04300 NURSERY			1, 156, 775 561, 168		30. 00 43. 00
	ANCI LLARY SERVI CE COST CENTERS			301, 100		43.00
	05000 OPERATI NG ROOM		0. 1493	81 1, 549, 075	231, 402	50.00
	05200 DELIVERY ROOM & LABOR ROOM		0. 2241			
	05300 ANESTHESI OLOGY		0. 0121			
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 0992			
60.00	06000 LABORATORY		0. 2155	99 590, 023	127, 208	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000	00 0	l	1
65.00	06500 RESPI RATORY THERAPY		0. 2659	89 135, 808	36, 123	65.00
66.00	06600 PHYSI CAL THERAPY		0. 4066	17 9, 403	3, 823	66. 00
	06700 OCCUPATI ONAL THERAPY		0. 9163		2, 090	
	06800 SPEECH PATHOLOGY		0. 6665		0	
	06900 ELECTROCARDI OLOGY		0.0049			
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2437		58, 190	
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4639			1
	07300 DRUGS CHARGED TO PATIENTS		0. 2849		230, 594	
	07697 CARDI AC REHABI LI TATI ON		0.0000		0	
	07698 HYPERBARI C OXYGEN THERAPY		0.0000		0	
	07699 LI THOTRI PSY		0.0000	00 0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS		2 21//	00 227	747	00.00
	09000 CLINIC		2. 2166		747	
	09001 INTENSIVE OUT PATIENT PROGRAM 09100 EMERGENCY		0. 0000 0. 3584		0 00 004	
			0. 3584			
	O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		U. 5296	<u>الان</u>	<u> </u>	92.00
	09500 AMBULANCE SERVICES					95. 00
200.00	Total (sum of lines 50-94 and 96-98)			5, 742, 087	1, 156, 676	
201.00		s (line 61)		0, 7, 12, 007	1, 155, 676	201.00
202.00		_ (01)		5, 742, 087		202.00
	1 1 1 1 1 2 2 2 2 2 2 2 2 2 3 3 3 3 3 3		1	1 27 : .27 007	ı	1

Health Financial Systems	WHITLEY MEMORIAL HOSPITA	_	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi de	r CCN: 15-0101	Peri od: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 3/30/2017 9:09 am

PART A - IMPATIENT MOSPITAL SERVICES UNDER IPPS 1.00			Title XVIII	Hospi tol	3/30/2017 9: 0	9 am
New York			TI LIE AVIII	Hospi tal	PPS	
DRK Amounts other than outlier Payments for discharges occurring prior to October 1 (see 1,288,581 1.01					1. 00	
1.00 DRC amounts other than outlier payments for discharges occurring on or after October 1 (see 1,288,531 1.01	1 00				0	1 00
1.02 BiRS assumate other than cuttler payment for discharges occurring on or after October 1 (see instructions) 1.02 Instructions 1.03 BiRS for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 0.04 1.04		DRG amounts other than outlier payments for discharges occurring p	prior to October 1 (s	see		
1.03 1.08	1. 02	DRG amounts other than outlier payments for discharges occurring of	on or after October	1 (see	447, 758	1. 02
1.04 Oktober 1 (see instructions) 1.04 Oktober 1 (see instructions) 1.7, 660 2.00 Oktifier payments for discharges. (see instructions) 1.7, 660 2.00 Oktifier payments for discharges. (see instructions) 2.00 0ktifier payments for discharges for Model 4 BPCI (see instructions) 2.02 0ktifier payment for discharges for Model 4 BPCI (see instructions) 2.02 0ktifier payment for discharges for Model 4 BPCI (see instructions) 2.02 0ktifier payment for discharges for Model 4 BPCI (see instructions) 2.03 0ktifier payment for discharges for Model 4 BPCI (see instructions) 2.03 0ktifier payment for discharges for Model 4 BPCI (see instructions) 2.04 0ktifier payment for discharges for Model 4 BPCI (see instructions) 2.04 0ktifier payment for discharges for discharges for for payment for discharges for for discharges for for feet payments for payments	1. 03	DRG for federal specific operating payment for Model 4 BPCI for di	ischarges occurring p	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 di	ischarges occurring o	on or after	0	1. 04
2.02 2.03 Outlier payment for discharges for Model 4 BPCI (see instructions) 0 2.03 2.00 Managed Care Simulated Payments 0 3.00 Managed Care Simulated Payments 2.04 4.00 1.00		Outlier payments for discharges. (see instructions)				
Red days available divided by number of days in the cost reporting period (see instructions) 26.34 4.00)			
Indirect Medical Education Adjustment Count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996, (see Instructions) Count for all opathic and osteopathic programs which meet the criteria for an add-on to the cap Ticount for all opathic and osteopathic programs which meet the criteria for an add-on to the cap To new programs in accordance with 42 CFR 413, 79(e) Count for all opathic and osteopathic programs which meet the criteria for an add-on to the cap To new programs in accordance with 42 CFR 413, 79(e) Country of the cost report straddles July 1, 2011 then see instructions. Country of the cost report straddles July 1, 2011 then see instructions. Country of the cost report straddles July 1, 2011 then see instructions. Country of the cost report straddles July 1, 2011 then see instructions. Country of the cost report straddles July 1, 2011 see instructions. Country of the cost report straddles July 1, 2011 see instructions. Country of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions) Country of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions) Country of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions) Country of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions) Country of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions) Country of increase if the hospital was awarded FTE cap slots from a closed teaching hospital close instructions) Country of increase if the hospital was awarded FTE cap slots from a closed teaching hospital close instructions in the current yea		, ,			-	
or before 12/31/1996, (see instructions) 1. OPERIOR COUNTRY of Inpathic and osteopathic programs which meet the criteria for an add-on to the cap 1. OPERIOR COUNTRY OF THE COUNTRY OF T	4. 00		g period (see instru	ctions)	26. 34	4. 00
To rew programs in accordance with 42 CFR 413.79(e)		or before 12/31/1996. (see instructions)				
ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(T)(1)(V)(B)(2) 0.00 7.01		for new programs in accordance with 42 CFR 413.79(e)		·		
If the cost report straddles July 1, 2011 then see Instructions.						
8.01 The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report stradides 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 section 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) 10.00 FTE count for solders in dental and podiatric programs in the current year from your records 0.00 1	8. 00	If the cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopathic	and osteopathic prog	grams for	0. 00	8. 00
B. 02	8. 01	The amount of increase if the hospital was awarded FTE cap slots u	under section 5503 o	f the ACA. If	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 10.00 FTE count for all opathic and osteopathic programs in the current year from your records 0.00 10.00 10.00 FTE count for residents in dental and podiatric programs. 0.00 12.00 12.00 13.00 13.00 14.00 14.00 14.01 14.00 14.01 14.00	8. 02	2 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital				8. 02
10.00 FTE count for allopathic and osteopathic programs in the current year from your records 0.00 10.	9. 00	, , ,				9. 00
12.00 Current year allowable FTE (see instructions) 0.00 12.00 13.00 10.00 13.00 10.00		FTE count for allopathic and osteopathic programs in the current	year from your record	ds		
13.00 Total allowable FTE count for the prior year. 0.00 13.00 14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero. 0.00 14.00 14.00 14.00 14.00 14.00 15.00		, , ,				
Otherwise enter zero. Sum of lines 12 through 14 divided by 3. 0.00 15.00 16		,				
16. 00 Adj ustment for residents in initial years of the program 0.00 16. 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 (see instructions) 0.000000 19. 00 20. 00 Prior year resident to bed ratio (see instructions) 0.000000 20. 00 21. 00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21. 00 22. 01 IME payment adj ustment (see instructions) 0.000000 21. 00 22. 01 IME payment adj ustment - Managed Care (see instructions) 0.000000 22. 01 Indirect Medical Education Adj ustment for the Add-on for Section 422 of the MMA 0.000000 23. 00 23. 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 26. 00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26. 00 27. 00 IME payments adjustment factor. (see instructions) 0.28.	14. 00		nded on or after Sept	tember 30, 1997,	0. 00	14. 00
17. 00		,				
18.00 Adjusted rolling average FTE count 0.00 18.00 19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.00 20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.01 IME payment adjustment (see instructions) 0.22.00 1 IME payment adjustment - Managed Care (see instructions) 0.22.01 1 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 0.00 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 0.00 23.00 (f)(1)(iv)(c). 0.1 0.00 24.00 25.00 16 the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.01 IME add-on adjustment amount (see instructions) 0.28.01 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0.29.01 2						
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 22.00 IME payment adjustment (see instructions) 0.000000 22.00 Image: Im						
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 0.000000 21.00 0.000000 21.00 0.000000 21.00 0.000000 22.00 0.000000 21.00 0.000000 22.00 0.000000 22.00 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.00000000		, ,				
21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00		,				
22.00 IME payment adjustment (see instructions) 1 IME payment adjustment - Managed Care (see instructions) 1 IME payment adjustment - Managed Care (see instructions) 22.01 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 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 26.00 IME payments adjustment factor. (see instructions) 27.00 IME payments adjustment factor. (see instructions) 28.01 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount (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 Sum of lines 30 and 31 31.00 Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions) 12.00 33.00 Allowable disproportionate share percentage (see instructions) 22.01 12.00 33.00						
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 0.00 23.00 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount (see instructions) 0.28.00 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.00 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) 0.29.01 Disproportionate Share Adjustment 0.000000 30.00 Sum of lines 30 and 31 34.25 32.00 31.00 Allowable disproportionate share percentage (see instructions) 12.00 33.00	22.00	IME payment adjustment (see instructions)			0	22. 00
23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 0.00 23.00 (f) (1) (iv) (C). 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the 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 26.00 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) 0.28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 Total IME payment (sum of lines 22 and 28) 0.29.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0.000000 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 2.2.2 30.00 31.00 Sum of lines 30 and 31 31.00 Allowable disproportionate share percentage (see instructions) 12.00 33.00	22. 01				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 payments adjustment amount (see instructions) 28.00 IME add-on adjustment amount (see instructions) 29.00 IME add-on adjustment amount - Managed Care (see instructions) 29.00 IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Sum of lines 30 and 31 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 32.00 33.00	23. 00	Number of additional allopathic and osteopathic IME FTE resident of		ec. 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 instructions) Resident to bed ratio (divide line 25 by line 4) 1ME payments adjustment factor. (see instructions) 1ME add-on adjustment amount (see instructions) 1ME add-on adjustment amount - Managed Care (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 10 28.01 Total IME payment (sum of lines 22 and 28) 10 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 10 Disproportionate Share Adjustment 20.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 20 20 Sum of lines 30 and 31 31.00 Allowable disproportionate share percentage (see instructions) 25.00 condition 24 (see instructions) 26.00 condition 25 by line 24 (see instructions) 27.00 condition 27 condition 28 condition 29 condi	24.00				0.00	24.00
26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount (see instructions) 0.28.00 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 29.00 Total IME payment (sum of lines 22 and 28) 0.29.00 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0.00 Disproportionate Share Adjustment 29.01 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 2.22 30.00 31.00 Percentage of Medicaid patient days (see instructions) 32.03 31.00 32.00 Allowable disproportionate share percentage (see instructions) 12.00 33.00		If the amount on line 24 is greater than -O-, then enter the lower	r 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 28. 00 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0 28. 01 29. 00 Total IME payment (sum of lines 22 and 28) 0 29. 00 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29. 01 Disproportionate Share Adjustment 20. 00 31. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 2. 22 30. 00 31. 00 Percentage of Medicaid patient days (see instructions) 32. 03 31. 00 32. 00 Allowable disproportionate share percentage (see instructions) 12. 00 33. 00	26 00				0 000000	26 00
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) 30.00 Percentage of Medicaid patient days (see instructions) 30.00 Sum of lines 30 and 31 30.00 Allowable disproportionate share percentage (see instructions)						
28. 01 IME add-on adjustment amount - Managed Care (see instructions) 7						
29.00 Total IME payment (sum of lines 22 and 28) 0 29.00 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) 2.22 30.00 32.00 Sum of lines 30 and 31 34.25 32.00 33.00 Allowable disproportionate share percentage (see instructions) 12.00 33.00	28. 01	`				
29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 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) 29. 01 29. 01 30. 00 29. 01 30. 00 20. 00 31. 00 32. 00 32. 00 33. 00		, , , , , , , , , , , , , , , , , , , ,				
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 33.00		Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				
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) 32.03 31.00 32.00 32.00 33.00	30.00		nt days (see instruc	tions)	2. 22	30.00
32.00 Sum of Lines 30 and 31 34.25 32.00 33.00 Allowable disproportionate share percentage (see instructions) 12.00 33.00			. :	•		
	32.00				34. 25	32.00
34.00 Disproportionate share adjustment (see instructions) 52,089 34.00		, , , , , , , , , , , , , , , , , , , ,				
	34. 00	Disproportionate share adjustment (see instructions)		l	52, 089	34. 00

		I AL HOSPI TAL		u of Form CMS-2	2552-10		
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0101	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Pre			
		Title XVIII	Hospi tal	3/30/2017 9: 0 ^o	9 am		
		THE XVIII	Prior to 10/1				
			1. 00	2. 00			
35. 00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		6 406 145 534	5, 977, 483, 147	35. 00		
35. 01	Factor 3 (see instructions)		0. 000030771	0. 000028279	•		
35. 02	Hospital uncompensated care payment (If line 34 is zero, (see instructions)	enter zero on this line)	197, 121	169, 037	•		
35. 03 36. 00	Pro rata share of the hospital uncompensated care payment a Total uncompensated care (sum of columns 1 and 2 on line 3)	5. 03)	147, 571 190, 178	42, 607	35. 03 36. 00		
40. 00	Additional payment for high percentage of ESRD beneficiary Total Medicare discharges on Worksheet S-3, Part I excludit 652, 682, 683, 684 and 685 (see instructions)		gn 46) 0		40. 00		
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	, 683, 684 an 685. (see	0		41. 00		
41. 01	Total ESRD Medicare covered and paid discharges excluding lan 685. (see instructions)				41. 01		
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not quantotal Medicare ESRD inpatient days excluding MS-DRGs 652, instructions)		0.00		42. 00 43. 00		
44. 00	Ratio of average length of stay to one week (line 43 divided days)	ed by line 41 divided by 7	0. 000000		44. 00		
45. 00	Average weekly cost for dialysis treatments (see instruction		0.00		45. 00		
46. 00 47. 00					46. 00 47. 00		
48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH,	, small rural hospitals	1, 996, 236 0		48. 00		
	only. (see instructions)	'					
				Amount 1.00			
49. 00	Total payment for inpatient operating costs (see instruction	ons)		1, 996, 236	49. 00		
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I			147, 347	50.00		
51. 00 52. 00	Exception payment for inpatient program capital (Wkst. L, I Direct graduate medical education payment (from Wkst. E-4,			0	51. 00 52. 00		
53. 00	Nursing and Allied Health Managed Care payment	Title 47 See Tilstructions).		0			
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, P	t. IV, col. 11 line 200)		0			
59. 00 60. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments			2, 143, 583 7, 188	ı		
61.00	Total amount payable for program beneficiaries (line 59 min	nus line 60)		2, 136, 395			
62. 00	Deductibles billed to program beneficiaries			445, 120	1		
63.00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			983	•		
65. 00	Adjusted reimbursable bad debts (see instructions)			31, 804 20, 673	1		
66. 00	Allowable bad debts for dual eligible beneficiaries (see in	nstructions)		18, 451	1		
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			1, 710, 965	1		
68. 00 69. 00	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96			0	1		
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	b). (101 3011 300 111311 det1011	3)	0	1		
70. 50	RURAL DEMONSTRATION PROJECT			0	70. 50		
70. 88	SCH or MDH volume decrease adjustment			0			
70. 89 70. 90	Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions)			0	1		
70. 90	HSP bonus payment HRR adjustment amount (see instructions)	,		0			
70. 92	Bundled Model 1 discount amount (see instructions)			0	70. 92		
70. 93	HVBP payment adjustment amount (see instructions)						
70. 94							

Heal th Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 CALCULATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 15-0101
Title XVIII Hospital PPS FFY (yyyy) Amount 0 1.00
FFY (yyyy) Amount 0 1.00 1.
70. 96 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1) 70. 97 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1) 70. 98 Low Volume Payment-3 70. 99 HAC adjustment amount (see instructions) 71. 00 Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70) 71. 01 Sequestration adjustment (see instructions) 72. 00 Interim payments 73. 00 Tentative settlement (for contractor use only) 74. 00 Balance due provider (Program) (line 71 minus lines 71. 01, 72, and 73) 75. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115. 2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)
To. 96 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1) To. 97 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1) Low Volume Payment-3 Low Volume Payment-3 HAC adjustment amount (see instructions) Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70) Sequestration adjustment (see instructions) 10 2017 2017 91, 124 70. 97 70. 98 18, 835 70. 99 21, 001 71. 001 Sequestration adjustment (see instructions) 10 2, 001 71. 01 72. 00 Interim payments 73. 00 Tentative settlement (for contractor use only) 74. 00 Balance due provider (Program) (line 71 minus lines 71. 01, 72, and 73) Protested amounts (nonal lowable cost report items) in accordance with (CMS Pub. 15-2, chapter 1, §115. 2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)
the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1) Low Volume Payment-3 Low Volume Payment-3 HAC adjustment amount (see instructions) Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70) Sequestration adjustment (see instructions) 11,00 Sequestration adjustment (see instructions) 11,00 Sequestration adjustment (see instructions) 11,00 Tentative settlement (for contractor use only) Tentative settlement (for contracto
70. 97 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1) 70. 98 Low Volume Payment-3 70. 99 HAC adjustment amount (see instructions) Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70) Sequestration adjustment (see instructions) 1.00 Sequestration adjustment (see instructions) 1.101 1.101 1.101 2.100 2.101 2
the corresponding federal year for the period ending on or after 10/1) Low Volume Payment-3 10.99 HAC adjustment amount (see instructions) 18,835 170.99 HAC adjustment amount (see instructions) 18,835 170.99 1.00 Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70) 1.01 Sequestration adjustment (see instructions) 1.01 1.02 1.03 1.04 1.04 1.05 1.05 1.06 1.06 1.06 1.07 1.07 1.07 1.07 1.08 1.08 1.08 1.09 1.09 1.09 1.09 1.00 1.00 1.00 1.00
70. 98 Low Volume Payment-3 70. 99 HAC adjustment amount (see instructions) 71. 00 Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70) 71. 01 Sequestration adjustment (see instructions) 72. 00 Interim payments 73. 00 Tentative settlement (for contractor use only) 8al ance due provider (Program) (line 71 minus lines 71. 01, 72, and 73) Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115. 2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)
70. 99 HAC adjustment amount (see instructions) 18, 835 70. 99 71. 00 Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70) 2, 081, 188 71. 00 71. 01 Sequestration adjustment (see instructions) 11 Interim payments 12, 109, 948 72. 00 73. 00 Tentative settlement (for contractor use only) 81 ance due provider (Program) (line 71 minus lines 71. 01, 72, and 73) Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115. 2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)
71.00 Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70) 71.01 Sequestration adjustment (see instructions) 72.00 Interim payments 73.00 Tentative settlement (for contractor use only) 74.00 Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73) 75.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)
71. 01 Sequestration adjustment (see instructions)
72. 00 Interim payments 2, 109, 948 72. 00 73. 00 74. 00 8al ance due provider (Program) (line 71 minus lines 71. 01, 72, and 73) 75. 00 Protested amounts (nonal lowable cost report items) in accordance with 197, 717 75. 00 CMS Pub. 15-2, chapter 1, §115. 2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) 75. 00
73.00 Tentative settlement (for contractor use only) 74.00 Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73) 75.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)
74.00 Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73) 75.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)
75.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)
TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)
90.00 Operating outlier amount from Wkst F Pt A line 2 (see instructions)
70:00 operating outries amount from wist. E, it. A, ithe 2 (see instructions)
91.00 Capital outlier from Wkst. L, Pt. I, line 2
92.00 Operating outlier reconciliation adjustment amount (see instructions) 0 92.00
93.00 Capital outlier reconciliation adjustment amount (see instructions) 0 93.00
94.00 The rate used to calculate the time value of money (see instructions) 0.00 94.00
95.00 Time value of money for operating expenses (see instructions) 0 95.00
96.00 Time value of money for capital related expenses (see instructions) 0 96.00
Prior to 10/1 On/After 10/1
1.00 2.00
HSP Bonus Payment Amount
100. 00 HSP bonus amount (see instructions) 0 0 100. 00
HVBP Adjustment for HSP Bonus Payment
101.00 HVBP adjustment factor (see instructions) 0.0000000000 0.000000000 101.00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions) 0 0 102.00
HRR Adjustment for HSP Bonus Payment
103.00 HRR adjustment factor (see instructions) 0.0000 0.0000 103.00
104.00 HRR adjustment amount for HSP bonus payment (see instructions) 0 0 104.00

In Lieu of Form CMS-2552-10

Period: Worksheet E
From 01/01/2016 Part A Exhibit 4
To 12/31/2016 Date/Time Prepared: 3/30/2017 9:09 am Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0101

					'	0 12/31/2016	3/30/2017 9:0	
	,		I		XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3. 00	4. 00	5. 00	
1. 00	DRG amounts other than outlier	1. 00	0	0	0.00		0	1. 00
1. 01	payments DRG amounts other than outlier	1. 01	1, 288, 531	0	1, 288, 531		1, 288, 531	1. 01
	payments for discharges occurring prior to October 1		1, 200, 001	J	., 200, 00.		., 200, 001	
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	447, 758	0		447, 758	447, 758	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	C		0	1. 03
1. 04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2. 00	17, 680	0	15, 985	1, 695	17, 680	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	C	0	0	2. 01
3.00	Operating outlier reconciliation	2. 01	0	0	C	0	0	3. 00
4. 00	Managed care simulated payments Indirect Medical Education Adju	3. 00	0	0	С	О	0	4. 00
5. 00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	0	0	0. 22222	0	0	6. 00
6. 01	instructions) IME payment adjustment for	22. 00	0	0	0	0	0	6. 01
0.01	managed care (see instructions)	22.01	Ŭ	0	C		0	0.01
	Indirect Medical Education Adju	ustment for the	Add-on for Se	ction 422 of t	he MMA			
7. 00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see	28. 00	0	0	C	0	0	8. 00
8. 01	instructions) IME payment adjustment add on for managed care (see	28. 01	0	0	C	O	0	8. 01
9. 00	instructions) Total IME payment (sum of lines 6 and 8)	29. 00	0	0	C	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	C	О	0	9. 01
	Disproportionate Share Adjustme	ent						
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 1200	0. 1200	0. 1200	0. 1200		10. 00
11. 00	instructions) Disproportionate share	34.00	52, 089	0	38, 656	13, 433	52, 089	11. 00
11. 01	adjustment (see instructions) Uncompensated care payments	36. 00	190, 178	0	147, 571	42, 607	190, 178	11. 01
	Additional payment for high per	centage of ESF		di scharges				
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	C	0	0	12. 00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH,	47. 00 48. 00	1, 996, 236 0	0	1, 490, 743 C	505, 493 0	1, 996, 236 0	13. 00 14. 00
15. 00	small rural hospitals only.) (see instructions) Total payment for inpatient	49. 00	1, 996, 236	0	1, 490, 743	505, 493	1, 996, 236	15. 00
	operating costs (see instructions)							
16. 00	Payment for inpatient program capital	50. 00	147, 347	0	109, 399	37, 948		
17. 00	Special add-on payments for new technologies	54. 00	0	0	C	0	0	17. 00
17. 01 17. 02	Net organ aquisition cost Credits received from	55. 00 68. 00	0	0	C	-	0	17. 01 17. 02
18. 00	manufacturers for replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see	93.00	0	0	C	0	0	18. 00
	instructions)							

							From 01/01/2016 To 12/31/2016		Part A Exhibi Date/Time Pre 3/30/2017 9:0	pared:
				Title	Title XVIII		PPS			
			Amounts (from	Pre/Post	Period Prior		Total (Col 2			
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)			
		0	1. 00	2.00	3.00	4. 00	5. 00			
19. 00	SUBTOTAL			0	1, 600, 14	2 543, 441	2, 143, 583	19. 00		
		W/S L, line	(Amounts from							
			L)							
		0	1.00	2.00	3.00	4. 00	5. 00			
20.00	Capital DRG other than outlier	1. 00	138, 667	0	102, 37	9 36, 288	138, 667	20.00		
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0		0	0	20. 01		
	than outlier									
21.00	Capital DRG outlier payments	2. 00	8, 680	0	7, 02	0 1, 660	8, 680	21. 00		
21. 01	Model 4 BPCI Capital DRG	2. 01	0	0		0	0	21. 01		
	outlier payments									
22.00	Indirect medical education	5. 00	0. 0000	0.0000	0.000	0.0000		22. 00		
	percentage (see instructions)									
23.00	Indirect medical education	6. 00	0	0		0	0	23. 00		
	adjustment (see instructions)									
24.00	Allowable disproportionate	10.00	0. 0000	0.0000	0.000	0.0000		24.00		
	share percentage (see									
	instructions)									
25.00	Di sproporti onate share	11. 00	0	0		0	0	25. 00		
	adjustment (see instructions)									
26.00	Total prospective capital	12.00	147, 347	0	109, 39	9 37, 948	147, 347	26. 00		
	payments (see instructions)									
			(Amounts to E,							
		line	Part A)							
		0	1. 00	2. 00	3. 00	4. 00	5. 00			
27. 00	Low volume adjustment factor				0. 17767	9 0. 167679		27. 00		
28. 00	Low volume adjustment	70. 96			284, 31	2	284, 312	28. 00		
	(transfer amount to Wkst. E,									
	Pt. A, line)									
29. 00	Low volume adjustment	70. 97				91, 124	91, 124	29. 00		
	(transfer amount to Wkst. E,									
	Pt. A, line)									
100.00	Transfer low volume		Υ					100.00		
	adjustments to Wkst. E, Pt. A.									

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 15-0101	Peri od: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 3/30/2017 9:09 am

			To 12/31/2016	Date/Time Pre 3/30/2017 9:0	
		Title XVIII	Hospi tal	PPS	<u> </u>
	DART R. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
1.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			0	1. 00
2. 00	Medical and other services (see Thistractions)	tions)		4, 490, 602	
3. 00	PPS payments			3, 219, 605	
4.00	Outlier payment (see instructions)			15, 327	4. 00
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0. 000	•
6. 00	Line 2 times line 5			0	
7. 00 8. 00	Sum of line 3 plus line 4 divided by line 6 Transitional corridor payment (see instructions)			0. 00 0	•
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	IV col 13 line 200		0	
10. 00	Organ acquisitions	. 1, 33.1 13, 11113 233		0	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			0	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
10.00	Reasonable charges			0	10.00
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	12. 00 13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)	THE 07)		0	
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for p				15. 00
16. 00	Amounts that would have been realized from patients liable for		n a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(6) Ratio of line 15 to line 16 (not to exceed 1.000000)	9)		0. 000000	17. 00
18. 00	Total customary charges (see instructions)			0.00000	18. 00
19. 00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds li	ne 11) (see	0	19. 00
20.00	instructions)	luiflima 11 avasada lii	no 10) (ooo	0	20.00
20. 00	Excess of reasonable cost over customary charges (complete onlinstructions)	y it time it exceeds it	ne 18) (See	0	20. 00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	e instructions)		0	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			3, 234, 932	24. 00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			713, 972	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for	r CAH, see instructions)		0	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	olus the sum of lines 22	and 23] (see	2, 520, 960	27. 00
28. 00	instructions) Direct graduate medical education payments (from Wket E 4 Li	no EO)		0	28. 00
29. 00	Direct graduate medical education payments (from Wkst. E-4, li ESRD direct medical education costs (from Wkst. E-4, line 36)	The 50)		0	
30. 00	Subtotal (sum of lines 27 through 29)			2, 520, 960	•
31. 00	Pri mary payer payments			886	31. 00
32. 00	Subtotal (line 30 minus line 31)			2, 520, 074	32. 00
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE Composite rate ESRD (from Wkst. I-5, line 11)	CES)		0	33. 00
33. 00 34. 00	Allowable bad debts (see instructions)			104, 093	ł
35. 00	Adjusted reimbursable bad debts (see instructions)			67, 660	1
36.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		78, 478	36. 00
	Subtotal (see instructions)			2, 587, 734	
	MSP-LCC reconciliation amount from PS&R			0	•
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	-)		0	39. 00 39. 50
39. 98	Partial or full credits received from manufacturers for replace		tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	304 401. 303 (303 40	11 01.0)	0	39. 99
40.00	Subtotal (see instructions)			2, 587, 734	40. 00
40. 01	Sequestration adjustment (see instructions)				40. 01
41.00					41.00
42.00	,				42.00
43. 00 44. 00					43. 00 44. 00
11.00	§115. 2				00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
91. 00 92. 00	The rate used to calculate the Time Value of Money				91.00
93. 00	Time Value of Money (see instructions)			0.00	•
	Total (sum of lines 91 and 93)			0	1
			·		

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

Interim payments payable on individual bills, either submitted or to be submitted for the cost reporting period. If none, write "NoNE" or enter a zero that it is separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NoNE" or enter a zero (1) Program to Provider ADJUSTMENTS TO PROVIDER						3/30/2017 9:0	9 am
March Marc			Title	XVIII		PPS	
1.00 2.00 3.00 4.00			I npati en	t Part A	Par	t B	
1.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Interim payments payable on individual bills, either submitted or to be submitted for the cost reporting period. If none, write "NoNE" or enter a zero that it is separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NoNE" or enter a zero (1) Program to Provider ADJUSTMENTS TO PROVIDER			1. 00		3. 00	4. 00	
Submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 2,000 2				2, 109, 948			1. 00
3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	2.00	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,		0		0	2. 00
3.01 ADJUSTMENTS TO PROVIDER	3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3. 00
3. 02 3. 03 3. 04 3. 05 3. 05 3. 05 3. 06 3. 07 3. 08 3. 09 3. 09 3. 00							
3.03 3.04 3.05 Provider to Program 3.50 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment. If none, write "NONE" or enter a zero. (1) Program to Provider TENTATIVE TO PROGRAM TO SETTLEMENT TO PROGRAM TO SETLEMENT TO PROGRAM TO SETTLEMEN		ADJUSTMENTS TO PROVIDER		_			
3.04 0 0 0 3.04 3.05 5.				_		1	
3.05				· ·			
Provider to Program							
3. 50 ADJUSTMENTS TO PROGRAM	3.05	Don't don't be Discourse		0		0	3.05
3.51 3.52 3.53 3.54 3.50	2 50						2 50
3.52 3.53 3.54 3.99 3.50 3.53 3.54 3.99 3.50 3.53 3.54 3.99 3.50 3.53 3.59 3.50		ADJUSTMENTS TO PROGRAM					
3.53 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)				_		"	
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 3.54 3.99 3.50-3.98 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2,109,948 2,454,665 4.00 4							
3. 99 Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 3. 50-3. 98) 4. 00 10 tal interim payments (sum of lines 1, 2, and 3. 99) 2, 109, 948 2, 454, 665 4. 00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR				_			
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		Subtotal (sum of lines 3 01_3 49 minus sum of lines					
Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR	3. 77						3. 77
TO BE COMPLÉTED BY CONTRACTOR S. 00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider O	4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		2, 109, 948		2, 454, 665	4. 00
5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NNDNE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
TENTATI VE TO PROVIDER	5. 00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
S. 02 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 6. 50-5. 98) Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 6. 50-5. 98) Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 6. 50-5. 98) Subtotal (sum of lines 5. 50-5. 98) Subtotal (sum of lines 5. 50-5. 98) Subtotal (sum of lines 5. 50-5. 98) Subtotal (sum of lines 6. 50-5. 98) Subtotal (sum of lines 5. 50-5. 98) Subtotal (sum of lines 6. 50-5.				_		_	
Solution Section Sec		TENTATI VE TO PROVI DER					
Provider to Program							
TENTATI VE TO PROGRAM 0	5.03	Donaldon to Donaman		0		U	5.03
5.51	E E0						E E0
5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 81,314 6.01 6.02 SETTLEMENT TO PROGRAM 70,384 0 6.02 7.00 Total Medicare program liability (see instructions) 2,039,564 2,535,979 7.00 Contractor NPR Date (Mo/Day/Yr) Number (Mo/Day/Yr) 0 1.00 2.00 Contractor NPR Date (Mo/Day/Yr) 0 Contractor NPR Date (Mo/Day/Yr) Contracto		ILIVIATIVE TO FROGRAM		_		1	
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 81,314 6.01 6.02 SETTLEMENT TO PROGRAM 70,384 0 6.02 7.00 Total Medicare program liability (see instructions) 2,039,564 2,535,979 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00						"	
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00		Subtotal (sum of lines 5 O1-5 49 minus sum of lines		_		-	
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00		5. 50-5. 98)				Ŭ	
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00		the cost report. (1)		0		01 214	
7.00 Total Medicare program liability (see instructions) 2,039,564 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				70 204			
Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00				· ·			
Number (Mo/Day/Yr) 0 1.00 2.00	7.00	Total medicale program frability (see instructions)		2,037,304	Contractor		7.00
0 1.00 2.00							
			()			
	8. 00	Name of Contractor					8. 00

Heal th F	Financial Systems WHITLEY MEMORIA	L HOSPITAL	In Lie	u of Form CMS-2	2552-10	
CALCULA	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0101 Period: Worksheet E-1 From 01/01/2016 Part II					
			To 12/31/2016			
-		Title XVIII	Hospi tal	9:00 PPS	9 alli	
		THE AVIII	nospi tai	113		
				1. 00		
Т	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
F	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	14	1, 574	1.00	
	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	3-12		1, 159	2.00	
	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			1, 037	3. 00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12		3, 790	4.00	
	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			184, 469, 635	5. 00	
	Total hospital charity care charges from Wkst. S-10, col. 3 I			2, 076, 642	6. 00	
I .	CAH only - The reasonable cost incurred for the purchase of $\mathfrak c$	certified HIT technology	Wkst. S-2, Pt. I	0	7. 00	
	line 168					
1	Calculation of the HIT incentive payment (see instructions)			0	8. 00	
	Sequestration adjustment amount (see instructions)			0	9. 00 10. 00	
	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)					
-	NPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH			_	30. 00	
	30.00 Initial/interim HIT payment adjustment (see instructions)					
	Other Adjustment (specify)		,	0	31. 00	
32. 00 E	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ns)	0	32. 00	

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

Provider CCN: 15-0101 Period: From 01

Peri od: From 01/01/2016 To 12/31/2016 Date/Ti me Prepared: 3/30/2017 9:09 am

oni y)				12, 01, 2010	3/30/2017 9:0	9 am
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2. 00	3. 00	4. 00	
	CURRENT ASSETS			т		
1.00	Cash on hand in banks	297, 432		0	0	1.00
2. 00 3. 00	Temporary investments Notes receivable	0		-	0	2. 00 3. 00
4. 00	Accounts recei vable	22, 564, 679	1	1	0	
5. 00	Other recei vable	162, 454			0	
6. 00	Allowances for uncollectible notes and accounts receivable	-15, 037, 947		o o	0	
7. 00	Inventory	343, 813		o o	0	7. 00
8.00	Prepai d expenses	38, 166		0	0	8. 00
9.00	Other current assets	0) (0	0	9. 00
10.00	Due from other funds	0)	0	0	10. 00
11. 00	Total current assets (sum of lines 1-10)	8, 368, 597	' (0	0	11. 00
	FIXED ASSETS					
12. 00	Land	260, 483	1		-	
13.00	Land improvements	2, 469, 451	1	-	0	
14.00	Accumulated depreciation	-230, 087	1	-		14.00
15. 00	Buildings	14, 588, 065	1	-	0	15.00
16. 00 17. 00	Accumulated depreciation Leasehold improvements	-971, 033 48, 824	1	-	0	16. 00 17. 00
18. 00	Accumulated depreciation	-48, 824	1	-	0	18. 00
19. 00	Fi xed equi pment	6, 263, 961		1	0	19.00
20. 00	Accumulated depreciation	-770, 303	1		0	20.00
21. 00	Automobiles and trucks	446, 861	1	o o	Ö	21. 00
22. 00	Accumulated depreciation	-263, 787	1	-	ő	22. 00
23. 00	Major movable equipment	15, 450, 609	1	o o	Ō	23. 00
24.00	Accumul ated depreciation	-8, 544, 463	1	0	0	24. 00
25.00	Mi nor equi pment depreci abl e	0		0	0	25. 00
26.00	Accumulated depreciation	0) (0	0	26. 00
27. 00	HIT designated Assets	0)	0	0	27. 00
28. 00	Accumulated depreciation	0) (0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0) (0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	28, 699, 757	' (0	0	30.00
	OTHER ASSETS	10.00/.100				
31.00	Investments	49, 036, 400		-	-	31.00
32.00	Deposits on leases	0		-	0	32. 00 33. 00
33. 00 34. 00	Due from owners/officers Other assets	0		_	0	34.00
35. 00	Total other assets (sum of lines 31-34)	49, 036, 400	1	1	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	86, 104, 754	1	·		36.00
00.00	CURRENT LI ABI LI TI ES	00, 101, 701		<u>, </u>		00.00
37. 00	Accounts payable	1, 967, 159		0	0	37. 00
38. 00	Salaries, wages, and fees payable	967, 668	1	0	0	38. 00
39.00	Payrol I taxes payable	0) (0	0	39. 00
40.00	Notes and Loans payable (short term)	0) (0	0	40. 00
41.00	Deferred income	0) (0	0	41. 00
42. 00	Accel erated payments	0)			42. 00
43. 00	Due to other funds	0		0	0	
44.00	Other current liabilities	58, 485		1	Ĭ	
45. 00	Total current liabilities (sum of lines 37 thru 44)	2, 993, 312		0	0	45. 00
46. 00	LONG TERM LIABILITIES Mortgage payable	1			0	46. 00
47. 00	Notes payable	9, 887, 279				
48. 00	Unsecured Loans	7,007,279		-	0	48. 00
49. 00	Other long term liabilities	-8, 633, 476		-	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	1, 253, 803		-		
51. 00	Total liabilities (sum of lines 45 and 50)	4, 247, 115		o o		
	CAPITAL ACCOUNTS					
52.00	General fund balance	81, 857, 639)			52. 00
53.00	Specific purpose fund					53. 00
54.00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00	Donor created - endowment fund balance - unrestricted		1	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
FC 66	replacement, and expansion	04 057 177		_	_	F0 22
59.00	Total fund balances (sum of lines 52 thru 58)	81, 857, 639		J 0	0	59.00
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	86, 104, 754		0 ار	0	60.00
	l∝,\	I	1	I	ı	I

Provider CCN: 15-0101

					То	12/31/2016	Date/Time Prep 3/30/2017 9:09	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	<i>y</i>
				·				
	I 	1.00	2. 00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		30, 076, 825			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		10, 947, 964			0		2.00
3. 00 4. 00	Total (sum of line 1 and line 2) CREDIT ADJUSTMENTS	40, 832, 850	41, 024, 789		0	0	0	3. 00 4. 00
4. 00 5. 00	CREDIT ADJUSTMENTS	40, 832, 850			0		0	4. 00 5. 00
6. 00					0		0	6. 00
7. 00					0		0	7. 00
8. 00					0		0	8. 00
9. 00					0		0	9. 00
10.00	Total additions (sum of line 4-9)		40, 832, 850		Ĭ	0	Ü	10. 00
11. 00	Subtotal (line 3 plus line 10)		81, 857, 639			0		11. 00
12. 00	Deductions (debit adjustments) (specify)	0	0.70077007		0	J	0	12. 00
13. 00	, (, (, (, /, /, /, /	o			0		0	13. 00
14. 00		o			0		0	14. 00
15.00		O			0		0	15.00
16.00		0			0		0	16.00
17.00		O			0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0			0		18.00
19. 00	Fund balance at end of period per balance		81, 857, 639			0		19.00
	sheet (line 11 minus line 18)			L				
		Endowment Fund	PI ant	Funa				
		6.00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0.00	7.00	0.00	0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)]						2. 00
3.00	Total (sum of line 1 and line 2)	o			0			3. 00
4.00	CREDIT ADJUSTMENTS		0					4. 00
5.00			0					5.00
6.00			0					6.00
7.00			0					7.00
8.00			0					8. 00
9.00			0					9. 00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11. 00	Subtotal (line 3 plus line 10)	0			0			11. 00
12. 00	Deductions (debit adjustments) (specify)		0					12.00
13. 00			0					13. 00
14.00			0					14.00
15.00			0					15. 00
16.00			0					16.00
17. 00 18. 00	Total deductions (sum of lines 12-17)		U		0			17. 00 18. 00
19.00	Fund balance at end of period per balance				0			18.00
17.00	sheet (line 11 minus line 18)	١						17.00
	10.000 (1.1.0 11 111100 11110 10)	1		Į.	1			

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

			T	o 12/31/2016	Date/Time Prep 3/30/2017 9:09	
	Cost Center Description	11	npati ent	Outpati ent	Total	, d
			1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES				0.00	
	General Inpatient Routine Services					
1.00	Hospi tal		7, 639, 177		7, 639, 177	1. 00
2.00	SUBPROVI DER - I PF					2. 00
3.00	SUBPROVI DER - I RF					3. 00
4.00	SUBPROVI DER					4. 00
5. 00	Swing bed - SNF		0		0	5. 00
6.00	Swing bed - NF		0		0	6. 00
7.00	SKILLED NURSING FACILITY		0		0	7. 00
8.00	NURSING FACILITY					8. 00
9. 00	OTHER LONG TERM CARE					9. 00
10.00	Total general inpatient care services (sum of lines 1-9)		7, 639, 177		7, 639, 177	10. 00
	Intensive Care Type Inpatient Hospital Services	· · · · · · · · · · · · · · · · · · ·			,	
11. 00	INTENSIVE CARE UNIT					11. 00
12.00	CORONARY CARE UNIT					12. 00
13.00	BURN INTENSIVE CARE UNIT					13. 00
14.00	SURGI CAL INTENSIVE CARE UNIT					14. 00
15.00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16.00	Total intensive care type inpatient hospital services (sum of li	nes	0		0	16. 00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)		7, 639, 177		7, 639, 177	17. 00
18.00	Ancillary services		25, 845, 914	155, 146, 066	180, 991, 980	18. 00
19.00	Outpati ent servi ces		0	o	0	19. 00
20.00	RURAL HEALTH CLINIC		0	o	0	20. 00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	o	0	21. 00
22.00	HOME HEALTH AGENCY					22. 00
23.00	AMBULANCE SERVICES		0	o	0	23. 00
24.00	CMHC					24. 00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00
26.00	HOSPI CE					26. 00
27.00	OTHER (SPECIFY)		0	o	0	27. 00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst.	33, 485, 091	155, 146, 066	188, 631, 157	28. 00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			56, 194, 953		29. 00
30.00	ADD (SPECIFY)		0			30.00
31.00			0			31.00
32.00			0			32.00
33.00			0			33. 00
34.00			0			34.00
35.00			0			35. 00
36.00	Total additions (sum of lines 30-35)			0		36. 00
37.00	DEDUCT (SPECIFY)		0			37. 00
38. 00			0			38. 00
39. 00		1	0			39. 00
40.00			0			40. 00
41.00			0			41. 00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		56, 194, 953		43.00
	to Wkst. G-3, line 4)	[

Heal th	Financial Systems WHITLEY MEMORIAL	. HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-0101	Peri od:	Worksheet G-3	
			From 01/01/2016 To 12/31/2016	Date/Time Pre 3/30/2017 9:0	pared: 9 am
1 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	20)		1. 00 188, 631, 157	1 00
1. 00 2. 00	Less contractual allowances and discounts on patients' account			126, 979, 445	1. 00 2. 00
3. 00	Net patient revenues (line 1 minus line 2)	13		61, 651, 712	3. 00
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		56, 194, 953	4. 00
5. 00	Net income from service to patients (line 3 minus line 4)	40)		5, 456, 759	
0.00	OTHER I NCOME			0, 100, 707	0.00
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			882, 927	7. 00
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14. 00	Revenue from meals sold to employees and guests			181, 064	14. 00
15. 00	Revenue from rental of living quarters			4, 835	
16. 00	Revenue from sale of medical and surgical supplies to other the	han patients		0	16. 00
17. 00	Revenue from sale of drugs to other than patients			936, 962	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20. 00 21. 00	Revenue from gifts, flowers, coffee shops, and canteen Rental of vending machines			29, 536 0	20. 00 21. 00
22. 00	Rental of hospital space			561, 172	21.00
23. 00	Governmental appropriations			0	23. 00
24. 00	OTHER (SPECIFY)			0	24. 00
24. 00	GAIN ON DISPOSAL OF ASSETS			37, 655	
24. 02	COUNTY REIMBURSEMENT OF AMBULANCE SE			340, 000	24. 02
24. 03	REVENUE FROM SALE OF SCRAP			0 10, 000	24. 03
24. 04	MI SCELLANEOUS			470, 702	
25. 00	Total other income (sum of lines 6-24)			3, 444, 853	
26. 00	Total (line 5 plus line 25)			8, 901, 612	
27. 00				-2, 046, 352	
28. 00	Total other expenses (sum of line 27 and subscripts)			-2, 046, 352	
29. 00	Net income (or loss) for the period (line 26 minus line 28) 10,947,964 29				

Heal th	Financial Systems WHITLEY MEMO	DRIAL HOSPITAL	Inlie	eu of Form CMS-2	2552_10		
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0101	Period: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III	pared:		
		Title XVIII	Hospi tal	PPS			
				1. 00			
	PART I - FULLY PROSPECTIVE METHOD						
4 00	CAPITAL FEDERAL AMOUNT			400 (47	4 00		
1.00	Capital DRG other than outlier			138, 667	1.00		
1. 01 2. 00	Model 4 BPCI Capital DRG other than outlier Capital DRG outlier payments			0 8, 680			
2.00	Model 4 BPCI Capital DRG outlier payments			8, 680			
3. 00	Total inpatient days divided by number of days in the cos	t reporting period (see inst	ructions)	10. 97			
4.00	Number of interns & residents (see instructions)	t reporting perrou (see riist	i uctions)	0.00			
5. 00	Indirect medical education percentage (see instructions)			0.00			
6. 00	Indirect medical education adjustment (multiply line 5 by	the sum of lines 1 and 1 01	columns 1 and	0.00			
0.00	1.01) (see instructions)	the sam of fines f and f. of	, cordiiiis i and		0.00		
7. 00	Percentage of SSI recipient patient days to Medicare Part 30) (see instructions)	A patient days (Worksheet E	, part A line	0.00	7. 00		
8.00	Percentage of Medicaid patient days to total days (see in	structions)		0.00	8. 00		
9. 00	Sum of lines 7 and 8			0.00			
10.00	Allowable disproportionate share percentage (see instruct	i ons)			10.00		
11. 00	Disproportionate share adjustment (see instructions)			0	11. 00		
12.00	Total prospective capital payments (see instructions)			147, 347	12. 00		
				1. 00			
	PART II - PAYMENT UNDER REASONABLE COST						
1.00	Program inpatient routine capital cost (see instructions)			0			
2.00	Program inpatient ancillary capital cost (see instruction			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	Program inpatient capital costs for extraordinary circums	,		0			
3.00	Net program inpatient capital costs (line 1 minus line 2)			0			
4.00	Applicable exception percentage (see instructions)			0.00			
5. 00 6. 00	Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (se			0.00			
7. 00	Adjustment to capital minimum payment level for extraordi		· Lino ()	0.00			
7. 00 8. 00	Capital minimum payment level (line 5 plus line 7)	nary crrcumstances (rine 2 x	. Title 6)				
9. 00	, , , , , , , , , , , , , , , , , , , ,	nnlicable)		0			
10. 00					10.00		
11. 00							
	Worksheet L, Part III, line 14)			0			
12.00	Net comparison of capital minimum payment level to capital	0					
13.00	Current year exception payment (if line 12 is positive, e	0					
14. 00							
15. 00	(if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see	0	15. 00				
16. 00							
	Current year exception offset amount (see instructions)	<i>5</i> ,		-	17. 00		
	of partient year exception offset amount (see first actions)						