Heal th Financia	al Systems	WITHAM MEMORIAL H	OSPI TAL		In Lieu	u of Form	CMS-2552-1
	required by law (42 USC 1395g; 42 since the beginning of the cost re	. , ,					ROVED 0938-0050
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX COST R SUMMARY	EPORT CERTIFICATION	Provi der CCN: 150°	From O	1/01/2014 2/31/2014		
PART I - COST	REPORT STATUS						
Provi der use only	1. [X] Electronically filed cost 2. [] Manually submitted cost re 3. [0] If this is an amended report. 4. [F] Medicare Utilization. Enter	eport ort enter the number of	f times the provide for low.		e: 5/28/20 [.] ed this co		ne: 2:31 p
Contractor use only	5. [1]Cost Report Status 6. Da (1) As Submitted 7. Co (2) Settled without Audit 8. [(3) Settled with Audit 9. [ntractor No.	this Provider CCN		or's Vendo	lumn 1 is	

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 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 (150104) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)	
	Officer or Administrator of Provider(s)
	,
Title	
11 11 0	
Date	

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	64, 969	76, 899	53, 779	-495, 458	1.00
2.00	Subprovi der - IPF	0	0	-181		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3. 00
4.00	SUBPROVI DER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
200.00	Total	0	64, 969	76, 718	53, 779	-495, 458	200. 00

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

	Medicaid paid days	Medi cai d el i gi bl e unpai d days	State Medicaid paid days	State Medi cai d el i gi bl e unpai d	HMO days	Medi cai d days	
	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. 25.00 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 eligible unpaid 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.	0	640	0	0	853	0	24. 00

care or general surgery. (see instructions)

Health Financial Systems WITHAM MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150104 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/28/2015 2:17 pm Program Name Program Code Unweighted IME Unwei ghted Direct GME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 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 and enter in column 4, 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 and enter in column direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62 01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N 63.00 for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) Unwei ahted Ratio (col. 1/ Unwei ahted **FTES** FTEs in (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1. 00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.000000 64.00 0.00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider 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) Unwei ghted Program Name Program Code Unwei ghted Ratio (col. 3/ FTĔs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to

rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

Health Financial Systems WITHAM MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150104 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/28/2015 2:17 pm Unwei ghted Unwei ghted Ratio (col. (col. 1 + col FTEs FTEs in Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 0. 00 66.00 Enter in column 1 the number of unweighted non-primary care resident 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. 3/ FTEs FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2 00 3. 00 4.00 5 00 67.00 Enter in column 1, the program 0.00 0.00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 Ν 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF Ν 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions) 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 81.00 | Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N 81.00 Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section N 85.00 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.

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Health Financial Systems WITHAM MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150104 Peri od: Worksheet S-2 From 01/01/2014 Part I 12/31/2014 Date/Time Prepared: 5/28/2015 2:17 pm 1. 00 2.00 128.00|If 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|f 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 of 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 olf 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 If this is an organ procurement organization (0P0), enter the 0P0 number in column 1 134 00 and termination date, if applicable, in column 2. All Providers 140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, Ν 140.00 chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)

1.00

2.00 3 00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number. 141. 00 Name: Contractor's Name: Contractor's Number: 141.00 142. 00 Street: 143. 00 Ci ty: PO Box: 142. 00 State: Zip Code: 143. 00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144.00 145.00 If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no. N 145.00 1. 00 2.00 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146. 00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 147. 00 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 148. 00 Ν 149.00|Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for Ν 149.00 no. Title V Part A 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) N N 155.00 155.00 Hospi tal Ν Ν Ν 156.00 Subprovi der - IPF Ν Ν Ν 156.00 157.00 Subprovi der - IRF Ν 157. 00 N Ν Ν 158. 00 SUBPROVI DER 158 00 159. 00 SNF Ν Ν Ν Ν 159.00 160.00 HOME HEALTH AGENCY N Ν Ν N 160. 00 161.00 CMHC 161.00 Ν Ν Ν 1.00 Multicampus 165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no. N 165.00 Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no. 167.00 168.00| If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the d168. 00 reasonable cost incurred for the HIT assets (see instructions) 169.00|If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 0.50169.00 transition factor. (see instructions)

WITHAM MEMORIAL HO	SPI TAL	In Lie	u of Form CMS-	2552-10	
CATION DATA	Provider CCN: 150104				
		10 12/31/2014			
			5/28/2015 2:1	7 pm	
		Begi nni ng	Endi ng		
		1. 00	2.00		
			1.00		
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)					
	ate and ending date	ate and ending date for the reporting	Provider CCN: 150104 Period: From 01/01/2014 To 12/31/2014 Period: From 01/01/2014 Perio	Period: From 01/01/2014 To 12/31/2014 Period: Period: From 01/01/2014 To 12/31/2014 Period: Period	

	Financial Systems AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	WITHAM MEMORIAL HOSPITAL STIONNAIRE Provider	F	In Lie eriod: rom 01/01/2014 o 12/31/2014		epared:
				Y/N	Date	i / piii
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	oonses. Enter N for all NO re	esponses. Enter	1.00 all dates in	2.00 the	
1.00	Provider Organization and Operation Has the provider changed ownership immediatel reporting period? If yes, enter the date of	y prior to the beginning of the change in column 2. (see	the cost instructions)	N		1. 00
			Y/N 1.00	Date 2.00	V/I 3. 00	
2.00	Has the provider terminated participation in yes, enter in column 2 the date of termination voluntary or "I" for involuntary.		N N	2.00	3.00	2.00
3. 00	Is the provider involved in business transaction contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or the control of			3.00		
			Y/N 1.00	Type 2. 00	Date	
	Financial Data and Reports		1.00	2.00	3. 00	
4.00	Column 1: Were the financial statements prepared Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or	Audited, "C" for Compiled, enter date available in	Y	А		4. 00
5.00	column 3. (see instructions) If no, see instructions are the cost report total expenses and total those on the filed financial statements? If y	revenues different from	N			5. 00
	Approved Educational Activities			Y/N 1. 00	Legal Oper. 2.00	
6.00	Column 1: Are costs claimed for nursing schol the legal operator of the program?	N		6. 00		
7. 00 8. 00	Are costs claimed for Allied Health Programs' Were nursing school and/or allied health prog	N N		7. 00 8. 00		
9. 00	cost reporting period? If yes, see instruction Are costs claimed for Intern-Resident program yes, see instructions.	N		9. 00		
10. 00	Was an Intern-Resident program been initiated period? If yes, see instructions.	N		10. 00		
11. 00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see		roved	N	V (0)	11. 00
	Bad Debts				Y/N 1.00	
	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad del			t reporting	Y N	12. 00
	period? If yes, submit copy. If line 12 is yes, were patient deductibles a	, ,	3	. 3	N	14. 00
15 00	Bed Complement Did total beds available change from the price	or cost reporting period? If	ves see instr	uctions	N	15. 00
10.00	pria total bodo atalitable onaligo il oli tilo pri t		Par	t A	Part B	10.00
		Description 0	Y/N 1.00	Date 2.00	Y/N 3. 00	
16. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see		N		N	16. 00
17. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns		Y	04/24/2015	Y	17. 00
18. 00	2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file		N		N	18. 00
19. 00	this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see		N		N	19. 00
20. 00	instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

Heal th Financial Systems WITHAM MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 150104 From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/28/2015 2:17 pm

Part A Part B

Description Y/N Date Y/N

0 1.00 2.00 3.00

				1	To 12/31/2014	Date/Time Pr 5/28/2015 2:					
				Par	⁻t A	Part B	17 pili				
		Descr	iption	Y/N	Date	Y/N					
			0	1.00	2. 00	3.00					
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N		N	21. 00				
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost										
22.00	Have assets been relifed for Medicare purpose	es? If yes, see	e instructions			N	22. 00				
23. 00	Have changes occurred in the Medicare depreci	ation expense	due to apprais	als made durin	ng the cost	N	23. 00				
	reporting period? If yes, see instructions.										
24. 00	Were new leases and/or amendments to existing	g Leases enter	ed into during	this cost repo	orting period?	N	24. 00				
25. 00	If yes, see instructions Have there been new capitalized leases entere	ed into durina	the cost repor	ting period? L	f ves. see	N	25. 00				
	i nstructi ons.	· · · · · · · · · · · · · · · · · ·		and particular	. ,						
26. 00	Were assets subject to Sec. 2314 of DEFRA acqu	uired during tl	ne cost reporti	ng period? If	yes, see	N	26. 00				
	instructions.						07.00				
27. 00	Has the provider's capitalization policy char	nged during the	e cost reportin	ig period? If y	es, submit	N	27. 00				
	copy. Interest Expense										
28. 00	Were new Loans, mortgage agreements or Letter	rs of credit e	ntered into dur	ing the cost r	reporting	N	28. 00				
	period? If yes, see instructions.			9	5						
29. 00	Did the provider have a funded depreciation a			ebt Service Res	serve Fund)	N	29. 00				
	treated as a funded depreciation account? If										
30. 00	Has existing debt been replaced prior to its instructions.	scheduled mati	urity with new	debt? IT yes,	see	N	30. 00				
31. 00	Has debt been recalled before scheduled matur	ity without i	ssuance of new	deht? If ves	See	N	31.00				
01.00	instructions.	rty wrthoat r	ssuance of new	dobt. It you,	300	''	01.00				
	Purchased Services										
32. 00	Have changes or new agreements occurred in pa	N	32. 00								
00.00	arrangements with suppliers of services? If	1 1 1 1 2 1 6		00.00							
33. 00	If line 32 is yes, were the requirements of 9 no, see instructions.	sec. 2135.2 app	olled pertainin	ig to competiti	ve brading? IT	N	33. 00				
	Provi der-Based Physi ci ans										
34. 00	Are services furnished at the provider facili	ty under an ai	rrangement with	provi der-base	ed physicians?	Υ	34.00				
	If yes, see instructions.	.,	3		1 3						
35. 00	If line 34 is yes, were there new agreements			its with the pr	rovi der-based	N	35. 00				
	physicians during the cost reporting period?	If yes, see i	nstructions.		N/ (N)	D 1					
					Y/N 1. 00	2. 00					
	Home Office Costs				1.00	2.00					
36. 00	Were home office costs claimed on the cost re	eport?			N		36. 00				
37.00	If line 36 is yes, has a home office cost sta		repared by the	home office?	N		37. 00				
	If yes, see instructions.										
38. 00	If line 36 is yes, was the fiscal year end of				N		38. 00				
39. 00	the provider? If yes, enter in column 2 the 1 If line 36 is yes, did the provider render se				N		39. 00				
37.00	see instructions.	er vices to oth	er charri comport	ients: 11 yes,	IN IN		37.00				
40.00	If line 36 is yes, did the provider render se	ervices to the	home office?	If yes, see	N		40.00				
	i nstructi ons.		_								
	Cook Descrit Description Control Information	00									
41. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title		41. 00								
41.00	held by the cost report preparer in columns 1	•	TI NA		SEVERS		41.00				
	respectively.	., 2, and 0,									
42.00	Enter the employer/company name of the cost r	report	BLUE & CO., LL	С			42. 00				
	preparer.										
43. 00	Enter the telephone number and email address		317-713-7946		TSEVERS@BLUEAN	DCO. COM	43. 00				
	report preparer in columns 1 and 2, respective	rei y.			1		II				

From 01/01/2014 To 12/31/2014 Part II Date/Time Prepared: 5/28/2015 2:17 pm Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 16.00 Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R 04/24/2015 17.00 Report for 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) 18.00 | If line 16 or 17 is yes, were adjustments 18.00 made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of 19.00 other PS&R Report information? If yes, see i nstructi ons. If line 16 or 17 is yes, were adjustments 20.00 made to PS&R Report data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If yes, see 21.00 21.00 instructions. 3.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position MANAGER 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. Enter the employer/company name of the cost report 42.00 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 43.00

report preparer in columns 1 and 2, respectively.

Heal th Fi nancialSystemsWI THAMHOSPITALANDHOSPITAL HEALTH CARE COMPLEXSTATISTICAL DATA Provider CCN: 150104

| Peri od: | Worksheet S-3 | From 01/01/2014 | Part I | To 12/31/2014 | Date/Time Prepared:

					10) 12/31/2014	5/28/2015 2:1	
							I/P Days / 0/P	, p
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	35p31.0111	Line Number		0. 2000	Avai I abl e	57.11 1.15 d.1 5		
		1. 00		2. 00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		60	21, 900	0.00	0	1, 00
	8 exclude Swing Bed, Observation Bed and				,			
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)			İ				2.00
3.00	HMO IPF Subprovider			İ				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, 900	0.00	0	7. 00
	beds) (see instructions)				=-,,		_	
8.00	INTENSIVE CARE UNIT	31. 00		8	2, 920	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)	10.00		68	24, 820	0.00	ő	14.00
15. 00	CAH visits				2 17 020	0.00	Ö	15. 00
16. 00	SUBPROVI DER - I PF	40. 00		10	3, 650		Ö	16. 00
17. 00	SUBPROVI DER - I RF	41. 00		0	0,000		Ö	17. 00
18. 00	SUBPROVI DER	42. 00		Ö	0		0	18.00
19. 00	SKILLED NURSING FACILITY	12. 00		ĭ	J			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	00.00						25. 00
26. 00	RURAL HEALTH CLINIC							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER							26. 25
27. 00	Total (sum of lines 14-26)			78				27. 00
28. 00	Observation Bed Days			, 9			0	28. 00
29. 00	Ambul ance Tri ps						U	29.00
30. 00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days (see l'istruction)							31.00
32. 00	Labor & delivery days (see instructions)			0	0			32.00
32. 00	Total ancillary labor & delivery room			٩	U			32.00
32.01	outpatient days (see instructions)							32.01
33 00	LTCH non-covered days			ŀ				33. 00
33.00	Eron non covered days		l	ı			I	1 33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150104 | Period: | Worksheet S-3 | From 01/01/2014 | Part I | Date/Time Prepared:

33.00

5/28/2015 2:17 pm Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 10.00 6.00 7.00 8.00 9.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 2, 255 417 5, 150 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 707 2 00 HMO and other (see instructions) 1, 437 2 00 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 0 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 0 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 C 0 6.00 7.00 Total Adults and Peds. (exclude observation 2, 255 417 5, 150 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 763 1, 487 8.00 CORONARY CARE UNIT 9.00 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 997 13.00 14.00 Total (see instructions) 3,018 417 7,634 0.00 560. 56 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 2.987 0.00 20.33 16.00 2.474 0 16.00 SUBPROVIDER - IRF 0.00 17.00 0 0 C 0.00 17.00 18.00 SUBPROVI DER 0 0 0.00 0.00 18.00 19.00 SKILLED NURSING FACILITY 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 HOSPI CE 24 00 24 00 24. 10 HOSPICE (non-distinct part) 0 0 0 24.10 25.00 CMHC - CMHC 25.00 26, 00 RURAL HEALTH CLINIC 26, 00 FEDERALLY QUALIFIED HEALTH CENTER 26.25 26.25 27.00 Total (sum of lines 14-26) 0.00 580.89 27.00 28.00 Observation Bed Days 0 1, 146 28.00 29.00 29.00 Ambul ance Trips 347 30.00 Employee discount days (see instruction) 93 30.00 31.00 Employee discount days - IRF 0 31.00 Labor & delivery days (see instructions) 59 88 32.00 32.00 0 Total ancillary labor & delivery room 32.01 0 32.01 outpatient days (see instructions)

33.00 LTCH non-covered days

 Heal th Financial
 Systems
 WITHAM

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

				10) 12/31/2014	5/28/2015 2:1	
		Full Time		Di sch	arges	0, 20, 2010 211	, p
		Equi val ents			J		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	·	Workers				Pati ents	
		11. 00	12. 00	13.00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	163	152	2, 247	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)			210	0		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0. 00	0	163	152	2, 247	14.00
15.00	CAH visits						15.00
16. 00	SUBPROVI DER - I PF	0.00	0	37	0	207	16.00
17. 00	SUBPROVI DER - I RF	0.00	0	0	0	0	17.00
18. 00	SUBPROVI DER	0.00	0	0	0	0	18.00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00							21. 00
22. 00							22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00							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						26. 25
27. 00		0.00					27. 00
28. 00	,						28.00
29. 00							29. 00
30. 00	1						30.00
31. 00	1 ' 3						31. 00
32. 00							32.00
32. 01							32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00

					T	12/31/2014	Date/Time Pre 5/28/2015 2:1	
		Worksheet A	Amount	Reclassificati	Adjusted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries (from	Sal ari es (col . 2 ± col .	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				Worksheet A-6)	3)	col. 4	ŕ	
	PART II - WAGE DATA	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
	SALARI ES						,	
1.00	Total salaries (see instructions)	200. 00	38, 423, 454	1, 928, 665	40, 352, 119	1, 208, 260. 00	33. 40	1.00
2.00	Non-physician anesthetist Part		0	0	0	0.00	0.00	2. 00
3. 00	A Non-physician anesthetist Part		0	0	0	0. 00	0.00	3. 00
	В		-					
4. 00	Physician-Part A - Administrative		U	0	0	0. 00	0.00	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician-Part B		0	0	0	0. 00 0. 00	1	
6.00	Non-physician-Part B		0	0	0	0.00		
7. 00	Interns & residents (in an	21. 00	0	0	0	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and		0	О	0	0.00	0.00	7. 01
	residents (in an approved programs)							
8.00	Home office personnel		0	0	0	0.00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 15, 531, 968	0 1, 535, 290	0 17, 067, 258	0. 00 391, 505. 00		
10.00	instructions)		15, 551, 900	1, 555, 290	17, 067, 238	391, 505. 00	43. 59	10.00
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		384, 972	1 0	384, 972	4, 482. 00	85. 89	11. 00
11.00	Care		364, 972		364, 972	4, 462. 00	05. 09	11.00
12. 00	Contract Labor: Top Level management and other		0	0	0	0. 00	0. 00	12. 00
	management and administrative							
13. 00	services Contract Labor: Physician-Part		0	0	0	0.00	0. 00	13. 00
	A - Administrative		Ö					
14. 00	Home office salaries & wage-related costs		0	0	0	0.00	0. 00	14. 00
15. 00	Home office: Physician Part A		0	0	0	0.00	0. 00	15. 00
16. 00	- Administrative Home office and Contract		0	О	0	0.00	0. 00	16. 00
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see		8, 805, 929	0	8, 805, 929			17. 00
18. 00	instructions) Wage-related costs (other)		0	0	0			18. 00
	(see instructions)		_	_				
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		4, 468, 912 0	0	4, 468, 912 0			19.00
	A		_					
21. 00	Non-physician anesthetist Part B		U	0	0			21. 00
22. 00	Physician Part A - Administrative		0	0	0			22. 00
22. 01	Physician Part A - Teaching		0	О	0			22. 01
23. 00	Physician Part B		0	_	0			23.00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	0			24. 00 25. 00
	approved program) OVERHEAD COSTS - DIRECT SALARIE	c						
26. 00	Employee Benefits Department	4. 00	1, 241, 540	5, 073	1, 246, 613	9, 124. 00	136. 63	26. 00
27. 00	Administrative & General	5. 00	4, 698, 765	196, 179	4, 894, 944			
28. 00	Administrative & General under contract (see inst.)		U	0	0	0. 00	0.00	28. 00
29. 00	Maintenance & Repairs	6. 00	0	0	0	0.00		
30. 00 31. 00	Operation of Plant Laundry & Linen Service	7. 00 8. 00	519, 471 22, 322		·			
31.00	Housekeepi ng	9. 00	330, 914		·			
33. 00	Housekeeping under contract	7. 00	0		0	0.00		
34. 00	(see instructions) Dietary	10. 00	643, 108	-299, 011	344, 097	14, 968. 00	22. 99	34.00
35. 00	Dietary under contract (see		0	0	0	0.00		
36. 00	i nstructi ons) Cafeteri a	11. 00	0	309, 237	309, 237	26, 406. 00	11. 71	36. 00
37. 00	Maintenance of Personnel	12. 00	0	0	0	0.00	0. 00	37. 00
38. 00 39. 00	Nursing Administration Central Services and Supply	13. 00 14. 00	446, 153	6, 055 0	452, 208	11, 601. 00 0. 00		38. 00 39. 00
40. 00	1 ,	15. 00	398, 168	3, 868	402, 036			40.00

Health Financial Systems		WITHAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der		Period: From 01/01/2014		
					To 12/31/2014	Date/Time Prep 5/28/2015 2:1	
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Salaries in	col . 5)	
			Worksheet A-6)	3)	col. 4		
	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
41.00 Medical Records & Medical Records Library	16. 00	839, 349	15, 775	855, 12	4 36, 127. 00	23. 67	41. 00
42.00 Social Service	17. 00	0	0		0.00	0.00	42.00
43.00 Other General Service	18. 00	0	0		0.00	0.00	43. 00

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 150104 Peri od: Worksheet S-3 From 01/01/2014 To 12/31/2014 Part III Date/Time Prepared: 5/28/2015 2:17 pm Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 38, 423, 454 1, 928, 665 40, 352, 119 1, 208, 260. 00 33. 40 1.00 instructions) 2.00 Excluded area salaries (see 15, 531, 968 1, 535, 290 17, 067, 258 391, 505. 00 43. 59 2.00 instructions) 3.00 Subtotal salaries (line 1 22, 891, 486 393, 375 23, 284, 861 816, 755. 00 28. 51 3.00 minus line 2) 4.00 Subtotal other wages & related 384, 972 384, 972 4, 482. 00 85.89 4.00

Ω

393, 375

254, 320

8, 805, 929

32, 475, 762

9, 394, 110

0.00

821, 237. 00

331, 184. 00

37.82

39 54

28.37

5.00

6.00

7.00

8, 805, 929

32, 082, 387

9, 139, 790

costs (see inst.)

(see inst.)

instructions)

5.00

6.00

7.00

Subtotal wage-related costs

Total overhead cost (see

Total (sum of lines 3 thru 5)

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 150104	Peri od: Worksheet S-3
		From 01/01/2014 Part IV

	To 12/31/2014	Date/Time Pre 5/28/2015 2:1	
		Amount	
		Reported	
	DADT LV WAGE BELATED COCTO	1. 00	
	PART IV - WAGE RELATED COSTS Part A - Core List		
	RETIREMENT COST		
1. 00	401K Employer Contributions	1, 597, 908	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	1, 377, 700	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4. 00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
4.00	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		4.00
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
7.00	HEALTH AND INSURANCE COST		,,,,,,
8.00	Health Insurance (Purchased or Self Funded)	8, 551, 023	8.00
9.00	Prescription Drug Plan	175, 632	9. 00
10.00	Dental, Hearing and Vision Plan	-68, 186	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	56, 634	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)	147, 083	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15. 00	'Workers' Compensation Insurance	410, 596	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
	FICA-Employers Portion Only	2, 390, 180	
	Medicare Taxes - Employers Portion Only	0	
	Unempl oyment Insurance	10, 613	
20.00	State or Federal Unemployment Taxes	0	20. 00
21 00	OTHER		01 00
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21. 00
22 00	Day Care Cost and Allowances	0	22. 00
	Tui ti on Rei mbursement	0	23. 00
	Total Wage Related cost (Sum of lines 1 -23)	13, 271, 483	
2 7. 00	Part B - Other than Core Related Cost	10,271,400	21.00
25. 00	MORALE FUND / RECOGNITION	72, 058	25. 00

HOSPITAL CONTRACT LABOR AND BENEFIT COST	Heal th	Financial Systems	WITHAM MEMORIAL H	OSPI TAL		In Lie	u of Form CMS-:	2552-10
PART V - Contract Labor and Benefit Cost				Provi der	CCN: 150104	Period: From 01/01/2014	Worksheet S-3 Part V Date/Time Pre	pared:
PART V - Contract Labor and Benefit Cost		Cost Center Description						
Hospital and Hospital - Based Component I dentification:		DADT V. O. I.				1. 00	2. 00	
1.00 Total facility's contract labor and benefit cost 0 0 1.00 2.00 Hospital 0 0 2.00 3.00 Subprovi der - IPF 0 0 0 3.00 4.00 Subprovi der - IRF 0 0 0 4.00 5.00 Subprovi der - (Other) 0 0 5.00 6.00 Swi ng Beds - SNF 0 0 0 6.00 7.00 Swi ng Beds - NF 0 0 7.00 8.00 Hospi tal -Based SNF 9.00 9.00 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			C' ' '					
2. 00 Hospi tal 0 0 2. 00 3. 00 Subprovi der - I PF 0 0 3. 00 4. 00 Subprovi der - I RF 0 0 4. 00 5. 00 Subprovi der - (Other) 0 0 5. 00 6. 00 Swi ng Beds - SNF 0 0 6. 00 7. 00 Swi ng Beds - NF 0 0 7. 00 8. 00 Hospi tal -Based SNF 9. 00 9. 00 9. 00 Hospi tal -Based NF 9. 00 9. 00 10. 00 Hospi tal -Based OLTC 10. 00 11. 00 Hospi tal -Based HHA 11. 00 12. 00 Separatel y Certi fi ed ASC 12. 00	1 00						0	1 00
3.00 Subprovi der - I PF 0 0 0 3.00 4.00 Subprovi der - I RF 0 0 0 4.00 5.00 Subprovi der - (Other) 0 0 0 5.00 6.00 Swi ng Beds - SNF 0 0 0 0 6.00 7.00 Swi ng Beds - NF 0 0 0 7.00 8.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 9.00 10.00 Hospi tal -Based OLTC 11.00 Hospi tal -Based HHA 12.00 Separately Certified ASC		1	COST			0	_	
4.00 Subprovi der - IRF 0 0 0 4.00 5.00 Subprovi der - (Other) 0 0 0 5.00 6.00 Swing Beds - SNF 0 0 0 0 6.00 7.00 Swing Beds - NF 0 0 0 7.00 8.00 Hospi tal -Based SNF 8.00 Hospi tal -Based NF 9.00 Hospi tal -Based OLTC 11.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 12.00						0	_	•
5.00 Subprovi der - (Other) 0 0 5.00 6.00 Swing Beds - SNF 0 0 0 6.00 7.00 Swing Beds - NF 0 0 0 7.00 8.00 Hospi tal -Based SNF 8.00 9.00 Hospi tal -Based OLTC 11.00 Hospi tal -Based HHA 12.00 Separately Certified ASC						0	_	
6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - NF 8.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11.00 Hospi tal -Based HHA 12.00 Separately Certified ASC						0	ı	
7. 00 Swi ng Beds - NF 0 0 7. 00 8. 00 Hospi tal - Based SNF 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 Separatel y Certified ASC 12. 00						0	_	
8. 00 Hospi tal -Based SNF 9. 00 Hospi tal -Based NF 10. 00 Hospi tal -Based OLTC 11. 00 Hospi tal -Based HHA 12. 00 Separatel y Certified ASC 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 10. 00 11. 00 11. 00 12. 00						0		•
9. 00 Hospi tal -Based NF 10. 00 Hospi tal -Based OLTC 11. 00 Hospi tal -Based HHA 12. 00 Separatel y Certified ASC 9. 00 10. 00 11. 00 12. 00								
10. 00 Hospi tal -Based OLTC 10. 00 11. 00 Hospi tal -Based HHA 11. 00 12. 00 Separatel y Certified ASC 12. 00								
11. 00 Hospi tal -Based HHA 11. 00 12. 00 Separatel y Certified ASC 12. 00								•
12.00 Separately Certified ASC 12.00								
								1
	13. 00	Hospi tal -Based Hospi ce						13. 00
14.00 Hospital-Based Health Clinic RHC	14.00							14.00
15.00 Hospital-Based Health Clinic FOHC	15. 00							15. 00
16. 00 Hospi tal -Based-CMHC 16. 00	16.00							16.00
17.00 Renal Dialysis 17.00	17.00	Renal Dialysis						17. 00
18. 00 Other 0 18. 00	18. 00	Other				0	0	18. 00

HOSPI 7	ealth Financial Systems WITHAM MEMORIAL HOSPITAL In Lieu of F									
	TAL UNCOMPENSATED AND INDIGENT CARE DATA	rovider CCN: 150104	Peri od:	Worksheet S-10)					
	From 01/01/2014 To 12/31/2014									
	To 12/31/2014 Date/7 5/28/2									
				1.00						
	Uncompensated and indigent care cost computation			1. 00						
1. 00										
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8) 0. 234492 Medicaid (see instructions for each line)									
2. 00	Net revenue from Medicaid			10, 917, 063	2.00					
3.00	Did you receive DSH or supplemental payments from Medicaid?				3. 00					
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental pa	nyments from Medicai	d?	Υ	4. 00					
5.00	If line 4 is "no", then enter DSH or supplemental payments from Me	edi cai d		0	5. 00					
6.00	Medi cai d charges			27, 602, 225	6. 00					
7.00	Medicaid cost (line 1 times line 6)			6, 472, 501	7. 00					
8.00	Difference between net revenue and costs for Medicaid program (lin	ne 7 minus sum of Li	nes 2 and 5; if	0	8. 00					
	<pre>< zero then enter zero) Chata Children Lind the Language (CCLUD) (</pre>	- 6 I:								
0.00	State Children's Health Insurance Program (SCHIP) (see instruction	is for each line)			0.00					
9. 00 10. 00	Net revenue from stand-alone SCHIP Stand-alone SCHIP charges			0	9. 00 10. 00					
11. 00	Stand-alone SCHIP cost (line 1 times line 10)			0						
12. 00	Difference between net revenue and costs for stand-alone SCHIP (li	ne 11 minus line 9	if < zero then	0	12. 00					
12.00	enter zero)	ne ii iii iida i iiie 7,	TT \ Zero then		12.00					
	Other state or local government indigent care program (see instruc	tions for each line	e)							
13.00	Net revenue from state or local indigent care program (Not include	9)	0	13.00						
14.00										
	10)									
15. 00										
16. 00										
	13; if < zero then enter zero) Uncompensated care (see instructions for each line)									
17. 00	Private grants, donations, or endowment income restricted to fundi	ng charity care		0	17. 00					
18. 00				Ö	18. 00					
19. 00			ams (sum of lines	0	19. 00					
	8, 12 and 16)	3 1 3	•							
		Uni nsured		Total (col. 1						
		patients		+ col . 2)						
		1.00	2. 00							
20.00	T-1-1 :-::1:-1::			3.00	20.00					
20. 00	Total initial obligation of patients approved for charity care (at	full 5, 005,			20. 00					
	charges excluding non-reimbursable cost centers) for the entire fa	full 5,005, acility	783 0	5, 005, 783						
		full 5,005, acility	783 0	5, 005, 783						
	charges excluding non-reimbursable cost centers) for the entire fa Cost of initial obligation of patients approved for charity care (full 5,005, acility	783 0	5, 005, 783	21. 00					
21. 00 22. 00	charges excluding non-reimbursable cost centers) for the entire fa Cost of initial obligation of patients approved for charity care (times line 20) Partial payment by patients approved for charity care	full 5,005, acility	783 0 316 0	5, 005, 783 1, 173, 816 0	21. 00 22. 00					
21. 00 22. 00	charges excluding non-reimbursable cost centers) for the entire fa Cost of initial obligation of patients approved for charity care (times line 20) Partial payment by patients approved for charity care	full 5,005, acility (line 1 1,173,	783 0 316 0	5, 005, 783 1, 173, 816 0 1, 173, 816	21. 00 22. 00					
21. 00 22. 00 23. 00	charges excluding non-reimbursable cost centers) for the entire fa Cost of initial obligation of patients approved for charity care (times line 20) Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22)	full 5, 005, acility 1, 173, 1	783 0 316 0 0 0 316 0	5, 005, 783 1, 173, 816 0	21. 00 22. 00 23. 00					
21. 00 22. 00 23. 00	charges excluding non-reimbursable cost centers) for the entire fa Cost of initial obligation of patients approved for charity care (times line 20) Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient da	full 5,005, acility 1,173, 1,173, 1, 1	783 0 316 0 0 0 316 0	5, 005, 783 1, 173, 816 0 1, 173, 816	21. 00 22. 00 23. 00					
21. 00 22. 00 23. 00 24. 00	charges excluding non-reimbursable cost centers) for the entire fa Cost of initial obligation of patients approved for charity care (times line 20) Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient da imposed on patients covered by Medicaid or other indigent care pro	full 5,005, acility (line 1 1,173, state of the second along the second al	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5, 005, 783 1, 173, 816 0 1, 173, 816	21. 00 22. 00 23. 00 24. 00					
21. 00 22. 00 23. 00 24. 00 25. 00	charges excluding non-reimbursable cost centers) for the entire fa Cost of initial obligation of patients approved for charity care (times line 20) Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient da imposed on patients covered by Medicaid or other indigent care pro If line 24 is "yes," charges for patient days beyond an indigent	t full 5,005, acility (line 1 1,173, state of the state o	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5, 005, 783 1, 173, 816 0 1, 173, 816 1. 00	21. 00 22. 00 23. 00 24. 00 25. 00					
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00	charges excluding non-reimbursable cost centers) for the entire fa Cost of initial obligation of patients approved for charity care (times line 20) Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient da imposed on patients covered by Medicaid or other indigent care pro If line 24 is "yes," charges for patient days beyond an indigent Total bad debt expense for the entire hospital complex (see instru	t full 5,005, decility 1,173,	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5, 005, 783 1, 173, 816 0 1, 173, 816 1. 00 0 13, 869, 697	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00					
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00	charges excluding non-reimbursable cost centers) for the entire fa Cost of initial obligation of patients approved for charity care (times line 20) Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient da imposed on patients covered by Medicaid or other indigent care pro If line 24 is "yes," charges for patient days beyond an indigent Total bad debt expense for the entire hospital complex (see instruction Medicare bad debts for the entire hospital complex (see instruction)	full 5,005, decility 1,173, de	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5, 005, 783 1, 173, 816 0 1, 173, 816 1. 00 0 13, 869, 697 102, 742	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00					
24. 00 25. 00 26. 00 27. 00 28. 00	charges excluding non-reimbursable cost centers) for the entire fa Cost of initial obligation of patients approved for charity care (times line 20) Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient daimposed on patients covered by Medicaid or other indigent care pro If line 24 is "yes," charges for patient days beyond an indigent Total bad debt expense for the entire hospital complex (see instruction Non-Medicare and non-reimbursable Medicare bad debt expense (line	e full 5,005, decility 1,173,	783 0 316 0 0 0 316 0 of stay limit	5, 005, 783 1, 173, 816 0 1, 173, 816 1. 00 0 13, 869, 697 102, 742 13, 766, 955	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00					
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00	charges excluding non-reimbursable cost centers) for the entire fa Cost of initial obligation of patients approved for charity care (times line 20) Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient daimposed on patients covered by Medicaid or other indigent care pro If line 24 is "yes," charges for patient days beyond an indigent Total bad debt expense for the entire hospital complex (see instruction Non-Medicare and non-reimbursable Medicare bad debt expense (line Cost of non-Medicare and non-reimbursable Medicare bad debt expense	e full 5,005, decility 1,173,	783 0 316 0 0 0 316 0 of stay limit	5, 005, 783 1, 173, 816 0 1, 173, 816 1. 00 0 13, 869, 697 102, 742	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00					

Heal th	Financial Systems	WITHAM MEMORIAL	_ HOSPITAL		In Lie	u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet A Date/Time Pre 5/28/2015 2:1	
	Cost Center Description	Sal ari es	Other	Total (col. 7 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	Pill
	T	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT		1, 736, 039	1, 736, 03	9 156, 153	1, 892, 192	1.00
2.00	00200 NEW CAP REL COSTS-BLDG & FIXT		1, 730, 039 N		0 2, 706, 904	2, 706, 904	1
3.00	00300 OTHER CAPITAL RELATED COSTS		0	1	0 2,700,701	2, 700, 701	1
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 241, 540	10, 770, 047			10, 322, 173	
5.00	00500 ADMINISTRATIVE & GENERAL	4, 698, 765	16, 052, 232			19, 974, 631	1
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	519, 471 22, 322	2, 906, 632 222, 919			3, 366, 492 245, 752	1
9. 00	00900 HOUSEKEEPING	330, 914	150, 744			487, 472	1
10.00	01000 DI ETARY	643, 108	654, 958			602, 143	1
11. 00	01100 CAFETERI A	0	0		0 701, 941	701, 941	
13.00	01300 NURSI NG ADMI NI STRATI ON	446, 153	37, 918			488, 487	1
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	398, 168 839, 349	2, 031, 986 312, 918			1, 310, 243 1, 163, 642	1
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	007,017	012,710	1, 102, 20	7 11,070	1, 100, 012	10.00
30.00	03000 ADULTS & PEDIATRICS	2, 607, 985	745, 967	3, 353, 95	2 -148, 559	3, 205, 393	30.00
31.00	03100 I NTENSI VE CARE UNI T	921, 548	218, 594			1, 081, 020	
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	1, 060, 759	248, 196 0	1, 308, 95	5 6, 155	1, 315, 110 0	1
42. 00	04200 SUBPROVI DER		0			0	1
43. 00	04300 NURSERY	0	42, 950	42, 95	o o	42, 950	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 782, 925	5, 571, 254			1, 227, 255	1
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	989, 329	2, 139, 428	3, 128, 75	7 -190, 059	2, 938, 698 0	1
55. 01	05501 ULTRA SOUND	262, 283	161, 472	423, 75	5 -44, 456	379, 299	
57.00	05700 CT SCAN	108, 736	1, 021, 586	1, 130, 32	2 -498, 435	631, 887	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	277, 738	876, 965			731, 220	1
59.00	05900 CARDI AC CATHETERI ZATI ON	155, 871	427, 379			313, 198	1
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	1, 809, 469	3, 184, 631 135, 539			4, 843, 937 135, 539	1
64. 00	06400 I NTRAVENOUS THERAPY	O	0	.55,55	o o	0	1
66. 00	06600 PHYSI CAL THERAPY	969, 054	211, 128			1, 175, 514	1
67.00	06700 OCCUPATI ONAL THERAPY	369, 309	242, 674			615, 341	1
67. 01 68. 00	06701 AUDI OLOGY 06800 SPEECH PATHOLOGY	146, 968 61, 343	205, 347 5, 060			338, 330 67, 051	1
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	1
69. 01	06901 CARDI OLOGY	684, 516	169, 617			827, 267	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	19, 691			1, 978, 191	1
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS		0	1	0 4, 726, 493 0 1, 015, 548	4, 726, 493 1, 015, 548	1
73.00	OUTPATIENT SERVICE COST CENTERS				0 1,010,040	1,013,340	73.00
	09000 CLI NI C	0	0		0 0	_	
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	174, 881	123, 458	298, 33	9 -6, 588	291, 751	
90. 02 90. 03	09002 CLI NI C 09003 DERMATOLOGY CLI NI C	0	1, 507	1, 50	7 0	0 1, 507	
90. 04	09004 ENT CLINIC	o	35			35	1
90. 05	09005 SURGERY CLINIC	0	1, 152	1, 15	2 -653	499	90. 05
90. 07	09007 UROLOGY CLINIC	0	5, 125			1, 669	1
90. 09 90. 11	09009 GASTROENTEROLOGY CLINIC 09011 NEUROLOGY CLINIC	21	8, 665 4, 447			9, 754 1, 124	1
90. 11	09012 OPTHAMOLOGY CLINIC	0	59, 759			17, 804	1
90. 13	09013 ALLERGY CLINIC	72, 197	44, 931			117, 013	1
90. 14	09014 WOUND CARE	204, 874	162, 613			343, 062	1
91.00	09100 EMERGENCY	2, 152, 649	2, 311, 663	4, 464, 31	2 -196, 859	4, 267, 453	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00	09500 AMBULANCE SERVICES	1, 265, 960	374, 470	1, 640, 43	0 -124, 639	1, 515, 791	95. 00
118.00		25, 218, 205	53, 601, 696	78, 819, 90	1 -1, 401, 126	77, 418, 775	118. 00
100.00	NONREI MBURSABLE COST CENTERS		^			^	100.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0 13, 177, 148	5, 439, 088	1	0 6 1, 400, 924	20, 017, 160	190. 00 192. 00
	07950 THORNTOWN OFFICE BUILDING	0	0, .57, 500		0 -332		194. 00
194. 01	07951 CAFE/BOUTI QUE	0	0		0 0	0	194. 01
	07952 OTHER NONREIMBURSABLE COST CENTERS	28, 101	102, 111			130, 746	
200.00	TOTAL (SUM OF LINES 118-199)	38, 423, 454	59, 142, 895	97, 566, 34	9 0	97, 566, 349	₁ 200.00

Peri od: From 01/01/2014 To 12/31/2014 Worksheet A Date/Time Prepared: 5/28/2015 2:17 pm

			5/28/2015 2: 1	7 pm
Cost Center Description		Net Expenses for Allocation		
	6.00	7. 00		
GENERAL SERVICE COST CENTERS				
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT	-597, 859	1, 294, 333		1. 00
2.00 O0200 NEW CAP REL COSTS-MVBLE EQUIP	0	2, 706, 904		2. 00
3.00 00300 OTHER CAPITAL RELATED COSTS	0	0		3. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-3, 479, 802	6, 842, 371		4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	-914, 504	19, 060, 127		5. 00
7.00 O0700 OPERATION OF PLANT	-50	3, 366, 442		7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	245, 752		8. 00
9. 00 00900 HOUSEKEEPI NG	0	487, 472		9. 00
10. 00 01000 DI ETARY	-76, 724	525, 419		10. 00
11. 00 01100 CAFETERI A	-213, 039	488, 902		11. 00
13.00 01300 NURSING ADMINISTRATION	0	488, 487		13. 00
15. 00 01500 PHARMACY	0	1, 310, 243		15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	1, 163, 642		16. 00
INPATIENT ROUTINE SERVICE COST CENTERS				1
30. 00 03000 ADULTS & PEDI ATRI CS	0	3, 205, 393		30. 00
31.00 03100 INTENSIVE CARE UNIT	0	1, 081, 020		31.00
40. 00 04000 SUBPROVI DER - I PF	-47, 755	1, 267, 355		40. 00
41. 00 04100 SUBPROVI DER - I RF	0	0		41. 00
42. 00 04200 SUBPROVI DER	0	0		42. 00
43. 00 04300 NURSERY	0	42, 950		43. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	-833, 000	394, 255		50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-222	2, 938, 476		54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		55. 00
55. 01 05501 ULTRA SOUND	0	379, 299		55. 01
57. 00 05700 CT SCAN	0	631, 887		57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	731, 220		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	313, 198		59. 00
60. 00 06000 LABORATORY	-252, 500	4, 591, 437		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	135, 539		63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		64. 00
66. 00 06600 PHYSI CAL THERAPY	0	1, 175, 514		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	-3, 767	611, 574		67. 00
67. 01 06701 AUDI OLOGY	-205, 821	132, 509		67. 01
68. 00 06800 SPEECH PATHOLOGY	0	67, 051		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		69. 00
69. 01 06901 CARDI OLOGY	-10, 712	816, 555		69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-113, 628	1, 864, 563		71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENT	0	4, 726, 493		72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	-26, 311	989, 237		73. 00
OUTPATIENT SERVICE COST CENTERS		اء		
90. 00 09000 CLI NI C	0	0		90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	291, 751		90. 01
90. 02 09002 CLI NI C	1 507	0		90. 02
90. 03 09003 DERMATOLOGY CLINIC	-1, 507	0		90. 03
90. 04 09004 ENT CLINI C 90. 05 09005 SURGERY CLINI C	0	35		90. 04
	-499	0		90. 05
90. 07 09007 UROLOGY CLINIC	-1, 669	U		90. 07
90. 09 09009 GASTROENTEROLOGY CLINIC	-9, 754	0		90.09
90. 11 09011 NEUROLOGY CLINIC 90. 12 09012 0PTHAMOLOGY CLINIC	-1, 124 0	17 004		90. 11
90. 12 09012 0PTHAMOLOGY CLINI C 90. 13 09013 ALLERGY CLINI C	-	17, 804		90. 12
90. 14 09014 WOUND CARE	0	117, 013		
91. 00 09100 EMERGENCY	1 450 050	343, 062		90. 14
	-1, 459, 050	2, 808, 403		1
				92.00
OTHER REI MBURSABLE COST CENTERS	405	1 E1E 104		05 00
95. 00 09500 AMBULANCE SERVI CES SPECIAL PURPOSE COST CENTERS	-685	1, 515, 106		95. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-8, 249, 982	60 160 702		118 00
,	-0, 249, 982	69, 168, 793		118. 00
NONREI MBURSABLE COST CENTERS				100 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	20 017 160		190. 00 192. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES 194.00 07950 THORNTOWN OFFICE BUILDING		20, 017, 160		194. 00
194.00 07950 THORNTOWN OFFICE BUTEDING 194.01 07951 CAFE/BOUTIQUE		-332 0		194. 00
194.02 07952 OTHER NONREIMBURSABLE COST CENTERS		130, 746		194. 01
200.00 TOTAL (SUM OF LINES 118-199)	-8, 249, 982			200. 00
200.00 TOTAL (SUM OF LIMES 110-177)	-0, 247, 702	89, 316, 367		1200.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 150104

					015 2: 17 pm
		Increases		·	
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3. 00	4. 00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0_	236, 493	1. 00
	TOTALS		0	236, 493	
	B - INSURANCE RECLASS				
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	176, 318	1. 00
	FI XT				
	TOTALS		0	176, 318	
	C - CAFETERIA RECLASS				
1.00	CAFETERI A	11. 00	309, 237	392, 704	1. 00
	TOTALS		309, 237	392, 704	
	D - MME DEPRECIATION				
1.00	NEW CAP REL COSTS-MVBLE	2.00	0	2, 706, 904	1.00
	EQUI P				
2.00		0.00	0	0	2. 00
3.00		0.00	o	0	3. 00
4.00		0.00	O	0	4. 00
5. 00		0.00	o	0	5. 00
6. 00		0.00	Ö	0	6. 00
7. 00		0.00	Ö	0	7. 00
8. 00		0.00	o	0	8. 00
9. 00		0.00	o	0	9. 00
10. 00		0.00	o	0	10.00
11. 00		0.00	0	0	11. 00
12. 00		0.00	0	0	12.00
				-	4
13.00		0.00	0	0	13.00
14.00		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	0	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
26.00		0.00	0	0	26. 00
27. 00		0.00	o	0	27. 00
28. 00		0.00	o	0	28. 00
29. 00		0.00	O	0	29. 00
30.00		0.00	O	0	30.00
31. 00		0.00	o	0	31.00
32. 00		0.00	o	0	32.00
33. 00		0.00	o	0	33. 00
34. 00		0.00	Ö	0	34.00
35. 00		0.00	o	0	35. 00
36. 00		0.00	o	0	36.00
37. 00		0.00	o	0	37. 00
37.00	TOTALS		- — — 	2, 706, 904	37.00
	E - DRUGS RECLASS		U _I	2, 700, 704	
1.00	DRUGS CHARGED TO PATIENTS	73. 00	O	1, 117, 693	1. 00
1.00	TOTALS			1, 117, 693 1, 117, 693	1.00
	F - MED SUPPLY IMPLANTS		U	1, 117, 093	
1 00	IMPL. DEV. CHARGED TO	72.00	ol	1 724 102	1 00
1. 00	PATIENT	72.00	٩	4, 726, 493	1. 00
2 00	ATTEN	0. 00	o	0	2.00
2.00		0.00	0	0	2.00
3.00			O O	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	<u></u>	0.00	0	0	7. 00
	TOTALS		0	4, 726, 493	
	G - CHARGABLE MED SUPPLIES				
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	1, 975, 200	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	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	0	9. 00
		<u> </u>	<u>'</u>	<u>'</u>	

Health Financial Systems RECLASSIFICATIONS Provi der CCN: 150104

Cost Center						5/28/2015 2: 1	7 pm
10.00			Increases				
10.00		Cost Center	Li ne #	Sal ary	0ther		
10.00		2. 00	3.00	4.00	5. 00		
11.00 12.00 13.00 10.00 10.00 10.00 10.00 10.00 11.00 15.00 15.00 10.00 10.00 10.00 11.00 15.00 15.00 16.00 17.00 16.00 17.00 16.00 17.00 17.00 17.00 18.00	10. 00		0.00	0	0		10. 00
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21.00 0.00 0 0 0 0 0 22.00	19. 00		0.00	0	0		19.00
TOTALS	20.00		0.00	0	0		20.00
TOTALS	21.00		0.00	0	0		21.00
TOTALS	22.00		0.00	o	0		22. 00
H - BONUS RECLASS 1.00		TOTALS			1, 975, 200		
1.00		H - BONUS RECLASS					
2.00 ADMINISTRATIVE & GENERAL 5.00 196.179 0 3.00 4.00 LAUNDRY & LINEN SERVICE 8.00 5.34 0 4.00 5.00 HOUSEKEEPING 9.00 7.532 0 5.00 5.00 HOUSEKEEPING 9.00 7.532 0 6.00 9.00 NURSI NG ADMINISTRATION 13.00 6.055 0 8.00 HARMACY 15.00 3.8668 0 8.00 9.00 MEDICAL RECORDS & LIBRARY 16.00 15.775 0 9.00 MEDICAL RECORDS & LIBRARY 16.00 15.775 0 10.00 ADULTS & PEDIATRICS 30.00 21.7777 0 11.00 INTENSIVE CARE UNIT 31.00 8.419 0 11.00 INTENSIVE CARE UNIT 31.00 8.419 0 11.00 SUBPROVIDER - IPF 40.00 12.2177 0 11.00 ADULTS & PEDIATRICS 30.00 17.023 0 13.00 PARATING ROOM 50.00 17.023 0 14.00 RADIOLOGY-DIAGNOSTIC 54.00 15.306 0 14.00 RADIOLOGY-DIAGNOSTIC 54.00 15.306 0 15.00 ULTRA SOUND 55.01 55.01 16.00 UTRA SOUND 55.01 55.00 17.00 MAGNETIC RESONANCE IMAGING 58.00 2.314 0 (MRI) 18.00 CARDIAC CATHETERIZATION 59.00 1.246 0 17.00 MAGNETIC RESONANCE IMAGING 58.00 2.314 0 (MRI) 18.00 CARDIAC CATHETERIZATION 59.00 1.246 0 17.00 MAGNETIC RESONANCE IMAGING 58.00 2.314 0 (MRI) 2.00 DHYSICAL THERAPY 66.00 2.7790 0 19.00 LOCUPATIONAL THERAPY 66.00 2.790 0 20.00 AUDIOLOGY 67.01 1.578 0 22.00 CARDIAC CATHETENISERVICE 90.01 3.382 0 23.00 SPECCHPATHOLOGY 68.00 712 0 24.00 CARDIAL CARE SERVICES 90.01 3.500 0 24.00 CARDIAL CARE SERVICES 90.01 3.500 0 25.00 OTHER OUTPATIENT SERVICE 90.01 3.382 0 25.00 OTHER OUTPATIENT SERVICE 90.01 3.500 0 26.00 OTHER OUTPATIENT SERVICE 90.01 3.500 0 27.00 AUDIOLOGY 90.01 4.4094 0 29.00 OTHER OUTPATIENT SERVICE 90.01 3.500 0 30.00 PHYSICAL THERAPY 90.01 4.761 0 30.00 PHYSICAL SERVICES 95.00 13.500 0 31.00 PHYSICAL SERVICES 95.00	1.00		4.00	5. 073	0		1. 00
3. 00 OPERATION OF PLANT 7. 00 9. 078 0 4. 00 1.			l I		0		
4. 00 1. LAUNDRY & LINEN SERVICE 8. 00 5. 00 1. 00 DIUSEKEEPING 9. 00 7. 532 0 1. 00 1. 00 DIUSEKEEPING 9. 00 7. 00 NURSING ADMINISTRATION 13. 00 6. 055 0 8. 00 9. 00 NERSING ADMINISTRATION 13. 00 15. 00 3. 868 0 9. 00 MEDI CAL RECORDS & LI BRARY 16. 00 15. 775 0 10. 00 NULS & PEDI ATRICS 30. 00 21. 777 0 10. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 12. 01 13. 00 14. 00 12. 217 0 12. 00 13. 00 14. 00 15. 00 16. 00 17. 023 0 13. 00 18. 00 19. 00 18. 00 19. 00 19. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 12. 01 12. 00 13. 00 14. 00 15. 00 15. 00 16. 00 17. 023 0 18. 00 18. 00 19. 00 18. 00 19. 00 18. 00 19. 00 18. 00 19. 00 18. 00 19. 00					-		
5. 00 HOUSEKEEPI NG 9. 00 7, 532 0 6. 00 0 6. 00 0 1 6. 00 0 0 0 0 0 0 0 0 0					-		
6. 00 DI ETARY 10. 00 10. 226 0 7. 00 NURSI NG ADMIN ISTRATI ON 13. 00 6. 055 0 8. 00 9. 00 NURSI NG ADMIN ISTRATI ON 13. 00 6. 055 0 8. 00 9. 00 MEDI CAL RECORDS & LI BRARY 16. 00 15. 775 0 9. 00 10. 00 ADULTS & PEDI ATRICS 30. 00 21. 777 0 10. 00 ADULTS & PEDI ATRICS 131. 00 11. 00 10 NUTS & CARE UNIT 131. 00 12. 1777 0 11. 00 10 NUTS & CARE UNIT 131. 00 12. 1777 0 12. 00 12. 00 SUBPROVI DER C I FP 40. 00 12. 217 0 12. 00 13. 00 0 PERATI NG ROOM 50. 00 17. 023 0 13. 00 14. 00 RADI OLOGY-DI AGNOSTI C 54. 00 15. 306 0 14. 00 15. 00 11. TRA SOUND 55. 01 2. 153 0 15. 00 1			l I		-		
7. 00 NURSI NC ADMINISTRATION 13. 00 6, 055 0 8. 00 8. 00 9HARMACY 15. 00 3, 868 0 9 9. 00 MEDI CAL RECORDS & LI BRARY 16. 00 15, 775 0 9. 00 10. 00 ADULTS & PEDI ATRI CS 30. 00 21, 777 0 10. 00 11. 00 11. TRISIS VE CARE UNIT 31. 00 8, 419 0 11. 00 12. 00 SUBPROVI DER - I PF 40. 00 12, 217 0 12. 00 13. 00 OPERATI NG ROOM 50. 00 17, 023 0 12. 00 14. 00 RADI 01.00 OPERATI NG ROOM 50. 00 17, 023 0 14. 00 15. 00 14. 00 15. 00 17. 00 11.			l I		-		
8. 00 PHARMACY 15. 00 3, 868 0 9, 00 MBDI CAL RECORDS & LIBRARY 16. 00 15, 775 0 9, 00 10. 00 ADULTS & PEDIATRICS 30. 00 21, 777 0 110. 00 INTENSIVE CARE UNIT 31. 00 8, 419 0 12. 00 SUBPROVIDER - IPF 40. 00 12, 217 0 12. 00 SUBPROVIDER - IPF 50. 00 17, 023 0 12. 00 14. 00 RADIOLOGY-DIAGNOSTIC 54. 00 15, 306 0 14. 00 15. 00 17. 023 0 15. 00 15. 00 17.					-		
9. 00 MEDICAL RECORDS & LIBRARY 16. 00 15, 775 0 10. 00 ADULTS & PEDIATRICS 30. 00 21, 777 0 110. 00 11. 00			l I		9		
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13. 00 OPERATING ROOM 50. 00 17, 023 0 13. 00 14. 00 RADI OLOGY-DI AGNOSTI C 54. 00 15, 306 0 14. 00 15. 00 ULTRA SOUND 55. 01 2, 153 0 15. 00 16. 00 CT SCAN 57. 00 801 0 16. 00 17. 00 MAGNETI C RESONANCE I MAGI NG 58. 00 2, 314 0 17. 00 18. 00 CARDI AC CATHETERI ZATI ON 59. 00 1, 246 0 18. 00 19. 00 LABORATORY 60. 00 21, 790 0 19. 00 19. 00 OPHYSI CAL THERAPY 66. 00 8, 794 0 20. 00 21. 00 OCCUPATI ONAL THERAPY 67. 00 7, 230 0 21. 00 22. 00 AUDI OLOGY 67. 01 1, 578 0 22. 00 23. 00 SPEECH PATHOLOGY 68. 00 712 0 22. 00 24. 00 CARDI OLOGY 69. 01 5, 539 0 22. 00 25. 00 OTHER OUTPATI ENT SERVI CE COST CENTER 26. 00 GASTROENTEROLOGY CLI NI C 90. 09 1, 068 0 26. 00 27. 00 ALLERGY CLI NI C 90. 13 1, 068 0 27. 00 28. 00 WOUND CARE 90. 14 4, 094 0 22. 00 29. 00 EMERGENCY 91. 00 13, 500 0 30. 00 AMBULANCE SERVI CES 95. 00 13, 500 0 31. 00 PHYSI CLI NNS' PRI VATE OFFI CES 192. 00 32. 00 CENTER NORSEI MBURSABLE COST 194. 02 CENTERS 10 TOTALS 1, 1928, 665 0					-		
14. 00 RADI OLOGY-DI AGNOSTI C 54. 00 15, 306 0 15. 00 15.			40.00	12, 217	0		12. 00
15. 00 ULTRA SOUND 55. 01 2, 153 0 16. 00 17. 00	13. 00	OPERATING ROOM	50.00	17, 023	0		13. 00
16. 00 CT SCAN 57. 00 801 0 16. 00 17. 00 MAGNETI C RESONANCE I MAGI NG 58. 00 2, 314 0 17. 00 MAGNETI C RESONANCE I MAGI NG 58. 00 2, 314 0 17. 00 18. 00 18. 00 19. 00 CARDI AC CATHETERI ZATI ON 59. 00 1, 246 0 18. 00 19. 00 LABORATORY 60. 00 21, 790 0 19. 00 20. 00 PHYSI CAL THERAPY 66. 00 8, 794 0 20. 00 21. 00 0 0 0 0 0 0 0 0 0	14.00	RADI OLOGY-DI AGNOSTI C	54.00	15, 306	0		14.00
17. 00 MAGNETIC RESONANCE IMAGING (MRI) 17. 00 18. 00 18. 00 19. 00 18. 00 19. 00 18. 00 19. 00 18. 00 19.	15.00	ULTRA SOUND	55. 01	2, 153	0		15.00
18. 00 CARDI AC CATHETERI ZATI ON 59. 00 1, 246 0 18. 00 19. 00 LABORATORY 66. 00 21, 790 0 20. 00 PHYSI CAL THERAPY 66. 00 8, 794 0 21. 00 OCCUPATI ONAL THERAPY 67. 00 7, 230 0 22. 00 AUDI OLOGY 67. 01 1, 578 0 23. 00 SPEECH PATHOLOGY 68. 00 712 0 24. 00 CARDI OLOGY 69. 01 5, 539 0 25. 00 OTHER OUTPATI ENT SERVI CE 90. 01 3, 382 0 25. 00 COST CENTER 26. 00 GASTROENTEROLOGY CLI NI C 90. 09 1, 068 0 27. 00 ALLERGY CLI NI C 90. 13 1, 068 0 28. 00 WOUND CARE 90. 14 4, 094 0 29. 00 EMERGENCY 91. 00 14, 761 0 30. 00 AMBULANCE SERVI CES 95. 00 13, 500 0 31. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 1, 509, 039 0 32. 00 OTHER NONREI MBURSABLE COST 194. 02 534 0 CENTERS TOTALS 1, 928, 665 0	16.00	CT SCAN	57.00	801	0		16. 00
18. 00 CARDÍ AC CATHETERI ZATI ON 59. 00 1, 246 0 18. 00 19. 00 LABORATORY 60. 00 21, 790 0 19. 00 20. 00 PHYSI CAL THERAPY 66. 00 8, 794 0 20. 00 21. 00 OCCUPATI ONAL THERAPY 67. 00 7, 230 0 21. 00 22. 00 AUDI OLOGY 67. 01 1, 578 0 22. 00 23. 00 SPEECH PATHOLOGY 68. 00 712 0 23. 00 24. 00 CARDÍ OLOGY 69. 01 5, 539 0 24. 00 25. 00 OTHER OUTPATI ENT SERVI CE 70. 01 3, 382 7. 00 26. 00 GASTROENTEROLOGY CLI NI C 90. 09 1, 068 0 26. 00 27. 00 ALLERGY CLI NI C 90. 13 1, 068 0 27. 00 28. 00 WOUND CARE 90. 14 4, 094 0 28. 00 29. 00 EMERGENCY 91. 00 14, 761 0 29. 00 30. 00 AMBULANCE SERVI CES 95. 00 13, 500 0 31. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 1, 509, 039 0 32. 00 OTHER NONREI MBURSABLE COST 194. 02 534 0 32. 00 CENTERS 102. 00 1, 928, 665 0	17.00	MAGNETIC RESONANCE IMAGING	58.00	2, 314	0		17.00
19. 00 LABORATORY 60. 00 21, 790 0 19. 00 20. 00 PHYSI CAL THERAPY 66. 00 8, 794 0 20. 00 21. 00 OCCUPATI ONAL THERAPY 67. 00 7, 230 0 21. 00 22. 00 AUDI OLOGY 67. 01 1, 578 0 22. 00 23. 00 SPEECH PATHOLOGY 68. 00 712 0 23. 00 24. 00 CARDI OLOGY 69. 01 5, 539 0 24. 00 25. 00 OTHER OUTPATI ENT SERVI CE 90. 01 3, 382 0 25. 00 26. 00 GASTROENTEROLOGY CLI NI C 90. 09 1, 068 0 27. 00 28. 00 WOUND CARE 90. 14 4, 094 0 28. 00 29. 00 EMERGENCY 91. 00 14, 761 0 29. 00 30. 00 AMBULANCE SERVI CES 95. 00 13, 500 0 31. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 1, 509, 039 0 32. 00 OTHER NONREI MBURSABLE COST 194. 02 534 0 CENTERS TOTALS		(MRI)					
19. 00 LABORATORY 60. 00 21, 790 0 19. 00 20. 00 PHYSI CAL THERAPY 66. 00 8, 794 0 20. 00 21. 00 OCCUPATI ONAL THERAPY 67. 00 7, 230 0 21. 00 22. 00 AUDI OLOGY 67. 01 1, 578 0 22. 00 23. 00 SPEECH PATHOLOGY 68. 00 712 0 23. 00 24. 00 CARDI OLOGY 69. 01 5, 539 0 24. 00 25. 00 OTHER OUTPATI ENT SERVI CE 90. 01 3, 382 0 25. 00 26. 00 GASTROENTEROLOGY CLI NI C 90. 09 1, 068 0 27. 00 28. 00 WOUND CARE 90. 14 4, 094 0 28. 00 29. 00 EMERGENCY 91. 00 14, 761 0 29. 00 30. 00 AMBULANCE SERVI CES 95. 00 13, 500 0 31. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 1, 509, 039 0 32. 00 OTHER NONREI MBURSABLE COST 194. 02 534 0 CENTERS TOTALS	18.00	CARDI AC CATHETERI ZATI ON	59.00	1, 246	0		18. 00
20. 00 PHYSI CAL THERAPY 66. 00 8, 794 0 21. 00 OCCUPATI ONAL THERAPY 67. 00 7, 230 0 22. 00 AUDI OLOGY 67. 01 1, 578 0 23. 00 SPEECH PATHOLOGY 68. 00 712 0 24. 00 CARDI OLOGY 69. 01 5, 539 0 25. 00 OTHER OUTPATI ENT SERVI CE 90. 01 3, 382 0 COST CENTER 26. 00 GASTROENTEROLOGY CLI NI C 90. 09 1, 068 0 27. 00 ALLERGY CLI NI C 90. 13 1, 068 0 28. 00 WOUND CARE 90. 14 4, 094 0 29. 00 EMERGENCY 91. 00 14, 761 0 30. 00 AMBULANCE SERVI CES 95. 00 13, 500 0 31. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 1, 509, 039 0 32. 00 OTHER NONREI MBURSABLE COST 194. 02 534 0 CENTERS 1, 928, 665 0	19.00		60.00	21, 790	0		19. 00
21. 00 OCCUPATI ONAL THERAPY 67. 00 7, 230 0 22. 00 AUDI OLOGY 67. 01 1, 578 0 23. 00 SPEECH PATHOLOGY 68. 00 712 0 24. 00 CARDI OLOGY 69. 01 5, 539 0 25. 00 OTHER OUTPATI ENT SERVI CE COST CENTER COST CENTER 90. 13 1, 068 0 27. 00 ALLERGY CLINI C 90. 13 1, 068 0 28. 00 WOUND CARE 90. 14 4, 094 0 29. 00 EMERGENCY 91. 00 14, 761 0 30. 00 AMBULANCE SERVI CES 95. 00 13, 500 0 31. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 1, 509, 039 0 32. 00 OTHER NONREI MBURSABLE COST 194. 02 534 0 0 CENTERS 1,928, 665 0			l I		0		
22. 00 AUDI OLOGY 67. 01 1, 578 0 22. 00 23. 00 SPEECH PATHOLOGY 68. 00 712 0 24. 00 CARDI OLOGY 69. 01 5, 539 0 25. 00 OTHER OUTPATI ENT SERVI CE COST CENTER COST CENTER GASTROENTEROLOGY CLI NI C 90. 03 1, 068 0 27. 00 ALLERGY CLI NI C 90. 13 1, 068 0 28. 00 WOUND CARE 90. 14 4, 094 0 29. 00 EMERGENCY 91. 00 14, 761 0 30. 00 AMBULANCE SERVI CES 95. 00 13, 500 0 31. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 1, 509, 039 0 32. 00 OTHER NONREI MBURSABLE COST 194. 02 534 0 CENTERS TOTALS 1, 928, 665 0			l I		0		
23. 00 SPEECH PATHOLOGY 68. 00 712 0 23. 00 24. 00 CARDI OLOGY 69. 01 5, 539 0 25. 00 OTHER OUTPATI ENT SERVI CE 90. 01 3, 382 0 COST CENTER 26. 00 GASTROENTEROLOGY CLINI C 90. 09 1, 068 0 27. 00 ALLERGY CLINI C 90. 13 1, 068 0 28. 00 WOUND CARE 90. 14 4, 094 0 29. 00 EMERGENCY 91. 00 14, 761 0 30. 00 AMBULANCE SERVI CES 95. 00 13, 500 0 31. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 1, 509, 039 0 32. 00 OTHER NONREI MBURSABLE COST 194. 02 534 0 CENTERS 1, 928, 665 0			1		-		
24. 00 CARDI OLOGY 69. 01 5, 539 0 24. 00 25. 00 OTHER OUTPATIENT SERVICE 90. 01 3, 382 0 COST CENTER 26. 00 GASTROENTEROLOGY CLINIC 90. 09 1, 068 0 27. 00 ALLERGY CLINIC 90. 13 1, 068 0 28. 00 WOUND CARE 90. 14 4, 094 0 29. 00 EMERGENCY 91. 00 14, 761 0 30. 00 AMBULANCE SERVICES 95. 00 13, 500 0 31. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 1, 509, 039 0 32. 00 OTHER NONREI MBURSABLE COST 194. 02 534 0 CENTERS 1, 928, 665 0					-		
25. 00 0 OTHER OUTPATIENT SERVICE 0 COST CENTER 26. 00 GASTROENTEROLOGY CLINIC 27. 00 ALLERGY CLINIC 28. 00 WOUND CARE 29. 00 EMERGENCY 30. 00 31. 00 31. 00 31. 00 32. 00 0 OTHER NONREI MBURSABLE COST 1, 928, 665 0 OTHER NONREI MBURSABLE COST 1, 928, 665 0 OTHER NONREI MBURSABLE COST 1, 928, 665 0 OTHER NONREI MSURSABLE COST 25. 00 26. 00 26. 00 27. 00 26. 00 27. 00 28. 00 29. 00 29. 00 31. 00 32. 00 32. 00 33. 00 34. 00 35. 00 35. 00 35. 00 35. 00 35. 00 35. 00 35. 00 35. 00 35. 00 35. 00 35. 00 35. 00 36. 00 37. 00 37. 00 38. 00 38. 00 39.					o o		
COST CENTER GASTROENTEROLOGY CLINIC 90.09 1,068 0 27.00 ALLERGY CLINIC 90.13 1,068 0 28.00 WOUND CARE 90.14 4,094 0 29.00 EMERGENCY 91.00 14,761 0 30.00 AMBULANCE SERVICES 95.00 13,500 0 31.00 PHYSICIANS' PRIVATE OFFICES 192.00 1,509,039 0 32.00 OTHER NONREI MBURSABLE COST 194.02 534 0 CENTERS 1,928,665 0					-		
26. 00 GASTROENTEROLOGY CLINIC 90. 09 1, 068 0 27. 00 27. 00 ALLERGY CLINIC 90. 13 1, 068 0 27. 00 28. 00 WOUND CARE 90. 14 4, 094 0 28. 00 29. 00 EMERGENCY 91. 00 14, 761 0 29. 00 30. 00 AMBULANCE SERVICES 95. 00 13, 500 0 30. 00 31. 00 PHYSICIANS' PRIVATE OFFICES 192. 00 1, 509, 039 0 31. 00 32. 00 OTHER NONREI MBURSABLE COST 194. 02 534 0 CENTERS 70TALS 1, 928, 665 0	25.00		90.01	3, 382	U		25.00
27. 00 ALLERGY CLINIC 90. 13 1, 068 0 28. 00 WOUND CARE 90. 14 4, 094 0 29. 00 EMERGENCY 91. 00 14, 761 0 30. 00 AMBULANCE SERVICES 95. 00 13, 500 0 31. 00 PHYSICIANS' PRIVATE OFFICES 192. 00 1, 509, 039 0 32. 00 OTHER NONREIMBURSABLE COST 194. 02 534 0 CENTERS 1,928, 665 0	24 00		00.00	1 0/0	0		27 00
28. 00 WOUND CARE 90. 14 4,094 0 28. 00 29. 00 EMERGENCY 91. 00 14, 761 0 29. 00 30. 00 AMBULANCE SERVICES 95. 00 13, 500 0 31. 00 PHYSI CI ANS' PRI VATE OFFICES 192. 00 1, 509, 039 0 32. 00 OTHER NONREI MBURSABLE COST 194. 02 534 0 32. 00 CENTERS 7 1,928, 665 0					-		
29. 00 30. 00 31. 00 31. 00 32. 00 AMBULANCE SERVICES PHYSICIANS' PRIVATE OFFICES OTHER NONREIMBURSABLE COST TOTALS 91. 00 14, 761 0 0 30. 00 13, 500 0 13, 500 0 0 1, 509, 039 0 31. 00 32. 00					-		
30. 00 AMBULANCE SERVICES 95. 00 13, 500 0 31. 00 31. 00 9HYSICIANS' PRIVATE OFFICES 192. 00 1, 509, 039 0 31. 00 32. 00 CENTERS					O		
31. 00 PHYSICIANS' PRIVATE OFFICES 192. 00 1, 509, 039 0 31. 00 32. 00 OTHER NONREIMBURSABLE COST 194. 02 534 0 32. 00 CENTERS			l I		-		
32. 00 OTHER NONREI MBURSABLE COST 194. 02 534 0 32. 00 CENTERS			l I		-		
CENTERS			l I		-		
TOTALS 1, 928, 665 0	32.00		194. 02	534	0		32.00
		CENTERS	<u> </u>				
500.00 Grand Total: Increases 2,237,902 11,331,805 500.00							
	500.00	Grand Total: Increases		2, 237, 902	11, 331, 805		500.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 150104

						5/28/2015 2:	17 pm
	Cook Cooker	Decreases	C-1	0+1	 		
	Cost Center 6.00	Li ne # 7. 00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	A - EMPLOYEE BENEFITS	7.00	0.00	7.00	10.00		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	236, 493	0		1.00
	TOTALS			236, 493			
	B - INSURANCE RECLASS						
1. 00	ADMI NI STRATI VE & GENERAL		0_	17 <u>6, 3</u> 18			1. 00
	TOTALS		0	176, 318			_
1. 00	C - CAFETERI A RECLASS DI ETARY	10.00	309, 237	392, 704	0		1.00
1.00	TOTALS		309, 237	3 <u>72, 7</u> 0 <u>4</u> 392, 704			1.00
	D - MME DEPRECIATION		0077207	372,731	I I		
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	20, 165	9		1.00
	FLXT						
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2, 315			2. 00
3.00	ADMINISTRATIVE & GENERAL	5. 00	0	559, 734	1		3.00
4. 00 5. 00	OPERATION OF PLANT LAUNDRY & LINEN SERVICE	7. 00 8. 00	0	68, 689 23			4. 00 5. 00
6. 00	HOUSEKEEPI NG	9. 00	0	1, 718			6. 00
7. 00	DI ETARY	10.00	o	4, 208	1		7. 00
8.00	NURSING ADMINISTRATION	13.00	O	1, 639	1		8. 00
9.00	PHARMACY	15. 00	0	1, 492	0		9.00
10.00	MEDICAL RECORDS & LIBRARY	16. 00	0	4, 400			10.00
11.00	ADULTS & PEDIATRICS	30.00	0	70, 027	1		11.00
12.00	INTENSIVE CARE UNIT	31. 00 40. 00	0	17, 778	1		12.00
13. 00 14. 00	OPERATING ROOM	50. 00	0	1, 735 246, 935			13. 00 14. 00
15. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	146, 251	0		15. 00
16. 00	ULTRA SOUND	55. 01	o	45, 270			16. 00
17.00	CT SCAN	57.00	0	494, 405			17. 00
18.00	MAGNETIC RESONANCE IMAGING	58. 00	0	425, 563	0		18. 00
	(MRI)						
19.00	CARDI AC CATHETERI ZATI ON	59.00	0	26, 619	1		19. 00
20. 00 21. 00	LABORATORY PHYSI CAL THERAPY	60. 00 66. 00	0	171, 184	1		20.00
21.00	OCCUPATIONAL THERAPY	67. 00	0	13, 452 3, 473			22. 00
23. 00	AUDI OLOGY	67. 01	0	15, 563			23. 00
24. 00	SPEECH PATHOLOGY	68. 00	Ö	64			24. 00
25.00	CARDI OLOGY	69. 01	0	31, 218	0		25. 00
26.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	65	0		26. 00
07.00	PATI ENTS	00.01		7 400			07.00
27. 00	OTHER OUTPATIENT SERVICE COST CENTER	90. 01	0	7, 409	0		27. 00
28. 00	SURGERY CLINIC	90. 05	0	653	0		28. 00
29. 00	UROLOGY CLINIC	90. 07	Ö	3, 198			29. 00
30.00	NEUROLOGY CLINIC	90. 11	0	3, 323	0		30.00
31.00	OPTHAMOLOGY CLINIC	90. 12	0	41, 955			31. 00
32. 00	ALLERGY CLINIC	90. 13	0	939			32. 00
33.00	WOUND CARE	90. 14	0	6, 404	0		33. 00
34. 00 35. 00	EMERGENCY AMBULANCE SERVICES	91. 00 95. 00	0	29, 506 131, 890			34. 00 35. 00
36. 00	PHYSICIANS' PRIVATE OFFICES	192.00	o	107, 310			36.00
37. 00	THORNTOWN OFFICE BUILDING	194.00	o	332			37. 00
	TOTALS			2, 706, 904			
	E - DRUGS RECLASS						
1.00	PHARMACY	<u>15.</u> 00	•	<u>1, 117, 6</u> 93			1. 00
	TOTALS		0	1, 117, 693			_
1 00	F - MED SUPPLY IMPLANTS	20.00	ما	2 142			1 00
1. 00 2. 00	ADULTS & PEDIATRICS OPERATING ROOM	30. 00 50. 00	0	2, 142 4, 307, 018	1		1.00
3.00	RADI OLOGY-DI AGNOSTI C	54.00	0	58, 487			3.00
4. 00	CARDI AC CATHETERI ZATI ON	59.00	ő	241, 672	1		4. 00
5. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	o	9, 761			5. 00
	PATI ENTS						1
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	102, 145			6. 00
7. 00	WOUND CARE	90.14	0	5, 268			7. 00
	TOTALS G - CHARGABLE MED SUPPLIES		O	4, 726, 493			+
1.00	PHARMACY	15. 00	ol	4, 594	0		1.00
2. 00	ADULTS & PEDIATRICS	30.00	Ö	98, 167			2. 00
3. 00	INTENSIVE CARE UNIT	31. 00	Ö	49, 763			3. 00
4. 00	SUBPROVI DER - I PF	40.00	o	4, 327	1		4. 00
5.00	OPERATING ROOM	50.00	o	1, 589, 994	0		5. 00
6.00	RADI OLOGY-DI AGNOSTI C	54.00	O	627			6. 00
7. 00 8. 00	ULTRA SOUND	55. 01	0	1, 339	1		7. 00
	CT SCAN	57. 00	Ol	4, 831	ol		8. 00

Period: Worksheet A-0
From 01/01/2014
To 12/31/2014 Date/Time Prepared: 5/28/2015 2:17 pm

						5/28/2015 2: 1	7 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00	,	
9. 00	MAGNETIC RESONANCE IMAGING (MRI)	58. 00	0	234	0		9. 00
10.00	CARDIAC CATHETERIZATION	59.00	0	3, 007	0		10. 00
11.00	LABORATORY	60.00	0	769	0		11. 00
12.00	PHYSI CAL THERAPY	66.00	0	10			12. 00
13.00	OCCUPATI ONAL THERAPY	67. 00	0	399			13. 00
14.00	CARDI OLOGY	69. 01	0	1, 187			14. 00
15. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6, 874	0		15. 00
16. 00	OTHER OUTPATIENT SERVICE COST CENTER	90. 01	0	2, 561	0		16. 00
17.00	UROLOGY CLINIC	90. 07	0	258	0		17. 00
18.00	ALLERGY CLINIC	90. 13	0	244	0		18. 00
19.00	WOUND CARE	90. 14	0	16, 847	0		19. 00
20.00	EMERGENCY	91.00	0	182, 114	0		20. 00
21.00	AMBULANCE SERVICES	95.00	0	6, 249			21. 00
22. 00	PHYSICIANS' PRIVATE OFFICES	192.00		805			22. 00
	TOTALS		0	1, 975, 200			
	H - BONUS RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 928, 665			1. 00
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	0	0	0		5. 00
6.00		0.00	0	0	0		6. 00
7. 00 8. 00		0. 00 0. 00	0	0			7. 00 8. 00
9. 00	+	0.00	0	0			9. 00
10.00	+	0.00	0	0			10.00
11. 00		0.00	0	0	0		11. 00
12. 00		0.00	o	0			12.00
13. 00		0.00	o	0			13. 00
14. 00		0.00	ő	0			14. 00
15. 00		0.00	o	0	0		15. 00
16. 00		0.00	o	0			16. 00
17. 00		0.00	o	0			17. 00
18. 00		0.00	o	0			18. 00
19.00		0.00	O	0	0		19. 00
20.00		0.00	O	0	0		20. 00
21.00		0.00	O	0	0		21. 00
22.00		0.00	o	0	0		22. 00
23.00		0.00	O	0	0		23. 00
24.00		0.00	0	0	0		24. 00
25.00		0.00	0	0	0		25. 00
26.00		0.00	0	0	0		26. 00
27. 00		0.00	0	0	0		27. 00
28. 00		0.00	0	0	0		28. 00
29. 00		0.00	0	0			29. 00
30.00		0.00	0	0	0		30. 00
31. 00		0.00	0	0			31. 00
32. 00		0.00	•	0	0		32. 00
F00 07	TOTALS		0	1, 928, 665			F00 00
500.00	Grand Total: Decreases		309, 237	13, 260, 470			500. 00

WITHAM MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Health Financial Systems RECONCILIATION OF CAPITAL COSTS CENTERS Worksheet A-7 Provi der CCN: 150104 Peri od: From 01/01/2014 To 12/31/2014 Part I Date/Time Prepared: 5/28/2015 2:17 pm Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Retirements 5.00 Bal ances 2.00 3.00 4. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 0 1.00 5, 270, 585 6, 172, 915 2.00 Land Improvements 7, 721, 719 5, 270, 585 2.00 0 0 0 0 Buildings and Fixtures Building Improvements 3.00 76, 044, 243 6, 172, 915 3.00 0 4.00 0 4.00 5.00 Fi xed Equipment 2, 235, 789 4,706 4, 706 5.00 6.00 Movable Equipment 37, 769, 977 0 4, 934, 925 4, 934, 925 300, 342 6.00 0 HIT designated Assets 7.00 7.00 0 8.00 Subtotal (sum of lines 1-7) 123, 771, 728 16, 383, 131 16, 383, 131 300, 342 8.00 0 9.00 Reconciling Items 9.00 10.00 Total (line 8 minus line 9) 16, 383, 131 300, 342 123, 771, 728 0 16, 383, 131 10.00 Endi ng Bal ance Fully

Depreci at	ted
Assets	
6.00 7.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	
1. 00 Land 0	0 1.00
2.00 Land Improvements 12,992,304	0 2.00
3.00 Buildings and Fixtures 82,217,158	0 3.00
4.00 Building Improvements 0	0 4.00
5.00 Fi xed Equi pment 2, 240, 495	0 5.00
6.00 Movable Equipment 42,404,560	0 6.00
7.00 HIT designated Assets 0	0 7.00
8.00 Subtotal (sum of lines 1-7) 139,854,517	0 8.00
9.00 Reconciling Items 0	0 9.00
10.00 Total (line 8 minus line 9) 139,854,517	0 10.00

Heal th	Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150104	Peri od: From 01/01/2014	Worksheet A-7 Part II	
					To 12/31/2014	Date/Time Pre	pared:
			SI	JMMARY OF CAP	I TAI	5/28/2015 2:1	/ pili
			0.0				
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	•	
					instructions)	instructions)	
		9. 00	10. 00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	1, 736, 039	0		0 0	0	1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	1, 736, 039	0		0 0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	IN 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	1, 736, 039				1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
3.00	Total (sum of lines 1-2)	0	1, 736, 039				3. 00
		•	=				

Health Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet A-7 Part III Date/Time Pre 5/28/2015 2:1	pared:
	COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPI					
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio (col. 1 - col	instructions)		
			2)			
	1.00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00 NEW CAP REL COSTS-BLDG & FLXT	82, 217, 158	0	82, 217, 15		0	1. 00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		0. 000000		2. 00
3.00 Total (sum of lines 1-2)	82, 217, 158		82, 217, 15			3. 00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY C	OF CAPITAL	
Cost Center Description	Taxes	0ther	Total (sum of	f Depreciation	Lease	
		Capi tal -Relate				
		d Costs	through 7)			
DADT III DECONOLILATION OF CARLTAL COCTO OF	6. 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS	1 0		0 1, 715, 874	(2.12)	1. 00
2.00 NEW CAP REL COSTS-BLDG & FIXT	0	0		0 1, 715, 874		2.00
3.00 Total (sum of lines 1-2)	0	0		0 4, 422, 778	l .	
3.00 Total (Suill of Titles 1-2)	U	SI SI	I JMMARY OF CAPI		-03, 130	3.00
		30	DIVINIANT OF CALL	IAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
		instructions)	instructions)	Capi tal -Relate		
				d Costs (see	through 14)	
				instructions)		
DART III DECONCILIATION OF CARITAL COCTO OF	11.00	12.00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		174 210			1 204 222	1. 00
2.00 NEW CAP REL COSTS-BLDG & FIXT	-534, 723	176, 318 0		0 0	1, 294, 333 2, 706, 904	2.00
3.00 Total (sum of lines 1-2)	-534, 723			0 0		
5. 00 Total (Suil Of TITIES 1-2)	-554,725	170,310	I	Ο Ι	4,001,237	J. 00

Health Financial Systems WITHAM MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 150104 Peri od: Worksheet A-8 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/28/2015 2:17 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - NEW CAP ONEW CAP REL COSTS-BLDG & 1. 00 1.00 REL COSTS-BLDG & FLXT (chapter IFT XT 2.00 Investment income - NEW CAP ONEW CAP REL COSTS-MVBLE 2.00 2.00 REL COSTS-MVBLE EQUIP (chapter EQUI P 3 00 Investment income - other 0 3 00 0 00 (chapter 2) 4.00 Trade, quantity, and time 0.00 4.00 di scounts (chapter 8) Refunds and rebates of 5.00 0.00 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) 7.00 Tel ephone services (pay В -5. 106 ADMINISTRATIVE & GENERAL 5.00 7.00 stations excluded) (chapter 21) 8.00 Tel evision and radio service 0 0.00 8.00 0 (chapter 21) Parking Lot (chapter 21) 9.00 0.00 9.00 -2, 594, 572 10.00 Provider-based physician A-8-2 10.00 adj ustment 11.00 Sale of scrap, waste, etc. 0 0.00 11.00 (chapter 23) 12.00 Related organization A-8-1 0 12.00 transactions (chapter 10) 13.00 Laundry and linen service 0.00 13.00 14.00 Cafeteria-employees and guests В -213, 039 CAFETERI A 11.00 14.00 15.00 Rental of quarters to employee 15.00 0.00 and others 16.00 Sale of medical and surgical 0 0.00 16.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 17.00 pati ents Sale of medical records and 18 00 18.00 0 00 abstracts 19.00 Nursing school (tuition, fees, 0.00 19.00 books, etc.) Vending machines -4, 078 DI ETARY 20.00 В 10.00 20.00 Income from imposition of 21.00 0.00 21.00 interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare 0.00 22.00 overpayments and borrowings to repay Medicare overpayments 23 00 Adjustment for respiratory A-8-3 0 *** Cost Center Deleted *** 65 00 23 00 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 24.00 66.00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review -0 *** Cost Center Deleted *** 114.00 25.00 physicians' compensation (chapter 21) 26.00 Depreciation - NEW CAP REL ONEW CAP REL COSTS-BLDG & 1.00 26.00 COSTS-BLDG & FLXT FLXT 27.00 Depreciation - NEW CAP REL ONEW CAP REL COSTS-MVBLE 2.00 27.00 COSTS-MVBLE EQUIP FOUL P 28.00 Non-physician Anesthetist * Cost Center Deleted *** 19.00 28.00 Physicians' assistant 29.00 0.00 29 00 Adjustment for occupational OCCUPATIONAL THERAPY 30.00 A-8-3 67.00 30.00 therapy costs in excess of limitation (chapter 14) OADULTS & PEDIATRICS 30 99 30.99 Hospice (non-distinct) (see 30.00 instructions) 31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.00 pathology costs in excess of limitation (chapter 14)

0

0 00

32 00

32 00

CAH HIT Adjustment for

Depreciation and Interest

Health Financial Systems WITHAM MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 150104 Peri od: Worksheet A-8 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/28/2015 2:17 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code (2) Cost Center Description Cost Center Line # Wkst. A-7 Ref. Amount 1.00 2.00 3.00 4.00 5.00 33.00 HOSPTIAL ADMIN -207, 716 ADMINI STRATI VE & GENERAL 5.00 Α SPONSORSHI PS/DONATI ON 33.01 0.00 33.01 33.02 LEASE INCOME В -25, 906 NEW CAP REL COSTS-BLDG & 1.00 10 33.02 FLXT 33.03 RENTAL REVENUE -27, 030 NEW CAP REL COSTS-BLDG & 10 33.03 В 1.00 IFT XT -3, 000 ADMINISTRATIVE & GENERAL 33.04 MEDICAL STAFF FEES R 5.00 0 33.04 EMPLOYEE RECORD FEES -50 ADMINISTRATIVE & GENERAL 33.05 В 5.00 33.05 PATIENT ACCOUNTS -6, 154 ADMINI STRATI VE & GENERAL 5.00 33.06 В -583 ADMI NI STRATI VE & GENERAL MISC INCOME RECEIVED 33 07 В 5 00 33 07 33.08 MEALS ON WHEELS В -46, 887 DI ETARY 10.00 33.08 DI ETARY TAX REVENUE 819 DI ETARY 33.09 33.09 В 10.00 33.10 XRAY FEES В -222 RADI OLOGY-DI AGNOSTI C 54.00 33. 10 DEMATOLOGY CLINIC RENT -1, 507 DERMATOLOGY CLINIC 90.03 33 11 В 33.11 33. 12 SURGERY CLINIC RENT В -499 SURGERY CLINIC 90.05 33.12 -10, 712 CARDI OLOGY 33.13 CARDI OLOGY В 69.01 33.13 UROLOGY CLINIC RENT -1, 669 UROLOGY CLINIC 33. 14 В 90.07 0 33.14 GASTROENTEROLOGY CLINIC RENT -9, 754 GASTROENTEROLOGY CLINIC 33. 15 В 90.09 33.15 NEUROLOGY CLINIC RENT -1, 124 NEUROLOGY CLINIC 90.11 33. 16 33.16 В -685 AMBULANCE SERVICES 33.17 AMBUL ANCE В 95.00 33.17 33. 18 33.18 0.00 0 2005 PREMIUM AMORTIZATION 33.19 В 11

Health Financial Systems	WITHAM MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
ADJUSTMENTS TO EXPENSES		Provi der CCN: 15		eri od:	Worksheet A-8		
				To	rom 01/01/2014 o 12/31/2014		
			Expense Classifica	ation on	Worksheet A		
			To/From Which the Am	nount is t	to be Adjusted		
Coat Contan Decarintian	Dania (Cada (2)	Amount	Cost Center		Line #	Wkst. A-7 Ref.	
Cost Center Description							
	1. 00	2. 00	3. 00		4. 00	5. 00	
50.00 TOTAL (sum of lines 1 thru 49)		-8, 249, 982					50.00
(Transfer to Worksheet A,							
column 6, line 200.)							

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

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

 B. Amount Received if cost cannot be determined.
 (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
 Note: See instructions for column 5 referencing to Worksheet A-7.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 150104

					1	Го 12/31/2014	Date/Time Pre 5/28/2015 2:1	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	, biii
		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	40. 00	SUBPROVIDER - IPF	112, 210	0	112, 210	154, 100	870	1. 00
2.00	50. 00	OPERATING ROOM	833, 000		0	0	0	2.00
3.00	60. 00	LABORATORY	251, 000	251, 000	0	0	0	3.00
4.00	67. 00	OCCUPATIONAL THERAPY	3, 767	3, 767	0	0	0	4.00
5.00	91. 00	EMERGENCY	1, 459, 050	1, 459, 050	0	0	0	5.00
6.00	0. 00		0	0	0	0	0	6. 00
7.00	0. 00		0	0	0	0	0	7. 00
8.00	0. 00		0	0	0	0	0	8. 00
9.00	0. 00		0	0	0	0	0	9. 00
10.00	0. 00		0	0	0	0	0	10.00
200.00			2, 659, 027	2, 546, 817	112, 210		870	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
				Li mi t	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13.00	14. 00	
1.00		SUBPROVIDER - IPF	64, 455	· ·	0		0	1. 00
2.00		OPERATING ROOM	0	0	0		0	2. 00
3.00		LABORATORY	0	0	0	1	0	3. 00
4. 00		OCCUPATIONAL THERAPY	0	0	0	0	0	4. 00
5.00		EMERGENCY	0	0	0	0	0	5. 00
6.00	0. 00		0	0	0	0	0	6. 00
7.00	0. 00		0	0	0	0	0	7. 00
8.00	0. 00		0	0	0	0	0	8. 00
9.00	0. 00		0	0	0	0	0	9. 00
10.00	0. 00		0	0	0	0	0	10. 00
200.00			64, 455			0	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		ldenti fi er	Component	Li mi t	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00		
1. 00		SUBPROVIDER - IPF	15.00		47, 755			1. 00
2.00		OPERATING ROOM	0	04, 455	47,755			2. 00
3.00			0	ľ	0			3. 00
4. 00		LABORATIONAL THERADY	0	0	0			4. 00
		OCCUPATI ONAL THERAPY	0	0	0	3, 767		
5.00		EMERGENCY		0	0	1, 459, 050		5. 00
6.00	0. 00 0. 00				0			6. 00
7.00					0			7. 00
8.00	0. 00 0. 00				0	0		8. 00
9.00	0.00				0	0		9. 00
10.00	0.00			0	47 755	2 504 572		10.00
200.00			0	64, 455	47, 755	2, 594, 572		200. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

						o 12/31/2014	Date/Time Pre	
				CAPI TAL REL	_ATED COSTS		5/28/2015 2:1	/ pm
Cook Conton Docomination		Not Francisco	NEW DLDC 0	NEW MADE	EMDL OVEE	Ch. + - + - I		
		Cost Center Description	Net Expenses for Cost	NEW BLDG & FLXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
			Allocation			DEPARTMENT		
			(from Wkst A col. 7)					
			0	1. 00	2. 00	4. 00	4A	
		AL SERVICE COST CENTERS						
1. 00 2. 00	1	NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP	1, 294, 333 2, 706, 904	1, 294, 333	2, 706, 904			1. 00 2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	6, 842, 371	2, 944				4. 00
5.00	1	ADMINISTRATIVE & GENERAL	19, 060, 127	94, 076	· ·		20, 208, 567	5. 00
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	3, 366, 442 245, 752	123, 249 0	1		3, 840, 052 249, 756	7. 00 8. 00
9. 00		HOUSEKEEPI NG	487, 472	14, 192			590, 642	9. 00
10.00		DIETARY	525, 419	31, 768	1		683, 913	
11. 00 13. 00	1	CAFETERIA NURSING ADMINISTRATION	488, 902 488, 487	0			543, 082 567, 716	
15. 00		PHARMACY	1, 310, 243	9, 807		, == .	1, 410, 999	
16. 00		MEDICAL RECORDS & LIBRARY	1, 163, 642	15, 492	32, 399	149, 822	1, 361, 355	16. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	3, 205, 393	103, 043	215, 499	460, 747	3, 984, 682	30. 00
31. 00	03100	INTENSIVE CARE UNIT	1, 081, 020	28, 299	59, 182	162, 935	1, 331, 436	31. 00
40.00		SUBPROVIDER - IPF SUBPROVIDER - IRF	1, 267, 355	32, 400 0	i .		1, 555, 507	40. 00 41. 00
41. 00 42. 00		SUBPROVI DER	0	0		-	0	41.00
43.00	04300	NURSERY	42, 950	0	(0	42, 950	
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	394, 255	82, 240	171, 993	315, 360	963, 848	50. 00
54. 00	1	RADI OLOGY-DI AGNOSTI C	2, 938, 476	100, 580			3, 425, 421	54. 00
55. 00		RADI OLOGY-THERAPEUTI C	0	0	(0	0	55. 00
55. 01 57. 00		ULTRA SOUND CT SCAN	379, 299 631, 887	0	(46, 331 19, 191	425, 630 651, 078	
58. 00	1	MAGNETIC RESONANCE IMAGING (MRI)	731, 220	8, 629	18, 046		806, 962	
59.00		CARDI AC CATHETERI ZATI ON	313, 198	7, 273			363, 210	
60. 00 63. 00	1	LABORATORY BLOOD STORING, PROCESSING & TRANS.	4, 591, 437 135, 539	46, 906 0	· ·		5, 057, 286 135, 539	
64. 00	06400	INTRAVENOUS THERAPY	0	0	(o	0	64. 00
66.00	1	PHYSI CAL THERAPY	1, 175, 514	45, 399	94, 945		1, 487, 182	
67. 00 67. 01		OCCUPATI ONAL THERAPY AUDI OLOGY	611, 574 132, 509	0		65, 972 26, 026	677, 546 158, 535	
68. 00	06800	SPEECH PATHOLOGY	67, 051	0	(10, 872	77, 923	68. 00
69. 00 69. 01		ELECTROCARDI OLOGY CARDI OLOGY	0 816, 555	0 4, 678	9, 784	0 120, 901	0 951, 918	69. 00 69. 01
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 864, 563	4, 070	· ·		1, 864, 563	
72. 00		IMPL. DEV. CHARGED TO PATIENT	4, 726, 493	0			4, 726, 493	
73. 00		DRUGS CHARGED TO PATIENTS TIENT SERVICE COST CENTERS	989, 237	0		0	989, 237	73. 00
90.00		CLI NI C	0	0	(0	0	90. 00
90. 01		OTHER OUTPATIENT SERVICE COST CENTER CLINIC	291, 751	19, 331			382, 743	
90. 02 90. 03		DERMATOLOGY CLINIC	0	31, 080 0	1		96, 080 0	90. 02 90. 03
90. 04	09004	ENT CLINIC	35	0	(0	35	90. 04
90. 05 90. 07		SURGERY CLINIC UROLOGY CLINIC	0	0			0	90. 05 90. 07
90. 09		GASTROENTEROLOGY CLINIC	0	0		191	191	90. 09
90. 11	1	NEUROLOGY CLINIC	0	0	(0	0	90. 11
90. 12 90. 13	1	OPTHAMOLOGY CLINIC ALLERGY CLINIC	17, 804 117, 013	0	(12, 836	17, 804 129, 849	90. 12 90. 13
90. 14	1	WOUND CARE	343, 062	17, 723	· ·		434, 461	90. 14
91.00		EMERGENCY	2, 808, 403	124, 251	259, 851	379, 741	3, 572, 246	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS					0	92. 00
95. 00	09500	AMBULANCE SERVICES	1, 515, 106	24, 075	50, 350	224, 168	1, 813, 699	95. 00
118. 00	-	AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	69, 168, 793	967, 435	2, 023, 245	4, 273, 371	4E E00 124	110 00
118.00		IMBURSABLE COST CENTERS	09, 108, 793	907, 435	2, 023, 243	4, 2/3, 3/1	65, 580, 136	118.00
	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	3, 156				190. 00
		PHYSICIANS' PRIVATE OFFICES THORNTOWN OFFICE BUILDING	20, 017, 160 -332	210, 649 0			23, 241, 434	192. 00 194. 00
		CAFE/BOUTIQUE	-332	9, 185		-	-332 28, 394	
194. 02	07952	OTHER NONREIMBURSABLE COST CENTERS	130, 746	103, 908			456, 979	194. 02
200. 00 201. 00	1	Cross Foot Adjustments Negative Cost Centers		0	(0		200. 00 201. 00
202.00	1	TOTAL (sum lines 118-201)	89, 316, 367	1, 294, 333	· ·		89, 316, 367	
			<u> </u>	<u> </u>		·		

					5/28/2015 2:1	7 pm
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5.00	7. 00	8. 00	9. 00	10.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 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	20, 208, 567					5. 00
7.00 00700 OPERATION OF PLANT	1, 122, 908	4, 962, 960)			7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	73, 034	0	322, 790			8. 00
9. 00 00900 HOUSEKEEPI NG	172, 716	75, 762	o o	839, 120		9.00
10. 00 01000 DI ETARY	199, 990			52, 028	l	•
11. 00 01100 CAFETERI A	158, 808	0		17, 347	0	11.00
· · · · · · · · · · · · · · · · · · ·		0			l	
13. 00 01300 NURSING ADMINISTRATION	166, 012	U	1	7, 844	0	13. 00
15. 00 01500 PHARMACY	412, 604	52, 353		15, 838	l	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	398, 087	82, 701	0	34, 694	0	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	1, 165, 201	550, 072	18, 124	263, 554	599, 094	30.00
31.00 03100 INTENSIVE CARE UNIT	389, 339			69, 991	168, 779	31.00
40. 00 04000 SUBPROVI DER - PF	454, 861	172, 962		83, 228		•
		172, 702	4, 020	03, 220		1
41. 00 04100 SUBPROVI DER - I RF	0	0	1 0	U	0	41.00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42. 00
43. 00 04300 NURSERY	12, 559	0	1, 880	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	281, 848	439, 021	48, 565	15, 537	0	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 001, 662	536, 923		70, 292	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
55. 01 05501 ULTRA SOUND	124, 463	0	9, 308	4, 525	ĺ	55. 01
l l		0				
57. 00 05700 CT SCAN	190, 388		37, 002	6, 939		57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	235, 972	46, 062		6, 637	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	106, 210	38, 826	4, 001	0	0	59. 00
60. 00 06000 LABORATORY	1, 478, 852	250, 398	55, 993	29, 716	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	39, 634	0		. 0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0,7,001	0	2, 763	0	Ö	64. 00
66. 00 06600 PHYSI CAL THERAPY	434, 882	242, 352		10 710		66. 00
		242, 352		10, 710	l	•
67. 00 06700 OCCUPATI ONAL THERAPY	198, 128	0	1, 493			67. 00
67. 01 06701 AUDI OLOGY	46, 359	0	1, 022	3, 771	0	67. 01
68.00 06800 SPEECH PATHOLOGY	22, 786	0	521	2, 263	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	Ō	0	0	69. 00
69. 01 06901 CARDI OLOGY	278, 360	24, 975	12, 030	22, 777	0	69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	545, 236	21, 770		22, 7,7	0	71. 00
		_		0		
	1, 382, 121	0	-,	0	0	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	289, 273	0	15, 099	16, 442	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	111, 922	103, 194	0	40, 426	0	90. 01
90. 02 09002 CLI NI C	28, 096	165, 915	1	59, 432	l e	90. 02
90. 03 09003 DERMATOLOGY CLI NI C	0	1 .00, 7.10		07, 102	Ö	90. 03
90. 04 09004 ENT CLINIC		0		0	0	90. 04
	10	0		U		1
90. 05 09005 SURGERY CLI NI C	0	0	0	0	0	90. 05
90. 07 09007 UROLOGY CLI NI C	0	0	169	0	0	90. 07
90. 09 09009 GASTROENTEROLOGY CLINIC	56	0	0	0	0	90. 09
90. 11 09011 NEUROLOGY CLINIC	0	0	748	0	0	90. 11
90. 12 09012 OPTHAMOLOGY CLINIC	5, 206	0	100	o	0	90. 12
90. 13 09013 ALLERGY CLI NI C	37, 970	0	1, 685	0	0	90. 13
+ I					Ö	
· · · · · · · · · · · · · · · · · · ·	127, 045				l e	90. 14
91. 00 09100 EMERGENCY	1, 044, 596	663, 283	33, 986	0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	530, 362	47, 520	6, 987	0	0	95. 00
SPECIAL PURPOSE COST CENTERS						ĺ
118. 00 SUBTOTALS (SUM OF LINES 1-117)	13, 267, 556	3, 907, 579	322, 790	839, 120	1, 105, 518	118 00
NONREI MBURSABLE COST CENTERS	13, 201, 330	3, 701, 317	322, 170	037, 120	1, 103, 310	1110.00
	2.050	1/ 040	1 0			100 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2, 853	16, 848	1	0	l .	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	6, 796, 225	989, 501	0	0		192. 00
194.00 07950 THORNTOWN OFFICE BUILDING	0	0	0	0		194. 00
194. 01 07951 CAFE/BOUTI QUE	8, 303	49, 032	0	ol	0	194. 01
194. 02 07952 OTHER NONREIMBURSABLE COST CENTERS	133, 630	<u> </u>	n	n		194. 02
200.00 Cross Foot Adjustments	. 55, 550	ĺ	l ĭ	Ĭ	i	200. 00
201.00 Negative Cost Centers	0	_		^	^	201. 00
1 1 9	20 200 5/7	4 042 040	322 700	020 120	l e	
202.00 TOTAL (sum lines 118-201)	20, 208, 567	4, 962, 960	322, 790	839, 120	1, 105, 518	2U2. UU

			l C	12/31/2014	Date/IIme Pre 5/28/2015 2:1	
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	, piii
	11.00	13.00	15. 00	16.00	24. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT						5. 00 7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	719, 237					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	13, 916		1 010 (2)			13.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	27, 832 56, 396		1, 919, 626 0	1, 933, 233		15. 00 16. 00
I NPATIENT ROUTINE SERVICE COST CENTERS	30, 370	<u> </u>	U ₁	1, 433, 233		10.00
30. 00 03000 ADULTS & PEDIATRICS	189, 697	167, 164	5, 323	475, 077	7, 417, 988	30.00
31.00 03100 INTENSIVE CARE UNIT	15, 381		675	98, 778	2, 281, 816	
40. 00 04000 SUBPROVI DER - PF	24, 170	85, 169	169	117, 593	2, 835, 332	40.00
41. 00 04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY	0		0	0	57, 389	42. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS		<u> </u>	<u> </u>	<u> </u>	37, 307	1 43.00
50. 00 05000 OPERATI NG ROOM	16, 846	131, 480	34, 388	170, 510	2, 102, 043	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	20, 508	0	3, 253	456, 262	5, 539, 198	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
55. 01 05501 ULTRA SOUND 57. 00 05700 CT SCAN	2, 197 2, 930		2, 302 3, 584	49, 389 56, 445	617, 814 948, 366	55. 01 57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	7, 324		5, 666	30, 574	1, 154, 138	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	10, 198	41	0	522, 486	
60. 00 06000 LABORATORY	60, 058		396	47, 037	6, 979, 736	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	176, 274	1
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0	2, 763	1
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	30, 029 12, 451	54, 073 24, 077	10, 644	91, 723 39, 982	2, 368, 617 958, 806	66. 00 67. 00
67. 01 06701 AUDI OLOGY	13, 184		0	37, 702	234, 524	1
68. 00 06800 SPEECH PATHOLOGY	13, 916		49, 107	Ö	166, 516	1
69. 00 06900 ELECTROCARDI OLOGY	0	o	0	o	0	69. 00
69. 01 06901 CARDI OLOGY	30, 029	45, 607	125	88, 195	1, 454, 016	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	15, 381	0	0	0	2, 430, 858	1
72.00 O7200 IMPL. DEV. CHARGED TO PATIENT 73.00 O7300 DRUGS CHARGED TO PATIENTS	0		0	0	6, 115, 014 1, 310, 051	
OUTPATIENT SERVICE COST CENTERS	0	<u> </u>	U ₁	<u> </u>	1, 310, 031	73.00
90. 00 09000 CLINIC	0	0	0	0	0	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	24, 902	11, 618	0	197, 557	872, 362	
90. 02 09002 CLI NI C	0	0	0	0	349, 523	
90. 03 09003 DERMATOLOGY CLINIC 90. 04 09004 ENT CLINIC	0	0	0	0	0 45	
90. 05 09005 SURGERY CLINIC	0		84	0	84	1
90. 07 09007 UROLOGY CLINIC	0	l o	1, 544	o	1, 713	1
90. 09 09009 GASTROENTEROLOGY CLINIC	0	10, 346	72	О	10, 665	
90. 11 09011 NEUROLOGY CLI NI C	0	0	24	0	772	
90. 12 09012 0PTHAMOLOGY CLINIC	0	0	676	0	23, 786	
90. 13 09013 ALLERGY CLI NI C 90. 14 09014 WOUND CARE	46, 875	7, 389 15, 646	1, 878 5, 518	0	178, 771 727, 008	
91. 00 09100 EMERGENCY	40, 675		122, 928	0	5, 562, 638	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		120,077	122, 720	S S	0, 002, 000	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	95, 215	0	15, 327	0	2, 509, 110	95. 00
SPECIAL PURPOSE COST CENTERS	740.007	754 070	2/2 72/		55 040 000	
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	719, 237	751, 979	263, 724	1, 919, 122	55, 910, 222	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	1	1, 655, 902	14, 111	32, 700, 393	
194. 00 07950 THORNTOWN OFFICE BUILDING 194. 01 07951 CAFE/BOUTIQUE	0	1	0	0		194. 00 194. 01
194.02 07952 OTHER NONREIMBURSABLE COST CENTERS	0	289	0	Ol Ol	590, 898	
200.00 Cross Foot Adjustments		20/		Ĭ		200. 00
201.00 Negative Cost Centers	0	0	0	О	0	201. 00
202.00 TOTAL (sum lines 118-201)	719, 237	755, 488	1, 919, 626	1, 933, 233	89, 316, 367	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS In Lieu of Form CMS-2552-10 WITHAM MEMORIAL HOSPITAL Peri od: Worksheet B From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared: 5/28/2015 2:17 pm Provi der CCN: 150104 Cost Center Description Intern & Total Residents Cost & Post

		& POST			
		Stepdown			
		Adjustments 25.00	26. 00		
CENEDAL	SEDVI CE COST CENTEDS	25.00	20.00		_
	SERVICE COST CENTERS EW CAP REL COSTS-BLDG & FIXT				1.00
	EW CAP REL COSTS-BEDG & TTXT				2.00
					1
1 1	MPLOYEE BENEFITS DEPARTMENT				4. 00
	DMINISTRATIVE & GENERAL				5. 00
1 1	PERATION OF PLANT				7. 00
1 1	AUNDRY & LINEN SERVICE				8. 00
1 1	OUSEKEEPI NG				9. 00
10. 00 01000 DI					10. 00
1 1	AFETERI A				11. 00
1 1	URSING ADMINISTRATION				13. 00
15. 00 01500 PI					15. 00
	EDICAL RECORDS & LIBRARY				16. 00
	NT ROUTINE SERVICE COST CENTERS				1
	DULTS & PEDI ATRI CS	0	7, 417, 988		30. 00
31.00 03100 11	NTENSIVE CARE UNIT	0	2, 281, 816		31. 00
40. 00 04000 St	UBPROVIDER - IPF	0	2, 835, 332		40. 00
	UBPROVI DER - I RF	0	0		41. 00
42. 00 04200 SI	UBPROVI DER	0	0		42.00
43.00 04300 NU	URSERY	0	57, 389		43.00
ANCI LLA	RY SERVICE COST CENTERS				
50. 00 05000 OF	PERATING ROOM	0	2, 102, 043		50. 00
54. 00 05400 RA	ADI OLOGY-DI AGNOSTI C	O	5, 539, 198		54.00
55. 00 05500 RA	ADI OLOGY-THERAPEUTI C	o	0		55. 00
55. 01 05501 UI	LTRA SOUND	o	617, 814		55. 01
57. 00 05700 C	T SCAN	o	948, 366	l .	57. 00
1 1	AGNETIC RESONANCE IMAGING (MRI)	o	1, 154, 138	•	58. 00
1 1	ARDI AC CATHETERI ZATI ON	0	522, 486	1	59. 00
1 1	ABORATORY	0	6, 979, 736	•	60.00
	LOOD STORING, PROCESSING & TRANS.	o	176, 274	l .	63. 00
1 1	NTRAVENOUS THERAPY	o	2, 763	l .	64. 00
1 1	HYSI CAL THERAPY	o	2, 368, 617	•	66.00
1 1	CCUPATI ONAL THERAPY		958, 806	•	67. 00
1 1	UDI OLOGY		234, 524	l .	67. 01
	PEECH PATHOLOGY		166, 516	•	68. 00
	LECTROCARDI OLOGY		0	1	69. 00
1 1	ARDI OLOGY	0	1, 454, 016	l .	69. 01
	EDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 430, 858	•	71. 00
	MPL. DEV. CHARGED TO PATIENT	0	6, 115, 014	•	72.00
1 1	RUGS CHARGED TO PATIENTS	0	1, 310, 051	•	73. 00
	ENT SERVICE COST CENTERS	<u> </u>	1, 310, 031		73.00
90. 00 09000 CI		٥	0		90. 00
1 1	THER OUTPATIENT SERVICE COST CENTER	0	872, 362	•	90.00
90. 02 09002 CI		0	349, 523	•	90. 02
	ERMATOLOGY CLINIC	0	0 0		90. 03
1 1	NT CLINIC	0	45	l .	90.03
	URGERY CLINIC	0	84	l .	90.04
90. 03 09003 30		0	1, 713	•	90.03
	ASTROENTEROLOGY CLINIC	0	10, 665		90.07
	EUROLOGY CLINIC	0	772		90. 09
	PTHAMOLOGY CLINIC	0		•	90. 11
90. 12 09012 01 90. 13 09013 Al		0	23, 786	•	
		O O	178, 771		90. 13
90. 14 09014 W		U O	727, 008	•	90. 14
91. 00 09100 EM		U O	5, 562, 638		91.00
	BSERVATION BEDS (NON-DISTINCT PART)	U			92. 00
	EI MBURSABLE COST CENTERS	ما	2 500 110		05.00
	MBULANCE SERVICES	0	2, 509, 110		95. 00
	PURPOSE COST CENTERS	ما	FF 040 000		440.00
	UBTOTALS (SUM OF LINES 1-117)	0	55, 910, 222		118. 00
	BURSABLE COST CENTERS	ما	00 457		400 00
	IFT, FLOWER, COFFEE SHOP, & CANTEEN	0	29, 457		190. 00
	HYSI CI ANS' PRI VATE OFFI CES	0	32, 700, 393	1	192. 00
	HORNTOWN OFFICE BUILDING	0	-332		194. 00
194. 01 07951 CA		0	85, 729	•	194. 01
1 1	THER NONREIMBURSABLE COST CENTERS	0	590, 898		194. 02
	ross Foot Adjustments	0	0	l control of the cont	200. 00
	egative Cost Centers	0	0	l .	201. 00
202. 00 TO	OTAL (sum lines 118-201)	0	89, 316, 367		202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150104

					Ic	12/31/2014	Date/lime Prep 5/28/2015 2:1	
				CAPI TAL REI	_ATED COSTS			
		Cost Center Description	Directly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
		osst somes. Poss. (pt. o	Assigned New	FLXT	EQUI P	oubtota.	BENEFITS	
			Capi tal Rel ated Costs				DEPARTMENT	
			0	1. 00	2.00	2A	4. 00	
1 00		AL SERVICE COST CENTERS	T T					4 00
1. 00 2. 00		NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	o	2, 944	6, 156	9, 100	9, 100	4. 00
5.00	1	ADMINISTRATIVE & GENERAL	o	94, 076		290, 821	1, 141	5. 00
7.00	1	OPERATION OF PLANT	0	123, 249		381, 006	123	7. 00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	0	0 14, 192		0 43, 873	5 79	8. 00 9. 00
10.00	1	DI ETARY		31, 768		98, 206	80	10. 00
11. 00	1	CAFETERI A	o	0		0	72	11. 00
13.00		NURSI NG ADMI NI STRATI ON	0	0	_	0	105	13.00
15. 00 16. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY		9, 807 15, 492	20, 510 32, 399	30, 317 47, 891	94 199	15. 00 16. 00
10.00		I ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	10, 172	02, 077	17,071	177	10.00
30. 00	1	ADULTS & PEDIATRICS	0	103, 043		318, 542	613	30. 00
31. 00 40. 00		INTENSIVE CARE UNIT SUBPROVIDER - IPF	0	28, 299		87, 481 100, 161	217 250	31. 00 40. 00
41. 00	1	SUBPROVIDER - IPF		32, 400 0	67, 761 0	100, 161	250	40.00
42. 00		SUBPROVI DER	o	0	0	o	0	42. 00
43.00		NURSERY	0	0	0	0	0	43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	l ol	82, 240	171, 993	254, 233	419	50. 00
54. 00		RADI OLOGY-DI AGNOSTI C	l o	100, 580		310, 928	234	54. 00
55. 00		RADI OLOGY-THERAPEUTI C	0	0	· -	o	0	55. 00
55. 01	1	ULTRA SOUND	0	0	0	0	62	55. 01
57. 00 58. 00	1	CT SCAN MAGNETIC RESONANCE IMAGING (MRI)		8, 629	18, 046	26, 675	26 65	57. 00 58. 00
59.00		CARDI AC CATHETERI ZATI ON	l o	7, 273		22, 484	37	59. 00
60.00		LABORATORY	0	46, 906		145, 003	427	60. 00
63. 00 64. 00		BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00 64. 00
66. 00	1	I NTRAVENOUS THERAPY PHYSI CAL THERAPY		45, 399	94, 945	140, 344	228	66. 00
67. 00		OCCUPATI ONAL THERAPY	o	0	0	0	88	67. 00
67. 01	1	AUDI OLOGY	0	0	0	0	35	67. 01
68. 00 69. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	0	0	0	14 0	68. 00 69. 00
69. 01		CARDI OLOGY		4, 678	9, 784	14, 462	161	69. 01
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0		0	0	71. 00
72.00		IMPL. DEV. CHARGED TO PATIENT	0	0		0	0	72. 00
73. 00		DRUGS CHARGED TO PATIENTS TIENT SERVICE COST CENTERS	l ol	0	<u> </u>	U	0	73. 00
90.00		CLINIC	0	0	0	0	0	90. 00
90. 01		OTHER OUTPATIENT SERVICE COST CENTER	0	19, 331		59, 759	42	
90. 02 90. 03	1	CLINIC DERMATOLOGY CLINIC		31, 080 0	i	96, 080 0	0	90. 02 90. 03
90. 04		ENT CLINIC	l o	0	0	o	0	90. 04
90. 05	1	SURGERY CLINIC	0	0	0	0	0	90. 05
90. 07 90. 09		UROLOGY CLINIC GASTROENTEROLOGY CLINIC	0	0	0	0	0	90. 07 90. 09
90. 09		NEUROLOGY CLINIC		0	0	0	0	90. 09
90. 12		OPTHAMOLOGY CLINIC	o	0	0	O	0	90. 12
90. 13		ALLERGY CLINIC	0	0	0	0	17	90. 13
90. 14 91. 00		WOUND CARE EMERGENCY	0	17, 723 124, 251		54, 787 384, 102	49 505	90. 14 91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)		124, 231	257, 051	0	303	92. 00
	OTHER	REIMBURSABLE COST CENTERS						
95. 00		AL PURPOSE COST CENTERS	0	24, 075	50, 350	74, 425	298	95. 00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	967, 435	2, 023, 245	2, 990, 680	5, 685	118. 00
100.00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP, & CANTEEN		0.457		0.75		100.00
		PHYSICIANS' PRIVATE OFFICES		3, 156 210, 649		9, 756 651, 191		190. 00 192. 00
		THORNTOWN OFFICE BUILDING		2.10, 049	0	0		194. 00
	1	CAFE/BOUTI QUE	0	9, 185		28, 394		194. 01
194. 02 200. 00		OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments	0	103, 908	217, 308	321, 216	7	194. 02 200. 00
200.00	1	Negative Cost Centers		0	0	ol	o	200. 00
202. 00	1	TOTAL (sum lines 118-201)	o	1, 294, 333	2, 706, 904	4, 001, 237		202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150104

Peri od: Worksheet B From 01/01/2014 Part II To 12/31/2014 Date/Time Prepared:

5/28/2015 2:17 pm Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FLXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 291, 962 5 00 5 00 7.00 00700 OPERATION OF PLANT 16, 224 397, 353 7.00 00800 LAUNDRY & LINEN SERVICE 1,055 8.00 1,060 8.00 9.00 00900 HOUSEKEEPI NG 2, 495 6, 066 52, 513 9.00 C 01000 DI ETARY 2.890 118, 010 10.00 10.00 13, 578 0 3.256 01100 CAFETERI A 2, 295 0 1,086 11.00 11.00 0 13 00 01300 NURSING ADMINISTRATION 2,399 0 491 0 13.00 01500 PHARMACY 15 00 5.961 4. 192 0 991 15 00 0 16.00 01600 MEDICAL RECORDS & LIBRARY 5, 752 0 2, 171 0 16.00 6, 621 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 63, 951 30.00 16, 835 44, 041 54 16, 494 18, 017 12, 095 4, 380 03100 INTENSIVE CARE UNIT 5.625 31.00 13 31.00 04000 SUBPROVIDER - IPF 40.00 6,572 13, 848 12 5, 209 36,042 40.00 04100 SUBPROVIDER - IRF 41.00 0 41.00 04200 SUBPROVI DER 0 42.00 0 0 0 42.00 C 04300 NURSERY 43.00 181 6 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 4,072 35, 150 143 972 n 50.00 05400 RADI OLOGY-DI AGNOSTI C 4, 399 54.00 14, 472 42, 988 73 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C r 0 0 55.00 55. 01 05501 ULTRA SOUND 1,798 0 27 283 0 55.01 05700 CT SCAN 2, 751 109 57.00 57.00 434 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 3, 409 58 00 3.688 44 415 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 1,535 3, 109 12 0 59.00 0 06000 LABORATORY 60.00 21, 367 20,048 273 1,860 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 573 3 0 0 63.00 06400 INTRAVENOUS THERAPY 64.00 8 0 0 64.00 66.00 06600 PHYSI CAL THERAPY 6, 283 19, 404 21 670 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 2,863 321 0 67.00 67 01 06701 AUDI OLOGY 670 3 236 0 67 01 Ω 06800 SPEECH PATHOLOGY 2 68.00 329 0 142 0 68.00 06900 ELECTROCARDI OLOGY 0 0 69.00 69.00 0 69.01 06901 CARDI OLOGY 4.022 2.000 36 0 69.01 1.425 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 17 71.00 7.878 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 19,969 C 19 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 4, 180 0 45 1, 029 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER 1,617 8, 262 0 2, 530 0 90.01 90.02 09002 CLI NI C 406 13, 284 0 3, 719 90.02 0 09003 DERMATOLOGY CLINIC 0 90 03 90.03 0 0 0 90.04 09004 ENT CLINIC 0 C 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 90.07 0 0 0 09009 GASTROENTEROLOGY CLINIC 90 09 90 09 1 Ω 0 0 90.11 09011 NEUROLOGY CLINIC 0 0 2 0 90.11 09012 OPTHAMOLOGY CLINIC 0 0 90.12 75 0 90.12 0 09013 ALLERGY CLINIC 549 90. 13 90.13 5 0 90.14 90 14 09014 WOUND CARE 1.836 7 575 8 0 0 91.00 09100 EMERGENCY 100 0 91.00 15,093 53, 105 0 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 7,663 3, 805 21 0 0 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 191, 695 312, 859 1, 060 52, 513 118, 010 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 41 1, 349 0 0 0 190, 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 98, 175 79, 219 0 0 0 192.00 194. 00 07950 THORNTOWN OFFICE BUILDING 0 194.00 0 0 0 194. 01 07951 CAFE/BOUTI QUE 120 3, 926 0 0 0 194, 01 194. 02 07952 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 194. 02 1,931 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201, 00 0 202.00 TOTAL (sum lines 118-201) 291, 962 397, 353 1, 060 52.513 118, 010 202. 00

Provi der CCN: 150104

					5/28/2015 2:1	7 pm
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	PHARMACY	MEDICAL RECORDS &	Subtotal	
	11 00	40.00	45.00	LI BRARY	0.4.00	
GENERAL SERVICE COST CENTERS	11. 00	13. 00	15. 00	16. 00	24. 00	
1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT						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						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10. 00
11. 00 01100 CAFETERI A	3, 453	3				11. 00
13.00 O1300 NURSING ADMINISTRATION	67					13. 00
15. 00 01500 PHARMACY	134		41, 689			15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	271	0	0	62, 905		16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	910	(70	11/	15 450	477, 692	20.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 NTENSI VE CARE UNI T	74		116 15	15, 458 3, 214	131, 342	30. 00 31. 00
40. 00 04000 SUBPROVI DER - I PF	116		15	3, 826	166, 385	40.00
41. 00 04100 SUBPROVI DER - I RF		1	0	3, 020	0	41. 00
42. 00 04200 SUBPROVI DER		1	0	0	0	42. 00
43. 00 04300 NURSERY		1	0	o	187	43. 00
ANCILLARY SERVICE COST CENTERS			- 1	-1		
50. 00 05000 OPERATING ROOM	81	533	747	5, 548	301, 898	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	98		71	14, 846	388, 109	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	C		0	0	0	55. 00
55. 01 05501 ULTRA SOUND	11		50	1, 607	3, 838	55. 01
57. 00 05700 CT SCAN	14		78	1, 837	5, 249	57. 00
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	35		123	995	35, 449	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		1	4 504	27, 219	59.00
60. 00 06000 LABORATORY	288	1	9	1, 531	190, 806	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	C	1	0	0	576	63.00
64. 00 06400 NTRAVENOUS THERAPY 66. 00 06600 PHYSI CAL THERAPY	144	1	0 231	2, 985	8 170, 529	64. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	60		231	1, 301	4, 735	1
67. 00 06700 0CC0PATTOWAL THERAPT	63	1	0	1, 301	1, 054	67. 00
68. 00 06800 SPEECH PATHOLOGY	67		1, 066	0	1, 620	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	1	0	o	0	69. 00
69. 01 06901 CARDI OLOGY	144	185	3	2, 870	25, 308	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	74		0	0	7, 969	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	C	0	0	0	19, 988	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	C	0	0	0	5, 254	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	C		0	0	0	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	120	1	0	6, 428	78, 805	90. 01
90. 02 09002 CLI NI C	C		0	0	113, 489	90. 02
90. 03 09003 DERMATOLOGY CLI NI C 90. 04 09004 ENT CLI NI C			0	U O	0	90. 03
90. 04 09004 ENT CLI NI C 90. 05 09005 SURGERY CLI NI C			0	0	2	90. 04 90. 05
90. 07 09007 UROLOGY CLI NI C			34	0	34	
90. 09 09009 GASTROENTEROLOGY CLINIC		42	2	0	45	90.09
90. 11 09011 NEUROLOGY CLI NI C			1	0	3	90. 11
90. 12 09012 OPTHAMOLOGY CLINIC			15	0	90	90. 12
90. 13 09013 ALLERGY CLINIC			41	o	642	90. 13
90. 14 09014 WOUND CARE	225		120	0	64, 663	
91. 00 09100 EMERGENCY	C		2, 670	0	456, 084	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	457	0	333	0	87, 002	95. 00
SPECIAL PURPOSE COST CENTERS						
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	3, 453	3, 048	5, 732	62, 446	2, 766, 074	118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	C	0	0	n	11 146	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES			35, 957	459	868, 422	
194. 00 07950 THORNTOWN OFFICE BUILDING		1	0., 7.97	.57		194. 00
194. 01 07951 CAFE/BOUTI QUE	d	1	Ö	ol		194. 01
194. 02 07952 OTHER NONREIMBURSABLE COST CENTERS		1	Ō	o	323, 155	
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	C	1	0	O		201. 00
202.00 TOTAL (sum lines 118-201)	3, 453	3, 062	41, 689	62, 905	4, 001, 237	202. 00

In Lieu of Form CMS-2552-10
Worksheet B
01/2014 Part II
031/2014 Date/Time Prepared:
5/28/2015 2:17 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS WITHAM MEMORIAL HOSPITAL Provi der CCN: 150104 Peri od: From 01/01/2014 To 12/31/2014 Intern & Residents Cost & Post Cost Center Description Total

	& Post		
	Stepdown Adjustments		
	25. 00	26.00	
GENERAL SERVICE COST CENTERS			
1.00 00100 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 7.00 00700 OPERATION OF PLANT			5. 00 7. 00
8.00 00800 LAUNDRY & LINEN SERVICE			8.00
9. 00 00900 HOUSEKEEPI NG			9. 00
10. 00 01000 DI ETARY			10. 00
11. 00 01100 CAFETERI A			11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON			13. 00
15. 00 01500 PHARMACY			15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS			16. 00
30. 00 03000 ADULTS & PEDI ATRI CS	0	477, 692	30. 00
31. 00 03100 I NTENSI VE CARE UNI T	o	131, 342	31. 00
40. 00 04000 SUBPROVI DER - 1 PF	o	166, 385	40. 00
41.00 04100 SUBPROVI DER - I RF	0	0	41. 00
42. 00 04200 SUBPROVI DER	0	0	42. 00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	187	43. 00
50. 00 05000 OPERATING ROOM	O	301, 898	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		388, 109	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	o	0	55. 00
55. 01 05501 ULTRA SOUND	o	3, 838	55. 01
57.00 05700 CT SCAN	0	5, 249	57. 00
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	0	35, 449	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	27, 219	59. 00 60. 00
60. 00 06000 LABORATORY 63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	190, 806 576	63.00
64. 00 06400 I NTRAVENOUS THERAPY		8	64. 00
66. 00 06600 PHYSI CAL THERAPY	o	170, 529	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	o	4, 735	67. 00
67. 01 06701 AUDI OLOGY	0	1, 054	67. 01
68. 00 06800 SPEECH PATHOLOGY	0	1, 620	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	69.00
69. 01 06901 CARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	25, 308 7, 969	69. 01 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		19, 988	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	o	5, 254	73. 00
OUTPATIENT SERVICE COST CENTERS	-1		
90. 00 09000 CLI NI C	0	0	90. 00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	78, 805	90. 01
90. 02 09002 CLI NI C	0	113, 489	90. 02
90. 03 09003 DERMATOLOGY CLINIC 90. 04 09004 ENT CLINIC	0	0	90. 03 90. 04
90. 05 09005 SURGERY CLINIC		2	90.04
90. 07 09007 UROLOGY CLINIC		34	90. 07
90. 09 09009 GASTROENTEROLOGY CLINIC	0	45	90. 09
90. 11 09011 NEUROLOGY CLINIC	0	3	90. 11
90. 12 09012 OPTHAMOLOGY CLINIC	0	90	90. 12
90. 13 09013 ALLERGY CLINIC	0	642	90. 13
90. 14 09014 WOUND CARE 91. 00 09100 EMERGENCY	0	64, 663	90. 14 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		456, 084	92.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>		72.00
95. 00 09500 AMBULANCE SERVI CES	0	87, 002	95. 00
SPECIAL PURPOSE COST CENTERS			
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	2, 766, 074	118. 00
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	11, 146	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 194.00 07950 THORNTOWN OFFICE BUILDING	0	868, 422 0	192. 00 194. 00
194. 01 07951 CAFE/BOUTI QUE		32, 440	194. 00
194. 02 07952 OTHER NONREI MBURSABLE COST CENTERS	o	323, 155	194. 02
200.00 Cross Foot Adjustments	o	0	200. 00
201.00 Negative Cost Centers	o	o	201. 00
202.00 TOTAL (sum lines 118-201)	0	4, 001, 237	202. 00

	LOCATION - STATISTICAL BASIS	WI ITIAW WEWORT			Peri od:	Worksheet B-1	
				F	rom 01/01/2014	Date/Time Pre	pared:
		CAPITAL REL	ATED COSTS			5/28/2015 2:1	7 pm
	Cost Contor Dosoriation	NEW PLDC 9	NEW MVDLE	EMPLOYEE	Doconci Li ati on	ADMI NI STRATI VE	
	Cost Center Description	NEW BLDG & FLXT	NEW MVBLE EQUIP	BENEFITS	Reconciliation	& GENERAL	
		(SQUARE	(SQUARE	DEPARTMENT		(ACCUM.	
		FEET)	FEET)	(GROSS SALARI ES)		COST)	
		1.00	2.00	4. 00	5A	5. 00	
	ENERAL SERVI CE COST CENTERS	255, 907					1 00
	0100 NEW CAP REL COSTS-BLDG & FIXT 0200 NEW CAP REL COSTS-MVBLE EQUIP	255, 907	255, 907				1.00
4.00 0	0400 EMPLOYEE BENEFITS DEPARTMENT	582	582				4. 00
	10500 ADMINISTRATIVE & GENERAL	18, 600	18, 600				
	10700 OPERATION OF PLANT 10800 LAUNDRY & LINEN SERVICE	24, 368	24, 368 0			3, 840, 052 249, 756	1
9.00 0	0900 HOUSEKEEPI NG	2, 806	2, 806	338, 446	0	590, 642	9. 00
	11000 DI ETARY 11100 CAFETERI A	6, 281	6, 281 0	344, 097 309, 237		683, 913	1
	11300 NURSING ADMINISTRATION	0	0			543, 082 567, 716	
15. 00 0	1500 PHARMACY	1, 939	1, 939	402, 036	0	1, 410, 999	15. 00
	11600 MEDICAL RECORDS & LIBRARY NPATIENT ROUTINE SERVICE COST CENTERS	3, 063	3, 063	855, 124	0	1, 361, 355	16. 00
	3000 ADULTS & PEDIATRICS	20, 373	20, 373	2, 629, 762	2 0	3, 984, 682	30.00
	3100 I NTENSI VE CARE UNI T	5, 595	5, 595				
	14000 SUBPROVI DER – I PF 14100 SUBPROVI DER – I RF	6, 406	6, 406	1, 072, 976	0	1, 555, 507 0	1
	14200 SUBPROVI DER		0		0		1
	4300 NURSERY	0	0	(0	42, 950	43. 00
	NCILLARY SERVICE COST CENTERS 15000 OPERATING ROOM	16, 260	16, 260	1, 799, 948	0	963, 848	50.00
	5400 RADI OLOGY-DI AGNOSTI C	19, 886	19, 886				1
	5500 RADI OLOGY-THERAPEUTI C	0	0	· ·	_	0	
	15501 ULTRA SOUND 15700 CT SCAN	0	0	264, 436 109, 537		425, 630 651, 078	1
	5800 MAGNETIC RESONANCE IMAGING (MRI)	1, 706	1, 706			806, 962	
59. 00 0	5900 CARDI AC CATHETERI ZATI ON	1, 438	1, 438	· ·		363, 210	1
	16000 LABORATORY 16300 BLOOD STORING, PROCESSING & TRANS.	9, 274	9, 274 0	1, 831, 259		5, 057, 286 135, 539	1
	16400 I NTRAVENOUS THERAPY	0	0		0	133, 339	1
	6600 PHYSI CAL THERAPY	8, 976	8, 976			1, 487, 182	1
	16700 OCCUPATI ONAL THERAPY 16701 AUDI OLOGY	0	0	376, 539 148, 546		677, 546 158, 535	1
	6800 SPEECH PATHOLOGY	o o	0	62, 055		77, 923	
	6900 ELECTROCARDI OLOGY	0	0	(00.055		0	
	16901 CARDIOLOGY 17100 MEDICAL SUPPLIES CHARGED TO PATIENTS	925	925 0	690, 055	0	951, 918 1, 864, 563	
72. 00 0	7200 IMPL. DEV. CHARGED TO PATIENT	O	0	Ċ	0	4, 726, 493	72. 00
	17300 DRUGS CHARGED TO PATIENTS UTPATIENT SERVICE COST CENTERS	0	0	(0	989, 237	73. 00
	19000 CLINIC	0	0		0	0	90.00
	9001 OTHER OUTPATIENT SERVICE COST CENTER	3, 822	3, 822			382, 743	90. 01
	19002 CLINIC 19003 DERMATOLOGY CLINIC	6, 145	6, 145		0	96, 080 0	
	19004 ENT CLINIC		0		0	35	
	9005 SURGERY CLINIC	0	0	(_	0	
	19007 UROLOGY CLINIC 19009 GASTROENTEROLOGY CLINIC	0	0	1, 089		0 191	
	19011 NEUROLOGY CLINIC	0	0	1,00	0	0	
	9012 OPTHAMOLOGY CLINIC	0	0	(0	17, 804	
	19013 ALLERGY CLINIC 19014 WOUND CARE	3, 504	0 3, 504	73, 265 208, 968		129, 849 434, 461	1
	19100 EMERGENCY	24, 566	24, 566	· ·		3, 572, 246	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	THER REIMBURSABLE COST CENTERS 19500 AMBULANCE SERVICES	4, 760	4, 760	1, 279, 460	0	1, 813, 699	95. 00
	PECIAL PURPOSE COST CENTERS	4,700	4, 700	1, 277, 400	,	1,013,077	75.00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	191, 275	191, 275	24, 390, 684	-20, 208, 567	45, 371, 569	118. 00
	ONREIMBURSABLE COST CENTERS 9000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	624	624		0	9, 756	190. 00
192.001	9200 PHYSICIANS' PRIVATE OFFICES	41, 648	41, 648			23, 241, 434	192. 00
	17950 THORNTOWN OFFICE BUILDING	0	1 01/	(332		194. 00
	17951 CAFE/BOUTI QUE 17952 OTHER NONREIMBURSABLE COST CENTERS	1, 816 20, 544	1, 816 20, 544		0	28, 394 456, 979	194. 01 194. 02
200.00	Cross Foot Adjustments		==, =			, . , ,	200. 00
201.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	1 204 222	2 704 004	4 OF1 474		20 200 5/3	201. 00
202.00	Part I)	1, 294, 333	2, 706, 904	6, 851, 471		20, 208, 567	202.00
· '		'					

Health Financial Systems	WITHAM MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150104		Peri od:	Worksheet B-1	
				From 01/01/2014 Fo 12/31/2014	Date/Time Pre 5/28/2015 2:1	pared: 7 pm
	CAPITAL REL	ATED COSTS				
Cost Center Description	NEW BLDG & FLXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
	1. 00	2.00	4. 00	5A	5. 00	
203.00 Unit cost multiplier (Wkst. B, Part I)	5. 057826	10. 577686	0. 17520	5	0. 292420	203. 00
204.00 Cost to be allocated (per Wkst. B,			9, 10	O	291, 962	204. 00
Part II) Unit cost multiplier (Wkst. B, Part II)			0. 00023	3	0. 004225	205. 00

COST CENTER DESCRIPTION OPERATION OF PLANT (SQUARE FOR POWNERS) NEW SERVICE (CROSS) OPERATION OF PLANT (SQUARE FOR POWNERS) OPERATION OF SERVICE (CROSS) OPERATION OF SERVICE		FINANCIAI SYSTEMS	WI THAM MEMORI		CCN: 150104 D		Warksheet D 1	
Control of Principle Control of Principle	COST	LLUCATION - STATISTICAL BASIS		Provi der	Fi	om 01/01/2014		pared:
		Cost Center Description	PLANT (SQUARE	LINEN SERVICE (GROSS	(HOURS OF	(MEALS	CAFETERI A (MEALS	
Company Comp					9.00	10.00	11 00	
2.00 00000 INDUSTRY CAP FILE COSTS-MANUE EQUIP 4.00 00000 INDUSTRY CAP 5.00 000000 INDUSTRY CAP 5.00 00000 INDUSTRY		GENERAL SERVICE COST CENTERS	7.00	0.00	7. 00	10.00	11.00	
4.00 0000000000000000000000000000000000								
5.00 DOCOOD ADMINISTRATIVE & CENERAL 183, 813 238, 431, 672 7,70 DOTOOD OPERATION OF PLANT 1,70 7,70 DOTOOD OPERATION OF PLANT 1,70 7,70 1,70 7,70								
8.00 000000 IMAINERY & ILTUMUN STRVICE 0 238.431, 5772 0 00000 DISECREPT IND 0 0 0 1, 30 0.73 0.90 0 0 0.10 0 1.00 0 0 1.00 0 0 0 0 0 0 0 0 0								
9.00 00000 MUSICKEEPI NG			1					
10.00 01000 DETARY 0.281			1					
13.00 01300 NURSING ADMINISTRATION 0 0 1,300 0 19 13.00			1			38, 043		
15.00 01500 MARMACY 1.9.39 0 2.675 0 33 15.00 77 16.00 77 1			0	0		o		
16.00			1 939	0		0		
30.00 30000 ADULTS & PEDIATRICS 20,373 13,385,201 43,681 20,616 259 30.00 30.00 30000 MERINGUID BR - I PF 6,406 2,974,630 13,794 11,619 33 40.00 40.00 30000 SIBRROVID BR - I PF 6,406 2,974,630 13,794 11,619 33 40.00 42						Ö		
31,00 03100 INTERSIVE CARE UNIT 5,959 3,288,671 11,600 5,800 21 31,00			00.070	10.005.004		00 (4)	0.50	
40.00 04000 SUBPROVIDER - I PF			1					
42.00 04200 MIRSERY 0 1,388,576 0 0 0 42.00								1
43.00 0.4300 MURSERY				0	_	-1	-	
ANCILLARY SERVICE COST CENTRES				1 200 576		- 1	-	
54.00 0.5400 RADIOLOGY-ID AGNOSTIC 19,886 18,373,262 11,650 0 0 0 0 55.00 55.00 55.00 0.5500 0.500 0.500 0.500 0.500 0.500 0.55.00 0.550 0	43.00			1, 366, 576	<u> </u>	<u> </u>	0	43.00
55.00						1		1
55.01 05501 ULTRA SOUND 0 6,874,166 750 0 3 55.01 57.00 05700						1		
57.00				1		- 1		
59.00 05900 CARDIAC CATHETERIZATION 1,488 2,954,793 0 0 59.00	57. 00	05700 CT SCAN		27, 327, 666	1, 150	o	4	57. 00
60.00 06000 LABORATORY 0 9, 274 41, 300, 225 4, 925 0 82 60.00 0 63.00 63.00 06400 BLOOD STORI NO, PROCESSING & TRANS. 0 813, 223 0 0 0 0 0 64.00 06400 PHYSICAL THERAPY 8, 96 5, 185, 883 1, 775 0 0 141 66.00 06600 PHYSICAL THERAPY 8, 96 5, 185, 883 1, 775 0 0 17, 67.00 07.00 06701 AUDITORY 1 8, 976 5, 185, 883 1, 775 0 0 17, 67.00 17, 67.00 07.01 06701 AUDITORY 1 8, 976 5, 185, 883 1, 775 0 182, 67.00 18, 67.00 1						0		
63.00 0.6300 0.6000 STORI NO, PROCESSI NO & TRANS. 0 813, 233 0 0 0 63.00						ol Ol	-	
66.00 O6600 PHYSICAL THERAPY 8,976 5,185,883 1,775 0 41 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 754,679 625 0 18 67.01 67.00 06700 OCCUPATI ONAL THERAPY 0 0 754,679 625 0 18 67.01 68.00 08600 SPECH PATHOLOGY 0 0 0 0 0 0 0 0 0		1	1			ō		
67.00 06700 06700 06700 06700 06700 06700 06700 06700 06701 06701 06701 06701 04001 04000 06800			0 074			0	-	
67.01						ol Ol		
69 00 06900 06900 06900 06900 06900 06900 06900 06900 06900 06900 071000 07100 071000 07100 071000			0			٩		
69.01 OASPOT CARDIO LOGY 10.00			0	384, 615	375	O		
17.00			925	U 8 884 597	0 3 775	0		
73. 00			0			Ö		
OUTPATLENT SERVICE COST CENTERS O			-			1		
90. 00 09000 CLI NI C 0 0 0 0 0 0 0 0 0	/3.00		0	11, 151, 658	2, 725	U _I	0	73.00
90.02 09002 CLINIC 6,145 0 9,850 0 0 90.02 90.03 09003 DERMATOLOGY CLINIC 0 0 0 0 0 0 0 90.04 09004 ENT CLINIC 0 0 0 0 0 0 0 0 90.05 09005 SURGERY CLINIC 0 0 0 0 0 0 0 0 90.07 09007 UROLOGY CLINIC 0 124,890 0 0 0 0 0 90.09 09009 GASTROENTEROLOGY CLINIC 0 0 0 0 0 0 0 90.11 09011 NEUROLOGY CLINIC 0 552,704 0 0 0 0 0 90.12 0912 DETHANDOLOGY CLINIC 0 552,704 0 0 0 0 0 90.13 09013 ALLERGY CLINIC 0 73,658 0 0 0 0 0 90.14 09014 NEUROLOGY CLINIC 0 73,658 0 0 0 0 90.15 0913 ALLERGY CLINIC 0 73,658 0 0 0 0 90.16 09101 NEUROLOGY CLINIC 0 73,658 0 0 0 0 90.17 09010 DERERGENCY 24,566 25,100,080 0 0 0 90.18 09100 O9100 EMERGENCY 24,566 25,100,080 0 0 0 91.00 09100 DERERGENCY 24,566 25,100,080 0 0 0 92.00 09200 DESERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 09500 AMBURANCE SERVI CES 1,760 5,159,925 0 0 130 95.00 SUBTOTALS (SUM OF LINES 1-117) 144,725 238,431,572 139,073 38,043 982 118.00 91.00 09000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 624 0 0 0 0 0 190.00 9192.00 19200 PHYSIC LANS' PRIVATE OFFICES 36,648 0 0 0 0 0 190.00 9194.00 07950 THORNTOWN OFFICE BUILDING 0 0 0 0 0 194.00 9194.00 07950 THORNTOWN OFFICE BUILDING 0 0 0 0 0 0 194.00 9194.00 07950 THORNTOWN OFFICE BUILDING 0 0 0 0 0 0 0 0 9194.00 07950 THORNTOWN OFFICE BUILDING 0 0 0 0 0 0 0 0 9194.00 07950 THORNTOWN OFFICE BUILDING 0 0 0 0 0 0 0 0 9194.00 07950 THORNTOWN OFFICE BUILDING 0 0 0 0 0 0 0 0 0 9194.00 07950 THORNTOWN OFFICE BUILDING 0 0 0 0 0 0 0 0 0	90.00		_	_				
90. 03 09003 DERMATOLOGY CLINIC								
90. 04 09004 ENT CLINIC 0 0 0 0 0 0 0 0 0				0		1		
90. 07 09007 URDLOGY CLINIC 0 124,890 0 0 0 90.07 90. 09 09009 GASTROENTERCLOGY CLINIC 0 0 0 0 0 0 90. 11 09011 NEUROLOGY CLINIC 0 552,704 0 0 0 0 90. 12 09012 0PTHAMOLOGY CLINIC 0 73,658 0 0 0 0 90. 14 09014 WOUND CARE 3,504 2,108,385 0 0 0 64 91. 10 09100 MERGENCY 24,566 25,100,080 0 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 07100 09500 OBSERVATION BEDS (NON-DISTINCT PART) 09500 MBULANCE SERVICES 1,760 5,159,925 0 0 130 95. 00 SUBTOTALS (SUM OF LINES 1-117) 144,725 238,431,572 139,073 38,043 982 118. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 624 0 0 0 0 192.00 194. 00 19500 AMBULANCH SERVICES 3,648 0 0 0 0 192.00 194. 00 19500 THORNTOWN OFFICE BUILDING 0 0 0 0 194.00 194. 01 07951 CAFE/BOUTI QUE 1,816 0 0 0 0 194.00 194. 02 07952 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194.00 200. 00 Cross Foot Adjustments 0 0 0 0 0 194.00 201. 00 Negative Cost Centers 200.00 Negative Cost Centers 200.00 202. 00 Cost to be allocated (per Wkst. B, 4,962,960 322,790 839,120 1,105,518 719,237 203. 00 Unit cost multiplier (Wkst. B, Part I) 27.000049 0.001354 6.033666 29.059696 732.420570 203. 00 Unit cost multiplier (Wkst. B, 397,353 1,060 52,513 118,010 3.453 204.00 204. 00 Cost to be allocated (per Wkst. B, 397,353 1,060 52,513 118,010 3.453 204.00 204. 00 Cost to be allocated (per Wkst. B, 397,353 1,060 52,513 118,010 3.453 204.00 205. 00 0 0 0 0 0 0 0 0 0				Ö		Ö		
90. 09 09009 GASTROENTEROLOGY CLINIC 0 552,704 0 0 0 0 0 0 0 0 0			0	0	_	0	-	
90. 11 09011 NEUROLOGY CLINIC 0 552, 704 0 0 0 0 90. 11 90. 12 09012 09014 NEUROLOGY CLINIC 0 73, 658 0 0 0 90. 12 90. 13 09013 ALLERGY CLINIC 0 73, 658 0 0 0 0 90. 12 90. 14 09014 WOUND CARE 3, 504 2, 108, 385 0 0 0 64 90. 14 91. 00 09100 EMERGENCY 24, 566 25, 100, 080 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 95. 00 09500 AMBULANCE SERVICES 1, 760 5, 159, 925 0 0 130 95. 00 SPECIAL PURPOSE COST CENTERS 95. 00 0 130 118. 00 SUBTOTALS (SUM OF LINES 1-117) 144, 725 238, 431, 572 139, 073 38, 043 982 119. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 624 0 0 0 0 0 190. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 36, 648 0 0 0 0 0 194. 00 194. 01 07951 CAFE/BOUTIQUE 1, 816 0 0 0 0 194. 00 194. 01 07951 CAFE/BOUTIQUE 1, 816 0 0 0 0 0 194. 00 194. 02 07952 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194. 00 200. 00 Cross Foot Adjustments 200. 00 200. 00 201. 00 Negative Cost Centers 201. 00 202. 00 Unit cost multiplier (Wkst. B, Part I) 27. 000049 0. 001354 6. 033666 29. 059696 732. 420570 203. 00 204. 00 Cost to be allocated (per Wkst. B, 397, 353 1, 060 52, 513 118, 010 3, 453 204. 00			0	124, 890		0	-	
90. 13 09013 ALLERGY CLINIC 0 1,244,326 0 0 0 90. 13 90. 14 90. 14 WOUND CARE 3,504 2,108,385 0 0 0 64 90. 14 90. 10 91. 00 91. 00 92. 00 09200 BMERGENCY 24,566 25,100,080 0 0 0 91. 00 92. 00 09200 BMERGENCY 09200 BMERGENCY 09200 BMERGENCY 09500 AMBULANCE SERVI CES 0 0 0 130 92. 00 92. 00 09500 AMBULANCE SERVI CES 0 0 0 130 95. 00 0 130 95. 00 0 130 95. 00 0 130 95. 00 0 130 95. 00 0 0 140. 00 0 0 0 0 0 0 0 0			0	552, 704	_	Ö	-	1
90. 14 09014 WOUND CARE 3,504 2,108,385 0 0 64 90. 14 91. 00 9100 EMERGENCY 24,566 25,100,080 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 O O O O O O O O O			0			0	-	
91. 00			3 504			0	-	
95. 00 OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES 1,760 5,159,925 0 0 0 130 95. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1-117) 144,725 238,431,572 139,073 38,043 982 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 624 0 0 0 0 0 190. 00 192. 00 1920 PHYSI CI ANS' PRI VATE OFFICES 36,648 0 0 0 0 0 0 192. 00 194. 00 194. 00 07950 THORNTOWN OFFICE BUILDING 0 0 0 0 0 194. 00 194. 01 194. 01 07951 CAFE/BOUTI QUE 1,816 0 0 0 0 0 0 194. 01 194. 01 194. 02 07952 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 194. 01 194. 02 07952 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 194. 02 200. 00 Cross Foot Adjustments 200. 00 Negative Cost Centers 201. 00 Negative Cost Centers 201. 00 Part I) Unit cost multiplier (Wkst. B, Part I) 27. 000049 0. 001354 6. 033666 29. 059696 732. 420570 203. 00 204. 00 Cost to be allocated (per Wkst. B, 397, 353 1, 060 52, 513 118, 010 3, 453 204. 00		l				Ö		
95. 00	92. 00							92.00
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 144,725 238,431,572 139,073 38,043 982 118.00	95 00		1 760	5 159 925	0	ol	130	95.00
NONRE MBURSABLE COST CENTERS NONRE MBURSABLE COST CENTERS NONRE MBURSABLE COST CENTERS NONRE MBURSABLE COST CENTERS NONRE MBURSABLE COST CENTERS NONRE MBURSABLE COST CENTERS NONRE MBURSABLE COST CENTERS NONRE MBURSABLE COST CENTERS NONRE MBURSABLE COST CENTERS NONRE MBURSABLE COST CENTERS NONRE MBURSABLE COST CENTERS NONRE MBURSABLE COST CENTERS NONRE MBURSABLE COST CENTERS NONRE MBURSABLE COST CENTERS NONRE MBURSABLE COST CENTERS NONRE MBURSABLE COST CENTERS NONRE MBURSABLE COST CENTERS NONRE MBURSABLE COST CENTERS NONRE MBURSABLE COST CENTERS NONRE NONRE MBURSABLE COST CENTERS NONRE NONRE MBURSABLE COST CENTERS NONRE	70.00		1,700			•	100	70.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 36,648 0 0 0 0 0 192.00 194.00 07950 THORNTOWN OFFICE BUILDING 0 0 0 0 194.00 194.01 07951 CAFE/BOUTIQUE 1,816 0 0 0 0 0 194.01 194.02 07952 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194.02 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 27.000049 0.001354 6.033666 29.059696 732.420570 203.00 204.00 Cost to be allocated (per Wkst. B, 397,353 1,060 52,513 118,010 3,453 204.00	118.00		144, 725	238, 431, 572	139, 073	38, 043	982	118. 00
194. 00 07950 THORNTOWN OFFICE BUILDING 0 0 0 0 0 194. 00 194. 01 07951 CAFE/BOUTIQUE 1, 816 0 0 0 0 0 194. 01 194. 02 07952 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194. 02 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 203. 00 Unit cost multiplier (Wkst. B, Part I) 204. 00 Cost to be allocated (per Wkst. B, 397, 353 1, 060 52, 513 118, 010 3, 453 204. 00			1	ł .				
194. 01 07951 CAFE/BOUTIQUE 1,816 0 0 0 0 0 194. 01 194. 02 07952 OTHER NONREIMBURSABLE COST CENTERS 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 203. 00 Unit cost multiplier (Wkst. B, Part I) 204. 00 Cost to be allocated (per Wkst. B, Part I) 205. 00 Cost to be allocated (per Wkst. B, Part I) 207. 000049 0. 001354 6. 033666 29. 059696 732. 420570 203. 00 208. 00 Cost to be allocated (per Wkst. B, Part I) 209. 00 Cost to be allocated (per Wkst. B, Part I) 200. 00 Cost to be allocated (per Wkst. B, Part I) 200. 00 Cost to be allocated (per Wkst. B, Part I) 200. 00 Cost to be allocated (per Wkst. B, Part I) 200. 00 Cost to be allocated (per Wkst. B, Part I) 200. 00 Cost to be allocated (per Wkst. B, Part I) 200. 00 Cost to be allocated (per Wkst. B, Part I) 200. 00 Cost to be allocated (per Wkst. B, Part I) 200. 00 Cost to be allocated (per Wkst. B, Part I) 200. 00 Cost to be allocated (per Wkst. B, Part I) 200. 00 Cost to be allocated (per Wkst. B, Part I) 200. 00 Cost to be allocated (per Wkst. B, Part I) 200. 00 Cost to be allocated (per Wkst. B, Part I) 200. 00 Cost to be allocated (per Wkst. B, Part I) 200. 00 Cost to be allocated (per Wkst. B, Part I)			36, 648			ol Ol		
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 4,962,960 322,790 839,120 1,105,518 719,237 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 27.000049 0.001354 6.033666 29.059696 732.420570 203.00 204.00 Cost to be allocated (per Wkst. B, 397,353 1,060 52,513 118,010 3,453 204.00	194. 01	07951 CAFE/BOUTI QUE	1, 816	0	0	o	0	194. 01
201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 27.000049 204.00 Cost to be allocated (per Wkst. B, 397, 353 1,060 52,513 118,010 3,453 204.00 201		l	0	0	0	0	0	
202.00 Cost to be allocated (per Wkst. B, Part I) 4,962,960 322,790 839,120 1,105,518 719,237 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 27.000049 0.001354 6.033666 29.059696 732.420570 203.00 204.00 Cost to be allocated (per Wkst. B, 397,353 1,060 52,513 118,010 3,453 204.00		1 1						
203.00 Unit cost multiplier (Wkst. B, Part I) 27.000049 0.001354 6.033666 29.059696 732.420570 203.00 204.00 Cost to be allocated (per Wkst. B, 397,353 1,060 52,513 118,010 3,453 204.00		Cost to be allocated (per Wkst. B,	4, 962, 960	322, 790	839, 120	1, 105, 518	719, 237	
		Unit cost multiplier (Wkst. B, Part I)	1		1	ı		
	204.00		397, 353	1, 060	52, 513	118, 010	3, 453	204. 00
		1 1, 2, 2, 2, 3	1	ı	ı	ı		·

Health Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2014	Worksheet B-1	
				To 12/31/2014	Date/Time Pre 5/28/2015 2:1	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	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	
205.00 Unit cost multiplier (Wkst. B, Part	2. 161724	0. 000004	0. 37759	3. 102016	3. 516293	205. 00
11)						

Provi der CCN: 150104

			То	12/31/2014 Date/Time Pre 5/28/2015 2:1	
Cost Center Description	NURSI NG	PHARMACY	MEDI CAL		
	ADMI NI STRATI ON	(COSTED REQUIS.)	RECORDS & LI BRARY		
	(DI RECT	REQUIS.)	(TIME		
	NRSING HRS)		SPENT)		
GENERAL SERVICE COST CENTERS	13. 00	15. 00	16. 00		
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT	T				1.00
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUI P					2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL					5. 00
7. 00 00700 0PERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE					7. 00
9.00 00900 HOUSEKEEPI NG					9.00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A					11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	342, 836				13. 00
15. 00 01500 PHARMACY	0	1, 124, 103	41 100		15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0	41, 100		16. 00
30. 00 03000 ADULTS & PEDI ATRI CS	75, 859	3, 117	10, 100		30.00
31.00 03100 INTENSIVE CARE UNIT	23, 579	395	2, 100		31. 00
40. 00 04000 SUBPROVI DER - 1 PF	38, 649	99	2, 500		40. 00
41. 00 04100 SUBPROVI DER - RF	0	0	0		41. 00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY	0	0	0		42. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	<u> </u>	<u> </u>	U ₁		43.00
50. 00 05000 OPERATING ROOM	59, 665	20, 137	3, 625		50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	1, 905	9, 700		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0		55. 00
55. 01 05501 ULTRA SOUND	0	1, 348	1, 050		55. 01
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	0	2, 099 3, 318	1, 200 650		57. 00 58. 00
59. 00 05900 CARDIAC CATHETERIZATION	4, 628	24	0		59. 00
60. 00 06000 LABORATORY	0	232	1, 000		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	1 050		64. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	24, 538 10, 926	6, 233 0	1, 950 850		66. 00 67. 00
67. 01 06701 AUDI OLOGY	5, 288	o	0		67. 01
68. 00 06800 SPEECH PATHOLOGY	0	28, 756	0		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0		69. 00
69. 01 06901 CARDI OLOGY	20, 696	73	1, 875		69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENT	0	ol Ol	0		71. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	ő	0		73. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0	0	0		90. 00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	5, 272	0	4, 200		90. 01
90. 02 09002 CLINI C 90. 03 09003 DERMATOLOGY CLINI C	0	0	0		90. 02
90. 04 09004 ENT CLINIC	0	o	0		90. 03
90. 05 09005 SURGERY CLINIC	O	49	Ö		90. 05
90. 07 09007 UROLOGY CLI NI C	0	904	0		90. 07
90. 09 09009 GASTROENTEROLOGY CLINIC	4, 695	42	0		90. 09
90. 11 09011 NEUROLOGY CLI NI C 90. 12 09012 0PTHAMOLOGY CLI NI C	0	14 396	0		90. 11
90. 13 09013 ALLERGY CLINIC	3, 353	1, 100	0		90. 12
90. 14 09014 WOUND CARE	7, 100	3, 231	0		90. 14
91. 00 09100 EMERGENCY	56, 996	71, 985	0		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					92. 00
OTHER REIMBURSABLE COST CENTERS		0.075	0		05.00
95. 00 09500 AMBULANCE SERVI CES SPECI AL PURPOSE COST CENTERS	0	8, 975	0		95. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	341, 244	154, 432	40, 800		118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 461	969, 671	300		192.00
194.00 07950 THORNTOWN OFFICE BUILDING 194.01 07951 CAFE/BOUTIQUE		0	0		194. 00 194. 01
194.02 07952 OTHER NONREIMBURSABLE COST CENTERS	131	o o	0		194. 01
200.00 Cross Foot Adjustments		٦			200. 00
201.00 Negative Cost Centers					201. 00
202.00 Cost to be allocated (per Wkst. B,	755, 488	1, 919, 626	1, 933, 233		202. 00
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I	2. 203643	1. 707696	47. 037299		203. 00
200.00 Joint Cost multiplier (WKSt. D, Part 1)	2. 203043	1. 707090	41.031277		1200.00

Heal th Finar	ncial Systems	WITHAM MEMORI.	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der		Period: From 01/01/2014	Worksheet B-	
					To 12/31/2014	Date/Time Pro 5/28/2015 2:	
	Cost Center Description	NURSI NG	PHARMACY	MEDI CAL			
		ADMI NI STRATI ON	(COSTED	RECORDS &			
			REQUIS.)	LI BRARY			
		(DI RECT		(TIME			
		NRSING HRS)		SPENT)			
		13.00	15. 00	16.00			
204. 00	Cost to be allocated (per Wkst. B, Part II)	3, 062	41, 689	62, 90	5		204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 008931	0. 037086	1. 53053	5		205. 00

Provider CCN: 150104

					10 12/31/2014	5/28/2015 2:1	
			Ti tl	e XVIII	Hospi tal	PPS	<u> </u>
	<u> </u>				Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	_					
30.00	03000 ADULTS & PEDI ATRI CS	7, 417, 988	l e	7, 417, 98			
31. 00	03100 INTENSIVE CARE UNIT	2, 281, 816		2, 281, 81		2,20.,0.0	
40. 00	04000 SUBPROVI DER - I PF	2, 835, 332		2, 835, 33			40. 00
41. 00	04100 SUBPROVI DER - I RF	0			0 0	0	41. 00
42. 00	04200 SUBPROVI DER	0		1	0		42. 00
43.00	04300 NURSERY	57, 389		57, 38	9 0	57, 389	43. 00
	ANCILLARY SERVICE COST CENTERS		ı		_1 _1		
50.00	05000 OPERATING ROOM	2, 102, 043		2, 102, 04			
54.00	05400 RADI OLOGY - DI AGNOSTI C	5, 539, 198		5, 539, 19		-,,	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0			0 0	_	55.00
55. 01	05501 ULTRA SOUND	617, 814		617, 81			55. 01
57. 00	05700 CT SCAN	948, 366	ŀ	948, 36			1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 154, 138		1, 154, 13		,	
59. 00	05900 CARDI AC CATHETERI ZATI ON	522, 486	l .	522, 48			
60.00	06000 LABORATORY	6, 979, 736		6, 979, 73		-, ,	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	176, 274		176, 27		,	63.00
64. 00 66. 00	06400 I NTRAVENOUS THERAPY 06600 PHYSI CAL THERAPY	2, 763	0	2, 76			64. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	2, 368, 617	· -	_, -, ,	- 1	_, -,	
		958, 806	0				1
67. 01 68. 00	06701 AUDI OLOGY 06800 SPEECH PATHOLOGY	234, 524	0	234, 52		234, 524	67. 01 68. 00
69. 00	06900 ELECTROCARDI OLOGY	166, 516	0	166, 51	0 0		69.00
69. 00	06901 CARDI OLOGY	1, 454, 016		1, 454, 01	-	1, 454, 016	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 430, 858	l e	2, 430, 85			
71.00	07200 IMPL. DEV. CHARGED TO PATIENT	6, 115, 014		6, 115, 01			
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 310, 051		1, 310, 05		1, 310, 051	73.00
73.00	OUTPATIENT SERVICE COST CENTERS	1,310,031		1, 310, 03	<u> </u>	1, 310, 031	73.00
90. 00	09000 CLINIC	0			ol ol	0	90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	872, 362	l .	872, 36		_	90. 01
90. 02	09002 CLINIC	349, 523		349, 52			90. 02
90. 03	09003 DERMATOLOGY CLINIC	0 17, 020		1	ol ol		90. 03
90. 04	09004 ENT CLINIC	45			5 0	45	
90. 05	09005 SURGERY CLINIC	84		•	4 0	84	90. 05
90. 07	09007 UROLOGY CLINIC	1, 713		1, 71			
90. 09	09009 GASTROENTEROLOGY CLINIC	10, 665		10, 66		10, 665	
90. 11	09011 NEUROLOGY CLINIC	772		77		772	90. 11
90. 12	09012 OPTHAMOLOGY CLINIC	23, 786		23, 78			1
90. 13	09013 ALLERGY CLINIC	178, 771		178, 77		178, 771	90. 13
90. 14	09014 WOUND CARE	727, 008		727, 00			
91.00	09100 EMERGENCY	5, 562, 638	l	5, 562, 63		5, 562, 638	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 350, 229		1, 350, 22		1, 350, 229	
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES	2, 509, 110		2, 509, 11	0 0	2, 509, 110	95. 00
200.00	Subtotal (see instructions)	57, 260, 451	0	57, 260, 45	1 47, 755	57, 308, 206	200. 00
201.00	Less Observation Beds	1, 350, 229		1, 350, 22	9	1, 350, 229	
202.00	Total (see instructions)	55, 910, 222	0	55, 910, 22	2 47, 755	55, 957, 977	202. 00

Provider CCN: 150104

					10 12/31/2014	5/28/2015 2:1	
			Ti tl	e XVIII	Hospi tal	PPS	
	·		Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·	·	·	+ col. 7)	Rati o	Inpati ent	
						Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	11, 128, 564		11, 128, 56			30.00
31.00	03100 INTENSIVE CARE UNIT	3, 258, 671		3, 258, 67	1		31. 00
40.00	04000 SUBPROVI DER - I PF	2, 974, 630		2, 974, 63	C		40. 00
41.00	04100 SUBPROVI DER - I RF	0			C		41. 00
42.00	04200 SUBPROVI DER	0			O		42. 00
43.00	04300 NURSERY	1, 388, 576		1, 388, 57	6		43. 00
	ANCILLARY SERVICE COST CENTERS	,					
50. 00	05000 OPERATING ROOM	6, 187, 842	29, 679, 893			0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 206, 080	17, 167, 182	1		0. 000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	1	0. 000000	0. 000000	
55. 01	05501 ULTRA SOUND	424, 905	6, 449, 261			0. 000000	
57.00	05700 CT SCAN	3, 318, 533	24, 009, 133			0. 000000	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	750, 304	10, 284, 223			0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 377, 164	1, 577, 629			0. 000000	
60.00	06000 LABORATORY	7, 486, 740	33, 903, 485			0. 000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	402, 433	410, 800			0. 000000	
64. 00	06400 I NTRAVENOUS THERAPY	956, 893	1, 084, 072			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	605, 203	4, 580, 680			0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	313, 319	788, 985			0. 000000	
67. 01	06701 AUDI OLOGY	431	754, 248			0. 000000	1
68. 00	06800 SPEECH PATHOLOGY	37, 545	347, 070			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	0	0	l .	0. 000000	0. 000000	
69. 01	06901 CARDI OLOGY	3, 632, 091	5, 252, 506			0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 905, 517	2, 288, 208			0. 000000	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	2, 445, 312	2, 281, 181			0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	5, 722, 414	5, 429, 244	11, 151, 65	8 0. 117476	0. 000000	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS	0		1	0.000000	0.000000	00 00
90. 00 90. 01	09000 CLINIC	0	0		0.000000	0.000000	
	09001 OTHER OUTPATIENT SERVICE COST CENTER 09002 CLINIC	0	0		0.000000	0.000000	
90. 02		0	0		0.00000	0.000000	
90. 03 90. 04	09003 DERMATOLOGY CLINIC 09004 ENT CLINIC	0	0	1	0.000000	0. 000000 0. 000000	
90. 04	09005 SURGERY CLINIC	0	0		0. 000000 0. 000000	0.00000	
90. 05 90. 07	09007 UROLOGY CLINIC	0	124, 890			0.00000	
90.07	09009 GASTROENTEROLOGY CLINIC	0	124, 890	124, 89	0.000000	0.000000	
90. 09	09011 NEUROLOGY CLINIC	0	552, 704	552, 70		0.00000	
90. 11	09012 OPTHAMOLOGY CLINIC	0	73, 658			0.00000	
90. 12	09013 ALLERGY CLINIC	0	1, 244, 326			0. 000000	
90. 13	09014 WOUND CARE	5, 982	2, 102, 403			0. 000000	
91. 00	09100 EMERGENCY	2, 848, 837	22, 251, 243			0.00000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 848, 837	2, 256, 637			0. 000000	
72.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	2, 230, 037	2, 250, 03	0. 570337	0.000000	, /2.00
95. 00	09500 AMBULANCE SERVICES	9, 769	5, 150, 156	5, 159, 92	0. 486269	0. 000000	95. 00
200.00		58, 387, 755	180, 043, 817			3.000000	200.00
201.00		00,00.,700	.00,0.0,017	200, .0.,07	=		201. 00
202.00		58, 387, 755	180, 043, 817	238, 431, 57	2		202. 00
						•	

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150104
Period: From 01/01/2014 To 12/31/2014
To 12/31/2014
Period: From 01/01/2014 To 12/31/2014
To 12/31/2015 2: 17 pm

				5/28/2015 2:17 p	pm
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
· ·	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS				30	30. 00
31. 00 03100 NTENSI VE CARE UNI T					31. 00
40. 00 04000 SUBPROVI DER - PF					10.00
41. 00 04100 SUBPROVI DER -					1.00
42. 00 04200 SUBPROVI DER				ı	2.00
43. 00 04300 NURSERY				43	13.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM	0. 058605				0.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 301481			54	4. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55	5.00
55. 01 05501 ULTRA SOUND	0. 089875			55	5. 01
57. 00 05700 CT SCAN	0. 034704			57	7. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 104593			58	8. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 176827				9. 00
60. 00 06000 LABORATORY	0. 168632				0.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 216757				3. 00
64. 00 06400 NTRAVENOUS THERAPY	0. 210757				4. 00
· · · · · · · · · · · · · · · · · · ·	1			·	
66. 00 06600 PHYSI CAL THERAPY	0. 456743			·	6. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 869820			•	7. 00
67. 01 06701 AUDI OLOGY	0. 310760				7. 01
68. 00 06800 SPEECH PATHOLOGY	0. 432942				8. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			I	9. 00
69. 01 06901 CARDI OLOGY	0. 163656			69	9. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 579642			71	1.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1. 293774			72	2.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 117476			73	3.00
OUTPATIENT SERVICE COST CENTERS	<u> </u>				
90. 00 09000 CLI NI C	0. 000000			90	0.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000				0. 01
90. 02 09002 CLINI C	0. 000000				0. 02
90. 03 09003 DERMATOLOGY CLINIC	0. 000000				0.02
90. 04 09004 ENT CLINIC	0. 000000			ı	0. 04
90. 05 09005 SURGERY CLINIC	0.00000				0. 04
	0. 013716				0.07
90. 09 09009 GASTROENTEROLOGY CLINIC	0. 000000				0.09
90. 11 09011 NEUROLOGY CLI NI C	0. 001397				0. 11
90. 12 09012 OPTHAMOLOGY CLINIC	0. 322925			l l	0. 12
90. 13 09013 ALLERGY CLI NI C	0. 143669			90	0. 13
90. 14 09014 WOUND CARE	0. 344817			90	0. 14
91. 00 09100 EMERGENCY	0. 221618			91	1.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 598337			92	2. 00
OTHER REIMBURSABLE COST CENTERS	<u>'</u>				
95. 00 09500 AMBULANCE SERVICES	0. 486269			9.5	5. 00
200.00 Subtotal (see instructions)	055257			·	0.00
201.00 Less Observation Beds				•	1. 00
202.00 Total (see instructions)					2. 00
202.00 10tal (300 1113ti deti 0113)	1			1202	,2.00

| Period: | Worksheet C | From 01/01/2014 | Part | Date/Time Prepared: | 5/28/2015 2:17 pm Provider CCN: 150104

						5/28/2015 2:1	7 pm
			Ti t	le XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	'	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.	,				
		26)					
		1.00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS			•			
30.00	03000 ADULTS & PEDI ATRI CS	7, 417, 988		7, 417, 98	3 0	7, 417, 988	30.00
31. 00	03100 NTENSIVE CARE UNIT	2, 281, 816		2, 281, 81		2, 281, 816	31.00
40. 00	04000 SUBPROVI DER - I PF	2, 835, 332		2, 835, 33		2, 883, 087	40. 00
41. 00	04100 SUBPROVI DER - I RF	0			0 0	0	41. 00
42. 00	04200 SUBPROVI DER	0				0	42. 00
43. 00	04300 NURSERY	57, 389		57, 38		57, 389	43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	37,307		37,30	<u>/ </u>	37, 307	75.00
50. 00	05000 OPERATING ROOM	2, 102, 043		2, 102, 04	3 ol	2, 102, 043	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	5, 539, 198		5, 539, 19		5, 539, 198	
55. 00	05500 RADI OLOGY-THERAPEUTI C	3, 337, 170				3, 337, 170	55. 00
55. 01	05501 ULTRA SOUND	1		1		-	55. 00
57. 00	05700 CT SCAN	617, 814		617, 81		617, 814	57. 00
		948, 366		948, 36		948, 366	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 154, 138		1, 154, 13		1, 154, 138	
59. 00	05900 CARDI AC CATHETERI ZATI ON	522, 486		522, 48		522, 486	
60. 00	06000 LABORATORY	6, 979, 736		6, 979, 73		6, 979, 736	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	176, 274		176, 27		176, 274	1
64. 00	06400 I NTRAVENOUS THERAPY	2, 763		2, 76		2, 763	64. 00
66. 00	06600 PHYSI CAL THERAPY	2, 368, 617	0			2, 368, 617	
67. 00	06700 OCCUPATI ONAL THERAPY	958, 806	0	958, 80	6 0	958, 806	
67. 01	06701 AUDI OLOGY	234, 524	0	234, 52	4 0	234, 524	67. 01
68. 00	06800 SPEECH PATHOLOGY	166, 516	0	166, 51	6 0	166, 516	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0			이	0	69. 00
69. 01	06901 CARDI OLOGY	1, 454, 016		1, 454, 01	6 0	1, 454, 016	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 430, 858		2, 430, 85	3 0	2, 430, 858	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	6, 115, 014		6, 115, 01	4 0	6, 115, 014	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 310, 051		1, 310, 05	1 0	1, 310, 051	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0			o o	0	90. 00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	872, 362		872, 36	2 0	872, 362	90. 01
90.02	09002 CLI NI C	349, 523		349, 52	3 0	349, 523	90. 02
90. 03	09003 DERMATOLOGY CLINIC	0			o o	0	90. 03
90.04	09004 ENT CLINIC	45		4	5 ol	45	90. 04
90.05	09005 SURGERY CLINIC	84		8	4 o	84	90. 05
90. 07	09007 UROLOGY CLINIC	1, 713		1, 71	3 ol	1, 713	90. 07
90.09	09009 GASTROENTEROLOGY CLINIC	10, 665		10, 66		10, 665	90. 09
90. 11	09011 NEUROLOGY CLINIC	772		77		772	90. 11
90. 12	09012 OPTHAMOLOGY CLINIC	23, 786		23, 78		23, 786	1
90. 13	09013 ALLERGY CLINIC	178, 771		178, 77		178, 771	90. 13
90. 14	09014 WOUND CARE	727, 008		727, 00		727, 008	
91. 00	09100 EMERGENCY	5, 562, 638		5, 562, 63		5, 562, 638	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 350, 229		1, 350, 22		1, 350, 229	92.00
,2.00	OTHER REIMBURSABLE COST CENTERS	1,000,227		1, 000, 22	·1	1, 000, 227	,2.00
95. 00	09500 AMBULANCE SERVICES	2, 509, 110		2, 509, 11	ol ol	2, 509, 110	95 00
200.00		57, 260, 451	0				
201.00	1	1, 350, 229	0	1, 350, 22		1, 350, 229	
202.00		55, 910, 222	0				
202.00	Trotal (See That detroils)	1 55, 710, 222	Ü	1 33, 710, 22	-1 47,755	55, 751, 711	1202.00

Provi der CCN: 150104

				'	0 12/01/2011	5/28/2015 2:1	7 pm
			Ti t	le XIX	Hospi tal	Cost	
	·		Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	'	'	'	+ col . 7)	Rati o	Inpati ent	
				_		Rati o	
		6.00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>			•		
30.00	03000 ADULTS & PEDIATRICS	11, 128, 564		11, 128, 564			30.00
31. 00	03100 INTENSIVE CARE UNIT	3, 258, 671		3, 258, 671			31. 00
40. 00	04000 SUBPROVI DER - I PF	2, 974, 630		2, 974, 630			40.00
41. 00	04100 SUBPROVI DER - I RF	2, ,, ,, ,, ,		2, ,, ,, ,,			41. 00
42. 00	04200 SUBPROVI DER	ا			ń		42. 00
43. 00	04300 NURSERY	1, 388, 576		1, 388, 576			43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	1, 300, 370		1, 300, 370	<u>'</u>		45.00
50. 00	05000 OPERATI NG ROOM	6, 187, 842	29, 679, 893	35, 867, 735	0. 058605	0. 000000	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 206, 080	17, 167, 182			0.000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 200, 000	17, 107, 102			0.000000	
		424 005	-	1			
55. 01	05501 ULTRA SOUND	424, 905	6, 449, 261			0.000000	
57. 00	05700 CT SCAN	3, 318, 533	24, 009, 133			0. 000000	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	750, 304	10, 284, 223			0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 377, 164	1, 577, 629			0. 000000	
60.00	06000 LABORATORY	7, 486, 740	33, 903, 485			0. 000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	402, 433	410, 800			0. 000000	
64. 00	06400 I NTRAVENOUS THERAPY	956, 893	1, 084, 072			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	605, 203	4, 580, 680	5, 185, 883		0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	313, 319	788, 985	1, 102, 304	0. 869820	0.000000	67. 00
67. 01	06701 AUDI OLOGY	431	754, 248	754, 679	0. 310760	0.000000	67. 01
68.00	06800 SPEECH PATHOLOGY	37, 545	347, 070	384, 615	0. 432942	0.000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	(0.000000	0.000000	69. 00
69. 01	06901 CARDI OLOGY	3, 632, 091	5, 252, 506	8, 884, 597	0. 163656	0.000000	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 905, 517	2, 288, 208	4, 193, 725	0. 579642	0. 000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	2, 445, 312	2, 281, 181	4, 726, 493	1. 293774	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 722, 414	5, 429, 244	11, 151, 658	0. 117476	0.000000	73. 00
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	0	0		0. 000000	0.000000	90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0			0. 000000	
90. 02	09002 CLI NI C	o o	0		0. 000000	0. 000000	
90. 03	09003 DERMATOLOGY CLINIC	٥	0			0. 000000	
90. 04	09004 ENT CLINIC	ا	0			0. 000000	
90. 05	09005 SURGERY CLINIC		0			0. 000000	
90. 07	09007 UROLOGY CLINIC		124, 890	1		0. 000000	
90.07	09009 GASTROENTEROLOGY CLINIC		124, 070	124, 070	0.000000	0.000000	
90. 09	09011 NEUROLOGY CLINIC		552, 704	552, 704		0.000000	
90. 11	09011 NEGROLOGY CLINIC						
		0	73, 658			0.000000	
90. 13	09013 ALLERGY CLINIC	5 000	1, 244, 326			0.000000	
90. 14	09014 WOUND CARE	5, 982	2, 102, 403			0. 000000	
91.00	09100 EMERGENCY	2, 848, 837	22, 251, 243			0.000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 256, 637	2, 256, 637	0. 598337	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS	1	·-·	I = 450			
95. 00	09500 AMBULANCE SERVICES	9, 769	5, 150, 156			0. 000000	
200.00		58, 387, 755	180, 043, 817	238, 431, 572	<u>'</u>		200. 00
201.00							201. 00
202.00	Total (see instructions)	58, 387, 755	180, 043, 817	238, 431, 572	<u>'</u>		202. 00

Heal th Financial Systems WI THAM MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150104
Period: From 01/01/2014 | Part I | To 12/31/2014 | Date/Time Prepared:

5/28/2015 2:17 pm

202. 00

Title XIX Hospi tal Cost PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 40. 00 | 04000 | SUBPROVI DER - I PF 40.00 04100 SUBPROVI DER - I RF 41.00 41.00 42.00 04200 SUBPROVI DER 42.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 55.01 05501 ULTRA SOUND 0.000000 55.01 57.00 05700 CT SCAN 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 0.000000 59.00 60.00 06000 LABORATORY 0.000000 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63.00 63.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 64.00 06600 PHYSI CAL THERAPY 0.000000 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 67.00 06701 AUDI OLOGY 67.01 0.000000 67.01 06800 SPEECH PATHOLOGY 0.000000 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 69.01 06901 CARDI OLOGY 0.000000 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0.000000 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 72.00 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 90.00 90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER 0.000000 90.01 90. 02 09002 CLI NI C 0.000000 90.02 09003 DERMATOLOGY CLINIC 0.000000 90. 03 90.03 90 04 09004 ENT CLINIC 0.000000 90 04 09005 SURGERY CLINIC 0.000000 90.05 90.05 09007 UROLOGY CLINIC 90.07 0.000000 90.07 90.09 09009 GASTROENTEROLOGY CLINIC 0.000000 90.09 09011 NEUROLOGY CLINIC 0.000000 90.11 90.11 09012 OPTHAMOLOGY CLINIC 90.12 0.000000 90.12 09013 ALLERGY CLINIC 90. 13 0.000000 90.13 90 14 09014 WOUND CARE 0.000000 90. 14 09100 EMERGENCY 91.00 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0.000000 95 00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201. 00

202.00

Total (see instructions)

Health Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS		CCN: 150104	Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 5/28/2015 2:1	pared: 7 pm
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	477, 692	0	477, 69	6, 296	75. 87	30.00
31.00 INTENSIVE CARE UNIT	131, 342		131, 34	1, 487	88. 33	31.00
40. 00 SUBPROVI DER - I PF	166, 385	0	166, 38	2, 987	55. 70	40.00
41. 00 SUBPROVI DER - I RF	0	0		0 0	0.00	41.00
42. 00 SUBPROVI DER	0	0		0 0	0.00	42. 00
43. 00 NURSERY	187	1	18	997	0. 19	43.00
200.00 Total (lines 30-199)	775, 606	,	775, 60	11, 767		200.00
Cost Center Description	I npati ent	Inpati ent		•	•	
· ·	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS	•		•			
30. 00 ADULTS & PEDIATRICS	2, 255	171, 087	'			30. 00
31.00 INTENSIVE CARE UNIT	763	67, 396	,			31.00
40. 00 SUBPROVI DER - I PF	2, 474	137, 802	2			40.00
41. 00 SUBPROVI DER - I RF	0					41.00
42. 00 SUBPROVI DER						42.00
43. 00 NURSERY	0		o			43. 00
200.00 Total (lines 30-199)	5, 492	376, 285				200. 00
	-1	1 2.2/200	1			

Heal th	Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der	CCN: 150104	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part II	
					10 12/31/2014	5/28/2015 2:1	pareu. 7 pm
			Ti tl	e XVIII	Hospi tal	PPS	, p
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.		. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
	ANOLILIARY OFRICAS COOT OFFITTERS	1.00	2. 00	3.00	4. 00	5. 00	
FO 00	ANCI LLARY SERVI CE COST CENTERS	201 000	25 0/7 725	- 0.00041	2 757 007	22.214	FO 00
50.00	05000 OPERATING ROOM	301, 898		1			1
54. 00	05400 RADI OLOGY - DI AGNOSTI C	388, 109			•	1	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	-	0.0000			55. 00
55. 01	05501 ULTRA SOUND	3, 838		•	•	l e	55. 01
57. 00	05700 CT SCAN	5, 249		•		304	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	35, 449		•	•		1
59.00	05900 CARDI AC CATHETERI ZATI ON	27, 219		•	•		1
60.00	06000 LABORATORY	190, 806		•		18, 485	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	576		1		0	63.00
64. 00	06400 NTRAVENOUS THERAPY	170 520	2, 040, 965				64.00
66.00	06600 PHYSI CAL THERAPY	170, 529					1
67. 00	06700 OCCUPATI ONAL THERAPY	4, 735				l .	1
67. 01	06701 AUDI OLOGY	1, 054		•		0	
68. 00	06800 SPEECH PATHOLOGY	1, 620	384, 615		•	l	1
69. 00 69. 01	06900 ELECTROCARDI OLOGY	0		0.0000		7 107	69. 00 69. 01
	06901 CARDI OLOGY	25, 308				1	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	7, 969 19, 988			•	17 4, 901	71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	5, 254		1			1
73.00	OUTPATIENT SERVICE COST CENTERS	5, 254	11, 131, 030	0.00047	3, 219, 343	1, 516	73.00
90. 00	09000 CLINIC	0		0.00000	00	0	90.00
90. 00	09001 OTHER OUTPATIENT SERVICE COST CENTER	78, 805	_	1			
90. 02	09002 CLINIC	113, 489		1			90. 02
90. 03	09003 DERMATOLOGY CLINIC	110, 107		1		·	90. 03
90. 04	09004 ENT CLINIC		1	1			90.04
90. 05	09005 SURGERY CLINIC	2		1		0	90. 05
90. 07	09007 UROLOGY CLINIC	34				1	90. 07
90. 09	09009 GASTROENTEROLOGY CLINIC	45		1		0	90. 09
90. 11	09011 NEUROLOGY CLINIC	3				0	90. 11
90. 12	09012 OPTHAMOLOGY CLINIC	90		•		0	90. 12
90. 13	09013 ALLERGY CLINIC	642		•		0	90. 13
90. 14	09014 WOUND CARE	64, 663		1		15	1
91. 00	09100 EMERGENCY	456, 084		1			
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	86, 949					1
	OTHER REIMBURSABLE COST CENTERS		,,,				1
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50-199)	1, 990, 415	214, 521, 206	5	19, 358, 316	115, 661	200. 00

Health Financial Systems	WITHAM MEMORI	AL HOSPITAL		In lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA		TS Provi der	CCN: 150104	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part III Date/Time Pre 5/28/2015 2:1	pared:
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School			Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
	4.00	0.00			minus col. 4)	
	1. 00	2.00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	_	-			· -	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0)	0	0	30. 00
31. 00 03100 I NTENSI VE CARE UNI T	0	0)	0	0	31. 00
40. 00 04000 SUBPROVI DER - I PF	0	0)	0	0	
41. 00 04100 SUBPROVI DER - I RF	0	0)	0	0	
42. 00 04200 SUBPROVI DER	0	0)	0	0	
43. 00 04300 NURSERY	0	0)	0	0	43. 00
200.00 Total (lines 30-199)	0	0		0	0	200. 00
Cost Center Description		Per Diem (col.		I npati ent		
	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
		7.00		col . 8)		
LAUDATI ENT. DOUTLANE OFFICE OF COOT OFFITEDO	6. 00	7.00	8. 00	9. 00		
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						00.00
30. 00 03000 ADULTS & PEDI ATRI CS	6, 296					30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 487					31.00
40. 00 04000 SUBPROVI DER - PF	2, 987			/4 0		40.00
41. 00 04100 SUBPROVI DER - RF	0	0.00		0		41. 00
42. 00 04200 SUBPROVI DER	0	0.00		0		42.00
43. 00 04300 NURSERY	997		•	0		43. 00
200.00 Total (lines 30-199)	11, 767	l	5, 49	92 0		200. 00

Health Financial Systems	WITHAM MEMORIAL H	IOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150104	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2014	Part IV

THROUG	H COSTS				o 12/31/2014		pared: 7 pm
			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician N	ursing School	Allied Health	All Other	Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	9	
		1.00	2.00	2.00	4.00	4)	
	ANCILLARY SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
50. 00	05000 OPERATING ROOM		0	0	٥	0	50.00
	05400 RADI OLOGY-DI AGNOSTI C		0	0	0	0	
	05500 RADI OLOGY-THERAPEUTI C		0	0	0	0	55.00
55. 01	05501 ULTRA SOUND		0	0	0	ا ا	55. 01
57. 00	05700 CT SCAN		0	0	0	l 0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	1
	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	06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
	06701 AUDI OLOGY	0	0	0	0	0	67. 01
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
	06901 CARDI OLOGY	0	0	0	0	0	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	Ö	1
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	0	Ö	72. 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. 01
	09002 CLI NI C	0	0	0	0	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
90. 05	09005 SURGERY CLINIC	0	0	0	0	0	90. 05
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	09012 OPTHAMOLOGY CLINIC	0	0	0	0	0	90. 12
90. 13	09013 ALLERGY CLINIC	0	0	0	0	0	90. 13
90. 14	09014 WOUND CARE	0	0	0	0	0	90. 14
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	_	_	_	_	_	95. 00
200. 00	Total (lines 50-199)	0	0	0	0	, 01	200. 00

Health Financial Systems	WITHAM MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT THROUGH COSTS	OUTPATIENT ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150104	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared:

THROUG	H COSTS					To 12/31/2014	Date/Time Prep 5/28/2015 2:1	
				Ti tl	e XVIII	Hospi tal	PPS	7 piii
	Cost Center Description	Total	Total		Ratio of Cost	Outpati ent	Inpati ent	
	·	Outpati ent	(from	Wkst. C,	to Charges	Ratio of Cost	Program	
		Cost (sum of	Part	I, col.	(col. 5 ÷ col.	to Charges	Charges	
		col . 2, 3 and		8)	7)	(col. 6 ÷ col.		
		4)				7)		
		6. 00		7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS							
	05000 OPERATING ROOM	0		5, 867, 735			2, 757, 997	50.00
	05400 RADI OLOGY-DI AGNOSTI C	0	1	8, 373, 262	0. 000000		946, 312	
	05500 RADI OLOGY-THERAPEUTI C	0		0	0. 000000		0	
	05501 ULTRA SOUND	0	I .	6, 874, 166			73, 933	1
	05700 CT SCAN	0	2	7, 327, 666	0. 000000	0.000000	1, 584, 674	57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1	1, 034, 527	0. 000000		730, 314	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0		2, 954, 793			425, 138	
	06000 LABORATORY	0	4	1, 390, 225			4, 009, 741	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		813, 233	0. 000000	0.000000	0	
64.00	06400 I NTRAVENOUS THERAPY	0		2,040,965	0. 000000	0.000000	167, 692	64. 00
66.00	06600 PHYSI CAL THERAPY	0		5, 185, 883	0. 000000	0.000000	349, 669	66. 00
67.00	06700 OCCUPATIONAL THERAPY	0	ĺ	1, 102, 304	0. 000000	0.000000	201, 067	67. 00
67. 01	06701 AUDI OLOGY	0	ĺ	754, 679	0. 000000	0.000000	0	67. 01
68. 00	06800 SPEECH PATHOLOGY	0		384, 615	0. 000000	0. 000000	29, 120	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	ĺ	0	0. 000000	0. 000000	0	69. 00
69. 01	06901 CARDI OLOGY	0		8, 884, 597	0. 000000	0. 000000	2, 526, 294	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	l	4, 193, 725	0. 000000	0. 000000	8, 854	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	l	4, 726, 493	0. 000000	0. 000000	1, 158, 965	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1	1, 151, 658	0. 000000	0. 000000	3, 219, 543	73. 00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLI NI C	0		0	0. 000000	0.000000	0	90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0		0	0. 000000	0.000000	0	90. 01
	09002 CLI NI C	0	ĺ	0	0. 000000	0. 000000	0	90. 02
90. 03	09003 DERMATOLOGY CLINIC	0	ĺ	0	0. 000000	0. 000000	0	90. 03
90. 04	09004 ENT CLINIC	0	ĺ	0	0. 000000	0. 000000	0	90. 04
90. 05	09005 SURGERY CLINIC	0	ĺ	0	0. 000000	0. 000000	0	90. 05
90. 07	09007 UROLOGY CLINIC	0	ĺ	124, 890	0. 000000	0. 000000	0	90. 07
90. 09	09009 GASTROENTEROLOGY CLINIC	0	l	0	0. 000000	0. 000000	0	90. 09
90. 11	09011 NEUROLOGY CLINIC	0	İ	552, 704	0. 000000	0. 000000	0	90. 11
90. 12	09012 OPTHAMOLOGY CLINIC	0	İ	73, 658	0. 000000	0. 000000	0	90. 12
	09013 ALLERGY CLINIC	0	l	1, 244, 326	0. 000000		0	90. 13
	09014 WOUND CARE	0	1	2, 108, 385	0. 000000		495	90. 14
	09100 EMERGENCY	0	1	5, 100, 080			1, 168, 508	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		2, 256, 637	0. 000000			92. 00
	OTHER REIMBURSABLE COST CENTERS			2, 200, 007	3. 555666	2. 000000	Ü	72.00
	09500 AMBULANCE SERVICES							95. 00
200.00	l	0	21	4, 521, 206			19, 358, 316	
200.00	1.212. ('		., 52., 200	1	1	. , , 555, 616	1-30.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

THROUGH COSTS

WITHAM MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Period: From 01/01/2014 To 12/31/2014 Date/Time Prepared:

				10 12/31/201	5/28/2015 2:	17 pm
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent	·		
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9	9		
	x col. 10)		x col. 12)			
	11. 00	12.00	13. 00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	8, 804, 862		0		50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	5, 327, 903		0		54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0)	0		55. 00
55. 01 05501 ULTRA SOUND	O	1, 352, 844		0		55. 01
57.00 05700 CT SCAN	O	5, 549, 871		0		57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	O	3, 392, 436		0		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	554, 932		0		59. 00
60. 00 06000 LABORATORY	0	3, 460, 410	1	0		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	131, 009	1	0		63. 00
64. 00 06400 I NTRAVENOUS THERAPY	O	258, 917		o		64. 00
66. 00 06600 PHYSI CAL THERAPY	o	2, 034		0		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	6	,	o		67. 00
67. 01 06701 AUDI OLOGY	0	107, 837		0		67. 01
68. 00 06800 SPEECH PATHOLOGY	0	0	1	0		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	,	0		69. 00
69. 01 06901 CARDI OLOGY	0	2, 157, 653		0		69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	426, 143	1	0		71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT		38, 943		0		72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	3, 262, 872		0		73. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	0,202,072	1	<u> </u>		70.00
90. 00 09000 CLI NI C	0	0		0		90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	o	0	,	o		90. 01
90. 02 09002 CLI NI C	0	0	,	0		90. 02
90. 03 09003 DERMATOLOGY CLINIC	0	0	,	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 CLINI C	0	0		0		90. 07
90. 09 09009 GASTROENTEROLOGY CLINIC	0	0		0		90. 09
90. 11 09011 NEUROLOGY CLI NI C	0	171, 553		0		90. 11
90. 12 09012 0PTHAMOLOGY CLINIC	0	722		0		90. 12
90. 13 09013 ALLERGY CLINIC	0	51, 949	1	0		90. 13
90. 14 09014 WOUND CARE		175, 979		o l		90. 14
91. 00 09100 EMERGENCY		3, 244, 316		Ö		91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	968, 248	l .	0		92. 00
OTHER REIMBURSABLE COST CENTERS	<u>, </u>	700, 240	1	<u> </u>		72.00
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	0	39, 441, 439	,	О		200. 00
	١	,, 10,	1	- 1		1

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 150104 Peri od: Worksheet D From 01/01/2014 Part V Date/Time Prepared: 12/31/2014 5/28/2015 2:17 pm Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.058605 8, 804, 862 516, 009 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 301481 5, 327, 903 0 0 54.00 1,606,262 05500 RADI OLOGY-THERAPEUTI C 0 55 00 0.000000 55 00 0 0 0 55.01 05501 ULTRA SOUND 0.089875 1, 352, 844 121, 587 55.01 57.00 05700 CT SCAN 0.034704 5, 549, 871 0 192, 603 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.104593 3, 392, 436 0 0 354.825 58 00 05900 CARDIAC CATHETERIZATION 0 59.00 0.176827 554, 932 98, 127 59.00 60.00 06000 LABORATORY 0.168632 3, 460, 410 583, 536 60.00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0. 216757 131, 009 0 28, 397 63.00 0 06400 I NTRAVENOUS THERAPY 258 917 64 00 0.001354 351 64 00 66.00 06600 PHYSI CAL THERAPY 0.456743 2,034 929 66.00 06700 OCCUPATIONAL THERAPY 0.869820 0 0 67.00 67.00 0 67.01 06701 AUDI OLOGY 0.310760 107, 837 0 67.01 33.511 06800 SPEECH PATHOLOGY 0 68.00 0.432942 0 68 00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 Ω 69.00 06901 CARDI OLOGY 2, 157, 653 0 0 353, 113 69.01 0.163656 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.579642 0 0 247, 010 71.00 71.00 426, 143 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 1. 293774 38, 943 0 50, 383 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.117476 3, 262, 872 9,684 383, 309 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLINIC 0.000000 0 0 09001 OTHER OUTPATIENT SERVICE COST CENTER 0 0 90.01 0.000000 0 90.01 09002 CLI NI C 0.000000 0 0 0 90.02 90.02 0 09003 DERMATOLOGY CLINIC 0 90. 03 0.000000 0 90.03 09004 FNT CLINIC 0.000000 0 90.04 90.04 0 0 90.05 09005 SURGERY CLINIC 0.000000 C Ω 90.05 90.07 09007 UROLOGY CLINIC 0.013716 0 0 0 90.07 0 90.09 09009 GASTROENTEROLOGY CLINIC 0.000000 O 90.09 0 09011 NEUROLOGY CLINIC 240 90 11 90 11 0.001397 171, 553 90. 12 09012 OPTHAMOLOGY CLINIC 0. 322925 722 233 90.12 0 09013 ALLERGY CLINIC 0 90. 13 0.143669 51, 949 7, 463 90.13 09014 WOUND CARE 0 0 60, 681 90.14 0.344817 175, 979 90.14 91.00 09100 EMERGENCY 0. 221618 3, 244, 316 718, 999 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.598337 968, 248 0 579, 339 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 95 00 0.486269 0 0 200.00 Subtotal (see instructions) 39, 441, 439 9,684 5, 936, 912 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00

0

39, 441, 439

9, 684

5, 936, 912 202. 00

Only Charges

Net Charges (line 200 +/- line 201)

202.00

| Period: | Worksheet D | From 01/01/2014 | Part V | Date/Time Prepared: | 5/28/2015 2:17 pm Provider CCN: 150104

					5/28/2015 2:17 pm
			Title XVIII	Hospi tal	PPS
		Costs			
C	cost Center Description	Cost	Cost		
		Reimbursed Re	eimbursed		
			rvices Not		
		Subject To Su	ubject To		
			. & Coins.		
			ee inst.)		
		6. 00	7. 00		
	ARY SERVICE COST CENTERS				
	PERATING ROOM	0	0		50. 00
1 1	ADI OLOGY-DI AGNOSTI C	0	0		54. 00
1 1	ADI OLOGY-THERAPEUTI C	0	0		55. 00
	ILTRA SOUND	0	0		55. 01
57. 00 05700 C		0	0		57. 00
	AGNETIC RESONANCE IMAGING (MRI)	0	0		58. 00
	ARDIAC CATHETERIZATION	0	0		59. 00
	ABORATORY	0	0		60.00
	LOOD STORING, PROCESSING & TRANS.	0	0		63. 00
	NTRAVENOUS THERAPY	0	0		64. 00
	PHYSI CAL THERAPY	0	0		66. 00
	CCUPATI ONAL THERAPY	0	0		67. 00
	JUDI OLOGY	0	0		67. 01
	PEECH PATHOLOGY	0	0		68. 00
	LECTROCARDI OLOGY	0	0		69. 00
	ARDI OLOGY	0	0		69. 01
1 1	IEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71. 00
	MPL. DEV. CHARGED TO PATIENT	0	0		72. 00
	RUGS CHARGED TO PATIENTS	0	1, 138		73. 00
	ENT SERVICE COST CENTERS				
90. 00 09000 C		0	0		90.00
	THER OUTPATIENT SERVICE COST CENTER	0	0		90. 01
90. 02 09002 C		0	0		90. 02
	PERMATOLOGY CLINIC	0	0		90. 03
	NT CLINIC	0	0		90. 04
	SURGERY CLINIC	0	0		90. 05
	ROLOGY CLINIC	0	0		90. 07
	ASTROENTEROLOGY CLINIC	0	0		90. 09
	EUROLOGY CLINIC	0	O _I		90. 11
	PTHAMOLOGY CLINIC	0	o _l		
	LLERGY CLINIC	0	O _I		90. 13
	OUND CARE		O _I		90. 14
1 1	MERGENCY		0		91.00
	BSERVATION BEDS (NON-DISTINCT PART)	0	0		92. 00
	REIMBURSABLE COST CENTERS MBULANCE SERVICES	0			95. 00
	imbulance services imbtotal (see instructions)		1 120		200.00
	ess PBP Clinic Lab. Services-Program		1, 138		200.00
	nly Charges				201.00
	let Charges (line 200 +/- line 201)	0	1, 138		202. 00
202.00	ict charges (True 200 17 True 201)	۱ ۹	1, 130		1202.00

Heal th	Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der	CCN: 150104 t CCN: 15S104	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Pre	pared:
			Ti tl	e XVIII	Subprovi der -	5/28/2015 2: 1 PPS	7 pm
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	I PF it I npati ent	Capital Costs	
	oost denter beschiptron		(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.			column 4)	
		Part II, col.	8)	2)		,	
		26)					
	T	1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	301, 898	, ,			1	
54.00	05400 RADI OLOGY-DI AGNOSTI C	388, 109					
55. 00	05500 RADI OLOGY-THERAPEUTI C	0		1		0	
55. 01	05501 ULTRA SOUND	3, 838				0	
57. 00	05700 CT SCAN	5, 249				0	
58. 00 59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	35, 449 27, 219			· ·	51 0	58. 00 59. 00
60.00	06000 LABORATORY	190, 806					
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	576				2, 130	1
64. 00	06400 I NTRAVENOUS THERAPY	8					
66. 00	06600 PHYSI CAL THERAPY	170, 529		•			
67. 00	06700 OCCUPATI ONAL THERAPY	4, 735		•			
67. 01	06701 AUDI OLOGY	1, 054		•		0	
68. 00	06800 SPEECH PATHOLOGY	1, 620	1	1		5	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	. (0.0000	00	0	69. 00
69. 01	06901 CARDI OLOGY	25, 308	8, 884, 597	0. 0028	49 61, 395	175	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 969	4, 193, 725	0. 0019	00 108	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	19, 988	4, 726, 493			0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 254	11, 151, 658	0. 0004	71 551, 351	260	73. 00
	OUTPATIENT SERVICE COST CENTERS	_					
90.00	09000 CLI NI C	0	1	1		-	
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	78, 805					
90. 02	09002 CLI NI C	113, 489					
90. 03	09003 DERMATOLOGY CLINIC	0	1	0.0000		-	
90. 04	09004 ENT CLINIC	0				-	
90. 05 90. 07	09005 SURGERY CLINIC 09007 UROLOGY CLINIC	24	124 000	1		-	
		34		1		0	1
90. 09 90. 11	O9009 GASTROENTEROLOGY CLINIC O9011 NEUROLOGY CLINIC	45		0.0000		0	
90. 11	09012 OPTHAMOLOGY CLINIC	90					
90. 12	09013 ALLERGY CLINIC	642				0	
90. 13	09014 WOUND CARE	64, 663					
91. 00	09100 EMERGENCY	456, 084					91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		•			1
0	OTHER REIMBURSABLE COST CENTERS				· · · · · · · · · · · · · · · · · · ·		1
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50-199)	1, 903, 466	214, 521, 206		1, 249, 876	5, 861	200. 00

	Financial Systems	WITHAM MEMORIAL	_ HOSPITAL		In Lie	u of Form CMS-2	<u> 2552-10</u>
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	VICE OTHER PASS		CCN: 150104 CCN: 15S104	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Pre 5/28/2015 2:1	pared:
			Ti tl	e XVIII	Subprovi der - I PF	PPS	<u>, Бш</u>
	Cost Center Description	Non Physician No Anesthetist Cost	ursing School	Allied Healt		4)	
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00 54. 00	05000 OPERATI NG ROOM 05400 RADI OLOGY-DI AGNOSTI C	0 0	0		0 0	0	50. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
55. 01 57. 00	05501 ULTRA SOUND 05700 CT SCAN		0		0 0	0	55. 01 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	o	0		0 0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59. 00
60. 00 63. 00	06000 LABORATORY	0	0		0 0	0	60. 00 63. 00
64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY		0		0 0	0	64. 00
66. 00	06600 PHYSI CAL THERAPY	o	0		0 0	Ö	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67. 00
67. 01	06701 AUDI OLOGY	0	0		0 0	0	67. 01
68. 00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68. 00
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 CARDI OLOGY		0		0 0	0	69. 00 69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0			0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS			Т			
90. 00 90. 01	09000 CLINIC 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0 0	0	90. 00 90. 01
90.01	109002 CLINIC		0		0 0	0	90.01
90. 03	09003 DERMATOLOGY CLINIC	o	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	0	90. 07
90. 09 90. 11	09009 GASTROENTEROLOGY CLINIC	0	0		0 0	0	90. 09
90. 11	O9011 NEUROLOGY CLI NI C O9012 OPTHAMOLOGY CLI NI C		0		0 0	0	90. 11 90. 12
90. 12	09013 ALLERGY CLINIC		0			0	90. 13
90. 14	09014 WOUND CARE	0	Ō		0 0	0	90. 14
91.00	09100 EMERGENCY	0	0		0 0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92. 00
05.00	OTHER REIMBURSABLE COST CENTERS						05.00
95. 00 200. 00	O9500 AMBULANCE SERVICES Total (lines 50-199)	o	0		0 0	n	95. 00 200. 00
200.00	1.232. (١	0	ı	-1	·	1-30.00

Cost Center Description	ORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI OUGH COSTS	RVICE OTHER PAS		1	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Pre 5/28/2015 2:1	pared: 7 pm
Total Outpatient Cost (sum of Poten) C			Ti tl	e XVIII			
COST (SUM of Part I, COL)	Cost Center Description		Total Charges	Ratio of Cost	Outpati ent		
ANCILLARY SERVICE COST CENTERS							
AND 1.00 3.00 9.00 10.00						Charges	
ANCILLARY SERVICE COST CENTERS			0)	/)			
ANCILLARY SERVICE COST CENTERS			7 00	8 00		10.00	
50.00	ANCILLARY SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
54.00 05400 RADI OLOGY-DI AGNOSTIC 0 18, 373, 262 0.000000 0.000000 95, 859 50.00 5500 RADI DLOGY-THERAPEUTIC 0 0.000000 0.000000 0.000000 0.557.00 0.5501 ULTRA SOUND 0 6, 874, 166 0.000000 0.000000 0.557.00 0.5501 ULTRA SOUND 0 6, 874, 166 0.000000 0.000000 0.000000 0.555.00 0.5000 MAGNETIC RESONANCE IMAGING (MRI) 0 11, 034, 527 0.000000 0.000000 0.555.00 0.5000 MAGNETIC RESONANCE IMAGING (MRI) 0 11, 034, 527 0.000000 0.000000 0.000000 22 56, 50.00 0.5000 CARDI AC CATHETERI ZATI ON 0 2, 954, 793 0.000000 0.000000 466, 300 460, 400		0	35, 867, 735	0. 000000	0.000000	131	50.00
15.5.01 05501 ULTRA SOUND 0 6, 874, 166 0.000000 0.000000 0.5		0			0. 000000	95, 859	54.0
57.00 05700 CT SCAN 0 27, 327, 666 0.000000 0.000000 0 0 0 0	00 05500 RADI OLOGY-THERAPEUTI C	0	0	0. 000000	0. 000000	0	55.0
158.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 11,034,527 0.000000 0.000000 15,880	01 05501 ULTRA SOUND	0	6, 874, 166	0. 000000	0. 000000	0	55.0
19.90 05900 CARDI AC CATHETERI ZATI ON 0 2, 954, 793 0.000000 0.000000 22 5		0	27, 327, 666	0. 000000	0. 000000	0	57.0
10.00 06000 LABDRATORY 0 41, 390, 225 0.000000 0.000000 466, 390 60, 300 06300 BLOOD STORING, PROCESSING & TRANS. 0 813, 233 0.000000 0.000000 0.000000 5, 678 60, 600 06400 INTRAVENOUS THERAPY 0 2, 040, 965 0.000000 0.000000 27, 459 60, 600 06400 INTRAVENOUS THERAPY 0 5, 185, 883 0.000000 0.000000 27, 459 60, 600 06700 OCCUPATI ONAL THERAPY 0 1, 102, 304 0.000000 0.000000 17, 708 60, 700 06700 OCCUPATI ONAL THERAPY 0 1, 102, 304 0.000000 0.000000 0.000000 17, 708 60, 700 06701 AUDI OLOGY 0 384, 615 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	11, 034, 527	0. 000000		15, 880	58. 0
033 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 813, 233 0.000000 0.0000	00 05900 CARDI AC CATHETERI ZATI ON	0			0. 000000	22	59.0
14.00 06400 NTRAVENOUS THERAPY 0 2,040,965 0,000000 0,000000 5,078 6 0 06600 PHYSI CAL THERAPY 0 1,102,304 0,000000 0,000000 27,459 6 0 06700 0CCUPATI ONAL THERAPY 0 1,102,304 0,000000 0,000000 0,000000 1,708 6 0 0 0 0 0 0 0 0 0		_				466, 390	
16.00 06600 PHYSICAL THERAPY 0 5, 185, 883 0.000000 0.000000 27, 459 60, 70 00, 6700 06700 06700 06700 060000 0.000000 11, 708 67, 70 0 06701 AUDI OLOGY 0 754, 679 0.000000 0.000000 0.000000 0.88 0.00 0.88 0.00 0.88 0.00 0.8900 0.890000 0.000000 0.000000 0.000000 0.000000 0.9000000 0.9000000 0.900000 0.900000 0.900000 0.900000 0.90000		0					63.0
1,700 06700 0CCUPATI ONAL THERAPY 0 1,102,304 0.000000 0.000000 11,708 67 7.01 06701 AUDI OLOGY 0 754,679 0.000000 0.00000							
17. 01 06701 AIDI OLOGY 0 754, 679 0.000000 0.000000 0.000000 0.88. 00 06800 SPEECH PATHOLOGY 0 384, 615 0.000000							
18.00 06800 SPEECH PATHOLOGY 0 384,615 0.000000 0.00			,			· ·	
090 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0							
99. 01 06901 CARDI OLOGY 0 8,884,597 0.000000 0.000000 61,395 67,100 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 4,193,725 0.000000 0.000000 108 7,100 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 4,726,493 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.000000 0.000000		_	00.70.0				
1. 00	· · · · · · · · · · · · · · · · · · ·	_	_				
12. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 4,726,493 0.000000 0.000000 0.000000 0.73.00 07300 DRUGS CHARGED TO PATIENTS 0 11,151,658 0.000000 0.000000 551,351 7.000000 0.0000000 0.0000000 0.0000000 0.0000000						· ·	
0.00 07300 DRUGS CHARGED TO PATIENTS 0 11, 151, 658 0.000000 0.000000 551, 351 70		_	.,				
OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTER							
00. 00 09000 CLI NI C 0 0 0 0 0 0 0 0 0			11, 151, 056	0.00000	0.00000	551, 551	73.0
0.0. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.000000 0.000000 0			0	0.00000	0.000000	0	90.0
0.0 0.0			l .				90.0
0.0.03 09003 DERMATOLOGY CLINIC 0 0 0 0 0 000000 0 0						-	90.0
0. 04 09004 ENT CLINIC 0 0 0 0 0 0 0 0 0			_			-	90.0
0.00 0.00		0	Ō				90.0
0.00 09009 GASTROENTEROLOGY CLINIC 0 0 0 0 0 0 0 0 0		0	0			0	90.0
00. 09 09009 GASTROENTEROLOGY CLINIC 0 0 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.00000	07 09007 UROLOGY CLINIC	0	124, 890	0. 000000	0. 000000	0	90.0
0. 12 09012 0PTHAMOLOGY CLINIC 0 73,658 0.0000000 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000	09 09009 GASTROENTEROLOGY CLINIC	0			0. 000000	0	90.0
0. 13	11 09011 NEUROLOGY CLINIC	0	552, 704	0. 000000	0. 000000	0	90. 1
00. 14 09014 WOUND CARE	12 09012 0PTHAMOLOGY CLINIC	0	73, 658	0.000000	0. 000000	0	90. 1
01.00 09100 EMERGENCY 0 25,100,080 0.000000 0.000000 13,245 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 2,256,637 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		0	1, 244, 326	0. 000000	0. 000000	0	90. 1
02. 00		0	2, 108, 385	0. 000000	0. 000000	15	90. 1
OTHER REI MBURSABLE COST CENTERS		0	25, 100, 080	0. 000000		13, 245	91.0
		0	2, 256, 637	0.00000	0.00000	0	92.0
P5. 00 09500 AMBULANCE SERVI CES							
200. 00 Total (lines 50-199) 0 214, 521, 206 1, 249, 876 20	•						95.0

Health Financial Systems	WI THAM MEMORIA	AL HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCI THROUGH COSTS	LLARY SERVICE OTHER PASS	i		CCN: 150104 CCN: 15S104	Peri od: From 01/01/2014 To 12/31/2014		
			Ti tl	e XVIII	Subprovi der – I PF	PPS	
Cost Center Description	I npati ent	0u	tpati ent	Outpati ent			

			Ti tl	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Inpati ent	Outpati ent	Outpati ent	IPF		
	oost content bosci i pti on	Program	Program	Program			
		Pass-Through	Charges	Pass-Through	1		
		Costs (col. 8	onal goo	Costs (col.			
		x col. 10)		x col. 12)			
		11.00	12. 00	13.00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0		50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0		55. 00
55. 01	05501 ULTRA SOUND	0	0		0		55. 01
57.00	05700 CT SCAN	0	0		0		57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0		59. 00
60.00	06000 LABORATORY	0	0		0		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0		63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0		64. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0		67. 00
67. 01	06701 AUDI OLOGY	0	0		0		67. 01
68.00	06800 SPEECH PATHOLOGY	0	0		0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	O	0		0		69. 00
69. 01	06901 CARDI OLOGY	O	0		0		69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	327		0		73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0		90. 00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0		90. 01
90. 02	09002 CLI NI C	0	0		0		90. 02
90. 03	09003 DERMATOLOGY CLINIC	0	0		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	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	0		0		90. 14
91.00	09100 EMERGENCY	0	0		0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0		92. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50-199)	0	327		0		200. 00

Health Financial Systems				WI THAM	MEMORIAL H	IOSPI TAL			In Lie	u of Form CM	//S-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH	SERVICES A	AND	VACCI NE	COST	Provi der	CCN:	150104	od: 01/01/2014	Worksheet Part V	D
						Component	CCN	l: 15S104	12/31/2014		

Cost Center Description							5/28/2015 2:1	.7 pm
Cost Center Description				Ti tl	e XVIII	Subprovi der - I PF	PPS	
Ratio From Worksheet Services					Charges		Costs	
ANCI LLARY SERVICE COST CENTERS		Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
Part I , col. 9		·	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
No. Company			Worksheet C,	inst.)	Servi ces	Services Not		
No. Company				ĺ	Subject To	Subject To		
ANCILLARY SERVICE COST CENTERS					Ded. & Coins.	Ded. & Coins.		
ANCILLARY SERVICE COST CENTERS					(see inst.)	(see inst.)		
SO. 00			1.00	2.00		4. 00	5. 00	
S4. 00 05400 RADIOLOGY-DIAGNOSTIC 0.301481 0 0 0 0 0 55. 00	ANCI	LLARY SERVICE COST CENTERS						
55. 00 05.00 05.00 05.00 05.00 05.50 05.	50.00 0500	O OPERATING ROOM	0. 058605	0	(0	0	50. 00
55.01 05501 UITRA SOUND	54.00 0540	O RADI OLOGY-DI AGNOSTI C	0. 301481	0	(0	0	54. 00
57.00 05700 CT SCAN 0.034704 0.034704 0.058000 0.058000 0.058000 0.058000 0.058000 0.058000 0.058000 0.058000 0.058000 0.058000 0.058000 0.058000 0.0580000 0.0580000 0.0580000 0.05800000 0.058000000 0.058000000 0.0580000000 0.05800000000 0.058000000000 0.058000000000 0.05800000000 0.05800000000000 0.058000000000000 0.05800	55. 00 0550	O RADI OLOGY-THERAPEUTI C	0. 000000	0	(0	0	55. 00
58.00 05800 MARNETIC RESONANCE I MAGINC (MRI) 0. 104593 0 0 0 0 58.00 05.00 05900 CARDITAC CATHETER ZATION 0. 176827 0 0 0 0 0 59.00 06.00 06000 LABORATORY 0. 168632 0 0 0 0 0 0 63.00 06.00 06300 LABORATORY 0. 168632 0 0 0 0 0 0 0 06.00 06400 INTRAVENOUS THERAPY 0. 456743 0 0 0 0 0 0 06.00 06400 INTRAVENOUS THERAPY 0. 456743 0 0 0 0 0 0 06.00 06600 PHYSI CAL THERAPY 0. 456743 0 0 0 0 0 0 06.01 06700 0CCUPATIONAL THERAPY 0. 456743 0 0 0 0 0 0 06.01 06701 AUDIOLOGY 0. 310760 0 0 0 0 0 0 06.01 06701 AUDIOLOGY 0. 310760 0 0 0 0 0 0 06.00 06900 ELECTROCARDIOLOGY 0. 310760 0 0 0 0 0 0 07.10 06701 AUDIOLOGY 0. 310760 0 0 0 0 0 0 08.00 06900 CARDIA CARDIOLOGY 0. 000000 0 0 0 0 0 0 07.10 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 579642 0 0 0 0 0 0 0 07.20 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 579642 0 0 0 0 0 0 0 07300 DRUGS CHARGED TO PATIENTS 0. 579642 0 0 0 0 0 0 0 07300 DRUGS CHARGED TO PATIENTS 0. 117476 327 0 815 38 73 000 07000 07000 0 0 0 0 0	55. 01 0550	1 ULTRA SOUND	0. 089875	0	(0	0	55. 01
59.00 05900 CARDI AC CATHETER ZATI ON	57. 00 0570	O CT SCAN	0. 034704	0	(0	0	57. 00
60. 00 06000 LABORATORY 0. 168632 0 0 0 0 0 60. 00 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0. 216757 0 0 0 0 0 0 63. 00 64. 00 06400 INTRAVENOUS THERAPY 0. 001354 0 0 0 0 0 64. 00 66. 00 06600 PHYSICAL THERAPY 0. 456743 0 0 0 0 0 0 66. 00 67. 00 06700 0CCUPATIONAL THERAPY 0. 869820 0 0 0 0 0 0 0 0 67. 01 06701 AUDITORIAL THERAPY 0. 869820 0 0 0 0 0 0 0 0 0	58. 00 0580	O MAGNETIC RESONANCE IMAGING (MRI)	0. 104593	0	(0	0	58. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0. 216757 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	59. 00 0590	O CARDI AC CATHETERI ZATI ON	0. 176827	0	(0	0	59. 00
64. 00 06400 INTRAVENOUS THERAPY 0. 001354 0 0 0 0 64. 00 66. 00 06600 PHYSI CAL THERAPY 0. 456743 0 0 0 0 0 66. 00 67. 01 06701 OCCUPATI ONAL THERAPY 0. 869820 0 0 0 0 0 67. 00 67. 01 06701 OCCUPATI ONAL THERAPY 0. 869820 0 0 0 0 0 0 67. 01 06701 AUDI OLOGY 0. 310760 0 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0. 432942 0 0 0 0 0 0 0 69. 01 06901 ELECTROCARDI OLOGY 0. 000000 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 579642 0 0 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0. 579642 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 117476 327 0 815 38 73 70. 00 07300 DRUGS CHARGED TO PATI ENT 0. 117476 327 0 815 38 73 70. 00 07000 CLI NIC 0. 000000 0 0 0 0 0 70. 01 09001 OTHER OUTPATI ENT SERVICE COST CENTER 0. 000000 0 0 0 0 0 70. 02 09002 CLI NIC 0. 000000 0 0 0 0 0 70. 03 09003 DERMATOLOGY CLI NIC 0. 000000 0 0 0 0 0 0 70. 05 09005 SURGERY CLI NIC 0. 000000 0 0 0 0 0 70. 05 09005 SURGERY CLI NIC 0. 000000 0 0 0 0 0 70. 05 09005 SURGERY CLI NIC 0. 000000 0 0 0 0 70. 07 09007 UROLOGY CLI NIC 0. 000000 0 0 0 0 70. 08 09005 SURGERY CLI NIC 0. 000000 0 0 0 0 70. 09 09007 OSATROCHORDORY CLI NIC 0. 000000 0 0 0 0 70. 01 09001 NEUROLOGY CLI NIC 0. 0013716 0 0 0 0 70. 01 09001 NEUROLOGY CLI NIC 0. 0013716 0 0 0 0 70. 01 09001 NEUROLOGY CLI NIC 0. 0013716 0 0 0 0 70. 01 09001 NEUROLOGY CLI NIC 0. 0013716 0 0 0 0 70. 01 09001 NEUROLOGY CLI NIC 0. 0013716 0 0 0 0 70. 01 09001 NEUROLOGY CLI NIC 0. 0013716 0 0 0 0 70. 01 09001 NEUROLOGY CLI NIC 0. 0013716 0 0 0 0 70. 01 09001 NEUROLOGY CLI NI	60.00 0600	O LABORATORY	0. 168632	0	(0	0	60.00
66.00 06600 PHYSICAL THERAPY	63. 00 0630	O BLOOD STORING, PROCESSING & TRANS.	0. 216757	0	(0	0	63.00
67. 00 06700 0CCUPATI ONAL THERAPY 0.869820 0 0 0 0 0 67. 00 67. 01 06701 AUDI OLOGY 0.310760 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.432942 0 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.579642 0 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATIENT 1.293774 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.117476 327 0 815 38 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.117476 327 0 815 38 73. 00 07400 IMPL DEV. CHARGED TO PATIENTS 0.117476 327 0 815 38 73. 00 07500 IMPL DEV. CHARGED TO PATIENTS 0.117476 327 0 815 38 73. 00 07500 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 0 74. 00 07500 DRUGS CHARGED TO PATIENTS 0.117476 327 0 815 38 75. 00 07500 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 0 76. 01 09000 CLI NI C 0.000000 0 0 0 0 0 77. 00 07500 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 0 78. 01 07500 DRUGS CHARGED TO PATIENTS 0.000000 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 79. 07 09007 UROLOGY CLI NI C 0.000000 0 0 0 0 0 79. 07 09007 UROLOGY CLI NI C 0.000000 0 0 0 0 79. 07 09007 UROLOGY CLI NI C 0.000000 0 0 0 0 79. 07 09007 UROLOGY CLI NI C 0.0013716 0 0 0 0 79. 01 09001	64.00 0640	O I NTRAVENOUS THERAPY	0. 001354	0		o	0	64. 00
67. 01 66701 AUDI OLOGY	66. 00 0660	O PHYSI CAL THERAPY	0. 456743	0		o	0	66. 00
68.00 06800 SPEECH PATHOLOGY	67. 00 0670	O OCCUPATIONAL THERAPY	0. 869820	0		o	0	67. 00
69. 00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 0 0 69. 00 69. 01 06901 CARDI OLOGY 0.163656 0 0 0 0 0 0 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.579642 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 1.293774 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.117476 327 0 815 38 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.117476 327 0 815 38 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.117476 327 0 815 38 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.117476 327 0 815 38 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.117476 327 0 815 38 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 0 90. 01 09000 OTHER OUTPATIENT SERVICE COST CENTER 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 CLI NI C 0.000000 0 0 0 0 0 90. 03 09003 DERMATOLOGY CLI NI C 0.000000 0 0 0 0 0 90. 05 09005 SURGERY CLI NI C 0.000000 0 0 0 0 90. 07 09007 UROLOGY CLI NI C 0.000000 0 0 0 0 90. 07 09007 UROLOGY CLI NI C 0.000000 0 0 0 0 90. 08 09009 OSERVENTEROLOGY CLI NI C 0.000000 0 0 0 0 90. 11 09011 NEUROLOGY CLI NI C 0.000000 0 0 0 0 90. 12 09012 OPTHAMOLOGY CLI NI C 0.322925 0 0 0 0 0 90. 14 09014 WOUND CARE 0.344817 0 0 0 0 0 90. 14 09014 WOUND CARE 0.344817 0 0 0 0 0 90. 09000 OBSERVATI ON BEDS (NON-DISTINCT PART) 0.598337 0 0 0 0 0 90. 00 OPTHER REIMBURSABLE COST CENTERS 0.000000 0 0 0 90. 00 OPTHER REIMBURSABLE COST CENTERS 0.000000 0 0 0 0 90. 00 OPTHER REIMBURSABLE COST CENTERS 0.0000000 0 0 0 0 90. 00 OPTHER REIMBURSABLE COST CENTERS 0.0000000 0 0 0 0 90. 00 OPTHER REIMBURSABLE COST CENTERS 0.00000000 0 0 0 0 90. 00 OPTHE	67. 01 0670	1 AUDI OLOGY	0. 310760	0		0	0	67. 01
06901 06901 CARDI OLOGY 0.163656 0 0 0 0 0 0 0 0 0 0 71.00	68. 00 0680	O SPEECH PATHOLOGY	0. 432942	0		0	0	68. 00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.579642 0 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 1.293774 0 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.117476 327 0 815 38 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.117476 327 0 815 38 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.117476 327 0 815 38 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.117476 327 0 815 38 73.00 73.00 07400 07400 0.11	69. 00 0690	O ELECTROCARDI OLOGY	0. 000000	0		0	0	69. 00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.579642 0 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1.293774 0 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.117476 327 0 815 38 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.117476 327 0 815 38 73.00 73.00 07400 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 0 70.01 09000 CLINIC 0.000000 0 0 0 0 0 0 0	69. 01 0690	1 CARDI OLOGY	0. 163656	0		0	0	69. 01
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 1. 293774 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 117476 327 0 815 38 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 117476 327 0 815 38 73. 00 09000 CLINIC 0. 000000 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 DERIMATOLOGY CLINIC 0. 000000 0 0 0 0 0 90. 04 09004 ENT CLINIC 0. 000000 0 0 0 0 0 90. 05 09005 SURGERY CLINIC 0. 000000 0 0 0 0 0 90. 07 09007 UROLOGY CLINIC 0. 013716 0 0 0 0 90. 09 09009 GASTROENTEROLOGY CLINIC 0. 000000 0 0 0 0 90. 11 09011 NEUROLOGY CLINIC 0. 001397 0 0 0 0 90. 12 09112 OPTHAMOLOGY CLINIC 0. 322925 0 0 0 0 90. 13 09013 ALLERGY CLINIC 0. 322925 0 0 0 0 90. 14 09014 WOUND CARE 0. 344817 0 0 0 0 90. 14 09014 WOUND CARE 0. 344817 0 0 0 0 91. 00 09100 EMERGENCY 0. 221618 0 0 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 598337 0 0 0 0 97. 00 09500 AMBULANCE SERVICES 0. 486269 0 0 90. 10 Charges 0 0 0 0 90. 10 0 0 0 90. 10 0 0 0 90. 10 0 0 0 90. 10 0 0 0 90. 10 0 0 90. 10 0 0 0 90. 10 0 0 90. 10 0 0 90. 10 0 0 90. 10 0 0 90. 11 00 0 90. 12 09100 DESERVATION BEDS (NON-DISTINCT PART) 0. 598337 0 0 0 90. 10 0 0 0 90. 11 09010 Charges 0 0 0 90. 12 09100 00 00 00 00 90. 10 00 00 00 00 90. 10 00 00 00 90. 10 00 00 00 90. 10 00 00 00 90. 10 00 00 90. 10 00 00 90. 10 00 00 90. 10 00 00 90. 10 00 00 90. 10 00 00 90. 10 00 00 90. 10 00 00 90. 10 00 00 90. 10 00 00 90. 10 00 00 90. 10 00 00 90. 10 00	71. 00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENTS				0	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 117476 327 0 815 38 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 117476 327 0 815 38 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 0 0 0 0 0 0 0		l .				0	0	
90. 00 09000 CLI NI C 0.000000 0 0 0 0 0 0 0			1			815	38	73. 00
90. 00								
90. 02 09002 CLINI C 0.000000 0 0 0 0 0 90. 02 90. 03 09003 DERMATOLOGY CLINI C 0.000000 0 0 0 0 90. 03 90. 04 09004 ENT CLINI C 0.000000 0 0 0 0 0 90. 03 90. 05 09005 SURGERY CLINI C 0.000000 0 0 0 0 0 0 90. 07 09007 UROLOGY CLINI C 0.013716 0 0 0 0 90. 07 90. 09 09009 GASTROENTEROLOGY CLINI C 0.000000 0 0 0 0 90. 07 90. 11 09011 NEUROLOGY CLINI C 0.001397 0 0 0 0 90. 11 90. 12 09012 OPTHAMOLOGY CLINI C 0.322925 0 0 0 0 90. 12 90. 13 09013 ALLERGY CLINI C 0.322925 0 0 0 0 90. 13 90. 14 09014 WOUND CARE 0.143669 0 0 0 90. 14 91. 00 09100 EMERGENCY 0.221618 0 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0.598337 0 0 0 0 92. 00 07HER REI MBURSABLE COST CENTERS 0.486269 0 0 0 95. 00 0010 Charges 0.0120 0.000000 0 0 0 0 0010 ON 201. 00 0 0 0 0 0010 ON 0.000000 0 0 0 0010 ON 0.000000 0 0 0 0010 0.000000 0.000000 0 0 0010 0.0000000 0.0000000 0 0 0010 0.0000000 0.0000000 0 0 0010 0.0000000 0.0000000 0 0 0010 0.00000000 0.00000000 0 0 0010 0.000000000 0.000000000 0 0 0010 0.0000000000 0.00000000000 0 0	90. 00 0900	O CLI NI C	0. 000000	0	(0	0	90.00
90. 02 09002 CLINI C 0.000000 0 0 0 0 0 90. 02 90. 03 09003 DERMATOLOGY CLINI C 0.000000 0 0 0 0 90. 03 90. 04 09004 ENT CLINI C 0.000000 0 0 0 0 0 90. 03 90. 05 09005 SURGERY CLINI C 0.000000 0 0 0 0 0 0 90. 07 09007 UROLOGY CLINI C 0.013716 0 0 0 0 90. 07 90. 09 09009 GASTROENTEROLOGY CLINI C 0.000000 0 0 0 0 90. 07 90. 11 09011 NEUROLOGY CLINI C 0.001397 0 0 0 0 90. 11 90. 12 09012 OPTHAMOLOGY CLINI C 0.322925 0 0 0 0 90. 12 90. 13 09013 ALLERGY CLINI C 0.322925 0 0 0 0 90. 13 90. 14 09014 WOUND CARE 0.143669 0 0 0 90. 14 91. 00 09100 EMERGENCY 0.221618 0 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0.598337 0 0 0 0 92. 00 07HER REI MBURSABLE COST CENTERS 0.486269 0 0 0 95. 00 0010 Charges 0.0120 0.000000 0 0 0 0 0010 ON 201. 00 0 0 0 0 0010 ON 0.000000 0 0 0 0010 ON 0.000000 0 0 0 0010 0.000000 0.000000 0 0 0010 0.0000000 0.0000000 0 0 0010 0.0000000 0.0000000 0 0 0010 0.0000000 0.0000000 0 0 0010 0.00000000 0.00000000 0 0 0010 0.000000000 0.000000000 0 0 0010 0.0000000000 0.00000000000 0 0	90. 01 0900	1 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	0		0	0	90. 01
90. 03			0. 000000	0		0	0	90. 02
90. 04 09004 ENT CLINIC 0.000000 0 0 0 0 90. 04 90. 05 09005 SURGERY CLINIC 0.000000 0 0 0 0 90. 05 90. 07 09007 UROLOGY CLINIC 0.013716 0 0 0 0 90. 07 90. 09 09009 GASTROENTEROLOGY CLINIC 0.000000 0 0 0 0 90. 07 90. 11 09011 NEUROLOGY CLINIC 0.001397 0 0 0 0 90. 19 90. 12 09012 OPTHAMOLOGY CLINIC 0.322925 0 0 0 0 90. 12 90. 13 09013 ALLERGY CLINIC 0.143669 0 0 0 90. 13 90. 14 09014 WOUND CARE 0.344817 0 0 0 0 90. 13 91. 00 09100 EMERGENCY 0.221618 0 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.598337 0 0 0 0 92. 00 OTHER REIMBURSABLE COST CENTERS 0.486269 0 0 0 95. 00 201. 00 Clarges 0 0 0 0 0 00 0 0 0		l e	1			0	0	1
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90. 12 09012 0PTHAMOLOGY CLINIC 0. 322925 0 0 0 0 90. 12 90. 13 09013 ALLERGY CLINIC 0. 143669 0 0 0 0 90. 13 90. 14 09014 WOUND CARE 0. 344817 0 0 0 0 90. 14 91. 00 09100 EMERGENCY 0. 221618 0 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 598337 0 0 0 0 95. 00 09500 AMBULANCE SERVICES 0. 486269 0 200. 00 Subtotal (see instructions) 327 0 815 38 200. 00 201. 00 Charges 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 201. 00 0 0 0 202. 00 0 0 0 203. 00 0 0 0 204. 00 0 0 205. 00 0 0 206. 00 0 0 207. 00 0 0 208. 00 0 0 209. 12 0 0 209. 13 0 0 209. 14 0 0 209. 15 0 200. 00 0 201. 00 0 201. 00 0 201. 00 0 201. 00 0 202. 00 0 203. 00 0 204. 00 0 205. 00 0 206. 00 0 207. 00 0 208. 00 0 209. 0				l e		0	0	90. 11
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90. 14 09014 WOUND CARE 0. 344817 0 0 0 0 0 90. 14 91. 00 09100 EMERGENCY 0. 221618 0 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0. 598337 0 0 0 0 0 OTHER REIMBURSABLE COST CENTERS 0. 486269 0 95. 00 200. 00 Subtotal (see instructions) 327 0 815 38 200. 00 201. 00 Clarges 0 0 0 0 Only Charges 0 0 0 Only Charges 0 0 0 Only Charges 0 Only Charges 0						0	0	
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92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0. 598337 0 0 0 0 0 0 0 0 0			1	0		0	0	1
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95. 00				-		-	-	
200.00 Subtotal (see instructions) 327 0 815 38 200.00 201.00 Charges 0 0 0 201.00 2			0. 486269					95. 00
201.00 Less PBP Clinic Lab. Services-Program 0 0 0 201.00 Only Charges				l .			38	1
Only Charges								
]			
	202.00			327		815	38	202. 00

Health Financial Systems	WITHAM MEMORI	AL HOS	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST				Peri od: From 01/01/2014 To 12/31/2014		pared.
					10 12/01/2011	5/28/2015 2: 1	7 pm
			Ti tl	e XVIII	Subprovi der - I PF	PPS	
	Cos	sts					
Cost Center Description	Cost Reimbursed	Reir	Cost mbursed				

Cost Center Description Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00 Cost Reimbursed Servi ces Not Subject To Ded. & Coins. (see inst.)	0. 00
Reimbursed Services Subject To Ded. & Coins. (see inst.) Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 6.00 Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
Reimbursed Services Subject To Ded. & Coins. (see inst.) Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 6.00 Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
Services Subject To Ded. & Coins. (see inst.) 6.00 Services Not Subject To Ded. & Coins. (see inst.) 7.00	
Subject To Ded. & Coins. (see inst.) 6.00 Subject To Ded. & Coins. (see inst.) 7.00	
Ded. & Coins. (see inst.) (see inst.) (seo inst.)	
(see inst.) (see inst.) 6.00 7.00	
6.00 7.00	
ANCILLARY SERVICE COST CENTERS	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54	4. 00
55. 00 05500 RADI 0LOGY-THERAPEUTI C 0 0 55	5. 00
55. 01 05501 ULTRA SOUND 0 0 55	5. 01
57. 00 05700 CT SCAN 0 0	7. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 5	8. 00
	9. 00
	0. 00
	3. 00
	4.00
	6. 00
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 67	7. 00
67. 01 06701 AUDI 0LOGY 0 0 67	7. 01
68. 00 06800 SPEECH PATHOLOGY 0 0 68	8. 00
69. 00 06900 ELECTROCARDI OLOGY 0 0	9. 00
	9. 01
	1. 00
11.11	2. 00
	3. 00
	3.00
OUTPATIENT SERVICE COST CENTERS	
	0. 00
	0. 01
	0. 02
90. 03 09003 DERMATOLOGY CLINIC 0 0 90	0. 03
90. 04 09004 ENT CLINIC 0 0 90	0. 04
90. 05 09005 SURGERY CLINIC 0 0 90	0. 05
90. 07 09007 UROLOGY CLINIC 0 0 90	0. 07
	0. 09
	0. 11
	0. 11
10.10 10.00	0. 13
	0. 14
	1. 00
	2. 00
OTHER REIMBURSABLE COST CENTERS	
95. 00	5. 00
	0. 00
	1. 00
Only Charges	50
	2. 00
202.001 [100.010.300 (1.10.200) 1.110.200]	00

Health Financial Systems	WITHAM MEMORIAL H	OSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150104	Peri od: From 01/01/2014	Worksheet D-1	
			To 12/31/2014	Date/Time Prep 5/28/2015 2:1	
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					

		Title XVIII	Hospi tal	PPS	
	Cost Center Description		-	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			6, 296	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days		vate room days	6, 296 0	2. 00 3. 00
3.00	do not complete this line.). IT you have only pri	vate room days,	O	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		5, 150	4.00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through December	31 of the cost	0	5. 00
4 00	reporting period	daya) aftar Dagambar (01 of the cost	0	
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after becember s	si di the cost	0	6. 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 reporting period (if calendar year, enter 0 on this line)	days) after December 3	of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-hed and	2, 255	9. 00
7. 00	newborn days)	the ringram (exertaining	Swifing bed did	2, 200	7. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instructi Swing-bed SNF type inpatient days applicable to title XVIII onl		om dava) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, ent		Joil days) arter	U	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.00
40.00	through December 31 of the cost reporting period				40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar year			0	13. 00
14. 00	Medically necessary private room days applicable to the Program			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
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	through December 21 of	f the cost	0.00	17. 00
17.00	reporting period	thi ough becember 31 of	the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of 1	the cost	0.00	18.00
40.00	reporting period			0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 or	the cost	0. 00	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0.00	20.00
	reporting period			7 447 000	
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December		ng period (line	7, 417, 988 0	21. 00 22. 00
22.00	5 x line 17)	or the cost reporti	ng perrou (Trie	O	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reporting	g period (line 6	0	23. 00
24.00	x line 18)	21 of the cost reporting	na nariad (lina	0	24. 00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reportin	ig perrod (Trile	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
0, 00	x line 20)				0, 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I	ing 21 minus ling 26)		0 7, 417, 988	26. 00 27. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	The 21 millus Title 20)		7,417,700	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	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)	00)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	a line 22) (and instruct	ti ana)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minu		LI UIIS)	0. 00 0. 00	34. 00 35. 00
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	31)		0.00	36. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost an	d private room cost dit	ferential (line	7, 417, 988	37. 00
37.00	27 minus line 36)	a private room cost uri	recential (Title	1,411,700	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		<u>'</u>		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS				
38. 00	Adjusted general inpatient routine service cost per diem (see i	*		1, 178. 21	38. 00
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program	•		2, 656, 864 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39 +	•		2, 656, 864	
		•	'		

instructions) (title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 7. 00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 8. 00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9. 00 Total still ed nursing facility/Order nursing	<u>Heal</u> th	Financial Systems	WITHAM MEMORI	AL HOSPITAL		<u> In_</u> Lie	eu of Form CMS-2	<u> 2552-1</u> 0
Cost Center Description	COMPUT	ATION OF INPATIENT OPERATING COST		Provi der				
Cost Center Description							Date/Time Pre	
Total Total Agriculture Program Pays Prog				Ti +I	e XVIII	Hosni tal		7 pm
1.00		Cost Center Description	Total				,	
1.00 2.00 3.00 4.00 5.00 0.00		'	Inpatient Cost	Inpatient Days	Diem (col. 1		(col. 3 x col.	
			1 00	2.00		4.00		
Section Compare Content Compare Content Compare Content Compare Content Cont	42. 00	NURSERY (title V & XIX onlv)						42. 00
44.00 CROMARY CARE UNIT 45.00 DIRNA TITISSIVE CARE UNIT 45.00 DIRNA TITISSIVE CARE UNIT 45.00 DIRNA TITISSIVE CARE UNIT 45.00 DIRNA TITISSIVE CARE UNIT 45.00 DIRNA TITISSIVE CARE UNIT 45.00 DIRNA TITISSIVE CARE UNIT 45.00 DIRNA TITISSIVE CARE UNIT 45.00 DIRNA TITISSIVE CARE UNIT 45.00 DIRNA TITISSIVE CARE UNIT 45.00 DIRNA TITISSIVE CARE UNIT 45.00 DIRNA TITISSIVE CARE UNIT 45.00 DIRNA TITISSIVE CARE UNIT 45.00 DIRNA TITISSIVE CARE UNIT 45.00 DIRNA TITISSIVE CARE UNIT 45.00 DIRNA TITISSIVE CARE UNIT 45.00 Program Inpatient costs (sun of Fires 4) through 48) (see instructions) 46.00 DIRNA TITISSIVE CARE UNIT 45.00 DIRNA TITISSIVE CA		Intensive Care Type Inpatient Hospital Units						
45.00 DIRN INTERSIVE CARE UNIT 45.00			2, 281, 816	1, 487	1, 534. 5	1 763	1, 170, 831	l
46.00 SINGS CALL INTERSIVE CARE UNIT 7.00 OTHER SPECIAL CARE (SPECIFY) 1.00 7.00 OTHER SPECIAL CARE (SPECIFY) 1.00 7.00 OTHER SPECIAL CARE (SPECIFY) 1.00 7.00 OTHER SPECIAL CARE (SPECIFY) 1.00 7.00 OTHER SPECIAL CARE (SPECIFY) 1.00 7.00 OTHER SPECIAL CARE (SPECIFY) 1.00 7.00 OTHER SPECIAL CARE (SPECIFY) 7.00 OTHER S								
### ### ### ### ### ### ### ### ### ##								
1.00	47. 00							47. 00
Program inpatient ancillary service cost (Wist D-3, col. 3, line 200) 4, 299,101 49,00 1014 Program inpatient costs (sum of lines 41 through 48)(see, Instructions) 8, 066, 796 49,00 1014 Program inpatient costs (sum of lines 41 through 48)(see instructions) 8, 066, 796 49,00 1014 Program inpatient costs (sum of lines 50 and 51) Pass through costs applicable to Program inpatient ancillary services (from Wist. D. sum of Parts II and 298, 483 50,00 Pass through costs applicable to Program inpatient ancillary services (from Wist. D. sum of Parts II and 298, 483 50,00 Pass through costs applicable to Program inpatient ancillary services (from Wist. D. sum of Parts II and 199, 298, 483 50,00 Pass through costs applicable to Program inpatient ancillary services (from Wist. D. sum of Parts II and 298, 483 50,00 Pass through costs applicable to Program inpatient ancillary services (from Wist. D. sum of Parts II and 298, 483 50,00 Pass through costs applicable to Program inpatient ancillary services (from Wist. D. sum of Parts II and 298, 483 50,00 Pass through costs and 51) 35,00 70,00		Cost Center Description					1.00	
10	48. 00	Program inpatient ancillary service cost (Wks	st. D-3. col. 3	3. Line 200)				48. 00
50.00 Pass through costs applicable to Program inpatient routine services (from Wist. D. sum of Parts I and I 238.481 50.00 111) 111.00 111 111.00 111 111.00 111 111.00 111 111.00 111 111.00 111 111.00 111 111.00					ons)			1
111 115,601 51.00 Pass through costs applicable to Program inpatient ancillarly services (from Wkst. D., sum of Parts II and IV) 354,144 52.00 Total Program excludable cost (sum of lines 50 and 51) 354,144 52.00 Total Program excludable cost (sum of lines 50 and 51) 354,144 52.00 7,712,652 53.00 7,712,652 7,712,6								
15.00 Pass through costs applicable to Program inpatient and Illary services (From Wist. 0, sum of Parts II and IV) 25.00 Total Program excludable cost (sum of lines 50 and 51) 254,144 52.00 25.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 7,712,652 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 7,712,652 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 7,712,652 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 7,712,652 53.00 Total Program inpatient operating cost and target amount (line 56 minus line 53) 54.00 55.00 56.00 Total Program inpatient operating cost and target amount (line 56 minus line 53) 0.58.00 55.00 55.00 55.00 56.00 Total Program inpatient operating cost and target amount (line 56 minus line 53) 0.58.00 58.00	50.00		atient routine	services (from	n Wkst. D, sum	of Parts I and	238, 483	50.00
17.10 17.1	51. 00		atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	115, 661	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 50 OPPOrgram discharges 10 0 54,00 50 Target amount per discharge 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		and IV)		•				
medical education costs (line 49" minus line 52)				lated non rb	elcian anacth	atist and		
TARCET MADURT AND LIMIT COMPUTATION 54.00 FOrgan discharge 0.54.00 Forgan discharge 0.00 55.00 1 Forgan discharge 0.00 55.00 55.00 1 Forgan amount (Tine 54 x Line 55) 0.56.00 55.00 55.00 55.00 55.00 56.00	აა. 00			nateu, non-pny	ısıcıan anestne	ztiSt, dNU	1, 112, 052	33.00
55.00 Target amount (in E 54 x line 55) 0.00 55.00 55.00 56.00 Target amount (line 54 x line 55) 0.56.00 57.			,					
1		, 3						•
Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57.00 58.00								•
Description Description		, ,	ing cost and ta	rget amount (I	ine 56 minus I	ine 53)		
market basket 60.00 Lesser of Ilines 53/54 is 1ess than the lower of Ilines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (Iline 55) are less than expected costs (Ilines 54 x 60), or 1% of the target amount (Iline 56), otherwise enter zero (see instructions) 63.00 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) et instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) et it ex VIII only) 65.00 Medicare swing-bed SNF inpatient routine costs (Iline 64 plus Iline 65) (title XVIII only). For CAH (see instructions) 67.00 Total Medicare swing-bed NF inpatient routine costs through December 31 of the cost reporting period (See instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (Init 2 x Iline 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (Init 3 x Iline 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (Init 3 x Iline 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (Iline 67 + Iline 68) 69.00 Part III - SKILLED NURSING FACILITY, Office Routine Service cost (Iline 37) 70.00 Medical Iline Service cost (Iline 9 x Iline 71) 70.00 Medical Iline Service cost (Iline 9 x Iline 71) 70.00 Medical Iline Service cost (Iline 9 x Iline 71) 70.00 Medical Iline Service cost (Iline 9 x Iline 71) 70.00 Medical Iline Service cost (Iline 7 + Iline 2) 71.00 Medicare swing-bed NF inpatient routine service costs (Irine 7 + Iline 2) 72.00 Program capital related costs (Iline 7 + Iline 2) 73.00 Medicare swing-bed NF inpatient routine service costs (Irine 7								
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 66.00 which operating costs (line 53) are less 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) 0.62.00 Relief payment (see instructions) 0.63.00 Relief payment (see instructions) (little XVIII only) 0.63.00 Relief payment (see instructions) (little XVIII only) 0.63.00 Relief payment (see instructions) (little XVIII only) 0.65.00 Relief payment (see instructions) (little XVIII only) 0.65.00 Relief payment (see instructions) (little XVIII only) 0.65.00 Relief payment (see instructions) (little XVIII only) 0.66.00 Relief payment (see instructions) 0.67.00 (little XVIII only) 0.66.00 Relief payment (see instructions) 0.67.00	59. 00		porting period	ending 1996, u	updated and cor	mpounded by the	0.00	59. 00
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87.00 Total observation bed days (see instructions) 1,146 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,178.21 88.00	86. 00			rough 85)				86.00
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89.00 Observation bed cost (line 87 x line 88) (see instructions) 1,350,229 89.00	88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	,			1, 178. 21	88. 00
	89. 00	Ubservation bed cost (line 87 x line 88) (see	e instructions)				1, 350, 229	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		Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014	Date/Time Prep 5/28/2015 2:1	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	477, 692	7, 417, 988	0. 06439	6 1, 350, 229	86, 949	90.00
91.00 Nursing School cost	0	7, 417, 988	0.00000	0 1, 350, 229	0	91.00
92.00 Allied health cost	0	7, 417, 988	0.00000	0 1, 350, 229	0	92.00
93.00 All other Medical Education	0	7, 417, 988	0.00000	0 1, 350, 229	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: 150104	Peri od: From 01/01/2014	Worksheet D-1
	Component CCN: 15S104	To 12/31/2014	Date/Time Prepared: 5/28/2015 2:17 pm
	Title XVIII	Subprovi der -	PPS

		TI LIE AVIII	I PF	FF3	
	Cost Center Description			4.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			2, 987	1. 00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed Private room days (excluding swing-bed and observation bed days)		voto room dove	2, 987 0	2. 00 3. 00
3.00	do not complete this line.	i. IT you have only pri	vate room days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		2, 987	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	days) after December 3	R1 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becomber t	or the cost	o .	0.00
7. 00	Total swing-bed NF type inpatient days (including private room o	days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room of	Mays) after December 21	L of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	lays) arter becember 3	of the cost	U	8.00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	2, 474	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only	, (including privata re	nom days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instruction		Joili days)	U	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only	(including private ro	oom days) after	0	11. 00
12.00	December 31 of the cost reporting period (if calendar year, enti-		s seem deve)	0	12.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX of through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
44.00	after December 31 of the cost reporting period (if calendar year		,		44.00
14. 00 15. 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed of	aays)	0	
16. 00	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through December 31 of	f the cost	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of t	the cost	0. 00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0. 00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services a	after December 31 of th	ne cost	0.00	20. 00
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	21 of the cost reporti	ng poriod (line	2, 883, 087 0	
22.00	5 x line 17)	31 of the cost reporti	ng perrod (Trile	U	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3	l of the cost reporting	period (line 6	0	23. 00
24.00	X line 18)	01 of the cost managetin	na nominal (Line	0	24.00
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1 = 19$	si oi the cost reportir	ig period (Title	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
27 00	x line 20)			0	27.00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I)	ne 21 minus line 26)		0 2, 883, 087	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			27 0007 007	27.00
	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)		28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ 1	ine 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	>		0. 00	
34. 00 35. 00	Average per diem private room charge differential (line 32 minus Average per diem private room cost differential (line 34 x line	, ,	tions)	0. 00 0. 00	1
36. 00	Private room cost differential adjustment (line 3 x line 35)	J1)		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and	d private room cost dif	ferential (line	2, 883, 087	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	MENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see in			965. 21	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 3			2, 387, 930	
40. 00 41. 00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +	•		0 2, 387, 930	40. 00 41. 00
11.00	1.0ta rogram gonerar impatront routino service cost (illie 37 +		ı	2, 307, 730	1 11.00

Cumpoment COX 155104 From 01/07/2016 Distortine Prevail (12/37/2016 2.17 PPF 20/37/2016 2.17 PPF 20/		Financial Systems ATION OF INPATIENT OPERATING COST	WITHAM MEMORIAL	HOSPITAL Provider CCN	: 150104 PA	In Lie	worksheet D-1	
Cost Center Description Total Total Number of Support of Program Days (Program Days Inpatient Cost Impatient Days) (En (Co.) 1. 1 (Co.) 2) 4.00 (Co.) 3.00 WII O I F	ATTOM OF THE ATTEM OF ENATING COST			Fr	om 01/01/2014			
Cost Center Description Total Inpatient Cost Inpatient Bays Merage Per Program Bays (col. 3 x Col. 3							5/28/2015 2:1	
Inpatient Cost Inpatient Days Brown (cost. 1 - col. 2) 4.00 5.00 42.00 IMBSERY (title V & XIX only) 0 0 0.00 0.00 Intensive Care Type Inpatient Inspit at Units. 43.00 IMTRISTY CARE UNIT 0 0 0.00 0.00 INTRISTY CARE UNIT 0 0 0.00 0.00 INTRISTY CARE UNIT 0 0 0.00 0.00 WITHING CARE UNIT 0 0 0.00 0.00 AND INTRISTY CARE UNIT 0 0 0.00 0.00 BROW INTENSIVE CARE UNIT 0 0 0 0.00 0.00 BROW INTENSIVE CARE UNIT 0 0 0 0.00 0.00 BROW INTENSIVE CARE UNIT 0 0 0 0.00 0.00 BROW INTENSIVE CARE UNIT 0 0 0 0.00 0.00 BROW INTENSIVE CARE UNIT 0 0 0 0.00 0.00 BROW INTENSIVE CARE UNIT 0 0 0 0.00 0.00 0 0 0 0 0 0 0 0 0 0 0				litle XV	VIII S		PPS	
1.00 2.00 3.00 4.00 5.00		Cost Center Description				Program Days		
			·		col. 2)	4.00		
Intensive Care Type Ingetient Hospital Units Intrinsive CARE UNIT ON INTENSIVE CARE UNIT ON ON ON ON ON ON ON ON ON ON ON ON ON O	. 00	NURSERY (title V & XIX only)						42. 0
44.00 COROMARY CARF UNIT 45.00 BURNINTENIVE CARE UNIT 46.00 SURGICAL INTENISIVE CARE UNIT 47.00 CHIER SPECIAL CARE (SPECIFY) 48.00 Program inputient acroid large service cost (West. D-3, col. 3, line 200) 48.00 Program inputient acroid service cost (West. D-3, col. 3, line 200) 48.00 Program inputient acroid service (service (from West. D, sum of Parts I and 1978) 49.00 DIROS Program inputient acroid service cost (West. D-3, col. 3, line 200) 48.01 Program inputient acroid service cost (West. D-3, col. 3, line 200) 48.02 Program inputient acroid service (from West. D, sum of Parts I and 1978) 49.03 DIROS Program exclusible cost (sum of lines 50 and 51) 49.04 DIROS Program exclusible cost (sum of lines 50 and 51) 49.05 DIROS Program exclusible cost (sum of lines 50 and 51) 49.06 DIROS Program exclusible cost (sum of lines 50 and 51) 49.07 DIROS Program exclusible cost (sum of lines 50 and 51) 49.08 DIROS Program exclusible cost (sum of lines 50 and 51) 49.09 DIROS Program exclusible cost (sum of lines 50 and 51) 49.00 DIROS Program exclusible cost (sum of lines 50 and 51) 49.00 DIROS Program exclusible cost (sum of lines 50 and 51) 49.00 DIROS Program exclusible cost (sum of lines 50 and 51) 49.00 DIROS Program exclusible cost (sum of lines 50 and 51) 49.00 DIROS Program exclusible cost (sum of lines 50 and 51) 49.00 DIROS Program exclusible cost (sum of lines 50 and 51) 49.00 DIROS Program exclusible cost (sum of lines 50 and 51) 49.00 DIROS Program exclusible cost (sum of lines 50 and 51) 49.00 DIROS Program exclusible cost (sum of lines 50 and 51) 49.00 DIROS Program exclusible cost (sum of lines 50 and 51) 49.00 DIROS Program exclusible cost (sum of lines 50 and 51) 49.00 DIROS Program exclusible cost (sum of lines 50 and 51) 49.00 DIROS Program exclusible cost (sum of lines 50 and 51) 49.00 DIROS Program lines (sum of lines 50 and 51) 49.00 DIROS Program lines (sum of lines 50 and 51) 49.00 DIROS Program lines (sum of lines 50 and 51) 49.00 DIROS Program lines (sum of lines 51) 49.00 DIROS Program lines (su		Intensive Care Type Inpatient Hospital Units			0.00			1
45.00 BURN INTENSIVE CARE UNIT 4.00 SURGEACH INTENSIVE CARE UNIT 4.70 OTHER SPECIAL CARE (SPECIFY)			O	O	0.00	O	0	43. 0 44. 0
### OPTION OF THE SECONAL CARRE (SPECIFY) **OBTION OF THE SECONAL CARRE (SPECIFY) **OBTION OF THE SECONAL CARRE (SPECIFY) ### OPTION OF THE SECONAL CAR	. 00	BURN INTENSIVE CARE UNIT						45. 0
Cost Center Description 1.00								46.0
Program inpatient ancillary service cost (Wist. D-3, col. 3, line 200) 210,311 2,598,241 2,598	. 00							47.0
19.00 Intal Program inpatient costs (sum of lines 41 through 48) (see instructions) 2.599.241 2.599.241 2.599.241 2.599.251 2.								
Section Sect								1
111 111]	PASS THROUGH COST ADJUSTMENTS	V , ,	,				
5.0.0 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV) 5.0.0 Total Program excludable cost (sum of lines 50 and 51) 5.0.0 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus lines 50) 6.0.0 TARRET AMOUNT AND LINIT COMPUTATION 6.0.0 Program discharges 6.0.0 If Forgram discharges 6.0.0 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 6.0 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 6.0 Difference between adjusted inpatient operating period ending 1996, updated and compounded by the market basket 6.0 Difference between adjusted inpatient operating period ending 1996, updated and compounded by the market basket 7.0 Difference between adjusted inpatient operating period ending 1996, updated and compounded by the market basket 7.0 Difference between adjusted inpatient operating period ending 1996, updated and compounded by the market basket 8.0 Difference between adjusted inpatient operating period ending 1996, updated and compounded by the market basket 8.0 Difference between adjusted inpatient operating period ending 1996, updated and compounded by the market basket 8.0 Difference between adjusted inpatient operating to the cost reporting period (see the second of the patient operation) (ITLE 53/54 is 158 from prior year cost report, updated by the market basket 8.0 Difference between adjusted inpatient routine costs through December 31 of the cost reporting period (see instructions) (ITLE 53/54 is 158 from prior year cost strong becember 31 of the cost reporting period (See Instructions) (ITLE 54/11 only). For Dital Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (ITLE 54 III only). For Dital Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (ITLE 54 III only). Swing-bed SNF inpatient routi		0	atient routine se	rvices (from Wk	st. D, sum o	f Parts I and	137, 802	50.0
12.00 Total Program excludable cost (sum of Flines 50 and 51) 12.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52) 12.00 Program discharges 12.454,578 12.00 Program discharges 13.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 2.454,578 13.00 Program discharges 13.00 Total Program discharges 13.00 Total Program discharges 13.00 Total Program discharges 13.00 Total Program discharges 13.00 Total Program discharges 13.00 Target amount per discharge 13.00 Total Program discharges 13.00 Total Program	- 1	,	atient ancillary	services (from \	Wkst. D, sum	of Parts II	5, 861	51.0
10 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 40 minus line 52) 14.00 Program of scharges 15.00 Program of scharges 15.00 Program of scharges 15.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 16.00 Total Rose payment (see instructions) 17.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 18.00 Bonus payment (see instructions) 19.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 19.00 Lesser of lines 53/54 or 55 from the cost report, updated by the market basket 19.00 Lesser of lines 53/54 or 55 from the cost report, updated by the market basket 19.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 19.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 19.00 Lesser of lines 53/54 or 55 from search cost report, updated by the market basket 19.00 Lesser of lines 53/54 or 55 from search cost report, updated by the market basket 19.00 Lesser of lines 53/54 or 55 from search cost report, updated by the market basket 19.00 Lesser of lines 53/54 or 55 from search cost report, updated by the market basket 19.00 Lesser of lines 53/54 or 55 from search cost search costs (lines 54 × 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 19.00 Lesser of lines 53/54 or 55 from the cost reporting period (see lines tructions) lines 19.00 Lesser of 19.00			50 and E1)				140 (/)	E2 0
medical education costs (iine 49 minus line 52) TARGET AMOUNT AMO LINT COMPUTATION 6.00 Program discharges 6.00 Target amount (line 54 x line 55) 6.00 Target amount per discharge 6.00 Target amount (line 54 x line 55) 7.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 8.00 Bonus payment (see instructions) 8.00 Bonus payment (see instructions) 8.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 8.00 Lesser of lines 53/54 or 55 from the cost report, updated by the market basket 8.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 8.00 Lesser of lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target mount (line 56), otherwise enter zero (see Instructions) 8.00 All allowable in Inpatient cost plus increntive payment (see instructions) 8.00 Allowable in Inpatient oast plus increntive payment (see instructions) 8.00 Allowable in Inpatient routine costs through December 31 of the cost reporting period (See instructions) (it is XVIII only) 8.00 Modicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (it is XVIII only) 8.00 Total decre swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (Instructions) (It is XVIII only) 8.00 Total for exwing-bed SNF inpatient routine costs through December 31 of the cost reporting period (Instructions) (It is XVIII only) 8.01 Title V or XIX swing-bed NF inpatient routine costs (Irine 64 plus line 65) (Itile XVIII only) 8.02 Total title V or XIX swing-bed NF inpatient routine costs (Irine 64 plus line 65) (Irine 37) 8.03 Total title V or XIX swing-bed NF inpatient routine costs (Irine 67 + Irine 68) 9.04 Total title V or XIX swing-bed NF inpatient routine costs (Irine 79 + Irine 58)			,	ted, non-physici	ian anesthet	ist, and		1
9.4 0.0 Program discharges 5.0 0 Target amount per discharge 5.0 0 Target amount (line 54 x line 55) 6.0 0 Target amount (line 54 x line 55) 6.0 0 Target amount (line 54 x line 55) 6.0 0 Target amount (see instructions) 6.0 0 Especial of the see instructions 6.0 0 Especial of line 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 6.0 0 Elesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 6.0 0 Elesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 6.1 0 Elesser of lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 6.2 0 Relief payment (see instructions) 6.3 0 Allowable Inpatient cost plus incentive payment (see instructions) 6.4 0 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (tile XVIII only) 6.5 0 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (tile XVIII only). For CAH (see instructions) 6.7 0 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (tile XVIII only). For CAH (see instructions) 6.7 0 Total tile V or XIX swing-bed NF inpatient routine costs (line 64 plus line 65) (tile XVIII only). For CAH (see instructions) 6.7 0 Total tile V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 7.0 0 Total tile V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 7.0 0 Total tile V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 7.0 0 Total tile V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 7.0 0 Total tile Of the swing special patient routine service costs (line 77 + line 79) 7.0 0 Medically necessary private room cost applicable to Program (line 14 x line 35) 7.0 0 Total tile Of the swing special p		medical education costs (line 49 minus line 5				·		
0.00 1 2 2 2 3 3 3 3 3 3 3							1 0	54. 0
0 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 Difference between adjusted inpatient operating cost and target amount (line 56). Both of the same of 100 Differenc	. 00	Target amount per discharge						
Bonus payment (see instructions) Bonus			ng oost and tang	ot omount (line	E/ minus li	no E2)		
Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket basket 0.00					1			
Description Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	. 00	Lesser of lines 53/54 or 55 from the cost rep	oorting period en	di ng 1996, upda	ted and comp	ounded by the	0.00	59. 0
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) Relief payment (see instructions)	1		cost report upda	ted by the mark	et basket		0.00	60.0
amount (Line 56), otherwise enter zero (see instructions) 20 Relief payment (see instructions) Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST 44.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 55.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 56.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 57.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 58.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 59.00 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/MR ONLY 70.00 Medicare inpatient routine service cost (line 70 + line 2) 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 75 + line 2) 77.00 Program capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 9 x line 77) 78.00 Inpatient routine service cost fer oxesse costs (from provider records) 78.00 Inpatient routine service cost (see instructions) 78.00 Inpatient routine service cost (see instructions) 78.00 Total Program inpatient ancillary services (see instructions) 78.00 Total Program inpatient ov	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					1		
Relief payment (see instructions) A lowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST 4.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 5.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 6.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 6.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 6.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 6.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 6.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 6.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 6.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 7.00 Skilled nursing facility/other nursing facility/ICF/MF routine service cost (line 37) 7.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 7.00 Total Program general inpatient routine service costs (line 72 + line 73) 7.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 7.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 7.00 Per diem capital-related costs (line 75 + line 2) 7.00 Program routine service cost (line 9 x line 70) 7.01 Program routine service cost (line 9 x line 70) 7.02 Program routine service cost (line 9 x line 70) 7.03 Program routine service cost (line 9 x line 70) 7.04 Program routine service cost (line 14 x line 35) 7.05 Program routine service cost (li				(lines 54 x 60)	, or 1% of t	he target		
PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 55. 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 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 through December 31 of the cost reporting period (line 12 x line 19) 88. 00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 99. 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/MR ONLY Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37) 71. 00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) Program routine service cost (line 9 x line 71) 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 (from Worksheet B, Part II, column 26, line 45) 75. 00 Capital-related costs (line 9 x line 2) Per diem capital-related costs (line 75 ± line 2) 77. 00 Program capital -related costs (line 7 x line 2) 78. 00 Capital-related costs (line 9 x line 76) 19. 10 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 19. 10 Aggregate charges to beneficiaries for excess costs (from provider records) 10. 10 Inpatient routine service cost see instructions) 10 Total Program inpatient ancillary services (see instructions) 10 Total Program inpatient ancillary service costs (see inst	1	· · · · · · · · · · · · · · · · · · ·	ristructrons)				0	62.0
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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 Total observation bed days (see instructions)	. 00	Inpatient routine service cost per diem limit	tati on			,,,		81.0
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)		•	· · · · · · · · · · · · · · · · · · ·					82.0
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)		•	· · · · · · · · · · · · · · · · · · ·					83. C
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 0 8	. 00	Utilization review - physician compensation	(see instructions					85.0
87.00 Total observation bed days (see instructions) 0 8	- +			ugh 85)				86. 0
	-						0	87. 0
	. 00	Adjusted general inpatient routine cost per o	diem (line 27 ÷ l	ine 2)				

Health Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component		From 01/01/2014 To 12/31/2014		
		Ti tl	e XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	166, 385	2, 883, 087	0. 05771	1 0	0	90. 00
91.00 Nursing School cost	0	2, 883, 087	0.00000	0 0	0	91.00
92.00 Allied health cost	0	2, 883, 087	0.00000	0	0	92.00
93.00 All other Medical Education	0	2, 883, 087	0. 00000	o o	0	93. 00

Health Financial Systems	WITHAM MEMORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN:		Period: From 01/01/2014	Worksheet D-1	
			To 12/31/2014	Date/Time Prep 5/28/2015 2:1	
	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)				6, 296	1. 00
			1		

Internation Internation International		III e XIX Hospital	Cost	
Impaction Application Ap		Cost Center Description	1 00	
IMPARTERN DAYS 1.00 Impartient days (including private room days and swing-bed days, excluding needorm) 6,206 1.00 Impartient days (including private room days, excluding swing-bed and nebborn days) 3.20 2.00		PART I - ALL PROVIDER COMPONENTS	1.00	
Impatient days (Including private room days, excluding safing-bed and newborn days) 0,290 2,000 3,000 Private room days, excluding safing-bed and observation bed days) 1 you have not private room days. 0,300 3,000 Private room days (Including private room days) 1,100 1,10		INPATIENT DAYS		
Private room days (excluding swing-bed and observation bed days) If you have only private room days. 0 3.00				1. 00
do not complete this line. 4. 00 Sell-private room days (excluding swing-bed and observation bed days) 5. 00 Intal swing-bed SN type inpatient days (including private room days) after December 31 of the cost 7. 00 Total swing-bed SN type inpatient days (including private room days) after December 31 of the cost 7. 00 Total swing-bed SN type inpatient days (including private room days) after December 31 of the cost 7. 00 Total swing-bed SN type inpatient days (including private room days) after December 31 of the cost 8. 00 Total swing-bed SN type inpatient days (including private room days) after December 31 of the cost 9. 00 Total swing-bed SN type inpatient days (including private room days) after December 31 of the cost 10. 00 Swing-bed SN type inpatient days (including private room days) after December 31 of the cost 10. 00 Swing-bed SN type inpatient days applicable to title XVIII only (including private room days) after 10. 00 Swing-bed SN type inpatient days applicable to title XVIII only (including private room days) after 11. 00 Swing-bed SN type inpatient days applicable to title XVIII only (including private room days) after 12. 00 Swing-bed SN type inpatient days applicable to title XVIII only (including private room days) after 13. 00 Swing-bed SN type inpatient days applicable to title XVIII only (including private room days) after 14. 00 Swing-bed SN type inpatient days applicable to title XVIII only (including private room days) 15. 00 Swing-bed SN type inpatient days applicable to title XVIII only (including private room days) 16. 00 Swing-bed SN type inpatient days applicable to title XVIII only (including private room days) 17. 00 Swing-bed N type inpatient days applicable to title XVIII only (including private room days) 18. 00 Swing-bed N type inpatient days applicable to title XVIII only (including private room days) 18. 00 Swing-bed N type inpatient days applicable to title XVIII only (including private room days) 18. 00 Swing-bed N type inpatient days applicable to ti				
Semi_private room days (excluding swing-ted and observation bed days) 5,500 Total swing-bed SM type inpartient days (including private room days) after December 31 of the cost reporting period 7,000	3.00		0	3.00
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Total swing-bed SNF type inpatient days (including private room days) after becember 31 of the cost reporting period (if c fealendar year, enter 0 on this line)				5. 00
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PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY 70. 00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37) 71. 00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72. 00 73. 00 74. 00 75. 00 Total Program general inpatient routine service costs (line 72 + line 73) 75. 00 76. 00 77. 00 78. 00 79. 00 7	40.00	1 '	couting costs /	(lino 47 : li	no 40)				40 00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 Total Program general inpatient routine service costs (line 72 + line 73) 74.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Program capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 77.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.01 Inpatient routine service cost per diem limitation 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 Utilization review - physician compensation (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 71.00 72.00 72.00 72.00 73.00 73.00 74.00	09.00								09.00
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) 73.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 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) 79.00 Total Program routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 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) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Inpatient routine service cost per diem (line 27 ÷ line 2)	70. 00		,			37)			1
73.00 74.00 75.00 76.00 76.00 77.00 77.00 78.00 78.00 78.00 79.00 79.00 79.00 79.00 79.00 79.00 70.00		, ,		ine 70 ÷ lir	ie 2)				
74.00 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 78 × line 76) Rould Inpatient routine service cost (from provider records) Rould Program routine service costs (from provider records) Rould Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Rould Program routine service cost per diem limitation Rould Inpatient routine service cost per diem limitation Rould Reasonable inpatient routine service costs (see instructions) Rould Reasonable inpatient routine service costs (see instructions) Rould Rou	73. 00			m (line 14 x	line 35)				
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 Inpatient routine service cost (line 74 minus line 77) 80.00 Aggregate charges to beneficiaries for excess costs (from provider records) 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) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 70 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1, 178.21 88.00	74. 00	Total Program general inpatient routine serv	ce costs (line	e 72 + line 7	(3)				74. 00
76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 77.00 Inpatient routine service cost (line 74 minus line 77) 78.00 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) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Inpatient routine captient routine cost per diem (line 27 ÷ line 2) 88.00	75. 00	'	routine service	e costs (from	Worksheet	B, Pa	rt II, column		75.00
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) 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 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 17.178.21 88.00	76. 00		ne 2)						76. 00
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 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Program inpatient ancillary services (see instructions) 83.00 Willization review - physician compensation (see instructions) 84.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 PRO NO NO NO NO NO NO NO NO NO NO NO NO NO	77. 00	, ,	,						
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Willization review - physician compensation (see instructions) 83.00 Total Program inpatient operating costs (sum of lines 83 through 85) 84.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 80.00 Inpatient routine 79 minus line 79) 81.00 St. 00 OBLOGRAM SED OBLOG		1 .		arovi don noce	urde)				
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 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 81.00 Sec. 00 82.00 Algorithm (line service cost per diem limitation 82.00 Sec. 00 82.00 Sec. 00 83.00 Sec. 00 84.00 Sec. 00 85.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Sec. 00 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00						8 minus	s line 79)		1
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 Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,178.21 88.00	81. 00	Inpatient routine service cost per diem limit	tati on		, ,		• •		81. 00
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	82.00	1		* .					
85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 1,178.21 88.00 88.00		1		15)					1
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 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,178.21 88.00	85. 00	, , , , , , , , , , , , , , , , , , , ,		ons)					
87.00 Total observation bed days (see instructions) 1,146 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,178.21 88.00	86. 00	Total Program inpatient operating costs (sum	of lines 83 th						86. 00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,178.21 88.00	87 00							1 1/4	87 00
89.00 Observation bed cost (line 87 x line 88) (see instructions) 1,350,229 89.00	88. 00	1		: line 2)				1, 178. 21	88. 00
	89. 00	Observation bed cost (line 87 x line 88) (see	e instructions))				1, 350, 229	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 CCN: 150104		Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014	Date/Time Prep 5/28/2015 2:1	
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	477, 692	7, 417, 988	0. 06439	6 1, 350, 229	86, 949	90.00
91.00 Nursing School cost	0	7, 417, 988	0.00000	0 1, 350, 229	0	91.00
92.00 Allied health cost	0	7, 417, 988	0.00000	0 1, 350, 229	0	92.00
93.00 All other Medical Education	0	7, 417, 988	0. 00000	0 1, 350, 229	0	93. 00

Health Financial Systems	WITHAM MEMORIAL	ΗΟςρι ΤΔΙ		In lie	eu of Form CMS-2	2552_10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	WI THAW WEWORTAL		CCN: 150104	Peri od:	Worksheet D-3	
				From 01/01/2014		
				To 12/31/2014	Date/Time Prep 5/28/2015 2:1	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description			Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS				2, 067, 532		30.00
31. 00 03100 I NTENSI VE CARE UNIT				1, 489, 614		31.00
40. 00 04000 SUBPROVI DER - 1 PF				0		40.00
41. 00 04100 SUBPROVI DER - I RF				0		41.00
42. 00 04200 SUBPROVI DER				0		42.00
43. 00 04300 NURSERY						43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM			0. 05860	2, 757, 997	161, 632	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 30148	946, 312	285, 295	54.00
EE OO OEEOO DADIOLOGY THEDADELITIC			0 00000	امر		EE 00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 150104	Peri od:	Worksheet D-3	3
	Component CCN: 15S104	From 01/01/2014 To 12/31/2014	Date/Time Pre 5/28/2015 2:1	
	Title XVIII	Subprovi der -	PPS	
Cost Center Description	Ratio of Co To Charge	st Inpatient	Inpatient Program Costs (col. 1 x col.	
	1.00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF		0 0 2, 460, 185		30. 0 31. 0 40. 0
41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY 04300 NURSERY OF COST CENTERS		0		41. 0 42. 0 43. 0
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	0.058	605 131	8	50.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 301 0. 000	481 95, 859 000 0	28, 900 0	54. 0 55. 0
55. 01 05501 ULTRA SOUND 57. 00 05700 CT SCAN	0. 089 0. 034		0	
58. 00 05700 CT 30AN 58. 00 05800 MAGNETI C RESONANCE MAGING (MRI)	0. 104		1	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 176			59. 0
60. 00 06000 LABORATORY	0. 168			
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 64.00 06400 INTRAVENOUS THERAPY	0. 216 0. 001		0 7	
66. 00 06600 PHYSI CAL THERAPY	0. 456			
67. 00 06700 OCCUPATI ONAL THERAPY	0. 869			
67. 01 06701 AUDI OLOGY	0. 310	760 0	0	1 .
68. 00 O6800 SPEECH PATHOLOGY	0. 432			1
69. 00 06900 ELECTROCARDI OLOGY	0.000		0	
69.01 06901 CARDIOLOGY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 163 0. 579			1
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1. 293		0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 117		64, 771	
OUTPATIENT SERVICE COST CENTERS	0.000	000	1 0	00.6
90.00 09000 CLINIC 90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0. 000 0. 000			
90. 02 09002 CLINI C	0.000			1
90. 03 09003 DERMATOLOGY CLINIC	0.000			
90. 04 09004 ENT CLINIC	0.000		0	90. (
00. 05 09005 SURGERY CLI NI C	0.000	000	0	90.
0. 07 09007 UROLOGY CLI NI C	0. 013			
20. 09 09009 GASTROENTEROLOGY CLINIC	0.000			
00. 11 09011 NEUROLOGY CLINIC	0.001			
PO. 12 09012 0PTHAMOLOGY CLINIC PO. 13 09013 ALLERGY CLINIC	0. 322 0. 143		1	
90. 14 09014 WOUND CARE	0. 143		1	
91. 00 09100 EMERGENCY	0. 221			1
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 598			
OTHER REIMBURSABLE COST CENTERS			ı	
05.00 09500 AMBULANCE SERVICES 000.00 Total (sum of lines 50-94 and 96-98)		1 249 876	210 311	95.
	l l	1 /49 8/6		

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

1, 249, 876 0

1, 249, 876

210, 311 200. 00 201. 00 202. 00

200.00 201.00 202. 00

	Financial Systems	WITHAM MEMORIAL HOSPITAL			u of Form CMS-2	
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150104	Peri od:	Worksheet D-3	
				From 01/01/2014 To 12/31/2014	Date/Time Pre 5/28/2015 2:1	pared:
		Ti t	le XIX	Hospi tal	Cost	, p
	Cost Center Description		Ratio of Cos		Inpati ent	
	·		To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS			1 000 7/0		
30.00	03000 ADULTS & PEDIATRICS			1, 283, 768		30.00
31. 00	03100 NTENSI VE CARE UNI T			73, 725		31.00
	04000 SUBPROVI DER - I PF			0		40.00
41. 00	04100 SUBPROVI DER - I RF			0		41.00
	04200 SUBPROVI DER			200 505		42.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS			290, 595		43.00
50. 00	05000 OPERATING ROOM		0. 05860	172, 922	10, 134	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 03800		12, 609	1
	05500 RADI OLOGY-THERAPEUTI C		0. 00000		12,009	1
55. 01	05501 ULTRA SOUND		0. 08987		1, 361	
	05700 CT SCAN		0. 03470	·	3, 206	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 10459		430	
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 17682	·	8, 182	
60.00	06000 LABORATORY		0. 16863	·	44, 385	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0. 21675		5, 021	
64. 00	06400 I NTRAVENOUS THERAPY		0. 00135		69	
66. 00	06600 PHYSI CAL THERAPY		0. 45674		4, 046	66.00
67. 00	06700 OCCUPATI ONAL THERAPY		0. 86982	0 4, 859	4, 226	67.00
67. 01	06701 AUDI OLOGY		0. 31076	0 0	0	67. 01
68. 00	06800 SPEECH PATHOLOGY		0. 43294	2 640	277	68.00
69. 00	06900 ELECTROCARDI OLOGY		0. 00000	0 0	0	69.00
69. 01	06901 CARDI OLOGY		0. 16365	6 85, 856	14, 051	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 57964	2 122, 185	70, 824	
	07200 I MPL. DEV. CHARGED TO PATIENT		1. 29377		0	
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 11747	6 209, 258	24, 583	73.00
	OUTPATIENT SERVICE COST CENTERS					
90. 00	09000 CLI NI C		0. 00000		0	
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER		0. 00000		0	90. 01
	09002 CLINIC		0.00000		0	90. 02
	09003 DERMATOLOGY CLINIC		0.00000		0	
90. 04	09004 ENT CLINIC		0.00000		0	
90. 05 90. 07	09005 SURGERY CLINIC		0.00000		0	90.05
	09007 UROLOGY CLINIC		0. 01371		0 0	90.07
90. 09 90. 11	O9009 GASTROENTEROLOGY CLINIC O9011 NEUROLOGY CLINIC		0. 00000 0. 00139		0	90. 09 90. 11
	09011 NEUROLOGY CLINIC		0. 32292		0	
90. 12	09013 ALLERGY CLINIC		0. 32242		0	
00.13	00014 WOUND CARE		0. 14300		0	

223, 206 200. 00

19, 795

19

89, 320

1, 230, 746

1, 230, 746

90. 14

91.00

92.00

95.00

201. 00

202. 00

0. 344817

0. 221618

0. 598337

09014 WOUND CARE

09100 EMERGENCY

09500 AMBULANCE SERVICES

OTHER REIMBURSABLE COST CENTERS

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (sum of lines 50-94 and 96-98)

Net Charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

90. 14

91.00

92.00

95.00

200.00

201.00

202.00

				From 01/01/2014 To 12/31/2014	Part A Date/Time Pre 5/28/2015 2:1	pared: 7 pm
		Ti tl	e XVIII	Hospi tal	PPS	
	DADT A LANDATIENT HOODITAL CERVILOGO UNDER LADO		0	1.00	2. 00	
1. 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0		1.00
1. 01	DRG amounts other than outlier payments for discharges occurrin	g prior		4, 020, 041		1. 01
1. 02	to October 1 (see instructions) DRG amounts other than outlier payments for discharges occurrin	a on or		1, 340, 014		1. 02
	after October 1 (see instructions)			1,010,011		
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			0		1. 03
1.04	DRG for federal specific operating payment for Model 4 BPCI for			0		1. 04
2.00	discharges occurring on or after October 1 (see instructions) Outlier payments for discharges. (see instructions)			19, 372		2.00
2. 01	Outlier reconciliation amount			0		2. 01
2. 02 3. 00	Outlier payment for discharges for Model 4 BPCI (see instructio Managed Care Simulated Payments	ns)		0		2. 02 3. 00
4.00	Bed days available divided by number of days in the cost report	i ng		64. 86		4. 00
	period (see instructions)					1
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most	recent		0.00		5.00
	cost reporting period ending on or before 12/31/1996. (see instr	uctions)				
6. 00	FTE count for allopathic and osteopathic programs which meet th criteria for an add-on to the cap for new programs in accordance			0.00		6. 00
	CFR 413.79(e)					
7. 00	MMA Section 422 reduction amount to the IME cap as specified un CFR $\S412.105(f)(1)(iv)(B)(1)$	der 42		0.00		7. 00
7. 01	ACA Section 5503 reduction amount to the IME cap as specified u			0.00		7. 01
	CFR $\S412.105(f)(1)(iv)(B)(2)$ If the cost report straddles July then see instructions.	1, 2011				
8.00	Adjustment (increase or decrease) to the FTE count for allopath			0.00		8. 00
	osteopathic programs for affiliated programs in accordance with 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67					
	(August 1, 2002).					
8. 01	The amount of increase if the hospital was awarded FTE cap slot section 5503 of the ACA. If the cost report straddles July 1, 2			0.00		8. 01
	instructions.	011, 366				
8. 02	The amount of increase if the hospital was awarded FTE cap slot closed teaching hospital under section 5506 of ACA. (see instru			0.00		8. 02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines			0.00		9. 00
10. 00	and 8,02) (see instructions) FTE count for allopathic and osteopathic programs in the curren	t vear		0.00		10.00
10.00	from your records	t your				
11. 00 12. 00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)			0. 00 0. 00		11. 00
13. 00	Total allowable FTE count for the prior year.			0.00		13. 00
14. 00	Total allowable FTE count for the penultimate year if that year	ended on		0.00		14. 00
15. 00	or after September 30, 1997, otherwise enter zero. Sum of lines 12 through 14 divided by 3.			0.00		15. 00
16. 00	Adjustment for residents in initial years of the program			0.00		16. 00
17. 00 18. 00	Adjusment for residents displaced by program or hospital closur Adjusted rolling average FTE count	е		0. 00 0. 00		17. 00 18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).			0. 000000		19. 00
20. 00 21. 00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0.000000		20.00
21.00	IME payment adjustment (see instructions)			0.000000		21. 00 22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)	400 6 1		0		22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for Section Number of additional allopathic and osteopathic IME FTE residen		ne MMA	0.00		23. 00
04.00	slots under 42 Sec. 412.105 (f)(1)(iv)(C).	•				
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the Lo	wer of		0. 00 0. 00		24. 00 25. 00
	line 23 or line 24 (see instructions)					
26. 00 27. 00	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)			0. 000000 0. 000000		26. 00 27. 00
28. 00	IME add-on adjustment amount (see instructions)			0		28. 00
28. 01 29. 00	IME add-on adjustment amount - Managed Care (see instructions) Total IME payment (sum of lines 22 and 28)			0		28. 01 29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0		29. 01
20.00	Disproportionate Share Adjustment	lont d-:::		0 74		20.00
30. 00	Percentage of SSI recipient patient days to Medicare Part A pat (see instructions)	rent days	1	3. 71		30.00
31.00	Percentage of Medicaid patient days (see instructions)			24. 48		31.00
32. 00 33. 00	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)			28. 19 12. 00		32. 00 33. 00
34. 00	, , , , , , , , , , , , , , , , , , , ,			160, 802		34. 00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Pre 5/28/2015 2:1	
		Title XVIII	Hospi tal	PPS	
			Prior to	On/After	
			October 1	October 1	
		0	1. 00	2. 00	
	Uncompensated Care Adjustment		T =		
35. 00	Total uncompensated care amount (see instructions)			7, 647, 644, 855	
35. 01	Factor 3 (see instructions)		0. 000059567	0. 000056846	1
35. 02	Hospital uncompensated care payment (If line 34 is zero,		538, 863	434, 737	35. 02
	enter zero on this line) (see instructions)				
35. 03	Pro rata share of the hospital uncompensated care payment		403, 040	109, 578	35. 03
	amount (see instructions)		540 (40		
36. 00	Total uncompensated care (sum of columns 1 and 2 on line		512, 618		36. 00
	35.03)				
	Additional payment for high percentage of ESRD beneficiary di	ischarges (Lines 40 through	ի 46)		
40. 00	Total Medicare discharges on Worksheet S-3, Part I		0		40. 00
	excluding discharges for MS-DRGs 652, 682, 683, 684 and				
44 00	685 (see instructions)				14 00
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652,		٩		41.00
11 01	682, 683, 684 an 685. (see instructions)				41 01
41. 01	Total ESRD Medicare covered and paid discharges excluding		٩		41. 01
42.00	MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0.00		12 00
42. 00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42. 00
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,				43.00
75.00	682, 683, 684 an 685. (see instructions)		"		-3.00
44. 00	Ratio of average length of stay to one week (line 43		0. 000000		44.00
TT. UU	divided by line 41 divided by 7 days)		0.000000		-4.00
45. 00	Average weekly cost for dialysis treatments (see		0.00		45. 00
	instructions)		0.00		.5. 50
46. 00	Total additional payment (line 45 times line 44 times line		0		46. 00
10.00	41.01)				10.00
47. 00	Subtotal (see instructions)		6, 052, 847		47. 00
48. 00	Hospital specific payments (to be completed by SCH and		0, 002, 017		48. 00
10. 00	MDH, small rural hospitals only. (see instructions)				10.00
49. 00	Total payment for inpatient operating costs (see		6, 052, 847		49.00
17.00	instructions)		0,002,017		'''
50. 00	Payment for inpatient program capital (from Wkst. L, Pt. I		433, 555		50.00
	and Pt. II, as applicable)		,		
51.00	Exception payment for inpatient program capital (Wkst. L,		o		51.00
	Pt. III, see instructions)				
52. 00	Direct graduate medical education payment (from Wkst. E-4,		o		52.00
	line 49 see instructions).				
53.00	Nursing and Allied Health Managed Care payment		o		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,		0		55.00
	line 69)				
56. 00	Cost of physicians' services in a teaching hospital (see		0		56. 00
	intructions)				
57. 00	Routine service other pass through costs (from Wkst. D,		0		57.00
	Pt. III, column 9, lines 30 through 35).				
58. 00	Ancillary service other pass through costs from Wkst. D,		0		58. 00
	Pt. IV, col. 11 line 200)				
59. 00	Total (sum of amounts on lines 49 through 58)		6, 486, 402		59. 00
60.00	Primary payer payments		3, 538		60.00
61. 00	Total amount payable for program beneficiaries (line 59		6, 482, 864		61.00
	minus line 60)				
62. 00	Deductibles billed to program beneficiaries		790, 112		62. 00
63. 00	Coinsurance billed to program beneficiaries		3, 040		63. 00
64. 00	Allowable bad debts (see instructions)		36, 409		64. 00
65. 00	Adjusted reimbursable bad debts (see instructions)		23, 666		65. 00
66. 00	Allowable bad debts for dual eligible beneficiaries (see		21, 366		66. 00
	instructions)				
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		5, 713, 378		67. 00
68. 00	Credits received from manufacturers for replaced devices		0		68. 00
	for applicable to MS-DRGs (see instructions)				
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and		0		69. 00
70.00	96). (For SCH see instructions)				70.00
70.00	PER PS&R		-1, 189		70.00
70. 50	RURAL DEMONSTRATION PROJECT		0		70. 50
70. 89	Pioneer ACO demonstration payment adjustment amount (see		0		70. 89
70.0-	instructions)				70 -
70. 90	HSP bonus payment HVBP adjustment amount (see		0		70. 90
70.01	instructions)				70.01
70. 91	HSP bonus payment HRR adjustment amount (see instructions)		0		70. 91
	Bundled Model 1 discount amount (see instructions)		0		70. 92
	HVBP payment adjustment amount (see instructions)		6, 747		70. 93
	HRR adjustment amount (see instructions)		-1, 600		70. 94
	Recovery of accelerated depreciation		ام		70. 95

Heal th	Financial Systems WITHAM MEMORI	IAL HOS	SPI TAL		In Lie	eu of Form CMS-:	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 1		Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Pre 5/28/2015 2:1	
			Title XVII	1	Hospi tal	PPS	
					Prior to	On/After	
					October 1	October 1	
			0		1. 00	2. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)			201	401, 135		70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)			201	169, 177		70. 97
70. 98	Low Volume Payment-3				0		70. 98
70. 99	HAC adjustment amount (see instructions)				21, 037		70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)				6, 266, 611		71. 00
71. 01	Sequestration adjustment (see instructions)				125, 332		71. 01
72.00	Interim payments				6, 076, 310		72. 00
73.00	Tentative settlement (for contractor use only)				0		73.00
74. 00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)				64, 969		74. 00
75. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				1, 885, 574		75. 00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)						
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)				0		90.00
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0		91.00
92. 00	Operating outlier reconciliation adjustment amount (see instructions)				0		92.00
93. 00	Capital outlier reconciliation adjustment amount (see instructions)				0		93. 00
94. 00	The rate used to calculate the time value of money (see instructions)				0.00		94. 00
95. 00	Time value of money for operating expenses (see instructions)				0		95. 00
96. 00	Time value of money for capital related expenses (see instructions)				0		96. 00

[TIISTI UCTI OIIS]			1
	Prior to 10/1	On/After 10/1	
	1. 00	2. 00	
HSP Bonus Payment Amount			
100.00 HSP bonus amount (see instructions)	C	0	100. 00
HVBP Adjustment for HSP Bonus Payment			
101.00 HVBP adjustment factor (see instructions)	C	0	101. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	C	0	102. 00
HRR Adjustment for HSP Bonus Payment			
103.00 HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	C	0	104. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet E
From 01/01/2014	Part A Exhibit 4
To 12/31/2014	Date/Time Prepared:
5/28/2015 2:17 pm	Provi der CCN: 150104

					'	0 12/31/2014	5/28/2015 2:1	
					e XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Peri od Pri or	Peri od	Total (Col 2	
		line 0	E, Part A) 1.00	Entitlement 2.00	to 10/01 3.00	On/After 10/01 4.00	through 4) 5.00	
1. 00	DRG amounts other than outlier	1. 00	1.00	2.00	3.00		0.00	1. 00
00	payments	00		ŭ	, and the second			
1. 01	DRG amounts other than outlier payments for discharges	1. 01	4, 020, 041	0	4, 020, 041	0	4, 020, 041	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	1, 340, 014	0	0	1, 340, 014	1, 340, 014	1. 02
1. 03	1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	0	0	0	1. 03
1. 04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1. 04	0	O O	0	0	0	1. 04
2. 00	October 1 Outlier payments for	2. 00	19, 372	0	14, 529	4, 843	19, 372	2. 00
2. 01	discharges (see instructions) Outlier payments for	2. 02	0	0	0	0	0	2. 01
3. 00	discharges for Model 4 BPCI Operating outlier	2. 01	0	0	0	0	0	3. 00
4. 00	reconciliation Managed care simulated payments	3. 00	0	0	0	0	0	4. 00
5. 00	Amount from Worksheet E, Part	ustment 21.00	0. 000000	0.000000	0. 000000	0.000000		5. 00
5.00	A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.00000		3.00
6.00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	0	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	0	0	0	0	0	6. 01
	instructions) Indirect Medical Education Adju	etment for the	Add-on for Se	ction 122 of t	he MMA			
7. 00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see	28. 00	0	0	0	0	0	8. 00
	instructions)			0	0			
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	U	U	U	U	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	O	0	0	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	0	O	0	9. 01
	Disproportionate Share Adjustme							
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 1200	0. 1200	0. 1200	0. 1200		10. 00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	160, 802	0	120, 601	40, 201	160, 802	11. 00
11. 01	Uncompensated care payments	36. 00	512, 618	0	403, 040	109, 578	512, 618	11. 01
	Additional payment for high per	centage of ESF	RD beneficiary					
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	0	0	0	12. 00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH,	47. 00 48. 00	6, 052, 847 0	0	4, 558, 211 0	1, 494, 636 0	6, 052, 847 0	13. 00 14. 00
15. 00	small rural hospitals only.) (see instructions) Total payment for inpatient	49. 00	6, 052, 847	0	4, 558, 211	1, 494, 636	6, 052, 847	15. 00
16. 00	operating costs (see instructions) Payment for inpatient program	50. 00	433, 555	0	325, 166	108, 389	433, 555	16. 00
17. 00	capital Special add-on payments for	54. 00	0	0	0	0	0	17. 00
17. 01	new technologies Net organ aguisition cost	55. 00	0	O	0	O	0	17. 01
17. 02	Capital received from manufacturers for replaced	68. 00	o	0	0	-	0	17. 02
18. 00	devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	O	0	0	0	18. 00
	This tructrons/		l l			l l		

							rom 01/01/2014 o 12/31/2014	Part A Exhibi Date/Time Pre 5/28/2015 2:1	pared:
				_ T	i tl	e XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post		Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlemer	nt	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00		3. 00	4. 00	5. 00	
19. 00	SUBTOTAL				0	4, 883, 377	1, 603, 025	6, 486, 402	19. 00
		W/S L, line	(Amounts from						
			L)						
		0	1. 00	2.00		3. 00	4. 00	5. 00	
20. 00	Capital DRG other than outlier	1. 00	428, 519		0	321, 389	107, 130	428, 519	20.00
20. 01	Model 4 BPCI Capital DRG other	1. 01	0		0	C	0	0	20. 01
	than outlier								
21.00	Capital DRG outlier payments	2. 00	5, 036		0	3, 777	1, 259	5, 036	21. 00
21. 01	Model 4 BPCI Capital DRG	2. 01	0		0		0	0	21. 01
	outlier payments								
22.00	Indirect medical education	5. 00	0.0000	0.0	000	0.0000	0.0000		22. 00
	percentage (see instructions)								
23.00	Indirect medical education	6. 00	0		0	C	0	0	23. 00
	adjustment (see instructions)								
24.00	Allowable disproportionate	10.00	0.0000	0.0	000	0.0000	0.0000		24. 00
	share percentage (see								
	instructions)								
25.00	Di sproporti onate share	11. 00	0		0	C	0	0	25. 00
	adjustment (see instructions)								
26.00	Total prospective capital	12.00	433, 555		0	325, 166	108, 389	433, 555	26. 00
	payments (see instructions)								
		W/S E, Part A	(Amounts to E,						
		line	Part A)						
		0	1. 00	2. 00		3.00	4. 00	5. 00	
27.00	Low volume adjustment factor					0. 082143	0. 105536		27. 00
28.00	Low volume adjustment	70. 96				401, 135		401, 135	28. 00
	(transfer amount to Wkst. E,								
	Pt. A, line)								
29.00	Low volume adjustment	70. 97					169, 177	169, 177	29. 00
	(transfer amount to Wkst. E,								
	Pt. A, line)								
100.00	Transfer low volume		Y						100. 00
	adjustments to Wkst. E, Pt. A.								

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provider CCN: 150104 Peri od: Worksheet E From 01/01/2014 Part A Exhibit 5 Date/Time Prepared: 12/31/2014 5/28/2015 2:17 pm Hospi tal Title XVIII PPS Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on Wkst. E, Pt. 10/01 A. line after 10/01 and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 4, 020, 041 4, 020, 041 4, 020, 041 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 1, 340, 014 1. 340. 014 1, 340, 014 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 С 1.03 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 1.04 0 0 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 19, 372 14, 529 4, 843 19, 372 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 0 0 2.01 0 **BPCI** Operating outlier reconciliation 3 00 2 01 O 0 Ω 3 00 4.00 Managed care simulated payments 3.00 0 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) 6 00 IME payment adjustment (see instructions) 22 00 0 0 0 6 00 IME payment adjustment for managed care (see 0 0 6.01 22.01 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 0.000000 0.000000 7.00 IME payment adjustment factor (see 27.00 0.000000 instructions) 8.00 IME adjustment (see instructions) 28.00 0 8.00 IME payment adjustment add on for managed 0 8.01 28.01 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 9.00 29.00 0 0 0 9.00 9.01 Total IME payment for managed care (sum of 29.01 0 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage 10.00 33.00 0.1200 0.1200 0.1200 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 160, 802 120, 601 40.201 160, 802 11.00 instructions) 512, 618 11.01 Uncompensated care payments 36.00 512, 618 403, 040 109, 578 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12 00 Total ESRD additional payment (see 12 00 46 00 0 0 instructions) 13.00 Subtotal (see instructions) 47.00 6, 052, 847 4, 558, 211 1, 494, 636 6, 052, 847 13.00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 15.00 49.00 6, 052, 847 4, 558, 211 1, 494, 636 6, 052, 847 15.00 (see instructions) 16.00 Payment for inpatient program capital 50.00 433, 555 433, 555 433, 555 16.00 Special add-on payments for new technologies 17.00 54.00 0 17.00 Net organ aquisition cost 55.00 0 17.01 17.01 C 0 0 17.02 Capital received from manufacturers for 68.00 0 0 0 17.02 replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment 18.00 93.00 0 18.00 amount (see instructions) SUBTOTAL 19 00 4, 558, 211 1 928 191 6, 486, 402 19. 00

Heal th	Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5	Provi der	F	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Exhibi Date/Time Pre 5/28/2015 2:1	pared:
			Ti tl	e 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	428, 519	C	428, 519	428, 519	20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	C	0	0	20. 01
21.00	Capital DRG outlier payments	2.00	5, 036	C	5, 036	5, 036	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	C	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0.0000	0.0000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	C	0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11.00	0	C	0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12.00	433, 555	C	433, 555	433, 555	26. 00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3. 00	4. 00	
27. 00							27. 00
28.00	Low volume adjustment prior to October 1	70. 96	401, 135	401, 135	5	401, 135	28. 00
29.00	Low volume adjustment on or after October 1	70. 97	169, 177		169, 177	169, 177	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	6, 747	C	6, 747	6, 747	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-1, 600	-1, 197	-403	-1, 600	31. 00
31. 01	HRR adjustment for HSP bonus payment (see	70. 91	0	C	0	0	31. 01

0

70. 99

1.00

Υ

0

3.00

21, 037

2.00

32. 00

100.00

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

4.00

21, 037

instructions)

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 HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150104	From 01/01/2014	Worksheet E Part B Date/Time Prepared: 5/28/2015 2:17 pm
	T1 11 30011		200

			To 12/31/2014	Date/Time Pre 5/28/2015 2:1	
		Title XVIII	Hospi tal	PPS	<u>, Ми</u>
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			1, 138	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		5, 936, 912	2. 00
3.00	PPS payments	ŕ		6, 908, 507	3. 00
4.00	Outlier payment (see instructions)			3, 152	
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0. 000	
6.00	Line 2 times line 5			0	6.00
7. 00 8. 00	Sum of line 3 plus line 4 divided by line 6 Transitional corridor payment (see instructions)			0. 00 0	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	, 5511 15, 11115 255		Ö	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			1, 138	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
10.00	Reasonable charges			0 (04	10.00
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, co	1 4)		9, 684 0	12. 00 13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)	1. 4)		9, 684	
	Customary charges			.,,,,,,	
15. 00	Aggregate amount actually collected from patients liable for pa	yment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for		on a chargebasis	0	16. 00
17.00	had such payment been made in accordance with 42 CFR §413.13(e)			0 000000	17.00
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 9, 684	
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds Li	ne 11) (see	8, 546	
. ,	instructions)		(555	0,010	171.00
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20. 00
21 00	instructions)	! + +! >		1 120	21 00
21. 00 22. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see Interns and residents (see instructions)	instructions)		1, 138 0	21. 00 22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			6, 911, 659	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions)	0411		0	
26. 00 27. 00	Deductibles and Coinsurance relating to amount on line 24 (for			1, 548, 192 5, 364, 605	
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) pl CAH, see instructions)	us the sum of filles 2.	2 and 23} (101	5, 304, 605	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 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)			5, 364, 605	
31.00	Primary payer payments			1, 089	
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	5)		5, 363, 516	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	5)		0	33. 00
34.00	Allowable bad debts (see instructions)			121, 656	34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)			79, 076	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		108, 044	
	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			5, 442, 592	37. 00 38. 00
39. 00	PER PS&R			1,089	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 50
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instru	ctions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION		·	0	39. 99
40. 00	Subtotal (see instructions)			5, 441, 585	1
40. 01	Sequestration adjustment (see instructions)			108, 832	
41.00	Interim payments			5, 255, 854 0	1
42. 00 43. 00	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)			76, 899	
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2.	chapter 1.	0	1
	§115. 2		<u> </u>	_	
90. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			^	00.00
90.00	Outlier reconciliation adjustment amount (see instructions)			0	
92. 00	The rate used to calculate the Time Value of Money				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	Provi der CCN: 150104	From 01/01/2014	
	Component CCN: 15S104	To 12/31/2014	Date/Time Prepared: 5/28/2015 2:17 pm
	Title XVIII	Subprovi der -	PPS

		Title XVIII	Subprovider - IPF	PPS	
				1 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			96	1. 00
2.00	Medical and other services reimbursed under OPPS (see instruction	ons)		38	2. 00
3. 00 4. 00	PPS payments Outlier payment (see instructions)			0	3. 00 4. 00
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0. 000	5. 00
6.00	Line 2 times line 5	,		0	6. 00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	7. 00
8. 00 9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV	col 13 line 200		0	8. 00 9. 00
10.00	Organ acquisitions	, сог. 13, 11110 200		0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			96	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12. 00	Reasonable charges Ancillary service charges			815	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, co	1. 4)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			815	14. 00
15. 00	Customary charges Aggregate amount actually collected from patients liable for pa	vment for services on	a charge hasis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for			0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)	. ,	Ü		
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 815	
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	719	
	instructions)		, ,		
20. 00	Excess of reasonable cost over customary charges (complete only instructions)	if line 11 exceeds li	ne 18) (see	0	20. 00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		96	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24. 00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for			0	26. 00
27. 00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) pl CAH, see instructions)	us the sum of lines 22	and 23} (For	96	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30. 00 31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			96 0	30. 00 31. 00
32. 00	Subtotal (line 30 minus line 31)			96	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	S)			
33. 00 34. 00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0	33. 00 34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)			0	35. 00
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		0	36. 00
37. 00 38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			96 0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 50
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruc	tions)	0	39. 98
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 96	39. 99 40. 00
40. 01	Sequestration adjustment (see instructions)			2	40. 01
41. 00	Interim payments			275	
42. 00 43. 00	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)			0 -181	
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	
	§115. 2		' '		
90. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90. 00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	
92. 00	The rate used to calculate the Time Value of Money				92. 00
93.00	Time Value of Money (see instructions)			0	
7 4. UU	Total (sum of lines 91 and 93)		l	O ₁	94. 00

Health Financial Systems WIT ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

					5/28/2015 2:1	7 pm
		Ti t	e XVIII	Hospi tal	PPS	
		Inpatie	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		6, 076, 310		5, 255, 854	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,		0		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) Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER		Ι ο		0	3. 01
3. 02	ADJUSTIMENTS TO TROVIDER					3. 02
3. 03						3. 02
3. 04						3. 04
3. 05						3. 05
3.03	Provider to Program					3.03
3. 50	ADJUSTMENTS TO PROGRAM		1 0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		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		0		0	3. 99
	3. 50-3. 98)		/ 07/ 210		E 255 054	
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)		6, 076, 310		5, 255, 854	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after		T			5. 00
3.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider			<u>'</u>		
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5.52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		64, 969		76, 899	6. 01
6. 02	SETTLEMENT TO PROGRAM		04, 707		70, 077	6. 02
7. 00	Total Medicare program liability (see instructions)		6, 141, 279		5, 332, 753	7. 00
00	(300 1131 401 613)		5,111,277	Contractor	NPR Date	7.00
			0	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		U	1.00	2.00	8. 00
0.00	name of contractor			I	1	0.00

Inpatient Part A			Ti tl	e XVIII	Subprovi der - I PF	PPS	
1.00 Total Interim payments paid to provider 2.08 3.00 4.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 2.00 3.00 4.00 2.00 1.00 1.00 1.00 2.00 1.00 1.00 2.00 1.00 1.00 2.00 1.00 2.00 1.00 2.00 2.00 1.00 2.00			Inpatien	t Part A	Par	rt B	
1.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Interim payments payable on Individual bills, either subtited 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	2.00	3. 00		
Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 Use 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)							
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero.	2.00			C)	0	2.00
write "NONE" or enter a zero 1. 00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3. 01 ADJUSTMENTS TO PROVIDER 3. 01 O 0 0 3. 02 3. 03 3. 04 O 0 0 0 3. 03 3. 04 3. 05 Provider to Program 4. 0 0 0 0 3. 03 3. 04 3. 05 Provider to Program 4. 0 0 0 0 3. 05 Provider to Program 4. 0 0 0 0 3. 05 3. 51 3. 52 O 0 0 0 3. 52 3. 53 3. 54 O 0 0 0 3. 52 3. 53 3. 54 O 0 0 0 0 3. 53 3. 53 3. 54 O 0 0 0 0 3. 52 3. 53 3. 54 O 0 0 0 0 3. 52 3. 53 3. 54 O 0 0 0 0 0 3. 52 3. 59 3. 50 O 0 0 0 0 3. 52 3. 50 O 0 0 0 3. 53 3. 54 O 0 0 0 0 0 3. 54 3. 59 Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 0 0 0 0 3. 54 3. 59 O Total interin payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) 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) Frogram to Provider 5. 01 TENTATIVE TO PROGRAM 5. 01 TENTATIVE TO PROGRAM 6 O 0 5. 01 5. 02 5. 03 6 O 0 0 5. 01 5. 05 5. 05 5. 09 6 Determined net settlement amount (balance due) based on the cost report. (1) 5. 01 SETILEMENT TO PROGRAM 6 O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
List separately each retroactive lump sum adjustment amount 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)							
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 ADJUSTMENTS TO PROVIDER O	2 00						2 00
For the cost reporting period. Also show date of each pagment. 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 3.03 3.04 3.05 3.03 3.04 3.05 3.03 3.04 3.05							
3.03 3.04 3.05 3.04 3.06 3.03 3.04 3.05 3.04 3.05 3.06	3.01	ADJUSTMENTS TO PROVIDER		C		0	3. 01
3. 04 0 0 0 3. 04 3. 05							
3.05							
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 3.50							
3. 50 ADJUSTMENTS TO PROGRAM 0 0 3. 50 3. 51 3. 52 0 0 0 0 3. 51 3. 52 0 0 0 3. 52 3. 53 3. 54 0 0 0 3. 53 3. 54 0 0 0 3. 50 3. 50 3. 50 3. 50 3. 50 3. 89 4. 00 Total interim payments (sum of lines 1, 2, and 3. 99) 2, 083, 166 275 4. 00 Total interim payments (sum of lines 1, 2, and 3. 99) 2, 083, 166 275 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) 70	3.05	Dravi dan ta Dragnam		C		0	3.05
3.51 3.52 3.53 0 0 0 3.51 3.52 3.53 3.53 0 0 0 3.53 3.53 3.54 0 0 0 3.53 3.54 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 0 3.59 4.00 0 0 0 0 0 0 0 0 0	3 50					0	3 50
3.52 3.53 3.54 3.99 3.50-3.98 3.50-3.99		ADJUSTIMENTS TO TROOKAM					
3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2,083,166 275 4.00 0 0 0 0 0 0 0 0 0							
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.09) 3.59-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2,083,166 275 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR							
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) 2,083,166 275 4.00	3.54			C)	0	3. 54
A.00	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, 083, 166	•	275	4. 00
TO BE COMPLETED BY CONTRACTOR							
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)							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	5 00						5 00
Write "NONE" or enter a zero. (1) Program to Provider S. 01 TENTATIVE TO PROVIDER O O S. 02 S. 03 O O S. 02 S. 03 O O S. 02 S. 03 O O S. 03 S. 05 S. 05 O O S. 05 S. 05 O O S. 05 S. 05 O O S. 05 S. 05 O O S. 05 S. 05 O O S. 05 S. 05 O O S. 05 S. 05 O O S. 05 O O S. 05 S. 05 O O S. 05 O O S. 05 O O S. 05 O O S. 05 O O S. 05 O O S. 05 O O S. 05 O O S. 05 O O S. 05 O O S. 05 O O S. 05 O O S. 05 O O O S. 05 O O O O O O O O O	0.00						0.00
TENTATI VE TO PROVI DER							
Solition Settlement amount (balance due) based on the cost report. (1) Settlement To PROGRAM Settlement amount (balance due) based on the Cost report. (1) Settlement To PROGRAM Settlement amount (balance due) based on the Cost report. (1) Settlement To PROGRAM Settlement amount (balance due) based on the Cost report. (1) Settlement To PROGRAM S							
Description Description		TENTATI VE TO PROVI DER					
Provider to Program						- 1	
TENTATI VE TO PROGRAM	5.03	Drawi dan ta Draggam		C		0	5. 03
5.51 5.52 0	5 50			0		0	5 50
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.52 0		TENTATI VE TO TROOKAWI		_			
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00							
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 0 0 6.01 6.02 SETTLEMENT TO PROGRAM 0 181 6.02 7.00 Total Medicare program liability (see instructions) 2,083,166 P4 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C)	0	5. 99
the cost report. (1) SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00		5. 50-5. 98)					
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	` '					6. 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	. 01						
7.00 Total Medicare program liability (see instructions) 2,083,166 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00						1	
Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00				_			
Number (Mo/Day/Yr) 0 1.00 2.00	7.00	Total medicale program frability (see Histractions)		2,003,100			7.00
0 1.00 2.00							
8.00 Name of Contractor 8.00)			
	8.00	Name of Contractor					8. 00

Heal th	Financial Systems WITHAM MEMORIAL H	IOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 150104	Peri od:	Worksheet E-1	
			From 01/01/2014 To 12/31/2014		nared:
			10 12/31/2014	5/28/2015 2:1	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst. §		14	2, 247	1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-1	12		3, 018	2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			707	3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-1	12		6, 637	4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			238, 431, 572	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 lir	ne 20		5, 005, 783	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of cer	tified HIT technology	Wkst. S-2, Pt. I	0	7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)			636, 249	8. 00
9.00	Sequestration adjustment amount (see instructions)			12, 725	9. 00
10.00	Calculation of the HIT incentive payment after sequestration (s	see instructions)		623, 524	10.00
	I NPATI ENT HOSPI TAL SERVI CES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			569, 745	30.00
	Other Adjustment (specify)			0	31.00
22 00	Polones due provider (line 0 (er line 10) minus line 20 and lin	. 21) (coo i notruoti on	۵۱ ا	E2 770	22.00

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

569, 745 30. 00 0 31. 00 53, 779 32. 00

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150104		Worksheet E-3
	0 1 000 450404	From 01/01/2014	
	Component CCN: 15S104	10 12/31/2014	
			5/28/2015 2:17 pm
	Title XVIII	Subprovi der -	PPS
		I PF	

	I PF		
		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS	1100	
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2, 262, 419	1. 00
2.00	Net IPF PPS Outlier Payments	47, 997	2. 00
3.00	Net IPF PPS ECT Payments	0	3. 00
4. 00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4. 00
4. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4. 01
5.00	New Teaching program adjustment. (see instructions)	0.00	5. 00
6. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6. 00
7. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7. 00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8. 00
9.00	Average Daily Census (see instructions)	8. 183562	9. 00
10.00		0.000000	10.00
11. 00			11. 00
12.00		2, 310, 416	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15. 00
16.00	Subtotal (see instructions)	2, 310, 416	16. 00
17.00	Primary payer payments	0	17. 00
18.00	Subtotal (line 16 less line 17).	2, 310, 416	18. 00
19.00	Deducti bl es	168, 928	19. 00
20.00	Subtotal (line 18 minus line 19)	2, 141, 488	20. 00
21.00	Coinsurance	15, 808	21. 00
22.00	Subtotal (line 20 minus line 21)	2, 125, 680	22. 00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23. 00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24. 00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25. 00
26.00	Subtotal (sum of lines 22 and 24)	2, 125, 680	26. 00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27. 00
28.00	Other pass through costs (see instructions)	0	28. 00
29.00	Outlier payments reconciliation	0	29. 00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30. 50
30. 99	Recovery of Accelerated Depreciation	0	30. 99
31.00	Total amount payable to the provider (see instructions)	2, 125, 680	31.00
31. 01	Sequestration adjustment (see instructions)	42, 514	31. 01
32.00	Interim payments	2, 083, 166	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	0	34.00
35. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35. 00
	TO BE COMPLETED BY CONTRACTOR	·	
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	47, 997	50.00
	Outlier reconciliation adjustment amount (see instructions)	0	51. 00
52.00	· · · · · · · · · · · · · · · · · · ·	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53. 00

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150104	Peri od: Worksheet E-3 From 01/01/2014 Part VII To 12/31/2014 Date/Time Prepared:

Part VI				To 12/31/2014	Date/Time Pre 5/28/2015 2:1	pared:
PART VII - CALCINATION OF RETUBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			Title XIX	Hospi tal		7 рііі
PART VII - CALCULATION OF RETUBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XLX SERVICES						
DART VII - CALCHATION OF RETINBURSEMENT - ALL OTHER HEALTH SERVICES 1.00						
COMPUTATION OF NET COST OF COVERED SERVICES		PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XI	X SERVICES		
Impatient hospit al /SNF/NF services						
Organ acquisition (certified transplant centers only)	1.00			714, 520		1.00
A.00 Subtotal (sum of lines 1, 2 and 3)	2.00	Medical and other services			0	2. 00
Inpatient primary payer payments 0 0 6.00	3.00	Organ acquisition (certified transplant centers only)		o		3. 00
0.00 0.00	4.00	Subtotal (sum of lines 1, 2 and 3)		714, 520	0	4. 00
1.00 Subtotal (line 4 less sum of lines 5 and 6)	5.00	Inpatient primary payer payments		0		5. 00
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 0 8. 00 0. 00						
Reasonable Charges	7.00			714, 520	0	7. 00
Routine service charges						
9,00 Ancillary service charges 1,230,746 0 9.00 10.00 Organ acquisition charges, net of revenue 0 0 10.00 10.00 Incentive from target amount computation 1,230,746 0 12.00 10.00 Total reasonable charges (sum of lines 8 through 11) 1,230,746 0 12.00 10.00 Total reasonable charges (sum of lines 8 through 11) 1,230,746 0 12.00 10.00 Total reasonable charges (sum of lines 8 through 11) 1,230,746 0 12.00 10.00 Total reasonable charges (sum of lines 8 through 11) 1,230,746 0 0 0 13.00 14.00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR \$413.13(e) 0 0 0 0 0 14.00 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 0 0 0 0 0 0 0 15.00 16.00 Total customery charges (see instructions) 0 0 0 0 15.00 16.00 Total customery charges (see instructions) 0 0 18.00 16.00 Total customery charges (see instructions) 0 0 18.00 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 10 0 18.00 16.00 See instructions) 0 0 19.00 17.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 10 0 19.00 10.00 Interns and Residents (see instructions) 0 0 0 19.00 10.00 Cost of physicians' services in a teaching hospital (see instructions) 0 0 174,520 0 21.00 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 714,520 0 22.00 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 714,520 0 23.00 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 0 0 24.00 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 0 0 24.00 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 0 0 25.00 10.00						
10.00 Organ acquisition charges, net of revenue 0 10.0				0		
11.00				1, 230, 746	0	
12.00 Total reasonable charges (sum of lines 8 through 11) 1, 230, 746 0 12.00				0		
CUSTOMARY CHARGES				1 220 744	0	1
13.00 Amount actually collected from patients liable for payment for services on a charge 0 0 13.00 20 20 20 20 20 20 20	12.00			1, 230, 746	0	12.00
basis 14.00 Anounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 0.000000 0.000000 15.00 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 1.00 10.000000 1.00 10.000000 15.00 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.0000000 10.0000000 10.0000000 10.0000000000	12 00		convices on a charge		0	12 00
Amounts that would have been realized from patients Liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 0.000000 0.000000 15.00 15.00 70 70 70 70 70 70 70	13.00		services on a charge	١	U	13.00
a charge basis had such payment been made in accordance with 42 CFR \$413.13(e) 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 16.00 Total customary charges (see instructions) 17.00 Excess of customary charges (see instructions) 18.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 16.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 19.00 Interns and Residents (see instructions) 19.00 Interns and Residents (see instructions) 19.00 Cost of physiclans' services in a teaching hospital (see instructions) 20.00 Cost of physiclans' services in a teaching hospital (see instructions) 20.00 Cost of physiclans' services in a teaching hospital (see instructions) 20.00 Cost of covered services (enter the lesser of line 4 or line 16) 20.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 22.00 Other than outlier payments 23.00 Outlier payments 24.00 Capital exception payments (see instructions) 25.00 Capital exception payments (see instructions) 26.00 Routline and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only) 28.00 Customary charges (title V or XIX PPS covered services only) 29.00 Titles V or XIX (sum of lines 21 and 27) 29.00 Computation Or ReIMBURSEMENT SETTLEMENT 20.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 20.00 Decensive of reasonable cost (from line 18) 20.00 Original cost of the provider (sum of lines 32 and 33) 20.01 Original cost of the provider (sum of lines 32 and 33) 20.01 Original cost of the provider (sum of lines 32 and 33) 20.01 Original cost of the provider (sum of lines 32 and 33) 20.01 Original cost of the provider (sum of lines 32 and 33) 20.01 Original cost of the provider (sum	14 00		navment for services on	0	0	14 00
15.00	14.00			٩	O	14.00
16. 00 Total customary charges (see instructions) 1, 230,746 0 16. 00	15. 00		5. K 3.15. 15(5)	0. 000000	0.000000	15. 00
Iine 4) (see instructions) Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 18.00 10 10 10 10 10 10 10	16.00			1, 230, 746	0	16. 00
18. 00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 19. 00 18. 00 16) (see instructions) 0 0 19. 00 19. 00 19. 00 10. 00	17.00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	516, 226	0	17. 00
16) (see instructions)		line 4) (see instructions)				
19.00 Interns and Residents (see instructions) 0 0 19.00 20.00 2	18.00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
20. 00 Cost of physicians' services in a teaching hospital (see instructions) 0 20. 00 21. 00 22. 00 23. 00 23. 00 23. 00 23. 00 23. 00 24. 00 25. 00 24. 00 25. 00 26. 00 26. 00 26. 00 26. 00 26. 00 27. 00 28. 00 29. 0						
21.00 Cost of covered services (enter the lesser of line 4 or line 16) 714,520 0 21.00				0	-	
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				٦		
22. 00 Other than outlier payments 0 0 22. 00 23. 00 Outlier payments 0 0 23. 00 24. 00 Program capit al payments 0 24. 00 25. 00 Capit al exception payments (see instructions) 0 0 25. 00 26. 00 Routine and Ancillary service other pass through costs 0 0 25. 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) 714, 520 0 29. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18) 0 0 30. 00 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 714, 520 0 31. 00 32. 00 Deductibles 0 0 32. 00 33. 00 Coinsurance 0 0 33. 00 34. 00<!--</td--><td>21. 00</td><td></td><td></td><td></td><td>0</td><td>21. 00</td>	21. 00				0	21. 00
23.00 Outlier payments 0 0 23.00 24.00 Program capital payments 0 0 24.00 25.00 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) 714,520 0 29.00 Titles V or XIX (sum of lines 21 and 27) 714,520 0 29.00 CoMPUTATION OF REIMBURSEMENT SETTLEMENT 0 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 714,520 0 31.00 32.00 Deductibles 0 0 32.00 33.00 Coinsurance 0 0 33.00 34.00 Allowable bad debts (see instructions) 0 0 34.00 35.00 Utilization review 0 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 714,520 0 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 714,520 0 40.00 41.00 Interim payments 1,209,978 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) 495,458 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00			ompleted for PPS provid			
24. 00		1 3				
25. 00 Capital exception payments (see instructions) 26. 00 Routine and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27) 29. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Excess of reasonable cost (from line 18) 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31. 00 Deductibles 30. 00 Eductibles 30. 00 Allowable bad debts (see instructions) 31. 00 Villization review 32. 00 Utilization review 33. 00 Utilization review 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 41. 00 Villier mayments 42. 00 Balance due provider/program (line 40 minus line 41) 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 25. 00 26. 00 27. 00 0 26. 00 0 714, 520 0					0	
26. 00 Routine and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Excess of reasonable cost (from line 18) 30. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31. 00 Deductibles 30. 00 Coinsurance 30. 01 Allowable bad debts (see instructions) 30. 00 Allowable bad debts (see instructions) 30. 00 Utilization review 30. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 31. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 32. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 33. 00 Frect graduate medical education payments (from Wkst. E-4) 34. 00 Interim payments 35. 00 Bal ance due provider/program (line 40 minus line 41) 40. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 26. 00 27. 00 28. 00 714, 520 9 0 30. 00 9 0 0 30. 00 9 0 0 30. 00 9 0 0 30. 00 9 0 0 30. 00 9 0 0 30. 00 9 0 0 30. 00 9 0 0 0 30. 00 9 0 0 0 30. 00 9 0 0 0 30. 00 9 0 0 0 30. 00 9 0 0 0 30. 00 9 0 0 0 30. 00 9 0 0 0 0 30. 00 9 0 0 0 0 0 0 0 0 0 0 9 0 0 0 0 0				-1		
27.00 Subtotal (sum of lines 22 through 26) 0 27.00				ı	0	1
28.00 Customary charges (title V or XIX PPS covered services only) Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 30.00 Allowable bad debts (see instructions) 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,				٩		1
Titles V or XIX (sum of lines 21 and 27) 714,520 0 29.00				ı	-	
COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 714,520 0 31.00 32.00 23.0				714 520		
30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31.00 Deductibles 32.00 Deductibles 33.00 Coinsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Balance due provider/program (line 40 minus line 41) 42.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 31.00 714,520 0 31.00 0 32.00 0 32.00 0 0 33.00 0 0 33.00 0 0 33.00 0 0 34.00 0 34.00 0 35.00 0 36.00 0 37.00 0 37.00 0 37.00 0 37.00 0 37.00 0 37.00 0 38.00 0 39.00 0 40.00	27.00			711,020		27.00
31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 33.00 Coinsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	30.00			0	0	30. 00
32.00 Deductibles 0 0 32.00 33.00 33.00 34.00 31.00 32.00 33.00 34.00 34.00 35.00				714, 520	0	31.00
34.00 Allowable bad debts (see instructions)	32.00			l I	0	32. 00
35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 35.00 36.00 37.4,520 0 36.00 37.00 37.00 38.00 39.00 714,520 0 40.00 1,209,978 0 41.00 42.00 43.00	33.00	Coinsurance		0	0	33. 00
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 36.00 714,520 0 36.00 714,520 0 38.00 714,520 0 49.00 1,209,978 -495,458 0 42.00	34.00	Allowable bad debts (see instructions)		o	0	34.00
37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 41. 00 Interim payments 42. 00 Balance due provider/program (line 40 minus line 41) 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 37. 00 37. 00 37. 00 37. 00 37. 00 37. 00 37. 00 37. 00 37. 00 37. 00 37. 00 37. 00 37. 00 37. 00 38. 00 39. 00 714, 520 0 40. 00 41. 209, 978 42. 00 43. 00	35.00	Utilization review		0		35. 00
38.00 Subtotal (line 36 ± line 37) 714,520 0 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 714,520 0 40.00 41.00 Interim payments 1,209,978 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) -495,458 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00	36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	714, 520	0	36. 00
39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 39.00 714,520 0 40.00 41.00 42.00 43.00				0		
40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 40.00 41.00 42.00 43.00				714, 520	0	
41.00 Interim payments 1, 209, 978 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00				0		
42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 42.00		1 3 1 1				1
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00		1 3				
		,	040 5			
	43.00		e with CMS Pub 15-2,	0	0	43.00
		Gliapter 1, \$115.2		1		I

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

Peri od: Worksheet G From 01/01/2014 To 12/31/2014 Date/Time Prepared:

			'	0 12/31/2014	5/28/2015 2:1	
		General Fund	Speci fi c	Endowment Fund		
			Purpose Fund			
	CHIDDENT ACCETC	1.00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	20, 955, 846	0		0	1.00
2. 00	Temporary investments	18, 585, 331		-	0	2.00
3. 00	Notes recei vabl e	0	٥	-	0	3.00
4. 00	Accounts receivable	13, 965, 401	0	0	0	4. 00
5.00	Other recei vable	2, 767, 779	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6. 00
7.00	Inventory	2, 483, 173	0	0	0	7. 00
8.00	Prepai d expenses	0	0	0	0	8. 00
9.00	Other current assets	3, 210, 000		0	0	9. 00
10.00	Due from other funds	0	0		0	10.00
11. 00	Total current assets (sum of lines 1-10)	61, 967, 530	0	0	0	11. 00
12. 00	FI XED ASSETS Land		0	O	0	12. 00
13. 00	Land improvements	12, 992, 304		-	0	13.00
14. 00	Accumulated depreciation	0		0	0	14. 00
15. 00	Bui I di ngs	2, 017, 431	0	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	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	22.00
23. 00 24. 00	Major movable equipment Accumulated depreciation	124, 844, 782 -55, 128, 404		0	0	23. 00 24. 00
25. 00	Mi nor equi pment depreci abl e	-55, 126, 404		0	0	25. 00
26. 00	Accumulated depreciation	0		1	0	26.00
27. 00	HIT designated Assets	l o	l o	-	0	27. 00
28. 00	Accumul ated 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)	84, 726, 113	0	0	0	30. 00
	OTHER ASSETS					
31. 00	Investments	0	0		0	31.00
32. 00	Deposits on Leases	0	0	-	0	32.00
33. 00	Due from owners/officers	14 750 114	0		0	33.00
34. 00 35. 00	Other assets Total other assets (sum of lines 31-34)	14, 758, 114 14, 758, 114		-	0	34. 00 35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	161, 451, 757			0	36.00
00.00	CURRENT LI ABI LI TI ES	101, 101, 707		<u> </u>		00.00
37.00	Accounts payable	4, 425, 892	0	0	0	37. 00
38.00	Salaries, wages, and fees payable	8, 427, 690	0	0	0	38. 00
39. 00	Payroll taxes payable	0	0	0	0	39. 00
40.00	Notes and Loans payable (short term)	51, 943	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 45. 00	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	6, 230, 726 19, 136, 251				
45.00	LONG TERM LIABILITIES	19, 130, 231		U U		45.00
46. 00	Mortgage payable	0	0	0	0	46. 00
47. 00	Notes payable	450, 175	ĺ	0	0	47. 00
48.00	Unsecured Loans	0	0	0	0	48. 00
49.00	Other long term liabilities	62, 259, 612	0	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49	62, 709, 787	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	81, 846, 038	0	0	0	51.00
	CAPITAL ACCOUNTS		ı			
52. 00	General fund balance	79, 605, 719				52.00
53. 00 54. 00	Specific purpose fund		0			53.00
	Donor created - endowment fund balance - restricted			0		54. 00 55. 00
55. 00 56. 00	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance					56.00
57. 00	Plant fund balance - invested in plant			U	0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58.00
20.00	replacement, and expansion				O	- 5. 55
59. 00	Total fund balances (sum of lines 52 thru 58)	79, 605, 719	0	0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	161, 451, 757	0	0	0	60. 00
	[59]	l				

					То	12/31/2014	Date/Time Prep 5/28/2015 2:17	
		General	Fund	Speci al	Purp	pose Fund	Endowment Fund	, piii
		1.00	2.00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		81, 706, 879			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2, 101, 160					2.00
3.00	Total (sum of line 1 and line 2)		79, 605, 719			0		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	8. 00
9. 00					0		0	9. 00
10. 00	Total additions (sum of line 4-9)		0			0	Ĭ	10. 00
11. 00	Subtotal (line 3 plus line 10)		79, 605, 719			0		11. 00
12. 00	Deductions (debit adjustments) (specify)	o	,,		0	_	ol	12. 00
13. 00	, , , , , , , , , , , , , , , , , , ,	0			0		0	13.00
14.00		0			0		0	14.00
15. 00		0			0		0	15.00
16. 00		0			0		0	16.00
17. 00		0			0		0	17. 00
18.00	Total deductions (sum of lines 12-17)		0			0		18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		79, 605, 719			0		19. 00
	Sheet (Title II illinus IIIIe 10)	Endowment Fund	PI ant	Fund				
		6.00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2.00
3.00	Total (sum of line 1 and line 2)	U	0		0			3.00
4. 00 5. 00	Additions (credit adjustments) (specify)		0					4. 00 5. 00
6.00			0					6. 00
7. 00			0					7. 00
8. 00			0					8. 00
9. 00			0					9. 00
10.00	Total additions (sum of line 4-9)	o	-		0			10.00
11.00	Subtotal (line 3 plus line 10)	0			0			11.00
12.00	Deductions (debit adjustments) (specify)		0					12.00
13.00			0					13.00
14. 00			0					14.00
15.00			0					15. 00
16.00			0					16.00
17.00	Total deductions (sum of lines 12-17)		O		0			17. 00 18. 00
18. 00 19. 00	Fund balance at end of period per balance	0			0			18. 00 19. 00
17.00	sheet (line 11 minus line 18)	١			J			1 7. 00
	10.000 (1.1.0 11 111100 10)	ı I		ı	ı		'	

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 150104

			To	12/31/2014	Date/Time Prep 5/28/2015 2:1	
	Cost Center Description	Inpatien	t	Outpati ent	Total	/ piii
		1.00		2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>				
	General Inpatient Routine Services					
1.00	Hospi tal	15, 114,	386		15, 114, 386	1.00
2.00	SUBPROVI DER - I PF	2, 974,	630		2, 974, 630	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					7. 00
8.00	NURSING FACILITY					8. 00
9.00	OTHER LONG TERM CARE	40.000			40.000.044	9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	18, 089,	016		18, 089, 016	10. 00
11 00	Intensive Care Type Inpatient Hospital Services	2 27/	214		2 27/ 21/	11 00
11. 00 12. 00	INTENSIVE CARE UNIT	3, 276,	314		3, 276, 314	11. 00 12. 00
13. 00	BURN INTENSIVE CARE UNIT					13. 00
14. 00	SURGI CAL INTENSIVE CARE UNIT					14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lin	nes 3, 276,	314		3, 276, 314	16. 00
10.00	11-15)	5, 270,	514		3, 270, 314	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	21, 365,	330		21, 365, 330	17. 00
18. 00	Ancillary services	36, 755,		153, 638, 292	190, 393, 927	18. 00
19. 00	Outpati ent servi ces	2, 883,		31, 874, 625	34, 757, 639	19. 00
20. 00	RURAL HEALTH CLINIC	, , , , , ,	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	o	0	21.00
22. 00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES		0	0	0	23.00
24.00	CMHC					24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE					26.00
27. 00	PHYS PRACTICE		121	32, 169, 852	32, 171, 973	27.00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst. 61,006,	100	217, 682, 769	278, 688, 869	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES		-	07 5/4 0/0		
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			97, 566, 349		29. 00
30.00	ADD (SPECIFY)		0			30.00
31.00			0			31.00
32. 00 33. 00			0			32. 00 33. 00
34. 00			0			34. 00
35. 00			0			35. 00
36. 00	Total additions (sum of lines 30-35)		U	0		36. 00
37. 00	DEDUCT (SPECIFY)		0	J		37. 00
38. 00	DEBOOT (SEESTEE)		0			38. 00
39. 00			0			39. 00
40. 00			0			40. 00
41. 00			Ó			41. 00
42. 00	Total deductions (sum of lines 37-41)			o		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		97, 566, 349		43.00
	to Wkst. G-3, line 4)					

Heal th	Financial Systems WITHAM MEMORIAL H	OSPI TAL	In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 150104	Peri od:	Worksheet G-3	
			From 01/01/2014 To 12/31/2014	Date/Time Pre 5/28/2015 2:1	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			278, 688, 869	1. 00
2.00	Less contractual allowances and discounts on patients' accounts	5		176, 387, 051	
3.00	Net patient revenues (line 1 minus line 2)			102, 301, 818	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43	3)		97, 566, 349	
5. 00	Net income from service to patients (line 3 minus line 4)			4, 735, 469	5. 00
,	OTHER I NCOME		1		,
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication s	servi ces		0	
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	
11.00	Rebates and refunds of expenses			-	11. 00
12.00	Parking lot receipts			-	12.00
13.00	Revenue from laundry and linen service			-	13.00
14.00	Revenue from meals sold to employees and guests			-	14.00
15. 00	Revenue from rental of living quarters			-	15. 00
16.00	Revenue from sale of medical and surgical supplies to other that	in patients			16. 00
	Revenue from sale of drugs to other than patients				17. 00
	Revenue from sale of medical records and abstracts			-	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
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/NONOPERATING			3, 999, 667	
25. 00	Total other income (sum of lines 6-24)			3, 999, 667	
	Total (line 5 plus line 25)			8, 735, 136	
	ADDTL EXP/TRANSFERS			10, 836, 296	
	Total other expenses (sum of line 27 and subscripts)			10, 836, 296	
29. 00	Net income (or loss) for the period (line 26 minus line 28)		l	-2, 101, 160	29.00

	Financial Systems WITHAM MEMORIAL	D 1 1 00N 450101	D : 1		2552-10
CALCUI	ATION OF CAPITAL PAYMENT	Provider CCN: 150104	Peri od: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prep 5/28/2015 2:17	oared: 7 pm
	<u> </u>	Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			428, 519	1. 00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2. 00	Capital DRG outlier payments			5, 036	2. 00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost re	eporting period (see inst	ructions)	18. 68	3. 00
4. 00	Number of interns & residents (see instructions)			0.00	4. 00
5. 00 6. 00	Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the	sum of lines 1 and 1 01	`	0.00	5. 00 6. 00
7. 00	Percentage of SSI recipient patient days to Medicare Part A p			0. 00	7. 00
7.00	30) (see instructions)	datient days (worksheet L	, part A Title	0.00	7.00
3. 00	Percentage of Medicaid patient days to total days (see instru	ictions)		0.00	8. 00
9. 00	Sum of lines 7 and 8			0.00	9. 00
10.00	Allowable disproportionate share percentage (see instructions	5)			10.00
11. 00	Disproportionate share adjustment (line 10 times the sum of I			0	11. 00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2,	2.01, 6 and 11)		433, 555	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1. 00	Program inpatient routine capital cost (see instructions)			0	1.00
2. 00	Program inpatient ancillary capital cost (see instructions)			0	2.00
3. 00	Total inpatient program capital cost (line 1 plus line 2)			0	3.00
4.00	Capital cost payment factor (see instructions)			0	4.00
5. 00	Total inpatient program capital cost (line 3 x line 4)			اء	
				0	5. 00
				1. 00	5. 00
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
	Program inpatient capital costs (see instructions)			1.00	1. 00
2. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance	ces (see instructions)		1.00	1. 00
2. 00 3. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2)	ces (see instructions)		1.00	1. 00 2. 00 3. 00
2. 00 3. 00 4. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)	ces (see instructions)		1.00 0 0 0 0 0.00	1. 00 2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstanc Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)			1. 00 0 0 0 0. 00	1. 00 2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstanc Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in	nstructions)	line 6)	1.00 0 0 0 0.00 0.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary	nstructions)	line 6)	1.00 0 0 0 0.00 0 0.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7)	nstructions) / circumstances (line 2 x	line 6)	1.00 0 0 0.00 0.00 0.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 3. 00 9. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli	nstructions) / circumstances (line 2 x cable)	,	1.00 0 0 0 0.00 0 0.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 3. 00 9. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurrent year comparison of capital minimum payment level to carryover of accumulated capital minimum payment level over constitutions.)	nstructions) / circumstances (line 2 x cable) capital payments (line 8	less line 9)	1.00 0 0 0.00 0.00 0.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level to comparison of capital minimum payment level to comparison of accumulated capital minimum payment level over comparison of land minimum payment level over comparison of capital minimum payment le	nstructions) voircumstances (line 2 x cable) capital payments (line 8 capital payment (from pri	less line 9) or year	1.00 0 0 0.00 0.00 0.00 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurrent year comparison of capital minimum payment level to carryover of accumulated capital minimum payment level over of Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payments of capital minimum payment level to capital payments.	nstructions) v circumstances (line 2 x cable) capital payments (line 8 capital payment (from pri	less line 9) or year e 11)	1.00 0 0 0.00 0.00 0.00 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurrent year comparison of capital minimum payment level to carryover of accumulated capital minimum payment level over of Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payment year exception payment (if line 12 is positive, enter	cable) capital payments (line 8 capital payment (from pri	less line 9) or year e 11)	1.00 0 0 0.00 0.00 0.00 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurrent year comparison of capital minimum payment level to carryover of accumulated capital minimum payment level over comparison of capital minimum payment level over comparison of capital minimum payment level to capital payment year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over comparison of accumulate	cable) capital payments (line 8 capital payment (from pri	less line 9) or year e 11)	1.00 0 0 0.00 0.00 0.00 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurrent year comparison of capital minimum payment level to carryover of accumulated capital minimum payment level over of Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payment year exception payment (if line 12 is positive, enter	estructions) y circumstances (line 2 x cable) capital payments (line 8 capital payment (from pri ayments (line 10 plus line the amount on this line capital payment for the f	less line 9) or year e 11)	1.00 0 0 0.00 0.00 0.00 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level to carryover of accumulated capital minimum payment level over comparison of capital minimum payment level over comparison of capital minimum payment level to capital payment year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over comparison of capital minimum payment level over compar	estructions) y circumstances (line 2 x cable) capital payments (line 8 capital payment (from pri ayments (line 10 plus line the amount on this line capital payment for the f	less line 9) or year e 11)	1.00 0 0 0.00 0.00 0.00 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 14. 00