This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0101 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/23/2024 12:06 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/23/2024 Time: 12:06 pm Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9.

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

(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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WHITLEY MEMORIAL HOSPITAL (15-0101) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

	·		Title XVIII				
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	33, 536	97, 446	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	TOTAL	0	33, 536	97, 446	0	0	200.00
Tho ob	and amounts conceent "due to" or "due from"	the applicable	program for t	he element of	the shows comp	lov indicated	

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0101 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/23/2024 12:06 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 1260 E STATE ROAD 205 PO Box: 1.00 State: IN Zip Code: 46725-9492 County: WHITLEY 2.00 City: COLUMBIA CITY 2.00 Provi der Component Name CCN CBSA Date Payment System (P, T, O, or N)

/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 WHITLEY MEMORIAL 150101 23060 07/01/1966 N 3.00 HOSPI TAI Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 10.00 Hospital -Based NF 10.00 11.00 Hospital -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital -Based Health Clinic - RHC 15 00 15 00 16.00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2023 12/31/2023 20.00 21.00 Type of Control (see instructions) 21.00 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR \$412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for 22.01 this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October

1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires a final UCP to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 Ν Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22 04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

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

Health Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0101 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/23/2024 12:06 pm In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days eligible Medi cai d Medi cai d days unpai d pai d days el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6. 00 24.00 If this provider is an IPPS hospital, enter the 872 34 24.00 63 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in 0 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 36 00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 0 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν N 40.00 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX V 1. 00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N N N 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N 47.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 Ν N Ν 48.00 Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? For cost reporting Ν Ν 56.00 periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, Ν 57.00 is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or

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

Health Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0101 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/23/2024 12: 06 pm XVIII XIX 1. 00 2.00 3.00 58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. Ν 58.00 Pt. I 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qualification Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 N instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. IME Direct GME IME Direct GME 1. 00 2.00 3. 00 4. 00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 0.00 61.00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61 02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ghted Unwei ghted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 0.00 61.10 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63.00 Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

Health Financial Systems	WHI TLEY	MEMORIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA	ATA Provi der		eriod: rom 01/01/2023 o 12/31/2023		pared:
			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	O6 pill
C+: FFOA + ACA D V	- FTE D! ! N		1.00	2. 00	3.00	
Section 5504 of the ACA Base Year period that begins on or after Ju			sinis base year	'is your cost	reporting	
64.00 Enter in column 1, if line 63 is in the base year period, the numbers ident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 2)	yes, or your facili per of unweighted no tations occurring in number of unweighte ur hospital. Enter i	ty trained resident n-primary care all nonprovider d non-primary care n column 3 the rati		0.00		64. 00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	Si te	4.00	E 00	-
65.00 Enter in column 1, if line 63	1. 00	2. 00	3.00	4. 00	5. 00 0. 000000	65.00
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unwei ghted	Unwei ghted	Ratio (col.	65.00
			FTEs Nonprovi der Si te	FTES in Hospital	1/ (col. 1 + col. 2))	
Section 5504 of the ACA Current	Voar ETE Dockdonts !	n Nonnroyi dan Catt	1.00	2.00	3. 00	
beginning on or after July 1, 20		ii Noripi ovi dei Setti	ingsEffective i	or cost report	ing perrous	
66.00 Enter in column 1 the number of u FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	ccurring in all nonp unweighted non-prima al. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66.00
(corumn i divided by (corumn i +	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
(7.00 5.11 1.	1. 00	2.00	3.00	4. 00	5. 00	(7
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0. 000000	0 67.00

Health Financial Systems WHITLEY MEMORIAL HOSPITAL	l r	n Lieu o	f Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-010		Wo	rksheet S-2 irt I	
	To 12/31/	′2023 Da	ite/Time Pre 23/2024 12:	
		- 07		, p
Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (Augu			1. 00	
68.00 For a cost reporting period beginning prior to October 1, 2022, did you obtain per MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, (August 10, 2022)?				68. 00
(August 11) Totaly		1 00	2.00 3.00	
Inpatient Psychiatric Facility PPS			2.00 3.00	
70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IP Enter "Y" for yes or "N" for no.	F subprovi der?	N		70.00
71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching progra recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" Column 3: If column 2 is Y, indicate which program year began during this cost rep	for no. (see teachi ng for no.		0	71.00
(see instructions) Inpatient Rehabilitation Facility PPS				<u>.</u>
75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an subprovider? Enter "Y" for yes and "N" for no.	I RF	N		75. 00
76.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching progra recent cost reporting period ending on or before November 15, 2004? Enter "Y" for no. Column 2: Did this facility train residents in a new teaching program in accor CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 indicate which program year began during this cost reporting period. (see instruct	yes or "N" for dance with 42 is Y,		0	76. 00
That date will on program your began during this cost reporting porrod. (see this truet	1 0113)		1 00	
Long Term Care Hospital PPS			1. 00	
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 81.00 Is this a LTCH co-located within another hospital for part or all of the cost repo "Y" for yes and "N" for no. TEFRA Providers	Enter	N N	80. 00 81. 00	
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR S §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	no.	N	85. 00 86. 00	
87.00 Is this hospital an extended neoplastic disease care hospital classified under sec 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	ti on		N	87. 00
	Approved Permane Adjustm (Y/N) 1.00	ent ent A	Number of Approved Permanent djustments 2.00	
88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and 89. (see instructions)	N			88. 00
Column 2: Enter the number of approved permanent adjustments. Wkst. A	Line Effecti	ve	Approved	
No.	Date	A	Permanent Idjustment Imount Per Discharge	
1.00 89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	0.00		3. 00	89. 00
on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the	0.00		Č	37. 00
TEFRA target amount per discharge.	V		XIX	
	1.00		2. 00	
Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y"	for N		Υ	90.00
yes or "N" for no in the applicable column. 91.00 s this hospital reimbursed for title V and/or XIX through the cost report either			N	91.00
full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (se			N N	91.00
instructions) Enter "Y" for yes or "N" for no in the applicable column. 93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? En			N	93.00
"Y" for yes or "N" for no in the applicable column.				
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.95.00 If line 94 is "Y", enter the reduction percentage in the applicable column.	0. 00		N 0. 00	94.00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N N		N N	96.00
97.00 filine 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0. 00	97. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider 0	CN: 15-0101	Peri od:	u of Form CMS Worksheet S-	
IOST THE THE HOST THE HEALTH GIVE GOIN LEX TREATH TO HIGH BITH	l l ovi dei e		From 01/01/2023 To 12/31/2023	Part I	epared
		l	V	XIX	
			1.00	2.00	
98.00 Does title V or XIX follow Medicare (title XVIII) for the stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX.			N	Y	98.0
Does title V or XIX follow Medicare (title XVIII) for the C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title XIX.				Y	98. 0
Does title V or XIX follow Medicare (title XVIII) for the bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes for title V, and in column 2 for title XIX.			N	Y	98. 0
P8.03 Does title V or XIX follow Medicare (title XVIII) for a cr reimbursed 101% of inpatient services cost? Enter "Y" for for title V, and in column 2 for title XIX.	1	N	98.0		
Does title V or XIX follow Medicare (title XVIII) for a CA outpatient services cost? Enter "Y" for yes or "N" for no in column 2 for title XIX.	N E	N	98.0		
Does title V or XIX follow Medicare (title XVIII) and add Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.		Y	98.0		
P8.06 Does title V or XIX follow Medicare (title XVIII) when cos Pts. I through IV? Enter "Y" for yes or "N" for no in colu- column 2 for title XIX.	N	Y	98.0		
Rural Providers			N		105.0
05.00 Does this hospital qualify as a CAH? 06.00 If this facility qualifies as a CAH, has it elected the al	L-inclusive me	thod of payme			106.0
for outpatient services? (see instructions)		triod or paymor			1.00.0
107.00 Column 1: If line 105 is Y, is this facility eligible for training programs? Enter "Y" for yes or "N" for no in colu Column 2: If column 1 is Y and line 70 or line 75 is Y, dapproved medical education program in the CAH's excluded	mn 1. (see in o you train I& IPF and/or IRF	structions) Rs in an			107. 0
Enter "Y" for yes or "N" for no in column 2. (see instruc 07.01 If this facility is a REH (line 3, column 4, is "12"), is reimbursement for I&R training programs? Enter "Y" for yes	it eligible fo				107. (
instructions) 08.00 s this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					108.0
	Physi cal 1.00	Occupati ona	Speech 3.00	Respiratory	4
09.00 f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		2. 00 N	N N	4. 00 N	109.0
Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W	"Y" for yes o	r "N" for no.	If yes,	1.00 N	110. (
Demonstration) for the current cost reporting period? Enter	"Y" for yes o	r "N" for no.	If yes,		110. (
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wapplicable.	"Y" for yes o orksheet E-2,	r "N" for no. lines 200 thro	If yes, bugh 215, as	N 2. 00	
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wapplicable.	"Y" for yes o brksheet E-2, the Frontier cost reporting column 1 is Y, articipating i	r "N" for no. lines 200 thre Community period? Enter enter the n column 2.	If yes, bugh 215, as	N	
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wapplicable. 11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is penter all that apply: "A" for Ambulance services; "B" for	"Y" for yes o brksheet E-2, the Frontier cost reporting column 1 is Y, articipating i	Community period? Enter enter the n column 2. s; and/or "C"	If yes, ough 215, as	2. 00 N	
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable. 11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is p Enter all that apply: "A" for Ambulance services; "B" for for tele-health services.	"Y" for yes o prksheet E-2, the Frontier cost reporting column 1 is Y, articipating i additional bed	Community period? Enter enter the n column 2. s; and/or "C"	If yes, bugh 215, as	N 2. 00	111.0
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable. 11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is p Enter all that apply: "A" for Ambulance services; "B" for for tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began partic demonstration. In column 3, enter the date the hospital c participation in the demonstration, if applicable.	"Y" for yes o prksheet E-2, the Frontier cost reporting column 1 is Y, articipating i additional bed alth Model reporting column 1 is i pating in the	Community period? Enter enter the n column 2. s; and/or "C"	If yes, ough 215, as	2. 00 N	111. (
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable. 11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is p Enter all that apply: "A" for Ambulance services; "B" for for tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital c participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	"Y" for yes operksheet E-2, the Frontier cost reporting column 1 is Y, articipating i additional bed alth Model reporting column 1 is i pating in the eased	Community period? Enter enter the n column 2. s; and/or "C"	If yes, ough 215, as	2. 00 N	111. 0
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable. 11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is p Enter all that apply: "A" for Ambulance services; "B" for for tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began partic demonstration. In column 3, enter the date the hospital c participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided.	"Y" for yes o orksheet E-2, the Frontier cost reporting column 1 is Y, articipating i additional bed alth Model reporting column 1 is ipating in the eased or "N" for no B, or E only) "93" percent (includes	Community period? Enter enter the n column 2. s; and/or "C"	If yes, ough 215, as	2. 00 N	111. 0
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable. 111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is p. Enter all that apply: "A" for Ambulance services; "B" for for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began partic demonstration. In column 3, enter the date the hospital control participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, §2208. 1. 116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	"Y" for yes of orksheet E-2, the Frontier cost reporting column 1 is Y, articipating in additional bed alth Model reporting column 1 is ipating in the eased or "N" for no B, or E only) "93" percent (includes ers) based on "for yes or	Community period? Enterenter the n column 2. s; and/or "C"	If yes, ough 215, as	2. 00 N	111. C
complete Worksheet E, Part A, lines 200 through 218, and Wapplicable. 111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is p. Enter all that apply: "A" for Ambulance services; "B" for for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began partic demonstration. In column 3, enter the date the hospital coparticipation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provid the definition in CMS Pub.15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y"	"Y" for yes operksheet E-2, the Frontier cost reporting column 1 is Y, articipating i additional bed alth Model reporting column 1 is ipating in the eased or "N" for no B, or E only) "93" percent (includes ers) based on "for yes or urance? Enter	Community period? Enterenter the n column 2. s; and/or "C" N N N	If yes, ough 215, as	2. 00 N	111. 0

Health Financial Systems	WHITLEY MEMOR	RLAL HOSPITAL		In	Lieu of Form CMS	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLI	EX IDENTIFICATION DATA	Provi der CC	CN: 15-0101	Period: From 01/01/2 To 12/31/2		repared:
					1.00	\dashv
147.00 Was there a change in the statist	ical basis? Enter "Y" for	ves or "N" for	no no		1.00 N	147. 00
148.00Was there a change in the order o					N	148. 00
149.00 Was there a change to the simplif				or no.	N	149.00
-	-	Part A	Part B	Title V	Title XIX	
		1. 00	2. 00	3. 00	4. 00	
Does this facility contain a provor charges? Enter "Y" for yes or						
155.00 Hospi tal		N	N	N	N	155. 00
156.00 Subprovi der - IPF		N	N	N	N	156. 00
157. 00 Subprovi der - I RF		N	N	N	N	157. 00
158. 00 SUBPROVI DER 159. 00 SNF		N		N	N.	158.00
160. OO HOME HEALTH AGENCY		N N	N N	N N	N N	159. 00 160. 00
161.00CMHC		IN	N N	N N	N N	161.00
TOT. OO CWITC			IN IN	IV	1.00	101.00
Multicampus					1.00	
165.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has o	one or more camp	ouses in dif	ferent CBSAs?	N	165. 00
	Name	County	State	Zip Code CBS	A FTE/Campus	
	0	1. 00	2.00	3.00 4.0	0 5.00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0. (00 166. 00
					1.00	
Health Information Technology (HI	T) incentive in the Ameri	can Recovery ar	nd Reinvestr	ment Act	1.00	
167.00 Is this provider a meaningful use					Υ	167. 00
168.00 If this provider is a CAH (line 1	05 is "Y") and is a meani	ngful user (lin	ne 167 is "Y	"), enter the		168.00
reasonable cost incurred for the 168.01 If this provider is a CAH and is	not a meaningful user, do	oes this provide	er qualify f	for a hardship		168. 01
exception under §413.70(a)(6)(ii) 169.00 If this provider is a meaningful	user (line 167 is "Y") an				the 9.	99169.00
transition factor. (see instructi	ons)			Begi nni n	g Endi ng	
				1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and ending	date for the r	reporting	1.00	2.00	170.00
period respectivery (mm/ du/ yyyy)				1.00	2.00	
171.00 fline 167 is "Y", does this pro	vider have any days for i	ndi vi dual s enco	lled in	1.00 N	2.00	0171.00
section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (reported on Wkst. S-3, Pt umn 1. If column 1 is yes	. I, line 2, co	ol. 6? Enter	-		5171.00

Health Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0101 Peri od: Worksheet S-2 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/23/2024 12:06 pm Y/N Date 1.00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If N 2 00 yes, enter in column 2 the date of termination and in column $\hat{\textbf{3}},$ "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Α 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from 5.00 Ν those on the filed financial statements? If yes, submit reconciliation Legal Oper. Y/N 1.00 2.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7 00 7 00 N 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 N 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved 11.00 Ν Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions Υ 15.00 Part A Part B Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? N N 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for 05/02/2024 05/02/2024 17.00 Υ 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R 18.00 18.00 Υ Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R 19.00 Ν Ν Report data for corrections of other PS&R Report information? If yes, see instructions.

HUSPLIAL A		AL HOSPITAL	ON 15 0101		u of Form CMS-				
	AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CO	JN: 15-0101	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S- Part II Date/Time Pro 5/23/2024 12	epared:			
		Descri	pti on	Y/N	Y/N	, 00 p			
		C)	1. 00	3. 00				
	line 16 or 17 is yes, were adjustments made to PS&R port data for Other? Describe the other adjustments:			N	N	20.00			
		Y/N	Date	Y/N	Date				
04 00 111		1.00	2. 00	3.00	4. 00	04.00			
	s the cost report prepared only using the provider's cords? If yes, see instructions.	N		N		21.00			
					1. 00				
COM	MPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	HOSPI TALS)						
	pital Related Cost								
	ve assets been relifed for Medicare purposes? If yes, see					22.00			
	ve changes occurred in the Medicare depreciation expense porting period? If yes, see instructions.	due to apprais	sars made dur	ing the cost		23.00			
24.00 Wer	re new leases and/or amendments to existing leases entere yes, see instructions	ed into during	this cost re	eporting period?		24.00			
25. 00 Hav	ve there been new capitalized leases entered into during	the cost repor	ting period?	Plf yes, see		25. 00			
	instructions. No Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see								
	structions.	ie cost reporti	ng perrou? i	i yes, see		26.00			
	s the provider's capitalization policy changed during the	e cost reportir	ng period? If	ges, submit		27.00			
Int	terest Expense					28. 00			
	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.								
	d the provider have a funded depreciation account and/or	bond funds (De	ebt Service F	Reserve Fund)		29. 0			
tre	eated as a funded depreciation account? If yes, see instr	ructions		,					
	s existing debt been replaced prior to its scheduled matu structions.	urity with new	debt? If yes	s, see		30.00			
31. 00 Has	s debt been recalled before scheduled maturity without is structions.	ssuance of new	debt? If yes	s, see		31.00			
	chased Services ve changes or new agreements occurred in patient care ser	rvices furnishe	ed through co	ontractual		32.00			
	rangements with suppliers of services? If yes, see instru								
	line 32 is yes, were the requirements of Sec. 2135.2 app	olied pertainir	ng to competi	tive bidding? If	•	33.0			
	, see instructions. ovider-Based Physicians								
	re services furnished at the provider facility under an a	arrangement wil	th provider-b	pased physicians?	Y	34.0			
lf	yes, see instructions.	Ü	·	. ,	·				
35.00 If	Iine 34 is yes, were there new agreements or amended exi ysicians during the cost reporting period? If yes, see in	sting agreemer nstructions.	nts with the	provi der-based		35.00			
,, ,				Y/N	Date				
	000			1. 00	2. 00				
	ne Office Costs re home office costs claimed on the cost report?			Υ		36.00			
		repared by the	home office?			37.00			
57. UU H.T.	yes, see instructions.								
lf	O If I ine 36 is yes , was the fiscal year end of the home office different from that of N								
38.00 If				= N		38.00			
38.00 If the 39.00 If	e provider? If yes, enter in column 2 the fiscal year end line 36 is yes, did the provider render services to othe	d of the home o	offi ce.						
38.00 If the 39.00 If see 40.00 If	e provider? If yes, enter in column 2 the fiscal year end line 36 is yes, did the provider render services to othe e instructions. line 36 is yes, did the provider render services to the	d of the home o er chain compor	office. nents? If yes			39.00			
38.00 If the 39.00 If see 40.00 If	e provider? If yes, enter in column 2 the fiscal year end line 36 is yes, did the provider render services to othe e instructions.	d of the home o er chain compor	office. nents? If yes	s, N		39.00			
38.00 If the 39.00 If see 40.00 If	e provider? If yes, enter in column 2 the fiscal year end line 36 is yes, did the provider render services to othe e instructions. line 36 is yes, did the provider render services to the	d of the home o er chain compor	office. nents? If yes If yes, see	s, N	00	39.00			
38.00 If the 39.00 If see 40.00 If ins	e provider? If yes, enter in column 2 the fiscal year end line 36 is yes, did the provider render services to other instructions. Iine 36 is yes, did the provider render services to the structions. St Report Preparer Contact Information	d of the home of chain compored home office?	office. nents? If yes If yes, see	S, N N	00	39.00			
38.00 If the 39.00 If see 40.00 If ins	e provider? If yes, enter in column 2 the fiscal year end line 36 is yes, did the provider render services to other instructions. Iine 36 is yes, did the provider render services to the structions. St Report Preparer Contact Information ter the first name, last name and the title/position ld by the cost report preparer in columns 1, 2, and 3,	d of the home of chain compor	office. nents? If yes If yes, see	S, N N	00	38. 00 39. 00 40. 00			
38.00 If the 39.00 If see 40.00 If ins 41.00 Ent hel res	e provider? If yes, enter in column 2 the fiscal year end line 36 is yes, did the provider render services to other instructions. Iine 36 is yes, did the provider render services to the structions. St Report Preparer Contact Information ter the first name, last name and the title/position ld by the cost report preparer in columns 1, 2, and 3, spectively.	d of the home of chain compored home office?	office. nents? If yes If yes, see	S, N N N 2.	00	39.00			
39.00 If the 39.00 If see 40.00 If ins 40.00 Ent hel res 42.00 Ent pre	e provider? If yes, enter in column 2 the fiscal year end line 36 is yes, did the provider render services to other e instructions. Iine 36 is yes, did the provider render services to the structions. St Report Preparer Contact Information ter the first name, last name and the title/position lid by the cost report preparer in columns 1, 2, and 3, spectively. The terms of the cost report eparer.	d of the home cer chain compore home office?	office. nents? If yes If yes, see	S, N N N 2.		39. 00 40. 00 41. 00			

Health Financial Systems WHITLEY MEMO	ORIAL HOSPITAL	In Lieu of Fo	rm CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0101		eet S-2
		From 01/01/2023 Part I To 12/31/2023 Date/T	
			024 12:06 pm
	3. 00		
Cost Report Preparer Contact Information			
41.00 Enter the first name, last name and the title/position	DIRECTOR, REIMBURSEMENT		41.00
held by the cost report preparer in columns 1, 2, and 3,			
respecti vel y.			
42.00 Enter the employer/company name of the cost report			42.00
preparer.			
43.00 Enter the telephone number and email address of the cost			43.00
report preparer in columns 1 and 2, respectively.			

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

					To 12/31/2023		pared:
						1/P Days /	oo piii
						0/P Visits /	
						Trips	
	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	Title V	
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	3	0 10, 950	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovi der						3. 00 4. 00
4. 00 5. 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF					o	5. 00
6. 00	Hospital Adults & Peds. Swing Bed SNF					0	6. 00
7. 00	Total Adults and Peds. (exclude observation		2	0 10, 950	0.00		7. 00
7.00	beds) (see instructions)		3	10, 73	0.00	0	7.00
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		3	0 10, 950	0.00	0	14.00
15.00	CAH visits					0	15.00
15. 10	REH hours and visits				0. 00	0	15. 10
16. 00	SUBPROVIDER - IPF						16.00
17. 00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY	44. 00		0	ס	0	19.00
20. 00 21. 00	NURSING FACILITY						20. 00 21. 00
	OTHER LONG TERM CARE						21.00
22. 00 23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPICE						24.00
24. 10	HOSPICE (non-distinct part)	30.00					24. 10
25. 00	CMHC - CMHC	00.00					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)		3	o			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	O		32.00
32. 01	Total ancillary labor & delivery room						32. 01
00.00	outpatient days (see instructions)						00.00
33.00							33.00
33. 01	LTCH site neutral days and discharges	30. 00				_ ا	33. 01 34. 00
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00		0	0	ا	34.00

Provi der CCN: 15-0101

Peri od: Worksheet S-3
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/23/2024 12:06 pm

		_				5/23/2024 12:	06 pm
		I/P Days	/ O/P Visits	/ Tri ps	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Patients	& Residents	Payrol I	
	DART I OTATIOTICAL DATA	6. 00	7. 00	8. 00	9. 00	10. 00	
	PART I - STATISTICAL DATA	4 000	,=				
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 093	67	5, 033			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
0.00	for the portion of LDP room available beds)	0.000	005				0.00
2.00	HMO and other (see instructions)	2, 330	935				2.00
3.00	HMO IPF Subprovi der	0	0				3.00
4.00	HMO IRF Subprovi der	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	1			5.00
6.00	Hospital Adults & Peds. Swing Bed NF	4 000	0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	1, 093	67	5, 033			7. 00
0.00	beds) (see instructions)						0.00
8. 00	I NTENSI VE CARE UNI T						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)		2.4	F24			12.00
13.00	NURSERY	1 000	24			200 22	13.00
14.00	Total (see instructions)	1, 093 0	91	5, 557		289. 33	
15.00	CAH visits	0	0				15.00
15. 10 16. 00	REH hours and visits	٩	U	U			15. 10
17. 00	SUBPROVIDER - I PF						16. 00 17. 00
18.00	SUBPROVIDER - IRF						18.00
19. 00	SUBPROVIDER SKILLED NURSING FACILITY	0	0	0	0. 00	0.00	
20.00	NURSING FACILITY	U U	U	·	0.00	0.00	20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00	HOSPICE						24.00
24. 00	HOSPICE (non-distinct part)			90			24. 00
25. 00	CMHC - CMHC			70			25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	
27. 00	Total (sum of lines 14-26)	U	U		0.00	289. 33	
28. 00	Observation Bed Days		13	163		207. 33	28.00
29. 00	Ambulance Trips	0	13	103			29.00
30.00	Employee discount days (see instruction)	U		o c			30.00
31. 00	Employee discount days (see Fristruction)						31.00
32. 00	Labor & delivery days (see instructions)	0	34	74			32.00
32. 00	Total ancillary labor & delivery room	١	34	1 74			32.00
32.01	outpatient days (see instructions)			١			32.01
33. 00	LTCH non-covered days	0					33.00
33. 01	LTCH site neutral days and discharges	0					33. 01
	Temporary Expansi on COVID-19 PHE Acute Care	0	0	O			34.00
54.00	Tramporary Expansion Govern-19 the Acute Care	ı 9	U	1	n - I	l	1 37.00

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part I | | To | 12/31/2023 | Date/Time Prepared: | From 01/2024 | Part | P Provi der CCN: 15-0101

				10) 12/31/2023	5/23/2024 12:	
		Full Time		Di sch	arges	0, 20, 2021 121	ос р
		Equi val ents			3		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	·	Workers				Pati ents	
		11. 00	12. 00	13.00	14. 00	15. 00	
	PART I - STATISTICAL DATA			·			
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		C	338	44	1, 996	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	463		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	SURGI CAL INTENSI VE CARE UNI T						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		_				13.00
14.00	Total (see instructions)	0. 00	C	338	44	1, 996	14.00
15.00	CAH visits						15.00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVIDER - I PF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER	0.00					18. 00 19. 00
19.00	SKILLED NURSING FACILITY	0.00					20.00
20. 00 21. 00	NURSING FACILITY OTHER LONG TERM CARE						20.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00	HOSPICE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days	0.00					28. 00
29. 00	Ambulance Trips						29. 00
30.00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days (see Fristi detreit)						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0101

					Т	o 12/31/2023	Date/Time Pre 5/23/2024 12:	
		Wkst. A Line	Amount	Reclassi fi cat	Adj usted	Paid Hours	Average	July 200
		Number	Reported	i on of Sal ari es	Sal ari es (col. 2 ± col.	Related to Salaries in	Hourly Wage (col. 4 ÷	
				(from Wkst.	3)	col. 4	col . 5)	
		1. 00	2. 00	A-6) 3.00	4.00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1.00	Total salaries (see	200.00	24, 492, 837	6, 905, 538	31, 398, 375	601, 810. 19	52. 17	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0.00	0. 00	2. 00
	A		_	_	_			
3. 00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3.00
4. 00	Physician-Part A - Administrative		86, 167	0	86, 167	508. 76	169. 37	4.00
4. 01	Physicians - Part A - Teaching		0	0			0.00	
5. 00	Physician and Non Physician-Part B		U	0	0	0. 00	0. 00	5.00
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0. 00	0. 00	6. 00
7. 00	Interns & residents (in an	21. 00	0	О	0	0. 00	0. 00	7. 00
7. 01	approved program) Contracted interns and		0	0	0	0. 00	0. 00	7. 01
7.01	residents (in an approved programs)		O			0.00	0.00	7.01
8. 00	Home office and/or related organization personnel		6, 905, 538	0	6, 905, 538	177, 214. 71	38. 97	8.00
9. 00	SNF	44. 00	0	О	О		0. 00	
10. 00	Excluded area salaries (see instructions)		2, 214, 001	20, 371	2, 234, 372	77, 408. 32	28. 86	10.00
	OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient Care		0	0	0	0. 00	0.00	11.00
12. 00	Contract Labor: Top Level		0	0	0	0. 00	0. 00	12.00
	management and other management and administrative							
13. 00	services Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0. 00	13. 00
14. 00	Home office and/or related organization salaries and		0	0	0	0. 00	0. 00	14.00
	wage-related costs							
	Home office salaries Related organization salaries		6, 905, 538 0	0	6, 905, 538	177, 214. 71 0. 00		14. 01 14. 02
	Home office: Physician Part A		0	ő	ő			15. 00
16. 00	- Administrative Home office and Contract		0	0	0	0. 00	0.00	16. 00
	Physicians Part A - Teaching		_	_	_			
16. 01	Home office Physicians Part A - Teaching		0	0	0	0. 00	0.00	16. 01
16. 02	Home office contract		0	0	0	0. 00	0. 00	16. 02
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see instructions)		9, 346, 841	0	9, 346, 841			17. 00
18. 00	Wage-related costs (other)				1			18. 00
19. 00	(see instructions) Excluded areas		938, 176	0	938, 176			19. 00
	Non-physician anesthetist Part		0	Ö	0			20.00
21. 00	Non-physician anesthetist Part		0	0	0			21.00
22. 00	Physician Part A - Administrative		0	0	0			22. 00
22. 01	Physician Part A - Teaching		0	О	0			22. 01
	Physician Part B		0	0	0			23.00
	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	1	1			24. 00 25. 00
25. 50	approved program) Home office wage-related		3, 488, 239	0	3, 488, 239			25. 50
	(core)							
25. 51	Related organization wage-related (core)		0	0	0			25. 51
25. 52	Home office: Physician Part A - Administrative -		0	0	0			25. 52
	wage-related (core)			I	I			I

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0101 Peri od: Worksheet S-3 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/23/2024 12:06 pm Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Sal ari es Related to Reported ion of (col. 2 ± col. Sal ari es Salaries in (from Wkst. 3) col. 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 25.53 Home office: Physicians Part A 0 25. 53 - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 2, 498, 783 -2, 498, 783 0.00 0. 00 26.00 192, 124. 11 27.00 Administrative & General 5.00 1, 454, 976 7, 089, 014 8, 543, 990 44. 47 27.00 28.00 0.00 0.00 28.00 Administrative & General under contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 30.00 Operation of Plant 7.00 621, 276 78, 345 699, 621 20, 200. 04 34. 63 30.00 . Laundry & Linen Service 8.00 0.00 31.00 31.00 0.00 25. 15 32.00 Housekeepi ng 842, 740 37, 727. 51 9.00 106, 272 949, 012 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 34.00 Dietary 10.00 532, 838 -384, 250 148, 588 3, 540. 00 41.97 34.00 Dietary under contract (see 35.00 0.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 0 435, 536 435, 536 18, 940. 23 23.00 36.00 0.00 37.00 Maintenance of Personnel 12.00 0.00 37.00 0 Nursing Administration 13.00 76, 016 60.96 38.00 38.00 602, 808 678, 824 11, 135. 50 39.00 Central Services and Supply 14.00 0.00 0.00 39.00 898, 852 16, 010. 79 40.00 Pharmacy 15.00 113, 348 1, 012, 200 63. 22 40.00 Medical Records & Medical Records Library 41.00 16.00 0 0.00 0.00 41.00

0

0

0

0

0

0

0.00

0.00

0.00 42.00

0.00 43.00

17.00

18.00

42.00

Social Service

43.00 Other General Service

near th	Titianciai systems	WIII TEET WEWORTAL HOSFI TAL			TH LIEU OF FORM CW3-2332-10			
HOSPITAL WAGE INDEX INFORMATION				Provi der C		Period: From 01/01/2023 To 12/31/2023		pared:
		Worksheet A	Amount	Recl assi fi cat	Adjusted	Pai d Hours	•	OO piii
					.,		Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.		(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4.00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		17, 587, 299	6, 905, 538	24, 492, 83	7 424, 595. 48	57. 69	1.00
	instructions)							
2.00	Excluded area salaries (see		2, 214, 001	20, 371	2, 234, 37	2 77, 408. 32	28. 86	2.00
	instructions)							
3.00	Subtotal salaries (line 1		15, 373, 298	6, 885, 167	22, 258, 46	5 347, 187. 16	64. 11	3.00
	minus line 2)							
4.00	Subtotal other wages & related		6, 905, 538	0	6, 905, 53	8 177, 214. 71	38. 97	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		12, 835, 080	l o	12, 835, 08	0.00	57. 66	5.00
	(coo i not)		, , , , , , , , , , , , , , , , , , , ,	_	, , , , , , , ,			

41, 999, 083

12, 467, 771

6, 885, 167

5, 015, 498

524, 401. 87

299, 678. 18

80. 09

41.60

6.00

7.00

35, 113, 916 7, 452, 273

6. 00

7.00

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

instructions)

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0101	From 01/01/2023	
		To 12/31/2023	Date/Time Prepared

	To 12/31/2023	3 Date/Time Pre 5/23/2024 12:	
		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	572, 964	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	1, 777, 063	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	5, 116	6.00
7.00	Employee Managed Care Program Administration Fees	94, 940	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	4, 149, 175	
8. 03	Health Insurance (Purchased)	0	
9.00	Prescription Drug Plan	1, 163, 550	
10.00	Dental, Hearing and Vision Plan	143, 002	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	27, 245	
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	100, 067	
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	
15.00		15, 689	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumul ative portion)		
	TAXES		
		2, 154, 500	
18. 00	Medicare Taxes - Employers Portion Only	0	
19. 00	Unempl oyment Insurance	0	
20. 00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (se	ee 16, 829	21.00
	instructions))		
22. 00	Day Care Cost and Allowances	0	22. 00
23. 00	Tuition Reimbursement	64, 878	
24. 00		10, 285, 018	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	1	25. 00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-01	From 01/01/2023	Worksheet S-3 Part V Date/Time Prepared: 5/23/2024 12:06 pm

		10	0 12/31/2023	5/23/2024 12:	
	Cost Center Description		Contract	Benefit Cost	
	·		Labor		
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		0	10, 285, 018	1.00
2.00	Hospi tal		0	10, 285, 018	2.00
3.00	SUBPROVI DER - I PF				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	SKILLED NURSING FACILITY		0	0	8.00
9.00	NURSING FACILITY				9.00
10.00	OTHER LONG TERM CARE I				10.00
11. 00	Hospi tal -Based HHA				11.00
12. 00	AMBULATORY SURGICAL CENTER (D. P.) I				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 I				17.00
18. 00	Other		0	0	18.00

Heal th	n Financial Systems WHITLEY MEMORIAL H	HOSPI TAL		In Lie	u of Form CMS-2	2552-10	
HOSPI T	HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA Provider CCN: 15-0101 Period: From 01/01/2023 To 12/31/2023 From 01/01/2023 From 01						
					1 00		
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				1. 00		
	Uncompensated and Indigent Care Cost-to-Charge Ratio						
1.00	Cost to charge ratio (see instructions)				0. 204095	1.00	
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid				2, 621, 118	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?				Υ	3.00	
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplemen	tal pavment	s from Medic	ai d?	Υ	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments fi	rom Medicai	d		0	5.00	
6.00	Medi cai d charges				26, 808, 287	6.00	
7.00	Medicaid cost (line 1 times line 6)				5, 471, 437	7. 00	
8.00	Difference between net revenue and costs for Medicaid program	(see instru	ıctions)		2, 850, 319	8.00	
	Children's Health Insurance Program (CHIP) (see instructions for	or each lir	ne)				
9.00	Net revenue from stand-alone CHIP				15, 324	9.00	
10.00	Stand-alone CHIP charges				14, 787	10.00	
11.00					3, 018	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP	(see instru	ıctions)		0	12.00	
	Other state or local government indigent care program (see inst	tructions f	or each line	·)		1	
13.00	Net revenue from state or local indigent care program (Not incl				6, 361, 287	13.00	
14.00	Charges for patients covered under state or local indigent care	e program (Not included	lin lines 6 or	48, 256, 653	14.00	
	10)						
15.00	State or local indigent care program cost (line 1 times line 14	4)			9, 848, 942	15. 00	
16.00	Difference between net revenue and costs for state or local inc	digent care	e program (se	e instructions)	3, 487, 655	16. 00	
	Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line)			gent care progra	ıms (see		
17.00					0		
18.00	Government grants, appropriations or transfers for support of I				0	18. 00	
19. 00		l indigent	care program	s (sum of lines	6, 337, 974	19. 00	
	8, 12 and 16)				T		
			Uni nsured	Insured	Total (col. 1		
			patients 1.00	patients 2.00	+ col . 2) 3.00		
	Uncompensated care cost (see instructions for each line)		1.00	2.00	3.00		
20.00)	5, 452, 0	73 2, 149, 224	7, 601, 297	20.00	
21. 00	Cost of patients approved for charity care and uninsured discounts		1, 112, 7		3, 091, 291		
21.00	instructions)	uiits (see	1, 112, 7	1, 770, 330	3,071,271	21.00	
22. 00	Payments received from patients for amounts previously written	off as		0 0	0	22. 00	
22.00	charity care	011 43			O	22.00	
23. 00			1, 112, 7	1, 978, 550	3, 091, 291	23.00	
					1. 00		
24. 00			nd a Length c	of stay limit	N	24. 00	
	imposed on patients covered by Medicaid or other indigent care						
25. 00		he indigent	care progra	m's length of	0	25. 00	
	stay limit						
25. 01	Charges for insured patients' liability (see instructions)				214, 440		
26. 00					5, 640, 332		
27. 00	` '				89, 580		
27 01	Medicare allowable bad debts (see instructions)				137. 816	i 27.01	

137, 816 27. 01

5, 502, 516 28. 00 1, 171, 272 29. 00 4, 262, 563 30. 00 10, 600, 537 31. 00

27.00 Medicare reimbursable bad debts (see instructions) 27.01 Medicare allowable bad debts (see instructions)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

28.00 Non-Medicare bad debt amount (see instructions)
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

llool +b	Financial Cystems	HOCDI TAI		la li o	u of Form CMC 1	DEED 10	
	Financial Systems WHITLEY MEMORIAL AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider C	CN: 15-0101	Peri od: From 01/01/2023 To 12/31/2023		0 pared:	
					1. 00		
	PART II - HOSPITAL DATA				11.00		
	Uncompensated and Indigent Care Cost-to-Charge Ratio						
1.00	Cost to charge ratio (see instructions)				0. 204095	1.00	
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid					2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?					3.00	
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplemen			ai d?		4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments f	rom Medica	i d			5.00	
6. 00	Medi cai d charges					6. 00	
7. 00	Medicaid cost (line 1 times line 6)					7.00	
8. 00	Difference between net revenue and costs for Medicaid program					8.00	
0.00	Children's Health Insurance Program (CHIP) (see instructions for	or each li	ne)				
9.00	Net revenue from stand-alone CHIP					9.00	
10.00	Stand-alone CHIP charges					10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)	(acc inctri	unti ana)			11.00	
12. 00	Difference between net revenue and costs for stand-alone CHIP			\		12.00	
13. 00	Other state or local government indigent care program (see ins					13.00	
14. 00							
14.00	10)	e program	(NOT THE dued	TH THIES 0 01		14.00	
15. 00	State or local indigent care program cost (line 1 times line 1	4)				15.00	
	Difference between net revenue and costs for state or local in		e program (se	e instructions)		16.00	
	Grants, donations and total unreimbursed cost for Medicaid, CH instructions for each line)				ıms (see		
17.00	Private grants, donations, or endowment income restricted to f	undi ng cha	rity care			17. 00	
18.00	Government grants, appropriations or transfers for support of	hospital o	perati ons			18.00	
19.00	Total unreimbursed cost for Medicaid , CHIP and state and loca	I indigent	care program	s (sum of lines		19.00	
	8, 12 and 16)						
			Uni nsured	Insured	Total (col. 1		
			patients	patients	+ col . 2)		
	Uncompensated care cost (see instructions for each line)		1. 00	2. 00	3. 00		
20. 00	Charity care charges and uninsured discounts (see instructions)	5, 452, 07	3 2, 149, 224	7, 601, 297	20.00	
21. 00	Cost of patients approved for charity care and uninsured disco	•	1, 112, 74		3, 091, 291		
21.00	instructions)	uiits (see	1, 112, 79	1, 770, 330	3, 071, 271	21.00	
22. 00	Payments received from patients for amounts previously written	off as		0	0	22. 00	
22.00	charity care	0 40			· ·	22.00	
23. 00	Cost of charity care (see instructions)		1, 112, 74	1, 978, 550	3, 091, 291	23.00	
					1. 00		
24.00	Does the amount on line 20 col. 2, include charges for patient		nd a Length o	f stay limit	N	24.00	
	imposed on patients covered by Medicaid or other indigent care						
25.00	If line 24 is yes, enter the charges for patient days beyond t	he indigen	t care progra	m's length of	0	25.00	
	stay limit						
25. 01	Charges for insured patients' liability (see instructions)				214, 440		
26.00	Bad debt amount (see instructions)				5, 640, 332		
27. 00	Medicare reimbursable bad debts (see instructions)				89, 580		
11 (11	Madicare allowable had debte (see instructions)				127 916	1 27 (11	

137, 816 27. 01

5, 502, 516 28. 00 1, 171, 272 29. 00 4, 262, 563 30. 00 4, 262, 563 31. 00

27.01 Medicare allowable bad debts (see instructions)

28.00 Non-Medicare bad debt amount (see instructions)
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)
30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

Heal th	Finar	ncial Systems	WHITLEY MEMORIAL			In Lie	u of Form CMS-:	2552-10
RECLAS	SSI FI C	ATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der C		Period: From 01/01/2023 To 12/31/2023	Worksheet A Date/Time Pre 5/23/2024 12:	pared:
		Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	, p
			1. 00	2. 00	3.00	4. 00	5. 00	
		AL SERVICE COST CENTERS						
1.00		CAP REL COSTS-BLDG & FIXT		4, 344, 724	4, 344, 72		3, 814, 275	1.00
2.00		CAP REL COSTS-MVBLE EQUIP		0		0 1, 484, 997	1, 484, 997	2.00
3.00		OTHER CAP REL COSTS EMPLOYEE BENEFITS DEPARTMENT	2, 498, 783	0 170 444	10 477 44	0 0	0 170 774	3. 00 4. 00
4. 00 5. 00		ADMINISTRATIVE & GENERAL	2, 496, 763 1, 454, 976	8, 178, 664 32, 602, 102	1		8, 178, 664 33, 692, 912	5.00
6. 00		MAINTENANCE & REPAIRS	0	02,002,102) 34,037,07	0 304, 100	03,072,712	6.00
7. 00		OPERATION OF PLANT	621, 276	1, 542, 896	2, 164, 17	2 77, 690	2, 241, 862	
8.00		LAUNDRY & LINEN SERVICE	0	326, 284			326, 284	
9. 00		HOUSEKEEPI NG	842, 740	234, 925	1		1, 183, 937	
10. 00 11. 00	1	DI ETARY	532, 838	436, 278	969, 11		217, 151	
12.00	1	CAFETERIA MAINTENANCE OF PERSONNEL	O O	0		0 803, 118	803, 118 0	
13. 00		NURSI NG ADMI NI STRATI ON	602, 808	10, 140	612, 94	8 76, 016	688, 964	
14.00		CENTRAL SERVICES & SUPPLY	0	0		0	0	
15.00	1	PHARMACY	898, 852	111, 678	1, 010, 53	0 113, 348	1, 123, 878	15. 00
16. 00		MEDICAL RECORDS & LIBRARY	0	0		0	0	
17. 00 19. 00		SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS	0	0		0	0	17. 00 19. 00
20.00		NURSING PROGRAM	0	0			0	20.00
21. 00		I &R SERVICES-SALARY & FRINGES APPRV	o	0		o o	0	21.00
22.00		I&R SERVICES-OTHER PRGM COSTS APPRV	О	0		0 0	0	22. 00
23.00		PARAMED ED PRGM-(SPECIFY)	0	0		0 0	0	23. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	4, 469, 262	1, 045, 098	5, 514, 36	0 -171, 567	5, 342, 793	30.00
43. 00		NURSERY	4, 407, 202	1, 043, 070	1	0 391, 431	391, 431	1
44.00		SKILLED NURSING FACILITY	O	0	1	0 0	0	
		LARY SERVICE COST CENTERS						
50.00	1	OPERATING ROOM	1, 563, 013	3, 263, 926	1	·	4, 494, 714	
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	58, 320 0	-2, 477 0	55, 84	3 755, 076 0 0	810, 919 0	1
54. 00		RADI OLOGY-DI AGNOSTI C	2, 360, 416	1, 402, 585	3, 763, 00	1 297, 655	4, 060, 656	1
60.00	06000	LABORATORY	0	4, 342, 154	4, 342, 15	4 0	4, 342, 154	60.00
62. 30		BLOOD CLOTTING FOR HEMOPHILIACS	0	0	1	0 0	0	
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	1, 093, 367 1, 615, 272	258, 511 37, 153	1		1, 209, 888 833, 983	
67.00		OCCUPATIONAL THERAPY	1, 013, 272	37, 133	1, 052, 42	923, 886	923, 886	
68.00	1	SPEECH PATHOLOGY	O	0		0 98, 246	98, 246	
69. 00		ELECTROCARDI OLOGY	0	0		0	0	
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 207, 582	1, 207, 58		625, 762	
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	6, 323, 823	6, 323, 82	0 581, 820 3 0	581, 820 6, 323, 823	
		CARDI AC REHABI LI TATI ON	0	0, 323, 023	0, 323, 02	0 0		76. 97
76. 98	07698	HYPERBARI C OXYGEN THERAPY	О	126	12	6 3, 874	4, 000	76. 98
76. 99		LI THOTRI PSY	0	0		0	0	
		ALLOGENEIC HSCT ACQUISITION CAR T-CELL IMMUNOTHERAPY	0	0	1	0 0 0	0	
70.00		TIENT SERVICE COST CENTERS	<u> </u>		'I	0 0	0	70.00
		CLINIC	0	0		0 0	0	
90. 01		INTENSIVE OUT PATIENT PROGRAM	0	0		0 0	0	
		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	3, 666, 913	1, 181, 406	4, 848, 31	9 459, 257	5, 307, 576	91. 00 92. 00
7 2.00		REIMBURSABLE COST CENTERS						72.00
	09500	AMBULANCE SERVICES	2, 178, 597	406, 261	2, 584, 85	8 -1, 650	2, 583, 208	95.00
102.00		OPIOID TREATMENT PROGRAM	0	0		0 0	0	102.00
113 00		AL PURPOSE COST CENTERS INTEREST EXPENSE		0		0 0	0	113. 00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)	24, 457, 433	67, 253, 839			91, 690, 901	
		IMBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6, 085				190.00
		PHYSI CI ANS' PRI VATE OFFI CES OCCUPATI ONAL HEALTH	35, 404	515, 765	551, 16	9 20, 371	571, 540	192.00
		PAIN CLINIC	ol O	0	6	0 0		194.00
		OAK POINTE	ő	Ö		o o		194. 02
		FOUNDATI ON	O	0		0		194. 03
		COMMUNITY & VOLUNTEER SERVICES	0	61, 273				194.04
		VACANT SPACE TELEHEALTH MEDICINE	O O	0	S)	0 0	0	194. 05 194. 06
200.00		TOTAL (SUM OF LINES 118 through 199)	24, 492, 837	67, 836, 962	92, 329, 79			
		- , ,						

Provi der CCN: 15-0101

| Period: | Worksheet A | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/23/2024 12:06 pm

			5/23/2024 12:	:06 pm
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For		
		Allocation		
CENEDAL CEDALCE COCT CENTEDO	6. 00	7. 00		
GENERAL SERVICE COST CENTERS 1. 00 O0100 CAP REL COSTS-BLDG & FLXT	-2, 695, 334	1, 118, 941		1.00
2.00 OO200 CAP REL COSTS-BLDG & FIXT	-2, 695, 334 -100	1, 116, 941		2.00
3. 00 00300 OTHER CAP REL COSTS	- 100	1, 464, 697		3.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	8, 178, 664		4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	-9, 139, 804	24, 553, 108		5.00
6. 00 00600 MAINTENANCE & REPAIRS	0	0		6.00
7.00 00700 OPERATION OF PLANT	-1, 913	2, 239, 949		7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	326, 284		8. 00
9. 00 00900 HOUSEKEEPI NG	0	1, 183, 937		9. 00
10. 00 01000 DI ETARY	0	217, 151		10.00
11. 00 01100 CAFETERI A	-310, 765	492, 353		11.00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0		12.00
13.00 01300 NURSING ADMINISTRATION	0	688, 964		13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0		14.00
15. 00 01500 PHARMACY	-105, 128	1, 018, 750		15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0		16.00
17. 00 01700 SOCIAL SERVICE	0	0		17.00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS 20. 00 02000 NURSI NG PROGRAM	0	0		19.00
20.00 O2000 NURSI NG PROGRAM 21.00 O2100 L&R SERVI CES-SALARY & FRI NGES APPRV	0	0		20.00
22. 00 02200 &R SERVICES-OTHER PRGM COSTS APPRV	0	0		22.00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	o	0		23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	٥		20.00
30. 00 03000 ADULTS & PEDIATRICS	-404, 540	4, 938, 253		30.00
43. 00 04300 NURSERY	0	391, 431		43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		44.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	-1, 308, 032	3, 186, 682		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	810, 919		52.00
53. 00 05300 ANESTHESI OLOGY	0	0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-24	4, 060, 632		54.00
60. 00 06000 LABORATORY	0	4, 342, 154		60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	1 200 01/		62. 30
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	-72 -45, 048	1, 209, 816 788, 935		65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	-43, 048	923, 886		67.00
68. 00 06800 SPEECH PATHOLOGY	0	98, 246		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	625, 762		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	581, 820		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	6, 323, 823		73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		76. 97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	4, 000		76. 98
76. 99 07699 LI THOTRI PSY	0	0		76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		77. 00
78.00 O7800 CAR T-CELL IMMUNOTHERAPY	0	0		78. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0	0		90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	F72 002	4 722 502		90. 01
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	-573, 983	4, 733, 593		91.00
OTHER REIMBURSABLE COST CENTERS				92.00
95. 00 09500 AMBULANCE SERVI CES	-3, 032	2, 580, 176		95. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0,032	2, 300, 170		102.00
SPECIAL PURPOSE COST CENTERS	<u> </u>	o _l		102.00
113. 00 11300 I NTEREST EXPENSE	0	0		113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-14, 587, 775	77, 103, 126		118.00
NONREI MBURSABLE COST CENTERS	,			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6, 085		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	571, 540		192.00
194. 00 07950 OCCUPATI ONAL HEALTH	0	0		194. 00
194. 01 07951 PALN CLINIC	0	0		194. 01
194. 02 07952 OAK POINTE	0	0		194. 02
194. 03 07953 FOUNDATI ON	0	0		194. 03
194. 04 07954 COMMUNITY & VOLUNTEER SERVICES	0	61, 273		194. 04
194. 05 07955 VACANT SPACE	0	0		194. 05
194. 06 07956 TELEHEALTH MEDICINE	0	77 740 004		194.06
200.00 TOTAL (SUM OF LINES 118 through 199)	-14, 587, 775	77, 742, 024		200. 00

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/23/2024 12:06 pm

				5/23/2024 12:06
	Increases			
Cost Center	Li ne #	Sal ary	Other	
2. 00	3. 00	4. 00	5. 00	
A - CAFETERIA RECLASS				
OO CAFETERI A	11. 00	43 <u>5, 5</u> 36	<u>367, 5</u> 82	1
0		435, 536	367, 582	
B - OB RECLASS				
00 NURSERY	43.00	358, 634	32, 797	1
DELIVERY ROOM & LABOR ROOM	52.00	685, 073	62, 649	2
0 — — — — —		1, 043, 707	95, 446	
E - BUILDING AND EQUIP LEAS	SE .	<u> </u>		
OO CAP REL COSTS-BLDG & FLXT	1.00	0	279, 867	1
OO CAP REL COSTS-MVBLE EQUIP	2. 00	o	531, 039	2
OO HYPERBARI C OXYGEN THERAPY	76. 98	0	3, 874	3
00 IIII ERBART O OXTOEN THERATT	0.00	0	0, 0, 1	4
00	0.00	0	Ö	5
00	0.00	0	-	6
		0	0	
0			0	7
0		U	814, 780	
G - INSURANCE RECLASS		.1	3 =1	
OO CAP REL COSTS-BLDG & FLXT	1.00	0	77, 561	1
OO CAP REL COSTS-MVBLE EQUIP			6 <u>6, 0</u> 81	2
0		0	143, 642	
H - DEPRECIATION RECLASS				
OO CAP REL COSTS-MVBLE EQUIP	2.00	0	887, 877	1
0 — — — — —			887, 877	
K - SALARY RECLASS				
OO ADMINISTRATIVE & GENERAL	5. 00	6, 905, 538	0	1
0	 	6, 905, 538	0	
L - REHAB THERAPY DEPT RECL	ASS	0,,00,000		
OCCUPATIONAL THERAPY	67. 00	905, 307	18, 579	1
OO SPEECH PATHOLOGY	68.00	96, 270	1, 976	2
<u> </u>		1, 001, 577	20, 555	2
N - PTO ACCRUAL RECLASS		1,001,377	20, 555	
	5. 00	183, 476	0	
•	7. 00		0	1 2
		78, 345		
O HOUSEKEEPI NG	9.00	106, 272	0	3
O DI ETARY	10.00	67, 192	0	4
O NURSING ADMINISTRATION	13. 00	76, 016	0	5
O PHARMACY	15. 00	113, 348	0	6
O ADULTS & PEDIATRICS	30.00	563, 586	0	7
O OPERATING ROOM	50.00	197, 100	0	8
O DELIVERY ROOM & LABOR ROOM	52.00	7, 354	0	g
OO RADI OLOGY-DI AGNOSTI C	54.00	297, 655	0	10
OO RESPIRATORY THERAPY	65.00	137, 877	0	11
00 PHYSICAL THERAPY	66.00	203, 690	0	12
OO EMERGENCY	91. 00	462, 407	Ö	13
OO PHYSICIANS' PRIVATE OFFICES		4, 465	Ö	14
h		2, 498, 783	— — ö	'
O - CLINIC DIETICIAN RECLAS	2:	2, 470, 700	<u> </u>	
		15, 906	0	
	192.00			1
O LANDI ANTARI E MEDI CAL CUE	DLLEC	15, 906	0	
R - IMPLANTABLE MEDICAL SUF		اء	F04 333	_
O IMPL. DEV. CHARGED TO	72. 00	O	581, 820	1
PATI ENTS	++	+		
0		0	581, 820	
T - RECLASS HOSPITALISTS TO				
O ADULTS & PEDIATRICS	30.00	0	404, 000	1
0	1		404, 000	
0.00 Grand Total: Increases		11, 901, 047	3, 315, 702	500

| Peri od: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

					10	4 12:06 pm
		Decreases		·		
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.	
	6. 00	7. 00	8. 00	9. 00	10. 00	
	A - CAFETERIA RECLASS					
1. 00	DI ETARY	<u>10.</u> 00	43 <u>5, 5</u> 36	36 <u>7, 5</u> 82		1.00
	0		435, 536	367, 582		
	B - OB RECLASS					
1.00	ADULTS & PEDIATRICS	30. 00	1, 043, 707	95, 446		1.00
2. 00		0.00		0		2. 00
	E - BUILDING AND EQUIP LEASE		1, 043, 707	95, 446		
1. 00	ADMINISTRATIVE & GENERAL	5. 00	٥	O	10	1.00
2. 00	RESPIRATORY THERAPY	65. 00	0	279, 867	1	2.00
3. 00	OPERATION OF PLANT	7. 00	0	655	1	3. 00
4. 00	DI ETARY	10. 00	0	133	1	4.00
5. 00	OPERATING ROOM	50. 00	0	529, 325		5. 00
6. 00	EMERGENCY	91. 00	ol	3, 150	1	6.00
7.00	AMBULANCE SERVICES	95. 00	O	1, 650		7. 00
				814, 780		
	G - INSURANCE RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	143, 642		1. 00
2.00		0.00	0	0	12	2. 00
	0		0	143, 642		
	H - DEPRECIATION RECLASS					
1. 00	CAP REL COSTS-BLDG & FIXT		•	88 <u>7, 8</u> 77		1.00
	0		0	887, 877		
	K - SALARY RECLASS	5 00				
1. 00	ADMI NI STRATI VE & GENERAL			6, 905, 538		1.00
	L - REHAB THERAPY DEPT RECLASS		0	6, 905, 538		
1. 00	PHYSICAL THERAPY	66. 00	1, 001, 577	20, 555	0	1.00
2. 00	FITTST CAL THERAFT	0.00	1,001,377	20, 555	o	2.00
2.00			1, 001, 577	20, 555		2.00
	N - PTO ACCRUAL RECLASS		1,001,077	20,000		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	2, 498, 783	C	0	1.00
2.00		0.00	0	O	1	2. 00
3.00		0.00	O	0	0	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	0	0	6. 00
7. 00		0. 00	0	0	0	7. 00
8. 00		0. 00	0	0	0	8. 00
9. 00		0.00	0	0	1	9.00
10.00		0.00	0	0	-	10.00
11.00		0.00	0	0		11.00
12. 00 13. 00		0. 00 0. 00	0	0		12. 00 13. 00
14. 00		0.00	0	0	1	14.00
14.00			2, 498, 783			14.00
	O - CLINIC DIETICIAN RECLASS		2, 470, 703			
1. 00	DI ETARY	10. 00	15, 906	0	0	1.00
1.00	0	 10. 00	15, 906	0	 	1.00
	R - IMPLANTABLE MEDICAL SUPPL	IES	.0, 700			
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	O	581, 820	0	1.00
	PATI ENT		1	,		
	0	= = - +		581, 820		
	T - RECLASS HOSPITALISTS TO A	DULTS & PED				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	404, 000		1.00
	0		0	404, 000		
500.00	Grand Total: Decreases		4, 995, 509	10, 221, 240	1	500.00

				Ť	o 12/31/2023	Date/Time Pre 5/23/2024 12:	pared: 06 pm
			<u> </u>	Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	616, 560	0	_	0	0	1.00
2.00	Land Improvements	2, 512, 929	3, 956, 762	0	3, 956, 762	0	2.00
3.00	Buildings and Fixtures	14, 918, 804	38, 235, 726	0	38, 235, 726	0	3.00
4.00	Building Improvements	48, 824	0	0	0	0	4.00
5.00	Fixed Equipment	6, 515, 388	17, 371, 849	0	17, 371, 849	0	5.00
6.00	Movable Equipment	18, 763, 007	7, 776, 763		7, 776, 763	2, 953, 142	6.00
7.00	HIT designated Assets	3, 173, 747	802, 037	0	802, 037	0	7. 00
8.00	Subtotal (sum of lines 1-7)	46, 549, 259	68, 143, 137	0	68, 143, 137	2, 953, 142	8. 00
9.00	Reconciling Items	3, 173, 747	802, 037	0	802, 037	0	9. 00
10.00	Total (line 8 minus line 9)	43, 375, 512	67, 341, 100	0	67, 341, 100	2, 953, 142	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1. 00	Land	616, 560	0				1.00
2.00	Land Improvements	6, 469, 691	44, 862				2.00
3.00	Buildings and Fixtures	53, 154, 530	1, 036, 190				3.00
4.00	Building Improvements	48, 824	48, 824				4. 00
5.00	Fixed Equipment	23, 887, 237	552, 087				5. 00
6.00	Movable Equipment	23, 586, 628	8, 872, 003				6. 00
7. 00	HIT designated Assets	3, 975, 784	0				7.00
8. 00	Subtotal (sum of lines 1-7)	111, 739, 254	10, 553, 966				8. 00
9.00	Reconciling Items	3, 975, 784	0				9. 00
10. 00	Total (line 8 minus line 9)	107, 763, 470	10, 553, 966				10.00

Heal th	n Financial Systems	WHITLEY MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 15-0101		Period: From 01/01/2023 To 12/31/2023		pared:
			SU	IMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10. 00	11. 00	12. 00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	1, 633, 246	2, 695, 334		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	1, 633, 246	2, 695, 334		0 0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1)				
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				

1.00 1.00 2.00 2.00 3.00 Total (sum of lines 1-2) 16, 144 4, 344, 724 3.00

Heal th	n Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2023 Fo 12/31/2023	Worksheet A-7 Part III Date/Time Prep 5/23/2024 12:0	
		COM	COMPUTATION OF RATIOS ALLOCATION OF OTHER CA				
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 -			
		1.00	0.00	col . 2)	1.00		
	DART III DECONCILIATION OF CARLTAL COSTS O	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C	84, 176, 842	0	84, 176, 842	0. 755464	0	1. 00
2. 00	CAP REL COSTS-BLDG & FIXT	27, 562, 411				0	2.00
3. 00	Total (sum of lines 1-2)	111, 739, 253				0	3. 00
3.00	Total (Sull of Titles 1-2)	ALLOCATION OF OTHER CAPITAL			SUMMARY 0	-	3.00
		ALEGORITOR OF OTHER ONE TIME					
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	·		Capi tal -Rel at	cols. 5	·		
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FIXT	0	1	(., ,		1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	0	1	(887, 777		2. 00
3. 00	Total (sum of lines 1-2)	0	J	(-1, 062, 188	3, 506, 240	3. 00
			SL	JMMARY OF CAPI	IAL		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see	instructions)	Capi tal -Rel at	,	
			instructions)		ed Costs (see	9 through 14)	
		11.00	10.00	10.00	instructions)	15.00	
	DART III DECONCILIATION OF CARLTAL COSTS O	11. 00	12. 00	13.00	14. 00	15. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS C		77 5/1	1 ,	14 144	1 110 041	1. 00
1. 00 2. 00	CAP REL COSTS-BLUG & FIXT	0	77, 561 66, 081			1, 118, 941 1, 484, 897	2.00
3. 00	Total (sum of lines 1-2)	0		•	-		
3.00	Total (Sum Of Titles 1-2)	1	143,042	1	10, 144	2,003,030	3.00

Peri od: From 01/01/2023 Provider CCN: 15-0101

Description					Fr To	rom 01/01/2023 12/31/2023	Date/Time Pre	
Cost Center Description					Expense Classification on	Worksheet A	5/23/2024 12:	06 pm
100 Investment Income - CAP REL 1.00 2.00 3.00 4.00 5.00 0 1.00								
100 Investment Income - CAP REL 1.00 2.00 3.00 4.00 5.00 0 1.00								
100 Investment Income - CAP REL 1.00 2.00 3.00 4.00 5.00 0 1.00								
100 Investment Income - CAP REL 1.00 2.00 3.00 4.00 5.00 0 1.00								
100 Investment Income - CAP REL 1.00 2.00 3.00 4.00 5.00 0 1.00		Cost Contor Description	Pasis/Codo	Amount	Cost Contor	Line #	Wks+ A 7	
Investment income - CAP REL OCAP REL COSTS-BLDG & FIXT 1.00 0 1.00 COSTS-BLDG & FIXT 1.00 COSTS-BLDG & FIX		cost center bescription		Amount	cost center	LITIE #		
COSTS-BLDG & FIXT (Chapter 2) COSTS-MMELE EQUIP COSTS-MMELE	1 00	Investment income - CAP PEL	1. 00					1 00
COSTS-MVBLE EDUIP (chapter 2)		COSTS-BLDG & FLXT (chapter 2)					0	
Investment income - other (Chapter 2) Trade, quantity, and time 0 0.00	2. 00			0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2.00
1.00 1.00	3.00	Investment income - other		0		0. 00	0	3. 00
Section Sect	4. 00			0		0. 00	0	4. 00
expenses (chapter 8)	5 00			0		0.00	0	5 00
Suppliers (chapter 8)	5.00	expenses (chapter 8)		0		0.00	0	3.00
Telephone services (pay stations excluded) (chapter 21)	6. 00			0		0. 00	0	6. 00
21) 8. 00 Television and radio service (chapter 21) 0 0. 00	7. 00	Tel ephone servi ces (pay		0		0. 00	0	7. 00
Parking Television and radio Service Chapter 21) 0 0 0 0 0 0 0 0 0		, , ,						
9.00 Parking I of (chapter 21) 0 0.00 0.00 0.9 0.00	8. 00		А	0	OPERATION OF PLANT	7. 00	0	8. 00
adjustment	9. 00			0		0. 00	0	9. 00
11.00 Sale of scrap, waste, etc. 0 0 0 0 0 11.00	10.00	. 3	A-8-2	-2, 289, 047			0	10.00
12.00 Related organization Chapter 10	11. 00	Sale of scrap, waste, etc.		0		0. 00	0	11.00
transactions (chapter 10)	12. 00		A-8-1	-6, 727, 453			0	12. 00
14. 00 Cafeterial-employees and guests B -250, 318 (AFETERIA 11. 00 0 14. 00 0 15. 00 0 15. 00 0 15. 00 0 15. 00 0 15. 00 0 15. 00 0 15. 00 0 15. 00 0 15. 00 0 16. 00 0 16. 00 0 16. 00 0 0 16. 00 0 16. 00 0 16. 00 0 16. 00 0 0 16. 00 0 0 16. 00 0 16. 00 0 0 16. 00 0 0 0 0 0 0 0 0 0		transactions (chapter 10)	-	2, , , , ,		0.00	0	
and others 16. 00 Sale of medical and surgical supplies to other than patients 17. 00 Sale of fugs to other than patients 18. 00 Sale of medical records and abstracts 19. 00 Nursing and allied health education (tuition, fees, books, etc.) 20. 00 Vending machines 20. 00 Vending machines 21. 00 Interest, finance or penal ty charges (chapter 21) 22. 00 Interest expense on Medicare overpayments and borrowings to repay Medicare o			В	-250, 318	CAFETERI A			
16.00 Sale of medical and surgical supplies to other than patients 17.00 Sale of drugs to other than patients 18.00 Sale of drugs to other than patients 18.00 Sale of medical records and abstracts 0 0.00	15. 00			0		0. 00	0	15. 00
patients Sale of drugs to other than B -4,687 PHARMACY 15.00 0 17.00 20.00	16. 00	Sale of medical and surgical		0		0. 00	0	16. 00
17.00 Sale of drugs to other than patients 18.00 17.00 17.00 21.00 22.00 22.00 22.00 23.00		1						
Sale of medical records and abstracts 0 0.00 0 18.00	17. 00	Sale of drugs to other than	В	-4, 687	PHARMACY	15. 00	0	17. 00
19.00 Nursing and allied health education (tuition, fees, books, etc.) 20.00 Vending machines 0 0 0 0 0 0 20.00	18. 00			0		0.00	0	18. 00
education (tuition, fees, books, etc.)	10 00			0		0.00	0	10 00
20.00 Vending machines 0 10.00	19.00	education (tuition, fees,		O		0.00	0	17.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments A-8-3 ORESPIRATORY THERAPY 65.00 23.00	20.00			0		0.00	0	20 00
charges (chapter 21) 22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP 27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist COSTS-MVBLE EQUIP 29.00 Physicians' assistant ONONPHYSICIAN ANESTHETISTS DEPRISED COSTS-MVBLE EQUIP 20.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see		Income from imposition of		0			-	
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist Depreciation - CAP REL COSTS-MVBLE EQUIP 28.00 Non-physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) A-8-3 ORESPIRATORY THERAPY 65.00 23.00 24.00 24.00 25.00 25.00 26.00 CAP REL COSTS-BLDG & FIXT 0 CAP REL COSTS-BLDG & FIXT 1.00 0 26.00 27.00 28.00 Non-physician Anesthetist 0 NONPHYSICIAN ANESTHETISTS 19.00 0.00 0 29.00 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see								
repay Medicare overpayments Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 23.00	22. 00	Interest expense on Medicare		0		0. 00	0	22. 00
therapy costs in excess of limitation (chapter 14) Adjustment for physical therapy costs in excess of limitation (chapter 14) Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist Physicians' assistant 29.00 Physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) A-8-3 OPHYSICAL THERAPY 66.00 24.00 25.00 26.00 CAP REL COSTS-BLDG & FIXT 0 CAP REL COSTS-BLDG & FIXT 1.00 0 26.00 27.00 CAP REL COSTS-MVBLE EQUIP 0 NONPHYSICIAN ANESTHETISTS 19.00 28.00 29.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see		repay Medicare overpayments						
I imitation (chapter 14) Adjustment for physical therapy costs in excess of limitation (chapter 14) Utilization review - physicians' compensation (chapter 21) Depreciation - CAP REL COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP COSTS-M	23. 00	, ,	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		limitation (chapter 14)						
Iimitation (chapter 14) Utilization review - Description Depreciation - CAP REL COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP Depreciation - CAP REL Depreciation - CAP REL COSTS-MVBLE EQUIP Depreciation - CAP REL Depreciation - CAP REL COSTS-MVBLE EQUIP Depreciation - CAP REL Depreciation - CAP REL Depreciation - CAP REL COSTS-MVBLE EQUIP Depreciation - CAP REL Depreciation - CAP REL Depreciation - CAP REL COSTS-MVBLE EQUIP Depreciation - CAP REL Depreciation - CAP REL COSTS-MVBLE EQUIP Depreciation - CAP REL Depreciation - CAP REL COSTS-MVBLE EQUIP Depreciation - CAP REL Depreciation - CAP REL COSTS-MVBLE EQUIP Depreciation - CAP REL Depreciation - CAP REL Depreciation - CAP REL COSTS-MVBLE EQUIP Depreciation - CAP REL Depreciation - Depreciation - CAP REL Depreciation - Depreciatio	24. 00	' ' '	A-8-3	0	PHYSI CAL THERAPY	66. 00		24.00
physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-BLDG & FIXT OCAP REL COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist ONONPHYSICIAN ANESTHETISTS 19.00 28.00 29.00 Physicians' assistant OCCUPATIONAL THERAPY 30.99 Hospice (non-distinct) (see	25 00	limitation (chapter 14)		0	*** C+ C+ D-I -+ ***	114 00		25 00
26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 26. 00 CAP REL COSTS-BLDG & FIXT 1.00 0 26. 00 CAP REL COSTS-BLDG & FIXT 1.00 0 27. 00 CAP REL COSTS-MVBLE EQUIP 2.00 0 CAP REL	25.00			Ü	AAA Cost Center Deleted AAA	114.00		25.00
COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see OCAP REL COSTS-MVBLE EQUIP OCAP REL COST	26 00	1 ' ' '		0	CAD DEL COSTS_BLDG & FLYT	1 00	0	26 00
28. 00 Non-physician Anesthetist ONONPHYSICIAN ANESTHETISTS 19. 00 28. 00 29. 00 29. 00 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30. 00 30. 99		COSTS-BLDG & FLXT						
28.00 Non-physician Anesthetist 0 NONPHYSICIAN ANESTHETISTS 19.00 29.00 29.00 Physicians' assistant 0 0 0 0 0 0 29.00 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see 0 APULTS & PEDIATRICS 30.00 30.99	27. 00			0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.00		Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS		-	
therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.99		1 3	A-8-3	0	OCCUPATI ONAL THERAPY		0	
30. 99 Hospi ce (non-distinct) (see 0 ADULTS & PEDIATRICS 30. 00 30. 99		therapy costs in excess of						
instructions)	30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
		instructions)						

Health Financial Systems		WHITLEY MEMOR	IAI HOSPITAI	Inlie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES		WITTELT MEMOR		Peri od:	Worksheet A-8	
				From 01/01/2023	Date/Time Pre 5/23/2024 12:	pared:
			Expense Classification or			
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	1. 00	2. 00	3.00	4. 00	5. 00	
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00 INTEREST EXPENSE	Α	0	ADMINISTRATIVE & GENERAL	5. 00	0	33.00
33.01 TELEMETRY ADJUSTMENT	A	0	ADULTS & PEDIATRICS	30. 00	0	33. 01
34.00 MISC REVENUE	A	-540	ADULTS & PEDIATRICS	30.00	0	34.00
34. 01 MISC REVENUE-LANDSCAPING	В	-1, 913	OPERATION OF PLANT	7. 00	0	34.01
35.00 POSTURE ASSESSMENTS	В	-45, 048	PHYSI CAL THERAPY	66. 00	0	35.00
37.00 MISC REVENUE	В	-24	RADI OLOGY-DI AGNOSTI C	54. 00	0	37.00
38.00 NON-PATIENT LAB REV.	В	-72	RESPIRATORY THERAPY	65. 00	0	38.00
39.00 TELEVISION OFFSET	A	-100	CAP REL COSTS-MVBLE EQUIP	2. 00	9	39.00
40.00 ANSWERING SERVICE	A	0	ADMINISTRATIVE & GENERAL	5. 00	0	40.00
41.00 PHYSICIAN RECRUITING	A		ADMINISTRATIVE & GENERAL	5. 00	0	41.00
43.00 VISITOR MEALS	A	-3, 412	CAFETERI A	11. 00	0	43.00
43.01 CAFETERIA - EMPLOYEE	A		CAFETERI A	11. 00	0	43. 01
44.00 PHARMACY SALES	A		PHARMACY	15. 00	0	1
45.00 HAF EXPENSE ADJUSTMENT	A	1	ADMINISTRATIVE & GENERAL	5. 00	0	45.00
48.00 LOBBY EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	1 .0.00
48.04 INTERUNIT RENT EXPENSE	A		RESPI RATORY THERAPY	65. 00	0	48. 04
48.05 INTERUNIT RENT EXPENSE	A		PHYSI CAL THERAPY	66. 00	0	1 .0.00
48.06 INTERUNIT RENT EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	48. 06
48.07 INTERUNIT RENT EXPENSE	A		OPERATION OF PLANT	7. 00	0	48. 07
48. 08 LI QUOR	A	1	ADMINISTRATIVE & GENERAL	5. 00	0	48. 08
48.09 PHYS ADMIN SAL ADD BACK	A		ADMINISTRATIVE & GENERAL	5. 00	0	1 .0.0,
49. 00 RENT EXPENSE - PHYSICIANS' CLINIC	A	0	PHYSICIANS' PRIVATE OFFICES	192. 00	0	49. 00
49.01 OPERATING INTEREST	A	0	PHARMACY	15. 00	0	49. 01

O OPERATING ROOM

-14, 587, 775

50.00

49.02

50.00

Α

50.00 TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A,

49. 02 OPERATING INTEREST

column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1. (2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

Heal th	Financial Systems	WHITLEY MEMOR	RIAL HOSPITAL	In Lieu of Form CMS-2552-10		
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO		Peri od:	Worksheet A-8	3-1
OFFI CE	COSTS			From 01/01/2023 To 12/31/2023		
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1. 00 2. 00		3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED (ORGANI ZATI ONS OF	R CLAIMED HOME	
	OFFICE COSTS:					
1.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	21, 055, 347	16, 159, 142	1.00
2.00	1.00	CAP REL COSTS-BLDG & FLXT	INTERUNIT RENTAL EXPENSE	0	2, 695, 334	2.00
3.00	5. 00	ADMINISTRATIVE & GENERAL	SUBSI DY ADJUSTMENT	0	9, 563, 208	3.00
4.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE INTEREST EXP ALL	634, 884	0	4.00
5.00	TOTALS (sum of lines 1-4).			21, 690, 231	28, 417, 684	5.00
	Transfer column 6, line 5 to					

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

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELA	FED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6. 00 B	0.00 PARKVI EW HEALTH	100.00	6.00
7. 00	0.00	0.00	7. 00
8. 00	0.00	0.00	8. 00
9. 00	0.00	0.00	9. 00
10. 00	0.00	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
- E. Individual is director, officer, administrator, or key person of provider and related organization.

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

Heal th	Financial Syste	ems	V	HITLEY MEMORIAL	HOSPI TAL		In Lieu	of Form CMS	-2552-10
		SERVICES FROM	RELATED ORGANI ZA	TIONS AND HOME	Provi der	CCN: 15-0101	Peri od:	Worksheet A-	8-1
OFFICE	COSTS						From 01/01/2023 To 12/31/2023	Date/Time Pr 5/23/2024 12	
	Net	Wkst. A-7 Ref.							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6. 00	7. 00							
		RED AND ADJUSTI	MENTS REQUIRED AS	A RESULT OF TRA	ANSACTI ONS	WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:								
1.00	4, 896, 205	0							1.00
2.00	-2, 695, 334	9							2.00
3.00	-9, 563, 208	0							3.00
4.00	634, 884	0							4.00
5.00	-6, 727, 453								5.00
* The	amounts on line	es 1-4 (and sub	oscripts as appro	oriate) are tran	sferred i	n detail to Wo	rksheet A, column	6, lines as	
appropr	iate. Positive a	amounts increas	se cost and negati	ve amounts decr	ease cost	. For related o	rganization or ho	me office cos	t which
has not	been posted to	o Worksheet A,	columns 1 and/or	2, the amount a	ıllowable	should be indi-	cated in column 4	of this part	
	Related Orga	ni zati on(s)						•	
	and/or Ho								
	Type of I	Busi ness							
		00							

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

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

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

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

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

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.

 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in

Provi der CCN: 15-0101

									To 12/31/2023		
	Wkst. A Line #	(Cost	Center/Physi ci an I denti fi er	Total Remuneration		ofessi onal omponent	Provider Component	RCE Amount	Physician/Provider Component	
	1.00				0.00			5.00		Hours	
1 00	1.00	DD	^	2. 00	3.00		4. 00	5. 00	6. 00	7. 00	4.00
1.00	30.00				404, 000		404, 000		,		1.00
2.00	50.00				1, 308, 032	1	1, 308, 032				2.00
3.00	91. 00				617, 605		542, 605				3.00
4.00	95. 00	DR.	D		11, 167		0	11, 167	1		4.00
5. 00	0.00				0		0	(0	0	5.00
6. 00	0.00				0		0	(0	0	6.00
7. 00	0. 00				0		0	(0	0	7. 00
8. 00	0.00				0		0	(0	0	8. 00
9. 00	0. 00				0		0		0	0	9. 00
10.00	0.00				0		0	() 0	0	10.00
200.00					2, 340, 804		2, 254, 637				200.00
	Wkst. A Line #	(Cost	Center/Physi ci an	Unadjusted RCE			Cost of	Provi der	Physician Cost	
				Identifier	Limit	Unac		Memberships &		of Malpractice	
							Limit	Conti nui ng	Share of col.	Insurance	
								Education	12		
	1. 00			2. 00	8. 00		9. 00	12. 00	13. 00	14. 00	
1. 00	30. 00				0		0	,	1	· -	
2.00	50.00				0		0		1	-	2.00
3.00	91. 00				43, 622		2, 181	C	1	-	3.00
4.00	95. 00	DR.	D		8, 135		407	C	0		4. 00
5.00	0.00				0		0	C	0	0	5. 00
6.00	0.00				0		0	C	0	0	6. 00
7.00	0.00				0		0	C	0	0	7. 00
8.00	0.00				0		0	C	0	0	8.00
9.00	0.00				0		0	C	0	0	9. 00
10.00	0.00				0		0	C	0	0	10.00
200.00					51, 757		2, 588		0	0	200.00
	Wkst. A Line #	(Cost	Center/Physi ci an	Provi der	Adj	usted RCE	RCE	Adjustment		
				ldenti fi er	Component		Limit	Di sal I owance			
					Share of col.						
					14						
	1.00			2. 00	15. 00		16. 00	17. 00	18. 00		
1.00	30. 00				0		0	C	1,		1. 00
2.00	50.00				0		0	(1, 308, 032		2.00
3.00	91.00				0		43, 622				3.00
4.00	95. 00	DR.	D		0		8, 135	3, 032	3, 032		4.00
5.00	0.00				0		0	(0		5.00
6.00	0.00				0		0	C	0		6.00
7.00	0.00				0		0	(0		7.00
8.00	0.00				0		0	C	0		8.00
9.00	0.00				0		0	(0		9. 00
10.00	0.00				0		0	(0		10.00
200.00					0		51, 757	34, 410	2, 289, 047		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 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/23/2024 12:06 pm CAPITAL RELATED COSTS Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal Cost Center Description for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 0 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1, 118, 941 1, 118, 941 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 1, 484, 897 1, 484, 897 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 8, 178, 664 4.00 8.178.664 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 349, 956 2, 225, 557 24, 553, 108 464, 411 27, 593, 032 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 2, 239, 949 81, 310 107, 903 182, 237 2, 611, 399 7.00 00800 LAUNDRY & LINEN SERVICE 3, 799 335, 125 8 00 326 284 5 042 8 00 00900 HOUSEKEEPI NG 9.00 1, 183, 937 3, 175 4, 214 247, 199 1, 438, 525 9.00 10.00 01000 DI ETARY 217, 151 13, 612 18,064 38, 704 287, 531 10.00 11.00 01100 CAFETERI A 492, 353 15, 351 20, 371 113, 448 641, 523 11.00 01200 MAINTENANCE OF PERSONNEL 12 00 12 00 13.00 01300 NURSING ADMINISTRATION 688, 964 925 1, 228 176, 820 867, 937 13.00 01400 CENTRAL SERVICES & SUPPLY 10, 991 25, 577 14.00 14, 586 14.00 01500 PHARMACY 1,018,750 9, 526 15.00 12.641 263, 658 1.304.575 15.00 01600 MEDICAL RECORDS & LIBRARY 3, 386 4, 493 7,879 16.00 0 0 16.00 17.00 01700 SOCIAL SERVICE 0 0 0 17.00 0 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 0 19.00 0 0 02000 NURSI NG PROGRAM 0 0 O 20 00 C 0 20 00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 C 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 0 0 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 4, 938, 253 148, 686 197, 314 1, 039, 091 6, 323, 344 30.00 04300 NURSERY 484, 848 43.00 391, 431 0 93, 417 43.00 04400 SKILLED NURSING FACILITY 44.00 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 186, 682 88, 796 117, 838 458, 474 3, 851, 790 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 810, 919 195, 555 1,006,474 52 00 05300 ANESTHESI OLOGY 53.00 53.00 0 0 05400 RADI OLOGY-DI AGNOSTI C 54 00 4,060,632 119, 316 158, 339 692, 374 5, 030, 661 54 00 06000 LABORATORY 4, 390, 550 60.00 4, 342, 154 20, 797 27, 599 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 06500 RESPIRATORY THERAPY 1, 209, 816 16, 444 65.00 21.822 320.714 1, 568, 796 65, 00 66.00 06600 PHYSI CAL THERAPY 788, 935 97, 131 128, 898 212, 912 1, 227, 876 66.00 67.00 06700 OCCUPATI ONAL THERAPY 923, 886 235, 814 1, 159, 700 67.00 06800 SPEECH PATHOLOGY 25, 076 68.00 98, 246 0 123, 322 68.00 06900 ELECTROCARDI OLOGY 0 69 00 C 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 625, 762 C 0 0 625, 762 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 581, 820 581,820 72.00 o 07300 DRUGS CHARGED TO PATIENTS 0 73.00 6. 323. 823 6, 323, 823 73.00 0 07697 CARDIAC REHABILITATION 0 76.97 C Ω 76.97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 4.000 0 0 4,000 76.98 76. 99 o 07699 LI THOTRI PSY 0 0 76.99 0 0 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77 00 0 0 77 00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 0 0 90.01 09001 INTENSIVE OUT PATIENT PROGRAM \cap Λ 90.01 91.00 09100 EMERGENCY 4, 733, 593 108, 830 144, 423 1,075,605 6, 062, 451 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 2, 580, 176 0 0 567, 481 3, 147, 657 95.00 102.00 10200 OPIOID TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 77, 103, 126 1,092,031 1, 449, 186 8, 164, 136 77, 025, 977 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 6. 085 407 540 7, 032 190. 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 14, 528 643, 093 192. 00 571, 540 24, 505 32, 520 194. 00 07950 OCCUPATIONAL HEALTH 0 194.00 0 0 0 194.01 194. 01 07951 PAIN CLINIC 0 0 0 194. 02 07952 OAK POINTE 0 0 0 0 0 194. 02 194. 03 07953 FOUNDATION 0 0 0 194.03 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 1, 998 65, 922 194. 04 61, 273 2,651 194. 05 07955 VACANT SPACE 0 0 0 0 194.05 0 194.06

0

C

0

0

0

0 200.00

0 201.00

200.00

201.00

194. 06 07956 TELEHEALTH MEDICINE

Cross Foot Adjustments

Negative Cost Centers

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider Co		Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Pre 5/23/2024 12:	pared: 06 pm	
	CAPI TA						
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal		
	0	1.00	2. 00	4. 00	4A		
202.00 TOTAL (sum lines 118 through 201)	77, 742, 024	1, 118, 941	1, 484, 89	7 8, 178, 664	77, 742, 024	202.00	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0101

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

5/23/2024 12:06 pm Cost Center Description ADMINISTRATIV MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG E & GENERAL **REPAIRS PLANT** LINEN SERVICE 5.00 6.00 7.00 9.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 00500 ADMINISTRATIVE & GENERAL 5.00 27, 593, 032 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 1, 436, 847 0 4,048,246 7.00 00800 LAUNDRY & LINEN SERVICE 541, 883 8 00 8 00 184.393 Ω 22, 365 9.00 00900 HOUSEKEEPI NG 791.507 0 18.693 2, 248, 725 9.00 01000 DI ETARY 158, 206 80, 135 44, 969 10.00 10.00 11.00 01100 CAFETERI A 352, 979 0 90, 368 0 50, 712 11.00 01200 MAINTENANCE OF PERSONNEL 0 12 00 0 0 0 12 00 13.00 01300 NURSING ADMINISTRATION 477.557 5, 447 3,057 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14,073 64, 702 0 36, 309 14.00 01500 PHARMACY 717, 805 0 15.00 56, 078 31, 469 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 4.335 C 19, 931 11, 184 16.00 17.00 01700 SOCIAL SERVICE 0 0 0 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 19 00 0 0 O 19.00 02000 NURSING PROGRAM 0 20.00 0 0 0 20.00 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 21 00 0 C 0 0 21 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 0 22.00 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3, 479, 237 0 875, 292 36, 616 491, 190 30.00 43.00 04300 NURSERY 266, 774 C 0 93, 842 0 43.00 04400 SKILLED NURSING FACILITY 44.00 0 0 0 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 2, 119, 336 50.00 522, 732 293, 343 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 553, 783 0 179, 233 52.00 0 0 05300 ANESTHESI OLOGY 53.00 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 767, 975 C 702, 396 0 394, 165 54.00 60.00 06000 LABORATORY 2, 415, 773 122, 430 0 68, 705 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 62.30 0 0 62.30 06500 RESPIRATORY THERAPY 96, 805 0 54.325 65.00 863. 185 C 65.00 66.00 06600 PHYSI CAL THERAPY 675, 603 0 571, 795 0 320, 876 66.00 06700 OCCUPATIONAL THERAPY o 67.00 638, 091 0 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 67.854 0 06900 ELECTROCARDI OLOGY 0 69.00 C 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 344, 307 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 320, 130 0 0 72.00 0 73 00 07300 DRUGS CHARGED TO PATIENTS 3, 479, 502 0 O 73 00 0 07697 CARDIAC REHABILITATION 76.97 C 0 0 76.97 07698 HYPERBARIC OXYGEN THERAPY 2, 201 0 0 76.98 76.98 0 76. 99 07699 LI THOTRI PSY 0 0 ol 0 76.99 0 07700 ALLOGENEIC HSCT ACQUISITION 77 00 Ω 0 0 77 00 0 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 0 0 0 0 09001 INTENSIVE OUT PATIENT PROGRAM 90 01 90 01 C 0 91.00 09100 EMERGENCY 3, 335, 688 640,665 232, 192 359, 524 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 1, 731, 907 0 0 0 0 95.00 102.00 10200 OPIOID TREATMENT PROGRAM 0 102.00 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 27, 199, 048 0 3, 889, 834 541, 883 2, 159, 828 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1, 343 190. 00 3.869 2.393 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 353.843 C 144, 259 0 80, 954 192. 00 194. 00 07950 OCCUPATIONAL HEALTH 0 0 194.00 0 0 194. 01 07951 PAIN CLINIC 0 0 0 0 194. 01 01 194. 02 07952 OAK POINTE 0 194. 02 0 0 0 194. 03 07953 FOUNDATI ON Λ C 0 0 0 194.03 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 6,600 194.04 36, 272 11, 760 194. 05 07955 VACANT SPACE 0 0 0 194.05 0 0 194. 06 07956 TELEHEALTH MEDICINE 0 194.06 0 C 0 0 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 0 201.00 201.00 202.00 TOTAL (sum lines 118 through 201) 27, 593, 032 4, 048, 246 541, 883 2, 248, 725 202. 00

Provider CCN: 15-0101

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Ti me Prepared: 5/23/2024 12:06 pm

				0 12/31/2023	5/23/2024 12:	
Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	
			OF PERSONNEL	ADMI NI STRATI O N	SERVI CES & SUPPLY	
	10. 00	11. 00	12.00	13.00	14. 00	
GENERAL SERVICE COST CENTERS 1.00 OO100 CAP REL COSTS-BLDG & FIXT			I			1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
6.00 00600 MAINTENANCE & REPAIRS						6. 00
7. 00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG						8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	570, 841					9. 00 10. 00
11. 00 01100 CAFETERI A	0	1, 135, 582				11.00
12.00 01200 MAINTENANCE OF PERSONNEL	Ö	0	C			12.00
13.00 01300 NURSING ADMINISTRATION	0	24, 798	0	1, 378, 796		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	140, 661	14.00
15. 00 01500 PHARMACY	0	36, 028	0	0	2, 225	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	0			0	16.00
17. 00 01700 SOCI AL SERVI CE 19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0		0	0	17. 00 19. 00
20. 00 02000 NURSI NG PROGRAM	0	0		0	0	20.00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV	Ö	0	C	0	0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	C	0	0	22. 00
23.00 O2300 PARAMED ED PRGM-(SPECIFY)	0	0	C	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	570.044	107.450	1	104 7/0	1 700	
30. 00 03000 ADULTS & PEDI ATRI CS 43. 00 04300 NURSERY	570, 841	197, 452			1, 728	30. 00 43. 00
44.00 04400 SKILLED NURSING FACILITY	0	18, 716 0	0	1	4, 427 0	44.00
ANCILLARY SERVICE COST CENTERS	<u> </u>			·I		44.00
50. 00 05000 OPERATING ROOM	0	85, 625	С	214, 594	40, 827	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	О	38, 835	0	97, 249	8, 456	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	1	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	154, 405	0	0	6, 770	54.00
60. 00 06000 LABORATORY 62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0	60. 00 62. 30
65. 00 06500 RESPI RATORY THERAPY	0	68, 781		0	6, 920	65.00
66. 00 06600 PHYSI CAL THERAPY	o	50, 533		Ö	316	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	44, 918		0	467	67.00
68. 00 06800 SPEECH PATHOLOGY	0	4, 211	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	0	43, 330	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0 3, 016	72. 00 73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	3,010	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	o	0		Ö	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	O	0	0	76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	C	0	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS 90. 00 O9000 CLINIC	٥	0.250	1 0	ا	4	00.00
90. 00 09000 CLINIC 90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	9, 358 0	0	1	4	90. 00 90. 01
91. 00 09100 EMERGENCY	0	228, 333		1	16, 811	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		,			,	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	168, 442			5, 108	
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE			T			 113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	570, 841	1, 130, 435		1, 378, 796	140, 405	
NONREI MBURSABLE COST CENTERS	370, 041	1, 130, 433		1, 370, 770	140, 403	1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	С	0	183	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	5, 147	0	0	4	192.00
194. 00 07950 OCCUPATI ONAL HEALTH	0	0	0	-		194. 00
194. 01 07951 PAIN CLINIC	0	0	0	0		194. 01
194. 02 07952 OAK POLNTE	O	0				194. 02 194. 03
194. 03 07953 FOUNDATI ON 194. 04 07954 COMMUNI TY & VOLUNTEER SERVI CES	O	0				194. 03
194. 05 07955 VACANT SPACE	0	0				194. 04
194. 06 07956 TELEHEALTH MEDICINE	o	0		ol ol		194.06
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	1		201. 00
202.00 TOTAL (sum lines 118 through 201)	570, 841	1, 135, 582	0	1, 378, 796	140, 661	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0101

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

5/23/2024 12:06 pm Cost Center Description **PHARMACY** MEDI CAL SOCI AL NONPHYSI CI AN NURSI NG **ANESTHETI STS** RECORDS & SERVI CE **PROGRAM** LI BRARY 17.00 19.00 20.00 15 00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10 00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15 00 2.148.180 16.00 01600 MEDICAL RECORDS & LIBRARY 43, 329 16.00 01700 SOCIAL SERVICE 17 00 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 19.00 0 0 02000 NURSING PROGRAM 0 20 00 0 C 0 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 7. 552 0 0 30.00 0 43.00 04300 NURSERY 1,044 0 0 43.00 0 04400 SKILLED NURSING FACILITY 0 44.00 0 0 0 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 1, 101 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 52.00 52.00 05300 ANESTHESI OLOGY 0 53.00 0 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 9,974 0 54.00 06000 LABORATORY 0 60.00 00000 C 0 0 0 0 0 0 0 0 60.00 62 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 62 30 C 0 06500 RESPIRATORY THERAPY 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 3,666 66.00 06700 OCCUPATI ONAL THERAPY 67.00 1,005 0 0 67.00 06800 SPEECH PATHOLOGY 0 68 00 68 00 0 212 0 0 69.00 06900 ELECTROCARDI OLOGY C 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 Ω 72 00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 2, 147, 944 C 0 73.00 76. 97 07697 CARDIAC REHABILITATION 0 76.97 0 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 76.98 07699 LI THOTRI PSY 0 0 76. 99 76 99 Ω 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 C 0 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLINIC 90 00 0 0 0 0 0 09001 INTENSIVE OUT PATIENT PROGRAM 90.01 0 C 0 0 0 90.01 09100 EMERGENCY 0 ol 91.00 91.00 18, 775 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 92.00 92.00 95.00 09500 AMBULANCE SERVICES 0 0 0 0 95.00 102.00 10200 OPI OID TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 147, 944 43, 329 0 0 0 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190, 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 0 C 194. 00 07950 OCCUPATIONAL HEALTH 0 0 0 194.00 0 0 0 0 0 194. 01 07951 PAIN CLINIC 0 0 194. 01 194. 02 07952 OAK POINTE 0 0 0 194, 02 C 194. 03 07953 FOUNDATI ON 0 0 C 0 194.03 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 0 194.04 0 0 0 0 0 0 236 194. 05 07955 VACANT SPACE 0 0 194, 05 0 C 0 0 194.06 194. 06 07956 TELEHEALTH MEDICINE 0 C Cross Foot Adjustments 0 200.00 200.00 201.00 Negative Cost Centers 0 0 201.00 0 202.00 TOTAL (sum lines 118 through 201) 43, 329 0 202.00 2, 148, 180

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0101

				-	Γο 12/31/2023	Date/Time Pre 5/23/2024 12:	
		INTERNS &	RESI DENTS			372372024 12.	OO piii
	Cost Center Description		SERVI CES-OTHE	PARAMED ED	Subtotal	Intern &	
		RY & FRINGES APPRV	R PRGM COSTS APPRV	PRGM		Residents Cost & Post	
		71111	ALLIKY			Stepdown	
		21.22	22.22	00.00	0.1.00	Adjustments	
	GENERAL SERVICE COST CENTERS	21. 00	22. 00	23. 00	24. 00	25. 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 6. 00	OO5OO ADMINISTRATIVE & GENERAL OO6OO MAINTENANCE & REPAIRS						5. 00 6. 00
7. 00	00700 OPERATION OF PLANT			•			7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A						11.00
12. 00	01200 MAINTENANCE OF PERSONNEL						12.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY						14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16.00
17. 00	01700 SOCIAL SERVICE						17. 00
19.00	01900 NONPHYSI CI AN ANESTHETI STS						19.00
20. 00 21. 00	02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRV						20. 00 21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)				0		23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	.I	12 470 020	1 0	20.00
30. 00 43. 00	03000 ADULTS & PEDI ATRI CS 04300 NURSERY	C	_	1	12, 478, 020 869, 651	0 0	
44. 00	04400 SKILLED NURSING FACILITY			1	0		1
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	C	_	1	7, 129, 348		1
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY		0	1	1, 884, 030 0 0		
54.00	05400 RADI OLOGY-DI AGNOSTI C	i c	Ö	1	9, 066, 346		
60.00	06000 LABORATORY	C	0		6, 997, 458		60.00
62. 30 65. 00	06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 06500 RESPI RATORY THERAPY	0	0		٥	0	62. 30 65. 00
66.00	06600 PHYSI CAL THERAPY		0		2, 658, 812 2, 850, 665	1	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	C	0		1, 844, 181	0	1
68.00	06800 SPEECH PATHOLOGY	C	0	1	195, 599	0	
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0	1	0 1, 013, 399	0	69. 00 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS				901, 950	•	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	C	0		11, 954, 285		73. 00
	07697 CARDI AC REHABI LI TATI ON	C	0		0		
	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY		0	1	6, 201 0 0	0 0	
	07700 ALLOGENEIC HSCT ACQUISITION		Ö	1			1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	C	0		0	0	78. 00
00 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC				0.242		00.00
	09001 INTENSIVE OUT PATIENT PROGRAM	C	0	1	9, 362 0 0	0	1
	09100 EMERGENCY	C	Ö	1	11, 466, 624		1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
95 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	T C	0	1 (5, 053, 114	0	95.00
	10200 OPI OI D TREATMENT PROGRAM			1	0 3,033,114		102.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE				7/ 070 045		113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	C	0		76, 379, 045	0	118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	С	0		14, 820	0	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	C	0		1, 227, 300	0	192. 00
	07950 OCCUPATI ONAL HEALTH	C	0		0		194.00
	07951		0) 0		194. 01 194. 02
	07953 FOUNDATION						194. 02
194.04	07954 COMMUNITY & VOLUNTEER SERVICES		O		120, 859	0	194. 04
	07955 VACANT SPACE	C	0		0		194.05
194. 06 200. 00	07956 TELEHEALTH MEDICINE Cross Foot Adjustments						194. 06 200. 00
201.00	, ,		Ö				201.00
	· · ·						

Health Financial Systems	WHITLEY MEMORI	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C	CN: 15-0101	Peri od:	Worksheet B	
				From 01/01/2023 To 12/31/2023	Part Date/Time Pre	narod:
				10 12/31/2023	5/23/2024 12:	06 pm
	INTERNS &	RESI DENTS				
Cost Center Description	SERVI CES-SALA	SERVI CES-0THE	PARAMED ED	Subtotal	Intern &	
	RY & FRINGES	R PRGM COSTS	PRGM		Resi dents	
	APPRV	APPRV			Cost & Post	
					Stepdown	
					Adjustments	
	21. 00	22. 00	23.00	24.00	25. 00	
202.00 TOTAL (sum lines 118 through 201)	0	o		0 77, 742, 024	0	202. 00

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Ti me Prepared: 5/23/2024 12:06 pm Provider CCN: 15-0101

				5/23/2024 12:	
		Cost Center Description	Total 26. 00		
	GENERA	AL SERVICE COST CENTERS	20.00		
1.00		CAP REL COSTS-BLDG & FIXT			1.00
2.00		CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	1 1	ADMINISTRATIVE & GENERAL			5. 00
6. 00	1 1	MAINTENANCE & REPAIRS			6. 00
7. 00	1 1	OPERATION OF PLANT			7.00
8. 00		LAUNDRY & LINEN SERVICE			8.00
9. 00 10. 00	1 1	HOUSEKEEPI NG DI ETARY			9.00
	1 1	CAFETERI A	+		10.00
	1 1	MAINTENANCE OF PERSONNEL			12.00
		NURSI NG ADMI NI STRATI ON			13. 00
		CENTRAL SERVICES & SUPPLY			14.00
		PHARMACY			15. 00
		MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
	02000	NURSI NG PROGRAM			20. 00
	1 1	I&R SERVICES-SALARY & FRINGES APPRV			21.00
	1 1	I&R SERVICES-OTHER PRGM COSTS APPRV			22. 00
23. 00		PARAMED ED PRGM-(SPECIFY)			23. 00
		ENT ROUTINE SERVICE COST CENTERS	10 170 000		
		ADULTS & PEDIATRICS	12, 478, 020		30.00
		NURSERY SKILLED NURSING FACILITY	869, 651 0		43. 00 44. 00
44.00		ARY SERVICE COST CENTERS	U		44.00
50. 00		OPERATING ROOM	7, 129, 348		50.00
	1 1	DELIVERY ROOM & LABOR ROOM	1, 884, 030		52.00
	1 1	ANESTHESI OLOGY	0		53.00
	1 1	RADI OLOGY-DI AGNOSTI C	9, 066, 346		54.00
60.00	06000	LABORATORY	6, 997, 458		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		62. 30
65.00	1 1	RESPI RATORY THERAPY	2, 658, 812		65.00
66.00	1 1	PHYSI CAL THERAPY	2, 850, 665		66. 00
	1 1	OCCUPATI ONAL THERAPY	1, 844, 181		67.00
68.00	1 1	SPEECH PATHOLOGY	195, 599		68.00
		ELECTROCARDI OLOGY	1 012 200		69.00
	1 1	MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	1, 013, 399 901, 950		71.00 72.00
		DRUGS CHARGED TO PATIENTS	11, 954, 285		73. 00
		CARDI AC REHABI LI TATI ON	0		76. 97
	1 1	HYPERBARI C OXYGEN THERAPY	6, 201		76. 98
76. 99	07699	LI THOTRI PSY	0		76. 99
77. 00	07700	ALLOGENEIC HSCT ACQUISITION	0		77. 00
78.00		CAR T-CELL IMMUNOTHERAPY	0		78. 00
		TIENT SERVICE COST CENTERS			
	09000		9, 362		90.00
		INTENSIVE OUT PATIENT PROGRAM EMERGENCY	11 466 624		90. 01 91. 00
		OBSERVATION BEDS (NON-DISTINCT PART	11, 466, 624		92.00
72.00		REIMBURSABLE COST CENTERS			72.00
95.00		AMBULANCE SERVICES	5, 053, 114		95.00
		OPIOID TREATMENT PROGRAM	0		102.00
		AL PURPOSE COST CENTERS			
		INTEREST EXPENSE			113. 00
118. 00)	SUBTOTALS (SUM OF LINES 1 through 117)	76, 379, 045		118. 00
100.00		MBURSABLE COST CENTERS	14 020		100.00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	14, 820		190.00
		PHYSI CI ANS' PRI VATE OFFI CES OCCUPATI ONAL HEALTH	1, 227, 300		192. 00 194. 00
	1 1	PAIN CLINIC	0		194. 00
		OAK POINTE	0		194. 01
		FOUNDATION	0		194. 02
		COMMUNITY & VOLUNTEER SERVICES	120, 859		194. 04
		VACANT SPACE	0		194. 05
		TELEHEALTH MEDICINE	o		194.06
200.00	1 1	Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	О		201.00
202.00)	TOTAL (sum lines 118 through 201)	77, 742, 024		202. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0101

				To	12/31/2023	Date/Time Pre 5/23/2024 12:	
			CAPI TAL REI	LATED COSTS		3/23/2024 12.	oo piii
	Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	cost center bescription	Assigned New	DEDO & TIXI	WVBEE EQUIT	Subtotal	BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS			2.00		11 00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	o	2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	4, 561, 831	349, 956	_	5, 376, 198		5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	81, 310 3, 799	1	189, 213 8, 841	0	7. 00 8. 00
9. 00	00900 HOUSEKEEPING	0	3, 175	1	7, 389		9. 00
10.00	01000 DI ETARY	0	13, 612	18, 064	31, 676		10.00
11.00		0	15, 351		35, 722	0	11.00
12. 00 13. 00	i i	0	0 925	1	0 2, 153	0	12. 00 13. 00
14. 00		0	10, 991		25, 577	0	14. 00
15. 00		0	9, 526	1	22, 167	0	15. 00
16. 00 17. 00	i i	0	3, 386	4, 493 0	7, 879 0	0 0	16. 00 17. 00
19. 00	l i	0	Ö	0	0	0	19.00
20. 00		0	0	0	0	0	20.00
21. 00		0	0	0	0	0	21. 00 22. 00
22. 00 23. 00	i i	0		0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		-			_	
30.00		0		1	346, 000		30.00
43. 00 44. 00	1 1	0	0		0		43. 00 44. 00
00	ANCILLARY SERVICE COST CENTERS			<u> </u>	<u> </u>	J	
50.00		0	1		206, 634	0	50.00
52. 00 53. 00		0	0		0	0	52. 00 53. 00
54. 00	1 1	0	119, 316	_	277, 655		54. 00
60.00		0	20, 797	1	48, 396		60.00
62. 30 65. 00	• • • • • • • • • • • • • • • • • • •	0	0 16, 444	_	0 38, 266	0	62. 30 65. 00
66. 00	• • • • • • • • • • • • • • • • • • •	0	97, 131	1	226, 029	0	66. 00
67. 00		0	0	0	0	0	67. 00
68. 00 69. 00	i i	0	0	0	0	0	68. 00 69. 00
71. 00		0		0	0	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	i i	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	0	76. 97 76. 98
	07699 LI THOTRI PSY	0	Ö	Ö	0		
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0		1	0		77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	78. 00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90. 01		0	0	0	0	0	90. 01
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	108, 830	144, 423	253, 253 0		91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>			<u> </u>		72.00
	09500 AMBULANCE SERVI CES	0			0		95.00
102.00	010200 OPIOLD TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
113.00	0 11300 INTEREST EXPENSE						113. 00
118.00	3 /	4, 561, 831	1, 092, 031	1, 449, 186	7, 103, 048	0	118. 00
190.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	407	540	947	0	190. 00
192.00	0 19200 PHYSICIANS' PRIVATE OFFICES	0	24, 505	1	57, 025	0	192. 00
	0 07950 OCCUPATI ONAL HEALTH	0	0	0	0		194.00
	1 07951 PAIN CLINIC 2 07952 0AK POINTE	0	0		0		194. 01 194. 02
	3 07953 FOUNDATION	0	0	o o	Ö	0	194. 03
	4 07954 COMMUNITY & VOLUNTEER SERVICES	0	1, 998	2, 651	4, 649		194. 04
	5 07955 VACANT SPACE 6 07956 TELEHEALTH MEDICINE	0	0	0	0		194. 05 194. 06
200.00					0		200. 00
201.00	Negative Cost Centers		0	0	0	0	201. 00
202.00	0 TOTAL (sum lines 118 through 201)	4, 561, 831	1, 118, 941	1, 484, 897	7, 165, 669	0	202. 00

Provider CCN: 15-0101

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2023 | Part II |
| To | 12/31/2023 | Date/Time | Prepared: | 5/23/2024 | 12:06 pm

				,	0 12/31/2023	5/23/2024 12:	
	Cost Center Description	ADMINISTRATIV E & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		5. 00	6.00	7. 00	8. 00	9. 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, 376, 198					5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700 OPERATION OF PLANT	279, 955	0	469, 168			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	35, 927	0	2, 592	47, 360		8. 00
9. 00	00900 HOUSEKEEPI NG	154, 217	0	2, 166	0	163, 772	1
10.00	01000 DI ETARY	30, 825	0	9, 287	0	3, 275	1
11.00	01100 CAFETERI A	68, 774	0	10, 473	1	3, 693	1
12. 00 13. 00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	93, 047	0	0 631	0	0 223	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	2, 742	0	7, 499	0	2, 644	1
15. 00	01500 PHARMACY	139, 857	0	6, 499		2, 292	1
16. 00	01600 MEDI CAL RECORDS & LIBRARY	845	Ö	2, 310	o	815	1
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	1
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000 NURSI NG PROGRAM	0	0	0	0	0	
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	0	0	
23. 00	02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	U	0	23. 00
30. 00	03000 ADULTS & PEDIATRICS	677, 894	0	101, 441	3, 200	35, 771	30.00
43. 00	04300 NURSERY	51, 978	Ö		8, 202	0	1
44. 00	04400 SKILLED NURSING FACILITY	0	l		0	0	1
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	412, 931	0	60, 582	0	21, 364	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	107, 899	0		15, 665	0	1
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	539, 312	0	81, 404		28, 707	1
60. 00 62. 30	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS	470, 689 0	0	14, 189 0	0	5, 004 0	1
65. 00	06500 RESPIRATORY THERAPY	168, 183	0	11, 219	0	3, 956	1
66. 00	06600 PHYSI CAL THERAPY	131, 634	0	66, 268	1	23, 369	1
67. 00	06700 OCCUPATI ONAL THERAPY	124, 326	Ö	00, 200	o	0	1
68.00	06800 SPEECH PATHOLOGY	13, 221	O	0	0	0	1
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	67, 085	0	0	0	0	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	62, 374	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	677, 920	0	0	0	0	
76. 97 76. 98	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	
76. 99	07699 LI THOTRI PSY	429	0		0	0	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	l ő	0	-	0	1
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0	0	0	90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0	1
91. 00	09100 EMERGENCY	649, 925	0	74, 249	20, 293	26, 184	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
05 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	227 445	0	0	O	0	05 00
	10200 OPI OI D TREATMENT PROGRAM	337, 445 0	l e				95. 00 102. 00
102.00	SPECIAL PURPOSE COST CENTERS	0		0	U U	0	102.00
113.00	11300 INTEREST EXPENSE						113. 00
118.00		5, 299, 434	0	450, 809	47, 360	157, 297	
	NONREI MBURSABLE COST CENTERS						1
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	754	0	277	0	98	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	68, 943	l e	16, 719	0		192. 00
	07950 OCCUPATI ONAL HEALTH	0	0	0	0		194.00
	07951 PAIN CLINIC	0	0	0	0		194. 01
	2 07952 0AK POI NTE 3 07953 FOUNDATI ON	0	0	0	0		194. 02 194. 03
	4 07954 COMMUNITY & VOLUNTEER SERVICES	7, 067		1, 363			194. 03
	07955 VACANT SPACE	7,007		1, 303			194.04
	07956 TELEHEALTH MEDICINE		l	1 0	0		194.06
200.00]					200.00
201.00	Negative Cost Centers	0	0	0	o		201.00
202.00	TOTAL (sum lines 118 through 201)	5, 376, 198	0	469, 168	47, 360	163, 772	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0101

Peri od: Worksheet B From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared:

5/23/2024 12:06 pm Cost Center Description DI ETARY CAFETERI A MAI NTENANCE NURSI NG CENTRAL ADMI NI STRATI O SERVICES & OF PERSONNEL Ν **SUPPLY** 10.00 11. 00 12.00 13.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 75,063 10 00 01100 CAFETERI A 11.00 118, 662 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 0 12.00 13.00 01300 NURSING ADMINISTRATION 0 2, 591 98, 645 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 38, 462 14.00 15.00 01500 PHARMACY 0 15.00 0 608 3, 765 0 0 16.00 01600 MEDICAL RECORDS & LIBRARY 0 0 16.00 01700 SOCIAL SERVICE 0 17 00 0 17.00 0 0 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 0 19.00 0 0 02000 NURSI NG PROGRAM 20 00 C 0 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 0 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 75.063 20, 633 0 472 30.00 43.00 04300 NURSERY 0 43.00 1, 956 1.211 04400 SKILLED NURSING FACILITY 0 44.00 0 0 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 8, 947 15, 353 11, 164 50.00 0 05200 DELIVERY ROOM & LABOR ROOM 4.058 0 6. 958 2.312 52.00 52.00 05300 ANESTHESI OLOGY 0 53.00 0 Ω 53.00 0 16, 135 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 1,851 54.00 06000 LABORATORY 0 0 60.00 0 0 C 0 60.00 62 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 62 30 C 0 0 06500 RESPIRATORY THERAPY 0 65.00 7, 187 1,892 65.00 06600 PHYSI CAL THERAPY 0000 5, 280 0 0 87 66.00 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 4,694 0 128 67.00 0 06800 SPEECH PATHOLOGY 0 68 00 440 68 00 0 06900 ELECTROCARDI OLOGY 0 69.00 C 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 11, 847 71.00 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72 00 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 C 825 73.00 76. 97 07697 CARDIAC REHABILITATION 0 76.97 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 76.98 07699 LI THOTRI PSY 0 76 99 76. 99 Ω 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 C 0 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLINIC 90 00 0 978 0 1 09001 INTENSIVE OUT PATIENT PROGRAM 90.01 0 0 0 0 90.01 09100 EMERGENCY 0 40, 936 91.00 23, 859 4,597 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 92.00 92.00 95.00 09500 AMBULANCE SERVICES 0 0 0 1, 397 95.00 17, 601 102.00 10200 OPI OID TREATMENT PROGRAM 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1 through 117) 75,063 118, 124 0 98, 645 38, 392 118. 00 118.00 NONREI MBURSABLE COST CENTERS 50 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 538 0 1 192.00 194. 00 07950 OCCUPATIONAL HEALTH 0 0 0 0 194.00 0 0 0 194. 01 07951 PAIN CLINIC 0 0 194.01 0 0 194. 02 07952 OAK POINTE 0 0 194 02 C 194. 03 07953 FOUNDATI ON 0 0 0 C 0 194.03 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 0 o 19 194. 04 0 0 194. 05 07955 VACANT SPACE 0 0 0 0 194, 05 C 0 194. 06 07956 TELEHEALTH MEDICINE 0 C 0 0 194.06 Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers 0 0 201.00 0 202.00 TOTAL (sum lines 118 through 201) 98, 645 38, 462 202. 00 75,063 118,662

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0101

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Ti

				To 12/31/2023	Date/lime Pr 5/23/2024 12	
Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	NURSI NG PROGRAM	. OO piii
	15. 00	16. 00	17. 00	19. 00	20. 00	
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						1. 00 2. 00 4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL 6. 00 00600 MAI NTENANCE & REPAI RS 7. 00 00700 OPERATI ON OF PLANT 8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 12. 00 01200 MAI NTENANCE OF PERSONNEL 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	175, 188					5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	11, 849				16.00
17. 00 01700 SOCIAL SERVICE 19. 00 01900 NONPHYSICIAN ANESTHETISTS	0	0		0		17. 00 19. 00
20. 00 02000 NURSI NG PROGRAM	0	0		0		
21. 00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0		21.00
22.00 02200 1&R SERVICES-OTHER PRGM COSTS APPRV 23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	•	0		22. 00 23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	-	-				
30. 00 03000 ADULTS & PEDI ATRI CS 43. 00 04300 NURSERY	0	2, 065 286		0		30. 00 43. 00
44. 00 04400 SKILLED NURSING FACILITY	0	0		0		44. 00
ANCILLARY SERVICE COST CENTERS		004	I		T	
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	301 0		0		50.00 52.00
53. 00 05300 ANESTHESI OLOGY	ō	0	•	0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0	2, 728 0		0		54. 00 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 67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 002 275		0		66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	Ö	58		0		68.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 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		0		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	175, 169	0		0		73.00
76. 97 O7697 CARDIAC REHABILITATION 76. 98 O7698 HYPERBARIC OXYGEN THERAPY	0	0		0		76. 97 76. 98
76. 99 07699 LI THOTRI PSY	0	0		0		76. 99
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0		77.00
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	U		0		78. 00
90. 00 09000 CLI NI C	0	0		O		90.00
90. 01 09001 INTENSI VE OUT PATI ENT PROGRAM 91. 00 09100 EMERGENCY	0	0 5, 134		0		90. 01 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		3, 134	·			92.00
OTHER REIMBURSABLE COST CENTERS		٥	Γ		T	05.00
95.00 09500 AMBULANCE SERVI CES 102.00 10200 OPI OI D TREATMENT PROGRAM	0	0		0		95. 00 102. 00
SPECIAL PURPOSE COST CENTERS	91	<u> </u>				
113. 00 11300 INTEREST EXPENSE	175 1/0	11 040				113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	175, 169	11, 849		0 0		118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	•	0		190. 00
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 194.00 07950 OCCUPATI ONAL HEALTH	0	0		0		192. 00 194. 00
194. 01 07951 PAIN CLINIC	0	0	l	0		194.00
194. 02 07952 OAK POINTE	0	0		0		194. 02
194. 03 07953 FOUNDATI ON 194. 04 07954 COMMUNI TY & VOLUNTEER SERVI CES	0	0		0		194. 03 194. 04
194. 05 07955 VACANT SPACE	0	0		0		194. 05
194. 06 07956 TELEHEALTH MEDICINE	0	0		0		194.06
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	0	n		0 0		200.00
202.00 TOTAL (sum lines 118 through 201)	175, 188	11, 849				202.00

Heal th Financial Systems

WHITLEY MEMORIAL HOSPITAL

Provider CCN: 15-0101

Period:
From 01/01/2023
To 12/31/2023

INTERNS & RESIDENTS

Cost Center Description

WHITLEY MEMORIAL HOSPITAL

Provider CCN: 15-0101
Period:
From 01/01/2023
To 12/31/2023
Part II
Date/Time Prepared:
5/23/2024 12: 06 pm

INTERNS & RESIDENTS

SERVICES-SALA SERVICES-OTHE
RY & FRINGES R PRGM COSTS
APPROV

APPROV

APPROV

APPROV

Cost & Post

			INTERNS &	RESI DENTS			5/23/2024 12:	U6 pili
		Cost Center Description	SERVI CES-SALA RY & FRI NGES APPRV	SERVI CES-OTHE R PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	CENED	AL SERVICE COST CENTERS	21. 00	22. 00	23. 00	24. 00	25. 00	
1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	00100 00200 00400 00500 00600 00700 00800 00900 01000	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY						1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00 23. 00	01200 01300 01400 01500 01600 01700 01900 02000 02100 02200 02300	CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS NURSING PROGRAM I&R SERVICES-SALARY & FRINGES APPRV I&R SERVICES-OTHER PRGM COSTS APPRV PARAMED ED PRGM-(SPECIFY) IENT ROUTINE SERVICE COST CENTERS	0	0	0			11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00 23. 00
30. 00 43. 00 44. 00	03000 04300	ADULTS & PEDIATRICS NURSERY SKILLED NURSING FACILITY				1, 297, 937 63, 633 0	0 0 0	30. 00 43. 00 44. 00
	ANCI L	LARY SERVICE COST CENTERS						
50. 00 52. 00 53. 00 54. 00 60. 00 62. 30 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00	05200 05300 05400 06000 06250 06500 06700 06800 06900 07100 07200	OPERATING ROOM DELIVERY ROOM & LABOR ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C LABORATORY BLOOD CLOTTING FOR HEMOPHILIACS RESPIRATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH PATHOLOGY ELECTROCARDI OLOGY MEDI CAL SUPPLIES CHARGED TO PATI ENT IMPL. DEV. CHARGED TO PATI ENTS DRUGS CHARGED TO PATI ENTS				737, 276 136, 892 0 947, 792 538, 278 0 230, 703 453, 669 129, 423 13, 719 0 78, 932 62, 374 853, 914	0 0 0 0 0 0 0 0 0	50. 00 52. 00 53. 00 54. 00 60. 00 62. 30 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00
76. 97 76. 98		CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY				0 429	0	76. 97 76. 98
76. 99 77. 00	07699 07700 07800	LITHOTRIPSY ALLOGENEIC HSCT ACQUISITION CAR T-CELL IMMUNOTHERAPY TIENT SERVICE COST CENTERS				0 0 0	0 0	76. 99 77. 00
90. 00	09000	CLINIC				979	0	90.00
	09100 09200	INTENSIVE OUT PATIENT PROGRAM EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS				0 1, 098, 430	0 0 0	90. 01 91. 00 92. 00
	09500 10200	AMBULANCE SERVICES OPIOID TREATMENT PROGRAM				356, 443 0		95. 00 102. 00
112 00		AL PURPOSE COST CENTERS INTEREST EXPENSE						113. 00
118.00	NONRE	SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	0	0	0	7, 000, 823		118. 00
192. 00 194. 00 194. 01 194. 02 194. 03	19200 07950 07951 07952 07953	GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES OCCUPATIONAL HEALTH PAIN CLINIC OAK POINTE FOUNDATION COMMUNITY & VOLUNTEER SERVICES				2, 126 149, 122 0 0 0 0 13, 598	0 0 0 0	190. 00 192. 00 194. 00 194. 01 194. 02 194. 03 194. 04
194.05	07955 07956	VACANT SPACE TELEHEALTH MEDICINE Cross Foot Adjustments Negative Cost Centers	0	0		0 0	0 0 0	194. 05 194. 06 200. 00 201. 00
						·		

WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
	Provi der C			Worksheet B	
			To 12/31/2023	Date/lime Pre	pared:
				5/23/2024 12:	06 pm
INTERNS &	RESI DENTS				
SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	Subtotal	Intern &	
RY & FRINGES	R PRGM COSTS	PRGM		Resi dents	
APPRV	APPRV			Cost & Post	
				Stendown	
21 00	22.00	22.00	24.00		
21.00	22.00	23.00			
0	0		0 7, 165, 669	0	202.00
	I NTERNS & SERVI CES-SALA RY & FRI NGES	I NTERNS & RESI DENTS SERVI CES-SALA SERVI CES-OTHE RY & FRI NGES APPRV RPRM COSTS APPRV	I NTERNS & RESI DENTS SERVI CES-SALA RY & FRI NGES APPRV Provi der CCN: 15-0101 PARAMED ED PRGM PRGM PRGM PRGM PRGM PRGM	Provi der CCN: 15-0101	Provider CCN: 15-0101 Period: From 01/01/2023 To 12/31/2023 Worksheet B Part II Date/Time Pres 5/23/2024 12: INTERNS & RESIDENTS SERVICES-SALA SERVICES-OTHE RY & FRINGES APPRV APPRV APPRV 21.00 22.00 23.00 24.00 25.00

Provider CCN: 15-0101

			5/23/2024 12:	06 pm
	Cost Center Description	Total		
	GENERAL SERVICE COST CENTERS	26. 00		
1. 00	00100 CAP REL COSTS-BLDG & FLXT			1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500 ADMINISTRATIVE & GENERAL			5.00
6. 00	00600 MAINTENANCE & REPAIRS			6.00
7. 00	00700 OPERATION OF PLANT			7.00
8. 00	00800 LAUNDRY & LINEN SERVICE			8.00
9.00	00900 HOUSEKEEPI NG			9.00
10.00	01000 DI ETARY			10.00
11. 00 12. 00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL			12.00
13. 00	01300 NURSING ADMINISTRATION			13.00
	01400 CENTRAL SERVICES & SUPPLY			14.00
15. 00	01500 PHARMACY			15.00
	01600 MEDICAL RECORDS & LIBRARY			16.00
17.00	01700 SOCI AL SERVI CE			17. 00
19.00	01900 NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000 NURSI NG PROGRAM			20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV			21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV			22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)			23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1 007 007		
30.00	03000 ADULTS & PEDI ATRI CS	1, 297, 937		30.00
43.00	04300 NURSERY	63, 633 0		43.00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS			44.00
50. 00	05000 OPERATING ROOM	737, 276		50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	136, 892		52.00
53. 00	05300 ANESTHESI OLOGY	0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	947, 792		54.00
60.00	06000 LABORATORY	538, 278		60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		62. 30
65.00	06500 RESPI RATORY THERAPY	230, 703		65.00
66. 00	06600 PHYSI CAL THERAPY	453, 669		66.00
67.00	06700 OCCUPATI ONAL THERAPY	129, 423		67.00
68.00	06800 SPEECH PATHOLOGY	13, 719		68.00
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0 78, 932		69. 00 71. 00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	62, 374		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	853, 914		73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	429		76. 98
76. 99	07699 LI THOTRI PSY	0		76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0		78. 00
	OUTPATIENT SERVICE COST CENTERS			
	09000 CLI NI C	979		90.00
	09001 INTENSIVE OUT PATIENT PROGRAM	0		90.01
	09100 EMERGENCY	1, 098, 430		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS			92.00
95 00	09500 AMBULANCE SERVICES	356, 443		95.00
	10200 OPI OI D TREATMENT PROGRAM	0 0		102.00
102.00	SPECIAL PURPOSE COST CENTERS			102.00
113.00	11300 I NTEREST EXPENSE			113.00
118.00		7, 000, 823		118.00
	NONREI MBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 126		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	149, 122		192. 00
	07950 OCCUPATI ONAL HEALTH	0		194. 00
	07951 PAIN CLINIC	0		194. 01
	07952 OAK POINTE	0		194. 02
	3 O7953 FOUNDATION	13 500		194. 03
	07954 COMMUNITY & VOLUNTEER SERVICES	13, 598		194. 04 194. 05
	07955 VACANT SPACE 07956 TELEHEALTH MEDICINE	0		194.05
200.00		0		200.00
200.00	1 1	0		200.00
202.00		7, 165, 669		202.00
_02.00	1.5 (Sa 111105 110 till Ough 201)	7, 100, 007		

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0101 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/23/2024 12:06 pm CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliatio ADMINISTRATIV Cost Center Description (SQUARE FEET) (SQUARE FEET) BENEFITS F & GENERAL n DEPARTMENT (ACCUM. COST) (GROSS SALARIES) 1. 00 2.00 4.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 159, 632 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 159, 632 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 31, 398, 375 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 49, 926 49, 926 8, 543, 990 -27, 593, 032 50, 148, 992 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 11,600 11,600 699, 621 0 2, 611, 399 7.00 00800 LAUNDRY & LINEN SERVICE 0 335, 125 8 00 542 542 8 00 949, 012 00900 HOUSEKEEPI NG 0 9.00 453 453 1, 438, 525 9.00 10.00 01000 DI ETARY 1, 942 1, 942 148, 588 287, 531 10.00 0 11.00 01100 CAFETERI A 2, 190 2, 190 435, 536 641, 523 11.00 0 01200 MAINTENANCE OF PERSONNEL 12 00 12 00 0 01300 NURSING ADMINISTRATION 13.00 132 132 678, 824 867, 937 13.00 01400 CENTRAL SERVICES & SUPPLY 0 25, 577 14.00 1.568 1, 568 14.00 0 01500 PHARMACY 1, 359 15.00 1.359 1,012,200 1.304.575 15.00 0 01600 MEDICAL RECORDS & LIBRARY 7, 879 16.00 483 483 0 16.00 17.00 01700 SOCIAL SERVICE 0 0 17.00 0 C 0 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 0 0 19.00 0 0 02000 NURSING PROGRAM 0 0 0 20 00 C 0 20 00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 C 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 0 22.00 0 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 21, 212 21, 212 3, 989, 141 0 6, 323, 344 30.00 04300 NURSERY 0 484, 848 43.00 358, 634 43.00 04400 SKILLED NURSING FACILITY 44.00 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 12,668 12, 668 1, 760, 113 3, 851, 790 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 750, 747 0 1,006,474 52.00 0 53.00 05300 ANESTHESI OLOGY 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 54 00 17.022 17,022 2, 658, 071 5, 030, 661 54 00 0 06000 LABORATORY 4, 390, 550 60.00 2,967 2, 967 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 62.30 06500 RESPIRATORY THERAPY 2.346 1, 231, 244 65.00 2.346 1, 568, 796 65, 00 66.00 06600 PHYSI CAL THERAPY 13, 857 13,857 817, 385 1, 227, 876 66.00 905, 307 67.00 06700 OCCUPATI ONAL THERAPY 0 1, 159, 700 67.00 06800 SPEECH PATHOLOGY 0 0 68.00 96, 270 123, 322 68.00 0 06900 ELECTROCARDI OLOGY 0 69.00 \cap 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 C 0 0 625, 762 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 581,820 72.00 0 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 6, 323, 823 73.00 0 07697 CARDIAC REHABILITATION 76.97 C 0 Ω 76.97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 4,000 76.98 76. 99 0 0 07699 LI THOTRI PSY 0 0 76.99 0 01 0 07700 ALLOGENEIC HSCT ACQUISITION 0 77 00 C 0 77 00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 0 0 0 0 90.01 09001 INTENSIVE OUT PATIENT PROGRAM \cap 0 0 90.01 91.00 09100 EMERGENCY 15, 526 15, 526 4, 129, 320 0 6, 062, 451 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0 0 2, 178, 597 0 3, 147, 657 95.00 102.00 10200 OPIOID TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113 00 49, 432, 945 118. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 155, 793 155, 793 31, 342, 600 -27, 593, 032 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 58 58 7, 032 190. 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 643, 093 192. 00 0 3.496 3, 496 55, 775 194. 00 07950 OCCUPATIONAL HEALTH 0 0 194.00 C 0 0 194.01 194. 01 07951 PAIN CLINIC 0 0 194. 02 07952 OAK POINTE 0 0 0 0 0 194. 02 194. 03 07953 FOUNDATION 0 C 0 0 0 194.03 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 285 65, 922 194. 04 285 194. 05 07955 VACANT SPACE 0 C 0 0 0 194.05 0 194.06 194. 06 07956 TELEHEALTH MEDICINE 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00

Health Fina	ancial Systems	WHITLEY MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10		
COST ALLOC	ATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 01/01/2023 Fo 12/31/2023		
		CAPITAL REL	LATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	DEPARTMENT	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
				(GROSS SALARI ES)			
		1. 00	2.00	4. 00	5A	5. 00	
202. 00	Cost to be allocated (per Wkst. B, Part I)	1, 118, 941	1, 484, 897	8, 178, 66	1	27, 593, 032	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	7. 009503	9. 302001	0. 260480		0. 550221	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)			(5, 376, 198	204.00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000000		0. 107205	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0101 Peri od: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

				1	0 12/31/2023	Date/lime Pre 5/23/2024 12:	
	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	оо рііі
		6. 00	7. 00	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	1					
15. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0 0 0 0 0 0 0	1, 568 1, 359	151, 515 0 0 0 0 0	97, 111 1, 942 2, 190 0 132 1, 568	15, 099 0 0 0 0	1.00 2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	483	0	483	0	16.00
17. 00 19. 00 20. 00 21. 00 22. 00 23. 00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	0 0 0 0 0	0 0 0 0 0	000000000000000000000000000000000000000	0 0 0 0 0	0 0 0 0 0	17. 00 19. 00 20. 00 21. 00 22. 00 23. 00
30.00	03000 ADULTS & PEDI ATRI CS	0	21, 212	10, 238	21, 212	15, 099	30.00
43.00	04300 NURSERY	0		26, 239		0	43.00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
50. 00 52. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	12, 668	50, 115	12, 668 0	0	50.00 52.00
53.00	05300 ANESTHESI OLOGY	0	1	0	_	0	53.00
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	17, 022 2, 967	0	17, 022 2, 967	0	54. 00 60. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		2, 907		2, 907	0	62.30
65.00	06500 RESPI RATORY THERAPY	0	2, 346	0	2, 346	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	13, 857	0	13, 857	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0		0	0	68. 00 69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT				0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	Ö	Ö	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98 76. 99	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	0	0	0	0	0	76. 98 76. 99
	07700 ALLOGENEIC HSCT ACQUISITION				0	0	77.00
	07800 CAR T-CELL IMMUNOTHERAPY	0	Ö	Ö	0	0	1
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	0	1	0	0	0	
	O9001 INTENSIVE OUT PATIENT PROGRAM O9100 EMERGENCY	0		64, 923	15, 526	0	90. 01 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		10,020	01,720	10, 020	Ü	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0				0	
102.00	10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
113.00	11300 I NTEREST EXPENSE						113.00
118.00		0	94, 267	151, 515	93, 272	15, 099	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 OCCUPATI ONAL HEALTH	0		0			192. 00 194. 00
	07951 PAIN CLINIC	0	Ö	Ö	o		194. 01
	07952 OAK POINTE	0	0	0	0		194. 02
	07953 FOUNDATION	0	0	0	0		194. 03
	07954 COMMUNITY & VOLUNTEER SERVICES 07955 VACANT SPACE	0	285	0	285		194. 04 194. 05
	07956 TELEHEALTH MEDICINE		0		ol		194.05
200.00	Cross Foot Adjustments	1					200. 00
201.00					0.015 = 1		201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	0	4, 048, 246	541, 883	2, 248, 725	570, 841	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	41. 264000	3. 576431	23. 156234	37. 806543	203. 00

Heal th Finar	ncial Systems	WHITLEY MEMORI	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 01/01/2023 To 12/31/2023	Date/Time Pre 5/23/2024 12:	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF		SERVED)	
				LAUNDRY)			
		6. 00	7. 00	8. 00	9. 00	10.00	
204.00	Cost to be allocated (per Wkst. B,	0	469, 168	47, 360	163, 772	75, 063	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	4. 782256	0. 312576	1. 686441	4. 971389	205.00
	[11]						
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						
·			•	•			-

	Financial Systems	WHITLEY MEMORI		20N 1F 0101 F		u of Form CMS-	
COSTA	LLOCATION - STATISTICAL BASIS		Provi der C		Period: From 01/01/2023	Worksheet B-1	
					o 12/31/2023		
	Cost Center Description	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	5/23/2024 12: PHARMACY	06 pm
		(FTES)	OF PERSONNEL	ADMI NI STRATI O	SERVICES &	(COSTED	
			(NUMBER	N	SUPPLY	REQUIS.)	
			HOUSED)	(DI RECT NRSI NG HRS)	(COSTED REQUIS.)		
		11. 00	12. 00	13.00	14. 00	15. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	OO200 CAP REL COSTS-MVBLE EQUIP OO400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 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 9. 00	OO8OO LAUNDRY & LI NEN SERVI CE OO9OO HOUSEKEEPI NG						8. 00 9. 00
10. 00	01000 DI ETARY						10.00
	01100 CAFETERI A	2, 427					11.00
	01200 MAI NTENANCE OF PERSONNEL	0	C	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			12.00
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	53		245, 209			13.00
	01500 PHARMACY	77				6, 143, 189	
	01600 MEDICAL RECORDS & LIBRARY	0	C			0	1
	01700 SOCIAL SERVICE	0	C		0	0	17. 00
	01900 NONPHYSI CI AN ANESTHETI STS	0	0		0	0	19.00
	02000 NURSING PROGRAM 02100 L&R SERVICES-SALARY & FRINGES APPRV	0) (0	0	20.00
	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	o o	Ċ		o o	Ö	1
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	C		0	0	23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	422		07.001	40, 202	0	20.00
	03000 ADULTS & PEDI ATRI CS 04300 NURSERY	422				0	
	04400 SKILLED NURSING FACILITY	0		1		0	1
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	183	C			0	
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	83		1		0	
	05400 RADI OLOGY-DI AGNOSTI C	330			_	0	1
60.00	06000 LABORATORY	0	С			0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C		0	0	62. 30
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	147 108			193, 090 8, 830	0	65. 00 66. 00
	06700 OCCUPATI ONAL THERAPY	96			13, 028	0	67.00
	06800 SPEECH PATHOLOGY	9	С	o c	0	0	
	06900 ELECTROCARDI OLOGY	0	C		_	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0			1, 208, 967	0	
	07300 DRUGS CHARGED TO PATIENTS	0			84, 155	6, 142, 514	1
76. 97	07697 CARDI AC REHABI LI TATI ON	0	C		0		76. 97
	07698 HYPERBARIC OXYGEN THERAPY	0	C		0	0	
	07699 LITHOTRIPSY 07700 ALLOGENEIC HSCT ACQUISITION	0			0	0	76. 99 77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0			0	0	1
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	20	C	1	113	0	
	09001 INTENSIVE OUT PATIENT PROGRAM 09100 EMERGENCY	0 488		1	0 469, 066	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	400		101, 739	407, 000	O	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	360	C	1		0	
102.00	10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	C) (0	0	102.00
113. 00	11300 INTEREST EXPENSE			Ι			113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	2, 416	C	245, 209	3, 917, 594	6, 142, 514	1
	NONREI MBURSABLE COST CENTERS	_				_	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0					190. 00 192. 00
	07950 OCCUPATI ONAL HEALTH	0			0		194.00
	07951 PAIN CLINIC	O	C		Ö		194. 01
	07952 OAK POINTE	0	C		0		194. 02
	07953 FOUNDATION	0			0		194.03
	07954 COMMUNITY & VOLUNTEER SERVICES 07955 VACANT SPACE				1, 924		194. 04 194. 05
	07956 TELEHEALTH MEDICINE				o o		194.06
200.00	Cross Foot Adjustments						200.00
201.00		1 125 500	,	1 270 70	140 (/1	2 140 100	201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	1, 135, 582	(1, 378, 796	140, 661	2, 148, 180	202.00
	(· · · · · · /	1	1	1	1	i	<u> </u>

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
				From 01/01/2023 To 12/31/2023		
Cost Center Description	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	PHARMACY	
	(FTES)	OF PERSONNEL	ADMI NI STRATI (SERVICES &	(COSTED	
		(NUMBER	N	SUPPLY	REQUIS.)	
		HOUSED)	(DI RECT	(COSTED		
			NRSING HRS)	REQUIS.)		
	11. 00	12. 00	13. 00	14.00	15. 00	
203.00 Unit cost multiplier (Wkst. B, Part I)	467. 895344	0. 000000	5. 62294	2 0. 035840	0. 349685	203. 00
204.00 Cost to be allocated (per Wkst. B,	118, 662	0	98, 64	5 38, 462	175, 188	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	48. 892460	0. 000000	0. 40228	9 0. 009800	0. 028517	205. 00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						

Health Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0101 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/23/2024 12:06 pm INTERNS & **RESI DENTS** MEDI CAL SOCI AL NONPHYSI CI AN NURSI NG SERVI CES-SALA Cost Center Description RY & FRINGES RECORDS & SERVI CE **ANESTHETLSTS PROGRAM** (ASSI GNED LI BRARY (TIME SPENT) **APPRV** (ASSI GNED (TIME SPENT) TIME) TIME) (ASSI GNED TIME) 16. 00 17. 00 19.00 20.00 21.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12 00 12 00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 10,000 16.00 17.00 01700 SOCIAL SERVICE 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 0 19.00 02000 NURSING PROGRAM 0 0 20 00 20 00 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22.00 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 1, 743 30.00 03000 ADULTS & PEDIATRICS 0 0 0 0 30.00 04300 NURSERY 0 0 0 0 43.00 43.00 241 04400 SKILLED NURSING FACILITY 44.00 0 0 0 0 44.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 254 0 0 0 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 0 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 54 00 2.302 0 0 54 00 06000 LABORATORY 60.00 60.00 0 0 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 62.30 06500 RESPIRATORY THERAPY 0 65.00 0 0 65.00 0 66.00 06600 PHYSI CAL THERAPY 846 0 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 232 0 0 67.00 06800 SPEECH PATHOLOGY 68.00 49 68.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 0 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 C 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 73.00 07697 CARDIAC REHABILITATION C 0 76.97 0 76.97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 76.98 76. 99 0 0 0 07699 LI THOTRI PSY 0 0 76.99 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 77 00 77 00 C 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 0 0 0 90.01 09001 INTENSIVE OUT PATIENT PROGRAM C 0 0 0 90.01 91.00 09100 EMERGENCY 4, 333 C 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0 0 0 0 Ol 95.00 102.00 10200 OPIOID TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 10,000 0 0 0 0 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 0 192.00 C o 194. 00 07950 OCCUPATIONAL HEALTH 0 0 0 0 194.00 194. 01 07951 PAIN CLINIC 0 0 0 0 194. 01 0 0 194. 02 07952 OAK POINTE 0 0 0 194. 02 194. 03 07953 FOUNDATI ON C 0 0 194.03 194. 04 07954 COMMUNITY & VOLUNTEER SERVICES 0 0 0 0 194.04 194. 05 07955 VACANT SPACE 0 0 0 0 0 194.05 194. 06 07956 TELEHEALTH MEDICINE 0 194, 06 0

200.00

201.00

Cross Foot Adjustments

Negative Cost Centers

200.00

201.00

Health Fina	ncial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der Co		Period: From 01/01/2023	Worksheet B-1	
					Γο 12/31/2023		
	Cont. Control Donnel at lan	MEDICAL	COCLAI	MONDHIVELCLAN	NUDCING	I NTERNS & RESI DENTS	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE (TIME SPENT)	NONPHYSI CI AN ANESTHETI STS (ASSI GNED		SERVI CES-SALA RY & FRI NGES APPRV	
		(TIME SPENT)		TIME)	TIME)	(ASSI GNED TIME)	
		16. 00	17. 00	19. 00	20.00	21. 00	
202. 00	Cost to be allocated (per Wkst. B, Part I)	43, 329	0		0	0	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	4. 332900	0. 000000	0. 00000	0. 000000	0.000000	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	11, 849	0	(0	0	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	1. 184900	0. 000000	0. 00000	0. 000000	0.000000	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0. 000000		207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 15-0101 Peri od: From 01/01/2023 To 12/31/2023 Worksheet B-1 Date/Time Prepared: 5/23/2024 12:06 pm INTERNS & RESI DENTS
SERVI CES-OTHE PARAMED ED Cost Center Description

		Cost Center Description	SERVI CES-OTHE	PARAMED ED		
			R PRGM COSTS	PRGM		
			APPRV (ASSI GNED	(ASSI GNED TIME)		
			TIME)	I I WIL)		
			22. 00	23. 00		
		AL SERVICE COST CENTERS				
1.00	1	CAP REL COSTS-BLDG & FIXT				1.00
2. 00 4. 00	1	CAP REL COSTS-MVBLE EQUIP				2.00
5. 00	1	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL				4. 00 5. 00
6. 00	1	MAINTENANCE & REPAIRS				6.00
7. 00	1	OPERATION OF PLANT				7.00
8.00	1	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPI NG				9. 00
10.00		DI ETARY				10.00
11.00	1	CAFETERI A				11.00
12.00		MAINTENANCE OF PERSONNEL				12.00
13. 00 14. 00	4	NURSING ADMINISTRATION				13. 00 14. 00
15. 00	1	CENTRAL SERVICES & SUPPLY PHARMACY				15.00
	1	MEDICAL RECORDS & LIBRARY				16.00
		SOCIAL SERVICE				17.00
	1	NONPHYSICIAN ANESTHETISTS				19.00
		NURSI NG PROGRAM				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRV	0			22.00
23. 00		PARAMED ED PRGM-(SPECIFY)		0		23.00
20.00		I ENT ROUTI NE SERVI CE COST CENTERS		0		20.00
30. 00 43. 00	1	ADULTS & PEDI ATRI CS NURSERY	0	0	•	30. 00 43. 00
	1	SKILLED NURSING FACILITY	0	0	•	44.00
44.00		LARY SERVICE COST CENTERS	<u> </u>			1 44.00
50.00		OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	1	ANESTHESI OLOGY	0	0		53.00
54.00	1	RADI OLOGY-DI AGNOSTI C	0	0	l .	54.00
60.00	1	LABORATORY	0	0	l .	60.00
62. 30 65. 00	1	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	l .	62.30
66.00	1	RESPI RATORY THERAPY PHYSI CAL THERAPY	0	0	l .	65. 00 66. 00
67. 00	1	OCCUPATI ONAL THERAPY	0	0	l .	67.00
68. 00	1	SPEECH PATHOLOGY	ő	0	l .	68.00
69.00	1	ELECTROCARDI OLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73. 00	1	DRUGS CHARGED TO PATIENTS	0	0	l .	73.00
76. 97	1	CARDI AC REHABI LI TATI ON	0	0	l .	76. 97
76. 98	1	HYPERBARI C OXYGEN THERAPY	0	0	l .	76. 98
76. 99 77. 00	1	LITHOTRIPSY ALLOGENEIC HSCT ACQUISITION	0	0	•	76. 99 77. 00
	1	CAR T-CELL IMMUNOTHERAPY	0	0	•	78.00
70.00		TIENT SERVICE COST CENTERS	V V			70.00
90.00		CLINIC	0	0		90.00
90. 01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0		90. 01
91.00		EMERGENCY	0	0		91.00
92.00		OBSERVATION BEDS (NON-DISTINCT PART				92.00
		REI MBURSABLE COST CENTERS				
		AMBULANCE SERVICES OPIOID TREATMENT PROGRAM	0	0		95.00
102.00		AL PURPOSE COST CENTERS	0	0		102.00
113 00		INTEREST EXPENSE				113.00
118.00	1	SUBTOTALS (SUM OF LINES 1 through 117)	0	0		118.00
		IMBURSABLE COST CENTERS	<u> </u>			1.10.00
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
		PHYSICIANS' PRIVATE OFFICES	0	0	•	192. 00
		OCCUPATIONAL HEALTH	이	0	l .	194.00
		PAIN CLINIC	0	0	l .	194. 01
		OAK POINTE	0	0		194. 02
	1	FOUNDATION COMMUNITY & VOLUNTEER SERVICES		0		194. 03 194. 04
	1	VACANT SPACE		0	l .	194. 04
		TELEHEALTH MEDICINE		0	l control of the cont	194.05
200.00	1	Cross Foot Adjustments				200.00
201.00	1	Negative Cost Centers				201.00

Health Fina	ancial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lieu	ı of Form CMS-255	52-10
COST ALLOC	ATION - STATISTICAL BASIS		Provi der C	CN: 15-0101	Peri od:	Worksheet B-1	
					From 01/01/2023 To 12/31/2023	Date/Time Prepa 5/23/2024 12:06	
	Cook Cooker Description	RESIDENTS	DADAMED ED				
	Cost Center Description	R PRGM COSTS APPRV (ASSI GNED	PARAMED ED PRGM (ASSI GNED TIME)				
		TIME)	•				
		22. 00	23. 00				
202. 00	Cost to be allocated (per Wkst. B, Part I)	0	0			20	02.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000			20	03.00
204. 00	Cost to be allocated (per Wkst. B, Part II)	0	0			20	04. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000			20	05.00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)		0			20	06. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0. 000000			20	07. 00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0101	From 01/01/2023	Worksheet C Part I Date/Time Prepared: 5/23/2024 12:06 pm
	Title XVIII	Hospi tal	PPS

				-	Γο 12/31/2023	Date/Time Pre 5/23/2024 12:	pared: 06 pm
			Title	XVIII	Hospi tal	PPS	
			<u>'</u>		Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
		1. 00	2.00	3. 00	4. 00	5. 00	
	PATIENT ROUTINE SERVICE COST CENTERS						
	DOO ADULTS & PEDIATRICS	12, 478, 020		12, 478, 020		12, 478, 020	
	300 NURSERY	869, 651		869, 65	1	869, 651	1
	400 SKILLED NURSING FACILITY	0		(0	0	44.00
	CILLARY SERVICE COST CENTERS	,					
	OOO OPERATING ROOM	7, 129, 348		7, 129, 348		7, 129, 348	
	200 DELIVERY ROOM & LABOR ROOM	1, 884, 030		1, 884, 030		1, 884, 030	
	300 ANESTHESI OLOGY	0		1	0	0	
	400 RADI OLOGY-DI AGNOSTI C	9, 066, 346		9, 066, 340		9, 066, 346	
	DOO LABORATORY	6, 997, 458		6, 997, 458		6, 997, 458	
	250 BLOOD CLOTTING FOR HEMOPHILIACS	0		l '	0	0	
	RESPI RATORY THERAPY	2, 658, 812	0	2,000,01	1	2, 658, 812	1
	600 PHYSI CAL THERAPY	2, 850, 665	0	2, 850, 66		2, 850, 665	
	700 OCCUPATI ONAL THERAPY	1, 844, 181	0	1, 844, 18 ⁻		1, 844, 181	
	BOO SPEECH PATHOLOGY	195, 599	0	195, 599		195, 599	
	900 ELECTROCARDI OLOGY	0		(۷۱ ۲	0	
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 013, 399		1, 013, 39	1	1, 013, 399	1
	200 I MPL. DEV. CHARGED TO PATIENTS	901, 950		901, 950	1	901, 950	
	300 DRUGS CHARGED TO PATIENTS	11, 954, 285		11, 954, 28		11, 954, 285	1
	697 CARDI AC REHABI LI TATI ON	0		(0	
	698 HYPERBARI C OXYGEN THERAPY	6, 201		6, 20		6, 201	76. 98
	699 LI THOTRI PSY	0		`	0	0	
	700 ALLOGENEIC HSCT ACQUISITION	0		1	0	0	77.00
	BOO CAR T-CELL IMMUNOTHERAPY	0			0	0	78. 00
	TPATIENT SERVICE COST CENTERS	0.040				0.040	
	DOO CLINIC	9, 362		9, 362		9, 362	1
	DO1 INTENSIVE OUT PATIENT PROGRAM	0		(٥,	0	90. 01
	100 EMERGENCY	11, 466, 624		11, 466, 624		11, 498, 002	1
	200 OBSERVATION BEDS (NON-DISTINCT PART	391, 440		391, 440)	391, 440	92.00
	HER REIMBURSABLE COST CENTERS 500 AMBULANCE SERVICES	F 0F2 114		F 0F2 11	1 2 022	F 0F/ 14/	05 00
	200 OPIOID TREATMENT PROGRAM	5, 053, 114 0		5, 053, 114		5, 056, 146	
	ECIAL PURPOSE COST CENTERS	l ol)	0	102.00
	300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	76, 770, 485	0	76, 770, 48!	34, 410	76, 804, 895	
200.00	Less Observation Beds	391, 440	0	391, 440		391, 440	
201.00	Total (see instructions)	76, 379, 045	0			•	
202.00	Tiotai (See Histiactions)	10,317,045	U	10, 317, 043	34,410	70, 413, 433	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	Peri od: Worksheet C From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

						To 12/31/2023	Date/Time Pre 5/23/2024 12:	
				Title	XVIII	Hospi tal	PPS	
				Charges				
		Cost Center Description	Inpati ent	Outpati ent		Cost or Other	TEFRA	
					+ col . 7)	Ratio	I npati ent	
			6. 00	7. 00	8. 00	9. 00	Rati o 10. 00	
	LNDAT	IENT ROUTINE SERVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
30. 00		ADULTS & PEDIATRICS	18, 903, 152		18, 903, 15	2		30.00
43. 00		NURSERY	2, 190, 820		2, 190, 82			43.00
		SKILLED NURSING FACILITY	2, 170, 020			Ö		44. 00
11.00		LARY SERVICE COST CENTERS	١			0		11.00
50. 00		OPERATING ROOM	5, 829, 649	38, 468, 839	44, 298, 48	8 0. 160939	0. 000000	50.00
52. 00		DELIVERY ROOM & LABOR ROOM	2, 894, 222	142, 907			0.000000	
53.00	05300	ANESTHESI OLOGY	0	0		0. 000000	0. 000000	53.00
54.00	05400	RADI OLOGY-DI AGNOSTI C	4, 957, 549	63, 289, 310	68, 246, 85	9 0. 132846	0. 000000	54.00
60.00	06000	LABORATORY	7, 375, 885	48, 977, 471	56, 353, 35	6 0. 124171	0. 000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0. 000000	0. 000000	62. 30
65.00	06500	RESPI RATORY THERAPY	3, 250, 469	15, 246, 588	18, 497, 05	7 0. 143742	0.000000	65.00
66.00	06600	PHYSI CAL THERAPY	425, 763	8, 032, 422	8, 458, 18	5 0. 337030	0. 000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	366, 636	1, 917, 021	2, 283, 65	7 0. 807556	0. 000000	67.00
68. 00		SPEECH PATHOLOGY	174, 764	358, 856	533, 62		0. 000000	
69. 00		ELECTROCARDI OLOGY	0	0		0. 000000	0. 000000	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	864, 392	4, 279, 535			0. 000000	
72.00		IMPL. DEV. CHARGED TO PATIENTS	118, 641	3, 519, 563			0. 000000	72.00
73. 00		DRUGS CHARGED TO PATIENTS	5, 923, 676	36, 952, 154	42, 875, 83		0. 000000	
76. 97		CARDIAC REHABILITATION	0	0		0. 000000	0. 000000	
76. 98		HYPERBARIC OXYGEN THERAPY	0	0		0. 000000	0. 000000	
76. 99		LI THOTRI PSY	0	0		0. 000000	0. 000000	
77. 00		ALLOGENEIC HSCT ACQUISITION	0	0		0. 000000	0. 000000	
78. 00		CAR T-CELL IMMUNOTHERAPY	0	0		0. 000000	0. 000000	78. 00
		TIENT SERVICE COST CENTERS	1 005					
90.00		CLINIC	1, 885	0	.,		0.000000	
90. 01		INTENSIVE OUT PATIENT PROGRAM	7 510 027	74 475 111		0.000000	0.000000	
91.00		EMERGENCY	7, 519, 937	74, 475, 111			0.000000	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS	338, 026	3, 136, 955	3, 474, 98	0. 112645	0. 000000	92.00
05 00		AMBULANCE SERVICES	l ol	14, 301, 367	14, 301, 36	7 0. 353331	0. 000000	95. 00
		OPLOID TREATMENT PROGRAM		14, 301, 307		0. 333331	0.00000	102.00
102.00		AL PURPOSE COST CENTERS	ı o	0		O _I		102.00
113.00		INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	61, 135, 466	313, 098, 099	374, 233, 56	5		200.00
201.00		Less Observation Beds	1 21,122,100	2.2/2.2/0//				201.00
202.00	4	Total (see instructions)	61, 135, 466	313, 098, 099	374, 233, 56	5		202.00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0101	Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/23/2024 12:06 pm

				5/23/2024 12:06 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
43. 00 04300 NURSERY				43.00
44.00 O4400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 160939			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 620333			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 132846			54.00
60. 00 06000 LABORATORY	0. 124171			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65. 00 06500 RESPI RATORY THERAPY	0. 143742			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 337030			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 807556			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 366551			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 197009			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 247911			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 278812			73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
76. 98 07698 HYPERBARIC OXYGEN THERAPY	0. 000000			76. 98
76. 99 07699 LI THOTRI PSY	0. 000000			76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
78.00 O7800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	4. 966578			90.00
90.01 09001 INTENSIVE OUT PATIENT PROGRAM	0. 000000			90. 01
91. 00 09100 EMERGENCY	0. 140228			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 112645			92. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 353543			95. 00
102.00 10200 OPI OI D TREATMENT PROGRAM				102. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202.00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL		In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der	CCN: 15-0101	To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/23/2024 12:06 pm
	т.	11 . 1/11/	11	200

5/23/2024 12:	
Cocts	
COSIS	
Cost Center Description Total Cost Therapy Limit Total Costs RCE Total Costs	
(from Wkst. Adj. Disallowance	
B, Part I,	
col. 26)	
1.00 2.00 3.00 4.00 5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00 03000 ADULTS & PEDI ATRI CS 12, 478, 020 12, 478, 020 0 12, 478, 020	30.00
43. 00 04300 NURSERY 869, 651 869, 651 0 869, 651	43.00
44.00 04400 SKILLED NURSING FACILITY 0 0 0 0	44.00
ANCILLARY SERVICE COST CENTERS	
50. 00 05000 0PERATI NG ROOM 7, 129, 348 7, 129, 348 0 7, 129, 348	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 1,884,030 1,884,030 0 1,884,030	52.00
53. 00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 9, 066, 346 9, 066, 346 0 9, 066, 346	54.00
60. 00 06000 LABORATORY 6, 997, 458 6, 997, 458 0 6, 997, 458	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 0 0 0 0 0 0	62.30
65. 00 06500 RESPI RATORY THERAPY 2, 658, 812 0 2, 658,	65.00
66. 00 06600 PHYSI CAL THERAPY 2, 850, 665 0 2, 850, 650, 650, 650, 650, 650, 650, 650, 6	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 1,844,181 0 1,844,181 0 1,844,181 68. 00 06800 SPEECH PATHOLOGY 195,599 0 195,599 0 195,599	67.00
68. 00 06800 SPEECH PATHOLOGY 195, 599 0 195, 599 0 195, 599 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0	68. 00 69. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 1, 013, 399 1, 013, 399 0 1, 013, 399	71.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1,013,399	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 11, 954, 285 11, 954, 285 0 11, 954, 285	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0	76. 97
76. 98 07698 HYPERBARI C 0XYGEN THERAPY 6, 201 6, 201 0 6, 201	76. 98
76. 99 07699 LI THOTRI PSY	76. 99
77.00 O7700 ALLOGENEI C HSCT ACQUISITION 0 0 0	77. 00
78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0 0 0 0	78.00
OUTPATIENT SERVICE COST CENTERS	70.00
90. 00 09000 CLINI C 9, 362 9, 362 0 9, 362	90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM 0 0 0 0	90. 01
91. 00 09100 EMERGENCY 11, 466, 624 11, 466, 624 31, 378 11, 498, 002	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 391,440 391,440 391,440 391,440	92.00
OTHER REIMBURSABLE COST CENTERS	
95. 00 O9500 AMBULANCE SERVICES 5, 053, 114 5, 053, 114 3, 032 5, 056, 146	95.00
102. 00 10200 OPI 0I D TREATMENT PROGRAM 0 0 0	02.00
SPECIAL PURPOSE COST CENTERS	
113. 00 11300 I NTEREST EXPENSE	13.00
200. 00 Subtotal (see instructions) 76, 770, 485 0 76, 770, 485 34, 410 76, 804, 895	
201.00 Less Observation Beds 391, 440 391, 440 391, 440	
202.00 Total (see instructions) 76,379,045 0 76,379,045 34,410 76,413,455	202. 00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0101	Period: Worksheet C From 01/01/2023 Part I
		To 12/31/2023 Date/Time Prepared:

					To 12/31/2023	Date/Time Pre 5/23/2024 12:	
			Ti tl	e XIX	Hospi tal	PPS	оо р
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·		•	+ col. 7)	Rati o	I npati ent	
				ĺ		Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	18, 903, 152		18, 903, 15	2	i	30.00
43.00	04300 NURSERY	2, 190, 820		2, 190, 82	0	1	43.00
44.00	04400 SKILLED NURSING FACILITY	0			0	i	44.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	5, 829, 649	38, 468, 839	44, 298, 48	0. 160939	0. 000000	50.00
	05200 DELIVERY ROOM & LABOR ROOM	2, 894, 222	142, 907	3, 037, 12	9 0. 620333	0.000000	
53.00	05300 ANESTHESI OLOGY	0	0		0. 000000	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 957, 549	63, 289, 310	68, 246, 85	9 0. 132846	0.000000	54.00
60.00	06000 LABORATORY	7, 375, 885	48, 977, 471	56, 353, 35	6 0. 124171	0.000000	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0. 000000	0.000000	62. 30
65.00	06500 RESPI RATORY THERAPY	3, 250, 469	15, 246, 588	18, 497, 05	7 0. 143742	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	425, 763	8, 032, 422	8, 458, 18	0. 337030	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	366, 636	1, 917, 021	2, 283, 65	7 0. 807556	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	174, 764	358, 856	533, 62	0. 366551	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0. 000000	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	864, 392	4, 279, 535	5, 143, 92	7 0. 197009	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	118, 641	3, 519, 563	3, 638, 20	0. 247911	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 923, 676	36, 952, 154	42, 875, 83	0. 278812	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
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0. 000000	0.000000	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0. 000000	0.000000	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	1, 885	0	1, 88	5 4. 966578	0.000000	90.00
	09001 INTENSIVE OUT PATIENT PROGRAM	0	0		0. 000000	0.000000	90. 01
91.00	09100 EMERGENCY	7, 519, 937	74, 475, 111	81, 995, 04	0. 139845	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	338, 026	3, 136, 955	3, 474, 98	0. 112645	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	14, 301, 367	14, 301, 36	7 0. 353331	0. 000000	95.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0		0		102.00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE					1	113.00
200.00		61, 135, 466	313, 098, 099	374, 233, 56	5		200. 00
201.00							201.00
202.00	Total (see instructions)	61, 135, 466	313, 098, 099	374, 233, 56	5		202.00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL		In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der	CCN: 15-0101	From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/23/2024 12:06 pm

				5/23/2024 12:06 pm
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
43. 00 04300 NURSERY				43.00
44.00 04400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 160939			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 620333			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 132846			54.00
60. 00 06000 LABORATORY	0. 124171			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 143742			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 337030			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 807556			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 366551			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 197009			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 247911			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 278812			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
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	4. 966578			90.00
90.01 09001 INTENSIVE OUT PATIENT PROGRAM	0. 000000			90. 01
91. 00 09100 EMERGENCY	0. 140228			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 112645			92.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 353543			95.00
102.00 10200 OPIOLD TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 NTEREST EXPENSE				113.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems		WHI TLEY	MEMORI AL	HOSPI TAL		In Lieu	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST	TO CHARGE	RATIOS NET	OF	Provi der (CCN: 15-0101	From 01/01/2023	Worksheet C Part II Date/Time Prepared:

					To 12/31/2023	Date/Time Pre 5/23/2024 12:	pared:
			Ti tl	e XIX	Hospi tal	PPS	оо рііі
	Cost Center Description	Total Cost	Capital Cost	Operating	Capi tal	Operating	
	μ	(Wkst. B,	(Wkst. B,	Cost Net of	Reducti on	Cost	
		Part I, col.	Part II col.	Capital Cost		Reduction	
		26)	26)	(col. 1 -		Amount	
		ŕ		col . 2)			
		1. 00	2. 00	3.00	4. 00	5. 00	
	LARY SERVICE COST CENTERS			,			
	OPERATING ROOM	7, 129, 348	737, 276			0	00.00
	DELIVERY ROOM & LABOR ROOM	1, 884, 030	136, 892	1, 747, 13	8 0	0	
	ANESTHESI OLOGY	0	0		0	0	
	RADI OLOGY-DI AGNOSTI C	9, 066, 346	947, 792			0	
	LABORATORY	6, 997, 458	538, 278	6, 459, 18	0	0	60.00
	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0	62. 30
	RESPI RATORY THERAPY	2, 658, 812	230, 703			0	65.00
66.00 06600	PHYSI CAL THERAPY	2, 850, 665	453, 669	2, 396, 99	6 0	0	66. 00
	OCCUPATI ONAL THERAPY	1, 844, 181	129, 423	1, 714, 75	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	195, 599	13, 719	181, 88	0	0	68. 00
	ELECTROCARDI OLOGY	0	0		0	0	69. 00
	MEDICAL SUPPLIES CHARGED TO PATIENT	1, 013, 399	78, 932	934, 46	7 0	0	
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	901, 950	62, 374	839, 57	6 0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	11, 954, 285	853, 914	11, 100, 37	1 0	0	73.00
76. 97 07697	CARDIAC REHABILITATION	0	0		0 0	0	76. 97
76. 98 07698	HYPERBARIC OXYGEN THERAPY	6, 201	429	5, 77	2 0	0	76. 98
76. 99 07699	LI THOTRI PSY	0	0		0 0	0	76. 99
77. 00 07700	ALLOGENEIC HSCT ACQUISITION	O	0		0	0	77. 00
78.00 07800	CAR T-CELL IMMUNOTHERAPY	O	0		0	0	78. 00
OUTPA	ATIENT SERVICE COST CENTERS						
	CLINIC	9, 362	979	8, 38	3 0	0	90.00
90. 01 09001	INTENSIVE OUT PATIENT PROGRAM	0	0		0 0	0	90. 01
91.00 09100	EMERGENCY	11, 466, 624	1, 098, 430	10, 368, 19	4 0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	391, 440	40, 717	350, 72	3 0	0	92.00
OTHER	R REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	5, 053, 114	356, 443	4, 696, 67	1 0	0	95.00
102. 00 10200	OPIOID TREATMENT PROGRAM	0	0		0 0	0	102.00
	AL PURPOSE COST CENTERS						
	INTEREST EXPENSE						113. 00
200.00	Subtotal (sum of lines 50 thru 199)	63, 422, 814	5, 679, 970	57, 742, 84	4 0		200. 00
201.00	Less Observation Beds	391, 440	40, 717	350, 72	3 0		201.00
202.00	Total (line 200 minus line 201)	63, 031, 374	5, 639, 253	57, 392, 12	1 0	0	202. 00

Heal th Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY Provider CCN: 15-0101 Provider CCN: 15-0101 Provider CCN: 15-0101 From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared:

Cost Center Description						10 12/31/202	5/23/2024 12:	
Capi tal and Operating Cost to Charge Ratio Coli of / Col				Ti tl	e XIX	Hospi tal	PPS	
ANCILLARY SERVICE COST CENTERS Reduction Cost Reduction Reduction Cost Reduction Redu		Cost Center Description						
Cost Reduction Col 7			•					
Reduct i on)		
ANCILLARY SERVICE COST CENTERS				column 8)				
ANCI LLARY SERVICE COST CENTERS								
50.00			6. 00	7. 00	8. 00			
52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 884, 030 3, 037, 129 0, 620333 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0						1		
53.00 05300 AMESTHESI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
54. 00 05400 RADI OLOGY-DI AGNOSTI C 9, 066, 346 68, 246, 859 0. 132846 54. 00 60. 00 06000 LABORATORY 6, 997, 458 56, 353, 356 0. 124171 60. 00 62. 30 06250 BLODO CLOTTI NG FOR HEMOPHI LI ACS 0 0 0 0. 000000 65. 00 06500 RESPI RATORY THERAPY 2, 850, 665 8, 458, 185 0. 337030 66. 00 66. 00 06600 PHYSI CAL THERAPY 1, 844, 181 2, 283, 657 0. 807556 67. 00 68. 00 06600 OCCUPATI ONAL THERAPY 1, 844, 181 2, 283, 657 0. 807556 67. 00 69. 00 06600 SPECCH PATHOLOGY 195, 599 533, 620 0. 366551 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0. 000000 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 1, 013, 399 5, 143, 927 0. 197009 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 901, 950 3, 638, 204 0. 247911 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 11, 954, 285 42, 875, 830 0. 278812 73. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0. 000000 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 6, 201 0 0. 000000 76. 98 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TION 0 0 0. 000000 77. 00 78. 00 07800 CAR T-CELL I IMMUNTHERAPY 0 0 0. 000000 77. 00 79. 00 07900 CLINIC 9, 362 8, 855 4, 966578 90. 00 90. 01 90000 ELINIC 9, 362 8, 95, 048 0. 139845 91. 00 91. 00 09000 DITRETISIS 0 0 0. 000000 90. 01 91. 00 09100 EMERGENCY 11, 466, 624 81, 995, 048 0. 139845 91. 00 92. 00 09500 AMBULANCE SERVI CES 5, 053, 114 14, 301, 367 0. 353331 95. 00 92. 00 09500 AMBULANCE SERVI CES 5, 053, 114 14, 301, 367 0. 353331 95. 00 92. 00 09500 ONDO 0 0 0 0 0 0 0 92. 00 09500 ONDO 0 0 0 0 0 0 92. 00 09500 ONDO 0 0 0 0 0 0 0 92. 00 00500 0 0 0 0 0 0 0			1 ' ' '					
60. 00 06000 LABORATORY 6, 997, 458 56, 353, 356 0. 124171 60. 00 62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 0. 000000 62. 30 65. 00 06500 RESPIRATORY THERAPY 2, 658, 812 18, 497, 057 0. 143742 65. 00 66. 00 06600 PHYSI CAL THERAPY 2, 850, 665 8, 458, 185 0. 337030 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 1, 844, 181 2, 283, 657 0. 807556 67. 00 68. 00 06600 SPEECH PATHOLOGY 195, 599 533, 620 0. 366551 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0. 000000 69. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1, 013, 399 5, 143, 927 0. 197009 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 901, 950 3, 638, 204 0. 247911 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 11, 954, 285 42, 875, 830 0. 278812 73. 00 76. 99 07697 CARDI JAC REHABILITATION 0 0 0 0. 000000 76. 97 76. 99 07697 CARDI JAC REHABILITATION 0 0 0. 000000 76. 97 76. 99 07699 LITHORIP PSY 6, 201 0 0. 000000 76. 98 76. 99 07699 LITHORIP PSY 0 0 0 0. 000000 76. 98 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0. 000000 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0. 000000 77. 00 79. 00 07000 CLI NI C 9, 362 1, 885 4, 966578 90. 00 90. 01 09000 CLI NI C 9, 362 1, 885 4, 966578 90. 00 91. 00 09100 EMERGENCY 11, 466, 624 81, 995, 048 0. 139845 91. 00 92. 00 09200 085ERVATI ON BEDS (NON-DI STI NCT PART 391, 440 3, 474, 981 0. 112645 92. 00 92. 00 09500 AMBULANCE SERVI CES 5, 053, 114 14, 301, 367 0. 353331 95. 00 95. 00 09500 AMBULANCE SERVI CES 5, 053, 114 14, 301, 367 0. 353331 95. 00 90. 00 10000 10 TREATMENT PROGRAM 0 0 0. 000000 10. 000000 91. 00 09500 AMBULANCE SERVI CES 5, 053, 114 14, 301, 367 0. 353331 95. 00 92. 00 09500 AMBULANCE SERVI CES 5, 053, 114 14, 301, 367 0. 353331 95. 00 910. 00 0000 0000 0000			_					
62. 30 06250 BLODD CLOTTI NG FOR HEMOPHILIACS 0 0 0.000000 62. 30 65. 00 06500 RESPI RATORY THERAPY 2, 658, 812 18, 497, 577 0.143742 65. 00 66. 00 06600 PHYSI CAL THERAPY 2, 850, 665 8, 458, 185 0. 337030 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 1, 844, 181 2, 283, 657 0. 807556 67. 00 68. 00 06800 SPEECH PATHOLOGY 195, 599 533, 620 0. 366551 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0. 000000 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 1, 013, 399 5, 143, 927 0. 197009 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 901, 950 3, 638, 204 0. 247911 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 11, 954, 285 42, 875, 830 0. 278812 73. 00 76. 97 07697 CARDI AC REHABILLI TATI ON 0 0 0. 000000 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 6, 201 0 0. 000000 76. 98 76. 99 07699 LITHOTRI PSY 0 0 0. 000000 77. 00 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0. 000000 77. 00 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0 0 0. 000000 0. 000000 78. 00 90. 01 09000 DEBECKATION BEDS (NON-DI STI NCT PART 391, 440 3, 474, 981 0. 112645 92. 00 91. 00 09500 AMBULANCE SERVI CES 5, 053, 114 14, 301, 367 0. 353331 95. 00 95ECT AL PURPOSE COST CENTERS 113. 00 102. 00 00000 DI DI TREATMENT PROGRAM 0 0 0. 000000 1000000 1000000 1000000 1000000 1000000 1000000 10000000 1000000 10000000 10000000 10000000 10000000 100000000								
65. 00			1 ' ' '	56, 353, 356				
66. 00 06600 PHYSICAL THERAPY			_	_				
67. 00 06700 OCCUPATIONAL THERAPY 1, 844, 181 2, 283, 657 0, 807556 68. 00 06800 SPEECH PATHOLOGY 195, 599 533, 620 0, 366551 68. 00 06900 ELECTROCARDI OLOGY 0 0 0, 0000000 69. 00 0, 0000000 69. 00 0, 0000000 69. 00 0, 0000000 69. 00 0, 0000000 69. 00 0, 0000000 69. 00 0, 0000000 69. 00 0, 0000000 69. 00 0, 0000000 69. 00 0, 0000000 71. 00 0 0, 000000 71. 00 0 0, 000000 71. 00 0, 000000 72. 00 0, 000000 72. 00 0, 000000 72. 00 0, 000000 72. 00 0, 000000 72. 00 0, 000000 72. 00 0, 000000 73. 00 0, 000000 74. 00 0, 000000 75. 00 0, 000000 0, 000000 75. 00 0, 0000								
68. 00								
69. 00 06900 ELECTROCARDI OLOGY 0 0.000000 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 1, 013, 399 5, 143, 927 0.197009 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 901, 950 3, 638, 204 0.247911 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 11, 954, 285 42, 875, 830 0.278812 73. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0.000000 76. 97 76. 98 07699 RIYPERBARI C OXYGEN THERAPY 6, 201 0 0.000000 76. 98 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0.000000 77. 09 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0.000000 77. 09 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0 0 0.000000 77. 09 90. 01 09001 INTENSI VE OUT PATI ENT PROGRAM 0 0.000000 90.000000 90. 0000000 90. 000000 90. 000000 90. 000000 90. 000000 90. 000000 90. 000000 90. 000000 90. 000000 90. 000000 90. 000000 90. 000000 90. 0000000 90. 000000 90. 000000 90. 000000 90. 000000 90. 000000 90. 0000000 90. 000000 90. 000000 90. 0000000 90. 0000000 90. 0000000 90. 0000000 90. 0000000 90. 0000000 90. 0000000 90. 00000000								
71. 00			195, 599	533, 620				
72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 901, 950 3, 638, 204 0. 247911 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 11, 954, 285 42, 875, 830 0. 278812 73. 00 76. 97 76. 97 CARDI AC REHABI LI TATI ON 0 0 0. 000000 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 6, 201 0 0. 000000 76. 98 76. 99 07699 LITHOTRI PSY 0 0 0. 000000 0. 000000 77. 00 77. 00 07700 ALLOGENEI C HSCT ACQUI SITI ON 0 0 0. 000000 0. 000000 0. 000000 77. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 000000 0. 000000			_	_				
73. 00								
76. 97			901, 950	3, 638, 204	0. 24791	11		
76. 98 07698 HYPERBARIC OXYGEN THERAPY 6, 201 0 0.000000 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0.000000 76. 99 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0.000000 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0.000000 77. 00 78. 00 0000 CLI NI C 9, 362 1, 885 4. 966578 90. 00 90. 01 09001 INTENSI VE OUT PATI ENT PROGRAM 0 0 0.000000 90. 01 91. 00 09100 EMERGENCY 11, 466, 624 81, 995, 048 0.139845 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 391, 440 3, 474, 981 0.112645 92. 00 95. 00 09500 AMBULANCE SERVI CES 5, 053, 114 14, 301, 367 0.353331 95. 00 102. 00 09500 AMBULANCE SERVI CES 5, 053, 114 14, 301, 367 0.000000 102. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 200. 00 Subtotal (sum of lines 50 thru 199) 63, 422, 814 353, 139, 593 200. 00 Subtotal (sum of lines 50 thru 199) 63, 422, 814 353, 139, 593 200. 00 201. 00 Less Observation Beds 391, 440 0 201. 00	73.00 07300	DRUGS CHARGED TO PATIENTS	11, 954, 285	42, 875, 830	0. 27881	12		73.00
76. 99 07699 LITHOTRIPSY 0 0 0.000000 76. 99 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0.000000 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0.000000 78. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 9, 362 1, 885 4.966578 90. 00 90. 01 09001 INTENSIVE OUT PATIENT PROGRAM 0 0 0.000000 99. 01 91. 00 09100 EMERGENCY 11, 466, 624 81, 995, 048 0.139845 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 391, 440 3, 474, 981 0.112645 92. 00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 5, 053, 114 14, 301, 367 0.35331 95. 00 102. 00 09500 AMBULANCE SERVICES 5, 053, 114 14, 301, 367 0.000000 10 D TREATMENT PROGRAM 0 0 0.000000 10 D TREATMENT PROGRAM 0 0 0 0.000000 10 D TREATMENT PROGRAM 0 0 0 0.000000 10 D TREATMENT PROGRAM 0 0 0 0.000000 10 D T	76. 97 07697	7 CARDIAC REHABILITATION	0	0	0. 00000	00		76. 97
77. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0 0 0 0 0 0 0 0 0	76. 98 07698	HYPERBARIC OXYGEN THERAPY	6, 201	0	0. 00000	00		76. 98
78. 00	76. 99 07699	P LI THOTRI PSY	0	0				
OUTPATIENT SERVICE COST CENTERS 90.00 O O O O O O O O O	77. 00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0. 00000	00		77. 00
90. 00 09000 CLINIC 9, 362 1, 885 4. 966578 90. 00 90. 01 09001 NTENSIVE OUT PATIENT PROGRAM 0 0 0. 0000000 90. 01 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 0900000 090000 0900000 0900000 0900000 0900000 0900000 09000000 090000000 090000000 0900000000	78.00 07800	CAR T-CELL IMMUNOTHERAPY	0	0	0. 00000	00		78. 00
90. 01 09001 NTENSI VE OUT PATIENT PROGRAM 0 0 0.0000000 90. 01 09100 EMERGENCY 11, 466, 624 81, 995, 048 0.139845 91. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 391, 440 3, 474, 981 0.112645 92. 00 OTHER REI MBURSABLE COST CENTERS 5, 053, 114 14, 301, 367 0.353331 95. 00 10200 OPIOI D TREATMENT PROGRAM 0 0.000000 102. 00 ODIOI D TREATMENT PROGRAM 0 0.000000 0.000000 102. 00 ODIOI D TREATMENT PROGRAM 0 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000								
91. 00 09100 EMERGENCY 11, 466, 624 81, 995, 048 0. 139845 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 391, 440 3, 474, 981 0. 112645 92. 00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 5, 053, 114 14, 301, 367 0. 353331 95. 00 10200 OPIOI D TREATMENT PROGRAM 0 0 0. 000000 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 200. 00 Subtotal (sum of lines 50 thru 199) 63, 422, 814 353, 139, 593 200. 00 201. 00 Less Observation Beds 391, 440 0 201. 00 201. 00	90.00 09000	CLI NI C	9, 362	1, 885	4. 96657	78		90.00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 391, 440 3, 474, 981 0.112645 92. 00 95. 00 09500 AMBULANCE SERVI CES 5, 053, 114 14, 301, 367 0. 353331 95. 00 102. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 200. 00 Subtotal (sum of lines 50 thru 199) 63, 422, 814 353, 139, 593 200. 00 201. 00 Less Observation Beds 391, 440 0 201. 00 201. 00			0	0	0. 00000	00		90. 01
OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 5,053,114 14,301,367 0.353331 95.00 102.00 10 TREATMENT PROGRAM 0 0 0.000000 102.00 SPECI AL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 200.00 Subtotal (sum of lines 50 thru 199) 63,422,814 353,139,593 200.00 201.00 Less Observation Beds 391,440 0 201.00	91.00 09100	EMERGENCY	11, 466, 624	81, 995, 048	0. 13984	45		91.00
95. 00 09500 AMBULANCE SERVICES 5,053,114 14,301,367 0.353331 95. 00 10200 0PI 0I D TREATMENT PROGRAM 0 0 0.000000 102. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE Subtotal (sum of lines 50 thru 199) 63,422,814 353,139,593 200. 00 201. 00 Less Observation Beds 391,440 0 201. 00	92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	391, 440	3, 474, 981	0. 11264	45		92.00
102.00 10200 OPI OI D TREATMENT PROGRAM O O 0.000000 102.00	OTHER	R REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (sum of lines 50 thru 199) 63,422,814 353,139,593 200.00 201.00 Less Observation Beds 391,440 0 201.00	95.00 09500	AMBULANCE SERVICES	5, 053, 114	14, 301, 367	0. 35333	31		95.00
113.00	102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0. 00000	00		102.00
200.00 Subtotal (sum of lines 50 thru 199) 63,422,814 353,139,593 200.00 201.00 Less Observation Beds 391,440 0	SPECI	AL PURPOSE COST CENTERS						
201.00 Less Observation Beds 391,440 0 201.00	113. 00 11300							113.00
			63, 422, 814	353, 139, 593				
202.00 Total (line 200 minus line 201) 63,031,374 353,139,593 202.00	201.00	Less Observation Beds	391, 440	0				
	202.00	Total (line 200 minus line 201)	63, 031, 374	353, 139, 593				202.00

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lieu of Form CMS-255			
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2023	Worksheet D Part I		
				To 12/31/2023		pared.	
				.0 12,01,2020	5/23/2024 12:	06 pm	
		Title	XVIII	Hospi tal	PPS		
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient			
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /		
	(from Wkst.		Related Cost		col. 4)		
	B, Part II,		(col. 1 -				
	col. 26)		col . 2)				
	1. 00	2. 00	3. 00	4. 00	5. 00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDIATRICS	1, 297, 937		1, 297, 93				
43. 00 NURSERY	63, 633		63, 633	524			
44.00 SKILLED NURSING FACILITY	0		(0	0. 00		
200.00 Total (lines 30 through 199)	1, 361, 570		1, 361, 570	5, 720		200.00	
Cost Center Description	Inpatient	I npati ent					
	Program days	Program					
		Capital Cost					
		(col. 5 x					
	/ 00	col . 6)					
INDATIENT DOUTINE CEDVICE COCT CENTEDO	6. 00	7. 00					
INPATIENT ROUTINE SERVICE COST CENTERS	1 000	272 021				20.00	
30. 00 ADULTS & PEDIATRICS	1, 093	273, 031			l	30.00	
43. 00 NURSERY	0	0			l	43.00	
44.00 SKILLED NURSING FACILITY	1 000	0 272 021			ļ	44.00	
200.00 Total (lines 30 through 199)	1, 093	273, 031	I			200. 00	

Heal th Financial	Systems	١	WHITLEY MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTI ONMENT OF	INPATIENT ANCILLARY SERVICE	CAPITAL	COSTS	Provi der C		Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Pre 5/23/2024 12:	
				Ti tl e	e XVIII	Hospi tal	PPS	
Cost	Center Description		Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
			Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
			(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
			D D					

						0/20/2021 12.	oo piii
				XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal		Ratio of Cost	I npati ent	Capital Costs	
		Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col . 2)			
		col. 26)					
	T.	1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	737, 276			670, 261	11, 155	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	136, 892	3, 037, 129		0	0	52.00
53. 00	05300 ANESTHESI OLOGY	0		0. 000000	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	947, 792			1, 208, 802		54.00
60.00	06000 LABORATORY	538, 278	56, 353, 356		1, 428, 121	13, 641	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0.00000	0		62. 30
65. 00	06500 RESPI RATORY THERAPY	230, 703			720, 844	8, 990	
66. 00	06600 PHYSI CAL THERAPY	453, 669	8, 458, 185		107, 763		
67.00	06700 OCCUPATI ONAL THERAPY	129, 423	2, 283, 657	0. 056674	92, 459	5, 240	67.00
68.00	06800 SPEECH PATHOLOGY	13, 719	533, 620	0. 025709	36, 144	929	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	0. 000000	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	78, 932	5, 143, 927	0. 015345	192, 691	2, 957	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	62, 374	3, 638, 204	0. 017144	88, 664	1, 520	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	853, 914	42, 875, 830	0. 019916	1, 107, 267	22, 052	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0. 000000	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	429	0	0.000000	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0.000000	0	0	76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	979	1, 885	0. 519363	0	0	90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0	0	0.000000	0	0	90. 01
91.00	09100 EMERGENCY	1, 098, 430	81, 995, 048	0. 013396	1, 910, 146	25, 588	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	40, 717	3, 474, 981	0. 011717	130, 039	1, 524	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	5, 323, 527	338, 838, 226		7, 693, 201	116, 164	200.00

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS			Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/23/2024 12:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
43. 00 04300 NURSERY	0	0		0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		0		44.00
200.00 Total (lines 30 through 199)	0	0		0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem	I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
	instructions)	minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	5, 19	0.00	1, 093	30.00
43. 00 04300 NURSERY		0	52	4 0.00	0	43.00
44.00 04400 SKILLED NURSING FACILITY		0		0.00	0	44.00
200.00 Total (lines 30 through 199)		0	5, 72	0	1, 093	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
43. 00 04300 NURSERY	0					43.00
44.00 04400 SKILLED NURSING FACILITY	0					44.00
200.00 Total (lines 30 through 199)	0					200. 00

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCI LLARY SERVI CE OTHER PASS Provi der CCN: 15-0101	Period: Worksheet D		

From 01/01/2023 Part IV To 12/31/2023 Date/Time Prepared: THROUGH COSTS 5/23/2024 12:06 pm Title XVIII Hospi tal PPS Cost Center Description Non Physician Nursi ng Nursi ng Allied Health Allied Health Anestheti st Program Post-Stepdown Program Post-Stepdown Adjustments Cost Adjustments 1. 00 2.00 ЗА 3. 00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0 0 50.00 0 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 0 54.00 0 06000 LABORATORY 60.00 0 60.00 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 0 62.30 65.00 06500 RESPIRATORY THERAPY 0 0 0 65.00 06600 PHYSI CAL THERAPY 0 0 66.00 66.00 0 06700 OCCUPATI ONAL THERAPY 67.00 0 Ω 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 0 71.00 0 0 71.00 0 72.00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 07697 CARDIAC REHABILITATION 0 0 76. 97 0 76.97 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY 76. 98 0 0 76. 99 07699 LI THOTRI PSY 0 0 76.99 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 o 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY o 78.00 78.00 0 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 0 0 90.00 09000 CLI NI C 0 0 0 0 90. 01 09001 INTENSIVE OUT PATIENT PROGRAM 0 0 0 90.01 0 0 91.00 09100 EMERGENCY C ol Ω 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00

0

0

0

0 200.00

200.00

Total (lines 50 through 199)

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY SERVI CE OTHER PASS	Provi der CCN: 15-0101	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/23/2024 12:06 pm

			Т	o 12/31/2023	Date/Time Pre 5/23/2024 12:	
		Title	xVIII	Hospi tal	PPS	оо р
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	1	1				
50.00 05000 OPERATING ROOM	0	0	1	44, 298, 488	1	l
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0	0	C	3, 037, 129		1
53. 00 05300 ANESTHESI OLOGY	0	0	C	0	0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0) C	00,210,007	1	
60. 00 06000 LABORATORY	0	0) C	56, 353, 356		
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0) C	0	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	0	0) C	18, 497, 057	0. 000000	
66. 00 06600 PHYSI CAL THERAPY	0	0) C	8, 458, 185		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0) C	2, 283, 657		
68.00 06800 SPEECH PATHOLOGY	0	0) C	533, 620		
69. 00 06900 ELECTROCARDI OLOGY	0	0	C	0	0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	5, 143, 927		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	3, 638, 204	0.000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	42, 875, 830		
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	C	0	0.000000	
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	C	0	0.000000	
76. 99 07699 LI THOTRI PSY	0	0	C	0	0.000000	76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	C	0	0.000000	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	C	0	0.000000	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	C	1, 885	0.000000	
90.01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0	C	0	0.000000	90. 01
91. 00 09100 EMERGENCY	0	0	C	81, 995, 048	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	C	3, 474, 981	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0	C	338, 838, 226		200. 00

Н	ealth Financial Systems	WHI TLE	MEMORI A	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
	APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OT	IER PASS	Provi der 0		Peri od: From 01/01/2023	Worksheet D Part IV	
	THROUGH COSTS					To 12/31/2023		pared:
_				Title	e XVIII	Hospi tal	PPS	00 piii
	Cost Center Description	0utpa	ient	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio	f Cost	Program	Program	Program	Program	
		to Ch	rges	Charges	Pass-Through	n Charges	Pass-Through	
		(col.	6 ÷		Costs (col.	8	Costs (col. 9	
		col .	7)		x col. 10)		x col. 12)	

		litie	XVIII	ноѕрі таі	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷	_	Costs (col. 8	, and the second	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS	<u> </u>					
50. 00 05000 OPERATING ROOM	0. 000000	670, 261	0	2, 842, 307	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	o	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0	o	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 208, 802	O	7, 684, 858	0	54.00
60. 00 06000 LABORATORY	0. 000000	1, 428, 121	0	2, 455, 268	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	0	0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 000000	720, 844	0	2, 365, 365	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	107, 763	o	76, 454	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	92, 459	o	21, 944	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	36, 144	0	15, 502	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0	0	. 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	192, 691	o	282, 760	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	88, 664	o	448, 880	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 107, 267	0	12, 577, 430	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0	0	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0	0	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0	o o	0	0	76. 99
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	o o	0	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	o o	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS		-	-1			
90. 00 09000 CLI NI C	0. 000000	0	0	0	0	90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0. 000000	0	o o	0	0	90. 01
91. 00 09100 EMERGENCY	0. 000000	1, 910, 146	o o	7, 352, 773	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	130, 039		463, 292		92.00
OTHER REIMBURSABLE COST CENTERS	3. 000000	1007007	<u> </u>	100, 2,2	<u> </u>	00
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)		7, 693, 201	О	36, 586, 833	0	200.00
	1	.,, 20.	۱	,, 000	ı	

Health Financial Systems	WHITLEY MEMORIAL	_ HOSPI TAL	In Lieu of I	Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0101	Period: Work	sheet D V

12/31/2023 Date/Time Prepared: 5/23/2024 12:06 pm Title XVIII Hospi tal PPS Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Part I, col. Ded. & Coins. 9 (see inst.) (see inst.) 1. 00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0. 160939 2, 842, 307 457, 438 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0.620333 52.00 52.00 05300 ANESTHESI OLOGY 53.00 0.000000 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.132846 7, 684, 858 0 0 0 0 1,020,903 54.00 60.00 06000 LABORATORY 0.124171 2, 455, 268 0 304, 873 60.00 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0.000000 Ω 62.30 65.00 06500 RESPIRATORY THERAPY 0. 143742 2, 365, 365 340,002 65.00 66.00 06600 PHYSI CAL THERAPY 0. 337030 76, 454 0 0 0 25, 767 66.00 0 67.00 06700 OCCUPATI ONAL THERAPY 0.807556 21, 944 17, 721 67.00 0 06800 SPEECH PATHOLOGY 0.366551 68.00 15, 502 5, 682 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 197009 282, 760 0 71.00 0 0 0 55, 706 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0.247911 72 00 448 880 111 282 72 00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0.278812 12, 577, 430 3, 506, 738 73.00 76. 97 07697 CARDIAC REHABILITATION 0.000000 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 0 76. 98 0.000000 0 76.98 0 07699 LI THOTRI PSY 0 0 76. 99 76. 99 0.000000 0 0 0 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0.000000 C 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 4. 966578 90.00 90 00 09000 CL LNLC 0 0 0 0 09001 INTENSIVE OUT PATIENT PROGRAM 90.01 0.000000 0 0 90.01 09100 EMERGENCY 0.139845 7, 352, 773 0 0 1, 028, 249 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 112645 463, 292 0 52, 188 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0. 353331 0 95.00 200.00 Subtotal (see instructions) 36, 586, 833 0 0 6, 926, 549 200. 00 0 Less PBP Clinic Lab. Services-Program 201.00 0 201.00 Only Charges 0 0 6, 926, 549 202. 00 202.00 Net Charges (line 200 - line 201) 36, 586, 833

Health Financial Systems	WHITLEY M	EMORI AL	HOSPI TAL		In Lieu	ı of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE C	COST	Provi der 0	CN: 15-0101	From 01/01/2023	Worksheet D Part V Date/Time Pre 5/23/2024 12:0	
			Title	e XVIII	Hospi tal	PPS	
		Costs					
Cost Center Description	Cost		Cost				

				1.5 1.2, 5.1, 2.52.5	5/23/2024 12:	
		Title	XVIII	Hospi tal	PPS	
	Cos	ts				
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. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
60. 00 06000 LAB0RAT0RY	0	0				60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62. 30
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
76. 97 07697 CARDIAC REHABILITATION	0	0				76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0				76. 98
76. 99 07699 LI THOTRI PSY	0	0				76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0				77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0				78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0				90.00
90. 01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0				90. 01
91. 00 09100 EMERGENCY	0	0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0					95.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						000 00
202.00 Net Charges (line 200 - line 201)	0	0				202.00

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2023 To 12/31/2023		narod:
				10 12/31/2023	5/23/2024 12:	06 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			,			
30.00 ADULTS & PEDIATRICS	1, 297, 937		1, 297, 93			1
43. 00 NURSERY	63, 633		63, 63	524		1
44.00 SKILLED NURSING FACILITY	0			0	0.00	
200.00 Total (lines 30 through 199)	1, 361, 570		1, 361, 57	5, 720		200. 00
Cost Center Description	Inpatient	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col . 6)				
LANDATI FUT DOUTLING OFFICE OCCUT OFFITTEDO	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS		4/ 707				00.00
30. 00 ADULTS & PEDIATRICS	67	16, 737				30.00
43. 00 NURSERY	24	2, 915				43.00
44.00 SKILLED NURSING FACILITY	0	0				44.00
200.00 Total (lines 30 through 199)	91	19, 652	l			200. 00

Health Financial Systems	WHITLEY MEMOR	I AL HOSI	PITAL		In Lie	u of Form CMS-2	552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CA	APITAL COSTS	Pro	ovider CO		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Prep 5/23/2024 12:0	
			Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal			Ratio of Cos	t Inpatient	Capital Costs	

	Ti tl	VII V		5/23/2024 12:	
	11 61	e XIX	Hospi tal	PPS	оо рііі
Cost Center Description Capital	Total Charges	Ratio of Cost		Capital Costs	
Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
B, Part II,	col. 8)	col . 2)	onal ges	COT GIIIIT 1)	
col. 26)	(01. 0)	001. 2)			
1,00	2.00	3, 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM 737, 276	44, 298, 488	0. 016643	61, 017	1, 016	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 136, 892	3, 037, 129	0. 045073	. 0	0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 000000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 947, 792	68, 246, 859	1		865	54.00
60. 00 06000 LABORATORY 538, 278	1 1	1		1, 066	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0. 000000		0	62. 30
65. 00 06500 RESPI RATORY THERAPY 230, 703	18, 497, 057	0. 012472	35, 380	441	65.00
66. 00 06600 PHYSI CAL THERAPY 453, 669	8, 458, 185	0. 053637	2, 763	148	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 129, 423			3, 345	190	67.00
68. 00 06800 SPEECH PATHOLOGY 13, 719			4, 340	112	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 000000		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 78,932	5, 143, 927	0. 015345	17, 275	265	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 62, 374	3, 638, 204	0. 017144		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 853, 914		1	76, 917	1, 532	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 000000	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY 429	9 (0. 000000	0	0	76. 98
76. 99 07699 LI THOTRI PSY		0. 000000	0	0	76. 99
77. 00 07700 ALLOGENEIC HSCT ACQUISITION		0. 000000	0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY		0. 000000	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS		1	<u>'</u>		
90. 00 09000 CLINIC 979	1, 885	0. 519363	3 0	0	90.00
90.01 09001 INTENSIVE OUT PATIENT PROGRAM		0. 000000	o	0	90. 01
91. 00 09100 EMERGENCY 1, 098, 430	81, 995, 048	0. 013396	136, 981	1, 835	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 40, 717	3, 474, 981	0. 011717	0	0	92.00
OTHER REIMBURSABLE COST CENTERS	•	•	•		
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (lines 50 through 199) 5,323,527	338, 838, 226	o	511, 942	7, 470	200. 00

Health Financial Systems	WHITLEY MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS	TS Provider C	1	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III Date/Time Pre 5/23/2024 12:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	IA	1.00	ZA	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS						20.00
43. 00 04300 NURSERY	0	0			0	
44.00 04400 SKI LLED NURSI NG FACI LI TY	0	0			U	44.00
	0	0			_	200.00
200.00 Total (lines 30 through 199) Cost Center Description	Cool and David	Total Costs	Total Patient	Per Diem	Inpati ent	200.00
cost center bescription	Swing-Bed Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,	Days	col . 6)	Frogram Days	
		minus col. 4)		COI . 0)		
	4. 00	5.00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0	5, 190	0.00	67	30.00
43. 00 04300 NURSERY		0	524		24	
44.00 04400 SKILLED NURSING FACILITY		0]		0	
200.00 Total (lines 30 through 199)		0	5, 720		91	200.00
Cost Center Description	Inpati ent	-	-7	-1		
, , , , , , , , , , , , , , , , , , ,	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
43. 00 04300 NURSERY	0					43.00
44.00 04400 SKILLED NURSING FACILITY	0	l .				44.00
200.00 Total (lines 30 through 199)	0					200. 00

Health Financial Systems	WHITLEY MEMORIAL HOS	SPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Pr			Worksheet D
THROUGH COSTS			From 01/01/2023	Part IV

THROUGH COSTS				To 12/31/2023	Date/Time Pre 5/23/2024 12:	pared: 06 pm
		Ti tl	e XIX	Hospi tal	PPS	- Juni
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0	0	00.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
60. 00 06000 LABORATORY	0	0		0	0	60.00
62.30 O6250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0		0	0	76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77. 00
78.00 O7800 CAR T-CELL IMMUNOTHERAPY	0	0	(0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0	0	70.00
90.01 09001 INTENSIVE OUT PATIENT PROGRAM	0	0		0	0	90. 01
91. 00 09100 EMERGENCY	0	0		0	0	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0		(O	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0	0	200. 00

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS		Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared:

THROUG	on CO313				o 12/31/2023	Date/Time Pre 5/23/2024 12:	
			Ti tl	e XIX	Hospi tal	PPS	00 piii
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	, , , , , , , , , , , , , , , , , , ,	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			·	and 4)	·	(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	(44, 298, 488		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	3, 037, 129	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	0	0	C	0	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	C	68, 246, 859	0.000000	54.00
60.00	06000 LABORATORY	0	0	C	56, 353, 356	0.000000	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	C	0	0.000000	62. 30
65.00	06500 RESPI RATORY THERAPY	0	0	(18, 497, 057	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	(8, 458, 185	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(2, 283, 657	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	(533, 620	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	(0	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(5, 143, 927	0.000000	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(3, 638, 204	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(42, 875, 830	0.000000	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	(0	0.000000	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	(0	0.000000	76. 98
76. 99	07699 LI THOTRI PSY	0	0	(0	0.000000	76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	(0	0.000000	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	(0	0.000000	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	C	1, 885	0.000000	90.00
90. 01	09001 INTENSIVE OUT PATIENT PROGRAM	0	0	(0	0.000000	90. 01
91.00	09100 EMERGENCY	0	0	(81, 995, 048	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	ı c	3, 474, 981	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	0	0	ıl c	338, 838, 226		200. 00

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0101	From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/23/2024 12:06 pm

TIROUGH COSTS					To 12/31/2023	Date/Time Pre 5/23/2024 12:	
			Ti tl	e XIX	Hospi tal	PPS	<u> </u>
Cost Cer	nter Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
	·	Ratio of Cost	Program	Program	Program	Program Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷	Ü	Costs (col. 8	3	Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11.00	12.00	13. 00	
ANCILLARY SERV	/ICE COST CENTERS						
50. 00 05000 OPERATI N	IG ROOM	0. 000000	61, 017		0	0	50.00
52. 00 05200 DELIVERY	ROOM & LABOR ROOM	0. 000000	0		0	0	52.00
53. 00 05300 ANESTHES	SI OLOGY	0. 000000	0		0	0	53.00
54. 00 05400 RADI 0L00	SY-DI AGNOSTI C	0. 000000	62, 297		0	0	54.00
60. 00 06000 LABORATO)RY	0. 000000	111, 627		0	0	60.00
62. 30 06250 BLOOD CL	OTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	62. 30
65. 00 06500 RESPI RAT	ORY THERAPY	0. 000000	35, 380		0 0	0	65.00
66. 00 06600 PHYSI CAL	THERAPY	0. 000000	2, 763		0 0	0	66.00
67. 00 06700 OCCUPATI	ONAL THERAPY	0. 000000	3, 345		o o	0	67.00
68.00 06800 SPEECH F	PATHOLOGY	0. 000000	4, 340		o o	0	68. 00
69. 00 06900 ELECTROC	CARDI OLOGY	0. 000000	. 0		o o	0	69.00
71. 00 07100 MEDICAL	SUPPLIES CHARGED TO PATIENT	0. 000000	17, 275		0	0	71.00
72.00 07200 I MPL. DE	V. CHARGED TO PATIENTS	0. 000000	, 0		0	0	72.00
	IARGED TO PATIENTS	0. 000000	76, 917		0	0	73. 00
	REHABI LI TATI ON	0. 000000	, 0, , 0		0	0	76. 97
	RIC OXYGEN THERAPY	0. 000000	0		0 0	o o	76. 98
76. 99 07699 LI THOTRI		0. 000000	0		0 0	0	76. 99
	IC HSCT ACQUISITION	0. 000000	0			0	77. 00
	ELL IMMUNOTHERAPY	0. 000000	0			0	78.00
	RVI CE COST CENTERS	0. 000000		l	0 0		70.00
90. 00 09000 CLI NI C	CVI DE GOOT GENTERO	0. 000000	0		0	0	90.00
	E OUT PATIENT PROGRAM	0. 000000	0		0 0	0	90. 01
91. 00 09100 EMERGENO		0. 000000	136, 981			0	91.00
	ION BEDS (NON-DISTINCT PART	0. 000000	130, 701			0	92.00
	SABLE COST CENTERS	0.000000		L	0		,2.00
95. 00 09500 AMBULANO		T					95.00
	ines 50 through 199)		511, 942		0 0	0	200.00
255.55	es es till ough 1777	1	011, 742	I	٥,	, 0	_ 50. 55

In Lieu of Form CMS-2552-10 Health Financial Systems WHITLEY MEMORIAL HOSPITAL APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-0101 Worksheet D From 01/01/2023 Part V 12/31/2023 Date/Time Prepared: 5/23/2024 12:06 pm Title XIX Hospi tal PPS Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Part I, col. Ded. & Coins. 9 (see inst.) (see inst.) 1. 00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0. 160939 235, 263 05200 DELIVERY ROOM & LABOR ROOM 0. 620333 0 0 0 0 05300 ANESTHESI OLOGY 0.000000 0 0 0 05400 RADI OLOGY-DI AGNOSTI C 0.132846 0 0 662, 591 0 06000 LABORATORY 0.124171 0 0 583, 163 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0 0 0 06500 RESPIRATORY THERAPY 0 0.143742 0 103, 228 0

Health Financial Systems	WHITLEY MEMORI	L HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0101	Peri od: From 01/01/2023	

					To 12/31/2023		
			Ti tl	e XIX	Hospi tal	PPS	
		Cos					
	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	,	1			50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	1			52.00
53.00	05300 ANESTHESI OLOGY	0	0				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	88, 023				54.00
60.00	06000 LABORATORY	0	72, 412	1			60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	1			62. 30
65.00	06500 RESPI RATORY THERAPY	0	14, 838				65. 00
66. 00	06600 PHYSI CAL THERAPY	0	28, 790				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	13, 439				67.00
68.00	06800 SPEECH PATHOLOGY	0	3, 108	1			68. 00
	06900 ELECTROCARDI OLOGY	0	0	1			69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	3, 782				71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	4, 400				72.00
	07300 DRUGS CHARGED TO PATIENTS	0	38, 242	1			73.00
	07697 CARDI AC REHABI LI TATI ON	0	0	1			76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	0	1			76. 98
	07699 LI THOTRI PSY	0	0				76. 99
	07700 ALLOGENEIC HSCT ACQUISITION	0		1			77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0				78. 00
	OUTPATIENT SERVICE COST CENTERS	_	_	1			
	09000 CLI NI C	0	0				90.00
	09001 INTENSIVE OUT PATIENT PROGRAM	0	0	1			90. 01
91.00	09100 EMERGENCY	0					91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	6, 314				92.00
05 00	OTHER REIMBURSABLE COST CENTERS	100 710					٠
	09500 AMBULANCE SERVICES	132, 718	l .				95. 00
200.00		132, 718	539, 348				200.00
201.00		0					201. 00
202 22	Only Charges	100 710	F20 242				202 00
202.00	Net Charges (line 200 - line 201)	132, 718	539, 348				202. 00

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0101	Peri od: From 01/01/2023	Worksheet D-1	
			To 12/31/2023	Date/Time Pre 5/23/2024 12:	
		Title XVIII	Hospi tal	PPS	
Cost Center Description		·			

PART 1 - ALL PROVIDER COMPONENTS PART 1 - ALL PROVIDER COMPONENTS 1.00			Title XVIII	Hooni tal	5/23/2024 12: PPS	06 pm
PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS 1.00 Inpatient days (including private room days and swing-bed days, excluding newborn) 5.196 1.00 1.		Cost Center Description	TI LIE XVIII	Hospi tal	PPS	
INPATIENT DNS 1.00 Inpatient days (including private room days and swing-bed days, excluding newborn) 5.196 2.00		·			1. 00	
Impatient days (including private room days and swing-bed days, excluding memborn) 5,196 1.00						
Impattent days (including private room days, excluding swing-bed and newborn days) 5,196 2,00	1. 00		rs. excludina newborn)		5. 196	1.00
do not complete this line. 4.00 Self-private room days (excluding swing-bed and observation bed days) 5.01 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost operating period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 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) 7.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 7.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 7.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 7.00 Swing-bed NF type inpatient days applicable to services through December 31 of the cost period (including private room days) 7.00 Swing-bed Swing-			,			
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15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) SWING BED ADJUSTMENT 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period Medicair rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period Medicair rate for swing-bed NF services applicable to services after December 31 of the cost reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (110, 20, 20, 20, 20, 20, 20, 20, 20, 20, 2	14. 00				0	14.00
SWING BED ADJUSTMENT 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 2 2.00 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 2 2.00 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average semi-private room per diem charge (line 29 + line 3) 30.00 Average semi-private room per diem charge (line 29 + line 3) 30.00 Average semi-private room per diem charge (line 30 + line 4)					0	15.00
17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19. 00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21. 00 Total general inpatient routine service cost (see instructions) 22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 25. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 19) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32. 00 Average semi-private room per diem charge (line 29 + line 3) 33. 00 Average semi-private room per diem charge (line 30 + line 4) 33. 00 Average semi-private room per diem charge (line 30 + line 4)	16. 00				0	16.00
reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost period period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost period reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost period reporting period period rotal general inpatient routine service cost (see instructions) 21.00 Total general inpatient routine services through December 31 of the cost reporting period (line single to SNF type services through December 31 of the cost reporting period (line single tine 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line single tine 19) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line single tine 19) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line single tine 20) 26.00 Total swing-bed cost (see instructions) 27.00 Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 30.00 Average semi-private room per diem charge (line 29 + line 3) 30.00 Average semi-private room per diem charge (line 30 + line 4) 30.00 Average semi-private room per diem charge (line 30 + line 4) 30.00 Average semi-private room per diem charge (line 30 + line 4)	47.00			6		1
18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 Deneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service cost net of swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average semi-private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 29 + line 3)	17.00	ů · · ·	es through December 31 o	of the cost	0.00	17.00
reporting period Medical drate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average semi-private room per diem charge (line 30 + line 4) 31.00 Average semi-private room per diem charge (line 30 + line 4)	18. 00		es after December 31 of	the cost	0.00	18.00
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7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 0 25.00 25.00 26.00 26.00 12, 478,020 27.00 27.00 28.00 29.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00	24.00		er 31 of the cost reporti	ng period (line	0	24.00
x line 20) 26.00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 0 26.00 26.00 27.00 28.00 29.00 29.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00			•	3 1		
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27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 9.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 27.00 28.00 29.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00	26 00				0	26 00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) O 29.00 Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) O 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) O 0.0000000 O 0 32.00 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			(line 21 minus line 26)		-	
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 0 29.00 0 30.00 0 0.000000 0 31.00 0 0.00 0 32.00 0 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0			(**************************************		,,	
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 0.00 30.00 0.000000 31.00 0.00 32.00 0.00 33.00			ed and observation bed ch	narges)		
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 0.000000 31.00 0.00 32.00 0.00 33.00						1
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 0.00 32.00 0.00 33.00			. Line 20)		_	1
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 0.00 33.00			- TITIE 20)			1
						1
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 0.00 34.00	34.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instrud	ctions)	0. 00	34.00
			ne 31)			
		1	and private room cost di	fforontial (1:50		36.00
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 12,478,020 37.00 27 minus line 36)	37.00		and private room cost di	irerential (IIN6	12, 478, 020	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY						
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			USTMENTS			
			-			
			•			
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 41.00 Total Program general inpatient routine service cost (line 39 + line 40) 2,624,807 41.00			,			ł
7. 35 15tal 115g. am general impatreme fourthe service cost (Time 37 + Time 40)	Ŧ 1. UU	protein riogram general impatrent routine service cost (IIIIe 37	11110 70)		2,024,007	1 71.00

COMPUTATION OF INPATIENT OPERATING COST		Provi der C		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/23/2024 12:	
		Title	e XVIII	Hospi tal	PPS	оо рііі
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00 NUDSERV (+i+Lo. V. 8. VI.V. on Lv.)	1.00	2. 00	3.00	4.00	5.00	42.00
42.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Ur		(л	0	0	42.00
43.00 INTENSIVE CARE UNIT						43.00
44. 00 CORONARY CARE UNIT 45. 00 BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1. 00	
48.00 Program inpatient ancillary service cost	(Wkst. D-3, col.	3, line 200)			1, 324, 803	48. 00
48.01 Program inpatient cellular therapy acquis				column 1)	0	
49.00 Total Program inpatient costs (sum of line PASS THROUGH COST ADJUSTMENTS	nes 41 through 48.	01)(see instru	ctions)		3, 949, 610	49.00
50.00 Pass through costs applicable to Program	inpatient routine	services (fro	m Wkst. D. sun	of Parts I and	273, 031	50.00
111)	•	•			,	
51.00 Pass through costs applicable to Program	inpatient ancilla	ry services (f	rom Wkst. D, s	sum of Parts II	116, 164	51.00
and IV) 52.00 Total Program excludable cost (sum of li	nes 50 and 51)				389, 195	52.00
53.00 Total Program inpatient operating cost ex	kcluding capital re	elated, non-ph	ysician anesth	etist, and	3, 560, 415	
medical education costs (line 49 minus li	ne 52)					
TARGET AMOUNT AND LIMIT COMPUTATION 54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	
55.01 Permanent adjustment amount per discharge					0.00	
55.02 Adjustment amount per discharge (contraction 56.00 Target amount (line 54 x sum of lines 55,	J.)			0.00	
57. 00 Difference between adjusted inpatient oper			line 56 minus	line 53)	ő	
58.00 Bonus payment (see instructions)					0	58.00
59.00 Trended costs (lesser of line 53 ÷ line ! updated and compounded by the market bas!		m the cost rep	orting period	ending 1996,	0.00	59.00
60.00 Expected costs (lesser of line 53 ÷ line		om prior year	cost report, u	pdated by the	0.00	60.00
market basket)	11 50 11 54			III EE .I		/4 00
61.00 Continuous improvement bonus payment (if 55.01, or line 59, or line 60, enter the 53) are less than expected costs (lines! enter zero. (see instructions)	lesser of 50% of	the amount by	which operatir	ng costs (line	0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive	payment (see instr	uctions)			0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine	costs through Dece	ambar 31 of th	e cost reporti	ng pariod (See	0	64. 00
instructions)(title XVIII only)	costs through become	ember 31 of tr	le cost reporti	ng perrou (see		04.00
65.00 Medicare swing-bed SNF inpatient routine	costs after Decemb	ber 31 of the	cost reporting	period (See	0	65.00
instructions)(title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient ro	outine costs (line	64 plus line	65)(title XVII	I only). for	0	66.00
CAH, see instructions	•	•		3,,		
67.00 Title V or XIX swing-bed NF inpatient rou	utine costs through	h December 31	of the cost re	eporting period	0	67.00
(line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient ro	utine costs after	December 31 of	the cost repo	orting period	0	68.00
(line 13 x line 20)		(1)				
69.00 Total title V or XIX swing-bed NF inpation PART III - SKILLED NURSING FACILITY, OTHE					0	69.00
70.00 Skilled nursing facility/other nursing fa						70.00
71.00 Adjusted general inpatient routine service	ce cost per diem (71.00
72.00 Program routine service cost (line 9 x li 73.00 Medically necessary private room cost app	,	m (line 14 v l	ine 35)			72.00
74.00 Total Program general inpatient routine s						74.00
75.00 Capital-related cost allocated to inpation	ent routine servic	e costs (from	Worksheet B, F	art II, column		75. 00
26, line 45) 76.00 Per diem capital-related costs (line 75	· lino 2)					76.00
77.00 Program capital-related costs (line 9 x l						77.00
78.00 Inpatient routine service cost (line 74 m	minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for ex 80.00 Total Program routine service costs for o	· ·			us lina 70)		79. 00 80. 00
81.00 Inpatient routine service costs for 6	•	cost iiiii taliC	ur (iiile to IIII	ius IIIIC /7)		80.00
82.00 Inpatient routine service cost limitation	n (line 9 x line 8					82.00
83.00 Reasonable inpatient routine service cos		ns)				83.00
84.00 Program inpatient ancillary services (see 85.00 Utilization review - physician compensati	· ·	ons)				84. 00 85. 00
86.00 Total Program inpatient operating costs	(sum of lines 83 t					86.00
PART IV - COMPUTATION OF OBSERVATION BED					1/0	87. 00
87.00 Total observation bed days (see instruction)						

COMPUTATION OF INPATIENT OPERATING COST Provider CCN: 15-0101 Period: From 01/01/2023 To 12/31/2023 Pate/Time Prepared: 5/23/2024 12: 06 pm PPS Cost Center Description 89. 00 Observation bed cost (line 87 x line 88) (see instructions) Cost Center Description Cost Routine Cost (from line Column 1 ÷ Column 2 Observation Bed Cost (from line R97 x line R99) Routine Cost (from line R99) Cost Center Description Cost Routine Cost (from line R99) Routine Cost (from line R99) Cost Center Description Routine Cost (from line R99)	Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
To 12/31/2023 Date/Time Prepared: 5/23/2024 12: 06 pm Title XVIII Hospital PPS Cost Center Description 89.00 Observation bed cost (line 87 x line 88) (see instructions) Cost Center Description Cost Center Description Cost Center Description Cost Routine Cost (from line column 1 ÷ (from line column 2) 21) Bate/Time Prepared: 5/23/2024 12: 06 pm 1.00 391, 440 89.00 Observation Bed Pass Through Cost (from line column 2) (col. 3 x col. 4) (see	COMPUTATION OF INPATIENT OPERATING COST		Provi der CC			Worksheet D-1	
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21) Bed Cost (from line (col. 3 x col. 4) (see	Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
(from line (col. 3 x 89) col. 4) (see			(from line	column 2	Observati on	Bed Pass	
89) col. 4) (see			21)		Bed Cost	Through Cost	
					(from line	(col. 3 x	
					89)	col. 4) (see	
instructions)						instructions)	
1.00 2.00 3.00 4.00 5.00		1. 00	2. 00	3. 00	4. 00	5. 00	
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WHITLEY MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	Provider CCN: 15-0101	Peri od:		
		To 12/31/2023		
			5/23/2024 12:	06 pm_
	Title XIX	Hospi tal	PPS	
			1. 00	
	WHITLEY MEMORIAL		Provider CCN: 15-0101 Period: From 01/01/2023 To 12/31/2023	Provider CCN: 15-0101

Inpattent days (including private room days, excluding swing-bed and newborn days) 5.196 2.1			Title XIX	Hospi tal	PPS	
INPATTENT DAYS InpatTent days (Including private room days and swing-bed days, excluding newborn) 5,196 1.		Cost Center Description			1 00	
Inpati ent days (including private room days and swing-bed adnessorm days) 5.196 1.2		PART I - ALL PROVIDER COMPONENTS			11.00	
Inpatient days (Including private room days, excluding swing-bed and newborn days) 5,196 2.1				1		
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34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 12, 478, 020) 37.00 The sum of the private room cost differential (line 12, 478, 020) 37.00 The sum of the private room cost differential (line 12, 478, 020)						•
36.00 Private room cost differential adjustment (line 3 x line 35) O 36.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 12,478,020) 37.00			nus line 33)(see instruc	ctions)		•
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 12,478,020 37.00		, , , , , , , , , , , , , , , , , , , ,	ne 31)			ı
		,	and nrivate room cost di	fferential (line		36. 00 37. 00
	37.00	,	and private room cost dr	rieichtial (IIIIe	12,4/0,020	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				1		[
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
		, , , , , , , , , , , , , , , , , , , ,	•			•
		,	•			1
41. 00 Total Program general inpatient routine service cost (line 39 + line 40) 160, 898 41.						

12. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
40.00	through December 31 of the cost reporting period		40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
14. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00	Total nursery days (title V or XIX only)		15.00
16. 00	Nursery days (title V or XIX only)	24	
10.00	SWING BED ADJUSTMENT	24	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
17.00	reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
	reporting period		
19.00	Medical drate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
	reporting period		
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
21 00	reporting period	12 470 020	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	12, 478, 020 0	21. 00 22. 00
22.00	15 x line 17)	۷	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
23.00	Swifing 180 Cost approvable to Swiftype services after becomber 31 of the cost reporting period (Time of	٥	23.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
2 00	7 x line 19)	ŭ.	2 00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	12, 478, 020	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
29. 00	Pri vate room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	12 470 020	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	12, 478, 020	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	2, 401. 47	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 98)	160, 898	
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	160, 8981	1 41.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	160, 898	41.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	160, 898	41.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	160, 898	41.00

COMPUTAT	TION OF INPATIENT OPERATING COST		Provi der C		Peri od:	Worksheet D-1	2552-10
					From 01/01/2023 To 12/31/2023	Date/Time Pre 5/23/2024 12:	
			Ti tl	e XIX	Hospi tal	PPS	00 piii
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
40.00	HIDGEDY (11 H. M. A. W. V. a. I.)	1. 00	2.00	3.00	4.00	5. 00	40.00
	URSERY (title V & XIX only) ntensive Care Type Inpatient Hospital Units	869, 651	524	1, 659. 6	4 24	39, 831	42.00
	NTENSIVE CARE UNIT						43.00
	ORONARY CARE UNIT						44. 00
	SURN INTENSIVE CARE UNIT						45.00
	URGICAL INTENSIVE CARE UNIT THER SPECIAL CARE (SPECIFY)			1			46. 00 47. 00
47.00 0	Cost Center Description						47.00
48. 00 P	rogram inpatient ancillary service cost (Wk	ct D 2 col 1	2 Line 200)			1. 00 86, 323	48. 00
	rogram inpatient cellular therapy acquisiti			III. line 10.	column 1)	00, 323	48. 01
	otal Program inpatient costs (sum of lines					287, 052	1
	ASS THROUGH COST ADJUSTMENTS						
	ass through costs applicable to Program inp II)	atient routine	services (fro	m Wkst. D, sun	of Parts I and	19, 652	50.00
	ass through costs applicable to Program inp	atient ancillar	ry services (f	rom Wkst. D, s	sum of Parts II	7, 470	51.00
a	nd IV)		•				
	otal Program excludable cost (sum of lines		alatad ===================================	vei ei an anasth	otict and	27, 122 259, 930	
	otal Program inpatient operating cost exclunedical education costs (line 49 minus line	0 .	erated, non-pn	ysician anestr	etist, and	259, 930	53.00
	ARGET AMOUNT AND LIMIT COMPUTATION	027					1
	rogram discharges					0	
	arget amount per discharge Permanent adjustment amount per discharge					0. 00 0. 00	1
	djustment amount per discharge (contractor	use onlv)				0.00	1
1	arget amount (line 54 x sum of lines 55, 55	J ,)			0	1
1	ifference between adjusted inpatient operat	ing cost and ta	arget amount (line 56 minus	line 53)	0	
	onus payment (see instructions) rended costs (lesser of line 53 ÷ line 54,	or lino 55 from	m the cost ron	orting ported	onding 1006	0.00	58. 00 59. 00
	updated and compounded by the market basket)	of Title 55 ITO	ii the cost rep	of tring period	enuring 1990,	0.00	39.00
60.00 E	xpected costs (lesser of line 53 ÷ line 54,	or line 55 fro	om prior year	cost report, ι	pdated by the	0. 00	60.00
1	arket basket) ontinuous improvement bonus payment (if lin	o 52 · lino 54	ie Lose than	the lowest of	Linos EE plus	0	61.00
5	5.01, or line 59, or line 60, enter the les 3) are less than expected costs (lines 54 x	ser of 50% of t	the amount by	which operatir	ng costs (line	0	01.00
	enter zero. (see instructions) Helief payment (see instructions)					0	62.00
	llowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	
_	ROGRAM INPATIENT ROUTINE SWING BED COST						1
	<pre>ledicare swing-bed SNF inpatient routine cos nstructions)(title XVIII only)</pre>	ts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64.00
	ledicare swing-bed SNF inpatient routine cos	ts after Decemb	oer 31 of the	cost reporting	period (See	0	65.00
i i	nstructions)(title XVIII only)						
	otal Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	l only); for	0	66.00
	AH, see instructions Title V or XIX swing-bed NF inpatient routin	e costs throuah	n December 31	of the cost re	porting period	0	67.00
(line 12 x line 19)	-					
	itle V or XIX swing-bed NF inpatient routin line 13 x line 20)	e costs after [Jecember 31 of	the cost repo	orting period	0	68. 00
	otal title V or XIX swing-bed NF inpatient	routine costs ((<u>line 67</u> + lin	e 68)		0	69. 00
PA	ART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY	, AND ICF/IID	ONLY			1
	killed nursing facility/other nursing facil djusted general inpatient routine service c						70.00
	rogram routine service cost (line 9 x line		THE 70 - TIME	<i>-)</i>			71.00
73. 00 M	ledically necessary private room cost applic	abĺe to Program					73.00
	otal Program general inpatient routine serv	•		,	loot II - I		74.00
	apital-related cost allocated to inpatient (6, line 45)	ioutine service	COSIS (Trom	worksneet B, F	artii, COIUMN		75.00
1	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
	rogram capital-related costs (line 9 x line						77.00
	npatient routine service cost (line 74 minu ggregate charges to beneficiaries for exces		orovider recor	ds)			78. 00 79. 00
	otal Program routine service costs for comp				nus line 79)		80.00
81. 00 I	npatient routine service cost per diem limi	tati on			,		81.00
1	npatient routine service cost limitation (82.00
	leasonable inpatient routine service costs (Program inpatient ancillary services (see in		ns)				83. 00 84. 00
1	tilization review - physician compensation	,	ons)				85.00
86. 00 T	otal Program inpatient operating costs (sum	of lines 83 th					86.00
PA	ART IV - COMPUTATION OF OBSERVATION BED PASS otal observation bed days (see instructions					4/0	87. 00
87. 00 T							

Health Financial Systems	WHITLEY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			391, 440	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 297, 937	12, 478, 020	0. 10401	8 391, 440	40, 717	90.00
91.00 Nursing Program cost	0	12, 478, 020	0. 00000	391, 440	0	91.00
92.00 Allied health cost	0	12, 478, 020	0. 00000	391, 440	0	92.00
93.00 All other Medical Education	0	12, 478, 020	0. 00000	391, 440	0	93.00

	inancial Systems WHITLEY MEMORI IT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0101	Peri od:	u of Form CMS-2 Worksheet D-3	
MIAIILN	II ANCIELANT SERVICE COST ALTORITONIMENT	Trovider c	CN. 13-0101	From 01/01/2023		,
				To 12/31/2023	Date/Time Pre 5/23/2024 12:	
		Ti tl e	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x	
					col . 2)	
	IDATI ENT. DOUTLINE OFFICE OF ACCT. OFFITEDO		1.00	2. 00	3. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS			0.045.054	I	
	3000 ADULTS & PEDIATRICS			2, 045, 851		30.0
	4300 NURSERY					43.0
	ICILLARY SERVICE COST CENTERS 5000 OPERATING ROOM		0.1(00	20 (70 2/1	107 071	
			0. 1609 0. 6203		107, 871	
	5200 DELIVERY ROOM & LABOR ROOM 5300 ANESTHESIOLOGY		0. 0203		0	
	5400 RADI OLOGY-DI AGNOSTI C		0. 00000		_	
	5000 LABORATORY		0. 1328			
	6250 BLOOD CLOTTING FOR HEMOPHILIACS		0. 1241			
	5500 RESPIRATORY THERAPY		0.0000		1	
	6600 PHYSI CAL THERAPY		0. 1437			
	5700 OCCUPATIONAL THERAPY		0. 3370			
	5800 SPEECH PATHOLOGY		0. 3665			
	6900 ELECTROCARDI OLOGY		0. 0000			
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1970		37, 962	
	7200 IMPL. DEV. CHARGED TO PATIENTS		0. 2479			
	7300 DRUGS CHARGED TO PATIENTS		0. 2788			
	7697 CARDI AC REHABI LI TATI ON		0.0000			
	7698 HYPERBARI C OXYGEN THERAPY		0.0000		0	
	7699 LI THOTRI PSY		0.0000		· -	
	7700 ALLOGENEIC HSCT ACQUISITION		0.0000			1
	7800 CAR T-CELL IMMUNOTHERAPY		0.0000			1
	JTPATI ENT SERVI CE COST CENTERS		0.0000	00		1 / 0. 0
	9000 CLI NI C		4. 9665	78 0	0	90.0
	9001 INTENSIVE OUT PATIENT PROGRAM		0. 0000			
- 1	9100 EMERGENCY		0. 1402		267, 856	
	9200 OBSERVATION BEDS (NON-DISTINCT PART		0. 1126			1
	THER REIMBURSABLE COST CENTERS				.,,,	1
	9500 AMBULANCE SERVICES					95.0
00.00	Total (sum of lines 50 through 94 and 96 through 98)			7, 693, 201	1, 324, 803	200.0
01.00	Less PBP Clinic Laboratory Services-Program only char	ges (line 61)		0		201.0
202.00	Net charges (line 200 minus line 201)	- , ,		7, 693, 201		202.0

	Financial Systems WHITLEY MEMORIAL INT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15_0101	Peri od:	u of Form CMS-: Worksheet D-3	
INFAILE	IN ANGILLANI SERVICE COST AFFORTIONWENT	110videl C	ON. 13-0101	From 01/01/2023	MOLVSHEET D-2	,
				To 12/31/2023	Date/Time Pre 5/23/2024 12:	pared 06 pr
		Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	st Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
			1.00	2. 00	3. 00	
-	NPATIENT ROUTINE SERVICE COST CENTERS					
0.00	03000 ADULTS & PEDIATRICS			149, 865		30.
	04300 NURSERY			28, 082		43.
	ANCILLARY SERVICE COST CENTERS					
0.00	O5000 OPERATING ROOM		0. 1609	39 61, 017	9, 820	50.
2.00	D5200 DELIVERY ROOM & LABOR ROOM		0. 6203	33 0	0	52.
3.00	D5300 ANESTHESI OLOGY		0.0000	00 0	0	53.
4. 00	D5400 RADI OLOGY-DI AGNOSTI C		0. 1328	46 62, 297	8, 276	54.
0.00	06000 LABORATORY		0. 1241	71 111, 627	13, 861	60.
2. 30	D6250 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000	00 0	0	62.
5.00	06500 RESPI RATORY THERAPY		0. 1437	42 35, 380	5, 086	65.
5.00	06600 PHYSI CAL THERAPY		0. 3370	30 2, 763	931	66.
7.00	06700 OCCUPATI ONAL THERAPY		0. 8075	56 3, 345	2, 701	67.
3.00	06800 SPEECH PATHOLOGY		0. 3665			68.
9.00	06900 ELECTROCARDI OLOGY		0.0000		0	69.
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1970	09 17, 275	3, 403	71.
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2479		0	72.
	07300 DRUGS CHARGED TO PATIENTS		0. 2788		21, 445	73.
	07697 CARDI AC REHABI LI TATI ON		0.0000		0	1
	07698 HYPERBARIC OXYGEN THERAPY		0.0000		0	76.
	07699 LI THOTRI PSY		0.0000		0	76.
	07700 ALLOGENEIC HSCT ACQUISITION		0. 0000			
	07800 CAR T-CELL IMMUNOTHERAPY		0. 0000			
	DUTPATIENT SERVICE COST CENTERS		0.0000	30, 3		1
	09000 CLINI C		4. 9665	78 0	0	90.
	09001 INTENSIVE OUT PATIENT PROGRAM		0.0000			
	09100 EMERGENCY		0. 1402		19, 209	
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 1402			1
	OTHER REIMBURSABLE COST CENTERS		0.1120	70 0		72.
	09500 AMBULANCE SERVICES					95.
00.00	Total (sum of lines 50 through 94 and 96 through 98)			511, 942	86, 323	
01.00	Less PBP Clinic Laboratory Services-Program only charge	s (lino 61)	1	011, 942	00, 323	200.
01.00	Net charges (line 200 minus line 201)	s (IIIIe ol)		511, 942		201.
12.00	INEL CHALGES (TITLE 200 IIII HUS TITLE 201)		I	511, 942	l	1202.

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-1	0
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0101	Peri od: Worksheet E From 01/01/2023 Part A To 12/31/2023 Date/Ti me Prepared: 5/23/2024 12:06 pm	

	Title XVIII	Hospi tal	5/23/2024 12: PPS	06 pm
			1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		1.00	
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (so instructions)	ee	0 1, 755, 210	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 instructions)	(see	785, 494	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring pill (see instructions)	rior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring of October 1 (see instructions)	n or after	0	1.04
2.00	Outlier payments for discharges. (see instructions) Outlier reconciliation amount		0	2.00
2. 02 2. 03 2. 04	Outlier payment for discharges for Model 4 BPCI (see instructions) Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see instructions)		0	2. 02 2. 03 2. 04
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost reporting period (see instructions)	tions)	0 29. 31	3. 00 4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most recent cost reporting period (see Fisher Laboratory).		0.00	5.00
5. 01	or before 12/31/1996. (see instructions) FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	· ·	0.00	5. 00
6. 00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on new programs in accordance with 42 CFR 413.79(e)		0.00	6. 00
6. 26	Rural track program FTE cap limitation adjustment after the cap-building window closed the CAA 2021 (see instructions)	under §127 of	0. 00	6. 26
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)		0. 00 0. 00	7. 00 7. 01
7. 02	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the hospital's rural track program FTE limitation track programs with a rural track for Medicare GME affiliated programs in accordance will and 87 FR 49075 (August 10, 2022) (see instructions)	` ′	0. 00	7. 02
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic prograffiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 1998), and 67 FR 50069 (August 1, 2002).		0.00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the All report straddles July 1, 2011, see instructions.	CA. If the cost	0.00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching under § 5506 of ACA. (see instructions)		0. 00	8. 02
8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA instructions)	·	0.00	8. 21
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) FTE count for allopathic and osteopathic programs in the current year from your records		0. 00	9.00
11. 00 12. 00	FTE count for residents in dental and podiatric programs. [Current year allowable FTE (see instructions)]	5	0. 00	10.00 11.00 12.00
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 Septential otherwise enter zero.	ember 30, 1997,		14.00
	Adjustment for residents in initial years of the program (see instructions)		0. 00	15. 00 16. 00
17. 00 18. 00	Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count		0. 00	17. 00 18. 00
19. 00 20. 00	Current year resident to bed ratio (line 18 divided by line 4). Prior year resident to bed ratio (see instructions)		0. 000000 0. 000000	
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0. 000000	
22. 00 22. 01	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)		0	22. 00 22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFI (EX.(4) (1) (2) (2)	R 412. 105	0.00	23. 00
24. 00 25. 00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than 0, then enter the lower of line 22 or line:	24 (500	0.00	
26. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 2 instructions) Resident to bed ratio (divide line 25 by line 4)	24 (See	0. 00	25. 00 26. 00
27. 00 28. 00	IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions)		0. 000000	27. 00 28. 00
28. 00	IME add-on adjustment amount - Managed Care (see instructions)		0	28. 00
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29. 00 29. 01
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	ions)	2. 51	30.00
31.00	Percentage of Medicaid patient days (see instructions)	- /	18. 82	31.00
32. 00 33. 00	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)		21. 33 6. 82	32. 00 33. 00
	· · · · · · · · · · · · · · · · · · ·			

	Financial Systems WHITLEY MEMOR ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0101	Peri od:	u of Form CMS-2 Worksheet E	2552-10
0712002			From 01/01/2023 To 12/31/2023	Part A Date/Time Pre	pared:
		Title XVIII	Hospi tal	5/23/2024 12: PPS	
		THE WITT	nospi tai		
34. 00	Disproportionate share adjustment (see instructions)			1. 00 43, 319	34.00
			Prior to 10/1	On/After 10/1	
	Uncompensated Care Payment Adjustment		1. 00	2. 00	
35.00	Total uncompensated care amount (see instructions)			5, 938, 006, 757	1
35. 01 35. 02	Factor 3 (see instructions) Hospital UCP, including supplemental UCP (see instructions	s)	0. 000129634 891, 160	0. 000128621 763, 752	
35. 02		I UCP (see instructions)	666, 539	191, 981	1
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03	3)	858, 520		36.00
40. 00	Additional payment for high percentage of ESRD beneficiary Total Medicare discharges (see instructions)	y discharges (lines 40 thro	ugn 46)		40.00
41.00	Total ESRD Medicare discharges (see instructions)		0		41.00
41. 01 42. 00	Total ESRD Medicare covered and paid discharges (see insti Divide line 41 by line 40 (if less than 10%, you do not qu		0.00		41. 01 42. 00
43. 00	Total Medicare ESRD inpatient days (see instructions)	darriy ror adjustment)	0.00		43.00
44. 00	Ratio of average length of stay to one week (line 43 divid	ded by line 41 divided by 7	0. 000000		44.00
45. 00	days) Average weekly cost for dialysis treatments (see instructi	i ons)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line	e 41.01)	0		46. 00 47. 00
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH	H, small rural hospitals	3, 442, 543 0		48.00
	only. (see instructions)			Amount	
				Amount 1.00	
49.00	Total payment for inpatient operating costs (see instructi		`	3, 442, 543	1
50. 00 51. 00	Payment for inpatient program capital (from Wkst. L, Pt. I Exception payment for inpatient program capital (Wkst. L,			192, 498 0	50.00 51.00
52.00	Direct graduate medical education payment (from Wkst. E-4,			0	52.00
53. 00 54. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			0 12, 563	53. 00 54. 00
54. 00	Islet isolation add-on payment			12, 503	54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lir	ne 69)		0	
55. 01 56. 00	Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see i	intructions)		0	55. 01 56. 00
57.00	Routine service other pass through costs (from Wkst. D, Pt		through 35).	Ö	57.00
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D. F	Pt. IV, col. 11 line 200)		2 647 604	58. 00 59. 00
60.00	Total (sum of amounts on lines 49 through 58) Primary payer payments			3, 647, 604 3, 579	
61.00	, , , , , , , , , , , , , , , , , , , ,	inus line 60)		3, 644, 025	
62. 00 63. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			422, 842 3, 525	
	Allowable bad debts (see instructions)			66, 111	64.00
	Adjusted reimbursable bad debts (see instructions)	i notrusti ono)		42, 972 11, 104	
67.00	Allowable bad debts for dual eligible beneficiaries (see i Subtotal (line 61 plus line 65 minus lines 62 and 63)	riistructrons)		11, 186 3, 260, 630	
68.00	Credits received from manufacturers for replaced devices t			0	68. 00
69. 00 70. 00	Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	96).(For SCH see instructio	ns)	0	69. 00 70. 00
70. 50	Rural Community Hospital Demonstration Project (§410A Demo	onstration) adjustment (see	instructions)	0	1
70. 75	N95 respirator payment adjustment amount (see instructions			0	
70. 87 70. 88	Demonstration payment adjustment amount before sequestrati SCH or MDH volume decrease adjustment (contractor use only			0	1
70. 89	Pioneer ACO demonstration payment adjustment amount (see i	instructions)			70. 89
70. 90 70. 91	HSP bonus payment HVBP adjustment amount (see instructions)			0	70. 90 70. 91
70. 91 70. 92	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions))		0	1
	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			0	70. 93
				0	70. 94

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
CALCULATION OF REIMBURSEMENT SETTLEM	ENT	Provi der C	CN: 15-0101	Peri od:	Worksheet E	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre 5/23/2024 12:	
		Title	xVIII	Hospi tal	PPS	оо рііі
	•			(уууу)	Amount	
				0	1. 00	
70.96 Low volume adjustment for federal year	eral fiscal year (yyyy) (Enter i for the period prior to 10/1)	n column 0		0	0	70. 96
70.97 Low volume adjustment for fede	eral fiscal year (yyyy) (Enter i for the period ending on or af		2	2023	352, 263	70. 97
70. 98 Low Volume Payment-3	for the period ending on or ar	tei 10/1)		2024	156, 191	70. 98
70.99 HAC adjustment amount (see ins	structions)		1	2024	130, 171	1
71.00 Amount due provider (line 67 m		69 & 70)			3, 769, 084	
71.01 Sequestration adjustment (see		o, a ,o,			75, 382	1
71. 02 Demonstration payment adjustme					0,002	1
71. 03 Sequestration adjustment-PARHN					· ·	71.03
72.00 Interim payments	Fg				3, 660, 166	
72.01 Interim payments-PARHM						72. 01
73.00 Tentative settlement (for cont	tractor use only)				0	73.00
73.01 Tentative settlement-PARHM (fo	or contractor use only)					73. 01
74.00 Balance due provider/program (73)	(line 71 minus lines 71.01, 71.0	2, 72, and			33, 536	74.00
74.01 Balance due provider/program-F	PARHM (see instructions)					74. 01
75.00 Protested amounts (nonallowabl	e cost report items) in accorda	nce with			68, 858	75.00
CMS Pub. 15-2, chapter 1, §115						
TO BE COMPLETED BY CONTRACTOR			1			
, ,	Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90.00
plus 2.04 (see instructions) 91.00 Capital outlier from Wkst. L.	D+ I line 2				0	91.00
The second secon	on adjustment amount (see instr	uctions)			0	1
93.00 Capital outlier reconciliation					0	
	e time value of money (see instruc				0. 00	
95.00 Time value of money for operat		uctions)			0.00	
96.00 Time value of money for capita		tions)			0	
		<u></u>		Prior to 10/1	On/After 10/1	
				1.00	2. 00	
HSP Bonus Payment Amount						
100.00 HSP bonus amount (see instruct				0	0	100.00
HVBP Adjustment for HSP Bonus						
101.00 HVBP adjustment factor (see in				0. 0000000000	0. 0000000000	
102.00 HVBP adjustment amount for HSF		s)		0	0	102.00
HRR Adjustment for HSP Bonus P						
103.00 HRR adjustment factor (see ins				0.0000		103.00
104.00 HRR adjustment amount for HSP				0	0	104.00
	stration Project (§410A Demonst					200.00
200.00 Is this the first year of the Century Cures Act? Enter "Y" f		i i ou under	LIE ZISL			200.00
Cost Reimbursement	or yes or in rol no.					
201. 00 Medicare inpatient service cos	sts (from Wkst D-1 Pt II lin	e 49)				201.00
202. 00 Medi care di scharges (see i nstr		· 1/)				202.00
203.00 Case-mix adjustment factor (se						203.00
	arget Amount Limitation (N/A in	first vear	of the curre	nt 5-vear demons	trati on	1 30.00
peri od)	J	Joan		, , , , , , , , , , , , , , , , , , ,		
204 00 Medicare target amount						1204 no

Health Financial Systems	WHITLEY MEMORIAL HOSPITAL		In Lieu	ı of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 15-0101		Worksheet E Part B Date/Time Prepared: 5/23/2024 12:06 pm
	Ti t	le XVIII	Hospi tal	PPS

		Title XVIII	Hospi tal	5/23/2024 12: PPS	06 pm
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			0	1.00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruc OPPS or REH payments	tions)		6, 926, 549 5, 134, 541	2. 00 3. 00
4. 00	Outlier payment (see instructions)			11, 954	4.00
4. 01	Outlier reconciliation amount (see instructions)			0	•
5.00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0. 000	1
6. 00 7. 00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0 0. 00	6. 00 7. 00
8. 00	Transitional corridor payment (see instructions)			0.00	1
9. 00	Ancillary service other pass through costs including REH dire	ct graduate medical educ	cation costs from	0	9. 00
10.00	Wkst. D, Pt. IV, col. 13, line 200			0	10.00
10. 00 11 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0	
00	COMPUTATION OF LESSER OF COST OR CHARGES			J	
	Reasonabl e charges				
	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ino 60)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13)	The 04)		0	ł
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for			0	
16. 00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(on a chargebasis	0	16. 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
	Total customary charges (see instructions)			0	
19. 00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds li	ne 11) (see	0	19. 00
20. 00	instructions) Excess of reasonable cost over customary charges (complete on	lv if line 11 exceeds li	ne 18) (see	0	20. 00
	instructions)	,	, (
	Lesser of cost or charges (see instructions)			0	21.00
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see inst	ructions)		0	22. 00 23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	r de trons)		5, 146, 495	•
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instruction	•		1, 014, 918	1
26. 00 27. 00	Deductibles and Coinsurance amounts relating to amount on lin Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			0 4, 131, 577	26. 00 27. 00
27.00	instructions)	prus the sum of fries 22	20] (300	1, 101, 077	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. 00
28. 50 29. 00	REH facility payment amount (see instructions)			0	28. 50 29. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27, 28, 28.50 and 29)			4, 131, 577	•
	Primary payer payments			1, 219	1
32.00	Subtotal (line 30 minus line 31)	050)		4, 130, 358	32.00
33 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI Composite rate ESRD (from Wkst. I-5, line 11)	CES)		0	33.00
	Allowable bad debts (see instructions)			71, 705	
	Adjusted reimbursable bad debts (see instructions)			46, 608	
	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (see instructions)	ructions)		31, 456	
	MSP-LCC reconciliation amount from PS&R			4, 176, 966 0	1
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		_	39. 50
39. 75 39. 97	N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration			0	
39. 98	Partial or full credits received from manufacturers for repla	ced devices (see instru	ctions)	0	ı
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	`	,	0	ı
	Subtotal (see instructions)			4, 176, 966	1
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			83, 539 0	40. 01 40. 02
	Sequestration adjustment-PARHM pass-throughs				40. 03
41.00	Interim payments			3, 995, 981	41.00
	Interim payments-PARHM			0	41.01
42. 00 42. 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42. 00 42. 01
43. 00	Balance due provider/program (see instructions)			97, 446	1
43. 01	Balance due provider/program-PARHM (see instructions)				43. 01
44. 00	Protested amounts (nonallowable cost report items) in accorda §115.2	nce with CMS Pub. 15-2,	chapter 1,	0	44. 00
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions)			0	
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92. 00 93. 00

Health Financial Systems	WHITLEY MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-:	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0101	Peri od:	Worksheet E	
			From 01/01/2023 To 12/31/2023	Part в Date/Time Pre	nared.
			10 12/31/2023	5/23/2024 12:	06 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94.00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

Health Financial Systems WHITE ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provi der CCN: 15-0101

				10 12/31/2023	5/23/2024 12:0	
		Title	e XVIII	Hospi tal	PPS	
	· · · · · · · · · · · · · · · · · · ·	I npati er	nt Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3, 632, 46	6	3, 995, 981	1. 00
2.00	Interim payments payable on individual bills, either			О	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider			_		
3. 01	ADJUSTMENTS TO PROVIDER	08/09/2023	27, 70		0	3. 01
3. 02			l .	0	0	3. 02
3. 03			•	0	0	3. 03
3. 04			l	0	0	3. 04
3.05				0	0	3.05
	Provi der to Program	<u> </u>				
3.50	ADJUSTMENTS TO PROGRAM		1	0	0	3.50
3. 51				0	0	3. 51
3. 52				0	0	3. 52
3.53			1	0	0 0	3.53
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			~	0	3. 54 3. 99
3. 99	3. 50-3. 98)		27, 70	٥	١	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 660, 16	6	3, 995, 981	4.00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		3,000,10		3, 773, 701	7.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR		1			
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	0	5. 02
5. 03				0	0	5. 03
	Provider to Program	ı		-		
5. 50	TENTATI VE TO PROGRAM			0	0	5.50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					50
6. 01	SETTLEMENT TO PROVIDER		33, 53	6	97, 446	6. 01
6. 02	SETTLEMENT TO PROGRAM			O	0	6. 02
7.00	Total Medicare program liability (see instructions)		3, 693, 70	2	4, 093, 427	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
			0	1. 00	2.00	
8.00	Name of Contractor					8.00

Heal th	Financial Systems WHITLEY MEMORIAL	HOSPI TAL	In Lie	ı of Form CMS-	2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0101 Period: From 01/01/			From 01/01/2023	Worksheet E-1 Part II Date/Time Prepared: 5/23/2024 12:06 pm		
	Title XVIII Hospital Pi					
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				1.00	
1.00	.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14					
2.00	2.00 Medicare days (see instructions)				2. 00 3. 00	
3.00						
4.00	4.00 Total inpatient days (see instructions)					
5.00	5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200					
6.00	6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20					
7. 00	7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168				7. 00	
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00	
9.00	0.00 Sequestration adjustment amount (see instructions)					
10.00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)				10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00	
31.00	Other Adjustment (specify)				31.00	
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ns)		32.00	

Health Financial Systems WHITLEY MEMORIAL HOSPITAL In Lieu		u of Form CMS-2	552-10		
OUTLI E	R RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0101	Peri od:	Worksheet E-5	
			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/23/2024 12:0	oared: 06 pm_
		Title XVIII		PPS	
				1. 00	
TO BE COMPLETED BY CONTRACTOR					
1.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)					1.00
2.00 Capital outlier from Wkst. L, Pt. I, line 2				0	2.00
3.00 Operating outlier reconciliation adjustment amount (see instructions)				0	3.00
4.00 Capital outlier reconciliation adjustment amount (see instructions)				0	4.00
5.00 The rate used to calculate the time value of money (see instructions)			0.00	5.00	
6.00 Time value of money for operating expenses (see instructions)				0	6.00
7.00 Time value of money for capital related expenses (see instructions)				0	7.00

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

Provider CCN: 15-0101

Peri od: Worksheet G From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/23/2024 12:06 pm

	·	General Fund	Speci fi c	Endowment	5/23/2024 12: Plant Fund	06 pm
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	3, 248	1	0	0	1.00
2. 00 3. 00	Temporary investments Notes receivable	0	0	0	0	2. 00 3. 00
4. 00	Accounts recei vable	34, 305, 166	-	0	0	4.00
5. 00	Other recei vabl e	0 1, 000, 100	Ö	o	0	5.00
6. 00	Allowances for uncollectible notes and accounts receivable	-19, 570, 275	0	Ö	0	6.00
7.00	Inventory	950, 597	0	0	0	7. 00
8.00	Prepai d expenses	-28, 843, 592	0	0	0	8. 00
9.00	Other current assets	0	0	0	0	9.00
10. 00 11. 00	Due from other funds	279, 400 -12, 875, 456		0	0	10.00 11.00
11.00	Total current assets (sum of lines 1-10) FIXED ASSETS	-12, 673, 430	l o	<u> </u>	0	11.00
12. 00	Land	616, 560	0	0	0	12.00
13. 00	Land improvements	2, 512, 929	- 1	Ö	0	13.00
14.00	Accumulated depreciation	-1, 555, 503	1	О	0	14.00
15.00	Bui I di ngs	21, 706, 437	0	0	0	15. 00
16.00	Accumulated depreciation	-7, 134, 967	0	0	0	16. 00
17. 00	Leasehold improvements	48, 824	0	0	0	17.00
18.00	Accumulated depreciation	-48, 824	0	0	0	18.00
19. 00 20. 00	Fixed equipment Accumulated depreciation	102, 346		U O	0	19. 00 20. 00
21. 00	Automobiles and trucks	-84, 230 1, 221, 253		0	0	20.00
22. 00	Accumulated depreciation	-781, 701	0	0	0	22.00
23. 00	Maj or movable equipment	16, 204, 975	- 1	Ö	0	23. 00
24.00	Accumulated depreciation	-13, 805, 701	0	o	0	24.00
25.00	Mi nor equi pment depreci abl e	86, 386	0	0	0	25. 00
26.00	Accumulated depreciation	-77, 945	0	0	0	26. 00
27.00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Minor equipment-nondepreciable	10.010.020	0	0	0	29.00
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	19, 010, 839	0	0	0	30.00
31.00	Investments	71, 256, 753	0	0	0	31.00
32. 00	Deposits on Leases	0	Ö	o	0	32.00
33.00	Due from owners/officers	0	0	o	0	33.00
34.00	Other assets	69, 024, 848	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	140, 281, 601	0	0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	146, 416, 984	0	0	0	36. 00
27 00	CURRENT LIABILITIES Accounts payable	3, 371, 978	0	ol	0	27.00
37. 00 38. 00	Salaries, wages, and fees payable	1, 362, 138	I	0	0	37. 00 38. 00
39. 00	Payrol I taxes payable	1, 302, 130	0	0	0	39.00
40. 00	Notes and Loans payable (short term)	276, 035	0	Ö	0	40.00
41.00	Deferred income	0	0	O	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	557, 603		0	0	43.00
44. 00	Other current liabilities	437, 479		0	0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44)	6, 005, 233	0	0	0	45. 00
46. 00	LONG TERM LIABILITIES Mortgage payable	1	0	ol	0	46. 00
47. 00	Notes payable	0	0	0	0	47.00
48. 00	Unsecured Loans	0	Ö	o	0	48. 00
49. 00	Other long term liabilities	0	0	Ö	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	o	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	6, 005, 233	0	0	0	51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	140, 411, 751				52.00
53.00	Specific purpose fund		0			53. 00 54. 00
54. 00 55. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant			٩	0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	replacement, and expansion					
59.00	Total fund balances (sum of lines 52 thru 58)	140, 411, 751	1	0	0	59.00
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	146, 416, 984	0	0	0	60.00
	- '/	I	ı	I		I

Provider CCN: 15-0101

| Peri od: | Worksheet G-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

					То	12/31/2023	Date/Time Pre 5/23/2024 12:	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	ļ
							i dila	
		1. 00	2. 00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		122, 838, 704			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		16, 939, 239					2.00
3.00	Total (sum of line 1 and line 2)	(04.004	139, 777, 943			0		3.00
4. 00 5. 00	NONALLOWABLE HOME OFFICE INTEREST EX	634, 884			0		0	
6. 00		0			0		0	
7. 00		0			0		0	
8. 00		o			0		Ö	
9. 00		O			0		0	1
10.00	Total additions (sum of line 4-9)		634, 884			0		10.00
11. 00	Subtotal (line 3 plus line 10)		140, 412, 827			0		11.00
12.00	OTHER	1, 076			0		0	
13.00		0			0		0	
14. 00 15. 00		0			0		0	
16. 00		0			0		0	
17. 00		0			0		Ö	
18. 00	Total deductions (sum of lines 12-17)	J	1, 076			0		18.00
19.00	Fund balance at end of period per balance		140, 411, 751			0		19.00
	sheet (line 11 minus line 18)							
		Endowment Fund	Plant	Fund				
		i unu						
		6. 00	7. 00	8. 00				
1. 00	Fund balances at beginning of period	0			0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				_			2.00
3. 00 4. 00	Total (sum of line 1 and line 2) NONALLOWABLE HOME OFFICE INTEREST EX	U	0		0			3. 00 4. 00
5. 00	INDIVALEDWADEL HOWE OFFICE TIMEREST EX		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 13. 00	OTHER		0					12. 00 13. 00
14. 00			0					14.00
15. 00		}	0					15.00
16. 00			0					16.00
17. 00			0					17. 00
18.00	Total deductions (sum of lines 12-17)	o			0			18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			19.00
		•		•				•

Health Financial Systems WH STATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-0101

			10	5 12/31/2023	5/23/2024 12:	
	Cost Center Description	Inpa	tient	Outpati ent	Total	ос р
			00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>		•		
	General Inpatient Routine Services					
1.00	Hospi tal	11,	968, 138		11, 968, 138	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)	11.	968, 138		11, 968, 138	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 I	i nes	0		0	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11,	968, 138		11, 968, 138	17.00
18. 00	Ancillary services		110, 238	ol	42, 110, 238	18.00
19. 00	Outpati ent servi ces		0	305, 849, 665	305, 849, 665	19.00
20.00	RURAL HEALTH CLINIC		0	0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21.00
22. 00	HOME HEALTH AGENCY			_	-	22. 00
23. 00	AMBULANCE SERVICES		0	14, 301, 367	14, 301, 367	23. 00
24. 00	CMHC		-	,,	, ,	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00
26. 00	HOSPI CE					26. 00
27. 00	OTHER (SPECIFY)		0	0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst. 54.	078, 376	320, 151, 032	374, 229, 408	28. 00
	G-3, line 1)		,	,,	, == . ,	
	PART II - OPERATING EXPENSES	<u> </u>		'		
29.00	Operating expenses (per Wkst. A, column 3, line 200)			92, 329, 799		29.00
30.00	HOME OFFICE INTEREST EXPENSE		634, 884			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)			634, 884		36.00
37.00	DEDUCT (SPECIFY)		0	·		37.00
38.00			0			38.00
39.00			0			39.00
40.00			0			40.00
41.00			0			41.00
42.00	Total deductions (sum of lines 37-41)			ol		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		92, 964, 683		43.00
	to Wkst. G-3, line 4)					
		•	'		•	

Heal th	Financial Systems WHITLEY MEI	MORIAL HOSPITAL	In lie	u of Form CMS-2	2552-10
	IENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0101	Peri od:	Worksheet G-3	
			From 01/01/2023 To 12/31/2023	Date/Time Pre 5/23/2024 12:	
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column			374, 229, 408	
2.00	Less contractual allowances and discounts on patients'	accounts		272, 775, 080	•
3. 00	Net patient revenues (line 1 minus line 2)			101, 454, 328	
4. 00	Less total operating expenses (from Wkst. G-2, Part II,			92, 964, 683	
5. 00	Net income from service to patients (line 3 minus line	4)		8, 489, 645	5.00
/ 00	OTHER I NCOME			0	/ 00
6. 00	Contributions, donations, bequests, etc			0 E00 E70	6.00
7. 00 8. 00	Income from investments	anti an comil acc		589, 570	
9. 00	Revenues from telephone and other miscellaneous communi- Revenue from television and radio service	cation services		0	
10.00	Purchase di scounts			0	
	Rebates and refunds of expenses			0	
	Parking lot receipts			0	
	Revenue from Laundry and Linen service			0	13.00
	Revenue from meals sold to employees and guests			228, 772	
	Revenue from rental of living quarters			220, 772	
	Revenue from sale of medical and surgical supplies to o	ther than nationts		0	
	Revenue from sale of drugs to other than patients	their than patrents		0	
	Revenue from sale of medical records and abstracts			- 1	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)				19.00
	Revenue from gifts, flowers, coffee shops, and canteen			0	
	Rental of vending machines			0	
22. 00	Rental of hospital space			0	
23. 00	Governmental appropriations			0	
24. 00	OTHER REVENUE			1, 543, 899	
24. 01	GAIN/LOSS ON SALE OF CAPITAL ASSETS			5, 812, 353	
24. 02	EMS SUBSIDY			275, 000	
24. 50	COVI D-19 PHE Fundi ng			0	
	Total other income (sum of lines 6-24)			8, 449, 594	25.00
26.00	Total (line 5 plus line 25)			16, 939, 239	26.00
27.00	OTHER EXPENSES (SPECIFY)			0	27. 00
28 00	Total other expenses (sum of line 27 and subscripts)			0	28 00

0 28.00 16, 939, 239 29.00

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

llool +h	Financial Systems WHITLEY MEMORIA	AL LIGGDITAL	la li o	. of Form CMC 1	DEE2 10
	Financial Systems WHITLEY MEMORIA ATION OF CAPITAL PAYMENT	Provider CCN: 15-0101	Period: From 01/01/2023 To 12/31/2023	worksheet L Parts I-III Date/Time Pre 5/23/2024 12:	pared:
		Title XVIII	Hospi tal	PPS	
		1. 00			
	PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier		1	192, 498	1.00
1. 00	Model 4 BPCI Capital DRG other than outlier			192, 490	1.00
2. 00	Capital DRG outlier payments			0	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2.01
3. 00	Total inpatient days divided by number of days in the cost	reporting period (see ins	tructions)	13. 99	3. 00
4. 00	Number of interns & residents (see instructions)	. span and parties (and the		0.00	4.00
5.00	Indirect medical education percentage (see instructions)			0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by t	he sum of lines 1 and 1.0	1, columns 1 and	0	6. 00
	1.01) (see instructions)				
7. 00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)	patient days (Worksheet	E, part A line	0. 00	7. 00
8. 00	Percentage of Medicaid patient days to total days (see inst	ructions)		0. 00	8. 00
9. 00	Sum of lines 7 and 8	ructions)		0.00	
10.00	Allowable disproportionate share percentage (see instruction	ns)		0.00	
11. 00	1 1 3 1	113)		0.00	11.00
	, , ,			192, 498	
				,	
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1. 00	Program inpatient routine capital cost (see instructions)			0	1. 00
2. 00	Program inpatient ancillary capital cost (see instructions)			0	2.00
3. 00	Total inpatient program capital cost (line 1 plus line 2)			0	3. 00
4. 00	Capital cost payment factor (see instructions)			0	4.00
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	1.00
2.00	Program inpatient capital costs for extraordinary circumsta	nces (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	3.00
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 (see	i notruoti ono)		0 0. 00	5. 00 6. 00
7. 00	Adjustment to capital minimum payment level for extraordina		v lino ()	0.00	
8. 00	Capital minimum payment level (line 5 plus line 7)	Ty CITCUIISTAILCES (TITIE 2	x iiile o)	0	8.00
9. 00	Current year capital payments (from Part I, line 12, as app	licable)		0	9.00
10.00	Current year comparison of capital minimum payment level to	,	less line 9)	0	10.00
11. 00	Carryover of accumulated capital minimum payment level over			0	11.00
50	Worksheet L, Part III, line 14)	224 221 E232112 (1.10m B)	. ,		
12.00	Net comparison of capital minimum payment level to capital	payments (line 10 plus li	ne 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, ent	er the amount on this lin	e)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over	capital payment for the	following period	0	14.00
	(if line 12 is negative, enter the amount on this line)				
15. 00				0	
	.00 Current year operating and capital costs (see instructions)				
	Current year operating and capital costs (see instructions) Current year exception offset amount (see instructions)			0	16. 00 17. 00