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 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0104 Worksheet S Peri od: From 01/01/2019 Parts I-III AND SETTLEMENT SUMMARY 12/31/2019 Date/Time Prepared: 3/31/2020 8:18 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically filed cost report Date: 3/31/2020 8: 18 am use only Manually submitted cost report ] If this is an amended report enter the number of times the provider resubmitted this cost report ] Medicare Utilization. Enter "F" for full or "L" for low. 6. Date Received: 7. Contractor No. 10. NPR Date: Contractor ]Cost Report Status (1) As Submitted

7. Contractor No.

(2) Settled without Audit 8. [ N ] Initial Report for this Provider CCN 12. [ 0 ] If line 5, column 1 is 4: Enter (3) Settled with Audit

9. [ N ] Final Report for this Provider CCN | number of times reopened = 0-9. 11. Contractor's Vendor Code: use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

## PART II - CERTIFICATION

(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 the Balance Sheet and Statement of Revenue and Expenses prepared by WITHAM MEMORIAL HOSPITAL (15-0104) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si gned) GEORGE POGAS
Officer or Administrator of Provider(s)
CFO

Title

(Dated when report is electronically signed.)

Date

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		2.00	3. 00	4. 00	5. 00	
III - SETTLEMENT SUMMARY						
i tal	0	146, 753	197, 455	0	-227, 374	1.00
rovider - IPF	0	6, 961	-370		0	2.00
rovider - IRF	0	0	0		0	3.00
ROVI DER I						4.00
g bed - SNF	0	0	0		0	5.00
g bed - NF	0				0	6.00
LED NURSING FACILITY	0	16, 903	-409		0	7.00
	0	170, 617	196, 676	0	-227, 374	200.00
i	tal  ovider - IPF  ovider - IRF  ovider - IRF  oviDER I  bed - SNF  bed - NF  LED NURSING FACILITY	1.00	Cost Center Description	1.00   2.00   3.00	Title V   Part A   Part B   HIT	Title V   Part A   Part B   HIT   Title XIX

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

Health Financial Systems WITHAM MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0104 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 3/31/2020 8:18 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 2605 N. LEBANON STREET 1.00 PO Box: 1.00 State: IN Zi p Code: 46052-2.00 City: LEBANON County: BOONE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal WITHAM MEMORIAL 150104 26900 07/01/1966 N 0 3.00 1 HOSPI TAI Subprovi der - IPF WITHAM HOSPITAL 4.00 15S104 26900 4 01/01/2000 Ν Ρ Ν 4.00 **GEROPSYCH** 5 00 Subprovi der - IRF 5 00 Subprovider - (Other) 6.00 6.00 Swing Beds - SNF Swing Beds - NF 7.00 7.00 8.00 8.00 9.00 Hospital -Based SNF WITHAM HOSPITAL ECU 155832 26900 05/07/2015 Р 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14 00 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 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: To: 1 00 2 00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2019 12/31/2019 20.00 21.00 Type of Control (see instructions) Q 21.00 1.00 2. 00 3.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for 22.00 N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care 22.02 Ν Ν payments to be 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 Ν Ν Ν 22 03 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. 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.

	In-State Medicaid paid days	In-State Medicaid eligible unpaid	Out-of State Medicaid paid days	Out-of State Medicaid eligible	Medicaid HMO days	Other Medicaid days	
		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 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.		1, 506	0	0	308	0	24. 00

PITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION	DATA	Provi der CC	CN: 15-0104	Peri od:			neet S-2	
				From 01/0 To 12/3	1/2019 1/2019	Date/T	ime Pre 2020 8:1	
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	ays   Me	Other di cai d days	
	1.00	2. 00	3. 00	4. 00	5. 0		6. 00	
00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-stat Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.		0	0	0		0	£ 0	25.
				Urban/k		Date o	r Geogr 00	-
00 Enter your standard geographic classification (not		s at the be	ginning of		1			26.
cost reporting period. Enter "1" for urban or "2" f 00 Enter your standard geographic classification (not reporting period. Enter in column 1, "1" for urban enter the effective date of the geographic reclassi	wage) status or "2" for i	rural. If a		st	1			27.
00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status i	n	C			35.
portion.				Begi n			i ng: 00	
00 Enter applicable beginning and ending dates of SCH		script line	36 for numl		50	2.	00	36.
of periods in excess of one and enter subsequent da 00 If this is a Medicare dependent hospital (MDH), ent		er of perio	ds MDH stati	us	C			37
is in effect in the cost reporting period.  O1 Is this hospital a former MDH that is eligible for accordance with FY 2016 OPPS final rule? Enter "Y"	the MDH trai	nsitional p "N" for no.	ayment in (see					37
instructions) 00 If line 37 is 1, enter the beginning and ending dat greater than 1, subscript this line for the number	tes of MDH s	tatus. If I	ine 37 is					38
enter subsequent dates.				Y/	'N	Y	/N	
				1.	00	2.	00	
00 Does this facility qualify for the inpatient hospit hospitals in accordance with 42 CFR §412.101(b)(2)( 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or ( or "N" for no. (see instructions)	(i), (ii), o t the mileage	r (iii)? En e requireme	ter in colum nts in	mn			Y	39
00 Is this hospital subject to the HAC program reducti "N" for no in column 1, for discharges prior to Oct no in column 2, for discharges on or after October	tober 1. Ente	er "Y" for					N 	40
					1. 0	XVIII 0 2.00		-
Prospective Payment System (PPS)-Capital								
00 Does this facility qualify and receive Capital paym with 42 CFR Section §412.320? (see instructions) 00 Is this facility eligible for additional payment ex					N	N N	N N	45
pursuant to 42 CFR §412.348(f)? If yes, complete Wk Pt. III.	kst. L, Pt. I	III and Wks	t. L-1, Pt.	I through				
00 Is this a new hospital under 42 CFR §412.300(b) PPS 00 Is the facility electing full federal capital payme					N N	N N	N N	47 48
Teaching Hospitals  On Is this a hospital involved in training residents in or "N" for no.	n approved (	GME program	s? Enter "	Y" for yes	N			56
00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" is "Y" did residents start training in the first mofor yes or "N" for no in column 2. If column 2 is	for yes or "I onth of this "Y", comple <sup>:</sup> II, if appli	N" for no i cost repor te Workshee icable.	n column 1. ting period t E-4. If co	If column ? Enter "\ olumn 2 is				57
"N", complete Wkst. D, Parts III & IV and D-2, Pt.		1 3	ans' service	es as				58
			. Pt. I.	-	N N	Pass-1	hrough	59
00 If line 56 is yes, did this facility elect cost rei		e wkst. D-2	NAHE 413.8 Y/N	35   Worksh Lin		Qualif Crit	i cati on eri on	
00 If line 56 is yes, did this facility elect cost rei defined in CMS Pub. 15-1, chapter 21, §2148? If yes		E WKST. D-Z	NAHE 413.8		e #	Qualif Crit Cc	i cati on	

Health Financial Systems WITHAM MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0104 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 3/31/2020 8:18 am Y/N IME Direct GME IME Direct GME 1.00 2.00 3.00 4.00 5.00 0 00 0.00 61.00 61.00 Did your hospital receive FTE slots under ACA 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) 61.04 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) Unwei ghted Program Name Program Code Unwei ghted IME FTE Count Direct GME FTE Count 1. 00 2.00 3. 00 4. 00 0.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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 62 01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) N 63.00

	Unv	wei ghted	Unwei ghted	Ratio (col.	
		FTEs	FTEs in	1/ (col . 1 +	
	Non	provi der	Hospi tal	col. 2))	
		Si te			
		1. 00	2. 00	3. 00	
Section 5504 of the ACA Base Year FTE Residents in Nonprov	der SettingsThis	base year	is your cost i	reporti ng	
period that begins on or after July 1, 2009 and before Jun	30, 2010.				
64.00 Enter in column 1, if line 63 is yes, or your facility train	ned residents	0.00	0. 00	0. 000000	64.00
in the base year period, the number of unweighted non-prima	ry care				
resident FTEs attributable to rotations occurring in all no	nprovi der				
settings. Enter in column 2 the number of unweighted non-	rimary care				
resident FTEs that trained in your hospital. Enter in colu	n 3 the ratio				
of (column 1 divided by (column 1 + column 2)). (see instru	ıctions)				

Health Financial Systems WITHAM MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0104 Peri od: Worksheet S-2 From 01/01/2019 Part I 12/31/2019 Date/Time Prepared: 3/31/2020 8:18 am Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs FTEs in 3/ (col. 3 + col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0.00 0. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col . 1 + col . 2)) FTEs in FTFs Nonprovi der Hospi tal Si te 1.00 2. 00 3. 00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs 3/ (col. 3 + FTEs in Nonprovi der col. 4)) Hospi tal Si te 1. 00 2.00 3. 00 4. 00 5.00 67.00 Enter in column 1, the program 0. 00 0. 00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

	1	. 00	2.00	3. 00	
Inpatient Psychiatric Facility PPS					
70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subpr	ovi der?	Υ			70.00
Enter "Y" for yes or "N" for no.		l			
71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in th	e most	N		0	71.00
recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no	. (see				
42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teachi	ng				
program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no					
Column 3: If column 2 is Y, indicate which program year began during this cost reporting	peri od.				
(see instructions)					
Inpatient Rehabilitation Facility PPS					
75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF		N			75.00
subprovi der? Enter "Y" for yes and "N" for no.					

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0104	Period: From 01/01, To 12/31,	/2019 /2019	Workshe Part I Date/Ti 3/31/20	me Pre	epared:
			1.00	2.00	3. 00	-
If line 75 is yes: Column 1: Did the facility have an approved recent cost reporting period ending on or before November 15, 2 no. Column 2: Did this facility train residents in a new teaching CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Co indicate which program year began during this cost reporting pe	004? Enter "Y" for yes ng program in accordar Lumn 3: If column 2 is	or "N" for nce with 42 S Y,	1.00	2.00	0	76. 00
				1. 0	00	
Long Term Care Hospital PPS  1.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "Statis a LTCH co-located within another hospital for part or a "Y" for yes and "N" for no.  TEFRA Providers		ng period?	Enter	N N		80. 00 81. 00
5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TE  5.00 Did this facility establish a new Other subprovider (excluded unled §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			r no.	N		85. 00 86. 00
7.00 Is this hospital an extended neoplastic disease care hospital c 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	lassified under sectio	n		N		87.0
(1000(d) (1) (b) (v1): Effect 1 101 yes 01 N 101 No.		V		XI)		
Title V and XIX Services		1.00		2. 0	0	
Does this facility have title V and/or XIX inpatient hospital solves or "N" for no in the applicable column.	ervices? Enter "Y" for	- N		Υ		90.0
1.00 Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the applical		N		Υ		91.0
2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual instructions) Enter "Y" for yes or "N" for no in the applicable	col umn.			N		92.0
3.00 Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column. 4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and		N N		N N		93.0
applicable column.  5.00 If line 94 is "Y", enter the reduction percentage in the application.		0.00		0. 0		95.0
5.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or applicable column.		N		N		96.0
7.00 If line 96 is "Y", enter the reduction percentage in the application. 3.00 Does title V or XIX follow Medicare (title XVIII) for the interest stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for column 1 for title V, and in column 2 for title XIX.	ns and residents post	0. 00 Y		0. 0 Y		97. 0 98. 0
B. 01 Does title V or XIX follow Medicare (title XVIII) for the repor C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title title XIX.				Υ		98.0
B. 02 Does title V or XIX follow Medicare (title XVIII) for the calcubed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "I for title V, and in column 2 for title XIX.		Y		Υ		98.0
3.03 Does title V or XIX follow Medicare (title XVIII) for a critical reimbursed 101% of inpatient services cost? Enter "Y" for yes of for title V, and in column 2 for title XIX.				N		98.0
3.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reioutpatient services cost? Enter "Y" for yes or "N" for no in co in column 2 for title XIX.		nd N		N		98.0
3.05 Does title V or XIX follow Medicare (title XVIII) and add back Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.				Υ		98. (
3.06 Does title V or XIX follow Medicare (title XVIII) when cost rein Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 column 2 for title XIX.  Rural Providers		Y		Y		98. (
05.00 Does this hospital qualify as a CAH?	lucivo mothed of o	N N				105.0
06.00   f this facility qualifies as a CAH, has it elected the all-inc   for outpatient services? (see instructions)	. ,					106.0
07.00 If this facility qualifies as a CAH, is it eligible for cost re training programs? Enter "Y" for yes or "N" for no in column 1. yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 reimbursed. If yes complete Wkst. D-2, Pt. II.	(see instructions) If					107.0
D8.00 Is this a rural hospital qualifying for an exception to the CRN.	A fee schedule? See 4	12 N				108.0

Health Financial Systems WITHAM MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0104 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 3/31/2020 8:18 am Physi cal Occupati onal Speech Respi ratory 1. 00 2. 00 3. 00 4. 00 109.00 If this hospital qualifies as a CAH or a cost provider, are Ν Ν Ν Ν 109.00 therapy services provided by outside supplier? Enter for yes or "N" for no for each therapy. 1.00 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes 110 00 N complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as appl i cabl e. 1.00 2.00 111.00|f this facility qualifies as a CAH, did it participate in the Frontier Community Ν 111.00 Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services. 1.00 2.00 3.00 Miscellaneous Cost Reporting Information 115.00|Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 Ν 0 115.00 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y" for yes or "N" for no. Ν 116.00 117.00|s this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for Υ 117.00 no. 118.00 118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence. Premi ums Losses Insurance 1. 00 2.00 3.00 0118.01 118.01 List amounts of mal practice premiums and paid losses: 998. 524 1. 00 2.00 118.02 Are mal practice premiums and paid losses reported in a cost center other than the 118. 02 Ν Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 119.00 DO NOT USE THIS LINE 119 00 120.00|s this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA Ν Ν 120.00 §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or 'N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 121.00|Did this facility incur and report costs for high cost implantable devices charged to 121.00 patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Ν 122.00 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If Ν 125.00 yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 of this is a Medicare certified kidney transplant center, enter the certification date 126.00 in column 1 and termination date, if applicable, in column 2. 127.00|If this is a Medicare certified heart transplant center, enter the certification date 127.00 in column 1 and termination date, if applicable, in column 2. 128.00 of this is a Medicare certified liver transplant center, enter the certification date 128.00 in column 1 and termination date, if applicable, in column 2. 129.00|If this is a Medicare certified lung transplant center, enter the certification date in 129, 00 column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter the certification 130.00 date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified intestinal transplant center, enter the certification 131.00 date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare certified islet transplant center, enter the certification date 132.00 in column 1 and termination date, if applicable, in column 2. 133.00 If this is a Medicare certified other transplant center, enter the certification date 133.00 in column 1 and termination date, if applicable, in column 2. 134.00 of this is an organ procurement organization (OPO), enter the OPO number in column 1 134 00 and termination date, if applicable, in column 2. All Providers

	EX IDENTIFICATION DATA	Provi der CCI	N: 15-0104	Peri od:	/01 /2010	Worksheet S-	2
					/01/2019 2/31/2019	Part I Date/Time Pr 3/31/2020 8:	
		·					
40.00 Are there any related organizatio	n or home office costs a	s defined in CMS	Dub 15_1		1. 00 N	2. 00	140. C
chapter 10? Enter "Y" for yes or are claimed, enter in column 2 th	"N" for no in column 1.	If yes, and home	office cost	s	IV .		140.0
1.00  If this facility is part of a cha office and enter the home office	in organization, enter o		ugh 143 the	name an	3.00 d address	of the home	
41.00 Name:	Contractor's Name:	Tactor Humber.	Contrac	tor's Nu	mber:		141. 0
42.00 Street:	PO Box:		7. 0. 1				142. (
13. 00 Ci ty:	State:		Zi p Code	9:			143. (
						1.00	
14.00 Are provider based physicians' co	sts included in Workshee	t A?				Y	144. (
					1. 00	2. 00	
IF.00 If costs for renal services are c inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N" H6.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/	" for yes or "N" for no clude Medicare utilizati for no in column 2. gy changed from the prev n column 1. (See CMS Pub	in column 1. If on for this cost iously filed cost	column 1 is reporting t report?	f	N		145. (
						1 00	-
7.00Was there a change in the statist	ical basis? Enter "Y" fo	r ves or "N" for	no.			1. 00 N	147.
8.00 Was there a change in the order o	f allocation? Enter "Y"	for yes or "N" for	or no.			N	148.
9.00Was there a change to the simplif	ied cost finding method?	Enter "Y" for ye	es or "N" fo Part B		tle V	N Title XIX	149.
		1. 00	2. 00		3. 00	4.00	1
Does this facility contain a prov							
or charges? Enter "Y" for yes or 5.00 Hospi tal	"N" for no for each comp	onent for Part A N	and Part B N	. (See 4	2 CFR §41: N	3. 13) N	155.
6.00 Subprovi der – IPF		N N	N		N	N	156.
7.00 Subprovider - IRF		N	N		N	N	157.
8. 00 SUBPROVI DER							
		N	N	i	N	N	
9. 00 SNF		N N	N N		N N	N N	159.
9.00 SNF 0.00 HOME HEALTH AGENCY							159. 160.
9.00 SNF 0.00 HOME HEALTH AGENCY			N		N	N N	159. 160.
9.00 SNF 0.00 HOME HEALTH AGENCY 11.00 CMHC  Multicampus	owners book to that has	N	N N	Forest Cl	N N	N N 1.00	159. 160. 161.
69.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC 	ampus hospital that has	N	N N uses in diff		N N	1. 00	159. 160. 161.
9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC  Multicampus 5.00 s this hospital part of a Multic	Name	one or more campu	N N uses in diff	p Code	N N BSAs?	N N N 1.00 N FTE/Campus	159. 160. 161.
9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC  Multicampus 5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.		one or more campu	N N uses in diff		N N BSAs?	N N 1.00 N FTE/Campus 5.00	159. 160. 161. 165.
9.00 SNF 10.00 HOME HEALTH AGENCY 11.00 CMHC  Multicampus 15.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	Name	one or more campu	N N uses in diff	p Code	N N BSAs?	N N 1.00 N FTE/Campus 5.00	159. 160. 161.
9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC  Multicampus 5.00 is this hospital part of a Multic Enter "Y" for yes or "N" for no.  6.00 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	Name	one or more campu	N N uses in diff	p Code	N N BSAs?	N N 1.00 N FTE/Campus 5.00 0.0	159. 160. 161. 165.
9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC  Multicampus 5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.  6.00 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	Name O	one or more campu County 1.00	State Z 2.00	p Code 3.00	N N BSAs?	N N 1.00 N FTE/Campus 5.00	159. 160. 161. 165.
9.00 SNF 1.00 CMHC  Multicampus 5.00 Is this hospital part of a Multicampus 6.00 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)  Health Information Technology (HI 7.00 Is this provider a meaningful use 8.00 If this provider is a CAH (line 1	Name  O  T) incentive in the Amer runder §1886(n)? Enter 05 is "Y") and is a mean	One or more campu County 1.00  Tican Recovery and "Y" for yes or " ingful user (line	N N N N N N N N N N N N N N N N N N N	p Code 3.00	N N SSAS? CBSA 4.00	N N 1.00 N FTE/Campus 5.00 0.0	159. 160. 161. 165. 0 166.
9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC  Multicampus 5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.  6.00 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)  Health Information Technology (HI 7.00 Is this provider a meaningful use 8.00 If this provider is a CAH (line 1 reasonable cost incurred for the 8.01 If this provider is a CAH and is	Name  O  T) incentive in the Amer runder §1886(n)? Enter 05 is "Y") and is a mean HIT assets (see instruct not a meaningful user, decreased the content of t	one or more campu  County 1.00  ican Recovery and "Y" for yes or " ingful user (line ions) oes this provider	N N N N N N N N N N N N N N N N N N N	ent Act  '), enter	N N 3SAs? CBSA 4.00	N N N N N N N N N N N N N N N N N N N	159. 160. 161. 165. 165.
Multicampus  5.00   Home Health Agency  1.00   Multicampus  5.00   Is this hospital part of a Multic Enter "Y" for yes or "N" for no.  6.00   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)  Health Information Technology (HI  67.00   Is this provider a meaningful use 18.01   If this provider is a CAH (line 1) reasonable cost incurred for the 18.01   If this provider is a CAH and is exception under §413.70(a)(6)(ii)	Name  O  T) incentive in the Amer r under §1886(n)? Enter 05 is "Y") and is a mean HIT assets (see instruct not a meaningful user, de? Enter "Y" for yes or "user (line 167 is "Y") a	County 1.00  Count	N N N N N N N N N N N N N N N N N N N	ent Act  y), enter	SSAS?  CBSA 4.00	N N N N N N N N N N N N N N N N N N N	159. 160. 161. 165. 0166.
Multicampus  55.00    Multicampus	Name  O  T) incentive in the Amer r under §1886(n)? Enter 05 is "Y") and is a mean HIT assets (see instruct not a meaningful user, de? Enter "Y" for yes or "user (line 167 is "Y") a	County 1.00  Count	N N N N N N N N N N N N N N N N N N N	ent Act  '), enter or a hard s' "N"), e	SSAS?  CBSA 4.00	N N N N N N N N N N N N N N N N N N N	158. (159. (160. (161. (

Health Financial Systems	In Lie	u of Form CMS-	2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDEN					
			From 01/01/2019 To 12/31/2019	Date/Time Pre	naradi
			10 12/31/2019	3/31/2020 8: 1	
			1. 00	2.00	
171.00 If line 167 is "Y", does this provider h	nave any days for indi	viduals enrolled in	N	C	171.00
section 1876 Medicare cost plans reporte					
"Y" for yes and "N" for no in column 1.	on				
1876 Medicare days in column 2. (see ins	structions)				

	Financial Systems WITHAM MEMORI TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0104 P	eriod:	worksheet S-2	
	The fine floor fine field with the fine floor of the flo		F	rom 01/01/2019 o 12/31/2019	Part II	
					3/31/2020 8: 1	
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	N for all NO re	esnonses Enter	1.00	2. 00	
	mm/dd/yyyy format.	TOT GIT NO IX	сэронэсэ. Епте	dir dates in	the	
	COMPLETED BY ALL HOSPITALS					
00	Provider Organization and Operation  Has the provider changed ownership immediately prior to the	o boginning of	the cost	N		1
. 00	reporting period? If yes, enter the date of the change in a			ĮN.		1.
	,		Y/N	Date	V/I	
			1.00	2. 00	3. 00	
. 00	Has the provider terminated participation in the Medicare I yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.
. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the providencers, medical staff, management personnel, or members of	offices, drug der or its	Y			3.
	of directors through ownership, control, or family and other relationships? (see instructions)					
			Y/N	Type	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
. 00	Column 1: Were the financial statements prepared by a Cer-Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date available.	for Compiled,	Y	А	05/30/2020	4.
. 00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues difference on the filed financial statements? If yes, submit reconstructions.		N			5.
				Y/N	Legal Oper.	
				1. 00	2.00	
00	Approved Educational Activities	1£ voo i o +l	ho providor io	N		1
. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	ir yes, is ti	ne provider is	N		6.
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved		d during the	N N		7. 8.
. 00	cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	N		9.
0. 00	Was an approved Intern and Resident GME program initiated of cost reporting period? If yes, see instructions.		the current	N		10.
1. 00	Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.	I & R in an App	proved	N		11.
					Y/N	
	Bad Debts				1. 00	
2. 00	Is the provider seeking reimbursement for bad debts? If yes	s, see instruc	ti ons.		Υ	12.
3. 00	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.	policy change (	during this cos		N	13.
4. 00	If line 12 is yes, were patient deductibles and/or co-payments	ents waived? I	f yes, see ins	tructions.	N	14.
5 00	Bed Complement Did total beds available change from the prior cost reporti	ing period? If	ves see insti	ructions	N	15.
0. 00	pro total bods avarrable onange from the prior cost reports		t A		rt B	10.
		Y/N	Date	Y/N	Date	
	loose a s	1. 00	2. 00	3. 00	4. 00	
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	N		N		16.
7. 00	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	Y	03/23/2020	Y	03/23/2020	17.
	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)					
8. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	N		N		18.
	but are not included on the PS&R Report used to file this					

Heal th	Financial Systems WITHAM MEMORI	IAL HOSPITAL		In Lie	u of Form CM	S-2552-10			
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 15-0104	Peri od: From 01/01/2019 To 12/31/2019	Worksheet S Part II	S-2 Prepared:			
			iption	Y/N	Y/N	, , , , , , , , , , , , , , , , , , ,			
20.00	LE Line 1/ and 17 in the property and the DCOD		0	1.00	3. 00 N	20.00			
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	IN	20.00			
		Y/N	Date	Y/N	Date				
04.00	III	1.00	2. 00	3.00	4. 00	21.22			
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00			
					1. 00				
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS	HOSPI TALS)						
22. 00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, se	o instructions				22. 00			
23. 00	Have changes occurred in the Medicare depreciation expense			ring the cost		23.00			
	reporting period? If yes, see instructions.	• •							
24. 00	Were new leases and/or amendments to existing leases enter If yes, see instructions	Š				24. 00			
25. 00	Have there been new capitalized leases entered into during instructions.	? If yes, see		25. 00					
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.	the cost report	ing period?	lf yes, see		26. 00			
27. 00	Has the provider's capitalization policy changed during th copy.	f yes, submit		27. 00					
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit e	t reporting		28. 00					
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	Reserve Fund)		29. 00					
	treated as a funded depreciation account? If yes, see inst	ructions		, i					
30. 00	Has existing debt been replaced prior to its scheduled mat instructions.	,	,			30.00			
31. 00	Has debt been recalled before scheduled maturity without instructions.	ssuance of new	debt? If yes	s, see		31.00			
32. 00	Purchased Services Have changes or new agreements occurred in patient care se		ned through co	ontractual		32. 00			
33. 00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap		ng to competi	tive bidding? If		33. 00			
	no, see instructions. Provider-Based Physicians								
34. 00	Are services furnished at the provider facility under an a	rrangement wit	h provi der-ba	ased physicians?		34.00			
35 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	vistina aaroomo	nto with the	provider based		25 00			
35.00	physicians during the cost reporting period? If yes, see i		ents with the	provider-based		35.00			
				Y/N 1,00	Date				
	Home Office Costs			1. 00	2. 00				
	Were home office costs claimed on the cost report?					36.00			
37. 00	If line 36 is yes, has a home office cost statement been p	prepared by the	home office	?		37. 00			
38. 00	If yes, see instructions.  If line 36 is yes, was the fiscal year end of the home of			f		38. 00			
39. 00				5,		39. 00			
40. 00	see instructions. If line 36 is yes, did the provider render services to the	e home office?	If yes, see			40. 00			
	instructions.								
		1.	. 00	2.	00				
44.05	Cost Report Preparer Contact Information	T. 110		CEVEDO		46.00			
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA		SEVERS		41.00			
42. 00	Enter the employer/company name of the cost report	BLUE & CO., LI	_C			42.00			
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946		TSEVERS@BLUEANI	DCO. COM	43. 00			
	report preparer in columns I and 2, respectively.								

Heal th I	Financial Systems	WITHAM MEMORI	AL HOSPITA	L	In Lieu of Form CMS-2552-10			
HOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi de	er CCN: 15-0104	riod: om 01/01/2019 12/31/2019	Worksheet S-2 Part II Date/Time Pre 3/31/2020 8:1	pared:	
				3. 00				
	Cost Report Preparer Contact Information			0.00	 			
I	Enter the first name, last name and the t held by the cost report preparer in colum respectively.		MANAGER				41. 00	
	Enter the employer/company name of the copreparer.	st report					42.00	
43. 00 i	Enter the telephone number and email addr report preparer in columns 1 and 2, respe						43.00	

 
 Health Financial
 Systems
 WITHAM

 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE COMPLEX
 STATISTICAL
 DATA
 Provi der CCN: 15-0104

							12/31/2019	Date/Time Prepared: 3/31/2020 8:18 am			
								1/P Days /	o am		
								0/P Visits /			
								Trips			
	Component	Worksheet A	No.	. of Beds	Bed Days		CAH Hours	Title V			
		Line Number		0.00	Available		4 00	F 00		L	
1 00	Illerai tel Adulte a Dede (celume 5 / 7 and	1. 00		2.00	3.00		4. 00	5. 00	1 00	1	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	30. 00		60	21, 90	JU	0. 00	U	1. 00		
	Hospice days) (see instructions for col. 2										
	for the portion of LDP room available beds)										
2. 00	HMO and other (see instructions)								2.00		
3. 00	HMO IPF Subprovider								3.00		
4. 00	HMO IRF Subprovider								4.00		
5. 00	Hospital Adults & Peds. Swing Bed SNF							0	5.00		
6. 00	Hospital Adults & Peds. Swing Bed NF							0	6.00		
7. 00	Total Adults and Peds. (exclude observation			60	21, 90	00	0. 00	0	7. 00		
	beds) (see instructions)										
8.00	INTENSIVE CARE UNIT	31.00		8	2, 92	20	0.00	0	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)			68	24, 82	20	0. 00	0	14.00		
15.00	CAH visits							0	15.00		
16.00	SUBPROVIDER - IPF	40.00		10	3, 65	0		0	16.00		
17.00	SUBPROVI DER - I RF	41. 00		0		0		0	17.00		
18.00	SUBPROVI DER	42. 00		0		0		0	18.00		
19. 00	SKILLED NURSING FACILITY	44. 00		18	6, 57	70		0	19.00		
20. 00	NURSING FACILITY								20.00		
21. 00	OTHER LONG TERM CARE								21.00		
22. 00	HOME HEALTH AGENCY								22. 00		
23. 00	AMBULATORY SURGICAL CENTER (D. P.)								23. 00		
24.00	HOSPI CE								24.00		
24. 10	HOSPICE (non-distinct part)	30. 00							24. 10		
25.00	CMHC - CMHC								25.00		
26.00	RURAL HEALTH CLINIC	00.00							26.00		
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00		0.4				0	26. 25		
27. 00	Total (sum of lines 14-26)			96					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 32. 00	Employee discount days - IRF Labor & delivery days (see instructions)			0		0			31. 00 32. 00		
32. 00 32. 01	Total ancillary labor & delivery room			0		U			32.00		
32. UI	outpatient days (see instructions)								32.01		
33.00	LTCH non-covered days								33.00		
33. 01	LTCH site neutral days and discharges								33. 01		

Health Financial SystemsWITHAMHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 01/01/2019 | Part I | To 12/31/2019 | Date/Time Prepared: Provi der CCN: 15-0104

				1	0 12/31/2019	3/31/2020 8:1	
		I/P Davs	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	2, 125	317	5, 428			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	1, 350	1, 725				2.00
3.00	HMO IPF Subprovider	9	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	2, 125	317	5, 428			7. 00
	beds) (see instructions)	704					
8.00	INTENSIVE CARE UNIT	781	0	1, 705			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)			4 000			12.00
13.00	NURSERY	0.00/	0	,	0.00	050 40	13.00
14.00	Total (see instructions)	2, 906	317	8, 213	0. 00	953. 48	1
15.00	CAH visits	2 525	0	0	0.00	20.27	15.00
16.00	SUBPROVIDER - I PF	2, 535	0	3, 211	0. 00 0. 00	30. 26	
17. 00 18. 00	SUBPROVI DER	o <sub>l</sub>	0	0	0.00		
19.00	SKILLED NURSING FACILITY	3, 051	0	5, 125	0.00	33. 26	1
20.00	NURSING FACILITY	3, 05 1	U	5, 125	0.00	33. 20	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)			3			24. 00
25. 00	CMHC - CMHC			3			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)	٩	J	0	0.00	1, 017. 00	
28. 00	Observation Bed Days		0	2, 058	0.00	1,017.00	28.00
29. 00	Ambulance Trips	1, 963	J	2,000			29.00
30.00	Employee discount days (see instruction)	1, 700		163			30.00
31. 00	Employee discount days - IRF			0			31.00
32. 00	Labor & delivery days (see instructions)	o	97	150			32.00
32. 01	Total ancillary labor & delivery room	٩	,,	n			32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	o					33.00
	LTCH site neutral days and discharges	Ö					33. 01
	,	,	'	•		•	•

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

				10	) 12/31/2019	3/31/2020 8:1	
		Full Time	<u>'</u>	Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	10.00	10.00	11.00	Pati ents	
1 00	Tu	11. 00	12. 00	13. 00	14. 00	15. 00	1.00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		0	812	63	2, 252	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			351	423		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 UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	0.00		010		0.050	13.00
14.00	Total (see instructions)	0.00	0	812	63	2, 252	14.00
15.00	CAH visits	0.00	0	157	o	224	15.00
16. 00 17. 00	SUBPROVIDER - IPF SUBPROVIDER - IRF	0. 00 0. 00	0		0	234	16. 00 17. 00
18. 00	SUBPROVI DER	0.00	0		0	0	18.00
19. 00	SKILLED NURSING FACILITY	0.00	0		o o	U	19.00
20. 00	NURSING FACILITY	0.00					20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23.00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00	Total (sum of lines 14-26)	0.00					27. 00
28.00	Observation Bed Days						28. 00
29.00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges			0			33. 01

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0104 Peri od: Worksheet S-3 From 01/01/2019 Part II Date/Time Prepared: 12/31/2019 3/31/2020 8:18 am Wkst. A Line Amount Recl assi fi cat Paid Hours Adj usted Average Hourly Wage (col. 4 ÷ col. 5) Number Reported ion of Sal ari es Related to Sal ari es (col. 2 ± col. Salaries in (from Wkst 3) col. 4 A-6)1.00 2.00 3.00 4.00 5.00 6.00 PART II - WAGE DATA SALARI ES 200 00 1.00 Total salaries (see 65, 734, 449 1, 154, 710 66, 889, 159 1, 706, 971. 00 39.19 1.00 instructions) 2.00 Non-physician anesthetist Part 0 0 0.00 0.00 2.00 3 00 O Non-physician anesthetist Part 0 C 0 00 0 00 3.00 4.00 Physician-Part A -0 0.00 0.00 4.00 Administrative 4.01 Physicians - Part A - Teaching 0 0.00 0.00 4.01 5.00 Physician and Non C 0 0.00 0.00 5.00 Physician-Part B 6.00 Non-physician-Part B for 0 0.00 0.00 6.00 hospital-based RHC and FQHC servi ces Interns & residents (in an 7.00 21.00 C 0 0.00 0.00 7.00 approved program) 7.01 Contracted interns and 0 0.00 0.00 7.01 residents (in an approved programs) 8.00 Home office and/or related 0 0.00 0.00 8.00 organization personnel 9 00 44.00 44, 099. 00 SNF 1,042,284 22.344 1,064,628 24 14 9 00 93, 444 10.00 Excluded area salaries (see 32, 762, 792 32, 856, 236 646, 162. 00 50.85 10.00 instructions) OTHER WAGES & RELATED COSTS 1, 608, 250 1, 608, 250 11.00 Contract labor: Direct Patient 19, 577. 00 82. 15 11.00 Contract Labor: Top Level 0 0.00 12.00 0 0.00 12.00 management and other management and administrative servi ces 13.00 Contract Labor: Physician-Part C 0 0.00 0.00 13.00 A - Administrative 14.00 Home office and/or related 0 0 0.00 0.00 14.00 organization salaries and wage-related costs 14.01 Home office salaries 0 0.00 0.00 14.01 Related organization salaries 0 0.00 14.02 0.00 14.02 15.00 Home office: Physician Part A 0 0.00 0.00 15.00 - Administrative 0.00 0 16.00 Home office and Contract C 0.00 16.00 Physicians Part A - Teaching WAGE-RELATED COSTS Wage-related costs (core) (see 11, 676, 599 0 17.00 11, 676, 599 17.00 instructions) 18.00 Wage-related costs (other) 18.00 (see instructions) 8, 890, 231 19.00 19.00 Excluded areas 8, 890, 231 Non-physician anesthetist Part C 20.00 20.00 C 21.00 Non-physician anesthetist Part 0 C 0 21.00 22.00 Physician Part A -0 22.00 Admi ni strati ve 22 01 Physician Part A - Teaching  $\cap$ 22 01 23.00 Physician Part B 0 23.00 Wage-related costs (RHC/FQHC) 24.00 0 24.00 25.00 Interns & residents (in an 0 C 0 25.00 approved program) 25.50 Home office wage-related C 0 25.50 (core) 25.51 Related organization 0 25.51 wage-related (core) Home office: Physician Part A 25.52 0 C 0 25.52 - Administrative wage-related (core) Home office & Contract 0 25.53 Physicians Part A - Teaching wage-related (core)

					T	o 12/31/2019	Date/Time Pre 3/31/2020 8:1	
		Wkst. A Line	Amount	Reclassi fi cat	Adjusted	Pai d Hours	Average	8 8111
		Number	Reported	i on of	Sal ari es	Related to	Hourly Wage	
		IVallibet	керог геа	Sal ari es	(col. 2 ± col.	Salaries in	(col. 4 ÷	
				(from Wkst.	3)	col . 4	col. 5)	
				A-6)	3)	COI. 4	COI. 3)	
		1. 00	2. 00	3.00	4, 00	5. 00	6. 00	
	OVERHEAD COSTS - DIRECT SALARI			0.00		0.00		
26.00	Employee Benefits Department	4.00	34, 331	0	34, 331	14, 289. 00	2. 40	26. 00
27.00	Administrative & General	5. 00	6, 921, 034	354, 402	7, 275, 436	215, 023. 00	33. 84	27. 00
28. 00	Administrative & General under		1, 680, 443		1, 680, 443			28. 00
	contract (see inst.)		, ,		, ,	,		
29.00	Maintenance & Repairs	6. 00	0	0	0	0.00	0. 00	29. 00
30.00	Operation of Plant	7. 00	666, 851	24, 463	691, 314	21, 920. 00	31. 54	30.00
31.00	Laundry & Linen Service	8. 00	31, 210	842	32, 052	2, 121. 00	15. 11	31.00
32.00	Housekeepi ng	9. 00	472, 740	7, 621	480, 361	29, 609. 00	16. 22	32.00
33.00	Housekeeping under contract		0	0	0	0.00	0. 00	33.00
	(see instructions)							
34.00	Dietary	10.00	982, 099	-129, 795	852, 304	40, 680. 00	20. 95	34.00
35.00	Di etary under contract (see		0	0	0	0.00	0. 00	35.00
	instructions)							
36.00	Cafeteri a	11. 00	0	155, 690	155, 690	12, 341. 00	12. 62	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	612, 959	17, 659	630, 618	13, 398. 00	47. 07	38. 00
39.00	Central Services and Supply	14. 00	0	0	0	0.00		39. 00
40.00	Pharmacy	15. 00	695, 146	13, 583	708, 729	19, 808. 00	35. 78	40.00
41.00	Medical Records & Medical	16.00	1, 329, 044	36, 431	1, 365, 475	48, 860. 00	27. 95	41.00
	Records Library							
42.00	Social Service	17. 00	0	0	0	0. 00	0. 00	42.00
43.00	Other General Service	18. 00	0	0	0	0. 00	0.00	43.00

Heal	th Financial Systems	WITHAM MEMORIA	L HOSPITAL		In Lie	u of Form CMS-:	2552-10
HOS	PITAL WAGE INDEX INFORMATION		Provi der	CCN: 15-0104	Peri od: From 01/01/2019	Worksheet S-3 Part III Date/Time Pre	
					10 12/31/2019	3/31/2020 8: 1	

					T	o 12/31/2019	Date/Time Pre 3/31/2020 8:1	
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		67, 414, 892	1, 154, 710	68, 569, 602	1, 728, 241. 00	39. 68	1.00
	instructions)							
2. 00	Excluded area salaries (see		33, 805, 076	115, 788	33, 920, 864	690, 261. 00	49. 14	2. 00
	instructions)							
3. 00	Subtotal salaries (line 1		33, 609, 816	1, 038, 922	34, 648, 738	1, 037, 980. 00	33. 38	3. 00
	minus line 2)							
4. 00	Subtotal other wages & related		1, 608, 250	0	1, 608, 250	19, 577. 00	82. 15	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		11, 676, 599	0	11, 676, 599	0. 00	33. 70	5. 00
	(see inst.)							
6. 00	Total (sum of lines 3 thru 5)		46, 894, 665	1				
7. 00	Total overhead cost (see		13, 425, 857	480, 896	13, 906, 753	439, 319. 00	31. 66	7. 00
	instructions)							

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lieu	of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS		Peri od: From 01/01/2019	Worksheet S-3 Part IV
		To 12/31/2019	Date/Time Prepared:

	To 12/31/2019	Date/Time Prep 3/31/2020 8:18	
		Amount	J dill
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		1
	RETI REMENT COST		1
1.00	401K Employer Contributions	2, 830, 438	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	o	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		1
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		l
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	12, 003, 428	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	1, 965, 942	9. 00
10.00		485, 058	
11. 00		94, 946	
12.00		0	12.00
13.00		266, 451	
14.00		0	14.00
15. 00		432, 585	
16. 00		0	16.00
	Non cumulative portion)		
47.00	TAXES	0.000.740	47.00
17.00		2, 389, 760	
18.00		0	18.00
19. 00		98, 222	•
20. 00		0	20.00
04 00	OTHER		04.00
21. 00		0	21.00
22.00	instructions)) Day Care Cost and Allowances	0	22.00
22. 00 23. 00			22.00
24. 00		ı "	24.00
24. UU	Total Wage Related cost (Sum of lines 1 -23)  Part B - Other than Core Related Cost	20, 566, 830	∠4.00
25 00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00
25.00	Totales who repaired addition (Areal II)	1	25.00

	Financial Systems	WITHAM MEMORIAL				u of Form CMS-	
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provi der Co	CN: 15-0104	Peri od: From 01/01/2019	Worksheet S-3	
					To 12/31/2019		nared.
					10 12/01/2017	3/31/2020 8: 1	8 am
	Cost Center Description				Contract	Benefit Cost	
					Labor		
					1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost						
	Hospital and Hospital-Based Component Ident						
1.00	Total facility's contract labor and benefit	cost			1, 608, 250		
2.00	Hospi tal				1, 608, 250	20, 566, 830	
3.00	Subprovi der - I PF				0	0	3.00
4.00	Subprovi der - I RF				0	0	4.00
5.00	Subprovider - (Other)				0	0	5.00
6.00	Swing Beds - SNF				0	0	6.00
7.00	Swing Beds - NF				0	0	
8.00	Hospi tal -Based SNF				0	0	8.00
9.00	Hospi tal -Based NF						9.00
10.00	Hospi tal -Based OLTC						10.00
11.00	Hospi tal -Based HHA						11.00
12.00	Separately Certified ASC						12.00
13.00	Hospi tal -Based Hospi ce						13.00
14.00	Hospital-Based Health Clinic RHC						14.00
15.00	Hospital-Based Health Clinic FQHC						15.00
16.00	Hospi tal -Based-CMHC						16. 00
17.00	Renal Dialysis						17. 00
18.00	Other				0	0	18.00

	Financial Systems WITHAM MEMORIAL HO			In Lie	u of Form CMS-2	
HOSPI 1	AL UNCOMPENSATED AND INDIGENT CARE DATA	rovi der CCI	N: 15-0104	Peri od: From 01/01/2019	Worksheet S-1	0
				To 12/31/2019	Date/Time Pre	nared.
					3/31/2020 8: 1	8 am
					1. 00	
	Uncompensated and indigent care cost computation					
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ided by lir	ne 202 colum	n 8)	0. 196421	1.0
	Medicaid (see instructions for each line)					
2. 00	Net revenue from Medicaid				-645, 987	2.0
. 00	Did you receive DSH or supplemental payments from Medicaid?			. 10		3.0
. 00	If line 3 is yes, does line 2 include all DSH and/or supplementa			ai d'?	0	4.0
i. 00 i. 00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid charges	om wedicaid	1		0 41, 685, 002	5. C
. 00 '. 00	Medicaid cost (line 1 times line 6)				8, 187, 810	
. 00	Difference between net revenue and costs for Medicaid program (	line 7 minu	ıs sum of Li	nes 2 and 5 if	8, 833, 797	
. 00	<pre>&lt; zero then enter zero)</pre>	7 11110	as sam or 11	nes z una e, i i	0,000,777	0.0
	Children's Health Insurance Program (CHIP) (see instructions for	r each line	e)	'		İ
. 00	Net revenue from stand-alone CHIP				0	9.0
	Stand-alone CHIP charges				0	1
1.00	Stand-alone CHIP cost (line 1 times line 10)				0	11. C
2. 00	Difference between net revenue and costs for stand-alone CHIP (	line 11 mir	nus line 9;	if < zero then	0	12.0
	enter zero) Other state or local government indigent care program (see insti	ructions fo	or each line	)		
3. 00	Net revenue from state or local indigent care program (Not included in the				0	13.0
	Charges for patients covered under state or local indigent care		Ö			
00	10)	p. 09. a (.			· ·	
5. 00	State or local indigent care program cost (line 1 times line 14)	)			0	15. (
6. 00	Difference between net revenue and costs for state or local indi	igent care	program (li	ne 15 minus line	0	16. (
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line)	P and state	e/Local indi	gent care progra	ıms (see	
7. 00	Private grants, donations, or endowment income restricted to fur	ndi ng chari	ty care		0	17. C
8. 00	Government grants, appropriations or transfers for support of ho	ospital ope	erati ons		0	18.0
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and local	indigent d	care program	s (sum of lines	8, 833, 797	19. (
	8, 12 and 16)				T	
			Uni nsured pati ents	Insured patients	Total (col. 1 + col. 2)	
		-	1.00	2. 00	3.00	
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00	
0.00	Charity care charges and uninsured discounts for the entire faci	ility	4, 199, 30	1, 719, 628	5, 918, 997	20. C
1. 00	(see instructions) Cost of patients approved for charity care and uninsured discou	nts (see	824, 84	1, 719, 628	2, 544, 472	21 (
1.00	instructions)	iits (see	024, 04	1, /19, 020	2, 344, 472	21.0
2. 00	Payments received from patients for amounts previously written	off as		o	0	22.0
	charity care				_	
3. 00	Cost of charity care (line 21 minus line 22)		824, 84	1, 719, 628	2, 544, 472	23.0
					1. 00	
4. 00	, , , , , , , , , , , , , , , , , , , ,		ond a Length	of stay limit	N	24.0
E 00	imposed on patients covered by Medicaid or other indigent care		0050 05005	mic longth of	0	25.0
5. 00	If line 24 is yes, enter the charges for patient days beyond the stay limit	e margent	care progra	m s rength or	0	25.0
6. 00	Total bad debt expense for the entire hospital complex (see ins	tructions)			9, 607, 393	26.0
7. 00	Medicare reimbursable bad debts for the entire hospital complex	,	ructions)		262, 134	
	Medicare allowable bad debts for the entire hospital complex (se	•			403, 284	
7. 01	Non-Medicare bad debt expense (see instructions)				9, 204, 109	28.0
27. 01 28. 00	Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt expe	ense (see i	nstructi ons	)	9, 204, 109 1, 949, 030	1
27. 01 28. 00 29. 00 30. 00		,	nstructi ons	)		29. C

Heal th	Financial Systems	WITHAM MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CO	CN: 15-0104	Peri od:	Worksheet A	
					From 01/01/2019 To 12/31/2019		
	Cook Courtous Donnel attitud	C-1	0+1	T-+-1 (1 1	D1: 6:+	3/31/2020 8: 1	8 am
	Cost Center Description	Sal ari es	0ther	+ col . 2)	Reclassificat ions (See	Reclassified Trial Balance	
				+ (01. 2)	A-6)	(col. 3 +-	
					7. 0)	col . 4)	
		1. 00	2.00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT		3, 091, 245	3, 091, 24			
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		0		0 4, 611, 701	4, 611, 701	1
3. 00 4. 00	O0300 OTHER CAPITAL RELATED COSTS   O0400 EMPLOYEE BENEFITS DEPARTMENT	24 221	10 277 440		0 721 424	17 490 244	
5. 00	00500 ADMINISTRATIVE & GENERAL	34, 331 6, 921, 034	18, 377, 469 17, 027, 320	18, 411, 80 23, 948, 35		17, 680, 366 22, 934, 368	
7. 00	00700 OPERATION OF PLANT	666, 851	3, 128, 007	3, 794, 85		3, 659, 511	1
8. 00	00800 LAUNDRY & LINEN SERVICE	31, 210	532, 881	564, 09		564, 773	1
9.00	00900 HOUSEKEEPI NG	472, 740	393, 465	866, 20	5 4, 002	870, 207	9.00
10.00	01000 DI ETARY	982, 099	1, 085, 032	2, 067, 13		1, 713, 140	
11.00	01100 CAFETERI A	0	0		349, 470		1
13. 00 15. 00	01300   NURSI NG   ADMI NI STRATI ON   01500   PHARMACY	612, 959	100, 165	713, 12 11, 120, 30			
16. 00	01600 MEDICAL RECORDS & LIBRARY	695, 146 1, 329, 044	10, 425, 154 363, 856	1, 692, 90		6, 830, 489 1, 719, 611	1
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	1, 327, 044	303, 030	1,092,90	20, 711	1, 717, 011	10.00
30.00	03000 ADULTS & PEDIATRICS	3, 775, 903	1, 178, 111	4, 954, 01	4 -355, 007	4, 599, 007	30.00
31.00	03100 INTENSIVE CARE UNIT	1, 318, 565	566, 860	1, 885, 42		1, 691, 702	31.00
40.00	04000 SUBPROVI DER - I PF	1, 120, 243	148, 294	1, 268, 53	7 -15, 675	1, 252, 862	40.00
41.00	04100 SUBPROVI DER - I RF	0	0	(	0	0	
42.00	04200 SUBPROVI DER	0	0	FF 04	0	0	
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	1, 042, 284	55, 910 598, 498			55, 910 1, 551, 553	
44.00	ANCI LLARY SERVI CE COST CENTERS	1, 042, 204	370, 470	1,040,76.	2  -07, 227	1, 551, 555	44.00
50. 00	05000 OPERATI NG ROOM	2, 335, 507	7, 760, 463	10, 095, 97	0 -6, 657, 141	3, 438, 829	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 658, 570	4, 374, 206	6, 032, 77			1
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	(	o o	0	55.00
55. 01	05501 ULTRA SOUND	353, 589	542, 971	896, 56			1
57.00	05700 CT SCAN	200, 381	1, 118, 808	1, 319, 18			1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	340, 254	733, 171	1, 073, 42			
59. 00 60. 00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	318, 990 3, 094, 530	1, 990, 483 4, 602, 983	2, 309, 47, 7, 697, 51		1, 438, 340 7, 433, 455	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	3, 074, 530	200, 237	200, 23		198, 700	1
64. 00	06400 I NTRAVENOUS THERAPY	o	0	200, 20	0 0	0	1
66.00	06600 PHYSI CAL THERAPY	1, 684, 271	338, 678	2, 022, 94	9 33, 803	2, 056, 752	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	413, 334	49, 795	463, 12			1
67. 01	06701 AUDI OLOGY	222, 951	199, 186	422, 13		416, 676	
68.00	06800 SPEECH PATHOLOGY	215, 088	22, 698	237, 78			
69. 00 69. 01	06900  ELECTROCARDI OLOGY   06901  CARDI OLOGY	1, 186, 464	420, 448		0 2 -123, 116	0 1, 483, 796	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 100, 404	-10, 328				1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	o	0		0 4, 970, 665		
73.00	07300 DRUGS CHARGED TO PATIENTS	o	0		0 4, 216, 352		1
	OUTPATIENT SERVICE COST CENTERS	<u>,                                      </u>					
90.00	09000 CLI NI C	0	0		0 0	_	
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	198, 697	87, 429	286, 12	6 1, 448		
90. 02 90. 03	09002   CLI NI C   09003   DERMATOLOGY   CLI NI C	0	2, 701	2, 70	1 0	0 2, 701	
90. 03	09004 ENT CLINIC		2, 701 0	2, 70		2,701	
90. 05	09005 SURGERY CLINIC	Ö	1, 090	1, 09	-653	437	1
90. 07	09007 UROLOGY CLINIC	0	7, 940	7, 94		6, 192	90.07
90. 09	09009 GASTROENTEROLOGY CLINIC	227	8, 723	8, 95		11, 963	1
90. 11	09011 NEUROLOGY CLINIC	0	4, 373	1		4, 373	
90. 12	09012 OPTHAMOLOGY CLINIC	0	28, 103	28, 10		7, 476	1
90. 13 90. 14	09013 ALLERGY CLINIC 09014 WOUND CARE	101, 810 247, 381	53, 589	155, 39 <sup>6</sup> 728, 65 <sup>6</sup>		154, 167	1
90. 14	09100 EMERGENCY	2, 517, 447	481, 278 3, 519, 304	6, 036, 75			1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,017,117	0,017,001	0,000,70	000, 110	J, 100, 000	92.00
	OTHER REIMBURSABLE COST CENTERS	<u>'</u>			"		
95.00	09500 AMBULANCE SERVICES	2, 478, 576	572, 216	3, 050, 79	2 -115, 919	2, 934, 873	95.00
118. 00		36, 570, 476	84, 182, 812	120, 753, 28	8 344, 218	121, 097, 506	118. 00
400 5	NONREI MBURSABLE COST CENTERS		-1			_	100 0-
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	20 025 540	10 224 527		0 0		190.00
194.00	19200  PHYSICIANS' PRIVATE OFFICES   07950  THORNTOWN OFFICE BUILDING	28, 825, 560	10, 236, 527	39, 062, 08	7 -341, 515 n		192.00
194.00	07950 THORNTOWN OFFICE BUILDING	0	0				194.00
	07952 OTHER NONREI MB	70, 919	76, 004	146, 92	3 -297	146, 626	
	07953 RETAIL PHARMACY	267, 494	1, 794, 786			2, 059, 874	194. 03
200.00	TOTAL (SUM OF LINES 118 through 199)	65, 734, 449	96, 290, 129	162, 024, 57	8 0	162, 024, 578	200.00

 Heal th Financial
 Systems
 WI THAM MEM

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0104

Peri od: From 01/01/2019 To 12/31/2019 Date/Ti me Prepared:

				3/31/2020 8	
	Cost Center Description	Adjustments	Net Expenses	1 0/01/2020	
		(See A-8)	For		
		6. 00	Allocation 7.00		
	GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT	-891, 284	2, 185, 708		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0	4, 611, 701		2. 00
3.00	00300 OTHER CAPITAL RELATED COSTS	0	0		3.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	-5, 538, 509			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-7, 471, 821			5.00
7. 00 8. 00	OO7OO  OPERATION OF PLANT   OO8OO  LAUNDRY & LINEN SERVICE	-104 0	1 ' ' 1		7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	0	1		9.00
10. 00	01000 DI ETARY	-351, 393	,		10.00
	01100 CAFETERI A	0			11.00
	01300 NURSING ADMINISTRATION	0	686, 825		13.00
	01500 PHARMACY	0	6, 830, 489		15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	-1, 368	1, 718, 243		16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	4 500 007		20.00
	03000   ADULTS & PEDIATRICS   03100   INTENSIVE CARE UNIT	0			30. 00 31. 00
	04000 SUBPROVI DER - I PF	0	, ,		40.00
	04100 SUBPROVI DER - I RF	0	1		41.00
42.00	04200 SUBPROVI DER	0	0		42.00
	04300 NURSERY	0	1		43.00
44. 00	04400 SKILLED NURSING FACILITY	0	1, 551, 553		44.00
EO 00	ANCILLARY SERVICE COST CENTERS	4 000	2 422 741		E0 00
	05000  OPERATI NG ROOM   05400  RADI OLOGY-DI AGNOSTI C	-6, 088 -410, 462	1 ' ' 1		50. 00 54. 00
	05500 RADI OLOGY-THERAPEUTI C	-410, 402	1 ' ' 1		55.00
	05501 ULTRA SOUND	Ö	I		55. 01
57.00	05700 CT SCAN	0	895, 731		57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	854, 467		58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	1, 438, 340		59.00
	06000 LABORATORY	-120, 000	1 1		60.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	198, 700		63. 00 64. 00
	06600 PHYSI CAL THERAPY	0	2, 056, 752		66.00
	06700 OCCUPATI ONAL THERAPY	Ö	475, 218		67.00
67. 01	06701 AUDI OLOGY	-261, 388			67. 01
	06800 SPEECH PATHOLOGY	0	243, 522		68. 00
	06900 ELECTROCARDI OLOGY	0	0		69.00
	06901 CARDI OLOGY	14 020	1, 483, 796		69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	-16, 029 0	1		71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	1 1		73.00
70.00	OUTPATIENT SERVICE COST CENTERS		1/210/002		75.55
	09000 CLI NI C	0	0		90.00
	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	287, 574		90. 01
	09002 CLINIC	0	0		90.02
	09003 DERMATOLOGY CLINIC 09004 ENT CLINIC	-2, 701	1		90. 03
90. 04 90. 05	09005 SURGERY CLINIC	0 -1, 090	1		90.04
	09007 UROLOGY CLINIC	-7, 940			90.07
	09009 GASTROENTEROLOGY CLINIC	-8, 950			90.09
90. 11	09011 NEUROLOGY CLINIC	-4, 373			90. 11
	09012 OPTHAMOLOGY CLINIC	-28, 103			90. 12
	09013 ALLERGY CLINIC	0	154, 167		90. 13
	09014 WOUND CARE	2 (02 200	667, 299		90. 14
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	-2, 602, 200	2, 866, 406		91.00
92.00	OTHER REIMBURSABLE COST CENTERS				92.00
95. 00	09500 AMBULANCE SERVICES	-8, 838	2, 926, 035		95. 00
	SPECIAL PURPOSE COST CENTERS				
118.00		-17, 732, 641	103, 364, 865		118. 00
40	NONREI MBURSABLE COST CENTERS				105
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1		190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 THORNTOWN OFFICE BUILDING	0	38, 720, 572 0		192. 00 194. 00
	07950 THORNTOWN OFFICE BUILDING	) n	0		194.00
	07952 OTHER NONREI MB	0	146, 626		194.01
	07953 RETAIL PHARMACY	Ö	1		194. 03
200.00	TOTAL (SUM OF LINES 118 through 199)	-17, 732, 641	144, 291, 937		200.00

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 01/01/2019 To 12/31/2019 Date/Time Prepared: 3/31/2020 8: 18 am Provider CCN: 15-0104

					3/31/2020 8: 1	18 am
		Increases		0.11		
	Cost Center 2.00	Li ne # 3.00	Sal ary 4. 00	0ther 5.00		
	A - EMPLOYEE BENEFITS	3.00	4.00	5.00		
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	432, 585		1.00
	TOTALS			432, 585		
	B - INSURANCE RECLASS					
1.00	NEW CAP REL COSTS-BLDG &	1. 00	0	100, 662		1.00
	FIXT	+				
	TOTALS		0	100, 662		
1. 00	C - CAFETERIA RECLASS CAFETERIA	11. 00	155, 690	193, 780		1.00
1.00	TOTALS		155, 690	193, 780		1.00
	D - MME DEPRECIATION RECLASS		133, 070	173, 700		
1. 00	NEW CAP REL COSTS-MVBLE	2. 00	0	4, 611, 701		1.00
	EQUI P					
2.00		0. 00	О	0		2.00
3.00		0. 00	0	0		3. 00
4.00		0. 00	0	0		4.00
5.00		0. 00	0	0		5. 00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8. 00		0.00	0	0		8.00
9. 00 10. 00		0. 00 0. 00	0	0		9. 00 10. 00
11. 00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13. 00		0. 00	0	Ö		13.00
14. 00		0. 00	Ö	Ö		14.00
15. 00		0. 00	Ö	Ö		15. 00
16.00		0. 00	О	0		16.00
17.00		0. 00	0	0		17.00
18.00		0. 00	О	0		18. 00
19.00		0.00	0	0		19.00
20.00		0. 00	0	0		20.00
21.00		0. 00	0	0		21.00
22.00		0. 00	0	0		22. 00
23. 00		0.00	0	0		23. 00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
27. 00		0.00	0	0		27.00
28. 00 29. 00		0. 00 0. 00	0	0		28. 00 29. 00
29. 00 30. 00		0.00	0	0		30.00
31. 00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33. 00		0. 00	ő	Ö		33.00
34.00		0. 00	o	0		34.00
35.00		0. 00	O	0		35.00
36.00		0.00	o	О		36.00
37.00		0. 00	О	О		37.00
38.00		0.00	o	О		38.00
	TOTALS		0	4, 611, 701		
	E - DRUGS RECLASS					
1. 00	DRUGS CHARGED TO PATIENTS		•	<u>4, 282, 0</u> 89		1. 00
	TOTALS		0	4, 282, 089		
1 00	F - MED SUPPLY IMPLANTS RECLAS			4 070 //5		1 00
1. 00	I MPL. DEV. CHARGED TO PATIENT	72. 00	0	4, 970, 665		1. 00
2. 00	FATTENT	0.00	o	0		2. 00
3. 00		0.00	0	0		3.00
4. 00		0.00		o		4.00
5. 00		0.00	o	o		5.00
6. 00		0. 00	o o	ő		6.00
7. 00		0. 00	ő	ő		7.00
	TOTALS			4, 970, 665		
	G - CHARGEABLE MED SUPPLIES RE	ECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	3, 294, 950		1.00
	PATI ENTS					
2.00		0. 00	0	0		2. 00
3.00		0.00	0	0		3. 00
4. 00		0. 00	0	0		4.00
5. 00		0.00	O	0		5. 00
6. 00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0. 00 0. 00	0	0		8. 00 9. 00
9.00						

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2019 To 12/31/2019 Date/Ti me Prepared: 3/31/2020 8:18 am Provider CCN: 15-0104

					3/31/2020 8:	18 am
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2.00	3.00	4. 00	5. 00		
10. 00		0.00	0	0		10.00
11. 00		0.00	o	0		11.00
12. 00		0.00	o	0		12. 00
			0	0		
13.00		0.00		_		13.00
14.00	1	0.00	0	0		14. 00
15. 00		0.00	0	0		15.00
16. 00		0.00	0	0		16. 00
17.00		0.00	0	0		17.00
18.00		0.00	o	0		18.00
19.00		0.00	o	0		19.00
20. 00		0.00	o	0		20.00
21. 00		0.00	o	0		21.00
22. 00		0.00	o	0		22.00
				_		
23. 00		0.00	0	0		23.00
24. 00		0.00	0	0		24.00
25.00		0.00	0	0		25. 00
26. 00		0.00	0	0		26. 00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28. 00
29.00		0.00	o	0		29. 00
30. 00		0.00	o	0		30.00
00.00	TOTALS — — — —		$ 0$	3, 294, 950		00.00
	H - BONUS RECLASS		U <sub>I</sub>	3, 274, 730		
1 00		F 00	254 402	0		1 00
1.00	ADMINISTRATIVE & GENERAL	5. 00	354, 402	0		1.00
2. 00	OPERATION OF PLANT	7. 00	24, 463	0		2. 00
3.00	LAUNDRY & LINEN SERVICE	8. 00	842	0		3. 00
4.00	HOUSEKEEPI NG	9. 00	7, 621	0		4.00
5.00	DI ETARY	10.00	25, 895	0		5.00
6.00	NURSING ADMINISTRATION	13. 00	17, 659	0		6.00
7.00	PHARMACY	15. 00	13, 583	0		7.00
8. 00	MEDICAL RECORDS & LIBRARY	16. 00	36, 431	0		8.00
9. 00	ADULTS & PEDIATRICS	30.00	97, 388	0		9. 00
10. 00	INTENSIVE CARE UNIT	31.00	28, 964	0		10.00
	SUBPROVIDER - I PF	40.00		0		1
11.00	1		27, 874	_		11.00
12.00	SKILLED NURSING FACILITY	44.00	22, 344	0		12.00
13. 00	OPERATING ROOM	50.00	70, 883	0		13.00
14.00	RADI OLOGY-DI AGNOSTI C	54. 00	59, 941	0		14.00
15. 00	ULTRA SOUND	55. 01	5, 531	0		15. 00
16.00	CT SCAN	57.00	7, 143	0		16. 00
17.00	MAGNETIC RESONANCE IMAGING	58. 00	10, 185	0		17.00
	(MRI)					1
18. 00	CARDI AC CATHETERI ZATI ON	59. 00	9, 338	0		18.00
19. 00	LABORATORY	60.00	69, 567	0		19.00
20. 00	PHYSI CAL THERAPY	66.00	53, 222	0		20.00
21. 00	OCCUPATIONAL THERAPY			0		
		67. 00	12, 590	_		21.00
22. 00	AUDI OLOGY	67. 01	5, 218	0		22.00
23. 00	SPEECH PATHOLOGY	68. 00	5, 736	0		23. 00
24. 00	CARDI OLOGY	69. 01	32, 566	0		24. 00
25.00	OTHER OUTPATIENT SERVICE	90. 01	8, 085	0		25.00
	COST CENTER					1
26.00	GASTROENTEROLOGY CLINIC	90. 09	3, 013	0		26. 00
27. 00	ALLERGY CLINIC	90. 13	2, 122	0		27. 00
28. 00	WOUND CARE	90. 13	9, 593	0		28.00
				0		
29. 00	EMERGENCY	91.00	66, 941	0		29. 00
30. 00	AMBULANCE SERVICES	<u>95.</u> 00	65, 570	0		30.00
	TOTALS		1, 154, 710	0		1
500.00	Grand Total: Increases		1, 310, 400	17, 886, 432		500.00

RECLASSI FI CATI ONS

Provider CCN: 15-0104

Period: Worksheet A-6 From 01/01/2019

12/31/2019 Date/Time Prepared: 3/31/2020 8:18 am Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - EMPLOYEE BENEFITS 1.00 ADMINISTRATIVE & GENERAL 5.00 432, 585 0 1.00 432, 585 **TOTALS** B - INSURANCE RECLASS 1.00 ADMINISTRATIVE & GENERAL 5.00 100, 662 1.00 12 TOTALS 100, 662 C - CAFETERIA RECLASS 1.00 DI ETARY <u>10.</u>00 15<u>5, 6</u>90 193, 780 0 1.00 **TOTALS** 155, 690 193, 780 D - MME DEPRECIATION RECLASS 1 00 NEW CAP REL COSTS-BLDG & 1 00 114 915 q 0 1 00 FI XT 2.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 7, 427 0 2.00 3.00 ADMINISTRATIVE & GENERAL 5.00 o 822, 887 0 3.00 OPERATION OF PLANT 0 0 4.00 7.00 159, 430 4.00 LAUNDRY & LINEN SERVICE 8.00 0 5.00 160 5.00 6.00 HOUSEKEEPI NG 9.00 0 2, 958 0 6.00 o 0 7.00 DI ETARY 10.00 30, 200 7.00 0 NURSING ADMINISTRATION 0 8.00 13.00 43.958 8.00 PHARMACY 0 9 00 15.00 3 999 9 00 MEDICAL RECORDS & LIBRARY 16.00 0 0 10.00 10.00 9,637 0 0 11.00 ADULTS & PEDIATRICS 30.00 160, 955 11.00 INTENSIVE CARE UNIT 0 0 12.00 31.00 72.135 12.00 13.00 SUBPROVIDER - IPF 40.00 0 12, 901 13.00 14.00 SKILLED NURSING FACILITY 44.00 0 61, 915 0 14.00 0 0 OPERATING ROOM 50.00 609, 228 15.00 15.00 16.00 RADI OLOGY-DI AGNOSTI C 54.00 0 454.876 16.00 ULTRA SOUND 55.01 0 134,056 0 17.00 17.00 0 0 18.00 CT SCAN 57.00 414,608 18.00 0 19.00 MAGNETIC RESONANCE I MAGING 58.00 0 222, 574 19.00 (MRI) 20.00 CARDIAC CATHETERIZATION 59.00 0 187, 439 0 20.00 LABORATORY 0 21.00 60.00 0 308, 056 21.00 22 00 BLOOD STORING, PROCESSING & 63 00 Ω 1.537 0 22 00 TRANS 23.00 PHYSI CAL THERAPY 66.00 0 18, 241 0 23.00 OCCUPATIONAL THERAPY 0 0 24.00 67.00 483 24.00 25.00 AUDI OLOGY 67.01 0 10, 574 0 25.00 27.00 0 27 00 CARDI OLOGY 69.01 0 141, 192 28.00 OTHER OUTPATIENT SERVICE 90.01 0 0 28.00 4,667 COST CENTER 29.00 SURGERY CLINIC 90.05 0 29.00 653 0| 30.00 UROLOGY CLINIC 90.07 0 24 30.00 31.00 OPTHAMOLOGY CLINIC 90.12 0 20,627 0 31.00 32.00 ALLERGY CLINIC 90.13 o 3, 221 0 32.00 0 33.00 WOUND CARE 90.14 o 26, 085 33.00 0 91.00 0 34.00 **IEMERGENCY** 132, 730 34.00 35.00 AMBULANCE SERVICES 95.00 0 162, 757 0 35.00 0 36.00 PHYSICIANS' PRIVATE OFFICES 192.00 0 251, 916 36.00 o 37 00 OTHER NONREIMB 194 02 297 0 37 00 <u>2, 3</u>83 38.00 RETAIL PHARMACY 194.03 0 38.00 TOTALS ō 4, 611, 701 E - DRUGS RECLASS 1 00 PHARMACY 4, 282, 089 15.00 0 0 1 00 o 4, 282, 089 - MED SUPPLY IMPLANTS RECLASS 1.00 INTENSIVE CARE UNIT 31. 00 0 908 0 1.00 2 00 OPERATING ROOM 50.00 0 4, 158, 884 0 2.00 3.00 RADI OLOGY-DI AGNOSTI C 54.00 0 41, 735 0 3.00 CARDIAC CATHETERIZATION 0 0 4.00 59.00 675, 453 4.00 MEDICAL SUPPLIES CHARGED TO 5.00 71.00 0 13,020 0 5.00 PATI ENTS 0 6.00 DRUGS CHARGED TO PATIENTS 73.00 65, 737 0 6.00 WOUND CARE 14, 928 7.00 90.14 0 7.00 ō TOTALS 4, 970, 665 G - CHARGEABLE MED SUPPLIES RECLASS 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 1,882 0 1.00 0 2.00 ADMINISTRATIVE & GENERAL 5.00 12, 254 0 2.00 OPERATION OF PLANT 0 3.00 7.00 380 0 3.00

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HOUSEKEEPI NG

MEDICAL RECORDS & LIBRARY

ADULTS & PEDIATRICS

DI ETARY

PHARMACY

4.00

5.00

6.00

7 00

8.00

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2019 To 12/31/2019 Date/Ti me Prepared: 3/31/2020 8: 18 am Provider CCN: 15-0104

	0 8:18 am
Decreases	
Cost Center Line # Salary Other Wkst. A-7 Ref.	
6.00 7.00 8.00 9.00 10.00	
9. 00   INTENSIVE CARE UNIT   31. 00   0   149, 644   0	9.00
10. 00 SUBPROVI DER - I PF 40. 00 0 30, 648 0	10.00
11.00 SKILLED NURSING FACILITY 44.00 0 49,658 0	11. 00
12. 00 OPERATING ROOM 50. 00 0 1, 959, 912 0	12. 00
13.00 RADI OLOGY-DI AGNOSTI C 54.00 0 48,575 0	13.00
14.00 ULTRA SOUND 55.01 0 6, 313 0	14. 00
15.00 CT SCAN 57.00 0 15,993 0	15. 00
16.00 MAGNETIC RESONANCE I MAGING 58.00 0 6,569 0	16.00
(MRI)	
17. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 17, 579 0	17. 00
18.00 LABORATORY 60.00 0 25, 569 0	18. 00
19. 00 PHYSI CAL THERAPY 66. 00 0 1, 178 0	19.00
20.00 OCCUPATIONAL THERAPY 67.00 0 18 0	20.00
21. 00 AUDI OLOGY 67. 01 0 105 0	21.00
22. 00   CARDI OLOGY   69. 01   0   14, 490   0	22.00
23.00 OTHER OUTPATIENT SERVICE 90.01 0 1,970 0	23. 00
COST CENTER	
24. 00   UROLOGY CLINIC 90. 07 0 1, 724 0	24.00
25. 00 ALLERGY CLINIC 90. 13 0 133 0	25. 00
26. 00 WOUND CARE 90. 14 0 29, 940 0	26.00
27. 00 EMERGENCY 91. 00 0 502, 356 0	27.00
28.00 AMBULANCE SERVICES 95.00 0 18, 732 0	28. 00
29.00 PHYSICIANS' PRIVATE OFFICES 192.00 0 89,599 0	29.00
30.00 RETAIL PHARMACY 194.03 0 23 0	30.00
TOTALS 0 3, 294, 950	00.00
H - BONUS RECLASS	
1. 00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 1, 154, 710 0	1.00
2.00	2.00
3.00 0 0 0 0	3.00
4.00	4.00
5.00	5. 00
6.00	6.00
7.00	7.00
8.00	8.00
9. 00	9. 00
10.00	10.00
11.00	11.00
12.00	12.00
13.00	13. 00
14.00	14. 00
15.00	15. 00
16.00	16. 00
17.00	17. 00
18.00	18. 00
19.00	19.00
	20.00
	21.00
	22.00
23. 00 0 0 0	23.00
24.00	24.00
25. 00 0 0 0	25. 00
26.00	26. 00
27. 00 0 0 0 0	27. 00
28.00 0 0 0	28. 00
29.00	29. 00
30.000_0	30.00
TOTALS 0 1, 154, 710	00.00
500.00 Grand Total: Decreases 155, 690 19, 041, 142	500.00

					o 12/31/2019	Date/Time Pre 3/31/2020 8:1	
				Acqui si ti ons		7 37 3 17 2020 0. 1	o aiii
		Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	15, 743, 378	76, 582	C	76, 582	0	1.00
2.00	Land Improvements	0	0	C	0	0	2.00
3.00	Buildings and Fixtures	84, 993, 937	839, 531	C	839, 531	0	3.00
4.00	Building Improvements	0	0	C	0	0	4.00
5.00	Fixed Equipment	2, 228, 155	43, 486	C	43, 486	0	5.00
6.00	Movable Equipment	56, 679, 756	4, 046, 529	C	4, 046, 529	12, 996	6.00
7.00	HIT designated Assets	0	0	C	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	159, 645, 226	5, 006, 128	C	5, 006, 128	12, 996	8.00
9.00	Reconciling Items	0	0	C	0	0	9. 00
10.00	Total (line 8 minus line 9)	159, 645, 226	5, 006, 128	C	5, 006, 128	12, 996	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	15, 819, 960	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	85, 833, 468	0				3. 00
4. 00	Building Improvements	0	0				4.00
5.00	Fi xed Equi pment	2, 271, 641	0				5.00
6.00	Movable Equipment	60, 713, 289	0				6. 00
7. 00	HIT designated Assets	0	0				7. 00
8. 00	Subtotal (sum of lines 1-7)	164, 638, 358	0				8. 00
9. 00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	164, 638, 358	0				10.00

Heal th	n Financial Systems	WITHAM MEMORIA	ORIAL HOSPITAL In Lieu of Form			u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-0104	Peri od: From 01/01/2019 To 12/31/2019		pared:
		SUMMARY OF CAPITAL					
	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, COLUN	MN 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	3, 091, 245	0		0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2.00
3.00	Total (sum of lines 1-2)	3, 091, 245	0		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1)				
		Capi tal -Relat	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	· · ·				
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	3, 091, 245			ļ	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0			ļ	2.00
3. 00	Total (sum of lines 1-2)	0	3, 091, 245				3.00

Health Financial Systems		WITHAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COS	STS CENTERS		Provi der C		Peri od:	Worksheet A-7	
					From 01/01/2019 To 12/31/2019		nared:
					10 12/31/2019	3/31/2020 8: 18	
		COMF	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
					5 (		
Cost Center Descr	ri pti on	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio (col. 1 -	instructions)		
				col . 2)			
		1. 00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIAT	ION OF CAPITAL COSTS CE	ENTERS					
1.00 NEW CAP REL COSTS-BLDG		85, 833, 468	0	85, 833, 468	0. 585707	0	1.00
2.00 NEW CAP REL COSTS-MVBL		60, 713, 289	0	00//.0/20		0	2.00
3.00 Total (sum of lines 1-	2)	146, 546, 757	0	146, 546, 75		0	3.00
		ALLOCAT	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
Cost Center Descr	ri pti on	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at				
			ed Costs	through 7)			
DART LLL BESSHOLLLAT	1011 05 0451 741 00070 05	6. 00	7. 00	8. 00	9. 00	10.00	
1.00 PART III - RECONCILIAT			0	,	2 07/ 220	F7 (F0	1 00
1.00 NEW CAP REL COSTS-BLDG 2.00 NEW CAP REL COSTS-MVBL		0	0		2, 976, 330 4, 611, 701	-57, 650 0	1. 00 2. 00
3.00 Total (sum of lines 1-		0	0		7, 588, 031	-57, 650	3. 00
5.00 Total (Suil of Titles 1-	2)	<u> </u>	SI	I JMMARY OF CAPI		-37,030	3.00
			00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	· / / L		
Cost Center Descr	ription	Interest	Insurance	Taxes (see	Other	Total (2)	
	·		(see	instructions)			
			instructions)		ed Costs (see	9 through 14)	
					instructions)		
DART LLL BESSHOLLLAT	1011 05 0451 741 00070 05	11. 00	12. 00	13. 00	14. 00	15. 00	
1.00 PART III - RECONCILIAT			100 ((2	,		2 105 700	1 00
1.00 NEW CAP REL COSTS-BLDG 2.00 NEW CAP REL COSTS-MVBL		-833, 634 0	100, 662 0		0	2, 185, 708 4, 611, 701	1. 00 2. 00
3.00 Total (sum of lines 1-		-833, 634		1	0	6, 797, 409	2. 00 3. 00
3. 00   Total (Sum of Titles 1-	<i>∠)</i>	-055, 054	100,002	1	<u>ا</u> ا	0, 171, 407	3.00

ADJUST	MENIS IO EXPENSES			Provider CCN: 15-0104	From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:
			To	Expense Classification o /From Which the Amount is		3/31/2020 8: 1	8 am
				711 Sill Will Gil Elle 7 Willouite 13	s to be haj astea		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1. 00	Investment income - NEW CAP	1. 00	2. 00 ONE	3.00 W CAP REL COSTS-BLDG &	4.00	5. 00 0	1.00
	REL COSTS-BLDG & FIXT (chapter 2)		FI			·	
2. 00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			W CAP REL COSTS-MVBLE UIP	2. 00	0	2. 00
3. 00	Investment income - other (chapter 2)		0		0. 00	0	3. 00
4. 00	Trade, quantity, and time discounts (chapter 8)		О		0. 00	0	4. 00
5. 00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5. 00
6. 00	Rental of provider space by suppliers (chapter 8)		О		0. 00	0	6. 00
7. 00	Telephone services (pay stations excluded) (chapter 21)	В	-4, 066 AD	MINISTRATIVE & GENERAL	5. 00	0	7. 00
8. 00	Tel evision and radio service (chapter 21)		0		0.00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -3, 132, 662		0.00	0	9. 00 10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0. 00	0	
12. 00	(chapter 23) Related organization	A-8-1	0			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0. 00	0	13. 00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee and others	В	-288, 242 DI 0	ETARY	10. 00 0. 00	0	
16. 00	Sale of medical and surgical supplies to other than	В	-700 ME	DI CAL RECORDS & LI BRARY	16. 00	0	16. 00
17. 00	3		0		0.00	0	17. 00
18. 00	patients Sale of medical records and abstracts		0		0.00	0	18. 00
19. 00	Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
19. 01	books, etc.) Nursing and allied health education (tuition, fees,		0		0.00	0	19. 01
20.00	books, etc.) Vending machines	В	-2, 049 DI	ETARY	10.00	0	
21. 00	Income from imposition of interest, finance or penalty		U		0.00	U	21.00
22. 00	overpayments and borrowings to		0		0. 00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0 **	* Cost Center Deleted ***	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	OPH	YSI CAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0 **	* Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - NEW CAP REL COSTS-BLDG & FIXT		O NE FI	W CAP REL COSTS-BLDG &	1.00	0	26. 00
27. 00	1		O NE	W CAP REL COSTS-MVBLE UIP	2. 00	0	27. 00
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		l l	* Cost Center Deleted **	* 19. 00 0. 00	Ω	28. 00 29. 00
_ /. 00	addi dealte	ı I	٥I		ا ٥. ٥٥١	O	, 27.00

				То	12/31/2019	Date/Time Pre 3/31/2020 8:1	
				Expense Classification on V		373172020 8. 1	o aiii
				To/From Which the Amount is t	o be Adjusted		
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	cost center bescription	(2)	Allourt	cost center	Line #	Ref.	
	T	1. 00	2. 00	3. 00	4. 00	5. 00	
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30.00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions)	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
31.00	Adjustment for speech pathology costs in excess of	H-0-3	0	SPEECH PAINULUGT	88.00		31.00
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0. 00	0	32.00
33. 00	Depreciation and Interest HOSPITAL ADMINISTRAT	А	-31, 775	ADMINISTRATIVE & GENERAL	5. 00	0	33.00
	SPONSORSHI PS/DO						
33. 01	LEASE INCOME	В	-43, 200	NEW CAP REL COSTS-BLDG &	1. 00	10	33. 01
33. 02	WELLNESS REVENUE	В	-55 220	FIXT EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 02
33. 03	EDUCATION REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	Ö	33. 03
33. 04	MEDICAL STAFF FEES	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 04
33. 05	VOLUNTEER MISC REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	0	33.05
33.06	CASH (SHORT) OVER	В		ADMINISTRATIVE & GENERAL	5. 00	0	33.06
33. 07 33. 08	MISC INCOME RECEIVED PLANT OPERATIONS	B B		ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5. 00 7. 00	0	33. 07 33. 08
33. 09	MEALS ON WHEELS	В		DIETARY	10. 00	0	33.00
33. 10	HEAD START	В		DI ETARY	10. 00	0	33. 10
33. 11	AMBULANCE REV	В		AMBULANCE SERVICES	95.00	0	33. 11
33. 12	CENTRAL SUPPLY	В	-3, 063	MEDICAL SUPPLIES CHARGED TO	71. 00	0	33. 12
33. 13	CICOA MEAL VOUCHERS	В	-3 850	PATI ENTS DI ETARY	10. 00	0	33. 13
33. 14	MEDI CAL RECORDS	В		MEDICAL RECORDS & LIBRARY	16. 00	o	33. 14
33. 15	CENTRAL SUPPLY PURCHASING	В		MEDICAL SUPPLIES CHARGED TO	71.00	0	33. 15
	DI SCOUNTS	_		PATI ENTS			
33. 16	BANK FEES	A		OPERATI NG ROOM	50.00	0	33. 16
33. 17 33. 18	DERMATOLOGY CLINIC RENT SURGERY CLINIC RENT	A A		DERMATOLOGY CLINIC SURGERY CLINIC	90. 03 90. 05	0	33. 17 33. 18
33. 19	UROLOGY CLINIC RENT	Ä		UROLOGY CLINIC	90. 03	0	33. 19
33. 20	GASTROENTEROLOGY CLINIC RENT	Α		GASTROENTEROLOGY CLINIC	90. 09	0	33. 20
33. 21	NEUROLOGY CLINIC RENT	A		NEUROLOGY CLINIC	90. 11	0	33. 21
33. 22	EYE INSTITUTE RENT	A	· ·	OPTHAMOLOGY CLINIC	90. 12	0	33. 22
33. 23	2015 BOND INTEREST ON INVEST	В	-61, 585	NEW CAP REL COSTS-BLDG & FLXT	1. 00	11	33. 23
33. 24	INTEREST INCOME - UNNECESSARY	В	-96, 404	NEW CAP REL COSTS-BLDG &	1. 00	11	33. 24
	BORROW			FIXT			
33. 25	GAIN ON INVESTMENT	В		NEW CAP REL COSTS-BLDG &	1. 00	11	33. 25
33. 26	VOLUNTEER REVENUE INTEREST	В		FIXT ADMINISTRATIVE & GENERAL	5. 00	0	33. 26
33. 27	GAIN/(LOSS) CIHA	Ā		ADMINISTRATIVE & GENERAL	5. 00	o	
33. 28	GAI N/(LOSS) SHO SPC	В		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 29	GAIN/(LOSS) SHO RRG	В	-42, 178	ADMINISTRATIVE & GENERAL	5. 00	0	33. 29
33. 30	HEARING AID COSTS	A		AUDI OLOGY	67. 01	0	33. 30
33. 31	BANK FEES	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 31
33. 32 33. 33	LOBBYING EXPENSE-IHA DUES LOBBYING EXPENSE-AHA DUES	A A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	33. 32 33. 33
33. 34	NON-REI MBURSABLE ADVERTI SI NG	Ä		ADMINISTRATIVE & GENERAL	5. 00	0	33. 34
	COSTS						
33. 35	SELF INSURANCE CLAIMS PAID	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	
33. 36	HAF FEE	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 36
33. 37 33. 38	EMPLOYEE HEALTH REV CLIENT 2017 BOND INTEREST ON	B B		ADMINISTRATIVE & GENERAL NEW CAP REL COSTS-BLDG &	5. 00 1. 00	0 11	
55. 50	INVESTMENT			FIXT	1.00	''	55. 50
33. 39	1208 N LEBANON RENTAL INCOME	В		NEW CAP REL COSTS-BLDG &	1. 00	10	33. 39
EO 00	TOTAL (cum of line 1 the 10)		17 700 / 44	FLXT			FO 00
50. 00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,		-17, 732, 641				50.00
	column 6, line 200.)						

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.

Health Financial Systems		WITHAM MEMORI	AL HOSPITAL	In Lieu of Form CMS-2552-10		
ADJUSTMENTS TO EXPENSES		Provider CCN: 15-0104	Peri od:	Worksheet A-8		
				From 01/01/2019 To 12/31/2019	Date/Time Pre	nared·
				127 017 2017	3/31/2020 8: 1	8 am
			Expense Classification o			
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	(2)				Ref.	
	1. 00	2. 00	3. 00	4. 00	5. 00	

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.

Peri od: From 01/01/2019 Worksheet A-8-2

						To 12/31/2019		epared:
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	0 4
		I denti fi er	Remuneration	Component	Component		ider Component	
				·	·		Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7.00	
1. 00	0. 00		0	(	-	0	0	1.00
2.00		RADI OLOGY-DI AGNOSTI C	410, 462	410, 462		C	0	2.00
3.00		LABORATORY	120, 000			) C	0	3.00
4.00		EMERGENCY	2, 602, 200	2, 602, 200	0	C	0	4.00
5. 00	0. 00		0	(	0	) C	0	5. 00
6. 00	0. 00		0	(	-	) C	ol ol	6. 00
7. 00	0. 00		0	(	0	) C	0	7. 00
8. 00	0. 00		0	(	0	) C	0	8. 00
9. 00	0. 00		0	(	0	0	0	9. 00
10. 00	0. 00		0	(	-	0	0	10.00
200.00			3, 132, 662			)	0	200.00
	Wkst. A Line #	1	Unadjusted RCE			Provi der	Physician Cost	
		I denti fi er	Limit		Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
	1.00	0.00	0.00	0.00	Education	12	11.00	
1 00	1.00	2. 00	8. 00	9. 00	12.00	13. 00	14.00	1 00
1.00	0.00		0			1		1.00
2.00		RADI OLOGY-DI AGNOSTI C	1			C		2.00
3. 00		LABORATORY	0				0	3.00
4. 00		EMERGENCY	0		-		0	4.00
5. 00	0.00	l .	0	(	-		0	5.00
6. 00	0.00		0	(	-		0	6.00
7. 00	0.00		0	(			0	7.00
8. 00	0.00		0				0	8.00
9. 00	0. 00 0. 00		0	(	-		0	9.00
10.00	0.00		0		9		0	10.00
200. 00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE		Adjustment	, U	200.00
	WKSt. A LINE #	I denti fi er	Component	Limit	Di sal I owance	Adjustillent		
		ruentiffei	Share of col.	LIIIII	Di Sai i Owance			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00	†	
1. 00	0.00		0		) (			1.00
2. 00		RADI OLOGY-DI AGNOSTI C	l ő			410, 462		2.00
3. 00		LABORATORY	0		-	120,000		3.00
4. 00		EMERGENCY	0			2, 602, 200		4.00
5. 00	0.00	1	l ő		-	] _, 332, 200	,	5. 00
6. 00	0.00		l 0		-	ا ا	)	6.00
7. 00	0.00	1	0		-	ol o	,	7. 00
8. 00	0.00		l 0		9	ا ا	)	8.00
9. 00	0.00	1	0		-	ol o	,	9. 00
10. 00	0.00		0		-	ol o	)	10.00
200.00	3.00		Ö			3, 132, 662		200.00
	•	1		•	•			

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-0104

				10	12/31/2019	Date/lime Pre   3/31/2020 8:1	
			CAPI TAL REI	ATED COSTS		0,01,2020 0.1	
	Cost Center Description	Net Expenses	NEW BLDG &	NEW MVBLE	EMPLOYEE	Subtotal	
		for Cost Allocation	FIXT	EQUI P	BENEFITS DEPARTMENT		
		(from Wkst A col. 7)					
		0	1. 00	2. 00	4. 00	4A	
4 00	GENERAL SERVICE COST CENTERS	0 405 700	0.405.700				
1. 00 2. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP	2, 185, 708	2, 185, 708				1.00 2.00
4. 00	100400 EMPLOYEE BENEFITS DEPARTMENT	4, 611, 701 12, 141, 857	4, 971	4, 611, 701 10, 488	12, 157, 316		4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	15, 462, 547	158, 863		1, 323, 009		1
7.00	00700 OPERATION OF PLANT	3, 659, 407	208, 128	439, 136	125, 713	4, 432, 384	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	564, 773	0	_	5, 829		1
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	870, 207	23, 966		87, 352		1
11. 00	01100 CAFETERI A	1, 361, 747 349, 470	53, 646 0	113, 190 0	154, 988 28, 312		1
13. 00	01300 NURSI NG ADMI NI STRATI ON	686, 825	0	Ö	114, 675		
15.00	01500 PHARMACY	6, 830, 489	16, 561	34, 943	128, 880		1
16. 00	01600 MEDI CAL RECORDS & LI BRARY	1, 718, 243	26, 161	55, 198	248, 306	2, 047, 908	16. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	4, 599, 007	174, 006	367, 142	704, 342	5, 844, 497	30.00
31. 00	03100 I NTENSI VE CARE UNI T	1, 691, 702	47, 787		245, 043		
40.00	04000 SUBPROVI DER - I PF	1, 252, 862	54, 714		208, 780		
41.00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	55, 910 1, 551, 553	41, 433	87, 420	0 193, 598	55, 910 1, 874, 004	1
44.00	ANCI LLARY SERVICE COST CENTERS	1, 551, 553	41, 433	67,420	193, 390	1, 674, 004	44.00
50.00	05000 OPERATI NG ROOM	3, 432, 741	138, 877	293, 022	437, 592	4, 302, 232	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 137, 069	169, 847		312, 504	5, 977, 786	1
55. 00	O5500   RADI OLOGY-THERAPEUTI C	7/1 722	0	=	(5.205	0	55.00
55. 01 57. 00	05501   ULTRA SOUND	761, 722 895, 731	0	0	65, 305 37, 737	827, 027 933, 468	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	854, 467	14, 571	_	63, 726		
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 438, 340	12, 282		59, 705	1, 536, 241	1
60.00	06000 LABORATORY	7, 313, 455	79, 209		575, 378		1
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	198, 700	0	0	0	198, 700 0	1
66. 00	06600 PHYSI CAL THERAPY	2, 056, 752	76, 664	_	315, 956	_	1
67.00	06700 OCCUPATI ONAL THERAPY	475, 218	0		77, 453		67.00
67. 01	06701 AUDI OLOGY	155, 288	0	0	41, 492		1
68. 00 69. 00	06800 SPEECH PATHOLOGY	243, 522	0	0	40, 156	283, 678 0	68. 00 69. 00
69. 00	06900  ELECTROCARDI OLOGY   06901  CARDI OLOGY	1, 483, 796	7, 900	16, 669	221, 676		
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 255, 573	0		0	3, 255, 573	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	4, 970, 665	0	_	0	.,	
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 216, 352	0	0	0	4, 216, 352	73. 00
00 00	OUTPATIENT SERVICE COST CENTERS  O9000 CLINIC	O	0	O	0	0	90.00
	09001 OTHER OUTPATIENT SERVICE COST CENTER	287, 574	32, 644		37, 602	426, 696	
90. 02	09002 CLINIC	0	0	0	0	0	1
90. 03	09003 DERMATOLOGY CLINIC	0	0	0	0	0	
90. 04	09004 ENT CLINIC	0	0	0	0	0	
90. 05 90. 07	09005   SURGERY   CLI NI C   09007   UROLOGY   CLI NI C	-653 -1, 748	0	0	0	-653 -1, 748	1
90. 09	09009 GASTROENTEROLOGY CLINIC	3, 013	0	Ö	589		
90. 11	09011 NEUROLOGY CLINIC	0	0	0	0	0	1
90. 12	09012 OPTHAMOLOGY CLINIC	-20, 627	0	0	0	-20, 627	
90. 13 90. 14	09013 ALLERGY CLINIC	154, 167	0	0	18, 900		
	09014 WOUND CARE 09100 EMERGENCY	667, 299 2, 866, 406	29, 928 209, 819		46, 730 469, 961		1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,000,100	207,017	112,701	107, 701	0, 700, 070	1
	OTHER REIMBURSABLE COST CENTERS						
95. 00	O9500   AMBULANCE   SERVI CES   SPECI AL   PURPOSE   COST   CENTERS	2, 926, 035	40, 655	85, 780	462, 643	3, 515, 113	95.00
118.00		103, 364, 865	1, 622, 632	3, 423, 651	6, 853, 932	96, 310, 355	118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	5, 330	11, 245	0	16, 575	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	38, 720, 572	366, 769		5, 241, 845	45, 103, 041	192. 00
	07950 THORNTOWN OFFICE BUILDING	0	0	_	0		194.00
	07951 CAFE/BOUTIQUE  07952 OTHER NONREIMB	144 624	12, 094 175, 467		0 12, 896		194.01
	07952 OTHER NONRETMB 07953 RETAIL PHARMACY	146, 626 2, 059, 874	3, 416		12, 896 48, 643		
200.00		_, 557, 571	3, 110	.,200	.5, 510		200.00
201.00			0	0	0		201.00
				<u>.</u>			

Health Financial Systems	WITHAM MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Peri od:	Worksheet B	
				From 01/01/2019 To 12/31/2019		pared: 8 am
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	0	1.00	2. 00	4. 00	4A	
202.00 TOTAL (sum lines 118 through 201)	144, 291, 937	2, 185, 708	4, 611, 70	1 12, 157, 316	144, 291, 937	202. 00

Provider CCN: 15-0104

Peri od: Worksheet B From 01/01/2019 Part I To 12/31/2019 Date/Ti me Prepared: 3/31/2020 8: 18 am

				''	0 12/31/2019	3/31/2020 8: 1	
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		E & GENERAL	PLANT	LINEN SERVICE			
	OFNEDAL CERVILOE COCT OFNEDC	5. 00	7. 00	8. 00	9. 00	10. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 NEW CAP REL COSTS-BLDG & FIXT					I	2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					I	4.00
5. 00	00500 ADMI NI STRATI VE & GENERAL	17, 279, 610				I	5.00
7. 00	00700 OPERATION OF PLANT	602, 902	5, 035, 286	,		I	7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	77, 614	0	648, 216		I	8.00
9.00	00900 HOUSEKEEPI NG	140, 387	76, 866		1, 249, 345	I	9.00
10.00	01000 DI ETARY	229, 003	172, 059	0	83, 368	2, 168, 001	10.00
11. 00	01100 CAFETERI A	51, 387	0	0	27, 796	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	109, 022	0	0	12, 569		1
15. 00		953, 633	53, 116		25, 379	0	15.00
16. 00		278, 561	83, 906	0	55, 592	0	16.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	704 000	FF0 000	00 700	400 040	004 444	00.00
30.00	I I	794, 980	558, 088			884, 446	30.00
31. 00 40. 00	+ I	283, 655 221, 961	153, 267 175, 483			0 494, 421	31.00 40.00
41.00	1 1	221, 901	175, 465	0, 300	133, 302	0	41.00
42. 00	+ I		0		0	0	
43. 00		7, 605	0	3, 181	0	Ö	43.00
44. 00	+ I	254, 906	132, 886			789, 134	1
	ANCILLARY SERVICE COST CENTERS	,	,				
50.00	05000 OPERATING ROOM	585, 198	445, 419	83, 054	24, 895	0	50.00
54.00		813, 110	544, 748	54, 311	112, 634	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
55. 01	05501 ULTRA SOUND	112, 494	0	14, 421	7, 251	0	55. 01
57.00	05700 CT SCAN	126, 972	0	71, 685		0	57.00
58.00		131, 058	46, 733			0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	208, 963	39, 392			0	59.00
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	1, 106, 562	254, 048 0			0	60.00
64.00	06400 I NTRAVENOUS THERAPY	27, 028	0	1, 757 5, 352		0	64.00
66. 00	+ I	355, 171	245, 884			0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	75, 175	243,004			Ö	67.00
67. 01	06701 AUDI OLOGY	26, 766	0			Ö	67.01
68. 00	06800 SPEECH PATHOLOGY	38, 586	0	1, 823		Ō	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	0	· · · · · · · · · · · · · · · · · · ·	0	69.00
69. 01	06901 CARDI OLOGY	235, 324	25, 339	25, 290	36, 497	0	69. 01
71. 00	· · · · · · · · · · · · · · · · · · ·	442, 830	0	,		0	71.00
72.00	I I	676, 120	0			0	72.00
73. 00		573, 517	0	62, 413	26, 346	0	73.00
00 00	OUTPATIENT SERVICE COST CENTERS		0	1 0	٥	0	00 00
90. 00 90. 01	09000 CLINIC 09001 OTHER OUTPATIENT SERVICE COST CENTER	0 58, 040	0 104, 698	1	0 64, 776	_	
90.01		36, 040	104, 070		04,770	0	90.01
90. 02	09003 DERMATOLOGY CLINIC		0		0	0	90.02
90. 04			0		Ö	Ö	
90. 05		l o	0	o o	o	Ö	
90. 07		0	0	248	0	0	
90.09	09009 GASTROENTEROLOGY CLINIC	490	0	0	0	0	90.09
90. 11	09011 NEUROLOGY CLINIC	0	0	0	0	0	90. 11
90. 12	I I	0	0	0	0	0	90. 12
90. 13	I I	23, 541	0	1, 139		0	
90. 14		109, 784	95, 987			0	90. 14
91.00	I I	542, 577	672, 949	50, 018	0	0	91.00
92.00							92.00
95. 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	478, 133	48, 213	6, 965	O	0	95.00
93.00	SPECIAL PURPOSE COST CENTERS	470, 133	40, 213	0, 900	U U	0	95.00
118. 00		10, 753, 055	3, 929, 081	648, 216	1, 249, 345	2, 168, 001	118 00
110.00	NONREI MBURSABLE COST CENTERS	10,700,000	0, 727, 001	010,210	1,217,010	2, 100, 001	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2, 255	17. 094	. 0	0	0	190.00
	19200 PHYSICIANS' PRIVATE OFFICES	6, 135, 010	1, 039, 365		· ·		192.00
194.00	07950 THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
	1 07951 CAFE/BOUTI QUE	5, 116	38, 789	0	0		194. 01
	2 07952 OTHER NONREI MB	95, 924	0	0	0		194. 02
	3 07953 RETAI L_PHARMACY	288, 250	10, 957	0	이	0	194. 03
200.00			=		_	-	200.00
201.00		17 270 410	0 5 025 201	0	1 240 245		201.00
202.00	TOTAL (sum lines 118 through 201)	17, 279, 610	5, 035, 286	648, 216	1, 249, 345	2, 168, 001	1202.00

Peri od: Worksheet B From 01/01/2019 Part I To 12/31/2019 Date/Ti me Prepared: 3/31/2020 8: 18 am Provider CCN: 15-0104

			10	12/31/2019	3/31/2020 8: 1	
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O N	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	
	11. 00	13. 00	15. 00	16. 00	24. 00	
GENERAL SERVICE COST CENTERS						
1. 00	456, 965 8, 841 17, 683 35, 831	931, 932 0 0	8, 060, 684 0	2, 501, 798		1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 15. 00
30. 00 03000 ADULTS & PEDIATRICS	120, 525	212, 251	1, 082	614, 799	9, 486, 764	30.00
31. 00   03100   INTENSIVE CARE UNIT 40. 00   04000   SUBPROVI DER - I PF 41. 00   04100   SUBPROVI DER - I RF 42. 00   04200   SUBPROVI DER 43. 00   04300   NURSERY 44. 00   04400   SKI LLED   NURSING FACILITY ANCI LLARY SERVICE COST CENTERS	9, 772 15, 356 0 0 0 0	71, 469 72, 246 0 0 0 80, 214	86 101 0 0 0 6, 227	127, 829 152, 177 0 0 0	2, 851, 261 2, 903, 274 0 0 66, 696 3, 142, 051	40. 00 41. 00 42. 00 43. 00
50. 00 05000 OPERATING ROOM	10, 703	140, 354	41, 606	220, 657	5, 854, 118	50.00
54. 00	13, 030 0 1, 396 1, 861 4, 653 0 38, 158 0 19, 079 7, 911 8, 376 8, 841 0 19, 079 9, 772 0 0	0 0 0 0 0 16, 636 0 0 0 62, 830 20, 668 14, 554 11, 008 0 66, 060 0	4, 684 2, 317 0 1, 757 4, 521 16 249 0 0 4, 431 0 0 0 298 0 0 0	590, 449 0 63, 915 73, 045 39, 566 0 60, 871 0 0 118, 698 51, 740 0 0 114, 133 0 0 0 255, 658	8, 110, 752 2, 317 1, 026, 504 1, 219, 906 1, 227, 562 1, 829, 152 9, 734, 987 227, 485 5, 352 3, 447, 444 722, 236 254, 016 347, 562 0 2, 252, 061 3, 722, 255 5, 671, 148 4, 878, 628	54. 00 55. 00 55. 01 57. 00 58. 00 59. 00 60. 00 63. 00 64. 00 67. 01 68. 00 69. 01 71. 00 72. 00 73. 00 90. 00 90. 01
90. 02   09002   CLI NI C 90. 03   09003   DERMATOLOGY   CLI NI C	0	0	0	0	0	
90. 04   09004   ENT CLINIC   90. 05   09005   SURGERY CLINIC   90. 07   09007   UROLOGY CLINIC   90. 09   09009   GASTROENTEROLOGY CLINIC   90. 11   09011   NEUROLOGY CLINIC   90. 12   09012   OPTHAMOLOGY CLINIC   90. 13   09013   ALLERGY CLINIC   90. 14   09014   WOUND CARE   91. 00   09100   EMERGENCY   92. 00   09200   OBSERVATION   BEDS (NON-DISTINCT PART)   OTHER REIMBURSABLE COST CENTERS	0 0 0 0 0 0 0 0 0 29, 782	0 0 0 9, 630 0 0 5, 984 16, 037 113, 341	266 961 0 8, 462 0 20, 162 20, 219 74, 654	000000000000000000000000000000000000000	0 -387 -539 13, 722 8, 462 -20, 627 223, 893 1, 057, 225 5, 472, 211	90. 04 90. 05 90. 07 90. 09 90. 11 90. 12 90. 13 90. 14 91. 00 92. 00
95. 00 09500 AMBULANCE SERVICES	60, 494	0	17, 690	0	4, 126, 608	95.00
SPECIAL PURPOSE COST CENTERS  118.00   SUBTOTALS (SUM OF LINES 1 through 117)   NONREI MBURSABLE COST CENTERS	456, 965	924, 935	209, 886	2, 483, 537	80, 801, 539	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 194.00 07950 THORNTOWN OFFICE BUILDING	0 0 0	0 3, 026 0	0 4, 675, 474 0	0 18, 261 0	56, 974, 177	190. 00 192. 00 194. 00
194.01 07951 CAFE/BOUTIQUE 194.02 07952 OTHER NONREIMB 194.03 07953 RETAIL PHARMACY 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	0 0	0 3, 971 0	0 0 3, 175, 324	0 0	81, 517 805, 108 5, 593, 672 0	194. 01 194. 02
202.00 TOTAL (sum lines 118 through 201)	456, 965	931, 932	8, 060, 684	2, 501, 798	144, 291, 937	1

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

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0104 Peri od: Worksheet B From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 3/31/2020 8:18 am Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 9, 486, 764 30.00 03100 INTENSIVE CARE UNIT 31.00 0 0 2, 851, 261 31.00 04000 SUBPROVI DER - I PF 40.00 40 00 2, 903, 274 41.00 04100 SUBPROVI DER - I RF Ω 41.00 04200 SUBPROVI DER 0 42.00 0 42.00 0 04300 NURSERY 43.00 43.00 66, 696 04400 SKILLED NURSING FACILITY 44.00 3, 142, 051 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 5, 854, 118 50.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 8, 110, 752 54 00 05500 RADI OLOGY-THERAPEUTI C 55.00 2, 317 55.00 55.01 05501 ULTRA SOUND 1,026,504 55.01 57.00 05700 CT SCAN 000000000000000 1, 219, 906 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58 00 1, 227, 562 58 00 59.00 05900 CARDI AC CATHETERI ZATI ON 1, 829, 152 59.00 06000 LABORATORY 9, 734, 987 60.00 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 227, 485 63.00 64.00 06400 I NTRAVENOUS THERAPY 5, 352 64 00 66.00 06600 PHYSI CAL THERAPY 3, 447, 444 66.00 06700 OCCUPATI ONAL THERAPY 67.00 722, 236 67.00 67.01 06701 AUDI OLOGY 254.016 67.01 06800 SPEECH PATHOLOGY 68.00 347, 562 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 69.01 06901 CARDI OLOGY 2, 252, 061 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3, 722, 255 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 5, 671, 148 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 4, 878, 628 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 97 90.00 90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER 0 937, 343 90.01 90 02 09002 CLI NI C 0 0 90.02 09003 DERMATOLOGY CLINIC 000000000 90.03 90.03 0 09004 ENT CLINIC 90.04 r 90.04 90.05 09005 SURGERY CLINIC 90.05 -387 09007 UROLOGY CLINIC 90.07 -539 90.07 09009 GASTROENTEROLOGY CLINIC 90.09 13, 722 90.09 90. 11 09011 NEUROLOGY CLINIC 8, 462 90.11 90.12 09012 OPTHAMOLOGY CLINIC -20, 627 90.12 09013 ALLERGY CLINIC 90.13 90. 13 223, 893 09014 WOUND CARE 90.14 1, 057, 225 90.14 0 91.00 09100 EMERGENCY 5, 472, 211 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 95.00 4, 126, 608 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 118.00 0 80, 801, 539 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 35, 924 190.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 56, 974, 177 192.00 0 194. 00 07950 THORNTOWN OFFICE BUILDING 0 194.00 194. 01 07951 CAFE/BOUTI QUE 81, 517 194 01 194. 02 07952 OTHER NONREIMB 805, 108 194.02 0 0 194. 03 07953 RETAIL PHARMACY 5, 593, 672 194.03 200.00 Cross Foot Adjustments 200.00 Ω 201.00 Negative Cost Centers 0 201.00  $\mathcal{C}$ 202.00 TOTAL (sum lines 118 through 201) 144, 291, 937 202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2019 Part II
To 12/31/2019 Date/Time Prepared:
3/31/2020 8:18 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0104

					10	12/31/2019	3/31/2020 8: 1	
				CAPI TAL REI	_ATED COSTS			
		Cost Center Description	Di rectly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
			Assigned New	FLXT	EQUI P		BENEFITS	
			Capital Related Costs				DEPARTMENT	
			0	1.00	2.00	2A	4. 00	
	GENER	AL SERVICE COST CENTERS						
1.00		NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00		NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	0	4, 971		15, 459	15, 459	4.00
5.00		ADMINISTRATIVE & GENERAL OPERATION OF PLANT	0	158, 863		494, 054	1, 681	5.00
7. 00 8. 00		LAUNDRY & LINEN SERVICE	0	208, 128 0		647, 264	160 7	7. 00 8. 00
9. 00		HOUSEKEEPI NG	0	23, 966		74, 533	111	9.00
10.00		DI ETARY	Ö	53, 646		166, 836	197	10.00
11.00	01100	CAFETERI A	0	0	0	0	36	11.00
13.00		NURSING ADMINISTRATION	0	0	0	0	146	
15. 00	1	PHARMACY	0	16, 561	34, 943	51, 504	164	15.00
16. 00		MEDICAL RECORDS & LIBRARY	0	26, 161	55, 198	81, 359	315	16. 00
30. 00		ENT ROUTINE SERVICE COST CENTERS  ADULTS & PEDIATRICS	ol	174, 006	367, 142	541, 148	895	30.00
31. 00		INTENSIVE CARE UNIT	0	47, 787		148, 615	311	31.00
40.00		SUBPROVI DER - I PF	Ö	54, 714		170, 157	265	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00		SUBPROVI DER	0	0	0	0	0	42. 00
43.00		NURSERY	0	0	0	0	0	43.00
44. 00		SKILLED NURSING FACILITY	0	41, 433	87, 420	128, 853	246	44. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	ol	138, 877	293, 022	431, 899	556	50.00
54. 00	4	RADI OLOGY-DI AGNOSTI C	0	169, 847		528, 213	397	54.00
55. 00		RADI OLOGY-THERAPEUTI C	Ö	0	0	0	0	55. 00
55. 01	05501	ULTRA SOUND	0	0	0	0	83	55. 01
57.00	1	CT SCAN	0	0	0	0	48	57. 00
58.00	1	MAGNETIC RESONANCE IMAGING (MRI)	0	14, 571	30, 744	45, 315	81	58.00
59.00	1	CARDI AC CATHETERI ZATI ON	0	12, 282		38, 196	76	
60. 00 63. 00	4	LABORATORY BLOOD STORING, PROCESSING & TRANS.	0	79, 209 0		246, 336 0	731 0	60. 00 63. 00
64.00		INTRAVENOUS THERAPY	0	0		0	0	64.00
66. 00		PHYSI CAL THERAPY	o	76, 664		238, 421	401	66.00
67.00		OCCUPATI ONAL THERAPY	0	0	0	0	98	67.00
67. 01	4	AUDI OLOGY	0	0	0	0	53	67. 01
68. 00	1	SPEECH PATHOLOGY	0	0	0	0	51	68.00
69.00		ELECTROCARDI OLOGY	0	7 000	14 440	0	0	69.00
69. 01 71. 00	4	CARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7, 900	16, 669	24, 569	282 0	69. 01 71. 00
72.00		IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00		DRUGS CHARGED TO PATIENTS	Ö	0		Ö	0	73.00
	OUTPA <sup>*</sup>	TIENT SERVICE COST CENTERS						
		CLI NI C	0	0		0	0	
		OTHER OUTPATIENT SERVICE COST CENTER	0	32, 644		101, 520	48	
90. 02 90. 03	4	CLINIC DERMATOLOGY CLINIC	0	0		O O	0	90. 02 90. 03
90.03		ENT CLINIC	0	0	0	0	0	90.03
90. 05		SURGERY CLINIC	o	0	0	Ö	0	90.05
90. 07		UROLOGY CLINIC	0	0	0	0	0	90. 07
90.09		GASTROENTEROLOGY CLINIC	0	0	0	0	1	90. 09
90. 11		NEUROLOGY CLINIC	0	0	0	0	0	90. 11
90. 12	1	OPTHAMOLOGY CLINIC	0	0	0	0	0	90. 12
90. 13 90. 14	1	ALLERGY CLINIC WOUND CARE	0	29, 928	63, 146	93, 074	24 59	90. 13 90. 14
91.00		EMERGENCY	0	209, 819		652, 523	597	91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)		207,017	112,701	0	077	92.00
	OTHER	REIMBURSABLE COST CENTERS						
95.00		AMBULANCE SERVICES	0	40, 655	85, 780	126, 435	588	95. 00
440.00		AL PURPOSE COST CENTERS		1 (00 (00	0 400 (54	5 044 000	0.700	
118.00		SUBTOTALS (SUM OF LINES 1 through 117) MBURSABLE COST CENTERS	0	1, 622, 632	3, 423, 651	5, 046, 283	8, 708	118. 00
190 00		GIFT, FLOWER, COFFEE SHOP, & CANTEEN	٥	5, 330	11, 245	16, 575	0	190. 00
		PHYSICIANS' PRIVATE OFFICES	Ö	366, 769		1, 140, 624		192.00
		THORNTOWN OFFICE BUILDING	Ö	0		0		194. 00
194. 01	07951	CAFE/BOUTI QUE	О	12, 094		37, 612	0	194. 01
		OTHER NONREIMB	0	175, 467	370, 224	545, 691		194. 02
		RETAIL PHARMACY	0	3, 416	7, 208	10, 624	62	194. 03
200. 00 201. 00	4	Cross Foot Adjustments		^		0	0	200. 00 201. 00
201.00		Negative Cost Centers TOTAL (sum lines 118 through 201)	0	2, 185, 708	0 4, 611, 701	6, 797, 409	15, 459	
	-1	(Sam 11.188 1.10 till Sagit 201)	<u>ا</u>	2, 100, 700	1 ., 511, 751	5, . , , , 10 /	10, 107	

Provider CCN: 15-0104

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2019 | Part II |
| To 12/31/2019 | Date/Time Prepared: 3/31/2020 8:18 am

					J 12/31/2019	3/31/2020 8: 1	
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		E & GENERAL	PLANT	LINEN SERVICE	2.22	10.00	
	CENEDAL SEDVICE COST CENTEDS	5. 00	7. 00	8.00	9. 00	10. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	495, 735					5.00
7.00	00700 OPERATION OF PLANT	17, 295	664, 719				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	2, 226	0	2, 233			8. 00
9. 00	00900 HOUSEKEEPI NG	4, 027	10, 147	1	88, 818		9. 00
10.00	01000 DI ETARY	6, 569	22, 714		5, 927	202, 243	1
11. 00 13. 00	O1100   CAFETERI A   O1300   NURSI NG   ADMI NI STRATI ON	1, 474 3, 127	0	_	1, 976 894	0	11. 00 13. 00
	01500 PHARMACY	27, 356	7, 012	-	1, 804	0	15.00
	01600 MEDICAL RECORDS & LIBRARY	7, 991	11, 077		3, 952	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	.,			27 : ==		
30.00	03000 ADULTS & PEDIATRICS	22, 805	73, 674	107	30, 023	82, 506	30. 00
31.00	03100 INTENSIVE CARE UNIT	8, 137	20, 233	1	7, 973	0	31.00
	04000 SUBPROVI DER - I PF	6, 367	23, 166		9, 481	46, 122	40.00
41.00	04100 SUBPROVI DER – I RF	0	0	_	0	0	41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	
43. 00 44. 00	04300 NURSERY  04400 SKILLED NURSING FACILITY	218 7, 312	17, 543	10	0	0 73, 615	43. 00 44. 00
44.00	ANCI LLARY SERVI CE COST CENTERS	1,312	17, 543	15	<u> </u>	73,013	44.00
50.00	05000 OPERATING ROOM	16, 787	58, 801	264	1, 770	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	23, 325	71, 913		8, 007	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
55. 01	05501 ULTRA SOUND	3, 227	0	46	515	0	55. 01
57.00	05700 CT SCAN	3, 642	0	228	790	0	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	3, 760	6, 169		756	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	5, 994	5, 200		0	0	59.00
60. 00 63. 00	06000   LABORATORY   06300   BLOOD STORING, PROCESSING & TRANS.	31, 743 775	33, 537 0	1	3, 385 0	0	60. 00 63. 00
64. 00	06400 I NTRAVENOUS THERAPY	7/3	0	_	0	0	64.00
66. 00	06600 PHYSI CAL THERAPY	10, 189	32, 460	1	1, 220	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	2, 157	0		584	0	67.00
67. 01	06701 AUDI OLOGY	768	0	5	430	0	67. 01
68. 00	06800 SPEECH PATHOLOGY	1, 107	0	6	258	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	_	0	0	69. 00
69. 01	06901 CARDI OLOGY	6, 751	3, 345		2, 595	0	69. 01
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12, 703 19, 396	0		0	0	71.00 72.00
	07200   IMPL. DEV. CHARGED TO PATIENT   07300   DRUGS CHARGED TO PATIENTS	16, 452			0 1, 873	0	72.00
73.00	OUTPATIENT SERVICE COST CENTERS	10, 432	0	170	1, 075	0	73.00
90.00	09000 CLINIC	l ol	0	0	ol	0	90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	1, 665	13, 821		4, 605	0	90. 01
90.02	09002 CLI NI C	o	0	0	o	0	90. 02
90. 03	09003 DERMATOLOGY CLINIC	0	0	0	0	0	90. 03
90. 04	09004 ENT CLINIC	0	0	0	0	0	90.04
	09005 SURGERY CLINIC	0	0	0	0	0	
90. 07 90. 09	09007   UROLOGY   CLINIC   09009   GASTROENTEROLOGY   CLINIC	0 14		0	U	0	90. 07 90. 09
90. 11	09011 NEUROLOGY CLINIC	0	0	1	0	0	90. 09
	09012 OPTHAMOLOGY CLINIC	0		_	Ö	0	90. 12
	09013 ALLERGY CLINIC	675	Ö	_	o	0	90. 13
90. 14	09014 WOUND CARE	3, 149	12, 671	26	O	0	90.14
91.00	09100 EMERGENCY	15, 565	88, 838	159	o	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS	1			.1		
95. 00	09500 AMBULANCE SERVICES	13, 716	6, 365	22	0	0	95.00
118. 00	SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1 through 117)	308, 464	E10 404	2, 233	88, 818	202, 243	110 00
116.00	NONREI MBURSABLE COST CENTERS	300, 404	518, 686	2, 233	00, 010	202, 243	1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	65	2, 257	' 0	O	0	190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	176, 038	137, 208	1	o		192.00
	07950 THORNTOWN OFFICE BUILDING	0	0	Ö	o		194.00
194. 01	07951 CAFE/BOUTI QUE	147	5, 121	0	o		194. 01
	07952 OTHER NONREIMB	2, 752	0	0	0		194. 02
	07953 RETAIL PHARMACY	8, 269	1, 447	0	0	0	194. 03
200.00			_			_	200.00
201. 00 202. 00		0 495, 735	664, 719	2, 233	0 88, 818		201.00
202.00	TOTAL (Sum TITIES TTO LINGUIGH 201)	470, 730	004, /19	2, 233	00, 010	202, 243	1202. UU

Provider CCN: 15-0104

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared: | 3/31/2020 8:18 am

Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O N	PHARMACY	MEDI CAL RECORDS & LI BRARY	3/31/2020 8: 1 Subtotal	8 am
	11. 00	13. 00	15. 00	16. 00	24.00	
GENERAL SERVICE COST CENTERS		T T				1 4 00
1. 00   00100   NEW CAP REL COSTS-BLDG & FIXT   2. 00   00200   NEW CAP REL COSTS-MVBLE EQUIP   4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT   5. 00   00500   ADMINISTRATIVE & GENERAL   7. 00   00700   OPERATION OF PLANT   8. 00   00800   LAUNDRY & LINEN SERVICE   9. 00   00900   HOUSEKEEPING   10. 00   01000   DIETARY   11. 00   01100   CAFETERIA   13. 00   01300   NURSING ADMINISTRATION   15. 00   01600   MEDICAL RECORDS & LIBRARY   INPATIENT ROUTINE SERVICE COST CENTERS	3, 486 67 135 273	4, 234 0	87, 975 0	104, 967		1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 15. 00
30. 00 03000 ADULTS & PEDIATRICS	920	964	12	25, 794	778, 848	30.00
31. 00   03100   INTENSIVE CARE UNIT 40. 00   04000   SUBPROVI DER - I PF 41. 00   04100   SUBPROVI DER - I RF 42. 00   04200   SUBPROVI DER 43. 00   04300   NURSERY 44. 00   04400   SKI LLED   NURSING   FACILITY ANCI LLARY   SERVICE   COST   CENTERS	75 117 0 0 0 0	328 0 0 0	1 1 0 0 0 0 68	5, 363 6, 385 0 0 0 0	191, 057 262, 409 0 0 228 228, 016	40. 00 41. 00 42. 00 43. 00
50. 00 05000 OPERATING ROOM	82	638	454	9, 258	520, 509	50.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 55. 00   05500   RADI OLOGY-THERAPEUTI C 55. 01   05501   ULTRA SOUND 57. 00   05700   CT SCAN 58. 00   05800   MAGNETI C RESONANCE I MAGING (MRI) 59. 00   05900   CARDI AC CATHETERI ZATI ON 60. 00   06000   LABORATORY	99 0 11 14 35 0 291	0 0 0 0	51 25 0 19 49 0	24, 773 0 2, 682 3, 065 1, 660 0 2, 554	656, 950 25 6, 564 7, 806 57, 910 49, 631 319, 047	55. 00 55. 01 57. 00 58. 00 59. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	291	-1	0	2, 554	781	63.00
64. 00   06400   INTRAVENOUS THERAPY   66. 00   06600   PHYSI CAL THERAPY   67. 00   06700   OCCUPATI ONAL THERAPY   67. 01   06701   AUDI OLOGY   68. 00   06800   SPEECH PATHOLOGY   69. 00   06900   ELECTROCARDI OLOGY   69. 01   06901   CARDI OLOGY   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENT   73. 00   07300   DRUGS CHARGED TO PATI ENTS   74. 00   07300   DRUGS CHARGED TO PATI ENTS   07300   DRUGS	0 146 60 64 67 0 146 75 0	0 285 94 66 50 0 300 0	0 0 48 0 0 0 0 0 3 3 0	0 0 4, 980 2, 171 0 0 0 4, 789 0 0	781 17 288, 191 5, 183 1, 368 1, 539 0 42, 860 12, 823 19, 473 18, 523	64. 00 66. 00 67. 00 67. 01 68. 00 69. 00 69. 01 71. 00 72. 00
90. 00 O9000 CLINIC	0	l ol	1	O	1	90.00
90. 00   09000   CEINIC   90. 01   09001   OTHER OUTPATIENT SERVICE COST CENTER   90. 02   09002   CLINIC   90. 03   09003   DERMATOLOGY   CLINIC   90. 04   09004   ENT   CLINIC   90. 05   09005   SURGERY   CLINIC   90. 07   09007   UROLOGY   CLINIC   90. 09   09009   GASTROENTEROLOGY   CLINIC   90. 11   09011   NEUROLOGY   CLINIC   90. 12   09012   OPTHAMOLOGY   CLINIC   90. 13   09013   ALLERGY   CLINIC   90. 14   09014   WOUND   CARE   91. 00   09100   EMERGENCY   92. 00   09200   OBSERVATION   BEDS   (NON-DISTINCT   PART)	0 121 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	53 0 0 0 0 0 44 0 0 27	0 0 0 0 3 10 0 92 0 220 221 815	10, 727 0 0 0 0 0 0 0 0 0 0 0	132, 560 0 0 0 3 11 59 92 0 950 109, 273 759, 239	90. 01 90. 02 90. 03 90. 04 90. 05 90. 07 90. 09 90. 11 90. 12 90. 13 90. 14
OTHER REIMBURSABLE COST CENTERS	47.1	ا ما	102		147 700	05.00
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	461		193	0	147, 780	
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	3, 486	4, 202	2, 289	104, 201	4, 619, 744	118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 194. 00 07950 THORNTOWN OFFICE BUILDING 194. 01 07951 CAFE/BOUTIQUE 194. 02 07952 OTHER NONREIMB 194. 03 07953 RETAIL PHARMACY 200. 00 Cross Foot Adjustments	0 0 0 0 0	14	0 51, 031 0 0 0 0 34, 655	0 766 0 0 0 0	42, 880 548, 477 55, 057	192. 00 194. 00 194. 01
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	0 3, 486	0 4, 234	0 87, 975	0 104, 967		201. 00

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

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0104 Peri od: Worksheet B From 01/01/2019 Part II Date/Time Prepared: 12/31/2019 3/31/2020 8:18 am Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 778, 848 30.00 03100 INTENSIVE CARE UNIT 0 31.00 191, 057 31.00 0 04000 SUBPROVI DER - I PF 40 00 40.00 262, 409 04100 SUBPROVI DER - I RF 41.00 0 41.00 04200 SUBPROVI DER 0 42.00 0 42.00 04300 NURSERY 228 43.00 43.00 0 04400 SKILLED NURSING FACILITY 44.00 228, 016 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 520, 509 50.00 0 0 0 656, 950 54.00 05400 RADI OLOGY-DI AGNOSTI C 54 00 05500 RADI OLOGY-THERAPEUTI C 55.00 25 55.00 55.01 05501 ULTRA SOUND 6,564 55.01 57.00 05700 CT SCAN 000000000000000 7,806 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58 00 57 910 58 00 59.00 05900 CARDI AC CATHETERI ZATI ON 49, 631 59.00 06000 LABORATORY 319, 047 60.00 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 781 63.00 64.00 06400 I NTRAVENOUS THERAPY 64 00 17 66.00 06600 PHYSI CAL THERAPY 288, 191 66.00 06700 OCCUPATI ONAL THERAPY 67.00 5, 183 67.00 67.01 06701 AUDI OLOGY 1.386 67.01 06800 SPEECH PATHOLOGY 68.00 1, 539 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 69.01 06901 CARDI OLOGY 42,860 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 12.823 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 19, 473 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 18, 523 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 0 132, 560 90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER 90.01 90 02 09002 CLI NI C 0 90.02 09003 DERMATOLOGY CLINIC 000000000 90.03 90.03 0 09004 ENT CLINIC 90.04 0 90.04 90.05 09005 SURGERY CLINIC 90.05 09007 UROLOGY CLINIC 90.07 11 90.07 09009 GASTROENTEROLOGY CLINIC 90.09 59 90.09 90. 11 09011 NEUROLOGY CLINIC 92 90.11 90.12 09012 OPTHAMOLOGY CLINIC 0 90.12 09013 ALLERGY CLINIC 950 90.13 90.13 09014 WOUND CARE 90.14 109.273 90.14 0 91.00 09100 EMERGENCY 759, 239 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 95.00 147, 780 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 118.00 0 4, 619, 744 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 18.897 190.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 1, 512, 354 192.00 0 194. 00 07950 THORNTOWN OFFICE BUILDING 0 194.00 194. 01 07951 CAFE/BOUTI QUE 42,880 194 01 194. 02 07952 OTHER NONREIMB 0 548, 477 194.02 0 194. 03 07953 RETAIL PHARMACY 55, 057 194.03 200.00 Cross Foot Adjustments 200.00 Ω 0

C

6, 797, 409

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

201.00

202.00

	Financial Systems	WITHAM MEMORIA				u or Form CMS-2	
COST A	LLOCATION - STATISTICAL BASIS		Provi der CC	F	eriod: from 01/01/2019 fo 12/31/2019		pared:
		CAPITAL RELA	ATED COSTS			3/31/2020 0. 1	O aiii
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliatio	ADMINISTRATIV	
	'	FLXT	EQUI P	BENEFI TS	n	E & GENERAL	
		(SQUARE	(SQUARE	DEPARTMENT		(ACCUM.	
		FEET)	FEET)	(GROSS		COST)	
				SALARI ES)		·	
		1. 00	2. 00	4. 00	5A	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	255, 907					1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		255, 907				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	582	582	66, 854, 828	3		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	18, 600	18, 600	7, 275, 436	-17, 279, 610	127, 035, 355	5.00
7.00	00700 OPERATION OF PLANT	24, 368	24, 368	691, 314	0	4, 432, 384	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	32, 052		,	8.00
9. 00	00900 HOUSEKEEPI NG	2, 806	2, 806			,	1
10. 00	01000 DI ETARY	6, 281	6, 281	852, 304		,	1
11. 00	01100 CAFETERI A	0	0	155, 690			1
13. 00	01300 NURSING ADMINISTRATION	0	0	630, 618			
15. 00	01500 PHARMACY	1, 939	1, 939				
16. 00	01600 MEDICAL RECORDS & LIBRARY	3, 063	3, 063	1, 365, 475	0	2, 047, 908	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				_		
30.00	03000 ADULTS & PEDI ATRI CS	20, 373	20, 373				
31.00	03100   NTENSI VE CARE UNI T	5, 595	5, 595				
40.00	04000 SUBPROVI DER - I PF	6, 406	6, 406	1, 148, 117		,	1
41. 00	04100 SUBPROVI DER - I RF	0	0	(	0		41.00
42.00	04200 SUBPROVI DER	0	0	(	0		42.00
43.00	04300 NURSERY	0	0	C	0		•
44.00	04400 SKILLED NURSING FACILITY	4, 851	4, 851	1, 064, 628	0	1, 874, 004	44.00
	ANCILLARY SERVICE COST CENTERS	4.0.0	4. 0.0				
50.00	05000 OPERATING ROOM	16, 260	16, 260				1
54.00	05400 RADI OLOGY-DI AGNOSTI C	19, 886	19, 886	1, 718, 511			1
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	(	0		55.00
55. 01	05501 ULTRA SOUND	0	0	359, 120		827, 027	1
57.00	05700 CT SCAN	0	0	207, 524			1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 706	1, 706				1
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 438	1, 438				1
60.00	06000 LABORATORY	9, 274	9, 274	3, 164, 097		-,,	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	l '	1
64.00	06400 I NTRAVENOUS THERAPY	0.07/	0.07/	1 707 400	0		64.00
66.00	06600 PHYSI CAL THERAPY	8, 976	8, 976			, , , ,	1
67.00	06700 OCCUPATI ONAL THERAPY	0	0	425, 924			
67. 01	06701 AUDI OLOGY		0	228, 169		196, 780	
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY		0	220, 824	0		68. 00 69. 00
69. 00	06901 CARDI OLOGY	925	925	1, 219, 030			ı
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	923	920	1, 219, 030		l	1
	07200 IMPL. DEV. CHARGED TO PATTENTS		0				
	07300 DRUGS CHARGED TO PATIENTS	0	0	1	_		
73.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>		, 0	4, 210, 332	73.00
90.00	09000 CLI NI C	0	0		0	0	90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	3, 822	3, 822				
90. 02	09002 CLINIC	0,022	3, 022 0	200, 702		l	1
90. 03	09003 DERMATOLOGY CLINIC	Ö	0				1
90. 04	09004 ENT CLINIC	o	0	Ì	0	Ö	90.04
90. 05	09005 SURGERY CLINIC	o	0	Ì	653		90.05
90. 07	09007 UROLOGY CLINIC	o	0	ĺ	1, 748	l e	90.07
90. 09	09009 GASTROENTEROLOGY CLINIC	o	0	3, 240		3, 602	•
90. 11	09011 NEUROLOGY CLINIC	o	0	0,210	0	0,002	90. 11
90. 12	09012 OPTHAMOLOGY CLINIC	o	0		20, 627	0	90. 12
90. 13	09013 ALLERGY CLINIC	o	0	103, 932			1
90. 14	09014 WOUND CARE	3, 504	3, 504				1
91.00	09100 EMERGENCY	24, 566	24, 566		0	l	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	4, 760	4, 760	2, 544, 146	0	3, 515, 113	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	189, 981	189, 981	37, 690, 855	-17, 256, 582	79, 053, 773	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	624	624			16, 575	190.00
	19200 PHYSICIANS' PRIVATE OFFICES	42, 942	42, 942	28, 825, 560	0	45, 103, 041	192. 00
	07950 THORNTOWN OFFICE BUILDING	0	0	0	0		194. 00
	07951 CAFE/BOUTI QUE	1, 416	1, 416		0	l .	194. 01
	07952 OTHER NONREI MB	20, 544	20, 544				
	07953 RETAIL PHARMACY	400	400	267, 494	0	2, 119, 141	1
200.00							200.00
201.00	Negative Cost Centers	<u>                                       </u>		<u> </u>	<u> </u>	<u> </u>	201.00
_							

Health Fin	ancial Systems	WITHAM MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
COST ALLOC	CATION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
					From 01/01/2019 Fo 12/31/2019		pared: 8 am
		CAPI TAL REL	ATED COSTS				
	Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	
		1. 00	2. 00	4. 00	5A	5. 00	
202.00	Cost to be allocated (per Wkst. B, Part I)	2, 185, 708	4, 611, 701	12, 157, 31	5	17, 279, 610	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	8. 541025	18. 021004	0. 18184	5	0. 136022	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)			15, 45	9	495, 735	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 00023	1	0. 003902	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

	Financial Systems	WI THAM MEMORI		011 45 0404   5		u of Form CMS-2	
COST A	LLOCATION - STATISTICAL BASIS		Provi der Co	Fi	eriod: rom 01/01/2019	Worksheet B-1	
				T		Date/Time Pre 3/31/2020 8:1	pared: <u>8 am</u>
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING (HOURS OF	DI ETARY (MEALS	CAFETERIA (MEALS	
		(SQUARE	(GROSS	SERVICE)	SERVED)	SERVED)	
		FEET) 7. 00	CHARGES) 8. 00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS	7.00	0.00	7.00	10.00	11.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
2. 00 4. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7. 00 8. 00	OO7OO  OPERATION OF PLANT   OO8OO  LAUNDRY & LINEN SERVICE	183, 813	411, 478, 661				7. 00 8. 00
9.00	00900 HOUSEKEEPI NG	2, 806	0	129, 223			9. 00
10. 00 11. 00	01000  DI ETARY   01100  CAFETERI A	6, 281	0	8, 623 2, 875	42, 240	982	10.00 11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	1, 300	ő	19	1
15.00	01500 PHARMACY	1, 939	0	2, 625	o	38	1
16.00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	3, 063	0	5, 750	0	77	16.00
30.00	03000 ADULTS & PEDIATRICS	20, 373			17, 232	259	30.00
31. 00 40. 00	03100   INTENSIVE CARE UNIT   04000   SUBPROVI DER -   I PF	5, 595 6, 406	4, 871, 688 4, 043, 285		9, 633	21 33	31. 00 40. 00
41.00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
42. 00 43. 00	04200  SUBPROVI DER   04300  NURSERY	0	0 2, 019, 366	0	0	0	42. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	4, 851	2, 971, 566		15, 375	0	44.00
EO 00	ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM	16 260	E2 722 742	2 575	ما	22	E0 00
50. 00 54. 00	05400 RADI OLOGY-DI AGNOSTI C	16, 260 19, 886	52, 732, 763 34, 483, 364		0	23 28	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	O	0	55.00
55. 01 57. 00	05501   ULTRA SOUND   05700   CT SCAN	0	9, 156, 109 45, 514, 164		0	3 4	55. 01 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 706	17, 071, 948	1, 100	О	10	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	1, 438 9, 274	17, 716, 676 58, 524, 884		0 0	0 82	59. 00 60. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	1, 115, 505		o	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	3, 398, 014		o	0	64.00
66. 00 67. 00	06600  PHYSI CAL THERAPY   06700  OCCUPATI ONAL THERAPY	8, 976 0	8, 292, 784 3, 716, 264		0	41 17	66. 00 67. 00
67. 01	06701 AUDI OLOGY	0	950, 473	625	o	18	1
68. 00 69. 00	06800  SPEECH   PATHOLOGY   06900  ELECTROCARDI OLOGY	0	1, 157, 664 0	375 0	0	19 0	68. 00 69. 00
69. 01	06901 CARDI OLOGY	925	16, 057, 275	3, 775	ō	41	69. 01
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	8, 939, 408 15, 468, 574		0	21 0	71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	39, 627, 105		ō	0	
00 00	OUTPATIENT SERVICE COST CENTERS  09000 CLINIC	0	0	0	0	0	90.00
	09000 CETNIC	3, 822	0	6, 700	0	34	ı
90. 02 90. 03	09002 CLINIC 09003 DERMATOLOGY CLINIC	0	0	0	0	0	
90. 03	09004 ENT CLINIC	0	0	0	0	0	90. 03 90. 04
90.05	09005 SURGERY CLINIC	0	0	0	0	0	90. 05
90. 07 90. 09	09007   UROLOGY   CLINIC   09009   GASTROENTEROLOGY   CLINIC	0	157, 556 0	0	0	0	90. 07 90. 09
90. 11	09011 NEUROLOGY CLINIC	0	0	0	ō	0	90. 11
90. 12	O9012  OPTHAMOLOGY CLINIC   O9013  ALLERGY CLINIC	0	0 723, 323	0	0	0	90. 12 90. 13
90. 14	09014 WOUND CARE	3, 504	5, 139, 410		ő	0	90. 14
91.00	09100 EMERGENCY	24, 566	31, 757, 712	0	0	64	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				l		92.00
95. 00	09500 AMBULANCE SERVICES	1, 760	4, 422, 344	0	0	130	95.00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	143, 431	411, 478, 661	129, 223	42, 240	982	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	624 37, 942	0	0	0 0		190. 00 192. 00
194.00	07950 THORNTOWN OFFICE BUILDING	0	0	0	o	0	194. 00
	07951 CAFE/BOUTI QUE 07952 OTHER NONREI MB	1, 416	0	0	0		194. 01 194. 02
194. 03	07953 RETAIL PHARMACY	400	o o	o o	ő		194. 03
200. 00 201. 00	1 1						200. 00 201. 00
202.00	Cost to be allocated (per Wkst. B,	5, 035, 286	648, 216	1, 249, 345	2, 168, 001	456, 965	
203.00	Part I) Unit cost multiplier (Wkst. B, Part I)	27. 393525	0. 001575	9. 668132	51. 325781	465. 341141	203 00
	, , , , , , , , , , , , , , , , , , ,		1 20.070	,	, 120,01		

Heal th Finar	ncial Systems	WITHAM MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CO	CN: 15-0104	Peri od:	Worksheet B-1		
					From 01/01/2019 To 12/31/2019	Date/Time Pre 3/31/2020 8:1		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NO	DI ETARY	CAFETERI A		
		PLANT	LINEN SERVICE	(HOURS OF	(MEALS	(MEALS		
		(SQUARE	(GROSS	SERVI CE)	SERVED)	SERVED)		
		FEET)	CHARGES)					
		7. 00	8. 00	9. 00	10.00	11. 00		
204.00	Cost to be allocated (per Wkst. B,	664, 719	2, 233	88, 81	8 202, 243	3, 486	204.00	
	Part II)							
205. 00	Unit cost multiplier (Wkst. B, Part	3. 616279	0. 000005	0. 68732	4. 787950	3. 549898	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)							
·				'	'	'		

Health Financial Systems WITHAM MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0104 Peri od: Worksheet B-1 From 01/01/2019 12/31/2019 Date/Time Prepared: 3/31/2020 8:18 am Cost Center Description NURSI NG PHARMACY MEDI CAL ADMI NI STRATI O RECORDS & (COSTED REQUIS.) LI BRARY Ν (DI RECT (TIME NRSING HRS) SPENT) 13. 00 15.00 16.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 444, 963 13.00 15.00 01500 PHARMACY 4, 143, 826 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 41, 100 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 101, 342 556 10, 100 30.00 03100 INTENSIVE CARE UNIT 31.00 34, 124 44 2, 100 31.00 04000 SUBPROVI DER - I PF 40 00 34, 495 40.00 52 2,500 41.00 04100 SUBPROVI DER - I RF 0 C 0 41.00 04200 SUBPROVI DER 42.00 0 0 0 42.00 04300 NURSERY 43.00 43.00 0 04400 SKILLED NURSING FACILITY 44.00 38, 299 3, 201 0 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 67, 014 21, 389 3, 625 50.00 2, 408 9, 700 54 00 05400 RADI OLOGY-DI AGNOSTI C 54 00 0 05500 RADI OLOGY-THERAPEUTI C 55.00 0 1, 191 0 55.00 55.01 05501 ULTRA SOUND 0 1,050 55.01 57.00 05700 CT SCAN 0 903 1, 200 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58 00 0 2.324 58 00 650 05900 CARDIAC CATHETERIZATION 59.00 7,943 59.00 06000 LABORATORY 60.00 0 128 1,000 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 C 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 C 64 00 66.00 06600 PHYSI CAL THERAPY 29, 999 2, 278 1,950 66.00 06700 OCCUPATI ONAL THERAPY 67.00 9.868 850 67.00 67.01 06701 AUDI OLOGY 6, 949 0 0 67.01 06800 SPEECH PATHOLOGY 68.00 5.256 C 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 0 69 01 06901 CARDI OLOGY 31, 541 153 1,875 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 71.00 0 C 07200 IMPL. DEV. CHARGED TO PATIENT O 72.00 0 C 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 50 0 90.00 90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER 5, 564 0 4, 200 90.01 90. 02 09002 CLI NI C 0 0 90.02 09003 DERMATOLOGY CLINIC 0 90.03 90.03 0 0 0 09004 ENT CLINIC 90.04 0 r 90 04 90.05 09005 SURGERY CLINIC 0 90.05 137 09007 UROLOGY CLINIC 0 90.07 0 494 90.07 09009 GASTROENTEROLOGY CLINIC 0 90.09 4,598 C 90.09 90.11 09011 NEUROLOGY CLINIC 0 4, 350 0 90.11 90.12 09012 OPTHAMOLOGY CLINIC 0 90.12 09013 ALLERGY CLINIC 2,857 10, 365 0 90.13 90.13 09014 WOUND CARE 0 90.14 7, 657 10, 394 90 14 91.00 09100 EMERGENCY 54, 116 38, 378 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 9, 094 0 95.00 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 118.00 441, 622 107, 897 40, 800 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 190.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 1, 445 2, 403, 562 300 192.00 194. 00 07950 THORNTOWN OFFICE BUILDING 0 0 194.00 194. 01 07951 CAFE/BOUTI QUE O 194 01 C 194. 02 07952 OTHER NONREIMB 1, 896 0 194.02 194. 03 07953 RETAIL PHARMACY 1, 632, 367 0 194.03 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00

931, 932

8,060,684

2, 501, 798

202.00

Part I)

Cost to be allocated (per Wkst. B,

202.00

Health Fina	ncial Systems	WITHAM MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2552-10
COST ALLOCA	COST ALLOCATION - STATISTICAL BASIS		Provi der CO	Provider CCN: 15-0104		Worksheet B-1
					From 01/01/2019 To 12/31/2019	Date/Time Prepared: 3/31/2020 8:18 am
	Cost Center Description	NURSI NG	PHARMACY	MEDI CAL		
		ADMI NI STRATI O	(COSTED	RECORDS &		
		N	REQUIS.)	LI BRARY		
		(DI RECT		(TIME		
		NRSING HRS)		SPENT)		
		13. 00	15. 00	16.00		
203. 00	Unit cost multiplier (Wkst. B, Part I)	2. 094403	1. 945227	60. 87099	98	203.00
204.00	Cost to be allocated (per Wkst. B,	4, 234	87, 975	104, 96	57	204.00
	Part II)					
205. 00	Unit cost multiplier (Wkst. B, Part	0. 009515	0. 021230	2. 55394	12	205. 00
20/ 00	NAUE adjustment amount to be alleged a					20/ 00
206. 00	NAHE adjustment amount to be allocated					206. 00
007.00	(per Wkst. B-2)					007.00
207. 00	NAHE unit cost multiplier (Wkst. D,					207. 00
	Parts III and IV)					I

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

					10 12/31/2019	3/31/2020 8:1	
			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	
	INPATIENT ROUTINE SERVICE COST CENTERS				_		
30.00	03000 ADULTS & PEDI ATRI CS	9, 486, 764		9, 486, 76		9, 486, 764	
31.00	03100 INTENSIVE CARE UNIT	2, 851, 261		2, 851, 26		2, 851, 261	31.00
40.00	04000 SUBPROVI DER - I PF	2, 903, 274		2, 903, 27	4 0	2, 903, 274	40. 00
41. 00	04100 SUBPROVI DER - I RF	0			0	0	41.00
42.00	04200 SUBPROVI DER	0			0	0	42.00
43.00	04300 NURSERY	66, 696		66, 69		66, 696	
44.00	04400 SKILLED NURSING FACILITY	3, 142, 051		3, 142, 05	1 0	3, 142, 051	44.00
	ANCILLARY SERVICE COST CENTERS	5 054 440		5 05 4 44		5 054 440	
50.00	05000 OPERATING ROOM	5, 854, 118		5, 854, 11			
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 110, 752		8, 110, 75		8, 110, 752	
55.00	05500 RADI OLOGY-THERAPEUTI C	2, 317		2, 31		2, 317	
55. 01	05501 ULTRA SOUND	1, 026, 504		1, 026, 50		1, 026, 504	
57.00	05700 CT SCAN	1, 219, 906		1, 219, 90		1, 219, 906	
58.00	05800   MAGNETIC RESONANCE   MAGING (MRI)	1, 227, 562		1, 227, 56		1, 227, 562	
59.00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	1, 829, 152		1, 829, 15		1, 829, 152	1
60.00		9, 734, 987		9, 734, 98		9, 734, 987	60.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS.	227, 485		227, 48		227, 485	
66.00	06400 I NTRAVENOUS THERAPY 06600 PHYSI CAL THERAPY	5, 352 3, 447, 444	0	5, 35 3, 447, 44		5, 352 3, 447, 444	
67.00	06700 OCCUPATI ONAL THERAPY	1 ' ' 1	0				1
67. 00	06701 AUDI OLOGY	722, 236 254, 016	0			722, 236 254, 016	1
68. 00	06800 SPEECH PATHOLOGY	347, 562	0	347, 56		347, 562	
69. 00	06900 ELECTROCARDI OLOGY	347, 302	0		0 0	347, 302	69.00
69. 01	06901 CARDI OLOGY	2, 252, 061		2, 252, 06		2, 252, 061	69.01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 722, 255		3, 722, 25		3, 722, 255	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	5, 671, 148		5, 671, 14		5, 671, 148	
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 878, 628		4, 878, 62		4, 878, 628	
70.00	OUTPATIENT SERVICE COST CENTERS	1,070,020		1, 0, 0, 02	<u>o</u>	1, 070, 020	70.00
90.00	09000 CLINIC	97		9	7 0	97	90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	937, 343		937, 34		937, 343	
90. 02	09002 CLI NI C	0			0	0	90.02
90. 03	09003 DERMATOLOGY CLINIC	l ol			o o	0	90.03
90. 04	09004 ENT CLINIC	0			0	0	90.04
90. 05	09005 SURGERY CLINIC	0			0	0	90.05
90. 07	09007 UROLOGY CLINIC	o			0 0	0	90. 07
90.09	09009 GASTROENTEROLOGY CLINIC	13, 722		13, 72	2 0	13, 722	90.09
90. 11	09011 NEUROLOGY CLINIC	8, 462		8, 46		8, 462	90. 11
90. 12	09012 OPTHAMOLOGY CLINIC	0			o o	0	90. 12
90. 13	09013 ALLERGY CLINIC	223, 893		223, 89	3 0	223, 893	90. 13
90. 14	09014 WOUND CARE	1, 057, 225		1, 057, 22	5 0	1, 057, 225	90. 14
91.00	09100 EMERGENCY	5, 472, 211		5, 472, 21	1 0	5, 472, 211	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 608, 042		2, 608, 04	2	2, 608, 042	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	4, 126, 608		4, 126, 60			
200.00	,	83, 431, 134	0	,,		83, 431, 134	
201.00		2, 608, 042		2, 608, 04		2, 608, 042	201.00
202.00	Total (see instructions)	80, 823, 092	0	80, 823, 09	2 0	80, 823, 092	202. 00

Peri od: Worksheet C From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared: 3/31/2020 8:18 am Provider CCN: 15-0104

						3/31/2020 8: 1	8 am
			Title	XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	•	'	•	+ col. 7)	Rati o	I npati ent	
				,	1	Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
30.00	03000 ADULTS & PEDIATRICS	16, 148, 736		16, 148, 73	5		30.00
31.00	03100 I NTENSI VE CARE UNI T	4, 871, 688		4, 871, 688			31.00
40.00	04000 SUBPROVI DER - I PF	4, 043, 285		4, 043, 28			40.00
41.00	04100 SUBPROVI DER - I RF	4, 043, 283		4, 043, 20			41.00
42.00		0					
	04200 SUBPROVI DER	2 010 2//		2.010.20			42.00
43.00	04300 NURSERY	2, 019, 366		2, 019, 36			43.00
44.00	04400 SKILLED NURSING FACILITY	2, 971, 566		2, 971, 56	0		44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	8, 591, 524	44, 141, 239			0. 000000	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 549, 019	32, 934, 345			0. 000000	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0			0. 000000	55.00
55. 01	05501 ULTRA SOUND	445, 936	8, 710, 173	9, 156, 10		0. 000000	55. 01
57.00	05700  CT SCAN	4, 899, 408	40, 614, 756	45, 514, 16	0. 026803	0. 000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	625, 029	16, 446, 919	17, 071, 948	0. 071905	0.000000	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	4, 048, 944	13, 667, 732	17, 716, 67	0. 103245	0.000000	59.00
60.00	06000 LABORATORY	9, 191, 085	49, 333, 799	58, 524, 88	0. 166339	0.000000	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	480, 854	634, 651			0.000000	63.00
64.00	06400 I NTRAVENOUS THERAPY	1, 350, 409	2, 047, 605			0.000000	
66.00	06600 PHYSI CAL THERAPY	2, 688, 509	5, 604, 275			0. 000000	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	2, 586, 658	1, 129, 606			0. 000000	67.00
67. 01	06701 AUDI OLOGY	398	950, 075			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	219, 397	938, 267			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	217, 377	730, 207		0.000000	0. 000000	69.00
69. 01	06901 CARDI OLOGY	5, 333, 221	10, 724, 054			0. 000000	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 658, 014	5, 281, 394			0.000000	
71.00	07200 IMPL. DEV. CHARGED TO PATIENT		11, 485, 154			0. 000000	
73.00		3, 983, 420					73.00
73.00	07300 DRUGS CHARGED TO PATIENTS	9, 080, 925	30, 546, 180	39, 627, 10	0. 123113	0. 000000	73.00
00.00	OUTPATIENT SERVICE COST CENTERS			1	0.00000	0.000000	00.00
90.00	09000 CLINIC	0	0		0.000000	0.000000	
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0.000000	0. 000000	90.01
90. 02	09002 CLI NI C	0	0		0. 000000	0. 000000	90.02
90. 03	09003 DERMATOLOGY CLINIC	0	0		0.000000	0. 000000	
90.04	09004 ENT CLINIC	0	0		0. 000000	0. 000000	
90.05	09005 SURGERY CLINIC	0	0		0. 000000	0. 000000	90. 05
90. 07	09007 UROLOGY CLINIC	0	157, 556	157, 55		0. 000000	
90.09	09009 GASTROENTEROLOGY CLINIC	0	0			0. 000000	90. 09
90. 11	09011 NEUROLOGY CLINIC	0	0		0. 000000	0. 000000	90. 11
90. 12	09012 OPTHAMOLOGY CLINIC	0	0		0.000000	0.000000	90. 12
90. 13	09013 ALLERGY CLINIC	o	723, 323	723, 32	0. 309534	0.000000	90. 13
90. 14	09014 WOUND CARE	102, 004	5, 037, 406	5, 139, 410	0. 205709	0.000000	90. 14
91.00	09100 EMERGENCY	3, 816, 803	27, 940, 909			0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	5, 300, 701			0. 000000	
50	OTHER REIMBURSABLE COST CENTERS	<u> </u>	-,,		220.0	2.223000	1
95 00	09500 AMBULANCE SERVICES	2, 032	4, 420, 312	4, 422, 34	0. 933127	0. 000000	95.00
200.00		92, 708, 230	318, 770, 431			2. 223000	200.00
201.00		72, 700, 200	310, 770, 401	111, 175, 00			201.00
202.00	1	92, 708, 230	318, 770, 431	411, 478, 66°	1		202.00
202.00	Total (See Histractions)	72, 100, 230	310, 770, 431	1 411, 470, 00	'		1202.00

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0104	Period: Worksheet C From 01/01/2019 Part I
		To 12/31/2019 Date/Time Prepared

				10 12/31/2019	3/31/2020 8:18 am
			Title XVIII	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
	·	Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVI DER - I PF				40.00
41.00	04100 SUBPROVI DER - I RF				41.00
42.00	04200 SUBPROVI DER				42.00
43.00	04300 NURSERY				43.00
	04400 SKILLED NURSING FACILITY				44.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 111015			50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 235208			54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
	05501 ULTRA SOUND	0. 112111			55. 01
	05700 CT SCAN	0. 026803			57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 071905			58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 103245			59.00
	06000 LABORATORY	0. 166339			60.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 203930			63.00
	06400 I NTRAVENOUS THERAPY	0. 001575			64. 00
66. 00	06600 PHYSI CAL THERAPY	0. 415716			66.00
	06700 OCCUPATI ONAL THERAPY	0. 194345			67.00
	06701 AUDI OLOGY	0. 267252			67. 01
	06800 SPEECH PATHOLOGY	0. 300227			68.00
	06900 ELECTROCARDI OLOGY	0. 000000			69.00
	06901 CARDI OLOGY	0. 140252			69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 416387			71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0. 366624			72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 123113			73.00
70.00	OUTPATIENT SERVICE COST CENTERS	0. 120110			70.00
90.00	09000 CLINIC	0. 000000			90.00
	09001 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000			90. 01
	09002 CLINIC	0. 000000			90. 02
	09003 DERMATOLOGY CLINIC	0. 000000			90.03
	09004 ENT CLINIC	0. 000000			90.04
	09005 SURGERY CLINIC	0. 000000			90. 05
	09007 UROLOGY CLINIC	0. 000000			90. 07
	09009 GASTROENTEROLOGY CLINIC	0. 000000			90.09
	09011 NEUROLOGY CLINIC	0. 000000			90.11
	09012 OPTHAMOLOGY CLINIC	0. 000000			90. 12
	09013 ALLERGY CLINIC	0. 309534			90. 13
	09014 WOUND CARE	0. 205709			90. 14
	09100 EMERGENCY	0. 172311			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 492018			92.00
72.00	OTHER REIMBURSABLE COST CENTERS	0. 472010			72.00
95. 00	09500 AMBULANCE SERVICES	0. 933127			95.00
200.00		0. 755127			200.00
201.00					201.00
202.00	l				202.00
202.00	1.3141 (300 111311 4011 0113)	1			1202.00

| Peri od: | Worksheet C | From 01/01/2019 | Part I | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-0104

					10 12/31/2019	3/31/2020 8:1	
			Ti tl	e XIX	Hospi tal	Cost	<u> </u>
			<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	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	9, 486, 764		9, 486, 76	4 0	9, 486, 764	30.00
31.00	03100 INTENSIVE CARE UNIT	2, 851, 261		2, 851, 26		2, 851, 261	31.00
40.00	04000 SUBPROVI DER - I PF	2, 903, 274		2, 903, 27	4 0	2, 903, 274	40. 00
41. 00	04100 SUBPROVI DER - I RF	0			0	0	41.00
42.00	04200 SUBPROVI DER	0		•	0	0	42.00
43.00	04300 NURSERY	66, 696		66, 69		66, 696	
44.00	04400 SKILLED NURSING FACILITY	3, 142, 051		3, 142, 05	0	3, 142, 051	44.00
	ANCILLARY SERVICE COST CENTERS	5 054 440				5 054 440	
50.00	05000 OPERATING ROOM	5, 854, 118		5, 854, 11			
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 110, 752		8, 110, 75		8, 110, 752	
55.00	05500 RADI OLOGY-THERAPEUTI C	2, 317		2, 31		2, 317	
55. 01	05501 ULTRA SOUND	1, 026, 504		1, 026, 50		1, 026, 504	
57.00	05700 CT SCAN	1, 219, 906		1, 219, 90		1, 219, 906	
58.00	05800   MAGNETIC RESONANCE   MAGING (MRI)	1, 227, 562		1, 227, 56		1, 227, 562	
59.00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	1, 829, 152		1, 829, 15		1, 829, 152 9, 734, 987	1
60. 00 63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	9, 734, 987 227, 485		9, 734, 98 227, 48			60. 00 63. 00
64. 00	06400 I NTRAVENOUS THERAPY	5, 352		5, 35		227, 485 5, 352	
66.00	06600 PHYSI CAL THERAPY	3, 447, 444	0			3, 447, 444	
67. 00	06700 OCCUPATI ONAL THERAPY	722, 236	0			722, 236	1
67. 01	06701 AUDI OLOGY	254, 016	0	,		254, 016	
68. 00	06800 SPEECH PATHOLOGY	347, 562	0	347, 56		347, 562	
69. 00	06900 ELECTROCARDI OLOGY	017,002	O		0 0	0 17, 332	69.00
69. 01	06901 CARDI OLOGY	2, 252, 061		2, 252, 06		2, 252, 061	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 722, 255		3, 722, 25		3, 722, 255	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	5, 671, 148		5, 671, 14		5, 671, 148	
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 878, 628		4, 878, 62		4, 878, 628	
	OUTPATIENT SERVICE COST CENTERS	<u> </u>		<u> </u>			
90.00	09000 CLI NI C	97		Ç	7 0	97	90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	937, 343		937, 34	.3 0	937, 343	90. 01
90.02	09002 CLI NI C	0			0 0	0	90. 02
90. 03	09003 DERMATOLOGY CLINIC	0			0 0	0	90. 03
90.04	09004 ENT CLINIC	0			0 0	0	90. 04
90.05	09005 SURGERY CLINIC	0			0	0	90.05
90. 07	09007 UROLOGY CLINIC	0			0	0	90. 07
90. 09	09009 GASTROENTEROLOGY CLINIC	13, 722		13, 72		13, 722	90. 09
90. 11	09011 NEUROLOGY CLINIC	8, 462		8, 46		8, 462	
90. 12	09012 OPTHAMOLOGY CLINIC	0			0	0	90. 12
90. 13	09013 ALLERGY CLINIC	223, 893		223, 89		223, 893	1
90. 14	09014 WOUND CARE	1, 057, 225		1, 057, 22		1, 057, 225	1
91.00	09100 EMERGENCY	5, 472, 211		5, 472, 21		5, 472, 211	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 608, 042		2, 608, 04	2	2, 608, 042	92.00
05 00	OTHER REIMBURSABLE COST CENTERS	4 407 700		4 407 15	.0	4 407 700	05.00
95.00	09500 AMBULANCE SERVICES	4, 126, 608	^	4, 126, 60			
200. 00 201. 00	,	83, 431, 134 2, 608, 042	0	83, 431, 13 2, 608, 04		83, 431, 134 2, 608, 042	
201.00		80, 823, 092	0				201.00
202.00		00, 023, 092	Ü	1 00,023,09	۷۱ ا	00, 023, 092	1202.00

In Lieu of Form CMS-2552-10
Worksheet C
01/2019 Part I
31/2019 Date/Time Prepared:
3/31/2020 8:18 am
tal Cost Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0104 Peri od: From 01/01/2019 To 12/31/2019 Title XIX Hospi tal

				e viv	nospi tai	COST	
			Charges	I <del></del>		TEED.	
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6		TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6. 00	7.00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	16, 148, 736		16, 148, 736			30.00
31.00	03100 INTENSIVE CARE UNIT	4, 871, 688		4, 871, 688			31.00
40.00	04000 SUBPROVI DER - I PF	4, 043, 285		4, 043, 285			40.00
41. 00	04100 SUBPROVI DER – I RF	0		0			41.00
42. 00	04200 SUBPROVI DER			0			42.00
43. 00	04300 NURSERY	2, 019, 366					43.00
44. 00				2, 019, 366			
44.00	04400 SKILLED NURSING FACILITY	2, 971, 566		2, 971, 566			44.00
	ANCILLARY SERVICE COST CENTERS	0 504 504		F0 700 7/0	0.44045	0.00000	
50. 00	05000 OPERATING ROOM	8, 591, 524	44, 141, 239			0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 549, 019	32, 934, 345			0. 000000	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0. 000000	0. 000000	
55. 01	05501 ULTRA SOUND	445, 936	8, 710, 173	9, 156, 109	0. 112111	0.000000	55. 01
57.00	05700 CT SCAN	4, 899, 408	40, 614, 756	45, 514, 164	0. 026803	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	625, 029	16, 446, 919			0.000000	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	4, 048, 944	13, 667, 732			0. 000000	1
60. 00	06000 LABORATORY	9, 191, 085	49, 333, 799			0. 000000	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	480, 854	634, 651			0. 000000	
						0. 000000	
64.00	06400   NTRAVENOUS THERAPY	1, 350, 409	2, 047, 605				
66. 00	06600 PHYSI CAL THERAPY	2, 688, 509	5, 604, 275			0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	2, 586, 658	1, 129, 606			0. 000000	1
67. 01	06701 AUDI OLOGY	398	950, 075			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	219, 397	938, 267	1, 157, 664	0. 300227	0. 000000	
69.00	06900 ELECTROCARDI OLOGY	0	0		0.000000	0.000000	69.00
69. 01	06901 CARDI OLOGY	5, 333, 221	10, 724, 054	16, 057, 275	0. 140252	0.000000	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 658, 014	5, 281, 394			0.000000	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	3, 983, 420	11, 485, 154			0.000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	9, 080, 925	30, 546, 180			0. 000000	1
70.00	OUTPATIENT SERVICE COST CENTERS	7,000,720	00, 010, 100	07,027,100	0. 120110	0.000000	70.00
90. 00	09000 CLINIC	0	0	0	0. 000000	0. 000000	90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER		0			0. 000000	
		0	-	1			
90. 02	09002 CLINIC	0	0	1		0.000000	
90. 03	09003 DERMATOLOGY CLINIC	0	0	0	0. 000000	0. 000000	1
90.04	09004 ENT CLINIC	0	0	0		0. 000000	
90. 05	09005 SURGERY CLINIC	0	0	0		0. 000000	
90. 07	09007 UROLOGY CLINIC	0	157, 556	157, 556	0. 000000	0.000000	90. 07
90.09	09009 GASTROENTEROLOGY CLINIC	0	0	0	0. 000000	0.000000	90.09
90. 11	09011 NEUROLOGY CLINIC	ol	0	l 0	0. 000000	0.000000	90. 11
90. 12	09012 OPTHAMOLOGY CLINIC	0	0	0	l .	0.000000	
90. 13	09013 ALLERGY CLINIC		723, 323	_		0. 000000	1
90. 13	09014 WOUND CARE	102, 004	5, 037, 406			0. 000000	
91.00							
	09100 EMERGENCY	3, 816, 803	27, 940, 909			0.000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	5, 300, 701	5, 300, 701	0. 492018	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS	1					l
95.00		2, 032	4, 420, 312		0. 933127	0. 000000	
200.00		92, 708, 230	318, 770, 431	411, 478, 661			200.00
201.00							201.00
202.00	Total (see instructions)	92, 708, 230	318, 770, 431	411, 478, 661			202.00
		•					

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15	From 01/01/2019	Worksheet C Part I Date/Time Prepared: 3/31/2020 8:18 am

					3/31/2020 8:18 am
			Title XIX	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
IN	NPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03	3000 ADULTS & PEDIATRICS				30.00
31.00 03	3100 INTENSIVE CARE UNIT				31.00
40.00 04	4000 SUBPROVI DER - I PF				40.00
41.00 04	4100 SUBPROVI DER - I RF				41.00
42.00 04	4200 SUBPROVI DER				42.00
43.00 04	4300 NURSERY				43.00
	4400 SKILLED NURSING FACILITY				44.00
	NCILLARY SERVICE COST CENTERS				
	5000 OPERATING ROOM	0. 000000			50.00
	5400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
	5500 RADI OLOGY-THERAPEUTI C	0. 000000			55.00
	5501 ULTRA SOUND	0. 000000			55. 01
	5700 CT SCAN	0. 000000			57.00
	5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58.00
	5900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
	6000 LABORATORY	0. 000000			60.00
	6300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
					63.00
	6400 I NTRAVENOUS THERAPY	0.000000			
	6600 PHYSI CAL THERAPY	0. 000000			66.00
	6700 OCCUPATI ONAL THERAPY	0. 000000			67.00
	6701 AUDI OLOGY	0. 000000			67. 01
	6800 SPEECH PATHOLOGY	0. 000000			68.00
	6900 ELECTROCARDI OLOGY	0. 000000			69. 00
	6901 CARDI OLOGY	0. 000000			69. 01
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
	7200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72.00
	7300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
	JTPATIENT SERVICE COST CENTERS				
	9000 CLI NI C	0. 000000			90.00
	9001 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000			90.01
90. 02 09	9002 CLI NI C	0. 000000			90.02
90. 03 09	9003 DERMATOLOGY CLINIC	0. 000000			90.03
90.04 09	9004 ENT CLINIC	0. 000000			90.04
90.05 09	9005 SURGERY CLINIC	0. 000000			90.05
90.07 09	9007 UROLOGY CLINIC	0. 000000			90.07
90.09 09	9009 GASTROENTEROLOGY CLINIC	0. 000000			90.09
90. 11 09	9011 NEUROLOGY CLINIC	0. 000000			90. 11
	9012 OPTHAMOLOGY CLINIC	0. 000000			90. 12
	9013 ALLERGY CLINIC	0. 000000			90. 13
	9014 WOUND CARE	0. 000000			90. 14
	9100 EMERGENCY	0. 000000			91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
	THER REIMBURSABLE COST CENTERS	0.000000			72.00
	9500 AMBULANCE SERVICES	0. 000000			95. 00
200.00	Subtotal (see instructions)	0.000000			200.00
200.00	Less Observation Beds				200.00
202.00	Total (see instructions)				201.00
202.00	Total (See Histractions)	1			<sub>[2</sub> 02.00

Health Financial Systems	WITHAM MEMORI				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2019 To 12/31/2019	Part I	narod:
				10 12/31/2019	Date/Time Pre 3/31/2020 8:1	pareu. 8 am
		Title	xVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col . 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	778, 848				104. 04	
31.00 INTENSIVE CARE UNIT	191, 057		191, 05		112. 06	
40. 00 SUBPROVI DER - I PF	262, 409	0	262, 40		81. 72	
41. 00 SUBPROVI DER - I RF	0	0		0	0. 00	
42. 00 SUBPROVI DER	0	0		0	0. 00	
43. 00 NURSERY	228	l	22	,	0. 21	43.00
44.00 SKILLED NURSING FACILITY	228, 016	l e	228, 01		44. 49	
200.00 Total (lines 30 through 199)	1, 460, 558		1, 460, 55	18, 607		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
LABORT FAIT DOUTLAS OFFICE COOK OFFITEDO	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	0.405	204 205				
30. 00 ADULTS & PEDIATRICS	2, 125					30.00
31. 00 INTENSIVE CARE UNIT	781	87, 519				31.00
40. 00 SUBPROVI DER - I PF	2, 535	1	1			40.00
41. 00 SUBPROVI DER – I RF	0	0				41.00
42. 00 SUBPROVI DER	0	0				42.00
43. 00 NURSERY	0	0				43.00
44.00 SKILLED NURSING FACILITY	3, 051					44.00
200.00 Total (lines 30 through 199)	8, 492	651, 503	1			200. 00

Health Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0104	Peri od:	Worksheet D	
				From 01/01/2019 To 12/31/2019	Part II Date/Time Pre	nared:
				10 12/31/2017	3/31/2020 8: 1	8 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			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)					
ANOLLI ADV. CEDVILOE, COCT. CENTEDO	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS  50. 00 05000 OPERATING ROOM	F20 F00	52, 732, 763	0.0000	1 4 044 407	47.010	
	520, 509				47, 819	50.00
	656, 950		1		18, 477	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	25	l e			0	55.00
55. 01   05501   ULTRA SOUND	6, 564	9, 156, 109			50	55. 01
57. 00   05700   CT   SCAN	7, 806	45, 514, 164			346	
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	57, 910				922	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	49, 631	17, 716, 676			1, 254	
60. 00 06000 LABORATORY	319, 047	58, 524, 884			22, 224	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	781	1, 115, 505		· ·	134	
64. 00 06400 I NTRAVENOUS THERAPY	17	3, 398, 014		· ·	3	64.00
66. 00   06600   PHYSI CAL THERAPY	288, 191	8, 292, 784			15, 362	
67. 00 06700 OCCUPATI ONAL THERAPY	5, 183				470	
67. 01   06701   AUDI OLOGY	1, 386		1		0	67. 01
68. 00 06800 SPEECH PATHOLOGY	1, 539	1, 157, 664			103	
69. 00 06900 ELECTROCARDI OLOGY	0	4/ 057 075	0.00000		0	69.00
69. 01 06901 CARDI OLOGY	42, 860				9, 569	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12, 823	8, 939, 408			1, 777	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	19, 473				0	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	18, 523	39, 627, 105	0. 00046	7 3, 090, 864	1, 443	73.00
90. 00   09000   CLINIC	1	0	0.00000	0 0	0	90.00
90. 01   09001 OTHER OUTPATIENT SERVICE COST CENTER	132, 560	l ~	1		0	90.00
90. 02   09002   CLINI C	132, 360		1		0	90.01
90. 03   09003   DERMATOLOGY   CLI NI C	0		0.00000		0	90.02
90. 04   09004 ENT CLINIC	0		1		0	90.03
90. 05   09005   SURGERY CLINIC	0		0.00000		0	90.04
90. 07   09007   UROLOGY   CLINIC	0		1		0	90.03
90. 09   09009 GASTROENTEROLOGY CLINIC	59		1		0	90.07
90. 11   09011   NEUROLOGY CLINIC	92		1		0	90. 09
90. 12   09012   0PTHAMOLOGY   CLINIC	0		1		0	90.11
90. 13   09013   ALLERGY CLINIC	950		1		0	90. 12
90. 14   09014   WOUND CARE	109, 273				82	90. 13
91. 00   09100   EMERGENCY	759, 239			· ·	39, 297	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	214, 115				0	92.00
OTHER REIMBURSABLE COST CENTERS	214,110	3,300,701	0.04039	<del>-</del> 1 υ	0	1 /2.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	3, 225, 507	376, 844, 120		23, 825, 728	159, 332	
	3,223,307	3.3,511,120	I .	20,020,720	107,002	,_00.00

Heal th Financial Systems							
Title   XVIII   Hospital   PPS   All 10 ther   PS   All 10 there    Health Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10	
Nursing School Post-Stepdown Adjustments	APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS			From 01/01/2019 To 12/31/2019	Part III Date/Time Pre 3/31/2020 8:1	pared: 8 am
School   Post-Stepdown Adjustments   Post-							
INPATI ENT ROUTINE SERVICE COST CENTERS   1.00	Cost Center Description	School Post-Stepdown		Post-Stepdow		Medi cal Educati on	
NATIENT ROUTINE SERVICE COST CENTERS   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1.00	24	2.00		
30. 00   03000   ADULTS & PEDIATRICS   0   0   0   0   0   0   0   0   0	INDATIENT DOUTINE CEDVICE COCT CENTEDS	I IA	1.00	2A	2.00	3.00	
41. 00	30. 00 03000 ADULTS & PEDIATRICS	_			0 0		
42.00	40. 00   04000   SUBPROVI DER - 1 PF	0	0		0 0	0	40.00
Ad. 00		0 0	0		0 0		
NPATIENT ROUTINE SERVICE COST CENTERS   Single National Cost (Sum of col. 4)   A 00   A 0 0   A 0		0	0		0 0	0	
NPATIENT ROUTINE SERVICE COST CENTERS   Swing-Bed Adjustment Adjustment (see instructions)   A.00   5.00   6.00   7.00   8.00		0	Ö		0 0	0	
Amount (see instructions)				Total Patien	t Per Diem	I npati ent	
INPATIENT ROUTINE SERVICE COST CENTERS				Days	,	Program Days	
A. 00   5. 00   6. 00   7. 00   8. 00					col. 6)		
INPATIENT ROUTINE SERVICE COST CENTERS   30.00   3000   ADULTS & PEDIATRICS   0   0   7,486   0.00   2,125   30.00   31.00   03100   INTENSIVE CARE UNIT   0   1,705   0.00   781   31.00   40.00   04000   SUBPROVIDER - IPF   0   0   0   3,211   0.00   2,535   40.00   41.00   04100   SUBPROVIDER - IRF   0   0   0   0.00   0   41.00   42.00   04200   SUBPROVIDER   0   0   0   0   0   0   0   0   42.00   43.00   04300   NURSERY   0   1,080   0.00   0   43.00   44.00   04400   SKI LLED NURSING FACILITY   0   5,125   0.00   3,051   44.00   200.00   Total (lines 30 through 199)   Inpatient   Program   Pass-Through   Cost (col. 7   x col. 8)   9.00   9.00							
30. 00	LAIDATLENT DOUTLAG CEDVICE COCT CENTEDO	4.00	5.00	6.00	7.00	8.00	
31. 00				7 40	0.00	2 125	20.00
40.00   04000   SUBPROVI DER - I PF   0 0 0 3, 211   0.00   2, 535   40.00   41.00   04100   SUBPROVI DER - I RF   0 0 0 0 0 0 0 0 0 0 41.00   42.00   04200   SUBPROVI DER   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
41. 00		0					
42. 00		0	0				
44.00   04400   200.00   04400   200.00   04400   200.00   04400   200.00   04400   200.00   04400   200.00   04400   200.00   04400   200.00   04400		0	Ö				
Total (lines 30 through 199)   0   18,607   8,492 200.00	43. 00 04300 NURSERY		0	1, 08	0.00	0	43.00
Cost Center Description  Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00			0				
Program Pass-Through Cost (col. 7 x col. 8) 9.00			0	18, 60	17	8, 492	200.00
Pass-Through Cost (col. 7 x col. 8) 9.00	Cost Center Description						
Cost (col. 7 x col. 8) 9.00							
x col . 8) 9.00							
9.00		,					

30.00

31.00

40. 00 41. 00 42. 00 43. 00

44. 00 200. 00

30. 00 03000 ADULTS & PEDIATRICS
31. 00 03100 INTENSIVE CARE UNIT

44.00 04400 SKILLED NURSING FACILITY 200.00 Total (lines 30 through 199)

40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY

Health Financial Systems	WITHAM MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0104	Peri od:	Worksheet D
TURQUIQUE GOOTO			Erom 01/01/2010	Dort IV

THROUGH COSTS 12/31/2019 | Part TV 12/31/2019 | Date/Time Prepared: 3/31/2020 8:18 am Title XVIII Hospi tal Cost Center Description Non Physician Nursi ng Nursi ng Allied Health Allied Health Anestheti st School Post-Stepdown School Post-Stepdown Cost Adjustments Adjustments 1. 00 2.00 ЗА 3. 00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 50 00 0 0 000000000000000000 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 55.00 05501 ULTRA SOUND 0 0 55.01 0 55.01 05700 CT SCAN 0 57.00 0 57.00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 59.00 06000 LABORATORY 0 60.00 60.00 0 0 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 0 64.00 66.00 06600 PHYSI CAL THERAPY 66.00 06700 OCCUPATI ONAL THERAPY 67.00 0 0 67.00 0 06701 AUDI OLOGY 67.01 C 0 67.01 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 0 0 69.00 0 06901 CARDI OLOGY 69 01 0 69.01 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 o 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 73.00 0 OUTPATIENT SERVICE COST CENTERS 0 0 90.00 90.00 09000 CLI NI C 0 0 0 09001 OTHER OUTPATIENT SERVICE COST CENTER 0 90.01 90. 01 0000000000000 0 0 0 0 0 90.02 09002 CLI NI C 0 Ω 90.02 0 09003 DERMATOLOGY CLINIC 0 90.03 90.03 0 90.04 09004 ENT CLINIC 0 0 90.04 09005 SURGERY CLINIC 0 90.05 0 0 0 0 90.05 09007 UROLOGY CLINIC 90.07 0 0 90.07 0 90.09 09009 GASTROENTEROLOGY CLINIC 0 0 90.09 09011 NEUROLOGY CLINIC 0 90.11 90.11 0 0 0 0 09012 OPTHAMOLOGY CLINIC 0 90.12 0 Ω 90.12 0 09013 ALLERGY CLINIC 90.13 90.13 C 0 90.14 09014 WOUND CARE 0 0 90.14 09100 EMERGENCY 0 91.00 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS 0 0 92.00 Ω 92.00 95. 00 09500 AMBULANCE SERVICES 95.00 0 200.00 200.00 Total (lines 50 through 199) 0 O 0 0

THROUGH COSTS

				1	o 12/31/2019	Date/Time Pre 3/31/2020 8:1	
			Title	XVIII	Hospi tal	PPS	<u>o an</u>
	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)			
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	T	г	1			
50.00	05000 OPERATING ROOM	0	0	(			
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1	1	- 1, 1, 1		
55.00	05500 RADI OLOGY-THERAPEUTI C	0	1	1	-	0.00000	
55. 01	05501 ULTRA SOUND	0	0	1	.,,		1
57. 00	05700 CT SCAN	0	0	`			1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		,		
60.00	06000 LABORATORY	0	0		,,		
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		.,		1
64. 00	06400 I NTRAVENOUS THERAPY	0	0		-,,		
66. 00	06600 PHYSI CAL THERAPY	0	0		-,,		1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		-, ,		
67. 01	06701 AUDI OLOGY	0	0				1
68.00	06800 SPEECH PATHOLOGY	0	0	-	.,,		1
69. 00	06900 ELECTROCARDI OLOGY	0	0	(	-	0. 000000	
	06901 CARDI OLOGY	0	0	(	16, 057, 275		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		-, ,		1
	07200 IMPL. DEV. CHARGED TO PATIENT	0			-,, -		1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(	39, 627, 105	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	l e				
	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	1		-	0. 000000	
	09002 CLI NI C	0	1	1	0	0.000000	1
90. 03	09003 DERMATOLOGY CLINIC	0	0	1	0	0.000000	1
90. 04	09004 ENT CLINIC	0	0	1	0	0. 000000	
	09005 SURGERY CLINIC	0	0	1	-	0.000000	
	09007 UROLOGY CLINIC	0	0		,		
	09009 GASTROENTEROLOGY CLINIC	0	0		0	0.000000	1
90. 11	09011 NEUROLOGY CLINIC	0	0		0	0. 000000	1
90. 12	09012 OPTHAMOLOGY CLINIC	0	0	`	·	0. 000000	
	09013 ALLERGY CLINIC	0	0		,		1
	09014 WOUND CARE	0	0		-, ,		
	09100 EMERGENCY	0	1		,,		1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(	5, 300, 701	0. 000000	92.00
05	OTHER REIMBURSABLE COST CENTERS			1			
95.00	09500 AMBULANCE SERVICES	_	_		077 004 /=:		95.00
200.00	Total (lines 50 through 199)	0	0	(	377, 001, 676		200. 00

Health Financial Systems	WITHAM MEMORIAL HO	OSPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS P	Provider CCN: 15-0104	Peri od:	Worksheet D
TURQUIQUE COCTO			Erom 01/01/2010	Dart IV

THROUGH COSTS To 12/31/2019 | Date/Time Prepared: 3/31/2020 8:18 am Title XVIII Hospi tal PPS I npati ent Outpati ent Cost Center Description Outpati ent I npati ent Outpati ent Ratio of Cost Program Program Program Program to Charges Pass-Through Pass-Through Charges Charges (col. 6 ÷ col. 7) Costs (col. 8 Costs (col. x col. 12) 13.00 x col. 10) 9. 00 10.00 11.00 12.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0.000000 4, 844, 427 15, 410, 988 50 00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 969, 860 11, 202, 131 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 55.00 55.00 0 05501 ULTRA SOUND 70, 105 0 998, 867 0.000000 55.01 0 55.01 0 9, 082, 757 05700 CT SCAN 2, 011, 146 57.00 0.000000 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 271, 886 5, 566, 627 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 447, 522 1, 754, 763 59.00 06000 LABORATORY 0 60. nn 0.000000 4, 077, 019 5, 704, 955 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 0.000000 191, 312 272, 707 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 523, 046 473, 661 64.00 0 66.00 06600 PHYSI CAL THERAPY 0.000000 442, 059 18, 426 0 66.00 06700 OCCUPATI ONAL THERAPY 0 0.000000 67.00 67.00 336, 611 9, 755 0 67.01 06701 AUDI OLOGY 0.000000 0 67.01 06800 SPEECH PATHOLOGY 0 68.00 0.000000 77,670 124, 006 0 68.00 0 69 00 06900 ELECTROCARDI OLOGY 0.000000 69.00 0 69.01 06901 CARDI OLOGY 0.000000 3, 585, 261 7, 472, 328 0 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 1, 239, 351 0 1, 041, 171 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0.000000 21, 760 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 3, 090, 864 73.00 0.000000 11, 111, 888 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 90.00 09001 OTHER OUTPATIENT SERVICE COST CENTER 0 0 90.01 0.000000 0 0 90.01 09002 CLI NI C 0.000000 0 90.02 90.02 0 0 90.03 09003 DERMATOLOGY CLINIC 0.000000 0 0 90.03 09004 ENT CLINIC 0 90.04 0.000000 0 0 0 0 90.04 09005 SURGERY CLINIC 0.000000 90.05 90.05 0 0 0 90.07 09007 UROLOGY CLINIC 90.07 0.000000 0 0 90.09 09009 GASTROENTEROLOGY CLINIC 0.000000 0 0 0 0 90.09 09011 NEUROLOGY CLINIC 0 90. 11 0.000000 0 0 0 90.11 0 09012 OPTHAMOLOGY CLINIC 0.000000 90 12 90 12 Ω 0 0 0 90.13 09013 ALLERGY CLINIC 0.000000 0 90.13 1, 062, 269 90. 14 09014 WOUND CARE 0.000000 0 90.14 3,865 0 91.00 09100 EMERGENCY 0.000000 1, 643, 724 0 5, 143, 853 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 2, 505, 637 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 95.00 Total (lines 50 through 199) 23, 825, 728 0 78, 978, 549 0 200.00 200.00

Heal th	Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C	CN: 15-0104	Peri od:	Worksheet D	
					From 01/01/2019	Part V	
					To 12/31/2019		pared:
						3/31/2020 8: 1	8 am
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins	. Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 111015	15, 410, 988		0 131	1, 710, 851	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 235208	11, 202, 131		0 4	2, 634, 831	54.00
	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0		1
	05501 ULTRA SOUND	0. 112111	998, 867		0 0	111, 984	
	05700 CT SCAN	0. 026803	9, 082, 757		0 577	243, 445	1
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 071905	5, 566, 627	1	0 377	400, 268	
	05900 CARDI AC CATHETERI ZATI ON	0. 071905	1, 754, 763		0 0		
	l e e e e e e e e e e e e e e e e e e e	1		1	-		
	06000 LABORATORY	0. 166339	5, 704, 955				
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 203930	272, 707		0		
1	06400 I NTRAVENOUS THERAPY	0. 001575	473, 661		0 0		
	06600 PHYSI CAL THERAPY	0. 415716	18, 426	1	0	,	
	06700 OCCUPATI ONAL THERAPY	0. 194345	9, 755		0	1, 896	
	06701 AUDI OLOGY	0. 267252	0	1	0		67. 01
68. 00	06800 SPEECH PATHOLOGY	0. 300227	124, 006		0	37, 230	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	0	)	0	0	69.00
69. 01	06901 CARDI OLOGY	0. 140252	7, 472, 328		0 53	1, 048, 009	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 416387	1, 041, 171		0 0	433, 530	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0. 366624	21, 760	1	0 0	1	
	07300 DRUGS CHARGED TO PATIENTS	0. 123113	11, 111, 888		0 63, 277	1	
1	OUTPATIENT SERVICE COST CENTERS		, ,	1		.,,,	1
	09000 CLINIC	0. 000000	0		0 0	0	90.00
	09001 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	0		0 0	l	90. 01
	09002 CLI NI C	0. 000000	0			l	90.02
	09003 DERMATOLOGY CLINIC	0. 000000	0		0 0		90.02
	09004 ENT CLINIC	0. 000000	0		0 0		90.03
	09005 SURGERY CLINIC		0		0 0		
		0. 000000	·		-	-	90.05
	09007 UROLOGY CLINIC	0. 000000	0		0 0	0	90. 07
	09009 GASTROENTEROLOGY CLINIC	0. 000000	0	1	0		90.09
	09011 NEUROLOGY CLINIC	0. 000000	0	1	0	· -	90. 11
	09012 OPTHAMOLOGY CLINIC	0. 000000	0	1	0	0	90. 12
90. 13	09013 ALLERGY CLINIC	0. 309534	0	1	0	0	90. 13
90. 14	09014 WOUND CARE	0. 205709	1, 062, 269	1	0 5, 316	218, 518	90. 14
91.00	09100 EMERGENCY	0. 172311	5, 143, 853		0 109	886, 342	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 492018	2, 505, 637		0 27	1, 232, 819	92.00
	OTHER REIMBURSABLE COST CENTERS	•		•	<u>'</u>		
	09500 AMBULANCE SERVICES	0. 933127			0		95.00
200.00	Subtotal (see instructions)		78, 978, 549	4, 43		11, 529, 866	
201.00	Less PBP Clinic Lab. Services-Program		. 5, 5, 61,	', '	0 0		201.00
201.00	Only Charges			1	ا ا	i	
202. 00	Net Charges (line 200 - line 201)		78, 978, 549	4, 43	69, 497	11, 529, 866	202 00
202. 00	1.10 571d gos (11110 200 11110 201)	I	, , , , , , , , , , , , , , , , , , , ,	1 7, 40	, 3,, 4,7	11, 327, 000	1-32.00

Peri od: Worksheet D From 01/01/2019 Part V To 12/31/2019 Date/Ti me Prepared:

					10 12,01,201,	3/31/2020 8:	18 am
			Title	XVIII	Hospi tal	PPS	
		Cost	ts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
			Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
ANCL	LLARY SERVICE COST CENTERS	0.00	71.00				
	O OPERATING ROOM	0	15				50.00
	O RADI OLOGY-DI AGNOSTI C	0	1				54.00
	O RADI OLOGY-THERAPEUTI C		o O				55. 00
	1 ULTRA SOUND		Ö				55. 01
	O CT SCAN		15				57.00
	O MAGNETIC RESONANCE IMAGING (MRI)		0				58.00
	, ,		0				
	O CARDI AC CATHETERI ZATI ON	727					59.00
	O LABORATORY	737	0				60.00
	O BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
	O I NTRAVENOUS THERAPY	0	0				64.00
	O PHYSI CAL THERAPY	0	0				66.00
	O OCCUPATIONAL THERAPY	0	0				67.00
	1 AUDI OLOGY	0	0				67. 01
68. 00   0680	O SPEECH PATHOLOGY	0	0				68. 00
	O ELECTROCARDI OLOGY	0	0				69. 00
	1 CARDI OLOGY	0	7				69. 01
71.00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72. 00 0720	O IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73.00 0730	O DRUGS CHARGED TO PATIENTS	0	7, 790				73.00
OUTP	ATIENT SERVICE COST CENTERS						
90.00 0900	O CLI NI C	0	0				90.00
90. 01 0900	1 OTHER OUTPATIENT SERVICE COST CENTER	0	0				90. 01
90. 02 0900	2 CLI NI C	o	o				90. 02
	3 DERMATOLOGY CLINIC	0	0				90. 03
	4 ENT CLINIC	0	0				90. 04
	5 SURGERY CLINIC	0	0				90.05
	7 UROLOGY CLINIC		0				90.07
	9 GASTROENTEROLOGY CLINIC		0				90.09
	1 NEUROLOGY CLINIC		0				90. 11
	2 OPTHAMOLOGY CLINIC		0				90. 11
			0				1
	3 ALLERGY CLINIC						90. 13
	4 WOUND CARE		1, 094				90. 14
	O EMERGENCY	0	19				91.00
	O OBSERVATION BEDS (NON-DISTINCT PART)	0	13				92.00
	R REIMBURSABLE COST CENTERS						1
	O AMBULANCE SERVICES	0					95.00
200. 00	Subtotal (see instructions)	737	8, 954				200.00
201. 00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)	737	8, 954				202.00

Hoal th	Financial Systems	WITHAM MEMORI	AL HOSDITAL		Inlie	u of Form CMS-:	2552_10
	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C	CN: 15-0104 CCN: 15-S104	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D	pared:
			Title	· XVIII	Subprovi der - I PF	PPS	<u>o ani</u>
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		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)	0.00	2.00	4.00	F 00	
	ANOLI LADV. CEDVI CE COCT. CENTEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	520, 509	52, 732, 763	0.0098	71 7, 876	78	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	656, 950		l .		844	
55. 00	05500 RADI OLOGY-THERAPEUTI C	25				0	
55. 00	05501 ULTRA SOUND	6, 564	ł	l .		2	
57. 00	05700 CT SCAN	7, 806				5	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	57, 910		l .		56	
59. 00	05900 CARDI AC CATHETERI ZATI ON	49, 631		l .		9	
60. 00	06000 LABORATORY	319, 047	, , , , ,	•		2, 918	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	781	1, 115, 505			0	1
64.00	06400 I NTRAVENOUS THERAPY	17	3, 398, 014	0. 00000	3, 693	0	64.00
66.00	06600 PHYSI CAL THERAPY	288, 191	8, 292, 784	0. 03475	38, 859	1, 350	66.00
67.00	06700 OCCUPATI ONAL THERAPY	5, 183	3, 716, 264	0. 00139	95 16, 125	22	67.00
67. 01	06701 AUDI OLOGY	1, 386	950, 473			0	
68. 00	06800 SPEECH PATHOLOGY	1, 539	1, 157, 664			10	1
69. 00	06900 ELECTROCARDI OLOGY	0	1			0	
69. 01	06901 CARDI OLOGY	42, 860				144	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12, 823				50	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	19, 473		l .		0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	18, 523	39, 627, 105	0. 00046	57 732, 157	342	73.00
00 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	1		0.0000	20 0	0	00.00
90. 00 90. 01	09000 CEINIC	132, 560	1			0	
90.01	09001 OTHER OUTPATTENT SERVICE COST CENTER	132,500	ł	l .		0	90.01
90. 02	09003 DERMATOLOGY CLINIC	0	1			0	
90. 04	09004 ENT CLINIC	0	ĺ	•		0	
90. 05	09005 SURGERY CLINIC	0	Ö	l .		Ö	
90. 07	09007 UROLOGY CLINIC	0		•		Ö	
90. 09	09009 GASTROENTEROLOGY CLINIC	59	Ö	l .		Ō	90.09
90. 11	09011 NEUROLOGY CLINIC	92	o	l .		0	90. 11
90. 12	09012 OPTHAMOLOGY CLINIC	0	0	0. 00000	00 0	0	90. 12
90. 13	09013 ALLERGY CLINIC	950	723, 323	0. 0013	13 0	0	90. 13
90. 14	09014 WOUND CARE	109, 273			52 15	0	90. 14
91.00	09100 EMERGENCY	759, 239				473	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	5, 300, 701	0. 00000	00 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS		T	1			
95. 00 200. 00	O9500   AMBULANCE SERVICES   Total (lines 50 through 199)	3, 011, 392	376, 844, 120		1, 544, 887	6, 303	95. 00 200. 00

ANCI LLARY 0. 00 05000 OPER/ 4. 00 05400 RADI ( 5. 00 05500 RADI ( 7. 00 05700 CT S( 8. 00 05800 MAGNE 9. 00 05900 CARDI ( 0. 00 06000 LABOR 4. 00 06400 INTR/ 6. 00 06600 PHYSI 7. 00 06700 OCCUR	OLOGY-DIAGNOSTIC OLOGY-THERAPEUTIC A SOUND CAN ETIC RESONANCE IMAGING (MRI) IAC CATHETERIZATION	Non Physician Anesthetist Cost 1.00	Nursi ng School Post-Stepdown Adjustments 2A 0		Subprovi der - IPF Allied Health Post-Stepdown Adjustments  3A	3/31/2020 8:1 PPS Allied Health 3.00	
ANCI LLARY 0. 00 05000 OPER/ 4. 00 05400 RADI ( 5. 00 05500 RADI ( 7. 00 05700 CT S( 8. 00 05800 MAGNE 9. 00 05900 CARDI ( 0. 00 06000 LABOR 4. 00 06400 INTR/ 6. 00 06600 PHYSI 7. 00 06700 OCCUR	SERVICE COST CENTERS ATING ROOM OLOGY-DIAGNOSTIC OLOGY-THERAPEUTIC A SOUND CAN ETIC RESONANCE I MAGING (MRI) I AC CATHETERIZATION	Anesthetist Cost  1.00  0 0 0 0 0	School Post-Stepdown Adjustments 2A 0	School 2.00	Allied Health Post-Stepdown Adjustments		
0. 00   05000   0PER/ 4. 00   05400   RADI (0 5. 00   05500   RADI (0 5. 01   05501   ULTR/ 7. 00   05700   CT   S( 8. 00   05900   CARDI (0 0. 00   06000   LABO/ 3. 00   06300   BLOOI 4. 00   06400   INTR/ 6. 00   06700   OCCUF	ATING ROOM OLOGY-DIAGNOSTIC OLOGY-THERAPEUTIC A SOUND CAN ETIC RESONANCE IMAGING (MRI) IAC CATHETERIZATION	0 0 0	0			3. 00	
0. 00   05000   0PER/ 4. 00   05400   RADI (0 5. 00   05500   RADI (0 5. 01   05501   ULTR/ 7. 00   05700   CT   S( 8. 00   05900   CARDI (0 0. 00   06000   LABO/ 3. 00   06300   BLOOI 4. 00   06400   INTR/ 6. 00   06700   OCCUF	ATING ROOM OLOGY-DIAGNOSTIC OLOGY-THERAPEUTIC A SOUND CAN ETIC RESONANCE IMAGING (MRI) IAC CATHETERIZATION	0 0	0				
4. 00   05400   RADI (05.00   05500   RADI (05.00   05500   RADI (05.00   05700   CT s.)  8. 00   05800   MAGNI (05.00   CARDI	OLOGY-DIAGNOSTIC OLOGY-THERAPEUTIC A SOUND CAN ETIC RESONANCE IMAGING (MRI) IAC CATHETERIZATION	0 0	0				4
5. 00   05500   RADI (0 5. 01   05501   ULTR/ 7. 00   05700   CT   S(0 8. 00   05800   MAGNE 9. 00   06900   CARDI 0. 00   06600   LABOF 3. 00   06400   INTR/ 6. 00   06600   PHYSI 7. 00   06700   OCCUF	OLOGY-THERAPEUTIC A SOUND CAN ETIC RESONANCE IMAGING (MRI) IAC CATHETERIZATION	0					
5. 01   05501   ULTR/ 7. 00   05700   CT   S0 8. 00   05800   MAGNI 9. 00   05900   CARDI 0. 00   06000   LABOI 4. 00   06400   BLOOI 4. 00   06600   PHYSI 7. 00   06700   OCCUF	A SOUND CAN ETIC RESONANCE IMAGING (MRI) IAC CATHETERIZATION	O	n		0 0		
7. 00 05700 CT SC 8. 00 05800 MAGNE 9. 00 05900 CARDI 0. 00 06000 LABOR 4. 00 06400 INTR 6. 00 06600 PHYSI 7. 00 06700 OCCUF	CAN ETIC RESONANCE IMAGING (MRI) IAC CATHETERIZATION	١	ŭ		0 0	_	
8. 00   05800   MAGNE 9. 00   05900   CARDI 0. 00   06000   LABOF 3. 00   06400   INTR 6. 00   06600   PHYSI 7. 00   06700   0CCUF	ETIC RESONANCE IMAGING (MRI) IAC CATHETERIZATION	UI UI	0		0 0	_	
9. 00   05900   CARDI 0. 00   06000   LABOR 3. 00   06300   BLOOR 4. 00   06400   I NTR/ 6. 00   06600   PHYSI 7. 00   06700   OCCUR	I AC CATHETERI ZATI ON	0	0		0 0		
0. 00   06000   LAB0F 3. 00   06300   BL00F 4. 00   06400   I NTR/ 6. 00   06600   PHYSI 7. 00   06700   OCCUF			0			_	
3. 00 06300 BL000 4. 00 06400 I NTRA 6. 00 06600 PHYSI 7. 00 06700 OCCUF			0			_	
4. 00   06400   I NTRA 6. 00   06600   PHYSI 7. 00   06700   OCCUR	D STORING, PROCESSING & TRANS.		0				
6. 00   06600 PHYSI 7. 00   06700 OCCUF	AVENOUS THERAPY		0				
7. 00   06700 OCCUF	I CAL THERAPY		0			_	
	PATI ONAL THERAPY	o	0		0 0	_	
7. 01  06701 AUDI (		o	0		0 0	l .	
	CH PATHOLOGY	o	0		0 0	0	68.00
9. 00 06900 ELECT	TROCARDI OLOGY	o	0		0	0	69.0
9. 01  06901 CARDI		0	0		0 0		
	CAL SUPPLIES CHARGED TO PATIENTS	0	0		0		
	. DEV. CHARGED TO PATIENT	0	0		0	l .	
	S CHARGED TO PATIENTS	0	0		0 0	0	73.0
	SERVICE COST CENTERS			<u> </u>			1 00 0
0. 00   09000   CLI NI		0	0		0 0		
0. 01  09001 0THEF 0. 02  09002 CLI NI	R OUTPATIENT SERVICE COST CENTER	0	0		0 0		
	ATOLOGY CLINIC		0			_	1
0. 04 09004 ENT (			0				
0. 05 09005 SURGE			0			_	
0. 07 09007 UROLO			0		0 0		
1 1	ROENTEROLOGY CLINIC		0		0		
	OLOGY CLINIC		0				
	AMOLOGY CLINIC	o	0		0		
0. 13 09013 ALLEF		Ö	0		0 0		
0. 14   09014   WOUNE	D CARE	o	0		0 0	0	90. 1
1.00 09100 EMERO	GENCY	o	0		0 0	0	91.0
	RVATION BEDS (NON-DISTINCT PART)	0			0	0	92.0
	BURSABLE COST CENTERS						4
1 1	LANCE SERVICES I (lines 50 through 199)	0	0		0 0		95. 00 200. 00

APP0R1	Financial Systems FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF GH COSTS	RVICE OTHER PAS		CN: 15-0104 CCN: 15-S104	Peri od: From 01/01/2019 To 12/31/2019		pared:
			Title	e XVIII	Subprovi der -	973172020 8: 1 PPS	<u>8 alli </u>
	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		(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
		4. 00	5. 00	and 4) 6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	4.00	5.00	0.00	7.00	6.00	
50. 00	05000 OPERATING ROOM	0	0		0 52, 732, 763	0.000000	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	-	1	0 34, 483, 364	0. 000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0			0 0 0	0. 000000	
55. 01	05501 ULTRA SOUND	0		1	0 9, 156, 109	0. 000000	
57. 00	05700 CT SCAN	0			0 45, 514, 164	0. 000000	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	Ö	l o	,	0 17, 071, 948		
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	,	0 17, 716, 676	0. 000000	
60.00	06000 LABORATORY	0	0		0 58, 524, 884	0. 000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 1, 115, 505	0. 000000	
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 3, 398, 014	0. 000000	64.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 8, 292, 784	0. 000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	1	0 3, 716, 264	0.000000	67.00
67.01	06701 AUDI OLOGY	0	0		0 950, 473	0.000000	67. 01
68.00	06800 SPEECH PATHOLOGY	0	0		0 1, 157, 664	0. 000000	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0. 000000	69.00
69. 01	06901 CARDI OLOGY	0	0		0 16, 057, 275	0.000000	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 8, 939, 408	0.000000	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0 15, 468, 574	0. 000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 39, 627, 105	0. 000000	73.00
	OUTPATIENT SERVICE COST CENTERS						1
90.00		0			0 0	0. 000000	
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0	1	0 0	0. 000000	
90. 02		0	0		0 0	0.000000	
90. 03	09003 DERMATOLOGY CLINIC	0	0	1	0 0	0.000000	
	09004 ENT CLINIC	0	0		0	0.000000	
90.05	09005 SURGERY CLINIC	0	0		0 0	0.000000	
90.07	09007 UROLOGY CLINIC		0	1	0 157, 556	0.000000	
90.09	09009 GASTROENTEROLOGY CLINIC 09011 NEUROLOGY CLINIC		0	1	0 0	0. 000000 0. 000000	
90. 11 90. 12	09011 NEUROLOGY CLINIC				0 0	0.000000	
90. 12					0 723, 323	0.000000	
90. 13	09014 WOUND CARE			1	0 5, 139, 410		
91.00	09100 EMERGENCY		-	l .	0 31, 757, 712	0. 000000	
92.00		0		1	0 5, 300, 701	0.000000	
00	OTHER REIMBURSABLE COST CENTERS	<u> </u>			5, 555, 761	2. 223000	1 50

0

0

377, 001, 676

95. 00 200. 00

90. 14 | 09014 | WOUND CARE 91. 00 | 09100 | EMERGENCY 92. 00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 95. 00 | 09500 | AMBULANCE SERVICES 200. 00 | Total (Lines 50 through 199)

Health Financial Systems		WITHAM MEMORIA	I HOSDITAI		Inlie	u of Form CMS-:	2552_10
APPORTIONMENT OF INPATIENTATHROUGH COSTS	OUTPATIENT ANCILLARY SE		Provi der Co	CN: 15-0104 CCN: 15-S104	Period: From 01/01/2019 To 12/31/2019	Worksheet D	epared:
			Title	XVIII	Subprovi der  - I PF	PPS	
Cost Center Des	scription	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7) 9.00	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. x col. 10) 11.00		Outpatient Program Pass-Through Costs (col. 9 x col. 12) 13.00	
ANCILLARY SERVICE CO	ST CENTERS						
50. 00   05000   OPERATI NG ROOM   54. 00   05400   RADI OLOGY-DI AGI   55. 00   05500   RADI OLOGY-THER/   55. 01   05501   ULTRA SOUND   57. 00   05700   CT SCAN   58. 00   05800   MAGNETI C RESON/   59. 00   05900   CARDI AC CATHETI   60. 00   06000   LABORATORY   63. 00   06300   BLOOD STORI NG,   64. 00   06400   INTRAVENOUS THI   66. 00   06600   PHYSI CAL THERAI   67. 00   06700   OCUPATI ONAL TI   67. 01   06701   AUDI OLOGY   68. 00   06800   SPEECH PATHOLOG   69. 00   06900   ELECTROCARDI OLOGY   69. 01   06901   CARDI OLOGY   CARDI OLOGY   06901   CARDI OLOGY   06900   06901   CARDI OLOGY   06901   06901   CARDI OLOGY   06901   06901   CARDI OLOGY   06500   06901   0	NOSTIC APEUTIC  ANCE IMAGING (MRI) ERIZATION  PROCESSING & TRANS. ERAPY PY HERAPY GY OGY ES CHARGED TO PATIENTS GGED TO PATIENTS	0. 000000 0. 000000	7, 876 44, 324 0 2, 597 28, 277 16, 567 3, 182 535, 363 38, 859 16, 125 0 7, 221 0 53, 970 34, 880 0 732, 157		0 0 0 0 37 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	54. 00 55. 00 55. 01 57. 00 58. 00 59. 00 60. 00 63. 00 64. 00 67. 00 67. 01 68. 00 69. 00 69. 01 71. 00 72. 00
90. 00   09000   CLINIC   90. 01   09001   OTHER OUTPATIE!   90. 02   09002   CLINIC   90. 03   09003   DERMATOLOGY CLINIC   90. 04   09004   ENT CLINIC   90. 05   09005   SURGERY CLINIC   90. 07   09007   UROLOGY CLINIC   90. 09   09009   GASTROENTEROLOGY   090. 11   09011   NEUROLOGY CLINIC   90. 12   09012   O9114   09014   WOUND CARE   91. 00   09100   EMERGENCY	NI C  SY CLINIC C NIC  OS (NON-DISTINCT PART)	0. 000000 0. 000000	0 0 0 0 0 0 0 0 0 15 19, 781		0 0	0 0 0 0 0 0 0 0 0 0	90. 01 90. 02 90. 03 90. 04 90. 05 90. 07 90. 09 90. 11 90. 12 90. 13 90. 14 91. 00
95. 00   09500   AMBULANCE SERVI 200. 00   Total (lines 50	CES		1, 544, 887		0 1, 260	0	95. 00 200. 00

Health Financial Systems	WITHAM MEMORI	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COST	Provi der C		Peri od:	Worksheet D	
		Component	CCN: 15-S104	From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:
					3/31/2020 8: 1	8 am
		litle	xVIII	Subprovi der -	PPS	
				I PF		
			Charges	_	Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.			. Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1. 00	2.00	3.00	4.00	5. 00	
ANCILLARY SERVICE COST CENTERS						
						1

Charge Ratio   From   From   From   For   From   From   For   From   F		Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
MORTESHORE C, Part I. col.   Subject To Ded. & Colins Ded. & Scolins Colon Ded. & Scolins Ded.							(see inst.)	
Part I				Services (see	Servi ces	Services Not		
9   (see inst.)				inst.)				
ANCILLARY SERVICE COST CENTERS			Part I, col.					
ANCI LLARY SERVICE COST CENTERS					(see inst.)			
50.00			1. 00	2. 00	3. 00	4. 00	5. 00	
54 00   05400   RADI DLOGY-DI AGNOSTIC   0. 235208   37								
55. 00   05500   RADI OLOGY-THERAPUTI C   0.0000000   0   0   0   55. 00   55. 00   55. 01   05500   ULTRA SOUND   0.12111   0   0   0   0   55. 00   55. 00   55. 00   55. 00   057. 00   057. 00   057. 00   057. 00   057. 00   057. 00   05800	50.00	05000   OPERATI NG ROOM	0. 111015			10	0	50.00
55.01   0.5501   ULTRA SOUND	54.00	05400   RADI OLOGY-DI AGNOSTI C	0. 235208	37	0	0	9	54.00
57. 00   05700   CT SCAN   0.05800   MAGNETIC RESONANCE IMAGING (MRI)   0.071905   0.0	55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	0	0	0	55.00
S8. 00   OSBOO   MAGNETI C RESONANCE I MAGING (MRI )	55. 01	05501 ULTRA SOUND	0. 112111	0	0	0	0	55. 01
S8. 00   OSBOO MAGNETI C RESONANCE I MAGING (MRI )	57.00	05700 CT SCAN	0. 026803	0	0	44	ĺ	57.00
59.00   05900   CARDI AC CATHETERI ZATI ON   0.103245   0   0   0   0   0.59.00				0	0			
60.00   06000   LABORATORY   0.166339   0   0   0   0   63.00	59.00		4	0	0	0	0	
63:00   06300   BLOOD STORING, PROCESSING & TRANS.   0.203930   0   0   0   0   0   63.00   64:00   06400   INTRANPOUST THERAPY   0.001575   0   0   0   0   0   64.00   66:00   06600   PHYSI CAL THERAPY   0.415716   0   0   0   0   0   0   67:00   06700   0CCUPATI ONAL THERAPY   0.415716   0   0   0   0   0   0   67:00   06700   0CCUPATI ONAL THERAPY   0.415716   0   0   0   0   0   0   68:00   06600   PHYSI CAL THERAPY   0.415716   0   0   0   0   0   0   68:00   06600   PHYSI CAL THERAPY   0.415716   0   0   0   0   0   0   69:01   06900   06900   0   0   0   0   0   0   0   69:00   06900   06900   0   0   0   0   0   0   0   69:00   06900   06900   0   0   0   0   0   0   69:00   06900   06900   0   0   0   0   0   0   69:00   06900   071000   07100   07100   07100   07100   07100   07100   0			1	0	0	0	l o	
64.00   06400   INTRAVENOUS THERAPY   0.001575   0 0 0 0 0   64.00   66.00   06600   PHYSI CAL THERAPY   0.415716   0 0 0 0 0 0   67.01   06700   0CCUPATI ONAL THERAPY   0.194345   0 0 0 0 0   67.01   06701   AUDI OLOGY   0.267252   0 0 0 0 0   67.01   06701   AUDI OLOGY   0.267252   0 0 0 0 0   68.00   06800   SPEECH PATHOLOGY   0.300227   0 0 0 0 0   69.00   06900   ELECTROCARDI OLOGY   0.000000   0 0 0 0   69.01   06901   CARDI OLOGY   0.140252   0 0 0 0   71.00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0.146387   0 0 0 0   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0.146387   0 0 0 0   73.00   07300   DRUGS CHARGED TO PATI ENTS   0.123113   0 0   4,827   0 73.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   0.123113   0 0   4,827   0 73.00   79.00   09000   CLI NI C   0.00000   0 0 0   0 0   0 0   79.01   09001   OTHER OUTPATI ENT SERVICE COST CENTER   0.000000   0 0   0 0   0 0   79.02   09002   CLI NI C   0.000000   0 0   0 0   0 0   79.03   09003   DERMATOLOGY CLI NI C   0.000000   0 0   0 0   0 0   79.04   09004   ENT CLI NI C   0.000000   0 0   0 0   0 0   79.05   09005   SURGERY CLI NI C   0.000000   0 0   0 0   0 0   79.07   09007   UROLOGY CLI NI C   0.000000   0 0   0   0   79.08   09005   SURGERY CLI NI C   0.000000   0   0   0   0   79.09   09009   OSSTROENTEROLOGY CLI NI C   0.000000   0   0   0   79.01   09011   NEUROLOGY CLI NI C   0.000000   0   0   0   79.02   0911   POUR CLI NI C   0.000000   0   0   0   79.03   09013   ALLERGY CLI NI C   0.000000   0   0   0   79.04   09012   DETHAMBLOGY CLI NI C   0.000000   0   0   0   79.05   09009   OSSTROENTEROLOGY CLI NI C   0.000000   0   0   0   79.01   09011   NEUROLOGY CLI NI C   0.000000   0   0   0   79.02   09012   OTHAMBLOGY CLI NI C   0.000000   0   0   0   79.03   09013   ALLERGY CLI NI C   0.000000   0   0   0   79.04   09014   WOUND CARE   0.90000   0   0   0   79.05   09000   OSSTROENTEROLOGY CLI NI C   0.000000   0   0   79.00   09000   OSSTROENTEROLOGY CLI NI C   0.000000   0   0   79.00   09000   OSSTROENTEROLOGY CLI				_	-	_	-	
66. 00   06600   06600   06000   0   0   0			4				-	
67.00   06700   06CUPATI ONAL THERAPY   0.194345   0   0   0   0   0   67.00   67.01   06701   04DI OLOGY   0.267252   0   0   0   0   0   67.00   68.00   06800   SPEECH PATHOLOGY   0.300227   0   0   0   0   0   68.00   69.00   06900   ELECTROCARDI OLOGY   0.000000   0   0   0   0   0   0   69.01   06901   CARDI OLOGY   0.140252   0   0   4   0   69.00   69.01   06901   CARDI OLOGY   0.140252   0   0   4   0   69.01   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0.416387   0   0   0   0   0   72.00   07200   IMPL. DEV. CHARGED TO PATIENT   0.366624   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENT   0.123113   0   0   4.827   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0.123113   0   0   4.827   0   73.00   07000   O00000   0   0   0   0   0   70.01   09001   OTHER OUTPATIENT SERVICE COST CENTER   0.000000   0   0   0   0   70.02   09002   CLINIC   0.000000   0   0   0   0   0   70.03   09003   DERNATOLOGY CLINIC   0.000000   0   0   0   0   0   70.04   09004   ENT CLINIC   0.000000   0   0   0   0   0   70.05   09005   SURGERY CLINIC   0.000000   0   0   0   0   70.07   09007   UROLOGY CLINIC   0.000000   0   0   0   0   70.09   09009   GASTROENTEROLOGY CLINIC   0.000000   0   0   0   0   70.01   09001   O100000   0   0   0   0   70.01   09001   O100000   0   0   0   0   70.02   09005   SURGERY CLINIC   0.000000   0   0   0   0   70.01   09001   O100000   0   0   0   70.01   09001   O100000   0   0   0   0   70.01   09001   O1000000   0   0   0   70.02   09005   O10000000   0   0   0   0   70.03   09003   O10000000   0   0   0   0   70.04   09004   O10000000   0   0   0   0   70.07   09007   UROLOGY CLINIC   0.000000   0   0   0   0   70.08   09005   O100000000   0   0   0   0   70.09   09009   05000000000000   0   0   0   0   70.00   090000000000000000000000000000000		1	1	_	1	_	1	
67.01   06701   AUDIOLOGY   0. 267252   0   0   0   0   0   67.01   68.00   06800   SPEECH PATHOLOGY   0. 300227   0   0   0   0   0   68.00   69.01   06900   ELECTROCARDIOLOGY   0. 000000   0   0   0   0   0   69.00   69.01   06901   CARDIOLOGY   0. 140252   0   0   4   0   69.01   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0. 146387   0   0   0   0   0   0   72.00   07200   IMPL DEV. CHARGED TO PATIENTS   0. 146387   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0. 123113   0   0   4. 827   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0. 123113   0   0   4. 827   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0. 123113   0   0   4. 827   0   73.00   07400   07400   07400   07400   07400   0   0   0   0   0   09.01   09000   CLI NI C   0. 000000   0   0   0   0   0   0   09.01   09000   OTHER OUTPATIENT SERVICE COST CENTER   0. 000000   0   0   0   0   0   0   09.02   09002   CLI NI C   0. 000000   0   0   0   0   0   0   09.03   09003   DERMATOLOGY CLINIC   0. 000000   0   0   0   0   0   0   09.04   09004   ENT CLI NI C   0. 000000   0   0   0   0   0   09.05   09005   SURGERY CLI NI C   0. 000000   0   0   0   0   0   09.07   09007   IMPL INDICAGY CLINIC   0. 000000   0   0   0   0   09.09   09009   GASTROENTEROLOGY CLINIC   0. 000000   0   0   0   0   09.09   09009   GASTROENTEROLOGY CLINIC   0. 000000   0   0   0   0   09.01   0911   NEUROLOGY CLINIC   0. 000000   0   0   0   0   09.01   0911   DEUROLOGY CLINIC   0. 000000   0   0   0   0   09.01   0911   DEUROLOGY CLINIC   0. 000000   0   0   0   0   09.01   0910   OTHAMOLOGY CLINIC   0. 000000   0   0   0   0   09.01   0910   OTHAMOLOGY CLINIC   0. 000000   0   0   0   0   09.01   0910   OTHAMOLOGY CLINIC   0. 000000   0   0   0   0   09.01   0910   DERGENCY   0. 172311   1. 223   0   0   0   00   0900   OSERVATION BEDS (NON-DISTINCT PART)   0. 492018   0   0   0   0   00   OTHER REI MBURSABLE COST CENTERS   0. 093127   0   0   0   00   OTHER REI MBURSABLE COST CENTERS   0. 093127   0   0   0   0   0   0   00   OTHE		1					-	
68.00   06800   SPEECH PATHOLOGY   0.300227   0   0   0   0   68.00   69.00   06900   ELECTROCARDI OLOGY   0.000000   0   0   0   0   0   0   69.00   0.000000   0   0   0   0   0   0		1	1	_			-	
69. 00   06900   ELECTROCARDI OLOGY   0.000000   0   0   0   0   69.00   69. 01   06901   CARDI OLOGY   0.140252   0   0   4   0   69.01   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0.416387   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0.366624   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   0.123113   0   0   4,827   0   73.00   74. 00   07300   DRUGS CHARGED TO PATIENTS   0.123113   0   0   4,827   0   73.00   75. 00   07300   DRUGS CHARGED TO PATIENTS   0.123113   0   0   0   0   0   76. 00   09000   CLINIC   0.000000   0   0   0   0   0   77. 00   09000   CLINIC   0.000000   0   0   0   0   0   78. 01   09001   OTHER OUTPATIENT SERVICE COST CENTER   0.000000   0   0   0   0   0   79. 02   09002   CLINIC   0.000000   0   0   0   0   0   0   79. 03   09003   DERMATOLOGY CLINIC   0.000000   0   0   0   0   0   0   79. 04   09004   ENT CLINIC   0.000000   0   0   0   0   0   0   79. 05   09005   SURGERY CLINIC   0.000000   0   0   0   0   0   0   790. 07   09007   UROLOGY CLINIC   0.000000   0   0   0   0   0   790. 09   09009   GASTROENTEROLOGY CLINIC   0.000000   0   0   0   0   0   790. 11   09011   NEUROLOGY CLINIC   0.000000   0   0   0   0   790. 12   09012   OPTHAMOLOGY CLINIC   0.000000   0   0   0   0   790. 14   09014   WOUND CARE   0.205709   0   0   0   0   790. 190. 09009   DESERVATION BEDS (NON-DISTINCT PART)   0.492018   0   0   0   0   791. 00   09000   DESERVATION BEDS (NON-DISTINCT PART)   0.492018   0   0   0   0   791. 00   09500   AMBULANCE SERVICES   0.933127   0   0   790. 00   09000   Subtotal (see instructions)   0.00000   0   0   0   790. 00   09000   Subtotal (see instructions)   0.00000   0   0   0   790. 00   09000   Subtotal (see instructions)   0.00000   0   0   790. 00   09000   Subtotal (see instructions)   0.00000   0   0   790. 00   09000   Subtotal (see instructions)   0.00000   0   0   790. 00   0000000000000000000000000000000				_			-	
69.01   0.6901   CARDI OLOGY   0.140252   0   0   4   0   69.01   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0.416387   0   0   0   0   0   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0.366624   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0.123113   0   0   0   4,827   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0.123113   0   0   0   4,827   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0.123113   0   0   0   0   90.01   09001   CLINIC   0.000000   0   0   0   0   0   90.01   09001   OTHER OUTPATIENT SERVICE COST CENTER   0.000000   0   0   0   0   0   90.02   09002   CLINIC   0.000000   0   0   0   0   0   90.03   09003   DERMATOLOGY CLINIC   0.000000   0   0   0   0   90.04   09004   ENT CLINIC   0.000000   0   0   0   0   90.05   09005   SURGERY CLINIC   0.000000   0   0   0   0   90.07   09007   URCLOGY CLINIC   0.000000   0   0   0   0   90.08   09009   GASTROENTEROLOGY CLINIC   0.000000   0   0   0   90.11   09011   NEUROLOGY CLINIC   0.000000   0   0   0   0   90.12   09012   OTHAMOLOGY CLINIC   0.000000   0   0   0   90.13   09013   ALLERGY CLINIC   0.000000   0   0   0   0   90.14   09014   WOUND CARE   0.205709   0   0   406   0   90.15   09009   OSERVATION BEDS (NON-DISTINCT PART)   0.492018   0   0   0   0   91.00   09200   OSERVATION BEDS (NON-DISTINCT PART)   0.492018   0   0   0   90.00   OSERVATION BEDS (NON-DISTINCT PART)   0.492018   0   0   0   90.10   OSERVATION BEDS (NON-DISTINCT PART)   0.492018   0   0   0   90.10   OSERVATION BEDS (NON-DISTINCT PART)   0.492018   0   0   0   90.10   OSERVATION BEDS (NON-DISTINCT PART)   0.492018   0   0   0   90.10   OSERVATION BEDS (NON-DISTINCT PART)   0.492018   0   0   0   0   90.10   OSERVATION BEDS (NON-DISTINCT PART)   0.492018   0   0   0   0   90.10   OSERVATION BEDS (NON-DISTINCT PART)   0.492018   0   0   0   0   90.10   OSERVATION BEDS (NON-DISTINCT PART)   0.492018   0   0   0   0   0   90.10   OSERVATION BEDS (NON-DISTINCT PART)   0.492018   0   0   0   0   0   90.10   OSERVATION BEDS (NON-DISTIN				_			1	
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0. 416387   0   0   0   0   0   0   71. 00   72. 00   72.00   07200   IMPL. DEV. CHARGED TO PATIENT   0. 366624   0   0   0   0   0   0   72. 00   73. 00   074. 00   074.		1	1	l .		_	-	
72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   0. 366624   0   0   0   0   0   72. 00   73.00   000000   000000   000000   000000   000000		1 1	1	0	1		1	
73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 123113   0   0   4,827   0   73. 00				0	1	_	•	
90. 00   09000   CLI NI C   0. 000000   0   0   0   0   0   0   0							_	
90. 00	73. 00		0. 123113	0	0	4, 827	<u> </u>	73.00
90. 01			T	1	T	T		
90. 02			1				-	
90. 03							0	1
90. 04   09004   ENT CLINIC   0. 000000   0   0   0   0   90. 04   90. 05   09005   SURGERY CLINIC   0. 000000   0   0   0   0   0   90. 05   90. 07   09007   UROLOGY CLINIC   0. 000000   0   0   0   0   0   90. 07   90. 09   09009   GASTROENTEROLOGY CLINIC   0. 000000   0   0   0   0   0   90. 07   90. 11   09011   NEUROLOGY CLINIC   0. 000000   0   0   0   0   90. 11   90. 12   09012   OPTHAMOLOGY CLINIC   0. 000000   0   0   0   0   90. 12   90. 13   09013   ALLERGY CLINIC   0. 309534   0   0   0   0   90. 13   90. 14   09014   WOUND CARE   0. 205709   0   406   0   90. 14   91. 00   09100   EMERGENCY   0. 172311   1, 223   0   0   211   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0. 492018   0   0   0   0   0016   DTHER REIMBURSABLE COST CENTERS   0. 933127   0   0. 5, 291   220   200. 00   Center   0. 00000   0   0   0   0   0019   Charges   0   0   0   0   0   0019   Charges   0   0   0   0   00100   0   0   0   0   0   00100   0   0   0   0   0   00100   0   0   0   0   00100   0   0   0   0   00100   0   0   0   0   00100   0   0   0   0   00100   0   0   0   00100   0   0   0   00100   0   0   0   00100   0   0   0   00100   0   0   0   00100   0   0   00100   0   0   0   00100   0   0   00100   0   0   0   00100   0   0   00   0   0   00   0   0   00   0		1		0	1		1	
90. 05				0			0	
90. 07	90. 04				0	0	0	90. 04
90. 09	90. 05	09005 SURGERY CLINIC	0. 000000	0	0	0	0	90.05
90. 11	90. 07	09007 UROLOGY CLINIC	0. 000000	0	0	0	0	90.07
90. 12	90.09	09009 GASTROENTEROLOGY CLINIC	0. 000000	0	0	0	0	90.09
90. 13   09013   ALLERGY CLINIC   0. 309534   0   0   0   0   90. 13   90. 14   09014   WOUND CARE   0. 205709   0   0   406   0   90. 14   91. 00   09200   BMERGENCY   0. 172311   1, 223   0   0   0   0   211   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0. 492018   0   0   0   0   0   92. 00   000	90. 11	09011 NEUROLOGY CLINIC	0. 000000	0	0	0	0	90. 11
90. 14   09014   WOUND CARE   0. 205709   0   0   406   0   90. 14   91. 00   09100   EMERGENCY   0. 172311   1, 223   0   0   0   211   91. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0. 492018   0   0   0   0   0   0   0   92. 00   OTHER REIMBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVICES   0. 933127   0   95. 00   0   0   0   0   0   0   0   0   0	90. 12	09012 OPTHAMOLOGY CLINIC	0. 000000	0	0	0	0	90. 12
91. 00	90. 13	09013 ALLERGY CLINIC	0. 309534	0	0	0	0	90. 13
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0. 492018   0   0   0   0   92. 00	90. 14	09014 WOUND CARE	0. 205709	0	0	406	0	90. 14
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0. 492018   0   0   0   0   92. 00			1	1, 223	0			
OTHER REIMBURSABLE COST CENTERS   O9500   AMBULANCE SERVICES   O. 933127   O   Subtotal (see instructions)   1, 260   O   5, 291   220 200.00   201.00   Less PBP Clinic Lab. Services-Program   Only Charges   Only C							•	
95. 00				-	-	_		1
200.00       Subtotal (see instructions)       1,260       0       5,291       220 200.00         201.00       Less PBP Clinic Lab. Services-Program Only Charges       0       0       0	95 00		0 933127		0			95.00
201.00 Less PBP Clinic Lab. Services-Program 0 0 0 201.00 Only Charges			0.700.27	1 260			220	
Only Charges				1, 200	1		1	
	201.00						1	201.00
202.00	202 00			1 260	1	5 201	220	202 00
	202.00	The coldinges (Trile 200 Trile 201)	I	1, 200		5, 271	, 220	1202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST								
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST   Provider CCN: 15-0104   Provider CCN: 13-0104   Provider	Heal th	Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
Component CON: 15-5104   To 12/31/2019   Date/Time Prepared: 3/31/2002/8: 18 am					CN: 15-0104			
Cost				Component	CCN: 15-S104		Date/Time Pre	epared: 18 am
Cost   Cost   Reimbursed   Services   Subject To   Ded. & Cost				Title	XVIII	Subprovi der -		
Cost Center Description			_			I PF		
Reimbursed Sort (ces Subject To Ded & Coins (see inst.)   7.00								
ANCILLARY SERVICE COST CENTERS   Services Not   Subject To   Ded. & Coins.		Cost Center Description						
ANCILLARY SERVICE COST CENTERS								
Ded. & Col ns.   See inst.								
See inst.   See inst.								
ANCILLARY SERVICE COST CENTERS								
AMCILLARY SERVICE COST CENTERS								
50.00		ANCLILARY SERVICE COST CENTERS	0.00	7.00	l			
54. 00 05400 RADI OLOGY—DI AGNOSTI C 0 0 0 55. 00 05500 RADI OLOGY—THERAPEUTI C 0 0 0 55. 00 055. 00 05500 RADI OLOGY—THERAPEUTI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50 00			1				50.00
55. 00   05500   RADIOLOGY-THERAPEUTI C		l l	1	1				
55. 01   05501   ULTRA SOUND   0   0   0   55. 01		l l	l .	<b>1</b>				1
57, 00   05700   CT SCAN   57, 00   58, 00   5800   MAGNETIC RESONANCE IMAGING (MRI)   0   0   0   0   0   0   0   0   0		l l	0	o o				
59,00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   0   0   0   0   0   0	57. 00	l	0	1				1
59,00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   0   0   0   0   0   0	58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   64. 00   64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   65. 00   06600   PHYSI CAL THERAPY   0   0   0   0   67. 00   06700   OCCUPATI ONAL THERAPY   0   0   0   0   67. 01   06701   AUDI OLOGY   0   0   0   68. 00   06800   SPEECH PATHOLOGY   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   69. 01   06901   CARDI OLOGY   0   0   1   69. 01   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   73. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   594   73. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   594   73. 00   07200   CLI NI C   0   0   90. 01   90000   CLI NI C   0   0   90. 01   90000   CLI NI C   0   0   90. 02   90. 03   O9003   DERMATOLOGY CLI NI C   0   0   90. 04   90004   ENT CLI NI C   0   0   90. 05   09005   SURGERY CLI NI C   0   0   90. 07   09007   INDLOGY CLI NI C   0   0   90. 08   09009   O9009   CLI NI C   0   0   90. 09   09009   O9009   CLI NI C   0   0   90. 01   9001   THEROLOGY CLI NI C   0   0   90. 02   09009   O9009   CLI NI C   0   0   90. 01   09001   DIRLOGY CLI NI C   0   0   90. 02   09009   O9009   CLI NI C   0   0   90. 03   O9009   O9009   CLI NI C   0   0   90. 04   09009   O9009   CLI NI C   0   0   90. 05   O9009   O9009   O9009   O9009   O9009   O9009   O9009   90. 11   O9011   NEUROLOGY CLI NI C   0   0   90. 12   O9012   OPTHAMOLOGY CLI NI C   0   0   90. 13   O9013   ALLERGY CLI NI C   0   0   90. 14   O9014   WOUND CARE   0   84   91. 00   O9000   O9000   O9000   O9000   O9000   O9000   90. 00   O9000   O9000   O9000   O9000   O9000   O9000   90. 00   O9000   O9000   O9000   O9000   O9000   90. 00   O9000   O9000   O9000   O9000   O9000   90. 00   O9000   O9000   O9000   O9000   90. 00   O9000   O9000   O9000   O9000   90. 01   O9000   O9000   90. 01   O9000   O9000	59.00		0	0				
64. 00   06400   INTRAVENOUS THERAPY   0   0   0   066.00   06600   PHYSI CAL THERAPY   0   0   0   0   067.00	60.00	06000 LABORATORY	0	0				60.00
66.00   06600   PHYSI CAL THERAPY   0   0   0   0   0   0   0   0   0	63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 67. 00 67. 01 06701 AUDI OLOGY 0 0 0 67. 01 68. 00 06800 SPECH PATHOLOGY 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 69. 00 69. 01 06901 CARDI OLOGY 0 1 1 69. 01 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 594  DUTPATI ENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 0 0 0 90. 01 90. 01 09001 OTHER OUTPATI ENT SERVI CE COST CENTER 0 90. 01 90. 02 09002 CLI NI C 0 0 0 90. 02 90. 03 09003 DERMATOLOGY CLI NI C 0 0 0 90. 03 90. 04 09004 ENT CLI NI C 0 0 0 90. 03 90. 04 09004 ENT CLI NI C 0 0 0 90. 04 90. 05 09005 SURGERY CLI NI C 0 0 0 90. 05 90. 07 09007 UROLOGY CLI NI C 0 0 0 90. 05 90. 07 09007 UROLOGY CLI NI C 0 0 0 90. 05 90. 07 09007 UROLOGY CLI NI C 0 0 0 90. 05 90. 07 09007 UROLOGY CLI NI C 0 0 0 90. 05 90. 07 09007 UROLOGY CLI NI C 0 0 0 90. 05 90. 07 09007 UROLOGY CLI NI C 0 0 0 90. 05 90. 07 09007 UROLOGY CLI NI C 0 0 0 90. 05 90. 07 09007 UROLOGY CLI NI C 0 0 0 90. 07 90. 07 09007 UROLOGY CLI NI C 0 0 0 90. 07 90. 07 09007 UROLOGY CLI NI C 0 0 0 90. 07 90. 09 09009 GASTROENTEROLOGY CLI NI C 0 0 0 90. 07 90. 11 09011 NEUROLOGY CLI NI C 0 0 0 90. 11 90. 12 09012 DYHAMOLOGY CLI NI C 0 0 0 90. 12 90. 13 09013 ALLERGY CLI NI C 0 0 0 90. 13 90. 14 09014 WOUND CARE 0 0 84 90. 14 90. 14 WOUND CARE 0 0 90. 09 90. 10 09000 DEMERGENCY 0 0 0 90. 09 90. 10 09000 DEMERGENCY 0 0 0 0 90. 09 90. 10 09000 DEMERGENCY 0 0 0 0 90. 09 90. 10 09000 DEMERGENCY 0 0 0 0 90. 09 90. 10 09000 DEMERGENCY 0 0 0 0 0 90. 09 90. 10 09000 DEMERGENCY 0 0 0 0 0 90. 09 90. 10 09000 DEMERGENCY 0 0 0 0 0 0 90. 09 90. 10 09000 DEMERGENCY 0 0 0 0 0 0 0 90. 09 90. 10 09000 DEMERGENCY 0 0 0 0 0 0 0 90. 09 90. 10 09000 DEMERGENCY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	64.00	06400 I NTRAVENOUS THERAPY	0	0				64.00
67. 01	66.00	06600 PHYSI CAL THERAPY	0	0				66.00
68. 00		1 1	0	1				67.00
69. 00 06900   ELECTROCARDI OLOGY		1 1	1	_				
69. 01 06901 CARDI OLOGY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	1				1
71. 00			1	1				
72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   0   594   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   594   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   594   73. 00   00				l .				1
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   594   73. 00   0000   0			1	1				1
OUTPATIENT SERVICE COST CENTERS   O								
90. 00   09000   CLINIC   00   00   00   00   00   00   00	73.00	OUTDATIENT SERVICE COST CENTERS		1 594				/3.00
90. 01   09001   07HER OUTPATIENT SERVICE COST CENTER   0   0   0   0   90. 02   90. 02   90. 03   09002   CLINIC   0   0   0   0   0   90. 03   90. 04   09004   ENT CLINIC   0   0   0   0   0   90. 05   90. 05   09005   SURGERY CLINIC   0   0   0   0   0   90. 05   90. 07   09007   UROLOGY CLINIC   0   0   0   0   90. 07   90. 09   09009   GASTROENTEROLOGY CLINIC   0   0   0   90. 07   90. 11   09011   NEUROLOGY CLINIC   0   0   0   0   90. 11   90. 12   09012   0PTHAMOLOGY CLINIC   0   0   0   90. 12   90. 13   09013   ALLERGY CLINIC   0   0   0   90. 13   90. 14   09014   WOUND CARE   0   84   90. 14   91. 00   09100   EMERGENCY   0   0   0   92. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   0   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   0   0   0	on nn			1				90 00
90. 02   09002   CLINIC   0   0   0   90. 02   90. 03   09003   DERMATOLOGY CLINIC   0   0   0   0   90. 03   90. 04   09004   ENT CLINIC   0   0   0   0   0   90. 04   90. 05   09005   SURGERY CLINIC   0   0   0   0   0   90. 05   90. 07   09007   UROLOGY CLINIC   0   0   0   0   90. 07   90. 09   09009   ASTROENTEROLOGY CLINIC   0   0   0   90. 11   09011   NEUROLOGY CLINIC   0   0   90. 11   90. 12   09012   OPTHAMOLOGY CLINIC   0   0   0   90. 12   90. 13   09013   ALLERGY CLINIC   0   0   0   90. 13   90. 14   09014   WOUND CARE   0   84   90. 14   91. 00   09100   EMERGENCY   0   0   0   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   92. 00   00   92. 00   09200		1	1	l .	1			1
90. 03   09003   DERMATOLOGY CLINIC   0   0   0   90. 03   90. 04   90. 04   90. 05   90. 05   90. 05   90. 05   90. 07   90. 07   90. 07   90. 07   90. 09   90. 07   90. 09   90. 07   90. 09   90. 11   90. 11   90. 12   90. 12   90. 13   90. 13   90. 13   90. 13   90. 14   90. 14   90. 14   90. 10   90. 15   90. 16   90. 17   90. 10								
90. 04   09004   ENT CLINIC   0   0   0   90. 04   90. 05   90. 05   90. 07   09007   URQLOGY CLINIC   0   0   0   0   90. 07   90. 09   09009   GASTROENTEROLOGY CLINIC   0   0   0   90. 11   09011   NEUROLOGY CLINIC   0   0   0   90. 11   90. 12   09012   09714   09012   09714   09013   ALLERGY CLINIC   0   0   0   0   90. 13   09013   ALLERGY CLINIC   0   0   0   90. 13   90. 14   09014   WOUND CARE   0   84   90. 14   91. 00   09100   EMERGENCY   0   0   0   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0   0   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0   0   0   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   0   0   0								1
90. 05   09005   SURGERY CLINIC   0   0   0   90. 05   90. 07   09007   UROLOGY CLINIC   0   0   0   90. 07   90. 09   09009   GASTROENTEROLOGY CLINIC   0   0   0   90. 09   90. 11   09011   NEUROLOGY CLINIC   0   0   0   90. 11   90. 12   09012   OPTHAMOLOGY CLINIC   0   0   0   90. 12   90. 13   09013   ALLERGY CLINIC   0   0   0   90. 13   90. 14   09014   WOUND CARE   0   84   90. 14   91. 00   09100   EMERGENCY   0   0   0   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   92. 00								1
90. 09   09009   GASTROENTEROLOGY CLINIC   0   0   0   90. 09   90. 11   09011   NEUROLOGY CLINIC   0   0   0   90. 11   90. 12   09012   OPTHAMOLOGY CLINIC   0   0   0   90. 12   90. 13   09013   ALLERGY CLINIC   0   0   0   90. 13   90. 14   09014   WOUND CARE   0   84   90. 14   91. 00   09100   EMERGENCY   0   0   0   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   0   92. 00   09200   0950		l	0	0				1
90. 09   09009   GASTROENTEROLOGY CLINIC   0   0   0   90. 09   90. 11   09011   NEUROLOGY CLINIC   0   0   0   90. 11   90. 12   09012   OPTHAMOLOGY CLINIC   0   0   0   90. 12   90. 13   09013   ALLERGY CLINIC   0   0   0   90. 13   90. 14   09014   WOUND CARE   0   84   90. 14   91. 00   09100   EMERGENCY   0   0   0   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   0   92. 00   09200   0950		l l						
90. 12   09012   0PTHAMOLOGY CLINIC   0   0   90. 12   90. 13   09013   ALLERGY CLINIC   0   0   90. 13   90. 14   09014   WOUND CARE   0   84   90. 14   91. 00   09100   EMERGENCY   0   0   0   092. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0   0   0   92. 00   092			0	0				1
90. 13   09013   ALLERGY CLINIC   0   0   90. 13   90. 14   09014   WOUND CARE   0   84   90. 14   91. 00   09100   EMERGENCY   0   0   0   092. 00   09200   OBSERVATION   BEDS (NON-DISTINCT PART)   0   0   0   0   0   92. 00   092. 00	90. 11	09011 NEUROLOGY CLINIC	0	0				90. 11
90. 14   09014   WOUND CARE   0   84   90. 14   91. 00   92. 00   09200   OBSERVATION   BEDS (NON-DISTINCT PART)   0   0   0   92. 00   92. 00   93. 00   94. 00   95	90. 12	09012 OPTHAMOLOGY CLINIC	0	0				90. 12
91. 00   09100   EMERGENCY   0   0   0   92. 00   09200   0BSERVATION   BEDS (NON-DISTINCT PART)   0   0   0   92. 00	90. 13	09013 ALLERGY CLINIC	0	0				90. 13
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92. 00	90. 14	09014 WOUND CARE	0	84				90. 14
			1	1	•			1
	92.00		0	0				92.00

0

681

681

95.00

200.00 201.00 202.00

	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	WI THAM MEMORI		ON 15 0104	T D -		u of Form CMS-:	2552-10
	TONMENT OF INPATTENT/OUTPATTENT ANCILLARY SER SH COSTS	RVICE UTHER PAS	SS Provider C	UN: 15-0104	Fr	eriod: com 01/01/2019	Worksheet D Part IV	
THROOG	66516		Component	CCN: 15-5832	To			pared:
			Title	XVIII	Sł	killed Nursing		<u>o un </u>
		I. 5			Щ	Facility		
	Cost Center Description	Non Physician Anesthetist	Nursi ng School	Nursi ng School		Allied Health Post-Stepdown	Allied Health	
		Cost	Post-Stepdown	SCHOOL		Adj ustments		
		0031	Adjustments			Auj us tillerits		
		1. 00	2A	2. 00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0		0	0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
55.00	05500  RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
55. 01	05501 ULTRA SOUND	0	0		0	0	0	55. 01
57. 00	05700 CT SCAN	0	0		0	0	0	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60.00	06000 LABORATORY	0	0		0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	0	0	64.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	66. 00 67. 00
67. 00	06700 OCCOPATIONAL THERAPT	0	0		0	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0			0	0	0	
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	Ö	69.00
69. 01	06901 CARDI OLOGY	0	0		0	0	Ö	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0	l o		0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLI NI C	0	0		0	0	0	90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	0	0	
90. 02	09002 CLI NI C	0	0		0	0	0	
90. 03	09003 DERMATOLOGY CLINIC	0	0		0	0	0	
90. 04	09004 ENT CLINIC	0	0		0	0	0	90. 04
90.05	09005 SURGERY CLINIC	0	0		0	0	0	
90. 07	09007 UROLOGY CLINIC	0	0		0	0	0	90.07
90.09	09009 GASTROENTEROLOGY CLINIC	0	0		0	0	0	90.09
90. 11	09011 NEUROLOGY CLINIC	0	0		0	0	0	90. 11
90. 12	O9012   OPTHAMOLOGY   CLINI C   O9013   ALLERGY   CLINI C				0	0	0	90. 12 90. 13
90. 13	09014 WOUND CARE				0	0	0	90. 13
91. 00	09100 EMERGENCY				0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		١		0	U	0	92.00
,2.00	OTHER RELIGIOUS ARE COST CENTERS		1				·	1 /2.00

0

0

95.00

0 200.00

90. 14 09014 WOUND CARE
91. 00 09100 EMERGENCY
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES
200. 00 Total (Lines 50 through 199)

Health Financi	al Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	OF INPATIENT/OUTPATIENT ANCILLARY SE	ERVICE OTHER PAS			Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Pre 3/31/2020 8:1	pared: 8 am
			Title	e XVIII	Skilled Nursing Facility	PPS	
С	ost 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)		·	
		4. 00	5. 00	6. 00	7. 00	8. 00	
ANCI LLA	ARY SERVICE COST CENTERS						
50.00 05000 0	PERATING ROOM	0	0	)	52, 732, 763	0.000000	50.00
54.00 05400 R	ADI OLOGY-DI AGNOSTI C	0	0	)	0 34, 483, 364	0.000000	54.00
55. 00   05500 R	ADI OLOGY-THERAPEUTI C	0	0	)	0	0.000000	55.00
55. 01   05501 U	LTRA SOUND	0	0	)	9, 156, 109	0.000000	55. 01
57.00 05700 C	T SCAN	0	0	)	0 45, 514, 164	0.000000	57.00
58.00 05800 M	AGNETIC RESONANCE IMAGING (MRI)	0	0	)	0 17, 071, 948	0.000000	58.00
59.00 05900 C	ARDIAC CATHETERIZATION	0	0	)	0 17, 716, 676	0.000000	59.00
60.00 06000 L	ABORATORY	0	0	)	0 58, 524, 884	0.000000	60.00
63. 00 06300 B	LOOD STORING, PROCESSING & TRANS.	0	0	)	0 1, 115, 505	0.000000	63.00
64. 00 06400 I	NTRAVENOUS THERAPY	0	0	)	3, 398, 014	0.000000	64.00
66. 00 06600 P	HYSI CAL THERAPY	0	0	)	0 8, 292, 784	0.000000	66.00
67.00 06700 0	CCUPATI ONAL THERAPY	0	0	)	3, 716, 264	0.000000	67.00
67. 01 06701 A	UDI OLOGY	0	0	)	950, 473	0.000000	67.01
68 00 106800 5	PEECH PATHOLOGY	1	l o	d (	1 157 664	0.000000	68 00

	Financial Systems	WI THAM MEMORIAL		ON 45 0404		u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der Co	JN: 15-0104	Peri od: From 01/01/2019	Worksheet D Part IV	
THROUG	H C0313		Component	CCN: 15-5832	To 12/31/2019	Date/Time Pre 3/31/2020 8:1	pared:
							8 am
			litle	XVIII	Skilled Nursing Facility	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		Pass-Through	
		(col. 6 ÷		Costs (col.	8	Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	0. 000000	63, 565		0 0	0	
54.00	05400  RADI OLOGY-DI AGNOSTI C	0. 000000	39, 577		0	0	54.00
55.00	05500  RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	55.00
55. 01	05501 ULTRA SOUND	0. 000000	2, 453		0	0	55. 01
57.00	05700  CT SCAN	0. 000000	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	26, 534		0 0	0	59.00
60.00	06000 LABORATORY	0. 000000	244, 122		0 0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	15, 511		0 0	0	64.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	1, 111, 384		0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	1, 199, 192		0 0	0	67.00
67.01	06701 AUDI OLOGY	0. 000000	0		0 0	0	67.01
68.00	06800 SPEECH PATHOLOGY	0. 000000	66, 995		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
69. 01	06901 CARDI OLOGY	0. 000000	513, 147		0 0	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	148, 488		0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 208, 563		0 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000  CLI NI C	0. 000000	0		0 0	0	90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	0		0 0	0	90. 01
90. 02	09002  CLI NI C	0. 000000	0		0 0	0	90.02
90. 03	09003 DERMATOLOGY CLINIC	0. 000000	0		0 0	0	90.03
90. 04	09004  ENT CLINIC	0. 000000	0		0	0	90.04
90. 05	09005 SURGERY CLINIC	0. 000000	0		0 0	0	90.05
90. 07	09007 UROLOGY CLINIC	0. 000000	0		0 0	0	90. 07
90.09	09009 GASTROENTEROLOGY CLINIC	0. 000000	0		0 0	0	90.09
90. 11	09011 NEUROLOGY CLINIC	0. 000000	0		0 0	0	90. 11
90. 12	09012 OPTHAMOLOGY CLINIC	0. 000000	0		0 0	0	90. 12
90. 13	09013 ALLERGY CLINIC	0. 000000	0		0 0	0	
90. 14	09014 WOUND CARE	0. 000000	122		0 0	0	90. 14
91.00	09100 EMERGENCY	0. 000000	672		0 0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95.00
200.00		1	4, 640, 325		0 0		200.00

Title XVIII Skilled Nursing **PPS** Facility Charges Costs PPS Cost Center Description Cost to Cost Cost PPS Services Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) Services (see From Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 111015 0 50.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 o 54 00 0 235208 54 00 0 0 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0.000000 0 0 55.00 55.01 05501 ULTRA SOUND 0.112111 0 0 0 55.01 57.00 05700 CT SCAN 0.026803 0 0 139 0 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 58.00 0.071905 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.103245 0 0 59.00 06000 LABORATORY 0 60.00 0.166339 0 0 0 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.203930 0 0 63.00 63.00 0 64.00 06400 I NTRAVENOUS THERAPY 0.001575 0 0 64.00 06600 PHYSI CAL THERAPY 0. 415716 0 0 66.00 0 0 0 66.00 06700 OCCUPATI ONAL THERAPY 0. 194345 0 67.00 67.00 0 0 06701 AUDI OLOGY 67.01 0.267252 0 0 67.01 68.00 06800 SPEECH PATHOLOGY 0.300227 0 0 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 69.00 69.00 06901 CARDI OLOGY 0.140252 0 0 0 69.01 16 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 71.00 0.416387 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 366624 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.123113 0 0 5, 101 0 73.00 OUTPATIENT SERVICE COST CENTERS 90 00 90.00 09000 CLI NI C 0.000000 0 0 0 90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER 0.000000 0 0 0 0 90.01 09002 CLI NI C 0 90. 02 0.000000 0 0 0 0 0 0 0 0 90.02 09003 DERMATOLOGY CLINIC 0.000000 0 0 90.03 90.03 0 90.04 09004 ENT CLINIC 0.000000 0 0 90.04 90.05 09005 SURGERY CLINIC 0.000000 0 90.05 09007 UROLOGY CLINIC 0 0 90.07 0.000000 0 90.07 09009 GASTROENTEROLOGY CLINIC 0 90 09 0.000000 0 90.09 0 90. 11 09011 NEUROLOGY CLINIC 0.000000 0 0 90.11 09012 OPTHAMOLOGY CLINIC 0 90. 12 90. 12 0.000000 0 0 0 8 0 09013 ALLERGY CLINIC 0 0.309534 90.13 90.13 0 0 09014 WOUND CARE 0 90.14 0. 205709 0 90.14 91.00 09100 EMERGENCY 0.172311 0 0 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0. 492018 0 0 92.00 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0. 933127 0 95.00 200.00 Subtotal (see instructions) 0 0 5, 264 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00

0

5, 264

0 202.00

Only Charges

Net Charges (line 200 - line 201)

202.00

Heal th	Financial Systems	WITHAM MEMORI	ΔΙ ΗΟΚΡΙΤΔΙ		In lie	u of Form CMS-	2552_10
	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND			CN: 15-0104	Peri od:	Worksheet D	2332-10
ALLOK	TIONWENT OF WEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	i i ovi dei c	CN. 13-0104	From 01/01/2019	Part V	
			Component	CCN: 15-5832	To 12/31/2019	Date/Time Pre	epared:
			Ti +L	e XVIII	Skilled Nursing	3/31/2020 8: 1 PPS	18 am
			11 (1)	ZVIII	Facility	FF3	
		Cos	sts		Tuoi i ty		
	Cost Center Description	Cost	Cost	1			
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
	TANGLEL ARV. GERVI GE GOOT GENTERO	6. 00	7.00				
FO 00	ANCI LLARY SERVI CE COST CENTERS						
	05000 OPERATING ROOM	0		1			50.00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	0		1			54.00
55. 00	05500  RADI OLOGY-THERAPEUTI C   05501  ULTRA SOUND	0					55.00
55. 01		0		1			55. 01
57. 00 58. 00	05700 CT SCAN	0		1			57.00
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	1	1			58. 00 59. 00
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0		1			
60. 00 63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		`	1			60.00
64. 00	06400 I NTRAVENOUS THERAPY			1			64.00
66. 00	06600 PHYSI CAL THERAPY		`	1			66.00
67. 00	06700 OCCUPATI ONAL THERAPY		-	1			67. 00
67. 01	06701 AUDI OLOGY		1	1			67. 01
68. 00	06800 SPEECH PATHOLOGY		1	1			68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	1	1			69.00
	06901 CARDI OLOGY	0	`	1			69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		1			71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0		1			72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0		1			73. 00
	OUTPATIENT SERVICE COST CENTERS	,		'			
90.00	09000 CLI NI C	0	(				90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	(				90. 01
90.02	09002 CLI NI C	0	(				90.02
90. 03	09003 DERMATOLOGY CLINIC	0	(				90.03
90.04	09004 ENT CLINIC	0	(				90.04
90. 05	09005 SURGERY CLINIC	0	(				90.05
90. 07	09007 UROLOGY CLINIC	0	(	)			90.07
90. 09	09009 GASTROENTEROLOGY CLINIC	0	C	1			90.09
90. 11	09011 NEUROLOGY CLINIC	0	1	1			90. 11
	09012 OPTHAMOLOGY CLINIC	0	(	1			90. 12
	09013 ALLERGY CLINIC	0		•			90. 13
	09014 WOUND CARE	0	_				90. 14
91.00	09100 EMERGENCY	0					91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	(	)			92.00

0

636

636

92.00 95.00

200.00 201.00

202.00

91.00 O9100 EMERGENCY
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS
95.00 O9500 AMBULANCE SERVICES
200.00 Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges
202.00 Net Charges (line 200 - line 201)

Health Financial Systems	WITHAM MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0104	Peri od: From 01/01/2019	Worksheet D-1	
			To 12/31/2019		
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1.00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
1.00 Inpatient days (including private room days and swing-bed days, excluding newborn)					1.00
2.00 Inpatient days (including private room days, excluding swing-bed and newborn days)				7, 486	2.00
					1 2 22

	Cost Center Description		
	NACT LAND PROVIDED COMPONENTS	1. 00	
	PART I - ALL PROVIDER COMPONENTS		
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days, excluding newborn)	7, 486	1. 00
2. 00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7, 486	2. 00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	7, 400	3. 00
3.00	do not complete this line.	۷	3.00
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	5, 428	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
3.00	reporting period	ĭ	3.00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	o	6.00
0.00	reporting period (if calendar year, enter 0 on this line)	Ĭ	0.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	o	7.00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)		
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	2, 125	9.00
	newborn days)		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)	_	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
10.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		10.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	o	13. 00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	٥	13.00
14. 00	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)	0	15. 00
16. 00	Nursery days (title V or XIX only)	0	16. 00
10.00	SWING BED ADJUSTMENT		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	Medicaid rate 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
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	9, 486, 764	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
00.00	5 x line 17)		00.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
24. 00	x line 18)   Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
24.00	7 x line 19)	٥	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
25.00	In string 20)	ĭ	23.00
26. 00	Total swing-bed cost (see instructions)	o	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9, 486, 764	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00		0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	o	29.00
30.00	Semi - pri vate room charges (excluding swing-bed charges)	o	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0. 00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	9, 486, 764	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 267. 27	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2, 692, 949	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0 0 0 0 0 0 0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2, 692, 949	41.00

	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)		
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7.00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)		
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	2, 125	9.00
	newborn days)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	
15. 00	Total nursery days (title V or XIX only)	0	
16. 00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17.00
40.00	reporting period	0.00	40.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
40.00	reporting period	0.00	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
20.00	reporting period	0.00	20.00
20. 00	Medical drate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20. 00
21 00	reporting period	9, 486, 764	21. 00
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	0	22.00
23. 00	5 x line 17)   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
23.00	Ix line 18)	0	23.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
24.00	7 x line 19)	U	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
23.00	x line 20)	O	23.00
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)	9, 486, 764	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	7, 100, 701	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)	0	
30.00	Semi - pri vate room charges (excluding swing-bed charges)	0	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32. 00			32.00
33. 00	Average semi-private room per diem charge (line 30 + line 4)		33.00
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		34.00
35. 00	Average per diem private room cost differential (line 34 x line 31)		35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	9, 486, 764	
	27 minus line 36)	.,,	
	PART II - HOSPITÁL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 267. 27	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2, 692, 949	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	
	Total Program general inpatient routine service cost (line 39 + line 40)	2, 692, 949	41.00
			,

26. 00	Total swing-bed cost (see instructions)	0	26.0
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9, 486, 764	27.0
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.0
29.00	Private room charges (excluding swing-bed charges)	0	29.0
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.0
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.0
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.0
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.0
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.0
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.0
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.0
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	9, 486, 764	37. C
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 267. 27	38.0
39.00	Program general inpatient routine service cost (line 9 x line 38)	2, 692, 949	39.0
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.0
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2, 692, 949	41.0
		,	

Heal th	ı Financial Systems WITHAM MEMORIAL HOSPITAL In Li	eu of Form CMS-2	2552-10			
COMPUT	FATION OF INPATIENT OPERATING COST Provider CCN: 15-0104 Period: From 01/01/201	Worksheet D-1				
	To 12/31/201	9 Date/Time Pre				
	Title XVIII Hospital	3/31/2020 8: 18 PPS	8 alli			
	Cost Center Description Total Total Average Per Program Days					
	Inpatient   Inpatient   Diem (col. 1   Cost   Days   ÷ col. 2)	(col. 3 x col. 4)				
	1.00 2.00 3.00 4.00	5. 00				
42. 00	NURSERY (title V & XIX only) 0 0 0.00 Intensive Care Type Inpatient Hospital Units	0 0	42. 00			
43.00	INTENSIVE CARE UNIT 2,851,261 1,705 1,672.29 78	1 1, 306, 058	43.00			
44.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT		44. 00 45. 00			
46.00			46.00			
47. 00	OTHER SPECIAL CARE (SPECIFY)		47. 00			
	Cost Center Description	1.00				
48. 00		3, 567, 399				
49. 00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)  PASS THROUGH COST ADJUSTMENTS	7, 566, 406	49. 00			
50.00		nd 308, 604	50.00			
F1 00		150 222	F1 00			
51. 00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts I and IV)	159, 332	51.00			
52.00	Total Program excludable cost (sum of lines 50 and 51)	467, 936				
53. 00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	7, 098, 470	53.00			
	TARGET AMOUNT AND LIMIT COMPUTATION					
54. 00 55. 00	Program di scharges Target amount per di scharge	0.00				
56.00		0.00	56.00			
57.00		0	57.00			
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the	0 ne 0.00	58. 00 59. 00			
	market basket					
60. 00 61. 00		0.00	60. 00 61. 00			
01.00	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target					
62. 00	amount (line 56), otherwise enter zero (see instructions) Relief payment (see instructions)	0	62. 00			
63.00						
(4.00	PROGRAM INPATIENT ROUTINE SWING BED COST					
64. 00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (Serinstructions)(title XVIII only)		64.00			
65.00		0	65. 00			
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For	0	66. 00			
	CAH (see instructions)		<b>.</b>			
67. 00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67. 00			
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period	0	68. 00			
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69. 00			
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70. 00 71. 00			70. 00 71. 00			
72.00			72.00			
73. 00 74. 00	Medically necessary private room cost applicable to Program (line 14 x line 35)  Total Program general inpatient routine service costs (line 72 + line 73)		73. 00 74. 00			
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column	1	74. 00 75. 00			
7/ 00	26, line 45)		7/ 00			
76. 00 77. 00			76. 00 77. 00			
78. 00	Inpatient routine service cost (line 74 minus line 77)		78. 00			
79. 00 80. 00	1 33 3 7		79. 00 80. 00			
81. 00	Inpatient routine service cost per diem limitation		81.00			
82. 00 83. 00			82. 00 83. 00			
84. 00			84.00			
85.00	Utilization review - physician compensation (see instructions)		85.00			
86.00	Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		86. 00			
87.00	Total observation bed days (see instructions)	2, 058	87.00			
88. 00 89. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) Observation bed cost (line 87 x line 88) (see instructions)	1, 267. 27 2, 608, 042	88. 00 89. 00			
57.00	Table in the cost (Time of A Time cost (See Time dott only)	2,000,042	37.00			

Health Financial Systems	WITHAM 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 01/01/2019 To 12/31/2019		
		Title	XVIII	Hospi tal	PPS	
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	778, 848	9, 486, 764	0. 08209	8 2, 608, 042	214, 115	90.00
91.00 Nursing School cost	0	9, 486, 764	0.00000	0 2, 608, 042	0	91.00
92.00 Allied health cost	0	9, 486, 764	0.00000	0 2, 608, 042	0	92.00
93.00 All other Medical Education	0	9, 486, 764	0. 00000	0 2, 608, 042	0	93.00

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0104		Worksheet D-1	
		From 01/01/2019		
	Component CCN: 15-S104	To 12/31/2019	Date/Time Pre	pared:
	·		3/31/2020 8: 1	8 am
	Title XVIII	Subprovi der -	PPS	
		I PF		

			I PF		
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			3, 211	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		ivate room days	3, 211 0	2. 00 3. 00
3. 00	do not complete this line.	ys). It you have only pr	rvate room days,	O	3.00
4. 00	Semi-private room days (excluding swing-bed and observation b			3, 211	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)			_	
7. 00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swi ng-bed and	2, 535	9. 00
10. 00	newborn days)   Swing-bed SNF type inpatient days applicable to title XVIII o	nlv (including private r	oom davs)	0	10.00
	through December 31 of the cost reporting period (see instruc	tions)		_	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.00
12.00	through December 31 of the cost reporting period	A only (merdaring private	o room days)	· ·	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.00
14. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14. 00
15. 00	Total nursery days (title V or XIX only)	aii (excruding swing-bed	uays)	0	15. 00
16.00	Nursery days (title V or XIX only)			0	16. 00
47.00	SWING BED ADJUSTMENT	The state of the s	C 11	0.00	17.00
17. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es through December 31 o	r the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18. 00
10.00	reporting period		*	0.00	10.00
19. 00	Medicald rate for swing-bed NF services applicable to service reporting period	s through becember 31 or	the cost	0.00	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to service	s after December 31 of t	ne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instruction	s)		2, 903, 274	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line		22. 00
22.00	5 x line 17)	21 -6		0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 or the cost reporting	g period (iine o	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)	or or the edet reperting	po ou ( o	· ·	
	Total swing-bed cost (see instructions)	(Line 21 minus Line 24)		0 2, 903, 274	26.00
27.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TITIE 21 IIIITIUS TITIE 20)		2, 903, 274	27.00
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	28. 00
	Private room charges (excluding swing-bed charges)			0	29.00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	· lino 29)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	- 111le 20)		0.00000	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34. 00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0. 00	
35.00	Average per diem private room cost differential (line 34 x li		,	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	- /		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line		37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see		T	904. 17	38, 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		2, 292, 071	39. 00
	Medically necessary private room cost applicable to the Progr			0	
41.00	Total Program general inpatient routine service cost (line 39	+ IINe 40)		2, 292, 071	41.00

	Financial Systems	WITHAM MEMORIA				u of Form CMS-:	
COMPUT	TATION OF INPATIENT OPERATING COST			CN: 15-0104	Peri od: From 01/01/2019	Worksheet D-1	
				CCN: 15-S104	To 12/31/2019	3/31/2020 8: 1	
			Title	e XVIII	Subprovi der  - I PF	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)		Program Cost (col. 3 x col. 4)	
40.00	AMIDOEDY (1: 11 - V o VIV - 1 )	1.00	2. 00	3.00	4.00	5. 00	40.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0. (	00 0	0	42.00
43.00	INTENSIVE CARE UNIT	0	C	0. (	0 00	0	
44. 00 45. 00	BURN INTENSIVE CARE UNIT						44. 00 45. 00
	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47.00
40.00	Danier i gati at anillani anila anila ant (Wi	-+ D 21 2	1 1: 200)			1.00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ons)		240, 024 2, 532, 095	
FO 00	PASS THROUGH COST ADJUSTMENTS	ationt routing	complete (Fre	m Wko+ D ou	m of Donto L and	207 140	FO 00
50. 00	Pass through costs applicable to Program inp	attent routine	services (Tro	m WKSL. D, SL	im or Parts I and	207, 160	50.00
51. 00	Pass through costs applicable to Program inp and IV)	atient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	6, 303	51.00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		طع معم ما	valalan anaat	hatiat and	213, 463	1
33.00	medical education costs (line 49 minus line		rateu, non-pn	ysi ci aii aliest	metrst, and	2, 318, 632	33.00
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55. 00							55.00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	rget amount (	line 56 minus	Line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)					0	
59. 00	59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 [					59.00	
60.00	60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00					1	
61. 00	61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target					61.00	
42.00	amount (line 56), otherwise enter zero (see instructions)					0	42.00
	62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	
PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See					0	64.00	
65. 00	instructions)(title XVIII only)					0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only) For	0	66. 00
	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin				-		67.00
	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	_					68.00
68. 00	(line 13 x line 20)			•	on tring perrou		
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70.00	Skilled nursing facility/other nursing facil				')		70.00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine /U ÷ iine	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applic	abĺe to Program					73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient			•	Part II. column		74. 00 75. 00
	26, line 45)		,		,		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	. *					76. 00 77. 00
	Inpatient routine service cost (line 74 minu	s line 77)					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus line 79)		79. 00 80. 00
81.00	Inpatient routine service cost per diem limi	tati on		,	, i		81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (		* .				82. 00 83. 00
84.00	Program inpatient ancillary services (see in	structions)					84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
00.00	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	ii ougii oo <i>)</i>				
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	line 2)			0 00	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (se	•	,				89. 00

Health Financial Systems	WITHAM 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	
		Component (	CCN: 15-S104	From 01/01/2019 To 12/31/2019		pared: 8 am
		Title	XVIII	Subprovi der -	PPS	
				I PF		
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	262, 409	2, 903, 274	0. 09038	34 0	0	90.00
91.00 Nursing School cost	0	2, 903, 274	0. 00000	00	0	91.00
92.00 Allied health cost	0	2, 903, 274	0. 00000	00	0	92.00
93.00 All other Medical Education	0	2, 903, 274	0. 00000	00	0	93.00

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0104	Peri od: From 01/01/2019	Worksheet D-1
	Component CCN: 15-5832		
	Title XVIII	Skilled Nursing	PPS
		Facility	
Cost Center Description			

		II the Aviii	Facility	FF3	
	Cost Center Description		,		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day	s, excluding newborn)		5, 125	1.00
2. 00	Inpatient days (including private room days, excluding swing-			5, 125	•
3. 00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ys). If you have only pr	ivate room days,	0	3.00
4. 00	Semi-private room days (excluding swing-bed and observation b	ed days)		5, 125	4.00
5. 00	Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost	0	5.00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private re	om days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7. 00
7.00	reporting period	dayo, t oag boodbo.	0. 0. 1 0001	Ü	7.00
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	o the Drogram (eveluding	swing had and	3, 051	9. 00
9.00	newborn days)	o the Program (excruding	Swifig-bed and	3,031	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	oom days)	0	10.00
	through December 31 of the cost reporting period (see instruc				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		oom days) after	0	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.00
	through December 31 of the cost reporting period	3			
13.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.00
14. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr	ear, enter 0 on this lin	e)	0	14.00
15. 00	Total nursery days (title V or XIX only)	am (excluding swing-bed	uays)	0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
	SWI NG BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18.00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through December 31 of	the cost	0. 00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0.00	20.00
	reporting period				
21. 00	Total general inpatient routine service cost (see instruction		ing ported (line	3, 142, 051	1
22. 00	Swing-bed cost applicable to SNF type services through Decemb $5 \times 1$ line 17)	er 31 of the cost report	ing period (iine	0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23.00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through Decembe $7 \times 1$ (ine 19)	r 31 of the cost reporti	ng period (line	0	24.00
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)	(line 21 minus line 24)		0 3, 142, 051	26. 00 27. 00
27.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TTHE 21 IIITHUS TTHE 20)		3, 142, 031	27.00
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	28. 00
	Private room charges (excluding swing-bed charges)			0	1
30.00	Semi-private room charges (excluding swing-bed charges)	. line 29)		0 000000	
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	- ITTIE 26)		0. 000000 0. 00	1
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	1
34.00	Average per diem private room charge differential (line 32 mi		tions)	0. 00	1
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	ł
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	0 3, 142, 051	36. 00 37. 00
37.00	27 minus line 36)			5, 172, 031	] 57.00
	PART II - HOSPITÁL AND SUBPROVIDERS ONLY				
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ		1		20 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	•			38. 00 39. 00
40. 00	Medically necessary private room cost applicable to the Progr				40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)			41.00

	Financial Systems	WITHAM MEMORI					
COMPUT	ATION OF INPATIENT OPERATING COST			CN: 15-0104 CCN: 15-5832	Peri od: From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:
			Ti tl e	e XVIII	Skilled Nursing	3/31/2020 8: 1 PPS	8 am
	Cost Center Description	Total I npati ent Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)		Program Cost (col. 3 x col. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.00
43.00	INTENSIVE CARE UNIT						43.00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col.	3, line 200)			1. 00	48. 00
49. 00	Total Program inpatient costs (sum of lines			ons)			49. 00
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program input	atient routine	services (fro	m Wkst. D, s	um of Parts I and	1	50.00
51. 00	III) Pass through costs applicable to Program inp	atient ancilla	rv services (f	rom Wkst D	sum of Parts II		51.00
	and IV)		. ,				
52. 00 53. 00	Total Program excludable cost (sum of lines I Total Program inpatient operating cost exclu		elated, non-ph	ysician anes	thetist, and		52. 00 53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)		-			
	Program di scharges						54.00
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)						55. 00 56. 00
57.00	Difference between adjusted inpatient operat	ing cost and t	arget amount (	line 56 minus	s line 53)		57.00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and	compounded by the	•	58. 00 59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report u	ndated by the	market haske	<b>.</b>		60.00
61.00	If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the les	ser of 50% o	f the amount by		61.00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		ts (lines 54 x	60), or 1% (	of the target		
62.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ont (soo instr	ueti one)				62. 00 63. 00
	PROGRAM INPATIENT ROUTINE SWING BED COST						03.00
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dec	ember 31 of th	e cost repor	ting period (See		64. 00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decem	ber 31 of the	cost reporti	ng period (See		65.00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XV	II only). For		66.00
67 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	e costs throug	h December 31	of the cost	reporting period		67.00
	(line 12 x line 19)	9					
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after	December 31 of	the cost re	porting period		68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NI		•				69. 00
70.00	Skilled nursing facility/other nursing facil	ity/ICF/IID ro	utine service	cost (line 3	7)	3, 142, 051	70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		line 70 ÷ line	2)		613. 08 1, 870, 507	
73.00	Medically necessary private room cost application	abĺe to Progra				0	73. 00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		•	Part II, column	1, 870, 507 0	74. 00 75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)				0. 00	76. 00
77. 00	Program capital-related costs (line 9 x line	76)				0	77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu: Aggregate charges to beneficiaries for exces:		provi der recor	ds)		0	78. 00 79. 00
80. 00 81. 00	Total Program routine service costs for compa	arison to the	•	*.	nus line 79)	0 0. 00	80.00
82.00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I	ine 9 x line 8	•			0	82.00
83. 00 84. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in:		ns)			1, 870, 507 1, 057, 932	1
85.00	Utilization review - physician compensation	(see instructi				0	85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS					2, 928, 439	86. 00
87. 00 88. 00	Total observation bed days (see instructions	)				0 0. 00	1
	Adjusted general inpatient routine cost per observation bed cost (line 87 x line 88) (see					0.00	

Health Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co	CN: 15-0104	Peri od:	Worksheet D-1	
			0011 45 5000	From 01/01/2019		
		Component	CCN: 15-5832	To 12/31/2019	Date/Time Pre 3/31/2020 8:1	
		Title	XVIII	Skilled Nursing		
				Facility		
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	0	0	0. 00000	00	0	90.00
91.00 Nursing School cost	0	0	0. 00000	00	0	91.00
92.00 Allied health cost	0	0	0. 00000	00	0	92.00
93.00 All other Medical Education	0	0	0. 00000	00	0	93.00

Heal th	Financial Systems	WITHAM MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10		
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0104	Peri od: From 01/01/2019	Worksheet D-1			
				To 12/31/2019	Date/Time Pre 3/31/2020 8:1	pared: 8 am		
			Title XIX	Hospi tal	Cost			
	Cost Center Description							
	·				1. 00			
	PART I - ALL PROVIDER COMPONENTS							
	I NPATI ENT DAYS							
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn) 7,486 1.							
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days) 7,486 2							
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.							

	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7, 486	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7, 486	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.00
4 00	do not complete this line.	F 400	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation bed days)	5, 428	4. 00 5. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	۷	5.00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	Ĭ	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7.00
	reporting period		
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	247	0 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	317	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)	ĭ	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
12.00	through December 31 of the cost reporting period		12 00
13. 00	Swing-bed NF 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)	0	13. 00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
	Total nursery days (title V or XIX only)	-	15. 00
	Nursery days (title V or XIX only)	0	
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
40.00	reporting period		40.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
19. 00	reporting period  Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
17.00	reporting period	0.00	17.00
20.00	Medicaid rate 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)	9, 486, 764	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	. 0	22. 00
23. 00	5 x line 17)   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	. 0	23. 00
23.00	Swifing to the cost appropriate to Swiftype services after becember 31 of the cost reporting period (This e	٥	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	o	24.00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
07.00	x line 20)		04 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	0 9, 486, 764	26. 00 27. 00
27.00	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT	7, 400, 704	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi -pri vate room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	
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 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line	0 9, 486, 764	36. 00 37. 00
37.00	27 minus line 36)	7, 400, 704	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 267. 27	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	401, 725	
	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)	401, 725	41.00

reporting period (if calendar year, enter 0 on this line)  7. 00 Total sing-bed NF type inpatient days (including private room days) through December 31 of the cost of the co	6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
reporting period  8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)  10. 00 Swing-bed Swinger 3 of the cost reporting period (including private room days)  11. 00 Swing-bed Swinger 3 of the cost reporting period (including private room days) after polescenber 31 of the cost reporting period (including private room days) after polescenber 31 of the cost reporting period (including private room days) after polescenber 31 of the cost reporting period (including private room days) after polescenber 31 of the cost reporting period (including private room days)  12. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days)  15. 00 Total nursery days (title V or XIX only)  16. 00 Nursery days (title V or XIX only)  17. 00 Nursery days (title V or XIX only)  18. 00 Medically necessary private room days applicable to services through December 31 of the cost reporting period (including swing-bed SMF services applicable to services through December 31 of the cost reporting period (including swing-bed SMF services applicable to services after December 31 of the cost 0.00 period (including swing-bed SMF services applicable to services after December 31 of the cost 0.00 period (including swing-bed SMF services applicable to services after December 31 of the cost 0.00 period (including swing-bed SMF services applicable to services after December 31 of the cost 0.00 period (including private room days (see instructions)  19. 00 Medical draft for swing-bed NF services after December 31 of the cost reporting period (line 0.00 period swing-bed c	7 00	reporting period (if calendar year, enter 0 on this line)		7 00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if realendar year, enter 0 on this line)	7. 00		0	7. 00
reporting period (if callendar year, enter 0 on this line)  10 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)  10 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  11 00 December 31 of the cost reporting period (see instructions)  12 00 Swing-bed SNF type inpatient days applicable to see instructions)  13 00 Swing-bed SNF type inpatient days applicable to see instructions on this line)  14 00 Swing-bed NF type inpatient days applicable to ititles V or XIX only (including private room days) after becember 31 of the cost reporting period (if callendar year, enter 0 on this line)  15 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  16 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  17 00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  18 00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  19 00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  10 00 Moreory days (title V or XIX only)  10 00 Moreory days (title V or XIX only)  10 00 Moreory days (title V or XIX only)  10 00 Moreory days (title V or XIX only)  10 00 Moreory days (title V or XIX only)  10 00 Moreory days (title V or XIX only)  11 00 Moreory days (title V or XIX only)  12 00 Moreory days (title V or XIX only)  13 00 Moreory days (title V or XIX only)  14 00 Moreory days (title V or XIX only)  15 00 Moreory days (title V or XIX only)  16 00 Moreory days (title V or XIX only)  17 00 Moreory days (title V or XIX only)  18 00 Moreory days (title V or XIX only)  19 00 Moreory days (title V or XIX only)  19 00 Moreory days (title V or XIX only)  20 00 Moreory days (title V or XIX only)  21 00 Moreory days (title V or XIX only)  22 00 Moreory days (title V or XIX only)  23 00 Moreory days (title V or XIX only)	0.00			0.00
Total Inpatient days Including private room days applicable to the Program (excluding swing-bed and newborn days)   10.00	8.00		O	8.00
newborn days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  11.00 bing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  15.00 Total nursery days (title V or wides applicable to the Program (excluding swing-bed days)  16.00 Total nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including swing-bed SNF services applicable to services after December 31 of the cost reporting period (including swing-bed SNF services applicable to services after December 31 of the cost reporting period (including swing-bed SNF services applicable to services after December 31 of the cost reporting period (including swing-bed SNF services applicable to services after December 31 of the cost reporting period (line 8 of SNF services applicable to services after December 31 of the cost reporting period (line 8 of SNF services applicable to services after December 31 of the cost reporting period (line 8 of SNF services applicable to services after December 31 of the cost reporting period (line 8 of SNF services applicable to SNF services after December 31 of the cost reporting period (line 8 of SNF services a	0.00		047	0.00
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after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   14.00   15.00   Total nursery days (title V or XIX only)   1,080   15.00   15.00   Total nursery days (title V or XIX only)   0   16.00   15.00	13 00		٥	13 00
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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 after December 31 of the cost reporting period (line 7 x line 19)  26. 00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 Sping-bed cost (see instructions)  29. 00 Private room charges (excluding 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)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 Average private room per diem charge (line 29 + line 3)  31. 00 Average per diem private room charge diem charge (line 34 x line 31)  32. 00 Average per diem private room charge diem charge (line 34 x line 35)  33. 00 Average per diem private room charge diem charge (line 34 x line 35)  34. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  35. 00 Average per diem private room charge diem charge (line 34 x line 35)  36. 00 Private room cost differential adjustment (line 34 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost per diem (see instructions)  40. 00 M	19. 00		0. 00	19. 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 7 x line 18)  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 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)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average private room per diem charge (line 30 + line 4)  34.00 Average per diem private room cost 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 34 x line 31)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  38.00 Adjusted general inpatient routine service cost (cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				
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 7 x line 19)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20)  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 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed charges)  29.00 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 per diem private room cost differential (line 32 minus line 33)(see instructions)  34.00 Average per diem private room cost differential (line 3 x line 31)  35.00 Average per diem private room cost differential (line 3 x line 35)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 36)  27 minus line 36)  28.00 Applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 21 minus line 26)  28.00 Private room cost differential (line 3 x line 21 minus line 33)(see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)  40.00 Medically necessary private room cost applicable to the Program (line 14 x li	20. 00		0. 00	20. 00
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 0 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0 24.00 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 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  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)  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)  31.00 Average perivate room per diem charge (line 29 + line 3)  32.00 Average per diem private room cost differential (line 30 + line 4)  33.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  36.00 Private room cost differential adjustment (line 3 x line 31)  37.00 Average per diem private room cost differential (line 3 x line 31)  38.00 Adjusted general inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 486, 764)  37.00 Program general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	04 00		0 40/ 7/4	04 00
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 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)  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)  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 charge differential (line 22 minus line 33) (see instructions)  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 9, 486, 764)  38. 00 Adjusted general inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 486, 764)  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost per diem (see instructions)  40. 00 Medically necessary private room cost diplicable to the Program (line 14 x line 35)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 8 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20)  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 Part VATE ROOM DIFFERENTIAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  28.00 Algorithm of the cost reporting period (line 8 to 50 px line 20)  29.00 Private room charges (excluding swing-bed cost (line 21 minus line 26) px 486, 764 px 486,	22.00		١	22.00
x line 18)  24.00 Swing-bed cost applicable to NF type services through 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)  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)  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 29 + line 3)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room charge differential (line 34 x line 31)  36.00 Average per diem private room cost differential (line 3 x line 31)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 486, 764)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	23 00		ا ا	23 00
24. 00  24. 00  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 Private ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 Semi-private room per diem charge (line 29 + line 3)  30. 00 Average per vate room per diem charge (line 29 + line 3)  31. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  32. 00 Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 35)  38. 00 Average per diem private room cost differential (line 35)  Average per diem private room cost differential (line 35)  Average per diem private room cost differential (line 35)  Average per diem private room cost differential (line 37 x line 38)  Average per diem private room cost differential (line 37 x line 38)  Average per diem private room cost differential (line 37 x line 38)  Average per diem private room cost differential (line 37 x line 38)  Average per diem private room cost differential (line 37 x line 38)  Average per diem private room cost differential (line 38 x line 39)  Average per diem private room cost differential (line 38 x line 39)  Average per diem private room cost diffe	20.00		Ĭ	20.00
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)  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32. 00 Average private room per diem charge (line 29 ÷ line 3)  33. 00 Average semi-private room per diem charge (line 30 ÷ line 4)  34. 00 Average per diem private room cost 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 (line 34 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 486, 764)  28. 00 Adjusted general inpatient routine service cost per diem (see instructions)  38. 00 Adjusted general inpatient routine service cost (line 9 x line 38)  401, 725 39. 00  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40. 00	24.00		ol	24. 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) 9, 486, 764  PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28.00  29.00 Private room charges (excluding swing-bed charges) 0 29.00  30.00 Semi-private room charges (excluding swing-bed charges) 0 29.00  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.000000  32.00 Average private room per diem charge (line 29 ÷ line 3) 0.00  33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 0.00  34.00 Average per diem private room cost differential (line 34 x line 31) 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) 0 36.00  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 486, 764)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Ajusted general inpatient routine service cost (line 9 x line 38) 40.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				
Total swing-bed cost (see instructions)  26.00  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)  O 29.00  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  O 29.00  30.00  Semi-private room charges (excluding swing-bed charges)  O 29.00  Average private room per diem charge (line 29 ÷ line 3)  Average semi-private room per diem charge (line 30 ÷ line 4)  Average per diem private room charge differential (line 32 minus line 33)(see instructions)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Private room cost differential adjustment (line 3 x line 35)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  O 40.00	25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
27. 00  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  9. 00  9		x line 20)		
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)  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)  30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 486, 764)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00		,	-	
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)  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)  Average semi-private room per diem charge (line 30 ÷ line 4)  30. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  31. 00 Average per diem private room cost differential (line 34 x line 31)  32. 00 Average per diem private room cost differential (line 34 x line 31)  33. 00 Average per diem private room cost differential (line 34 x line 35)  34. 00 Average per diem private room cost differential (line 34 x line 35)  35. 00 Average per diem private room cost differential (line 34 x line 35)  36. 00 Average per diem private room cost differential (line 3 x line 35)  37. 00 Average per diem private room cost differential (line 3 x line 35)  38. 00 Average per diem private room cost differential (line 9, 486, 764)  Adjusted general inpatient routine service cost per diem (see instructions)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28. 00 29. 00 29. 00 29. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27 minus line 36) 29. 486, 764 20. 00 28. 00 29. 00 29. 00 29. 00 29. 00 20. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27 minus line 36) 29. 486, 764 20. 00 28. 00 29. 00 29. 00 29. 00 29. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27 minus line 36) 29. 486, 764 20. 00 28. 00 29. 00 29. 00 29. 00 29. 00 29. 00 20.	27. 00		9, 486, 764	27. 00
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) 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 9, 486, 764)  37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 30.00 3			_	
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31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 486, 764)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  401,725 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.0000000000000000000000000000000000				
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 486, 764)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost (line 9 x line 38) 401,725 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.00 0.00 32.00 0.00 33.00 0.00 34.00 0.00 35.00 0.00 36			- 1	
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room cost 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 9, 486, 764)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  401,725 39.00  40.00				
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 9, 486, 764)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  401,725 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				
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 9, 486, 764 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  401,725 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 35.00 36.00  37.00 27.00 28.00 36.00  37.00 29.				
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  36.00 36.00 37.00 7.00 7.00 7.00 7.00 7.00 7.00				
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 486, 764)  27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00 486, 764  9, 486, 764  37.00 486, 764  9, 486, 764		, , ,		
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 267. 27 38.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00				
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,267.27 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  401,725 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	07.00		7, 100, 701	07.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 267. 27  38.00 Program general inpatient routine service cost (line 9 x line 38)  401, 725  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00				
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,267.27 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38)  401,725 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00				
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 401,725 39.00 40.00	38. 00		1, 267. 27	38.00
	39.00	Program general inpatient routine service cost (line 9 x line 38)	401, 725	39.00
41.00   Total Program general inpatient routine service cost (line 39 + line 40) 401,725   41.00				
	41.00	Total Program general inpatient routine service cost (line 39 + line 40)	401, 725	41.00

Provider COX 15-010    Period (27)   Provider COX   Provider COX   Provider COX   Provider COX   Provider   Propagation	From 01/01/2019   Date/Time F 3/31/2020   Street   Title XIX   Hospital   Cost Center Description   Total   Total   Average Per   Program Days   Program Cost Cost   Days   ÷ col. 2)   Cost   Cost	0 42.00
Cust Curter Description	Cost Center Description  Total Total Inpatient Diem (col. 1 Cost Cost Cost Cost Cost Cost Cost Cost	18 am t t t d d d d d d d d d d d d d d d d
Total   Tota	Cost Center Description  Total Total Average Per Program Days Program Cost Inpatient Cost Days col. 2)  Title XIX Hospital Cost Diem (col. 1 (col. 3 x col. 4)	0 42.00
Impaction   Impaction   Impaction   Diem (Col. 1   Col. 3 x   Col. 3 x   Col. 2   Col. 4   Col. 5	Inpatient Inpatient Diem (col. 1 (col. 3 x Cost Days ÷ col. 2) col. 4)	0 42.00
1.00		
NRSERY (LITLE V & XIX entry)	1.00   2.00   3.00   4.00   5.00	
INTERSIVE CARE WITT		0 43 00
44.00   CORDINARY CARE UNIT		
3.00   SURGICAL INTERSIVE CASE UNIT   46.00   Cast Center Description   1.00		
47.00   OTHER SPECIAL CASE (SPECIFY)   47.00   Cost Center Description   1.00   Cost Center Descr		
1.00   10   10   10   10   10   10   1	47.00 OTHER SPECIAL CARE (SPECIFY)	
18.00   Program Inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)   171, 394   48.00   190	·	
PASS_THROUGH_COST_ADJUSTNEMTS  50.00 Pass through costs applicable to Program inpatient routine services (from West. D. sum of Parts I and 0 50.00 Pass through costs applicable to Program inpatient ancillary services (from West. D. sum of Parts II 0 51.00 Pass through costs applicable to Program inpatient ancillary services (from West. D. sum of Parts II 0 51.00 Pass through costs applicable to Program inpatient ancillary services (from West. D. sum of Parts II 0 51.00 Pass through costs applicable to Program inpatient operating cost sext during capital related, non-physician anesthetist, and 0 53.00 medical education costs (Line 49 minus II ne 52)  14.00 Program discharges 0.53.00 medical education costs (Line 49 minus II ne 52)  15.00 Ilarget amount per discharges 0.05 s.00 larget amount (Line 54 x II no 55)  15.00 Ilarget amoun		
111   0   51.00   Pass through costs applicable to Program Inpatient ancillary services (from Wkst. D. sum of Parts II   0   51.00   Pass through costs applicable to Program Inpatient operating cost   0   52.00   Total Program   Inpatient operating cost excluding capital related, non-physician anesthetist, and   0   53.00   medical education costs (line 40 minus line 52   60   53.00   medical education costs (line 40 minus line 52   60   60   60   60   60   60   60   6		19 49.00
51.00 Pass through costs applicable to Program Inpatient ancillary services (from West. D. sum of Parts II of 101 and IV)  20.00 Total Program excludable cost (sum of lines 50 and 51)  30.00 Total Program excludable cost (sum of lines 50 and 51)  30.00 Total Program excludable cost (sum of lines 50 and 51)  51.00 Program discharges  52.00 Program discharges  53.00 Program discharges  54.00 Program discharges  55.00 Program discharges  55.00 Program discharges  50.00 Di Frence Retween adjusted inpatient operating cost and target amount (line 56 minus line 53)  55.00 Di Frence between adjusted inpatient operating cost and target amount (line 56 minus line 53)  55.00 Di Frence Instructions)  55.00 Di Frence Instructions  55.00 Di Frence Instructions  55.00 Di Instructions  55.00 Di Frence Instructions  56.00 Di Instructions  57.00 Di Instructions  57.00 Di Instructions  58.00 Di Instruc	50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and	0 50.00
52.00 Total Program excludable cost (sum of lines 50 and 51) 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and nedical education costs (line 49 mlnus line 52)  54.00 Program discharges 55.00 Total Refit AMOUNT AMO LIMIT COMPUTATION 55.00 Total Control of the Cost of the Cost of Co		0 51.00
Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)  TARSET AMOUNT AND LIMIT COMPUTATION  TARSET AMOUNT AND LIMIT COMPUTATION  55.00 Target amount per discharge  0.054.00 Total per discharge  1.056.00 Target amount per discharge target per discharge target amount per discharge target per discharge target per discharge target per discharget per disch		0 52 00
TARGET ANOUNT AND LIMIT COMPUTATION   0   54.00   0   55.00   1   7   7   7   7   7   7   7   7   7		
54.00   Program discharges   0, 54.00   75.00   Target amount for discharge   0, 00, 55.00   75.00   Target amount for discharge   0, 00, 55.00   75		
56.00   Target amount (line 54 x line 55)   0   56.00		0 54.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57.00 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the 0.00 59.00 market basket 0.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the 0.00 60.00 films 53/54 or 55 from prior year cost report, updated by the market basket 0.00 60.00 films 53/54 or 55 from prior year cost report, updated by the market basket 0.00 61.00 lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 61.00 lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 61.00 lines 53/54 or 55 from prior year costs report, updated by the market basket 0.00 61.00 lines 53/54 or 55 from prior year costs than expected costs (lines 54 x 60), or 1% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0.0 62.00 less from prior the cost properting period (see instructions) 1.0 63.00 less from prior of 1% of		
September   SaySa or 55 from the cost reporting period ending 1996, updated and compounded by the market basket   0.00   59.00		
market basket  0.00   60.00   If lines 53/54 or 55 from prior year cost report, updated by the market basket  0.00   60.00   If lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  22.00   Relief payment (see instructions)  33.00   Allowable Inpartient cost plus incentive payment (see instructions)  44.00   Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  45.00   Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  46.00   Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  47.00   Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  48.00   Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)  48.00   Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  49.00   Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  40.00   Total title V or XIX swing-bed NF inpatient routine costs (line 7 + line 2)  47.00   Aljusted general inpatient routine service cost period (line 13 x line 20)  48.00   Allowable cost (line 9 x line 71)  48.00   Allowable cost (line 9 x line 76)  48.00   Allowable cost (line 2 x line 76)  48.00   Allowabl		
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  62.00 Relief payment (see instructions)  63.00 Allowable Inpatient cost plus incentive payment (see instructions)  64.00 Medicare swing-bed SWF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (litle XVIII only)  65.00 Medicare swing-bed SWF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (litle XVIII only)  66.00 Total Medicare swing-bed SWF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see Instructions) (litle XVIII only) in CAH (see Instructions) (litle XVIII only) in CAH (see Instructions) (litle XVIII only). For CAH (see Instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  70.00 Sk litled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  70.00 Adjusted general inpatient routine service costs (line 72 + line 2)  71.00 Adjusted general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  72.00 Organ routine service cost (line 75 + line 2)  73.00 Allowable lands are routine service costs (from Worksheet B, Part II, column 26, line 45)  74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  75.00 Capital-related costs (line 75 + line 2)  77.00 Total Program routine service costs (line 76 x line 2)  77.00 Total Program routine service costs (line 76 x	market basket	
which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  2.2.00 Relief payment (see instructions)  3.00 Relief payment (see instructions)  4.00 Relief payment (see instructions)  6.00 Relief payment (see instructions)  8.00 Re		
62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions)  63.00 Allowable Inpatient cost plus incentive payment (see instructions)  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)  67.00 Title V or XIX swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  60.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 67 + line 68)  60.00 Total program routine service cost (line 67 + line 70 + line 2)  71.00 Adjusted general inpatient routine service costs (line 70 + line 2)  72.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  73.00 Total Program general inpatient routine service costs (line 72 + line 73)  74.00 Total Program application to the cost (line 72 + line 73)  75.00 Total Program routine service cost (l	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target	01.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)  64.00 PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  68.00 Total Medicare swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  69.00 Total V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine service costs (line 7 + line 2)  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  70.00 Adjusted general inpatient routine service costs per diem (line 70 + line 2)  71.00 Program routine service cost (line 9 x line 71)  72.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  73.00 Total Program general inpatient routine service costs (line 72 + line 73)  74.00 Total Program general inpatient routine service costs (line 77 + line 73)  75.00 Copi tall-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26. line 45)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Inpatient routine service cost (line 75 +		0 62 00
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(line 12 x line 19)  68.00  Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00  Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00  Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00  Adjusted general inpatient routine service cost per diem (line 70 ± line 2)  72.00  Program routine service cost (line 9 x line 71)  73.00  Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00  Total Program general inpatient routine service costs (line 72 + line 73)  75.00  Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00  Per diem capital-related costs (line 75 ± line 2)  77.00  Program capital-related costs (line 9 x line 76)  79.00  Aggregate charges to beneficiaries for excess costs (from provider records)  80.00  Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79)  81.00  Reasonable inpatient routine service costs (see instructions)  82.00  Reasonable inpatient routine service costs (see instructions)  84.00  Program inpatient ancillary services (see instructions)  85.00  Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  70.00  Total observation bed days (see instructions)  80.00  Total observation bed days (see instructions)  80.00  Total observation bed days (see instructions)  80.00  Total observation bed days (see instructions)	CAH (see instructions)	
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72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 18.00 Inpatient routine service cost (line 74 minus line 77) 80.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)		70.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient ancillary services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  73.00 74.00 75.00 76.00 76.00 77.00 76.00 77.00 77.00 77.00 78.00 79.00 79.00 79.00 79.00 80.		
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 77.00 Program capital-related costs (line 9 x line 77) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions) 2,058 87.00		
26, line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service cost limitation (line 9 x line 81)  83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  2,058 87.00		
77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Total observation bed days (see instructions)	26, line 45)	
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Total observation bed days (see instructions) 87.00 Total observation bed days (see instructions) 87.00 Total observation bed days (see instructions) 88.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  2,058 87.00	78.00 Inpatient routine service cost (line 74 minus line 77)	78. 00
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  2,058 87.00		
83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  88.00 2,008 86.00 86.00	81.00 Inpatient routine service cost per diem limitation	81.00
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  84.00 85.00 86.00 86.00 87.00		
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  86.00 200 200 200 200 200 200 200 200 200	84.00 Program inpatient ancillary services (see instructions)	84. 00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  2,058 87.00		
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	
88.00   Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,267.27   88.00		
89.00 Observation bed cost (line 87 x line 88) (see instructions) 2,608,042 89.00	89.00 Observation bed cost (line 87 x line 88) (see instructions) 2,608,0	42 89.00

Health Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lieu of Form CMS-25		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2019 To 12/31/2019		
		Ti tl	e XIX	Hospi tal	Cost	
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	778, 848	9, 486, 764	0. 08209	8 2, 608, 042	214, 115	90.00
91.00 Nursing School cost	0	9, 486, 764	0.00000	0 2, 608, 042	0	91.00
92.00 Allied health cost	0	9, 486, 764	0.00000	0 2, 608, 042	0	92.00
93.00 All other Medical Education	o	9, 486, 764	0. 00000	0 2, 608, 042	0	93.00

Health Financial Systems	WITHAM MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT				Peri od:	Worksheet D-3	
				From 01/01/2019 To 12/31/2019	Date/Time Pre 3/31/2020 8:1	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description			Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
LANDATI ENT. DOUTLAND OFFICE COOT, OFFITEDO			1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				0.000.050		
30. 00   03000   ADULTS & PEDI ATRI CS				2, 292, 350		30.00
31. 00 03100 I NTENSI VE CARE UNI T				1, 937, 539		31.00
40. 00   04000   SUBPROVI DER -   PF				0		40.00
41. 00   04100   SUBPROVI DER -				0		41.00
42. 00   04200   SUBPROVI DER				0		42.00
43. 00   04300   NURSERY   ANCI LLARY SERVICE COST CENTERS						43.00
50. 00 05000 OPERATING ROOM			0. 11101	5 4, 844, 427	537, 804	50.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C			0. 23520		228, 119	
55. 00   05500 RADI OLOGY-THERAPEUTI C			0. 00000	· ·	220, 119	1
55. 01   05501   ULTRA SOUND			0. 11211		7, 860	
57. 00   05700 CT SCAN			0. 02680	·	53, 905	1
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)			0. 02000		19, 550	
59. 00   05900   CARDI AC CATHETERI ZATI ON			0. 10324	·	46, 204	1
60. 00 06000 LABORATORY			0. 16633			1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.			0. 20393		39, 014	
64. 00 06400 I NTRAVENOUS THERAPY			0. 00157		824	1
66. 00   06600   PHYSI CAL THERAPY			0. 41571	· ·	183, 771	
67. 00 06700 OCCUPATI ONAL THERAPY			0. 19434		65, 419	1
67. 01   06701   AUDI OLOGY			0. 26725	· ·	0	
68. 00 06800 SPEECH PATHOLOGY			0. 30022		23, 319	
69. 00 06900 ELECTROCARDI OLOGY			0.00000		0	
69. 01 06901 CARDI OLOGY			0. 14025	2 3, 585, 261	502, 840	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 41638	1, 239, 351	516, 050	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT			0. 36662	4 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 12311	3, 090, 864	380, 526	73.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C			0.00000	0 0	0	90.00
90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER			0.00000	0 0	0	90. 01
90. 02  09002   CLI NI C			0.00000	0 0	0	
90. 03   09003   DERMATOLOGY CLINIC			0.00000	0 0	0	90. 03
90. 04   09004   ENT CLINIC			0.00000		0	
90. 05   09005   SURGERY CLINIC			0.00000		0	
90. 07   09007   UROLOGY CLINIC			0.00000		0	
90. 09 09009 GASTROENTEROLOGY CLINIC			0.00000		0	
90. 11   09011   NEUROLOGY CLINIC			0.00000		0	
00 12 00012 ODTUMOLOGY CLINIC			0 00000		0	00 10

0

0

0

3, 567, 399 200. 00

795

283, 232

90. 12

90.13

90.14

91.00

92.00

95.00

201.00

202.00

0

3, 865

1, 643, 724

23, 825, 728

23, 825, 728

0.000000

0. 309534

0. 205709

0. 172311

0. 492018

90. 12 09012 OPTHAMOLOGY CLINIC 90. 13 09013 ALLERGY CLINIC

09500 AMBULANCE SERVICES

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

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges (line 61)

09100 EMERGENCY

90. 14 09014 WOUND CARE

91.00

92.00

95.00

200.00

201.00

202.00

	inancial Systems WITHAM MEMORIAL				u of Form CMS-	
I NPATI EN	T ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0104	Peri od:	Worksheet D-3	3
		Component	CCN: 15-S104	From 01/01/2019 To 12/31/2019		
		Titl€	e XVIII	Subprovi der  - I PF	PPS	
	Cost Center Description	<u>'</u>	Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x	
			1.00	2.00	col . 2)	
LA	IPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
30.00 03	BOOO ADULTS & PEDI ATRI CS			0		30.00
	B100 INTENSIVE CARE UNIT			0		31.00
	1000 SUBPROVI DER - I PF			3, 181, 130		40.00
	H100 SUBPROVI DER - I RF			0, 101, 100		41.00
	1200 SUBPROVI DER			0		42.00
	1300 NURSERY					43.00
	ICILLARY SERVICE COST CENTERS				•	
50.00 05	OPERATING ROOM		0. 1110	15 7, 876	874	50.00
	5400 RADI OLOGY-DI AGNOSTI C		0. 23520	08 44, 324	10, 425	54.00
	5500 RADI OLOGY-THERAPEUTI C		0.00000		1	
	5501 ULTRA SOUND		0. 1121		291	
	5700 CT SCAN		0. 02680		758	
	MAGNETIC RESONANCE IMAGING (MRI)		0. 07190		1, 191	1
	5900 CARDI AC CATHETERI ZATI ON		0. 10324			
	5000 LABORATORY		0. 16633			
	6300 BLOOD STORING, PROCESSING & TRANS.		0. 20393		0	
	6400 I NTRAVENOUS THERAPY 6600 PHYSI CAL THERAPY		0.0015			
	5700 OCCUPATIONAL THERAPY		0. 4157° 0. 19434			
	5700 OCCUPATIONAL THERAPT		0. 1943		3, 134	1
	5800 SPEECH PATHOLOGY		0. 30022		2, 168	1
	5900 ELECTROCARDI OLOGY		0. 00000		0	1
	5901 CARDI OLOGY		0. 14025			1
1	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 41638			1
	7200 IMPL. DEV. CHARGED TO PATIENT		0. 36662		0	1
73.00 07	7300 DRUGS CHARGED TO PATIENTS		0. 1231	13 732, 157	90, 138	73.00
OL	JTPATIENT SERVICE COST CENTERS					
	9000 CLI NI C		0.00000			1
	OOO1 OTHER OUTPATIENT SERVICE COST CENTER		0.00000			
	9002 CLINI C		0.00000			
	2003 DERMATOLOGY CLINIC		0.00000			
	2004 ENT CLINIC		0.00000			
	2005 SURGERY CLINIC 2007 UROLOGY CLINIC		0.00000			1
	2009 GASTROENTEROLOGY CLINIC		0.00000			
	PO11 NEUROLOGY CLINIC		0. 00000			1
	PO12 OPTHAMOLOGY CLINIC		0. 00000			1
	PO13 ALLERGY CLINIC		0. 30953			
	9014 WOUND CARE		0. 20570			
	2100 EMERGENCY		0. 1723		3, 408	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4920			1
	THER REIMBURSABLE COST CENTERS					
	9500 AMBULANCE SERVICES					95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			1, 544, 887	240, 024	
201.00	Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		1	1, 544, 887	I	202.00

Health Financial Systems WITHAM MEMORIA INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0104	Peri od:	u of Form CMS-2 Worksheet D-3	
	Component	CCN: 15-5832	From 01/01/2019 To 12/31/2019	Date/Time Pre 3/31/2020 8:1	
	Ti tl e	e XVIII	Skilled Nursing Facility		O dili
Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x	
		1.00	2. 00	col . 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00   03100   I NTENSI VE CARE UNI T			0		31.00
40. 00   04000   SUBPROVI DER -   I PF			0		40.00
41. 00   04100   SUBPROVI DER -   RF			0		41.00
42. 00   04200   SUBPROVI DER 43. 00   04300   NURSERY			0		42.00
ANCILLARY SERVICE COST CENTERS					43.00
50. 00   05000   OPERATING ROOM		0. 1110	15 63, 565	7, 057	50.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 23520	· ·	9, 309	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.00000	00	0	55.00
55. 01   05501   ULTRA SOUND		0. 1121	11 2, 453	275	55.0
57. 00   05700   CT   SCAN		0. 02680		0	
58. 00   05800   MAGNETIC RESONANCE   MAGING (MRI)		0. 07190		0	
59. 00   05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY		0. 1032		2,740	
60.00   06000   LABORATORY 63.00   06300   BLOOD STORING, PROCESSING & TRANS.		0. 1663 0. 2039		40, 607 0	
64. 00   06400   I NTRAVENOUS THERAPY		0. 0015		24	
66. 00 06600 PHYSI CAL THERAPY		0. 4157		462, 020	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 1943		233, 057	67.0
67. 01   06701   AUDI OLOGY		0. 2672	52 0	0	67.0
68. 00 06800 SPEECH PATHOLOGY		0. 3002		20, 114	
69. 00 06900 ELECTROCARDI OLOGY		0. 00000		0	69.0
69. 01   06901   CARDI OLOGY		0. 1402!		71, 970	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 41638 0. 36663		61, 828 0	
73. 00 O7300 DRUGS CHARGED TO PATTENTS		0. 3000.		148, 790	
OUTPATIENT SERVICE COST CENTERS		0. 1201	1, 200, 000	110,770	70.0
90. 00 09000 CLI NI C		0.00000	00 00	0	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER		0. 00000	00	0	90.0
90. 02   09002   CLI NI C		0.00000		0	1
90. 03   09003   DERMATOLOGY   CLINIC		0. 00000		0	90.0
90. 04   09004 ENT CLINIC		0. 00000		0	
90. 05   09005   SURGERY   CLI NI C 90. 07   09007   UROLOGY   CLI NI C		0.00000		0 0	
90. 07   09007   UROLOGY   CLINIC 90. 09   09009   GASTROENTEROLOGY   CLINIC		0.0000		0	1
90. 11   09011   NEUROLOGY   CLINI C		0.0000		0	
90. 12   09012   OPTHAMOLOGY CLINIC		0. 00000		ő	1
90. 13   09013   ALLERGY CLINIC		0. 3095		0	
90. 14   09014   WOUND CARE		0. 20570	09 122	25	90. 1
91. 00   09100   EMERGENCY		0. 1723		116	•
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4920	18 0	0	92.00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES		T			OF A
95.00   09500   AMBULANCE SERVICES 200.00   Total (sum of lines 50 through 94 and 96 through 98)			4 640 325	1 057 932	95.00

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

95. 00 1, 057, 932 200. 00 201. 00 202. 00

4, 640, 325 0 4, 640, 325

200. 00 201. 00 202. 00

Health Financial Systems WITHAM MEMORI				u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der (	CCN: 15-0104	Peri od:	Worksheet D-3	
			From 01/01/2019 To 12/31/2019	Date/Time Pre	narod:
			10 12/31/2019	3/31/2020 8: 1	
	Ti t	le XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
		4.00	0.00	col . 2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS		1	794, 137		30.00
31. 00   03100   NTENSI VE CARE UNI T			95, 129		31.00
40. 00   04000  SUBPROVI DER -   PF			75, 127		40.00
41. 00   04100  SUBPROVI DER -   1 FF			0		41.00
42. 00   04200  SUBPROVI DER			0		42.00
43. 00   04300   NURSERY			213, 420		43.00
ANCI LLARY SERVI CE COST CENTERS			2.107.120		10.00
50. 00 05000 OPERATING ROOM		0. 11101	5 190, 891	21, 192	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 23520		5, 908	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.00000	0	0	55.00
55. 01   05501   ULTRA SOUND		0. 11211	1 12, 191	1, 367	55. 01
57. 00  05700   CT   SCAN		0. 02680	96, 143	2, 577	57.00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)		0. 07190	10, 108	727	58.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON		0. 10324	5 74, 259	7, 667	59.00
60. 00   06000   LABORATORY		0. 16633	9 200, 519	33, 354	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 20393	0 12, 963	2, 644	63.00
64. 00   06400   I NTRAVENOUS THERAPY		0. 00157	· ·	61	64.00
66. 00   06600   PHYSI CAL THERAPY		0. 41571	· ·	4, 725	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 19434	·	1, 148	
67. 01   06701   AUDI 0L0GY		0. 26725		0	
68. 00 06800 SPEECH PATHOLOGY		0. 30022		366	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0.00000		0	
69. 01   06901   CARDI OLOGY		0. 14025	·	9, 588	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		0. 41638	·		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 36662		0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 12311	3 155, 894	19, 193	73.00
OUTPATIENT SERVICE COST CENTERS		0.00000	0	0	00 00
90. 00   09000   CLINIC		0.00000			
90. 01   09001   OTHER OUTPATIENT SERVICE COST CENTER 90. 02   09002   CLINIC		0.00000			
90. 02   09002   CLINI C 90. 03   09003   DERMATOLOGY   CLINI C		0.00000		0	
90. 04   09004   ENT CLINIC		0.00000		0	
90. 05   09005   SURGERY CLINIC		0.00000		0	
90. 07   09007   UROLOGY   CLINIC		0. 00000		Ĭ	
90. 09 109009 GASTROENTEROLOGY CLINIC		0.00000			

0.000000

0.000000

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0. 309534

0. 205709

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171, 394 200. 00

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68, 989

1, 090, 341

1, 090, 341

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90. 13

90.14

91.00

92.00 0

95.00

201.00

202.00

09009 GASTROENTEROLOGY CLINIC

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

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges (line 61)

09011 NEUROLOGY CLINIC

09500 AMBULANCE SERVICES

90. 12 09012 OPTHAMOLOGY CLINIC 90. 13 09013 ALLERGY CLINIC

09014 WOUND CARE

09100 EMERGENCY

90.09

90. 14

91.00

92.00

95.00

200.00

201.00

202.00

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0104	Peri od: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 3/31/2020 8:18 am

			10 12/31/2019	3/31/2020 8: 1	
		Title XVIII	Hospi tal	PPS	
	DADT A LABATIENT HOCDITAL CERVILORG INDER LABO			1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0	1.00
1. 00 1. 01	DRG amounts other than outlier payments for discharges occurring	nrior to October 1 (	500	4, 595, 337	1.00
1.01	instructions)				1.01
1. 02	DRG amounts other than outlier payments for discharges occurring	on or after October	1 (see	1, 553, 725	1. 02
	instructions)		`		
1. 03	DRG for federal specific operating payment for Model 4 BPCI for d	li scharges occurri ng	prior to October	0	1. 03
	1 (see instructions)			_	
1. 04	DRG for federal specific operating payment for Model 4 BPCI for d	li scharges occurri ng	on or after	0	1. 04
2. 00	October 1 (see instructions) Outlier payments for discharges. (see instructions)				2. 00
2. 01	Outlier reconciliation amount			0	2.01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions	3)		0	2. 02
2. 03	Outlier payments for discharges occurring prior to October 1 (see	,		2, 113	2. 03
2.04	Outlier payments for discharges occurring on or after October 1 (			3, 628	2. 04
3.00	Managed Care Simulated Payments			0	3.00
4.00	Bed days available divided by number of days in the cost reportin	ng period (see instru	ctions)	62. 35	4.00
	Indirect Medical Education Adjustment				
5. 00	FTE count for allopathic and osteopathic programs for the most re	ecent cost reporting	period ending on	0. 00	5.00
6. 00	or before 12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs that meet the c	ritoria for an add o	n to the can for	0. 00	6. 00
0.00	new programs in accordance with 42 CFR 413.79(e)	criteria ioi an add-c	ii to the cap roi	0.00	0.00
7. 00	MMA Section 422 reduction amount to the IME cap as specified unde	er 42 CFR §412.105(f)	(1) (i v) (B) (1)	0. 00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42	- ,	. , . , . , . ,	0. 00	7. 01
	cost report straddles July 1, 2011 then see instructions.	.,,,,	, , , , ,		
8.00	Adjustment (increase or decrease) to the FTE count for allopathic			0. 00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c	c)(2)(iv), 64 FR 2634	0 (May 12,		
0.01	1998), and 67 FR 50069 (August 1, 2002).		ACA 16 4b4	0.00	0.01
8. 01	The amount of increase if the hospital was awarded FTE cap slots report straddles July 1, 2011, see instructions.	under § 5503 of the	ACA. IT the cost	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots	from a closed teachi	ng hosnital	0. 00	8. 02
0.02	under § 5506 of ACA. (see instructions)	Trom a crosca teachi	ng nospi tai	0.00	0.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (	[8, 8,01 and 8,02) (	see	0. 00	9.00
	instructions)				
10.00	FTE count for allopathic and osteopathic programs in the current	year from your recor	ds		10.00
	FTE count for residents in dental and podiatric programs.			0. 00	
	Current year allowable FTE (see instructions)				12.00
13. 00 14. 00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year e	anded on or after Ser	tombor 20 1007	0.00	13. 00 14. 00
14.00	otherwise enter zero.	ilided on or arter sep	Telliber 30, 1997,	0.00	14.00
15. 00	Sum of lines 12 through 14 divided by 3.			0.00	15. 00
	Adjustment for residents in initial years of the program				16.00
17.00	Adjustment for residents displaced by program or hospital closure	•		0. 00	17.00
	Adjusted rolling average FTE count				18. 00
	Current year resident to bed ratio (line 18 divided by line 4).			0. 000000	
	Prior year resident to bed ratio (see instructions)			0.000000	
21. 00 22. 00	Enter the lesser of lines 19 or 20 (see instructions)  IME payment adjustment (see instructions)			0. 000000	21.00
	IME payment adjustment (see Firstructions)			0	
22.01	Indirect Medical Education Adjustment for the Add-on for § 422 of	the MMA		J	22.01
23. 00	Number of additional allopathic and osteopathic IME FTE resident		FR 412. 105	0.00	23. 00
	(f)(1)(iv)(C).	·			
24.00	IME FTE Resident Count Over Cap (see instructions)			0. 00	24.00
25. 00	If the amount on line 24 is greater than -0-, then enter the lowe	er of line 23 or line	24 (see	0. 00	25. 00
01.00	instructions)				
26. 00	Resident to bed ratio (divide line 25 by line 4)			0.000000	
	IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions)			0. 000000 0	27. 00 28. 00
	IME add-on adjustment amount (see instructions)			0	28. 00
29. 00	Total IME payment ( sum of lines 22 and 28)			0	
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29. 01
	Disproportionate Share Adjustment				
30. 00	Percentage of SSI recipient patient days to Medicare Part A patie	ent days (see instruc	tions)	3. 37	
	Percentage of Medicaid patient days (see instructions)			25. 09	
	Sum of lines 30 and 31			28. 46	
33.00	Allowable disproportionate share percentage (see instructions)			12.00	
34.00	Disproportionate share adjustment (see instructions)			184, 472	34.00

	Financial Systems WITHAM MEMORIA ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Period:	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	From 01/01/2019	Worksheet E Part A	
			To 12/31/2019	Date/Time Pre 3/31/2020 8:1	
		Title XVIII	Hospi tal	PPS	
			Pri or to 10/1 1.00	0n/After 10/1 2.00	
	Uncompensated Care Adjustment		1.00	2.00	
35.00	Total uncompensated care amount (see instructions)		0	0	
35. 01 35. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, en	iter zero on this line) (s	0. 000000000 ee 834, 440	0. 000000000 950, 269	
	instructions)				
35. 03 36. 00	Pro rata share of the hospital uncompensated care payment a Total uncompensated care (sum of columns 1 and 2 on line 35	i. 03)	624, 115 862, 980	238, 865	35. 03 36. 00
40. 00	Additional payment for high percentage of ESRD beneficiary Total Medicare discharges on Worksheet S-3, Part I excludin 652, 682, 683, 684 and 685 (see instructions)		o (1971)		40. 00
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	683, 684 an 685. (see	0		41.00
41. 01		IS-DRGs 652, 682, 683, 68	4 0		41.01
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not qua Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0. 00 e 0		42. 00 43. 00
44. 00	<pre>instructions) Ratio of average length of stay to one week (line 43 divide days)</pre>	ed by line 41 divided by 7	0. 000000		44.00
45. 00	Average weekly cost for dialysis treatments (see instruction		0.00		45. 00
46. 00 47. 00	Total additional payment (line 45 times line 44 times line Subtotal (see instructions)	41. 01)	7, 202, 255		46. 00 47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, only. (see instructions)	small rural hospitals	0		48. 00
	y. (see Thistractions)			Amount	
40.00	Total nayment for impatient energing costs (see instruction	unc)		1.00	49. 00
49. 00 50. 00	Total payment for inpatient operating costs (see instruction Payment for inpatient program capital (from Wkst. L, Pt. I		)	7, 202, 255 499, 039	
51.00	Exception payment for inpatient program capital (Wkst. L, P			0	51.00
52. 00 53. 00	Direct graduate medical education payment (from Wkst. E-4, Nursing and Allied Health Managed Care payment	line 49 see instructions)		0	52. 00 53. 00
54. 00	Special add-on payments for new technologies			0	54.00
54. 01	Islet isolation add-on payment			0	54. 01
55. 00 56. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see in	•		0	55. 00 56. 00
57. 00	Routine service other pass through costs (from Wkst. D, Pt.		through 35).	0	57.00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt			0	58.00
59. 00	Total (sum of amounts on lines 49 through 58)			7, 701, 294	1
60. 00 61. 00	Primary payer payments	us line (O)		0 7, 701, 294	60.00
62.00	Total amount payable for program beneficiaries (line 59 min Deductibles billed to program beneficiaries	lus Title 60)		833, 164	
63.00	Coinsurance billed to program beneficiaries			5, 115	
64.00	Allowable bad debts (see instructions)			55, 302	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			35, 946	1
66.00	Allowable bad debts for dual eligible beneficiaries (see in	istructi ons)		15, 980	
67. 00 68. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo	or applicable to MS DDGs (	coo instructions	6, 898, 961 0	67. 00 68. 00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96			0	69.00
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,, (, ,, , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	0	70.00
70. 50	Rural Community Hospital Demonstration Project (§410A Demon	stration) adjustment (see	instructions)	0	70. 50
70. 87	Demonstration payment adjustment amount before sequestration			0	70. 87
70. 88 70. 89	SCH or MDH volume decrease adjustment (contractor use only)			0	70. 88
70. 89 70. 90	Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions)	*		0	1
70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	70. 91
	Bundled Model 1 discount amount (see instructions)			0	
70. 92	. 92 Bundled Model 1 discount amount (see instructions)				
70. 93	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			47, 973 -62, 363	

	Financial Systems WITHAM MEMORIAL		CN. 1F 0104		u of Form CMS-2	255Z- I
JALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0104	Peri od: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Pre 3/31/2020 8:1	pared:
		Title	· XVIII	Hospi tal	PPS	O dili
				(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period prior to 10/1)	n column 0		2019	591, 570	70. 90
0. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or af		:	2020	278, 676	70. 9 <sup>-</sup>
0. 98	Low Volume Payment-3				0	70. 9
0. 99	HAC adjustment amount (see instructions)				0	70. 9
1.00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			7, 754, 817	71.0
1. 01	Sequestration adjustment (see instructions)				155, 096	71.0
1. 02	Demonstration payment adjustment amount after sequestration				0	71.0
2. 00	Interim payments				7, 452, 968	72. C
3.00	Tentative settlement (for contractor use only)				0	73.0
4. 00	Balance due provider/program (line 71 minus lines 71.01, 71.073)	2, 72, and			146, 753	74.0
5. 00	Protested amounts (nonallowable cost report items) in accorda CMS Pub. 15-2, chapter 1, $\S 115.2$	nce with			132, 386	75.0
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		1			
0. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum plus 2.04 (see instructions)	of 2.03			0	
1. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	
2. 00	Operating outlier reconciliation adjustment amount (see instr				0	1
	Capital outlier reconciliation adjustment amount (see instruc				0	
4. 00	The rate used to calculate the time value of money (see instr	uctions)			0. 00	
5.00	Time value of money for operating expenses (see instructions)				0	1
6. 00	Time value of money for capital related expenses (see instruc	tions)		1	0	96.0
				Prior to 10/1		
	IICD Description			1. 00	2. 00	
00 00	HSP Bonus Payment Amount				0	100 6
00.00	HSP bonus amount (see instructions)			0	0	100. C
01 00	HVBP Adjustment for HSP Bonus Payment			0.000000000	0.000000000	101 6
	HVBP adjustment factor (see instructions)	<b>5</b> )		0. 0000000000	0. 0000000000	
02.00	HVBP adjustment amount for HSP bonus payment (see instruction	5)		0	0	102. C
02 00	HRR Adjustment for HSP Bonus Payment			0, 0000	0.0000	102 6
	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions	`		0.0000	0. 0000	104. 0
04.00			uctmont	0	0	1104. 0
00 00	Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe					200. C
.00. 00	Century Cures Act? Enter "Y" for yes or "N" for no.	i i od under	the Zist			200. 0
	Cost Reimbursement					1
01 00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin	0. 40)				201. 0
	Medicare discharges (see instructions)	C 47)				201.0
	Case-mix adjustment factor (see instructions)					202. 0
03. 00	Computation of Demonstration Target Amount Limitation (N/A in period)	first year	of the curre	nt 5-year demons		,200. 0
04.00	Medicare target amount					204. C
	Case-mix adjusted target amount (line 203 times line 204)					205.0
	Medicare inpatient routine cost cap (line 202 times line 205)					206.0
50.00	Adjustment to Medicare Part A Inpatient Reimbursement					1200. C
07 00	Program reimbursement under the §410A Demonstration (see inst	ructions)				207. C
	program recimbar sement under the 34 for pemonstration (SEE INST	1 40 (1 0113)		1		1 <u>-</u> 01.0
	Medicare Part A innationt service costs (from Wkst F Dt A	line 50)				208 r
00 .80	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare LPPS payments (see instructions)	line 59)				208. 209.

209.00

210. 00 211. 00

212. 00 213. 00 218. 00

209.00 Adjustment to Medicare IPPS payments (see instructions)

Comparision of PPS versus Cost Reimbursement

(line 212 minus line 213) (see instructions)

210.00 Reserved for future use
211.00 Total adjustment to Medicare IPPS payments (see instructions)

212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)

213.00 Low-volume adjustment (see instructions)
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Peri od: Worksheet E From 01/01/2019 Part A Exhibit 4 To 12/31/2019 Date/Time Prepared: 3/31/2020 8: 18 am Provider CCN: 15-0104

					10	12/31/2019	3/31/2020 8: 1	
		W (0 E D ) A			XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After	Total (Col 2 through 4)	
		Title	E, Pail A)	EIITI ti eilleiit	10 10/01	10/01	tili ough 4)	
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	DRG amounts other than outlier	1. 00	0	0	0	0	0	1.00
4 04	payments	4 04	4 505 007		4 505 007		4 505 007	4 04
1. 01	DRG amounts other than outlier payments for discharges	1. 01	4, 595, 337	0	4, 595, 337		4, 595, 337	1. 01
	occurring prior to October 1							
1. 02	DRG amounts other than outlier	1. 02	1, 553, 725	0		1, 553, 725	1, 553, 725	1.02
	payments for discharges							
	occurring on or after October							
1. 03	DRG for Federal specific	1. 03	0	0	0		0	1.03
	operating payment for Model 4							
	BPCI occurring prior to							
1. 04	October 1 DRG for Federal specific	1. 04	0	0		0	0	1. 04
1.01	operating payment for Model 4	1.01	Ö	J		Ü		1.01
	BPCI occurring on or after							
2. 00	October 1 Outlier payments for	2. 00						2.00
2.00	discharges (see instructions)	2.00						2.00
2. 01	Outlier payments for	2. 02	0	0	0	0	0	2. 01
	discharges for Model 4 BPCI	0.00	0.440		0.440			
2. 02	Outlier payments for discharges occurring prior to	2. 03	2, 113	0	2, 113		2, 113	2. 02
	October 1 (see instructions)							
2. 03	Outlier payments for	2. 04	3, 628	0		3, 628	3, 628	2.03
	discharges occurring on or							
	after October 1 (see instructions)							
3. 00	Operating outlier	2. 01	0	0	0	0	0	3.00
	reconciliation							
4. 00	Managed care simulated	3. 00	0	0	0	0	0	4. 00
	payments Indirect Medical Education Adj	ustment						
5.00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5.00
	A, line 21 (see instructions)		_	_	_	_	_	
6. 00	IME payment adjustment (see instructions)	22. 00	0	O	0	0	0	6. 00
6. 01	IME payment adjustment for	22. 01	0	0	0	0	0	6. 01
	managed care (see							
	instructions) Indirect Medical Education Adj	ustmant for the	a Add on for Co	ation 122 of t	the MMA			
7. 00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7.00
	(see instructions)							
8. 00	I ME adjustment (see	28. 00	0	0	0	0	0	8. 00
8. 01	instructions) IME payment adjustment add on	28. 01	0	0	0	0	0	8. 01
0.01	for managed care (see	20.01	Ö	J	J	O .		0.01
	instructions)							
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	0	9. 00
9. 01	Total IME payment for managed	29. 01	0	0	0	0	0	9. 01
	care (sum of lines 6.01 and							
	8. 01)							
10. 00	Disproportionate Share Adjustm Allowable disproportionate	33. 00	0. 1200	0. 1200	0. 1200	0. 1200		10.00
10.00	share percentage (see	33.00	0. 1200	0. 1200	0. 1200	0. 1200		10.00
	i nstructi ons)							
11. 00	Disproportionate share adjustment (see instructions)	34. 00	184, 472	0	137, 860	46, 612	184, 472	11.00
11. 01	Uncompensated care payments	36. 00	862, 980	0	624, 115	238, 865	862, 980	11. 01
	Additional payment for high pe	rcentage of ESI		di scharges	.,	-,	·	
12.00	Total ESRD additional payment	46. 00	0	0	0	0	0	12.00
13. 00	(see instructions) Subtotal (see instructions)	47. 00	7, 202, 255	0	5, 359, 425	1, 842, 830	7, 202, 255	13 00
14. 00	Hospital specific payments	48. 00	,, 202, 233	0	0, 337, 423	1, 542, 630	7, 202, 200	14.00
	(completed by SCH and MDH,					_	_	
	small rural hospitals only.)							
15. 00	(see instructions) Total payment for inpatient	49. 00	7, 202, 255	0	5, 359, 425	1, 842, 830	7, 202, 255	15 00
. 5. 66	operating costs (see	//. 55	,, 202, 200	J	5, 557, 425	1, 012, 030	,,202,200	.5.65
	instructions)							

LOW VO	LUME CALCULATION EXHIBIT 4			Provi der C		Period: From 01/01/2019 To 12/31/2019		pared.
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1. 00	2. 00	3.00	4. 00	5. 00	
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	499, 039	0	-124, 29		499, 039	16.00
17. 00	Special add-on payments for new technologies	54. 00	0	0		0 0	0	
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0		0 0	0	17. 01 17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)		0	0		0 0	0	18. 00
19. 00	SUBTOTAL			0	5, 235, 13	5 2, 466, 159	7, 701, 294	19.00
		W/S L, line	(Amounts from L)					
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier	1. 00 1. 01	497, 810 0	0	-123, 91	8 621, 728 0 0	497, 810 0	20. 00 20. 01
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments	2. 00 2. 01	1, 229 0	0 0	-37	2 1, 601 0 0	1, 229 0	21. 00 21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0.000	0. 0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0		0 0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0. 0000	0. 000	0. 0000		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	0		0 0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	499, 039	0	-124, 29	0 623, 329	499, 039	26. 00
		W/S E, Part A	(Amounts to					
		line	E, Part A)					
07.00		0	1. 00	2. 00	3.00	4.00	5. 00	07.00
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0. 11300 591, 57		591, 570	27. 00 28. 00
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				278, 676	278, 676	29. 00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

H02P1 1	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATTON EXHIBIT 5		F	From 01/01/2019  To 12/31/2019	Date/Time Pre 3/31/2020 8:1	pared:
				XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3. 00	4. 00	
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 00 1. 01	4, 595, 337	4, 595, 337	7	4, 595, 337	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	1, 553, 725		1, 553, 725	1, 553, 725	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0		D	0	1.03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00					2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	(	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	2, 113	2, 113	3	2, 113	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	3, 628		3, 628	3, 628	2. 03
3.00	Operating outlier reconciliation	2. 01	0	(			3.00
4. 00	Managed care simulated payments Indirect Medical Education Adjustment	3. 00	] 0	(	0	0	4.00
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0. 000000		5.00
6. 00	IME payment adjustment (see instructions)	22. 00	0	(	0	0	6. 00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	0	(	0	0	6. 01
	Indirect Medical Education Adjustment for the						
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000		7.00
8. 00	IME adjustment (see instructions)	28. 00	0	(	0	0	8. 00
8. 01	IME payment adjustment add on for managed	28. 01	0	(	0	0	8. 01
9. 00	care (see instructions) Total IME payment (sum of lines 6 and 8)	29. 00	0	,	0	0	9. 00
9. 01	Total IME payment for managed care (sum of	29. 01	0	į (	0	0	9. 01
	lines 6.01 and 8.01)						
10. 00	Disproportionate Share Adjustment Allowable disproportionate share percentage	33. 00	0. 1200	0. 1200	0. 1200		10.00
11. 00	(see instructions) Disproportionate share adjustment (see	34. 00	184, 472	137, 860			
	instructions)	0,4 00	0.00.000			.,	
11. 01	Uncompensated care payments  Additional payment for high percentage of ESI	36.00 RD beneficiary	862, 980	624, 115	238, 865	862, 980	11.01
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	(	0	0	12.00
13.00	Subtotal (see instructions)	47. 00	7, 202, 255	5, 359, 425	1, 842, 830	1	1
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48. 00	0	(	0	0	14.00
15. 00	1	49. 00	7, 202, 255	5, 359, 425	1, 842, 830	7, 202, 255	15. 00
		l	400 000	-124, 290	623, 329	499, 039	16.00
16. 00	1.	50. 00	499, 039	124, 27	020, 027	1,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
16. 00 17. 00 17. 01	Payment for inpatient program capital (from		499, 039	(	0	·	17. 00 17. 01
17. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies Net organ acquisition cost Credits received from manufacturers for		0	(	0 0	0	17. 00
17. 00 17. 01	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies Net organ acquisition cost	54. 00	0 0	(	0 0	0	17. 00 17. 01 17. 02

Heal th	Financial Systems	WITHAM MEMORI	AL HOSPLTAL		In lie	u of Form CMS-2	2552-10
	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA				Period: From 01/01/2019	Worksheet E	t 5 pared:
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1. 00	2. 00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1. 00	497, 810	-123, 91	621, 728	497, 810	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	(	0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	1, 229	-37	1, 601	1, 229	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	(	0	0	21.01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0		0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0. 000	0.0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	'	0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	499, 039	-124, 29	623, 329	499, 039	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt. A)				
		0	1, 00	2.00	3. 00	4. 00	
27. 00		0	1.00	2.00	3.00	4.00	27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	591, 570	591, 57	)	591, 570	
29. 00	Low volume adjustment on or after October 1	70. 97	278, 676		278, 676		
30.00	HVBP payment adjustment (see instructions)	70. 93	47, 973			47, 973	
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	, 00	0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-62, 363	-50, 08	9 -12, 274	-62, 363	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	12,00	0	0	31. 01
	· · · · · · · · · · · · · · · · · · ·					(Amt to	

0 70. 99

1.00

Ν

2.00

0

3.00

0

(Amt. to Wkst. E, Pt. A) 4.00

32.00

100.00

32.00 HAC Reduction Program adjustment (see

instructions)

100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

Health Financial Systems	WITHAM MEMORIAL HOS	PI TAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pro	ovider CCN: 15-0104	Peri od: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 3/31/2020 8:18 am
		T' 11 . \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	11	DDC

		10 12/31/	3/31/2020 8: 1	
		Title XVIII Hospital		<del>o am</del>
		Ti ti o XVIII		
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		9, 691	1.00
2.00	Medical and other services reimbursed under OPPS (see instruc	tions)	11, 529, 866	1
3.00	OPPS payments	,	13, 622, 383	
4.00	Outlier payment (see instructions)		9, 478	
4. 01	Outlier reconciliation amount (see instructions)		0	1
5.00	Enter the hospital specific payment to cost ratio (see instru	ctions)	0.000	
6.00	Line 2 times line 5	,	l 0	1
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		l 0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200	l 0	9.00
10.00	Organ acqui si ti ons		l 0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		9, 691	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES			1
	Reasonabl e charges			1
12.00	Ancillary service charges		73, 928	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		73, 928	14. 00
	Customary charges			
15.00	Aggregate amount actually collected from patients liable for	payment for services on a charge bas	sis 0	15.00
16.00	Amounts that would have been realized from patients liable fo	r payment for services on a chargeba	asis 0	16.00
	had such payment been made in accordance with 42 CFR §413.13(	e)		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0. 000000	1
18. 00	Total customary charges (see instructions)		73, 928	1
19. 00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds line 11) (see	64, 237	19.00
	instructions)			
20. 00	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds line 18) (see	0	20.00
	instructions)		0.404	
21. 00	Lesser of cost or charges (see instructions)		9, 691	1
22. 00	Interns and residents (see instructions)		0	
23. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		13, 631, 861	24. 00
05.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			1 05 00
25. 00	Deductibles and coinsurance amounts (for CAH, see instruction		886	1
26.00	Deductibles and Coinsurance amounts relating to amount on lin		2, 469, 169	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	prus the sum of fines 22 and 23] (Se	ee 11, 171, 497	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, I	ino 50)	0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	
30.00	Subtotal (sum of lines 27 through 29)		11, 171, 497	1
31. 00	Primary payer payments		903	1
32. 00	Subtotal (line 30 minus line 31)		11, 170, 594	
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)	11, 170, 374	32.00
33 00	Composite rate ESRD (from Wkst. I-5, line 11)	020)	0	33.00
34. 00	Allowable bad debts (see instructions)		310, 517	1
35. 00	Adjusted reimbursable bad debts (see instructions)		201, 836	1
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	225, 114	
	Subtotal (see instructions)	,	11, 372, 430	1
38. 00	MSP-LCC reconciliation amount from PS&R		141	1
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		l 0	1
39. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		39. 50
39. 97	Demonstration payment adjustment amount before sequestration		l 0	39. 97
39. 98	Partial or full credits received from manufacturers for repla	ced devices (see instructions)	l 0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	· · · · · · · · · · · · · · · · · · ·	l 0	39. 99
40.00	Subtotal (see instructions)		11, 372, 289	40.00
40. 01	Sequestration adjustment (see instructions)		227, 446	40. 01
40.02	Demonstration payment adjustment amount after sequestration		0	40. 02
41.00	Interim payments		10, 947, 388	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		197, 455	43.00
44.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2, chapter 1,	0	44.00
	§115. 2	<u> </u>		
	TO BE COMPLETED BY CONTRACTOR			4
	Original outlier amount (see instructions)		0	1
91.00	Outlier reconciliation adjustment amount (see instructions)		0	1
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	
94. 00	Total (sum of lines 91 and 93)		0	94.00

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Peri od:	Worksheet E
		From 01/01/2019	
	Component CCN: 15-S104	To 12/31/2019	Date/Time Prepared:
			3/31/2020 8: 18 am
	Title XVIII	Subprovi der -	PPS
		LDE	

		Title XVIII	Subprovi der - I PF	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			681	1.00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruc OPPS payments	tions)		220 346	2.00 3.00
4. 00	Outlier payment (see instructions)		0	4.00	
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0.000	5.00
6. 00	Line 2 times line 5			0	6.00
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	7. 00 8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV col 13 line 200		0	9.00
10.00	Organ acqui si ti ons	,		0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			681	11.00
	Reasonable charges				
	Ancillary service charges			5, 291	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			5, 291	14. 00
15. 00		payment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable fo			0	16.00
	had such payment been made in accordance with 42 CFR §413.13(	e)			
17. 00	,			0.000000	
18. 00 19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete on	lv if line 18 exceeds li	ne 11) (see	5, 291 4, 610	18. 00 19. 00
17.00	instructions)	if y 11 1111c to exceeds 11	110 11) (300	4,010	17.00
20.00	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds li	ne 18) (see	0	20. 00
21 00	instructions)			.01	21 00
21.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			681 0	21. 00 22. 00
23. 00	1	ructions)		0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	<u> </u>		346	24. 00
05.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		T		05.00
26.00	Deductibles and coinsurance amounts (for CAH, see instruction Deductibles and Coinsurance amounts relating to amount on lin	•	ructions)	0	25. 00 26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			1, 027	27.00
	instructions)		, ,	•	
28. 00	Direct graduate medical education payments (from Wkst. E-4, I			0	28. 00
29.00	1			1 027	29.00
30. 00 31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			1, 027 0	30. 00 31. 00
	Subtotal (line 30 minus line 31)			1, 027	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
35.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	34.00 35.00
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	36.00
37.00	Subtotal (see instructions)			1, 027	37.00
	MSP-LCC reconciliation amount from PS&R			0	38.00
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction			0	39. 00 39. 50
39. 30	Demonstration payment adjustment amount before sequestration	15)		0	39. 30
39. 98	Partial or full credits received from manufacturers for repla	ced devices (see instru	ctions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			1, 027	40.00
40. 01 40. 02	Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration			21 0	40. 01 40. 02
41. 00	Interim payments			1, 376	
42. 00	1			0	42. 00
43.00	Balance due provider/program (see instructions)			-370	
44. 00	Protested amounts (nonallowable cost report items) in accorda §115.2	ince with CMS Pub. 15-2,	chapter 1,	0	44. 00
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	90. 00
91.00	1			0	91.00
	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)				94.00
	,		'	_	

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0104	Peri od: From 01/01/2019	Worksheet E
	Component CCN: 15-5832		
	Title XVIII	Skilled Nursing	PPS

March   Math CAL Mod DIRBH HMALH SEMPLES			Title XVIII	Skilled Nursing Facility	PPS	
Medical and other services (see Instructions)   0.30   0.00   0				-	1. 00	
Medical and other services reinfourced under OPPS (see instructions)						
0.000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.000000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.00000000			±!>			•
4.00   Outlier payment (see instructions)		1	tions)		Ü	•
0.01   Dutil er reconcilitation amount (see instructions)   0.00   0.0		, ,				•
Line 2 times   fine 5						•
	5.00	Enter the hospital specific payment to cost ratio (see instru	ctions)			5.00
1.00   Content					- 1	1
0,00						
10.00			IV col 12 line 200		-	•
11.00   Total cost (sum of lines 1 and 10) (see instructions)   636   11.00			1 V, COI. 13, 111le 200			•
COMPUTATION OF LESSER OF COST OR CHARGES   Reasonable charges   Seasonable charges   Season		1 9 1			-	•
1.00   Ancil lary service charges   5,264   12.00   0   13.00   13.00   10.01   10.0						
13.00   organ acquisition charges (from Wist. D-4, Pt. III., col. 4, Iiin. 69)   0   13.00		9				
14.00   Total reasonable charges (sum of lines 12 and 13)   15.00   16.00   15.00   16.00			: (0)		5, 264	1
Customary charges			The 69)		5 264	
15.00   Aggregate amount actually collected from patients   Iable for payment for services on a chargebasis   0   16.00   Amounts that would have been realized from patients   Iable for payment for services on a chargebasis   0   16.00   Amounts that would have been realized from patients   Iable for payment for services on a chargebasis   0   16.00   Amounts that would have been realized from patients   Iable for payment for services on a chargebasis   0   16.00   Amounts   17.00   Total customary charges (see instructions)   0.000000   17.0	14.00				3, 204	14.00
had such payment been made in accordance with 42 CFR §413. 13(e)	15.00		payment for services on	a charge basis	0	15.00
17. 00	16.00	Amounts that would have been realized from patients liable fo	r payment for services of	on a chargebasis	0	16.00
18. 00   Total customary charges (see instructions)   5. 264   18. 00	47.00		e)			47.00
9, 00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see   4, 628   19, 00   instructions)   20, 00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20, 00						1
instructions    20.00			lv if line 18 exceeds li	ne 11) (see		ł
20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20.00	17.00		Ty TT TTTE TO EXCECUS TO	110 11) (300	1, 020	17.00
21.00   Lesser of cost or charges (see instructions)   0.20.00	20.00		ly if line 11 exceeds li	ne 18) (see	0	20.00
22.00   Interns and residents (see instructions)   0   22.00   23.00   Coto f physic ian's services in a teaching hospital (see instructions)   0   23.00   Coto f physic ian's services in a teaching hospital (see instructions)   0   24.00   Coto f physic ian's services in a teaching hospital (see instructions)   0   24.00   Coto f physic ian's services in a teaching hospital (see instructions)   0   25.00   Coto f physic ian's services in a teaching hospital (see instructions)   0   25.00   Coto f physic ian's services in a teaching hospital (see instructions)   0   25.00   Coto f physic ian's services in a teaching hospital (see instructions)   0   25.00   Coto f physic ian's services in a teaching hospital (see instructions)   0   25.00   Coto f physic ian's services in a teaching hospital (see instructions)   0   26.00   Coto f physic ian's services in a teaching hospital (see instructions)   0   26.00   Coto f physic ian's services in a teaching hospital (see instructions)   0   26.00   Coto f physic ian's services in a teaching hospital (see instructions)   0   29.00   Coto f physic ian's services in a teaching hospital (see instructions)   0   29.00   Coto f physic ian's services in a teaching hospital (see instructions)   0   29.00   Coto f physic ian's services in a teaching hospital (see instructions)   0   29.00   Coto f physic ian's services in a teaching hospital (see instructions)   0   29.00   Coto f physic ian's services in a teaching hospital (see instructions)   0   29.00   Coto f physic ian's services in a teaching hospital see instructions   0   29.00   Coto f physic ian's services in a teaching hospital see instructions   0   29.00   Coto f physic ian's services in a teaching hospital see instructions   0   29.00   Coto f physic ian's services in a teaching hospital see instructions   0   29.00   Coto f physic ian's services in a teaching hospital see instructions   0   29.00   Coto f physic ian's services in a teaching hospital see instructions   0   29.00   Coto f physic ian's services i						
23. 00   Cost of physicians' services in a teaching hospital (see instructions)   0   24. 00   24. 00   24. 00   24. 00   24. 00   24. 00   24. 00   24. 00   24. 00   24. 00   24. 00   24. 00   24. 00   24. 00   24. 00   25. 00   26. 0						ł
24. 00   Total prospective payment (sum of lines 3, 4, 4. 01, 8 and 9)   0   24. 00		1	ructions)		-	•
COMPUTATION OF REINBURSEMENT SETTLEMENT   25.00			r de trons)		-	•
26.00   Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   26.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   27.00   Instructions)   27.00   Instructions)   28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   0   28.00   29.00   ESRO direct medical education costs (from Wkst. E-4, line 36)   0   29.00   30.00   Subtotal (sum of lines 27 through 29)   636   30.00   30.00   Subtotal (sum of lines 27 through 29)   636   30.00   30.00   Finary payer payments   0   31.00   636   32.00   30.00   Allowable BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   0   34.0						
27.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)					0	•
Instructions   Direct graduate medical education payments (from Wkst. E-4, line 50)   0 28.00   29.00   ESRD direct medical education costs (from Wkst. E-4, line 36)   0 29.00   30.00   Subtotal (sum of lines 27 through 29)   636   30.00   31.00   31.00   31.00   31.00   32.0		, and the second	•		(2)	•
28.00	27.00	- · · · · · · · · · · · · · · · · · · ·	prus the sum of fines 2.	z and zaj (see	636	27.00
29.00   ESRD diffect medical education costs (from Wkst. E-4, line 36)   29.00   30.	28. 00		ine 50)		0	28. 00
31.00   Primary payer payments   0   31.00   Subtotal (line 30 minus line 31)   636   32.00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   32.00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   32.00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Allowable bad debts (see instructions)   0   34.00   Allowable bad debts (see instructions)   0   35.00   Adjusted reimbursable bad debts (see instructions)   0   35.00   Adjusted reimbursable bad debts (see instructions)   0   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   636   636   37.00   Subtotal (see instructions)   636   636   83.00   637.00   638   63	29. 00				0	29. 00
Subtotal (line 30 minus line 31)		,				•
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. I-5, line 11)   0   33.00   34.00   34.00   Allowable bad debts (see instructions)   0   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   0   35.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   36.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   36.00   38.00   MSP-LCC reconciliation amount from PS&R   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.50   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   93.90   93.90   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.97   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.99   40.00   Subtotal (see instructions)   636   40.00   40.01   Sequestration adjustment (see instructions)   13   40.01   40.01   Sequestration adjustment (see instructions)   13   40.01   40.02   Demonstration payment adjustment amount after sequestration   0   40.02   41.00   Interim payments   1,032   41.00   42.00   Tentative settlement (for contractors use only)   43.00   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   44.00   Forested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   44.00   Forested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   40.02   40.00					-	•
33.00   Composite rate ESRD (from Wkst. I - 5, line 11)   0   34.00   All owable bad debts (see instructions)   0   34.00   All owable bad debts (see instructions)   0   35.00   Adjusted reimbursable bad debts (see instructions)   0   35.00   Adjusted reimbursable bad debts (see instructions)   0   36.00   37.00   Subtotal (see instructions)   636   37.00   Subtotal (see instructions)   636   37.00   38.00   MSP-LCC reconciliation amount from PS&R   88.00   MSP-LCC reconciliation amount from PS&R   99.00   39.50   99.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.50   99.90	32.00		CES)		636	32.00
34.00   Allowable bad debts (see instructions)   0   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   0   35.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   36.00   37.00   Subtotal (see instructions)   636   37.00   38.00   MSP-LCC reconciliation amount from PS&R   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   Ploneer ACO demonstration payment adjustment (see instructions)   39.97   Demonstration payment adjustment amount before sequestration   0   39.97   39.99   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.99   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   40.00   Subtotal (see instructions)   636   40.00   40.01   40.01   40.01   40.02   40.01	33.00	· ·	023)		0	33.00
36.00	34.00	Allowable bad debts (see instructions)			0	1
37.00   Subtotal (see instructions)   636   37.00   38.00   MSP-LCC reconciliation amount from PS&R   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   97   97   97   97   97   97   97   9		, , , , , , , , , , , , , , , , , , , ,			-	1
38.00       MSP-LCC reconciliation amount from PS&R       38.00         39.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0 39.00         39.50       Pioneer ACO demonstration payment adjustment (see instructions)       39.50         39.97       Demonstration payment adjustment amount before sequestration       0 39.97         39.98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0 39.98         39.99       RECOVERY OF ACCELERATED DEPRECIATION       0 39.99         40.01       Subtotal (see instructions)       636 40.00         40.01       Sequestration adjustment (see instructions)       13 40.01         40.02       Demonstration payment adjustment amount after sequestration       0 40.02         41.00       Interim payments       1,032 41.00         42.00       Interim payments       1,032 41.00         43.00       Balance due provider/program (see instructions)       -40 43.00         44.00       Fortested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00       44.00         91.52       TO BE COMPLETED BY CONTRACTOR       90.00         91.00       Outlier reconciliation adjustment amount (see instructions)       91.00         92.00       The rate used to calculate the Time Value of Money       93.00<		,	ructions)		-	
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pi oneer ACO demonstration payment adjustment (see instructions) 39.77 Pi oneer ACO demonstration payment adjustment (see instructions) 39.97 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.02 Interim payments 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  \$\frac{\frac{\text{5115.2}}{\text{515.2}}}{\text{70 BE COMPLETED BY CONTRACTOR}}  90.00 Original outlier amount (see instructions) 71.00 Outlier reconciliation adjustment amount (see instructions) 72.00 The rate used to calculate the Time Value of Money 73.00 Time Value of Money (see instructions) 74.00 Time Value of Money (see instructions) 75.00 Time Value of Money (see instructions) 75.00 Time Value of Money (see instructions) 77.00 Time Value of Money (see instructions) 78.00 Time Value of Money (see instructions) 79.00 Time Value of Money (see instructions)					636	1
39.50 39.97 39.98 39.98 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 40.00 Subtotal (see instructions) 39.90 40.01 Sequestration adjustment (see instructions) 39.90 40.02 Interim payments 40.00 Balance due provider/program (see instructions) 40.00 41.00 Balance due provider/program (see instructions) 42.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					0	1
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions)  39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION  39. 99 40. 00 Subtotal (see instructions)  40. 01 Sequestration adjustment (see instructions)  40. 02 Demonstration payment adjustment amount after sequestration  41. 00 Interim payments  41. 00 Tentative settlement (for contractors use only)  43. 00 Balance due provider/program (see instructions)  44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  90. 00 Original outlier amount (see instructions)  90. 00 Outlier reconciliation adjustment amount (see instructions)  91. 00 Outlier reconciliation adjustment amount (see instructions)  92. 00 The rate used to calculate the Time Value of Money  93. 00 Time Value of Money (see instructions)  93. 00			s)		_	
39. 99   RECOVERY OF ACCELERATED DEPRECIATION   0   39. 99   40. 00   Subtotal (see instructions)   636   40. 00   40. 01   Sequestration adjustment (see instructions)   13   40. 01   40. 02   41. 00   Interim payment adjustment amount after sequestration   0   40. 02   41. 00   Interim payments   1, 032   41. 00   42. 00   42. 00   43. 00   Balance due provider/program (see instructions)   -409   43. 00   44. 00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   44. 00   44. 00   44. 00   45		, , , , , , , , , , , , , , , , , , , ,			0	
40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8115.2 80.00 Original outlier amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00		•	ced devices (see instru	ctions)		•
40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.02 Interim payments 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  \$\frac{\text{515.2}}{\text{10 BE COMPLETED BY CONTRACTOR}}  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00					-	ı
40.02 Demonstration payment adjustment amount after sequestration  41.00 Interim payments  Tentative settlement (for contractors use only)  43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  5115.2  TO BE COMPLETED BY CONTRACTOR  Original outlier amount (see instructions)  90.00 Outlier reconciliation adjustment amount (see instructions)  79.00 The rate used to calculate the Time Value of Money  91.00 Time Value of Money (see instructions)  92.00 Time Value of Money (see instructions)  93.00		1				ł
41.00 Interim payments  1,032 41.00  42.00 Tentative settlement (for contractors use only)  43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  5115.2  TO BE COMPLETED BY CONTRACTOR  Original outlier amount (see instructions)  90.00 Outlier reconciliation adjustment amount (see instructions)  91.00 The rate used to calculate the Time Value of Money  92.00 Time Value of Money (see instructions)  93.00		1 '				1
43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00    90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00    94.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 90.00    90.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 90.00    91.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 90.00    92.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 90.00    93.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 90.00    94.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 90.00    95.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 90.00    97.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 90.00    97.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 90.00    97.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 90.00    97.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 90.00    97.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 90.00    97.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 90.00    97.00 Protested amounts (nonallowable cost report items) in accordance with	41.00				1, 032	41.00
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00						1
\$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00		, , , , , , , , , , , , , , , , , , , ,	noo with CMC Dut 15 0	obonton 1		ł
TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  91.00 The rate used to calculate the Time Value of Money  92.00 Time Value of Money (see instructions)  93.00 Outlier reconciliation adjustment amount (see instructions)	44.00		nce with CMS Pub. 15-2,	chapter 1,	0	44.00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00						
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 91.00 92.00 93.00	90.00					90.00
93.00 Time Value of Money (see instructions)	91.00	Outlier reconciliation adjustment amount (see instructions)				
						1
74. 00   10 tai (Suiii 01 11 1165 71 aliu 73)		,				1
	74.00	Total (Sail of 111105 /1 and 70)		l	l	74.00

Health Financial Systems WITH ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2019 | Part | | To 12/31/2019 | Date/Time Prepared: Provi der CCN: 15-0104

			'	0 12/31/2019	3/31/2020 8: 1	
		Title	: XVIII	Hospi tal	PPS	
		I npati en	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		7, 452, 968		10, 947, 388	1. 00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,		C		0	2. 00
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		1 0		0	3. 01
3. 02 3. 03 3. 04 3. 05	ADJUSTIMENTS TO PROVIDER		000000000000000000000000000000000000000		0 0	3. 02 3. 03 3. 04 3. 05
	Provider to Program					
3. 50 3. 51	ADJUSTMENTS TO PROGRAM		0		0	3. 50 3. 51
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3. 54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		C		0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)  TO BE COMPLETED BY CONTRACTOR		7, 452, 968		10, 947, 388	4.00
F 00			T	T		E 00
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	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
	Provi der to Program		1		_	
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)		C		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVI DER		146, 753		197, 455	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		7, 599, 721	0	11, 144, 843	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
	I	(	0	1. 00	2. 00	
8.00	Name of Contractor					8.00

Health Financial Systems	WITHAM MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR S	SERVI CES RENDERED	Provi der CCN: 15-0104	Period: From 01/01/2019	Worksheet E-1 Part I	
		Component CCN: 15-S104	To 12/31/2019	Date/Time Prep 3/31/2020 8:18	
		Title XVIII	Subprovi der -	PPS	
			I PF		
		Innationt Dart A	Dor	+ D	

Inpatient Part A			Title	XVIII	Subprovi der - I PF	PPS	
1.00			I npati en	t Part A		t B	
1.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Interfim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.			1. 00				
Submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero				2, 321, 709	)	1, 376	1.00
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero lump sum adjustment a monut based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	2.00			C	)	0	2. 00
write "NONE" or enter a zero .0							
List separately each retroactive lump sum adjustment a mount based on subsequent revelsion 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							
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  ADJUSTMENTS TO PROVIDER  BOOK ON ADJUSTMENTS TO PROVIDER  ADJUSTMENTS TO PROGRAM	2 00						3. 00
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	3.00						3.00
payment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
ADJUSTMENTS TO PROVIDER							
3.02   0		Program to Provider					
3.04   0   0   0   3.	3. 01	ADJUSTMENTS TO PROVIDER		C	)		3. 01
3.05   Provider to Program							3. 02
3.50   ADJUSTMENTS TO PROGRAM							3. 03
Provider to Program   ADJUSTMENTS TO PROGRAM   0   0   0   3   3   5   5   5   5   5   5   5   5							3.04
3.50   ADJUSTMENTS TO PROGRAM	3. 05	Dravi dan ta Dragnam			)	0	3. 05
3.51	2 50				1		3. 50
3.52   3.53   3.54   3.59   3.50		ADJUSTIMENTS TO PROGRAM					3. 50
3.53   3.54   3.54   3.59   3.593   3.50-3.98   3.50							3. 52
3. 99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   0   0   3.50-3.98)   3. 50-3.98)   2. 321,709   1,376   4.							3. 53
3.50-3.98    7   7   7   7   7   7   7   7   7	3.54			C	)	0	3. 54
1,376   4.00   Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR	3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C	)	0	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR							
appropriate   TO BE COMPLETED BY CONTRACTOR	4. 00			2, 321, 709		1, 376	4. 00
TO BE COMPLÉTED BY CONTRACTOR							
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	5 00						5. 00
Write "NONE" or enter a zero. (1)   Program to Provider	5.00						3.00
TENTATI VE TO PROVI DER							
5. 02		Program to Provider					
Description		TENTATI VE TO PROVI DER					5. 01
Provider to Program							5. 02
TENTATIVE TO PROGRAM	5. 03	Dec. 1 Lea La Deceasion			)	0	5. 03
5.51   0	E E0						F F0
5. 52   0 0 0 5. 5. 59   Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98)   6. 00   Determined net settlement amount (balance due) based on the cost report. (1)   6. 01   SETTLEMENT TO PROVIDER   6, 961   0 6. 6. 02   SETTLEMENT TO PROGRAM   0 370   6. 7. 00   Total Medicare program liability (see instructions)   2, 328, 670   Contractor Number (Mo/Day/Yr)   0   1. 00   2. 00   Contractor Number (Mo/Day/Yr)   0   Contractor Number (Mo/Day/Yr)   0   Contractor Number (Mo/Day/Yr)   Contrac		TENTATIVE TO PROGRAM					5. 50 5. 51
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   O							5. 52
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  O 1.00 2.00		Subtotal (sum of lines 5.01-5.49 minus sum of lines					5. 99
the cost report. (1) SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1. 00 2. 00							
6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1. 00 2. 00	6.00	Determined net settlement amount (balance due) based on					6. 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  0 2,328,670 1,006 7.  Contractor Number (Mo/Day/Yr) 0 1.00 2.00							
7.00         Total Medicare program liability (see instructions)         2,328,670         1,006         7.           Contractor Number (Mo/Day/Yr)         0         1.00         2.00							6. 01
Contractor   NPR Date   Number   (Mo/Day/Yr)     0   1.00   2.00							6. 02
Number         (Mo/Day/Yr)           0         1.00         2.00	7.00	lotal Medicare program liability (see instructions)		2, 328, 670			7. 00
0 1.00 2.00							
				)			
8.00 INAME OF CONTRACTOR TO THE TENT OF THE STATE OF THE	8. 00	Name of Contractor			1.00	2.00	8. 00

Health Financial Systems	WITHAM MEMORIAL	HOSPI TAL	In Lieu	of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SER	VICES RENDERED	Provi der CCN: 15-0104		Worksheet E-1
		Component CCN: 15 E933	From 01/01/2019	

Component CCN: 15-5832 To 12/31/2019 Date/Time Prepared: 3/31/2020 8: 18 am

Title XVIII Skilled Nursing PPS

		Title	XVIII	Skilled Nursing Facility	PPS	
		I npati en	t Part A		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		1, 275, 849	9	1, 032	1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		(	D	0	2. 00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		(		0	3. 01
3. 02	ABSOSTIMENTS TO TROVIDER				Ö	3. 02
3. 03					0	3. 03
3. 04					ol	3. 04
3. 05			(		0	3. 05
	Provider to Program			•		
3.50	ADJUSTMENTS TO PROGRAM		(		0	3. 50
3.51			(		0	3. 51
3. 52					0	3. 52
3.53					0	3. 53
3.54					0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)				0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		1, 275, 849	9	1, 032	4.00
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		(		0	5. 01
5.02			(		o	5. 02
5.03			(		0	5. 03
	Provider to Program					
5. 50	TENTATIVE TO PROGRAM				0	5. 50
5. 51					0	5. 51
5. 52					0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		(		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		16, 90	5	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		1 202 75	ול	409	6. 02
7.00	Total Medicare program liability (see instructions)		1, 292, 752	Contractor	623 NPR Date	7. 00
				Number	(Mo/Day/Yr)	
0.55		(	)	1. 00	2. 00	0 -
8. 00	Name of Contractor	I		1	l l	8.00

Heal th	Financial Systems WITHAM MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-0104	Peri od:	Worksheet E-1	
			From 01/01/2019		
			To 12/31/2019	Date/Time Pre 3/31/2020 8:1	
		Title XVIII	Hospi tal	PPS	O dili
			110001 101		
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	V			1
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	. S-3, Pt. I col. 15 lin	e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8. 00	Calculation of the HIT incentive payment (see instructions)				8. 00
9. 00					
10. 00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.				
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)				30.00
	31.00 Other Adjustment (specify)				
32. 00	32.00  Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)   32.00				

Heal th	Financial Systems	WITHAM MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0104	Peri od:	Worksheet E-3	
				From 01/01/2019		
			Component CCN: 15-S104	To 12/31/2019		
					3/31/2020 8: 1	8 am
			Title XVIII	Subprovi der -	PPS	
				I PF		
					1. 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS					
1. 00	Net Federal IPF PPS Payments (excluding outli	ier, ECT, and med	lical education payments	)	2, 518, 099	1.00
2. 00	Net IPF PPS Outlier Payments				8, 683	2.00
3.00	Net IPF PPS ECT Payments				0	3.00
4. 00	Unweighted intern and resident FTE count in	the most recent c	ost report filed on or	before November	0. 00	4. 00

MEDICARE PART A SERVICES - IPF PPS  IN IPF PPS Payments (excluding outlier, ECT, and medical education payments)  IN Outlier Payments  IN SECT Payments  IN Intern and resident FTE count in the most recent cost report filed on or before November (see instructions)  IN INSERVE SECT PAYMENTS  IN INTERPRETARY SERVICES - IPF PPS  IN OUTLIER SECTION  IN INTERPRETARY SERVICES - IPF PPS  IN IPF PPS Payments  IN IN IPF PPS Payments  IN IN IN INTERPRETARY  IN INT	2, 518, 099 8, 683 0 0. 00 0. 00 0. 00 0. 00 0. 00 8. 797260 0. 000000 0, 526, 782
S Outlier Payments S ECT Payments I intern and resident FTE count in the most recent cost report filed on or before November (see instructions) sees for the unweighted intern and resident FTE count for residents that were displaced by hospital closure, that would not be counted without a temporary cap adjustment under 42 24(d)(1)(iii)(F)(1) or (2) (see instructions) ng program adjustment. (see instructions) sar's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new program" (see instructions) sar's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions) I resident count for IPF PPS medical education adjustment (see instructions) sily Census (see instructions) digustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1). digustment (line 1 multiplied by line 10). Net IPF PPS Payments (sum of lines 1, 2, 3 and 11) and Allied Health Managed Care payment (see instruction)	8, 683 0 0. 00 0. 00 0. 00 0. 00 0. 00 8. 797260 0. 000000 0 2, 526, 782
SECT Payments I intern and resident FTE count in the most recent cost report filed on or before November (see instructions) I see instructions I resident see instructions I resident count for IPF PPS medical education adjustment (see instructions) I resident count for IPF PPS medical education adjustment (see instructions) I see instructions I djustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}. I set in the new program is the instructions of the power of instruction of the power of ins	0.00 0.00 0.00 0.00 0.00 0.00 8.797260 0.000000 0.2,526,782
lintern and resident FTE count in the most recent cost report filed on or before November (see instructions) uses for the unweighted intern and resident FTE count for residents that were displaced by hospital closure, that would not be counted without a temporary cap adjustment under 42 24(d)(1)(iii)(F)(1) or (2) (see instructions) user's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new program" (see instructions) user's unweighted FTE count for residents within the new program growth period of a "new program" (see instructions) user's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions) user's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions) user's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions) user's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions) user's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions) user's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions) user's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions) user's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions) user's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions) user's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions) user's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions) user's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions) user's unweighted I&R	0.00  0.00  0.00  0.00  0.00  8.797260 0.00000  0.2,526,782
(see instructions) uses for the unweighted intern and resident FTE count for residents that were displaced by hospital closure, that would not be counted without a temporary cap adjustment under 42 24(d)(1)(iii)(F)(1) or (2) (see instructions) user's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new program" (see instructions) user's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions) user's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions) user's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions) user's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions) user's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions) user's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions) user's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions) user's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions) user's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions) user's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions) user's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions) user's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions) user's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions) user's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see i	0. 00 0. 00 0. 00 0. 00 8. 797260 0. 000000 0 2, 526, 782
chospital closure, that would not be counted without a temporary cap adjustment under 42 24(d)(1)(iii)(F)(1) or (2) (see instructions) are program adjustment. (see instructions) are sunweighted FTE count of I&R excluding FTEs in the new program growth period of a "new program" (see instructions) are sunweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions) are sident count for IPF PPS medical education adjustment (see instructions) adjustment factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}. Adjustment (line 1 multiplied by line 10).  Net IPF PPS Payments (sum of lines 1, 2, 3 and 11) and Allied Health Managed Care payment (see instruction)	0. 00 0. 00 0. 00 0. 00 8. 797260 0. 000000 0 2, 526, 782
ng program adjustment. (see instructions)  Par's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new program" (see instructions)  Par's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions)  Par's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions)  Par's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions)  Par's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions)  Par's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions)  Par's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions)	0. 00 0. 00 0. 00 8. 797260 0. 000000 0 2, 526, 782
war's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new program" (see instructions)  war's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions)  I resident count for IPF PPS medical education adjustment (see instructions)  will y Census (see instructions)  digustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.  digustment (line 1 multiplied by line 10).  Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)  digustment (line 1 multiplied by line 1)	0. 00 0. 00 8. 797260 0. 000000 0 2, 526, 782
var's unweighted I&R FTE count for residents within the new program growth period of a "new program" (see instructions) I resident count for IPF PPS medical education adjustment (see instructions) I value instructions) I value instructions (see instructions) I value instructions ((1 + (line 8/line 9)) raised to the power of .5150 -1). I value in the second in the	0. 00 8. 797260 0. 000000 0 2, 526, 782
ily Census (see instructions) djustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}. djustment (line 1 multiplied by line 10). Net IPF PPS Payments (sum of lines 1, 2, 3 and 11) d Allied Health Managed Care payment (see instruction)	8. 797260 0. 000000 0 2, 526, 782
djustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}. djustment (line 1 multiplied by line 10). Net IPF PPS Payments (sum of lines 1, 2, 3 and 11) d Allied Health Managed Care payment (see instruction)	0. 000000 0 2, 526, 782
djustment (line 1 multiplied by line 10). Net IPF PPS Payments (sum of lines 1, 2, 3 and 11) Id Allied Health Managed Care payment (see instruction)	0 2, 526, 782
Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)  Ind Allied Health Managed Care payment (see instruction)	2, 526, 782
d Allied Health Managed Care payment (see instruction)	1
: -: +: (DO NOT LICE THIC LINE)	0
· ·	
ysicians' services in a teaching hospital (see instructions)	0
see instructions)	2, 526, 782
yer payments	0
, , , , , , , , , , , , , , , , , , ,	2, 526, 782
es .	134, 844
·	2, 391, 938
e	22, 847
	2, 369, 091
	10, 928
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· · · · · · · · · · · · · · · · · · ·	0
	2, 376, 194
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1 3 /	2, 376, 194
· · · · · · · · · · · · · · · · · · ·	47, 524
, ,	0
	2, 321, 709
	0
amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	6, 961
LETED BY CONTRACTOR	
	8, 683
· · · · · · · · · · · · · · · · · · ·	0
,	0.00
ysylsielbebsd ysoinii	sition (DO NOT USE THIS LINE) sicians' services in a teaching hospital (see instructions) ee instructions) ee instructions) ee instructions) ee payments ine 16 less line 17).  ine 18 minus line 21) ad debts (exclude bad debts for professional services) (see instructions) imbursable bad debts (see instructions) ad debts for dual eligible beneficiaries (see instructions) um of lines 22 and 24) uate medical education payments (from Wkst. E-4, line 49) through costs (see instructions) ments reconciliation TMENTS (SEE INSTRUCTIONS) (SPECIFY) of demonstration payment adjustment (see instructions) on payment adjustment amount before sequestration it payable to the provider (see instructions) on adjustment (see instructions) on payment adjustment amount after sequestration ments ettlement (for contractor use only) provider/program (line 31 minus lines 31.01, 31.02, 32 and 33) mounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,

Heal th	Financial Systems WITHAM MEMOR	I AL HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Peri od:	Worksheet E-3	
		C CON 15 5022	From 01/01/2019	Part VI	
		Component CCN: 15-5832	To 12/31/2019	Date/Time Pre 3/31/2020 8:1	
		Title XVIII	Skilled Nursing	PPS	O dill
			Facility		
	F			1. 00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL	OTHER HEALTH SERVICES FOR	TITLE XVIII PART	A PPS SNF	
	SERVICES PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1. 00	Resource Utilization Group Payment (RUGS)			1, 462, 838	1.00
2.00	Routine service other pass through costs			1, 402, 030	2.00
3.00	Ancillary service other pass through costs			0	3.00
4. 00	Subtotal (sum of lines 1 through 3)			1, 462, 838	
00	COMPUTATION OF NET COST OF COVERED SERVICES			17 1027 000	
5.00	Medical and other services (Do not use this line as vaccir	ne costs are included in li	ne 1 of W/S E,		5.00
	Part B. This line is now shaded.)				
6.00	0 Deductible 0 6				
7.00	Coi nsurance			160, 952	7.00
8.00	Allowable bad debts (see instructions)			26, 537	
9.00	Reimbursable bad debts for dual eligible beneficiaries (se	ee instructions)		0	9. 00
10.00	Adjusted reimbursable bad debts (see instructions)			17, 249	
11. 00				0	11.00
12. 00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus line	es 10 and 11)(see instruction	ons)	1, 319, 135	
13.00	Inpatient primary payer payments			0	13.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	14.00
14. 50	Pioneer ACO demonstration payment adjustment (see instruct			0	14.50
14. 99	Demonstration payment adjustment amount before sequestrati	on		0	
15. 00					
15. 01					
15. 02		on		0	15. 02
	Interim payments			1, 275, 849	
	Tentative settlement (for contractor use only)	15 00 47		0	17.00
	Balance due provider/program (line 15 minus lines 15.01, 1		2	16, 903	
19.00	19.00 Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, 0 19.00 §115.2				

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0104	Peri od: Worksheet E-3 From 01/01/2019 Part VII To 12/31/2019 Date/Time Prepared: 3/31/2020 8:18 am

		1	0 12/31/2019	Date/lime Pre   3/31/2020 8:1		
		Title XIX	Hospi tal	Cost	<u> </u>	
			Inpati ent	Outpati ent		
			1. 00	2. 00		
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	ICES FOR TITLES V OR XI				
	COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		573, 119		1.00	
2.00	Medical and other services			0	2.00	
3.00	Organ acquisition (certified transplant centers only)		o		3.00	
4.00	Subtotal (sum of lines 1, 2 and 3)		573, 119	0		
5.00	Inpatient primary payer payments		0		5.00	
6.00	Outpatient primary payer payments			0		
7.00	Subtotal (line 4 less sum of lines 5 and 6)		573, 119	0		
	COMPUTATION OF LESSER OF COST OR CHARGES					
	Reasonable Charges					
8.00	Routine service charges		1, 102, 686		8.00	
9.00	Ancillary service charges		1, 090, 341	0	9.00	
10.00	Organ acquisition charges, net of revenue		0		10.00	
11.00	Incentive from target amount computation		0		11.00	
12.00	Total reasonable charges (sum of lines 8 through 11)		2, 193, 027	0	12.00	
	CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for s	services on a charge	0	0	13. 00	
	basis					
14.00	Amounts that would have been realized from patients liable for p		0	0	14.00	
45.00	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)			45.00	
	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0. 000000		
	Total customary charges (see instructions)	: E   : 1/	2, 193, 027	0		
17. 00	Excess of customary charges over reasonable cost (complete only line 4) (see instructions)	IT TIME 16 exceeds	1, 619, 908	0	17. 00	
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00	
10.00	16) (see instructions)	II Tille 4 exceeds Tille	J J	U	10.00	
19. 00	Interns and Residents (see instructions)		0	0	19.00	
	Cost of physicians' services in a teaching hospital (see instruc	ctions)	0	0		
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		573, 119	0		
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co				200	
22.00	Other than outlier payments	omprotou for the protru	0	0	22.00	
	Outlier payments		0	0	23.00	
	Program capital payments		0		24.00	
	Capital exception payments (see instructions)		0		25. 00	
26.00	Routine and Ancillary service other pass through costs		0	0	26.00	
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00	
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00	
29.00	Titles V or XIX (sum of lines 21 and 27)		573, 119	0	29. 00	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT					
	Excess of reasonable cost (from line 18)		0	0		
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		573, 119	0	31.00	
	Deducti bl es		0	0		
33. 00	Coi nsurance		0	0		
	Allowable bad debts (see instructions)		0	0		
	Utilization review		0		35.00	
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	33)	573, 119	0		
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0		
	Subtotal (line 36 ± line 37)		573, 119	0		
	Direct graduate medical education payments (from Wkst. E-4)		0		39.00	
	Total amount payable to the provider (sum of lines 38 and 39)		573, 119	0		
	Interim payments		800, 493	0		
42.00	Balance due provider/program (line 40 minus line 41)		-227, 374 0	0		
43. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2			0	43.00	
	Chapter 1, 3110.2		1		I	

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

Provi der CCN: 15-0104

Peri od: Worksheet G
From 01/01/2019
To 12/31/2019 Date/Time Prepared: 3/31/2020 8:18 am

——————————————————————————————————————					3/31/2020 8: 1	8 am
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	0.00	1. 00	
1.00	Cash on hand in banks	29, 757, 329	0	0	0	1.00
2.00	Temporary investments	5, 933, 032	0	0		2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts recei vable	22, 218, 310		0	0	4. 00
5. 00	Other receivable	1, 998, 485	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable		0	0	0	6.00
7. 00	Inventory	3, 329, 377	0	0	0	7.00
8. 00 9. 00	Prepai d expenses	1 500 034		0	0	8.00
10.00	Other current assets Due from other funds	1, 590, 034		0	0	9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	64, 826, 567		0		11.00
11.00	FIXED ASSETS	04, 020, 307	0	0	0	11.00
12. 00	Land	0	0	0	0	12.00
13. 00	Land improvements	5, 899, 319		0	Ō	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Bui I di ngs	38, 310, 413	o	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fi xed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22. 00
23.00	Major movable equipment	160, 192, 540	0	0	0	23. 00
24.00	Accumulated depreciation	-86, 014, 309	0	0	0	24.00
25.00	Mi nor equi pment depreciable	0	0	0	0	25. 00
26. 00	Accumulated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	118, 387, 963	0	0	0	30.00
04 00	OTHER ASSETS		.l			04 00
31.00	Investments Penerits on Leases		0	0	0	31. 00 32. 00
32. 00 33. 00	Deposits on leases			0	0	32.00
34.00	Due from owners/officers Other assets	27, 373, 446	1	0	0	34.00
35. 00	Total other assets (sum of lines 31-34)	27, 373, 446		0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	210, 587, 976		0	0	36.00
00.00	CURRENT LIABILITIES	210,007,770	,ı	<u> </u>		00.00
37.00	Accounts payable	4, 648, 996	0	0	0	37.00
38.00	Salaries, wages, and fees payable	10, 178, 495	0	0	0	38.00
39.00	Payroll taxes payable		o	0	0	39.00
40.00	Notes and Loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0	)			42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4, 427, 152	. 0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	19, 254, 643	0	0	0	45. 00
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	0	0	0	46. 00
47. 00	Notes payable	0	0	0	0	47. 00
48. 00	Unsecured Loans	0	0	0		48. 00
49. 00	Other long term liabilities	41, 711, 539		0	0	49. 00
50. 00	Total long term liabilities (sum of lines 46 thru 49)	41, 711, 539		0		50.00
51. 00	Total liabilities (sum of lines 45 and 50)	60, 966, 182	. 0	0	0	51.00
	CAPITAL ACCOUNTS	140 (04 704				
52.00	General fund balance	149, 621, 794				52.00
53.00	Specific purpose fund		0			53.00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			O	_	56.00
57.00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion					58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	149, 621, 794		0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	210, 587, 976		0	0	60.00
00.00	[59]	210, 301, 310	]	U		00.00
	1 * 2	1	1	!	1	1

In Lieu of Form CMS-2552-10
Period: Worksheet G-1
From 01/01/2019 Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 15-0104

					To	om 01/01/2019 12/31/2019	Date/Time P 3/31/2020 8		
		Genera	I Fund	Speci al F	Purp	pose Fund	Endowment Fund	. 10	alli
							i unu		
1 00		1. 00	2.00	3. 00		4. 00	5. 00		1.00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		141, 614, 729 8, 007, 065			0			1. 00 2. 00
3. 00	Total (sum of line 1 and line 2)		149, 621, 794	1		0		- 1	3.00
4.00	Additions (credit adjustments) (specify)	0			0			0	4.00
5.00		0			0			0	5.00
6. 00 7. 00		0			0			0	6. 00 7. 00
8. 00		0			0			0	8. 00
9. 00		0			0			0	9.00
10.00	Total additions (sum of line 4-9)		0			0		-	10.00
11. 00 12. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	149, 621, 794	i	0	0		0	11. 00 12. 00
13. 00	beddetrons (debrt day detiments) (specify)	o o			0			0	13.00
14.00		0			0			0	14.00
15.00		0			0			0	15.00
16. 00 17. 00		0			0			0	16. 00 17. 00
18. 00	Total deductions (sum of lines 12-17)	0	0			0		Ĭ	18. 00
19. 00	Fund balance at end of period per balance		149, 621, 794			0			19.00
	sheet (line 11 minus line 18)	Endowment	DI ant	Fund					
		Fund	Trant	. Turiu					
1. 00	Fund balances at beginning of period	6. 00	7. 00	8. 00	0			+	1. 00
2. 00	Net income (loss) (from Wkst. G-3, line 29)	O			١			- 1	2.00
3.00	Total (sum of line 1 and line 2)	0			0			- 1	3.00
4.00	Additions (credit adjustments) (specify)		0						4.00
5. 00 6. 00			0						5. 00 6. 00
7. 00			0					- 1	7. 00
8.00			0					-	8.00
9.00	T		0						9.00
10. 00 11. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0		1	0			-	10. 00 11. 00
12. 00	Deductions (debit adjustments) (specify)	0	0					- 1	12.00
13.00	, , , , , , , , , , , , , , , , , , , ,		0					- 1	13.00
14.00			0						14.00
15. 00 16. 00			0						15. 00 16. 00
17. 00			Ö						17. 00
18. 00	Total deductions (sum of lines 12-17)	0		1	0				18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0				19. 00

| Peri od: | Worksheet G-2 | From 01/01/2019 | Parts | & II | To 12/31/2019 | Date/Time Prepared: Health Financial Systems WASTATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0104

			To	12/31/2019	Date/Time Pre 3/31/2020 8:1	
	Cost Center Description	Inpatie	nt	Outpati ent	Total	o am
	5555 551151 55551 Pt 1511	1.00		2. 00	3. 00	
	PART I - PATIENT REVENUES	1 11 00	-	2.00	0.00	
	General Inpatient Routine Services					
1.00	Hospi tal	18, 16	3, 102		18, 168, 102	1.00
2.00	SUBPROVI DER - I PF	4, 04	3, 285		4, 043, 285	2.00
3.00	SUBPROVI DER - I RF		0		0	3.00
4.00	SUBPROVI DER		0		0	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	2, 97	1, 566		2, 971, 566	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)	25, 18	2, 953		25, 182, 953	10.00
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT	4, 87	1, 688		4, 871, 688	11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14. 00	SURGICAL INTENSIVE CARE UNIT					14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15.00
16. 00	Total intensive care type inpatient hospital services (sum of lin	es 4,87	1, 688		4, 871, 688	16. 00
47.00	11-15)				00 054 444	47.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	30, 05		07/ 440 /55	30, 054, 641	17.00
18.00	Ancillary services	58, 73		276, 412, 655	335, 145, 405	18.00
19.00	Outpatient services	3, 91	8, 807	39, 159, 895	43, 078, 702	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			4 420 212	4 400 044	22.00
23. 00	AMBULANCE SERVICES		2, 032	4, 420, 312	4, 422, 344	23.00
24. 00 25. 00	CMHC					24. 00 25. 00
26. 00	AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE					26.00
27. 00	EH&S, DIETARY, PHYSICIAN PRIVATE OFF	15	6, 042	60, 095, 293	59, 639, 251	27.00
27. 00	PROFESSIONAL FEE		7, 082	57, 144	-399, 938	27. 00
27. 01	SELF-I NSURED		6, 415	9, 709, 862	11, 156, 277	27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to			389, 855, 161	483, 096, 682	28. 00
20.00	G-3, line 1)	WK31. 75, 24	1, 321	307, 033, 101	403, 070, 002	20.00
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			162, 024, 578		29. 00
30.00	ADD (SPECIFY)		0			30.00
31.00			0			31.00
32.00			0			32.00
33.00			0			33.00
34.00			0			34.00
35.00			0			35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)		0			37.00
38.00			0			38. 00
39. 00			0			39.00
40.00			0			40.00
41.00			0			41.00
42. 00	Total deductions (sum of lines 37-41)	_		0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(t	ransfer		162, 024, 578		43.00
	to Wkst. G-3, line 4)	I		J		

Hoal th	Financial Systems WITHAM MEMORIAL	HOSDI TAI	In lie	u of Form CMS-2	0552_10
	ENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0104	Peri od:	Worksheet G-3	
			From 01/01/2019 To 12/31/2019	Date/Time Pre 3/31/2020 8:1	
			,	1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, li			483, 096, 682	1.00
2.00	Less contractual allowances and discounts on patients' account	nts		324, 279, 723	
3. 00	Net patient revenues (line 1 minus line 2)			158, 816, 959	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		162, 024, 578	
5. 00	Net income from service to patients (line 3 minus line 4)			-3, 207, 619	5.00
	OTHER I NCOME				
6. 00	Contributions, donations, bequests, etc			0	
7.00	Income from investments			0	
8. 00	Revenues from telephone and other miscellaneous communication	n services		0	
9.00	Revenue from television and radio service			0	
10. 00	Purchase di scounts			0	
	Rebates and refunds of expenses			0	11.00
	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	
	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical supplies to other	than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	OTHER OPERATING INCOME			3, 446, 256	24.00
24. 01	NON-OPERATING INCOME			7, 768, 428	24. 01
25.00	Total other income (sum of lines 6-24)			11, 214, 684	25.00
26.00	Total (line 5 plus line 25)			8, 007, 065	26.00
27.00	OTHER EXPENSES (SPECIFY)			0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29.00	Net income (or loss) for the period (line 26 minus line 28)			8, 007, 065	29.00
			·	•	

111-	Financial Customs	HOCDLTAL	1 = 1 : =:	£ F CMC (	NEE 2 4 0		
	Financial Systems WITHAM MEMORIAL ATION OF CAPITAL PAYMENT	Provider CCN: 15-0104	Peri od:	u of Form CMS-2 Worksheet L	2552-10		
CALCUL	ATTON OF CAPITAL PAYMENT	Provider CCN: 15-0104	From 01/01/2019	Parts I-III			
	To 12/31/2019				pared:		
	PPS						
	PART I - FULLY PROSPECTIVE METHOD			1. 00			
	CAPITAL FEDERAL AMOUNT						
1. 00	Capital DRG other than outlier			497, 810	1. 00		
1. 01	Model 4 BPCI Capital DRG other than outlier			477, 010	1. 01		
2. 00	Capital DRG outlier payments			1, 229	2.00		
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2.00		
3. 00	Total inpatient days divided by number of days in the cost re	enorting period (see ins	tructions)	20. 40	3. 00		
4. 00	Number of interns & residents (see instructions)	oper tring period (see this	tructrons)	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 the	e sum of lines 1 and 1 O	1 columns 1 and	0.00	6.00		
0.00	1.01) (see instructions)	e sum of fiftes f and f. o	i, cordinis rand	O	0.00		
7. 00	Percentage of SSI recipient patient days to Medicare Part A	patient davs (Worksheet	E. part A line	0. 00	7. 00		
	30) (see instructions)	,	, , ,				
8.00	Percentage of Medicaid patient days to total days (see instri	uctions)		0.00	8. 00		
9.00	Sum of lines 7 and 8			0.00	9.00		
10.00	Allowable disproportionate share percentage (see instructions		0.00	10.00			
11.00	Disproportionate share adjustment (see instructions)		0	11.00			
12.00	Total prospective capital payments (see instructions)		499, 039	12.00			
				1. 00			
1 00	PART II - PAYMENT UNDER REASONABLE COST			0	1 00		
1. 00 2. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions)			0	1. 00 2. 00		
3. 00	Total inpatient program capital cost (see instructions)			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		
3.00	Total Tripatrent program capital cost (Time 3 x Time 4)			U	3.00		
				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 circumstan	ces (see instructions)		0	2.00		
3.00	Net program inpatient capital costs (line 1 minus line 2)			0 0. 00	3.00		
4.00	Applicable exception percentage (see instructions)				4.00		
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0	5.00		
6. 00	Percentage adjustment for extraordinary circumstances (see i	,		0. 00	6. 00		
7. 00	Adjustment to capital minimum payment level for extraordinary	y circumstances (line 2	x line 6)	0	7.00		
8.00	Capital minimum payment level (line 5 plus line 7)			0	8.00		
9.00	Current year capital payments (from Part I, line 12, as applicable)				9. 00		
10. 00					10.00		
11. 00	Carryover of accumulated capital minimum payment level over	capital payment (from pr	ior year	0	11. 00		
12. 00	Worksheet L, Part III, line 14)	aymonts (line 10 plus li	no 11)	0	12. 00		
13. 00					13. 00		
14. 00			0	14.00			
14.00	00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)						
15. 00	,	0	15. 00				
16. 00			0	16.00			
	00   Current year exception offset amount (see instructions)				17. 00		
. , . 00	1 0 1 1 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2						