WITHAM MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

	s required by Iaw (42 USC 1395g; 42 CFR 413.20(b)). Fai since the beginning of the cost reporting period being			FORM APPROVED OMB NO. 0938-0050 EXPIRES 05-31-2019
AND SETTLEMENT		Provider CCN: 15-0104	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/22/2018 1:26 pm
PART I - COST				
Provi der use onl y	 [X] Electronically filed cost report 2. [] Manually submitted cost report 3. [0] If this is an amended report enter the number 4. [F] Medicare Utilization. Enter "F" for full or "L 	of times the provider for low	Date: 5/22/20 resubmitted this co	
Contractor use only	 5. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for (3) Settled with Audit 9. [N] Final Report for (4) Reopened (5) Amended 	11. or this Provider CCN 12.	NPR Date: Contractor's Vendc [0]If line 5, co number of tim	r Code: 4 Iumn 1 is 4: Enter es reopened = 0-9.
PART II - CERT	FI FI CATI ON			
ADMI NI STRATI VE PROVI DED OR PF ADMI NI STRATI VE CERTI VE I HERI el ect: Expens endi ne compli excep heal ti l aws a	FION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN T E ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. ROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A E ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. FICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF EBY CERTIFY that I have read the above certification st ronically filed or manually submitted cost report and t ses prepared by WITHAM MEMORIAL HOSPITAL (15-0104) for g 12/31/2017 and to the best of my knowledge and belief ete and prepared from the books and records of the prov t as noted. I further certify that I am familiar with n care services, and that the services identified in the and regulations.	FURTHERMORE, IF SERVICE KICKBACK OR WERE OTHER PROVIDER(S) catement and that I have the Balance Sheet and S or the cost reporting p f, this report and state ider in accordance with the laws and regulation his cost report were pro-	ES IDENTIFIED IN TH RWISE ILLEGAL, CRIM e examined the acco tatement of Revenue eriod beginning O1/ ement are true, cor h applicable instruns regarding the pr ovided in complianc	IS REPORT WERE INAL, CIVIL AND mpanying and (01/2017 and "rect, rect, rections, rovision of a with such
	I have read and agree with the above certification stat signature on this certification statement to be the leg	gally binding equivalen		
	(Si gned)		nistrator of Provid	r(c)
		UTTEEL OF ADDIT		
		Ti tl e		
		Date		

			litle	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	261, 895	80, 374	0	-58, 582	1.00
2.00	Subprovider - IPF	0	8	-1, 278		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVI DER I						4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	-227		0	7.00
200.00	Total	0	261, 903	78, 869	0	-58, 582	200.00

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

	Financial Systems		MEMORIAL H			15 0104					2552-10
ногы і	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DA	ЛА	PLOAI de	er CCN:	15-0104	Period: From 01/01 To 12/31	/2017	Part I	eet S-2 ime Pre	
	1						10 12/31			018 7:4	
	1.00 Hospital and Hospital Health Care Co		00		3.00			4.00			
1.00	Street: 2605 N. LEBANON STREET	PO Box:									1.00
2.00	City: LEBANON	State: I			: 46052		ty: BOONE			(5	2.00
		Component Na		CCN umber	CBSA Number	Provi dei r Type	- Date Certified		nt Syst 0, or		
								V	XVIII		
	Hospital and Hospital-Based Componen	1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
3.00	Hospi tal and Hospi tal -Based Componen Hospi tal	WITHAM MEMORIAL		50104	26900	1	07/01/196	6 N	Р	0	3.00
4.00	Subprovider - IPF	HOSPITAL WITHAM HOSPITAL	1!	5S104	26900	4	01/01/200		P	N	4.00
5.00 6.00	Subprovider - IRF Subprovider - (Other)	GEROPSYCH									5.00
7.00 8.00	Swing Beds – SNF Swing Beds – NF										7.00
9.00	Hospi tal -Based SNF	WITHAM HOSPITAL	ECU 1	55832	26900		05/07/201	5 N	Р	N	9.00
10.00	Hospital-Based NF										10.00
11. 00 12. 00	Hospi tal -Based OLTC Hospi tal -Based HHA										11.00
	Separately Certified ASC										13.00
	Hospi tal -Based Hospi ce										14.00
	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC										15.00 16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00 19.00	Renal Dialysis										18.00 19.00
19.00	other			I			From	n:	Tc		19.00
20.00	Cost Reporting Period (mm/dd/yyyy)						1.0		2.		20.00
	Type of Control (see instructions) Inpatient PPS Information						9		12/01		21.00
22.00	Does this facility qualify and is it share hospital adjustment, in accord								Ν	I	22.00
	for yes or "N" for no. Is this facil				2.106(c	:) (2) (Pi ckl	e				
22. 01	amendment hospital?) In column 2, en Did this hospital receive interim un				s cost	reportina	Y		Y	/	22.01
22.01	period? Enter in column 1, "Y" for y	es or "N" for no	for the po	ortion (of the	cost					22101
	reporting period occurring prior to for no for the portion of the cost r										
	(see instructions)	eporting period t		ni ui a		LODEI I.					
22. 02	Is this a newly merged hospital that						N		Ν	1	22. 02
	determined at cost report settlement or "N" for no, for the portion of th						S				
	in column 2, "Y" for yes or "N" for						n				
	or after October 1.		c								
22.03	Did this hospital receive a geograph of the OMB standards for delineating								Ν	1	22.03
	in column 1, "Y" for yes or "N" for	no for the portic	on of the c	ost re	oorting	period					
	prior to October 1. Enter in column cost reporting period occurring on o	,					ie				
	hospital contain at least 100 but no						h				
~~ ~~	42 CFR 412.105)? Enter in column 3,										
23.00	Which method is used to determine Me 1, enter 1 if date of admission, 2 i							3	Ν	4	23.00
	method of identifying the days in th	is cost reporting	g period di	fferen	t from	the method					
	used in the prior cost reporting per	iua: In column 2	2 <u>, enter "Y</u> In-State	/ for y In-St		Uut-of		Medi cai	d 0	ther	
			Medi cai d	Medi c	aid	State	State	HMO day	/s Med	di cai d	
			paid days	eligi unpa			Medicaid eligible		0	days	
				day	·		unpai d				
24.00	If this provider is as LDDC by the	optop the	1.00	2.0		3.00	4.00	5.00		5.00	24.00
24.00	If this provider is an IPPS hospital in-state Medicaid paid days in colum		192	<u>-</u>	1, 443	0	0	ł	504	0	24.00
	Medicaid eligible unpaid days in col	umn 2,									
	out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai										
	4, Medicaid HMO paid and eligible bu										
25.22	column 5, and other Medicaid days in	column 6.	-								
∠5. UU	If this provider is an IRF, enter th Medicaid paid days in column 1, the		C	ן ו	0	0	0		0		25.00
	Medicaid eligible unpaid days in col	umn 2,									
	out-of-state Medicaid days in column Medicaid eligible unpaid days in col										
	HMO paid and eligible but unpaid days										

th Financial Systems WITHAM PITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		AL HOSPITAL Provider CC		Period: From 01/01/201	ieu of For Workshe 17 Part I		
				o 12/31/201	17 Date/Ti	me Prepa)18 7:49	ared
				Urban/Rural	S Date of	Geogr	an
00 Enter your standard geographic classification (not w	ane) st	atus at the her	ninning of the	1.00	2.0		26. (
cost reporting period. Enter "1" for urban or "2" fo DO Enter your standard geographic classification (not w	r rural age) sta	atus at the end	d of the cost		1		27.0
reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif 00 If this is a sole community hospital (SCH), enter th	i cati on	in column 2.			0		35.
effect in the cost reporting period.				Doginning	Fadi	200	
				Begi nni ng: 1. 00	Endi 2. (
20 Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat		Subscript line	36 for number			:	36.
o If this is a Medicare dependent hospital (MDH), ente is in effect in the cost reporting period.		umber of period	ds MDH status		0	:	37.
D1 Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f instructions)				N		:	37.
00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.						:	38
				Y/N	Y/		
DO Does this facility qualify for the inpatient hospita	l paymer	nt adjustment 1	for low volume	1.00 Y	2. (Y		39.
hospitals in accordance with 42 CFR §412.101(b)(2)(i for yes or "N" for no. Does the facility meet the mi with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in colum instructions)) or (ii Leage re	i)? Enter in co equirements in	olumn 1 "Y" accordance				
20 Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. I	Enter "Y" for y		N	N		40
	. (See	riisti ucti olisj			V XVIII 00 2.00	XI X 3.00	
Prospective Payment System (PPS)-Capital					NI NI		
 Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks 	eption [.]	for extraordina	ary circumstan	ces			45 46
Pt. III. 20 Is this a new hospital under 42 CFR §412.300(b) PPS 20 Is the facility electing full federal capital paymen	capi tal '	? Enter "Y for	r yes or "N" f	or no.	N N		47. 48.
Teaching Hospitals 00 Is this a hospital involved in training residents in					N		56
or "N" for no. 10 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	r yes o th of tl Y", com	r "N" for no in his cost report plete Worksheet	n column 1. lf ting period?	column 1 Enter "Y"			57
00 If line 56 is yes, did this facility elect cost reim	bursemei	nt for physicia	ans' services	as		!	58
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, OO Are costs claimed on line 100 of Worksheet A? If ye	•		Pt. I.		N		59
			NAHE 413.85 Y/N	Worksheet / Line #	A Pass-Th Qualifi Criterio	cation	
			1.00	2.00	3. (
00 Are you claiming nursing and allied health education any programs that meet the criteria under §413.85?			N				60
	Y/N	IME	Direct GME	IME	Di rect		
DO Did your hospital receive FTE slots under ACA	1.00	2.00	3.00	4.00	5. (00	0.00	61
section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.			
21 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see							61
							61
 instructions) 22 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 							

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT	ΓA	AL HOSPITAL Provider CO	CN: 15-0104	Period: From 01/01/2017 To 12/31/2017		pared:
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
 51.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 51.05 Enter the difference between the baseline primary 						61. 04 61. 05
and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being						61. 06
used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						
care of general surgery. (see firstructions)	Pro	ogram Name	Program Cod	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
51.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME				0.00	0.00	61. 10
FTE unweighted count. 51.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61. 20
					1.00	-
ACA Provisions Affecting the Health Resources and Ser 52.00 Enter the number of FTE residents that your hospital				riod for which	0.00	62.00
your hospital received HRSA PCRE funding (see instruc 52.01 Enter the number of FTE residents that rotated from a	ti ons) Teachi	ng Health Cen	ter (THC) int			62.00
during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide			ns)			
53.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ttings	during this co			N	63.00
		is of through t	Unwei ghted FTEs		Ratio (col. 1/ (col. 1 + col.	
			Nonprovi der Si te		2))	
Contion EEOA of the ACA Door Voor ETE Dooldarts in No	nnroul -	lor Sottings	1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor			-	-		
54.00 Enter in column 1, if line 63 is yes, or your facility in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	y train -primar all non non-pr column	ed residents y care provider imary care 3 the ratio	0.1	00 0. OC	0. 000000	64.00
Program Name		ogram Code	Unwei ghted FTEs Nonprovi der Si te	FTEsin	Ratio (col. 3/ (col. 3 + col. 4))	
1.00		2.00	3.00	4.00	5.00	1

				om 01/01/2017	Part I	
			To	12/31/2017	Date/Time Pre 5/22/2018 7:4	epared 9 am
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	1
			FTEs Nonprovider	FTEs in Hospital	(col. 3 + col. 4))	
			Si te	nospi tai	4))	
	1.00	2.00	3.00	4.00	5.00	
.00 Enter in column 1, if line 63			0.00	0.00	0. 000000	65.0
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)						
		I	Unweighted	Unwei ghted	Ratio (col. 1/	/
			FTEs	FTEs in	(col. 1 + col.	
			Nonprovider Site	Hospi tal	2))	
			1.00	2.00	3.00	1
Section 5504 of the ACA Current Y	'ear FTE Residents i	n Nonprovider Settir				
.00 Enter in column 1 the number of u FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	curring in all nonp nweighted non-prima I. Enter in column	rovider settings. ry care resident 3 the ratio of	0. 00	0.00	0. 000000	66.
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	/
			FTEs Nonprovider	FTEs in Hospital	(col. 3 + col. 4))	
.00 Enter in column 1, the program	1.00	2.00	Nonprovi der		4))	_
.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00	2.00	Nonprovi der Si te 3.00	Hospi tal 4.00	4))	_
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	1.00	2.00	Nonprovi der Si te 3.00	Hospi tal 4.00 0.00	4)) 5.00 0.000000	_
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)	25		Nonprovi der Si te 3. 00 0. 00	Hospi tal <u>4.00</u> 0.00 <u>1.0</u>	4)) 5.00 0.000000 0.000000 0.000000	67.
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)	≫ <u>S</u> rchiatric Facility (Nonprovi der Si te 3. 00 0. 00	Hospi tal <u>4.00</u> 0.00 <u>1.0</u>	4)) 5.00 0.000000 0.000000 0.000000	
<pre>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)</pre>	YS Ychiatric Facility (the facility have a fore November 15, 2 umn 2: Did this fac 2: 412.424 (d)(1)(iii aate which program y	IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for	Nonprovi der Si te 3.00 0.00 itain an IPF subp ing program in t yes or "N" for m s in a new teach yes or "N" for m	Hospi tal 4.00 0.00 1.0 1.0 rovi der? Y he most N o. (see i ng o.	4)) 5.00 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000000	70.
<pre>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)</pre>	2S rchiatric Facility (the facility have a fore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii cate which program y 2 PPS nabilitation Facilit	IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for ear began during thi	Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in ti yes or "N" for m s in a new teach yes or "N" for m s cost reporting	Hospi tal 4.00 0.00 1.0 1.0 rovi der? Y he most N o. (see i ng o.	4)) 5.00 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000	_

Health Financial Systems	WI THAM MEMORIA	L HOSPI TAL		In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HE	ALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet S- Part I Date/Time Pr 5/22/2018 7:	epared:
					1.00	_
81.00 Is this a LTCH co- "Y" for yes and "N	m care hospital (LTCH)? Enter "Y" for yes located within another hospital for part o	and "N" for r all of the	no. cost reporting	g period? Enter	N N	80. 00 81. 00
86.00 Did this facility	nital under 42 CFR Section §413.40(f)(1)(i) establish a new Other subprovider (excluder P Enter "Y" for yes and "N" for no.				N	85.00 86.00
87.00 Is this hospital a	n extended neoplastic disease care hospital Penter "Y" for yes or "N" for no.	l classified	under section		Ν	87.00
				V 1.00	XI X 2.00	_
Title V and XIX Se	ervices / have title V and/or XIX inpatient hospita	l services? Fi	nter "V" for	N	Y	90.00
yes or "N" for no	in the applicable column.			N	Y	91.00
full or in part? E	eimbursed for title V and/or XIX through t nter "Y" for yes or "N" for no in the appl	icable column		IN IN		
instructions) Ente	atients occupying title XVIII SNF beds (dual r "Y" for yes or "N" for no in the application of the second sec	ble column.	<i>,</i> , ,		N	92.00
"Y" for yes or "N"	operate an ICF/IID facility for purposes of for no in the applicable column.			N	N	93.00
applicable column.	X reduce capital cost? Enter "Y" for yes, a			N	N	94.00
96.00 Does title V or XI	enter the reduction percentage in the app X reduce operating cost? Enter "Y" for yes			0. 00 N	0. 00 N	95.00 96.00
98.00 Does title V or XI stepdown adjustmen	enter the reduction percentage in the app X follow Medicare (title XVIII) for the in its on Wkst. B, Pt. I, col. 25? Enter "Y" fo	terns and res	idents post	0. 00 Y	0. 00 Y	97.00 98.00
98.01 Does title V or XI C, Pt. I? Enter "Y	e V, and in column 2 for title XIX. X follow Medicare (title XVIII) for the re " for yes or "N" for no in column 1 for ti			Y	Y	98.01
bed costs on Wkst.	X follow Medicare (title XVIII) for the ca D-1, Pt. IV, line 89? Enter "Y" for yes o			Y	Y	98.02
98.03 Does title V or XI reimbursed 101% of	n column 2 for title XIX. X follow Medicare (title XVIII) for a crit inpatient services cost? Enter "Y" for ye:			N	Ν	98.03
98.04 Does title V or XI	n column 2 for title XIX. X follow Medicare (title XVIII) for a CAH : s cost? Enter "Y" for yes or "N" for no in			Ν	Ν	98.04
	tle XIX. X follow Medicare (title XVIII) and add ba N. 4? Enter "Y" for yes or "N" for no in c			Y	Y	98.05
Pts. I through IV? column 2 for title	X follow Medicare (title XVIII) when cost P Enter "Y" for yes or "N" for no in column			Y	Y	98.06
Rural Providers 105.00 Does this hospital	qualify as a CAH?			N		105.00
	ualifies as a CAH, has it elected the all- vices? (see instructions)	inclusive met	hod of payment	I N		106.00
training programs? yes, the GME elimi	ualifies as a CAH, is it eligible for cost P Enter "Y" for yes or "N" for no in column nation is not made on Wkst. B, Pt. I, col.	1. (see inst	ructions) lf	N		107.00
108.00 Is this a rural ho	; complete Wkst. D-2, Pt. II. spital qualifying for an exception to the 13(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dul e? See 42	Ν		108. 00
		Physi cal 1.00	Occupational 2.00		Respi ratory 4.00	_
therapy services p	ualifies as a CAH or a cost provider, are rovided by outside supplier? Enter "Y" no for each therapy.	N	N	3.00 N	4.00 N	109.00
					1.00	-
Demonstration)for	participate in the Rural Community Hospita the current cost reporting period? Enter " E, Part A, lines 200 through 218, and Worl	Y" for yes or	"N" for no. I	f yes,	Ν	110. 00

leal th Financial Systems WITHAM MEMORIAL HO HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA F	Provider CCN: 1		Period: From 01/01, To 12/31,	/2017	u of For Workshe Part I Date/Ti 5/22/20	et S-2 me Pre	2 epared:
			1.00		2. (00	1
111.00 If this facility qualifies as a CAH, did it participate in the F Health Integration Project (FCHIP) demonstration for this cost r "Y" for yes or "N" for no in column 1. If the response to column integration prong of the FCHIP demo in which this CAH is partici Enter all that apply: "A" for Ambulance services; "B" for additi for tele-health services.	reporting perion 1 is Y, enter pating in colu	od? Enter r the umn 2.	N				111.00
				1.00	2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" is yes, enter the method used (A, B, or E only) in column 2. If 3 either "93" percent for short term hospital or "98" percent for psychiatric, rehabilitation and long term hospitals providers) b Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for	column 2 is "E or long term ca based on the de	E", enter are (inclu efinition	in column udes	N		0	115.00
117.00 Is this facility legally-required to carry malpractice insurance			"N" for	Y			117.00
no. 118.00 Is the malpractice insurance a claims-made or occurrence policy? claim-made. Enter 2 if the policy is occurrence.	?Enter 1 if th	ne policy	is	2			118.00
crann-made. Litter 2 th the portcy is occurrence.	F	Premiums	Losse	S	Insur	ance	
		1.00	2.00)	3. (00	-
118.01 List amounts of malpractice premiums and paid losses:		205, 43	30	0		(0 118. 01
			1.00		2. (00	-
118.02 Are malpractice premiums and paid losses reported in a cost cent Administrative and General? If yes, submit supporting schedule and amounts contained therein.			N				118.02
19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Har §3121 and applicable amendments? (see instructions) Enter in col "N" for no. Is this a rural hospital with < 100 beds that qualif Hold Harmless provision in ACA §3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no.	umn 1, "Y" for fies for the Ou	r yes or utpatient	N		N		119.00 120.00
121.00 Did this facility incur and report costs for high cost implantat patients? Enter "Y" for yes or "N" for no.	ole devices cha	arged to	Y				121.00
122.00 Does the cost report contain healthcare related taxes as defined Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is the Worksheet A line number where these taxes are included.	d in §1903(w)(3 "Y", enter in	3) of the column 2	N				122.00
Transplant Center Information 125.00Does this facility operate a transplant center? Enter "Y" for ye	es and "N" for	no. If	N				125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.001f this is a Medicare certified kidney transplant center, enter	the certificat	tion date					126.00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter 1	the certificati	on date					127.00
in column 1 and termination date, if applicable, in column 2. 28.00 of this is a Medicare certified liver transplant center, enter 1	the certificati	on date					128.00
in column 1 and termination date, if applicable, in column 2. 29.00 of this is a Medicare certified lung transplant center, enter the	ne certificatio	on date ir	n				129.00
column 1 and termination date, if applicable, in column 2. 30.00 of this is a Medicare certified pancreas transplant center, enter		cation					130.00
date in column 1 and termination date, if applicable, in column 31.00 of this is a Medicare certified intestinal transplant center, er	nter the certif	fi cati on					131.00
date in column 1 and termination date, if applicable, in column 32.00 of this is a Medicare certified islet transplant center, enter t		on date					132.00
in column 1 and termination date, if applicable, in column 2. 133.00 f this is a Medicare certified other transplant center, enter 1 and termination date if areliable.	the certificati	on date					133.00
in column 1 and termination date, if applicable, in column 2. 34.00 of this is an organ procurement organization (OPO), enter the OF	90 number in co	olumn 1					134.00
and termination date, if applicable, in column 2. All Providers							1
140.00 Are there any related organization or home office costs as defir chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, are claimed, enter in column 2 the home office chain number. (see the second se	and home offi	ce costs	N				140.00

	X IDENTIFICATION DATA	IAL HOSPITAL Provider CCN	15-0104			u of Form CMS Worksheet S- Part I Date/Time Pr 5/22/2018 7:	2 epared:
1.00		00			3.00		
If this facility is part of a cha				name a	nd address	of the	
home office and enter the home of 41.00Name:	Contractor name and Contractor's Name:	contractor number		ctor's M	lumber:		
42. 00 Street:	PO Box:			5101 3 1	diliber .		142.0
43. 00 Ci ty:	State:		Zip Coo	de:			143.0
		10				1.00	111
44.00 Are provider based physicians' cos	sts included in Worksheet	A?				Y	144.0
					1.00	2.00	-
15.00 If costs for renal services are cl	aimed on Wkst. A, line 74	4, are the costs	for				145. (
inpatient services only? Enter "Y							
no, does the dialysis facility ind	clude Medicare utilization	n for this cost r	reporting				
period? Enter "Y" for yes or "N"		weby filed east	nonor+2		N		146
16.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in				If	IN		146.0
yes, enter the approval date (mm/d		15 Z, Chapter 40	, 37020)				
						1.00	
17.00 Was there a change in the statisti						N	147.
48.00Was there a change in the order o 49.00Was there a change to the simplifi				or po		N N	148. 149.
		Part A	Part B		Title V	Title XIX	149.
		1.00	2.00		3.00	4.00	-
Does this facility contain a prov	ider that qualifies for a			cation			
or charges? Enter "Y" for yes or	<u>"N" for no for each compo</u>	<u>nent for Part A a</u>	and Part B	. (See			
55.00Hospi tal		N	N		N	N	155.
56.00 Subprovi der – IPF		N	N		N	N	156.
57. 00 Subprovi der – IRF 58. 00 SUBPROVI DER		N	Ν		Ν	N	157.0
59. 00/S06PR0VI DER 59. 00/SNF		N	Ν		N	N	158.0
60.00HOME HEALTH AGENCY		N	N		N	N	160. 0
61.00 CMHC			Ν		Ν	N	161. (
he 1						1.00	_
Multicampus 65.00 s this hospital part of a Multica	amous hospital that has or	a or more campus	os in dif	forent (^BSAs2	N	165. (
Enter "Y" for yes or "N" for no.	anipus nospitai that has or				JDJAS !	IN	105.0
	Name	County	State 2	Zip Code	e CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	
66.00 If line 165 is yes, for each						0.0	0166.0
campus enter the name in column							
0, county in column 1, state in							
0, county in column 1, state in column 2, zip code in column 3,							
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in							_
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	T) incontino in the Arry'		Deimissi	opt Act		1.00	_
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI				ent Act			167 (
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user	under §1886(n)? Enter '	"Y" for yes or "N	l" for no.			1.00 Y	
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the l	r under §1886(n)? Enter ' D5 is "Y") and is a meanin HIT assets (see instructio	"Y" for yes or "N ngful user (line ons)	l" for no. 167 is "Y	"), ente	er the		
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful used 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 68.01 If this provider is a CAH and is n	r under §1886(n)? Enter ' D5 is "Y") and is a meanin HIT assets (see instruction not a meaningful user, doe	"Y" for yes or "N ngful user (line ons) es this provider	l" for no. 167 is "Y qualify fo	"), ente or a ha	er the		0168. (
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful used 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I for this provider is a CAH and is in exception under §413.70(a) (6) (ii)	r under §1886(n)? Enter ' D5 is "Y") and is a meanin HIT assets (see instruction not a meaningful user, doo ? Enter "Y" for yes or "N"	"Y" for yes or "N ngful user (line ons) es this provider " for no. (see ir	l" for no. 167 is "Y qualify fo nstruction:	"), ento or a hai s)	er the rdship	Y	0168. (
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful used 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I exception under \$413.70(a)(6)(i)) 69.00 If this provider is a meaningful used	under §1886(n)? Enter ' 5 is "Y") and is a meanin 11 Tassets (see instruction not a meaningful user, doo 2 Enter "Y" for yes or "N' user (line 167 is "Y") and	"Y" for yes or "N ngful user (line ons) es this provider " for no. (see ir	l" for no. 167 is "Y qualify fo nstruction:	"), ento or a hai s)	er the rdship	Y	167. (0168. (168. (99169. (
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 57.001s this provider a meaningful user 58.001f this provider is a CAH (line 10 reasonable cost incurred for the 1 58.01 If this provider is a CAH and is i exception under §413.70(a)(6)(ii)'	under §1886(n)? Enter ' 5 is "Y") and is a meanin 11 Tassets (see instruction not a meaningful user, doo 2 Enter "Y" for yes or "N' user (line 167 is "Y") and	"Y" for yes or "N ngful user (line ons) es this provider " for no. (see ir	l" for no. 167 is "Y qualify fo nstruction:	"), ento or a han s) s "N"),	er the rdship enter the	Y 9. 9	0168. (
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the I exception under §413.70(a) (6) (ii) 59.00 If this provider is a meaningful user	under §1886(n)? Enter ' 5 is "Y") and is a meanin 11 Tassets (see instruction not a meaningful user, doo 2 Enter "Y" for yes or "N' user (line 167 is "Y") and	"Y" for yes or "N ngful user (line ons) es this provider " for no. (see ir	l" for no. 167 is "Y qualify fo nstruction:	"), ento or a han s) s "N"),	er the rdship	Y	0168. (
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 58.01 If this provider is a CAH and is n exception under §413.70(a) (6) (ii) 59.00 If this provider is a meaningful transition factor. (see instruction	r under §1886(n)? Enter ' D5 is "Y") and is a meanin HIT assets (see instruction a meaningful user, doo ? Enter "Y" for yes or "N" user (line 167 is "Y") and ons)	'Y" for yes or "M ngful user (line ons) es this provider ' for no. (see ir d is not a CAH (l	l" for no. 167 is "Y qualify fo nstruction: ine 105 i:	"), ento or a han s) s "N"), <u>E</u>	er the rdship enter the Beginning	Y 9. 9	0168. (168. (99169. (
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0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful used 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 68.01 If this provider is a CAH and is in exception under §413.70(a) (6) (ii) / 69.00 If this provider is a meaningful of transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I	r under §1886(n)? Enter ' D5 is "Y") and is a meanin HIT assets (see instruction a meaningful user, doo ? Enter "Y" for yes or "N" user (line 167 is "Y") and ons)	'Y" for yes or "M ngful user (line ons) es this provider ' for no. (see ir d is not a CAH (l	l" for no. 167 is "Y qualify fo nstruction: ine 105 i:	"), ento or a han s) s "N"), <u>E</u>	er the rdship enter the Beginning 1.00 7/01/2017	Y 9.9 Endi ng 2.00 09/30/2017	0168. (
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I exception under §413.70(a) (6) (ii) 69.00 If this provider is a meaningful user transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	r under §1886(n)? Enter ' 5 is "Y") and is a meanin HIT assets (see instruction not a meaningful user, down ? Enter "Y" for yes or "N' user (line 167 is "Y") and ons) peginning date and ending	'Y" for yes or "M ngful user (line ons) es this provider ' for no. (see ir d is not a CAH (l date for the rep	" for no. 167 is "Y qualify fo struction: ine 105 i: porting	"), ento or a han s) s "N"), <u>E</u>	er the rdship enter the Beginning 1.00 7/01/2017 1.00	Y 9.9 Endi ng 2.00 09/30/2017 2.00	0168. (168. (99169. (
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I exception under §413.70(a) (6) (ii) 69.00 If this provider is a meaningful u transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	r under §1886(n)? Enter ' 25 is "Y") and is a meanin HT assets (see instruction not a meaningful user, down ? Enter "Y" for yes or "N' user (line 167 is "Y") and poginning date and ending vider have any days for in	'Y" for yes or "M ngful user (line ons) es this provider ' for no. (see ir d is not a CAH (l date for the rep ndividuals enroll	" for no. 167 is "Y qualify fo istruction: ine 105 i: porting ed in	"), ento or a hau s) s "N"), <u>E</u> 0	er the rdship enter the Beginning 1.00 7/01/2017	Y 9.9 Endi ng 2.00 09/30/2017 2.00	0168. (168. (99169. (
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the I state of this provider is a CAH and is n exception under §413.70(a) (6) (ii) 59.00 If this provider is a meaningful user transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	r under §1886(n)? Enter ' D5 is "Y") and is a meanin HT assets (see instruction not a meaningful user, dow ? Enter "Y" for yes or "N" user (line 167 is "Y") and peginning date and ending vider have any days for in reported on Wkst. S-3, Pt.	'Y" for yes or "M ngful user (line ons) es this provider ' for no. (see ir d is not a CAH (l date for the rep ndividuals enroll . I, line 2, col.	" for no. 167 is "Y qualify fo istruction: ine 105 i: porting ed in 6? Enter	"), ent(or a hai s) s "N"), <u>E</u> 0	er the rdship enter the Beginning 1.00 7/01/2017 1.00	Y 9.9 Endi ng 2.00 09/30/2017 2.00	0168. (168. (99169. (

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0104	Period: From 01/01/2017	Worksheet S- Part II	2
				To 12/31/2017	Date/Time Pro 5/22/2018 7:4	
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO ro	sponsos Entr	1.00	2.00	-
	mm/dd/yyyy format.	TOT ALL NO LE	sponses. Ente		ne	
	COMPLETED BY ALL HOSPITALS					
. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	bogi ppi pg_of	the cost	N		1.0
. 00	reporting period? If yes, enter the date of the change in c					1.0
			Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.0
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe relationships? (see instructions)	ffices, drug er or its f the board	Y			3. (
			Y/N	Туре	Date	
			1.00	2.00	3.00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava	or Compiled,	Y	A		4.0
. 00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.0
				Y/N 1.00	Legal Oper. 2.00	
00	Approved Educational Activities	16		- N		
. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	TT yes, is th	le provider is	5 N		6.0
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved		during the	N N		7. 0 8. 0
. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	graduate medic	al education	Ν		9. (
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.		he current	Ν		10. (
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	roved	N		11. (
					Y/N 1.00	
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	see instruct	ions		Y	12. (
	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	N	13. (
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement		*		N	14. (
э. UU	Did total beds available change from the prior cost reporti	<u> </u>	yes, see inst t A	Par	N t B	15.0
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see	N		N		16. C
7. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/10/2018	Y	04/10/2018	17. (
8. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18.0
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19.

|--|

In Lieu of Form CMS-2552-10

Health Financial Systems WITHAM MEMORIA	AL_HOSPITAL		In Lie	eu of Form CM	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	1	Period: From 01/01/2017 To 12/31/2017		repared:
	Descri	ption	Y/N	Y/N	
)	1.00	3.00	
20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
-	Y/N	Date	Y/N	Date	
	1.00	2.00	3.00	4.00	
21.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	Ν		N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEP	PT CHILDRENS H	OSPI TALS)			
Capital Related Cost				[
22.00 Have assets been relifed for Medicare purposes? If yes, see					22.00
23.00 Have changes occurred in the Medicare depreciation expense of reporting period? If yes, see instructions.			0		23.00
24.00 Were new leases and/or amendments to existing leases entered If yes, see instructions	0	·	0.1		24.00
25.00 Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	lfyes, see		25.00
26.00 Were assets subject to Sec.2314 of DEFRA acquired during the instructions.	e cost reporti	ng period? If	yes, see		26.00
27.00 Has the provider's capitalization policy changed during the copy.	cost reportin	g period? If	yes, submit		27.00
Interest Expense 28.00 Were new Loans, mortgage agreements or letters of credit en	tered into dur	ina the cost	reportina		28.00
period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or I		-			29.00
treated as a funded depreciation account? If yes, see instru 30.00 Has existing debt been replaced prior to its scheduled matur	uctions				30.00
instructions. 31.00 Has debt been recalled before scheduled maturity without is:	-	-			31.00
instructions. Purchased Services		debt: 11 yes,			
32.00 Have changes or new agreements occurred in patient care serv		d through con	tractual		32.00
 arrangements with suppliers of services? If yes, see instructions. arrangements with suppliers of services? If yes, see instructions. 		g to competiti	ive bidding? If		33.00
Provi der-Based Physi ci ans					
34.00 Are services furnished at the provider facility under an ar	rangement with	provi der-base	ed physi ci ans?		34.00
If yes, see instructions.					
35.00 If line 34 is yes, were there new agreements or amended exis physicians during the cost reporting period? If yes, see ins		ts with the p	rovi der-based		35.00
			Y/N	Date	
llama Offica Casta			1.00	2.00	_
Home Office Costs 36.00 Were home office costs claimed on the cost report?					24 00
37.00 fline 36 is yes, has a home office cost statement been pro	epared by the	home office?			36.00 37.00
<pre>11 Jf yes, see instructions. 138.00 If line 36 is yes, was the fiscal year end of the home offi the provider? If yes, enter in column 2 the fiscal year end</pre>					38.00
39.00 If line 36 is yes, did the provider render services to other see instructions.					39.00
40.00 If line 36 is yes, did the provider render services to the l instructions.	home office?	lf yes, see			40.00
	1	00		00	_
Cost Report Preparer Contact Information	1.	00	Ζ.	00	
	TINA		SEVERS		41.00
respectively.	BLUE & CO., LL	С			42.00
preparer.	317-713-7946		TSEVERS@BLUEAN	DCO. COM	43.00
report preparer in columns 1 and 2, respectively.					

Heal th	Financial Systems	WI THAM MEMORIA	L HOSPITAL		In Lie	u of Form CMS-	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	ESTI ONNAI RE	Provi der	CCN: 15-0104	Peri od:	Worksheet S-2 Part II	
					From 01/01/2017 To 12/31/2017		pared: 9 am
				3.00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the titl	e/position M	IANAGER				41.00
	held by the cost report preparer in columns	1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost	report					42.00
	preparer.						
43.00	Enter the telephone number and email address	of the cost					43.00
	report preparer in columns 1 and 2, respecti	vel y.					

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	WITHAM MEMORIA	Provider CC	N. 15 0104	Period:	u of Form CMS-2 Worksheet S-3	
HUSPII	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	N: 15-0104	From 01/01/2017 To 12/31/2017	Part I Date/Time Pre	pared:
						5/22/2018 7:4 /P Days / O/P Visits / Trips	9 am
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	60	21, 90		0	1.00
2.00 3.00 4.00 5.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF					0	2.00 3.00 4.00 5.00
6.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)		60	21, 90	0.00	0	6. 00 7. 00
8.00 9.00 10.00 11.00 12.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)	31. 00	8	2, 9:	20 0.00	0	8.00 9.00 10.00 11.00 12.00
13.00 14.00 15.00	NURSERY Total (see instructions) CAH visits	43.00	68	24, 82	20 0.00	0 0 0	13.00 14.00 15.00
16.00 17.00 18.00	SUBPROVI DER – I PF SUBPROVI DER – I RF SUBPROVI DER	40.00 41.00 42.00	10 0 0	3, 6	50 0 0	0	16.00 17.00 18.00
19.00 20.00 21.00 22.00 23.00 24.00	SKI LLED NURSI NG FACI LI TY NURSI NG FACI LI TY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGI CAL CENTER (D. P.) HOSPI CE	44. 00	18	6, 5	-	0	19.00 20.00 21.00 22.00 23.00 24.00
24. 10 25. 00 26. 00	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	30. 00					24. 10 25. 00 26. 00
26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary Labor & delivery room	89. 00	96 0		0	0	26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00 32.01
33.00	LTCH site neutral days and discharges						33. 00 33. 01

10SPI 1	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2017 To 12/31/2017		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2, 213	189		8		1.00
2.00	HMO and other (see instructions)	970	1, 895				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.00
5.00	Hospital Adults & Peds. Swing Bed NF		0		0		6.00
7.00	Total Adults and Peds. (exclude observation	2, 213	189	5, 23	8		7.00
	beds) (see instructions)			4 75			0.00
3.00	INTENSIVE CARE UNIT	802	0	1, 75	1		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)		0	1 00	2		12.00
13.00	NURSERY	2 015	0	.,		150.04	13.00
14.00	Total (see instructions)	3, 015	189			159.94	
15.00 16.00	CAH visits	2 444	0		0	10 50	15.00
	SUBPROVIDER - IPF	2, 444	0		0 0.00 0 0.00		
17.00 18.00	SUBPROVI DER – I RF SUBPROVI DER	U	0		0 0.00		
19.00	SUBFROVIDER SKILLED NURSING FACILITY	3, 469	0				
20.00	NURSING FACILITY	3,409	0	5,27	2 0.00	17.00	20.00
21.00	OTHER LONG TERM CARE						20.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24.10	HOSPICE (non-distinct part)	0	0		0		24.10
25.00	CMHC - CMHC	Ű	0		0		25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00	0.00	
27.00	Total (sum of lines 14-26)	-	-		0.00		
28.00	Observation Bed Days		0	1, 21			28.00
29.00	Ambul ance Trips	1, 858		,			29.00
30.00	Employee discount days (see instruction)			9	5		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)	o	55	8	4		32.00
32.01	Total ancillary labor & delivery room				0		32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33.00
33 01	LTCH site neutral days and discharges	0					33.01

1.00	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC		Provider CO		Period: From 01/01/2017	Worksheet S-3 Part I	
					To 12/31/2017	Date/Time Pre	pared:
					10 12/01/2017	5/22/2018 7:4	
		Full Time		Di s	charges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	10.00	12.00	14.00	Pati ents	
	llachital Adulta & Dada (columna E. (. 7 and	11.00	12.00	13.00	14.00 07 49	15.00 2,308	1.00
	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		0	9	J7 49	2, 300	1.00
2.00	Hospice days) (see instructions for col. 2						
2.00	for the portion of LDP room available beds)						
	HMO and other (see instructions)			2	55 470		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
5.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7.00
	beds) (see instructions)						
	INTENSIVE CARE UNIT						8.00
	CORONARY CARE UNIT						9.00
	BURN INTENSIVE CARE UNIT						10.00
	SURGI CAL INTENSI VE CARE UNI T						11.00
	OTHER SPECIAL CARE (SPECIFY)						12.00
	NURSERY	0.00				0.000	13.00
1	Total (see instructions)	0.00	0	9	07 49	2, 308	
	CAH visits	0.00	0	1	38 0	233	15.00 16.00
	SUBPROVI DER – I PF SUBPROVI DER – I RF	0.00	0	1		233	17.00
	SUBPROVIDER	0.00	0		0 0	294	18.00
1	SKILLED NURSING FACILITY	0.00	0		0	274	19.00
1	NURSING FACILITY	0.00					20.00
	OTHER LONG TERM CARE						21.00
	HOME HEALTH AGENCY						22.00
	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24.10
	CMHC – CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00	Total (sum of lines 14-26)	0.00					27.00
	Observation Bed Days						28.00
	Ambul ance Trips						29.00
	Employee discount days (see instruction)						30.00
	Employee discount days - IRF						31.00
	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room						32.01
22 00	outpatient days (see instructions)				0		22.00
	LTCH non-covered days LTCH site neutral days and discharges				0		33.00 33.01

SPI T	AL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2017 To 12/31/2017		pare
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Related to	Average Hourly Wage (col. 4 ÷ col. 5)	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	SALARIES							
00	Total salaries (see	200.00	52, 835, 829	941, 120	53, 776, 94	9 1, 469, 280. 00	36.60	1.
00	instructions) Non-physician anesthetist Part		C	0	(0.00	0.00	2.
00	A Non physician anosthatist Dant		(0.00	0.00	3.
00	Non-physician anesthetist Part B		(,	0.00	0.00	3.
00	Physician-Part A - Administrative		C	0 0	(0.00	0.00	4.
D1	Physicians - Part A - Teaching		C	0 0	(0.00	0.00	4.
00	Physician and Non Physician-Part B		C	0 0	(0.00	0.00	5.
00	Non-physician-Part B for		C	0 0	(0.00	0.00	6.
	hospital-based RHC and FQHC services							
00	Interns & residents (in an	21.00	C	0 0	(0.00	0.00	7.
11	approved program)		(0.00	-
01	Contracted interns and residents (in an approved		(J U	,	0.00	0.00	7
	programs)							
00	Home office and/or related organization personnel		(0	(0.00	0.00	8
00	SNĚ	44.00	951, 265		969, 01			
00	Excluded area salaries (see instructions)		24, 737, 837	63, 888	24, 801, 72	5 526, 370. 00	47.12	10
	OTHER WAGES & RELATED COSTS						1	
00	Contract Labor: Direct Patient Care		1, 559, 211	0	1, 559, 21	1 23, 070. 00	67.59	11
00	Contract Labor: Top Level		C	0 0	(0.00	0.00	12
	management and other management and administrative							
	servi ces							
00	Contract Labor: Physician-Part A - Administrative		0	0 0	(0.00	0.00	13
00	Home office and/or related		C	0	(0.00	0.00	14
	orgainzation salaries and							
01	wage-related costs Home office salaries		C	0	(0.00	0.00	14
02	Related organization salaries		(0		0.00		
00	Home office: Physician Part A - Administrative		Ĺ) 0	(0.00	0.00	15
00	Home office and Contract		C	0 0	(0.00	0.00	16
	Physicians Part A - Teaching WAGE-RELATED COSTS							
00	Wage-related costs (core) (see		8, 062, 404	4 O	8, 062, 40	4		17
00	instructions) Wage-related costs (other)		75, 936	0	75, 93	6		18
	(see instructions)							
00 00	Excluded areas Non-physician anesthetist Part		5, 720, 721 (5, 720, 72			19
	A		C C		·			
00	Non-physician anesthetist Part B		(0	(C		21
00	Þ Physician Part A -		(0	(b		22
01	Administrative Physician Part A - Teaching		r			0		22
00	Physician Part B		(23
00	Wage-related costs (RHC/FQHC)		(0		D		24
00	Interns & residents (in an approved program)		((25
50	Home office wage-related		(0	(C		25
51	(core) Related organization		C	0	(b		25
	wage-related (core)							
52	Home office: Physician Part A - Administrative -		C	0	(U		25
	wage-related (core)							
53	Home office & Contract Physicians Part A - Teaching -		(0	(C		25
	wage-related (core)							
	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4. 00	511, 467	18, 427	529, 89	4 13, 090. 00	40. 48	26
00 00	Administrative & General	4.00 5.00	5, 950, 778		529, 89 6, 293, 74			

Heal th	Financial Systems		WI THAM MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part II Date/Time Pre 5/22/2018 7:4	pared:
		Wkst. A Line		Reclassi fi cati			Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.		col. 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		1, 058, 539	0	1, 058, 53	9 8, 029. 00	131.84	28.00
29.00	Maintenance & Repairs	6.00	0	0	(0.00	0.00	29.00
30.00	Operation of Plant	7.00	624, 573	14, 909	639, 48	2 23, 282. 00	27.47	30.00
31.00	Laundry & Linen Service	8.00	27,650		28, 21	4 2, 597.00	10. 86	31.00
32.00	Housekeepi ng	9.00	379, 884	8, 071	387, 95	5 27, 902. 00	13.90	32.00
33.00	Housekeeping under contract (see instructions)		0	0	(0.00	0.00	33.00
34.00	Dietary	10.00	752, 192	-150, 923	601, 26	9 34, 107. 00	17.63	34.00
35.00	Dietary under contract (see instructions)		0	0	(0.00	0.00	35.00
36.00	Cafeteri a	11.00	0	164, 573	164, 57	3 11, 805. 00	13.94	36.00
37.00	Maintenance of Personnel	12.00	0	0	(0.00	0.00	37.00
38.00	Nursing Administration	13.00	575, 271	15, 639	590, 910	0 14, 767. 00	40. 02	38.00
39.00	Central Services and Supply	14.00	0	0	(0.00	0.00	39.00
40.00	Pharmacy	15.00	536, 386	10, 924	547, 310	0 16, 772. 00	32.63	40.00
41.00	Medi cal Records & Medi cal Records Library	16. 00	1, 188, 988					
42.00	Soci al Servi ce	17.00	0	0	(0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	(0.00		43.00

Heal th	Financial Systems		WI THAM MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPI	AL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2017 To 12/31/2017	Date/Time Pre	
							5/22/2018 7:40	
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		53, 894, 368	941, 120	54, 835, 48	8 1, 477, 309. 00	37.12	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		25, 689, 102	81, 633	25, 770, 73	5 567, 823.00	45. 39	2.00
3.00	Subtotal salaries (line 1		28, 205, 266	859, 487	29, 064, 75	3 909, 486. 00	31.96	3.00
	minus line 2)							
4.00	Subtotal other wages & related		1, 559, 211	0	1, 559, 21	1 23, 070. 00	67.59	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		8, 138, 340	0	8, 138, 34	0 0.00	28.00	5.00
(00	(see inst.)		27 002 017	050 407		4 000 554 00	41 57	(00
6.00	Total (sum of lines 3 thru 5)		37, 902, 817					
7.00	Total overhead cost (see		11, 605, 728	455, 904	12, 061, 63	2 389, 026. 00	31.00	7.00
	instructions)			1				

Heal th	Financial Systems WITHAM MEMORIA	AL HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE RELATED COSTS	Provider CCN: 15-0104	Period: From 01/01/2017 To 12/31/2017		
				Amount	
				Reported	
				1.00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				
	RETI REMENT COST				
1.00	401K Employer Contributions			532, 369	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0	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
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan			0	6.00
7.00	Employee Managed Care Program Administration Fees			0	7.00
	HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			6, 417, 385	8.00
8.01	Health Insurance (Self Funded without a Third Party Adminis			0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administra	tor)		0	
8.03	Heal th Insurance (Purchased)			0	8.03
9.00	Prescription Drug Plan			2, 118, 084	
10.00	Dental, Hearing and Vision Plan			459, 872	
11.00	Life Insurance (If employee is owner or beneficiary)			72, 721 0	
12.00	Accident Insurance (If employee is owner or beneficiary) Disability Insurance (If employee is owner or beneficiary)			212, 517	
13.00 14.00	Long-Term Care Insurance (If employee is owner or beneficia	20		212, 517	
14.00	Workers' Compensation Insurance	Ty)		452, 894	
16.00	Retirement Health Care Cost (Only current year, not the ext	raordinary accrual roquir	d by EASP 106	452, 894	
10.00	Non cumulative portion)		a by 1A35 100.	0	10.00
	TAXES				
17.00	FICA-Employers Portion Only			3, 430, 766	17.00
18.00	Medicare Taxes - Employers Portion Only				18.00
19.00	Unemployment Insurance			86, 517	
20.00	State or Federal Unemployment Taxes				20.00
	OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost instructions))	Reported on lines 1 throu	igh 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances			0	22.00
	Tuition Reimbursement			0	
	Total Wage Related cost (Sum of lines 1 -23)			13, 783, 125	24.00
	Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS			75, 936	25.00

Heal th	Financial Systems	WI THAM MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-01		eriod:	Worksheet S-3	
					rom 01/01/2017	Part V	
				1	0 12/31/2017	Date/Time Pre 5/22/2018 7:49	
	Cost Center Description				Contract Labor	Benefit Cost	
					1.00	2.00	
	PART V - Contract Labor and Benefit Cost						
	Hospital and Hospital-Based Component Identi	fication:					
1.00	Total facility's contract labor and benefit	cost			1, 559, 211	13, 783, 125	1.00
2.00	Hospi tal				1, 559, 211	13, 783, 125	2.00
3.00	Subprovider - IPF				0	0	3.00
4.00	Subprovider - IRF				0	0	4.00
5.00	Subprovider - (Other)				0	0	5.00
6.00	Swing Beds - SNF				0	0	6.00
7.00	Swing Beds - NF				0	0	7.00
8.00	Hospital-Based SNF				0	0	8.00
9.00	Hospital-Based NF						9.00
10.00	Hospital-Based OLTC						10.00
11.00	Hospital-Based HHA						11.00
12.00	Separately Certified ASC						12.00
13.00	Hospital-Based Hospice						13.00
14.00	Hospital-Based Health Clinic RHC						14.00
15.00	Hospital-Based Health Clinic FQHC						15.00
16.00	Hospital-Based-CMHC						16.00
17.00	Renal Dialysis						17.00
18.00	Other				0	0	18.00

	Financial Systems WI THAM MEMORI				u of Form CMS-2	
PROSPE	CTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider C	F	eriod: rom 01/01/2017	Worksheet S-7	
			1	o 12/31/2017	Date/Time Pre 5/22/2018 7:4	
				1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all pa			N	2.00	1.00
	or was there no Medicare utilization? Enter "Y" for yes in complete the rest of this worksheet.	column 1 and c	lo not			
2.00	Does this hospital have an agreement under either section swing beds? Enter "Y" for yes or "N" for no in column 1.			N		2.00
	date (mm/dd/yyyy) in column 2.	Group	SNF Days		Total (sum of	
		1.00	2.00	Days 3.00	col. 2 + 3) 4.00	
3.00		RUX	0	0	0	3.00
4.00 5.00		RUL RVX	0	-	0 17	4.00 5.00
6.00		RVL	20		20	6.00
7.00		RHX	26			7.00
8.00 9.00		RHL RMX	19 0		19 0	8.00 9.00
10.00		RML	0	0	0	10.00
11.00 12.00		RLX RUC	0 229		0 229	11. 00 12. 00
13.00		RUB	109		109	13.00
14.00		RUA	115			
15.00 16.00		RVC RVB	549 527		549 527	15.00 16.00
17.00		RVA	592	0	592	17.00
18.00 19.00		RHC RHB	356		356 188	
20.00		RHA	183	0	183	20.00
21.00 22.00		RMC RMB	46		46	21.00 22.00
22.00		RMA	39			22.00
24.00		RLB	0		0	24.00
25.00 26.00		RLA ES3	0			25.00 26.00
27.00		ES2	0	0	0	27.00
28.00 29.00		ES1 HE2	0	-	0	28.00 29.00
30.00		HE1	0		0	30.00
31.00		HD2	14		14	31.00
32.00 33.00		HD1 HC2	0		0	32.00 33.00
34.00		HC1	0		0	34.00
35.00 36.00		HB2 HB1	4	-	4 92	35.00 36.00
37.00		LE2	0	0	0	37.00
38.00 39.00		LE1 LD2	0		0 24	38. 00 39. 00
40.00		LD1	60	0	60	40.00
41.00 42.00		LC2 LC1	0		0 7	41.00 42.00
43.00		LB2	0		0	43.00
44.00 45.00		LB1 CE2	0		0	44.00 45.00
46.00		CE1	0		0	46.00
47.00		CD2	10		10	47.00
48.00 49.00		CD1 CC2	9		9	48.00 49.00
50.00		CC1	13	0	13	50.00
51.00 52.00		CB2 CB1	6 140		6 140	51.00 52.00
53.00		CA2	0	0	0	53.00
54.00 55.00		CA1 SE3	23		23 0	54.00 55.00
55.00 56.00		SE2			0	55.00
57.00		SE1	0	0		57.00
58.00 59.00		SSC SSB	0		0	58.00 59.00
60.00		SSA	0	0	0	60.00
61.00 62.00		I B2 I B1	0		0	61.00 62.00
62.00 63.00		I A2			0	62.00 63.00
64.00		I A1	0	0	0	64.00
65. 00 66. 00		BB2 BB1	0		0	65. 00 66. 00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

Health Financial Systems	WITHAM MEMORIAL HO	SPI ΤΑΙ		Inlie	eu of Form CMS-	2552-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA			CN: 15-0104	Peri od:	Worksheet S-7	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/22/2018 7:4	
	G	roup	SNF Days	5	Total (sum of	
		1.00	2.00	Days 3.00	<u>col. 2 + 3)</u> 4.00	
69.00		PE2	2.00	0 0		69.00
70.00		PE1		0 0	0	
71.00		PD2		0 0	0	71.00
72.00		PD1		3 0	13	72.00
73.00		PC2		0 0	0	
74.00		PC1		4 0	4	•
75.00		PB2		0 0	0	
76.00		PB1		7 0	17	
77.00		PA2		0 0	0	
78.00		PA1		4 0	4	
199.00		AAA		0 0		199. 00
200. 00 TOTAL			3, 40			200.00
				CBSA at	CBSA on/after	
				Beginning of	October 1 of	
				Cost Reporting Period	the Cost Reporting	
				renou	Period (if	
					applicable)	
				1.00	2.00	
SNF SERVICES						
201.00 Enter in column 1 the SNF CBSA code or 5 cha	aracter non-CBSA code	if a rur	al facility,	26900	26900	201.00
in effect at the beginning of the cost repor						
in effect on or after October 1 of the cost	reporting period (if	appl i cab	· ·			
			Expenses	Percentage	Associ ated	
					with Direct	
					Patient Care	
					and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register V	olume 68. No. 149 Au	oust 4. 2				
payments beginning 10/01/2003. Congress expe						
expenses. For lines 202 through 207: Enter i						
column 2 the percentage of total expenses fo						
line 7, column 3. In column 3, enter "Y" for				s increases asso	oci ated	
with direct patient care and related expense	s for each category.	(see ins				
202.00 Staffing			951, 20			202.00
203.00 Recruitment				0 0.00		203.00
204.00 Retention of employees				0 0.00		204.00
			150 7	0 0.00		205.00
206.00 OTHER EXPENSES			659, 79		Y	206.00
207.00 Total SNF revenue (Worksheet G-2, Part I, li	ne /, column 3)		2, 768, 5	8	l	207.00

Heal th	Financial Systems WITHAM MEMORIAL H	IOSPI TAL		In Lie	eu of Form CMS-	2552-10
		Provider CC	CN: 15-0104	Period: From 01/01/2017	Worksheet S-1	
				To 12/31/2017	Date/Time Pre 5/22/2018 7:4	
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	/ided by lir	ne 202 columr	ı 8)	0. 205060	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				4, 740, 915	•
3.00	Did you receive DSH or supplemental payments from Medicaid?					3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement			ai d?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr	rom Medicai	d		0	5.00
6.00 7.00	Medicaid charges Medicaid cost (line 1 times line 6)				34, 705, 305 7, 116, 670	
7.00 8.00	Difference between net revenue and costs for Medicaid program (lino 7 minu	us sum of lir	os 2 and 5 if	2, 375, 755	
5. 00	< zero then enter zero)	•			2, 375, 755	0.00
	Children's Health Insurance Program (CHIP) (see instructions fo	or each line	e)			1 0 00
9.00	Net revenue from stand-alone CHIP				0	
10.00 11.00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 mir	nus lino 0 i	f < zero then		•
12.00	enter zero)				0	12.00
	Other state or local government indigent care program (see inst	ructions fo	or each line)		I	1
13.00	Net revenue from state or local indigent care program (Not incl				0	13.00
14.00	Charges for patients covered under state or local indigent care	e program (N	Not included	in lines 6 or	0	14.00
	10)					
5.00	State or local indigent care program cost (line 1 times line 14				0	
16.00	Difference between net revenue and costs for state or local inc	ligent care	program (lir	ne 15 minus line	0	16.00
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state	/local india	ont caro program		-
	instructions for each line)	r anu state		jent care progran	115 (566	
17.00	Private grants, donations, or endowment income restricted to fu	undi ng chari	itv care		0	17.00
	Government grants, appropriations or transfers for support of h				0	18.00
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	indigent o	care programs	s (sum of lines	2, 375, 755	19.00
			Uni nsured pati ents	Insured patients	Total (col. 1 + col. 2)	
		-	1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)	I	1100	2100	0.00	
0. 00	Charity care charges and uninsured discounts for the entire fac (see instructions)	cility	2, 353, 54	47 0	2, 353, 547	20.00
21.00	Cost of patients approved for charity care and uninsured discoul instructions)	unts (see	482, 67	18 0	482, 618	21.00
22.00	Payments received from patients for amounts previously written	off as		0 0	0	22.00
23.00	charity care Cost of charity care (line 21 minus line 22)		482, 61	18 0	482, 618	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patier	nt days beyo	ond a length	of stay limit		24.00
25.00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond th		care program	n's length of	0	25.00
	stay limit					
6.00	Total bad debt expense for the entire hospital complex (see ins				13, 230, 532	
7.00	Medicare reimbursable bad debts for the entire hospital complex				145, 839	
7.01	Medicare allowable bad debts for the entire hospital complex (s	see instruct	tions)		224, 368	
	Non-Medicare bad debt expense (see instructions)				13, 006, 164	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see i	instructions)		2, 745, 573	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			3, 228, 191 5, 603, 946	
31.00	Total unieniivulseu anu uncompensateu care cost (TTNE 19 prus TT	ne 30)			J 5, 003, 940	1 31.00

RECLAS	Financial Systems SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF		L HOSPITAL Provider CC		eriod: rom 01/01/2017	u of Form CMS-2 Worksheet A	2002 10
				Ť		Date/Time Pre 5/22/2018 7:4	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT		5, 283, 956	5, 283, 956	-77, 305	5, 206, 651	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		0	0	3, 865, 336	3, 865, 336	2.00
3.00	00300 OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINI STRATI VE & GENERAL	511, 467 5, 950, 778	11, 704, 770 12, 660, 655	12, 216, 237 18, 611, 433	-497, 281 -1, 097, 725	11, 718, 956 17, 513, 708	4.00 5.00
5.00 7.00	00700 OPERATI ON OF PLANT	624, 573	2, 519, 497	3, 144, 070		3, 038, 918	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	27, 650	272, 751	300, 401	323	300, 724	8.00
9.00	00900 HOUSEKEEPING	379, 884	224, 894	604, 778		609, 970	9.00
10.00 11.00	01000 DI ETARY 01100 CAFETERI A	752, 192 0	881, 749 0	1, 633, 941 0	-409, 380 397, 741	1, 224, 561 397, 741	10.00 11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	575, 271	96, 528	671, 799	-28, 575	643, 224	13.00
15.00	01500 PHARMACY	536, 386	4, 774, 001	5, 310, 387		3, 134, 027	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	1, 188, 988	367, 067	1, 556, 055	24, 741	1, 580, 796	16.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	3, 175, 858	1, 392, 498	4, 568, 356	-282, 766	4, 285, 590	30.00
31.00	03100 I NTENSI VE CARE UNI T	1,087,677	535, 068	1, 622, 745		1, 509, 676	31.00
40.00	04000 SUBPROVIDER - IPF	1, 151, 557	227, 227	1, 378, 784		1, 375, 465	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	0	0 24, 908	0 24, 908	0	0 24, 908	42.00 43.00
43.00	04400 SKI LLED NURSI NG FACI LI TY	951, 265	659, 798	1, 611, 063		1, 517, 398	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 980, 744	5, 808, 550	7, 789, 294		2, 679, 458	50.00
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	1, 299, 265 0	3, 000, 324 0	4, 299, 589	-327, 062	3, 972, 527 0	54.00 55.00
55.00	05501 ULTRA SOUND	336, 027	122, 595	458, 622	-4, 437	454, 185	55.00
57.00	05700 CT SCAN	140, 668	841, 789	982, 457	-376, 950	605, 507	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	373, 961	755, 182	1, 129, 143		815, 894	
59.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	138, 256	467, 714	605, 970		373, 524	59.00
60.00 63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2, 141, 255 0	3, 952, 804 169, 637	6, 094, 059 169, 637	-144, 290 -641	5, 949, 769 168, 996	60.00 63.00
64.00	06400 I NTRAVENOUS THERAPY	Ö	0	0	0	0	64.00
66.00	06600 PHYSI CAL THERAPY	1, 685, 071	252, 070	1, 937, 141	19, 017	1, 956, 158	
67.00 67.01	06700 OCCUPATI ONAL THERAPY 06701 AUDI OLOGY	273, 369 179, 917	33, 796 196, 403	307, 165 376, 320	6, 226 -10, 600	313, 391	67.00 67.01
68.00	06800 SPEECH PATHOLOGY	134, 951	198, 403	148, 799	2, 879	365, 720 151, 678	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
69.01	06901 CARDI OLOGY	962, 577	258, 146	1, 220, 723		1, 148, 576	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	364 0	364 0	2, 813, 874 3, 118, 992	2, 814, 238 3, 118, 992	
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	2, 119, 711	2, 119, 711	
	OUTPATIENT SERVICE COST CENTERS						
90.00		170 570	0	0	0	0	90.00
90. 01 90. 02	09001 OTHER OUTPATIENT SERVICE COST CENTER 09002 CLINIC	178, 572 0	126, 768 0	305, 340 0	-5, 829 0	299, 511 0	90.01 90.02
90.03	09003 DERMATOLOGY CLINIC	0	1, 486	1, 486	0	1, 486	
90.04	09004 ENT CLINIC	О	0	0	О	0	90.04
90.05	09005 SURGERY CLINIC	0	11, 177	11, 177	-1, 332	9,845	90.05
90. 07 90. 09	09007 UROLOGY CLINIC 09009 GASTROENTEROLOGY CLINIC	0 272	3, 612 7, 821	3, 612 8, 093	-535 1, 627	3, 077 9, 720	90.07 90.09
90. 09 90. 11	09011 NEUROLOGY CLINIC	2/2	565	565	0	565	90.09
90. 12	09012 OPTHAMOLOGY CLINIC	О	42, 628	42, 628	-37, 161	5, 467	90. 12
90.13	09013 ALLERGY CLINIC	97, 203	35, 078	132, 281	367	132, 648	
90.14 91.00	09014 WOUND CARE 09100 EMERGENCY	214, 449 2, 199, 446	298, 690 3, 047, 115	513, 139 5, 246, 561	-56, 770 -381, 490	456, 369 4, 865, 071	90.14 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 177, 440	3, 047, 113	3, 240, 301	301, 470	4,003,071	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	1, 971, 304	524, 544	2, 495, 848	-136, 044	2, 359, 804	95.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	31, 220, 853	61, 598, 073	92, 818, 926	280, 610	93, 099, 536	118 00
110.00	NONREI MBURSABLE COST CENTERS	01,220,000	01,070,070	72, 010, 720	200, 010	70,077,000	110.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES 07950 THORNTOWN OFFICE BUILDING	21, 300, 272	8, 576, 385	29, 876, 657		29, 599, 796	
	07950 THORNTOWN OFFICE BUILDING	0	0	0	0		194. 00 194. 01
	207952 OTHER NONRELIMB	67, 103	76, 989	144, 092	-1, 188	142, 904	
	07953 RETAIL PHARMACY	247, 601 52, 835, 829	1, 164, 649	1, 412, 250	-2, 561	1, 409, 689	194. 03
200.00			71, 416, 096	124, 251, 925	0	124, 251, 925	000 00

.00 0 .00 0	Cost Center Description ENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-BUDG & FIXT 00300 OTHER CAPITAL RELATED COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY NPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	Adj ustments (See A-8) 6.00 -150,243 0 0 -3,242,969 -5,208,855 0 0 -316,248 0 0 0 -316,248 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 865, 336 0 8, 475, 987 12, 304, 853 3, 038, 918 300, 724 609, 970 908, 313 397, 741 643, 224 3, 134, 027	From 01/01/201 To 12/31/201	7 Date/Time Prepared: 5/22/2018 7:49 am 1.0 2.0 3.0 4.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 13.0 13.0 15.0
.00 0 .00 0	ENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 0200 NEW CAP REL COSTS-MVBLE EQUIP 0300 OTHER CAPITAL RELATED COSTS 0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY NPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	(See A-8) 6.00 -150,243 0 0 -3,242,969 -5,208,855 0 0 0 -316,248 0 0 -316,248	For Al location 7.00 5,056,408 3,865,336 0 8,475,987 12,304,853 3,038,918 300,724 609,970 908,313 397,741 643,224 3,134,027		1.0 2.0 3.0 4.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 15.0
.00 0 .00 0	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAPITAL RELATED COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY NPATI ENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDI ATRICS 03100 INTENSI VE CARE UNIT	6.00 -150,243 0 -3,242,969 -5,208,855 0 0 -316,248 0 0 -316,248	7.00 5,056,408 3,865,336 0 8,475,987 12,304,853 3,038,918 300,724 609,970 908,313 397,741 643,224 3,134,027		2.0 3.0 4.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 15.0
.00 0 .00 0	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAPITAL RELATED COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY NPATI ENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDI ATRICS 03100 INTENSI VE CARE UNIT	0 0 -3, 242, 969 -5, 208, 855 0 0 0 -316, 248 0 0 0 -284	3, 865, 336 0 8, 475, 987 12, 304, 853 3, 038, 918 300, 724 609, 970 908, 313 397, 741 643, 224 3, 134, 027		2.0 3.0 4.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 15.0
.00 0 .00 0	00200 NEW CAP REL COSTS-MVBLE EQUI P 00300 OTHER CAPI TAL RELATED COSTS 00400 EMPLOYEE BENEFI TS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 INTENSI VE CARE UNI T	0 0 -3, 242, 969 -5, 208, 855 0 0 0 -316, 248 0 0 0 -284	3, 865, 336 0 8, 475, 987 12, 304, 853 3, 038, 918 300, 724 609, 970 908, 313 397, 741 643, 224 3, 134, 027		2.0 3.0 4.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 15.0
.00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0	00300 OTHER CAPITAL RELATED COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSI NG ADMINISTRATION 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY NPATI ENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0 -3, 242, 969 -5, 208, 855 0 0 -316, 248 0 0 0 0 284	0 8, 475, 987 12, 304, 853 3, 038, 918 300, 724 609, 970 908, 313 397, 741 643, 224 3, 134, 027		3.0 4.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 15.0
.00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 11000 DIETARY 1100 CAFETERIA 11300 NURSING ADMINISTRATION 11500 PHARMACY 11600 MEDICAL RECORDS & LIBRARY NPATIENT ROUTINE SERVICE COST CENTERS 13000 ADULTS & PEDIATRICS 13100 INTENSIVE CARE UNIT	-3, 242, 969 -5, 208, 855 0 0 -316, 248 0 0 -284	8, 475, 987 12, 304, 853 3, 038, 918 300, 724 609, 970 908, 313 397, 741 643, 224 3, 134, 027		4.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 15.0
.00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0 .00 0	00500 ADMI NI STRATI VE & GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01500 PHARMACY 01500 MEDI CAL RECORDS & LI BRARY NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	-5, 208, 855 0 0 -316, 248 0 0 -284	12, 304, 853 3, 038, 918 300, 724 609, 970 908, 313 397, 741 643, 224 3, 134, 027		5.0 7.0 8.0 9.0 10.0 11.0 13.0 15.0
. 00 . 00 0. 00 1. 00 3. 00 5. 00 6. 00 0 1. 00 0 0. 00 0 0 0 0 0 0 0 0 0 0 0 0	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01600 MEDI CAL RECORDS & LI BRARY	0 0 -316, 248 0 0 0 -284	300, 724 609, 970 908, 313 397, 741 643, 224 3, 134, 027		8. 0 9. 0 10. 0 11. 0 13. 0 15. 0
. 00 0 0. 00 0 1. 00 0 3. 00 0 5. 00 0 6. 00 0 1. 00 0 0. 00 0 0. 00 0	00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01600 ADULTS & PEDIATRICS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0 -316, 248 0 0 0 -284	609, 970 908, 313 397, 741 643, 224 3, 134, 027		9.0 10.0 11.0 13.0 15.0
0.00 1.00 3.00 5.00 6.00 0.00 1.00 0.00 0.00 0.00 0 0.00 0 0 0 0 0 0 0 0 0 0 0 0	01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	-316, 248 0 0 0 -284	908, 313 397, 741 643, 224 3, 134, 027		10. 0 11. 0 13. 0 15. 0
1.00 0 3.00 0 5.00 0 6.00 0 0.00 0 1.00 0 0.00 0 0.00 0	01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	0 0 -284	397, 741 643, 224 3, 134, 027		11. C 13. C 15. C
3.00 0 5.00 0 6.00 0 1.00 0 1.00 0 0.00 0	01300 NURSI NG ADMI NI STRATI ON 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	0 0 -284	643, 224 3, 134, 027		13. C 15. C
5.00 6.00 0 0.00 1.00 0.00 0	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY NPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0 -284	3, 134, 027		15. C
0. 00 0 1. 00 0 0. 00 0	NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T		1, 580, 512		
0.000 1.000 0.0000	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0			16.0
1.000 0.000	3100 I NTENSI VE CARE UNI T		1 005 500		
0. 00 0		0	4, 285, 590 1, 509, 676		30. 0 31. 0
	4000 SUBPROVIDER - IPF	-29, 097			40.0
	4100 SUBPROVI DER – I RF	27,077	0		40.0
2.00 0	4200 SUBPROVI DER	0	0		42.0
	4300 NURSERY	0	24, 908		43.0
	14400 SKI LLED NURSI NG FACI LI TY	-3, 800	1, 513, 598		44.0
	NCI LLARY SERVI CE COST CENTERS	0	2, 679, 458		50.0
	05400 RADI OLOGY-DI AGNOSTI C	-148, 101			54.0
	05500 RADI OLOGY-THERAPEUTI C	0	0		55.0
	5501 ULTRA SOUND	0	454, 185		55. C
	05700 CT SCAN	0	605, 507		57.0
	05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	0	815, 894		58. C 59. C
	6000 LABORATORY	-251, 182	373, 524 5, 698, 587		60.0
	6300 BLOOD STORING, PROCESSING & TRANS.	0	168, 996		63.0
	06400 I NTRAVENOUS THERAPY	0	0		64.0
	06600 PHYSI CAL THERAPY	0	1, 956, 158		66.0
	06700 OCCUPATIONAL THERAPY	0	313, 391		67.0
	06701 AUDI OLOGY 06800 SPEECH PATHOLOGY	-229, 212 0	136, 508 151, 678		67.0 68.0
	6900 ELECTROCARDI OLOGY	0	0		69.0
	06901 CARDI OLOGY	0	1, 148, 576		69.0
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-49,814	2, 764, 424		71. C
	7200 IMPL. DEV. CHARGED TO PATIENT	0			72.0
	07300 DRUGS CHARGED TO PATIENTS	0	2, 119, 711		73.0
	09000 CLINIC	0	0		90.0
	09001 OTHER OUTPATIENT SERVICE COST CENTER	0			90.0
0. 02 0	99002 CLI NI C	0	0		90. C
	09003 DERMATOLOGY CLINIC	-1, 486	0		90.0
		0.045	0		90.0
	99005 SURGERY CLINIC 99007 UROLOGY CLINIC	-9, 845 -3, 077			90. 0 90. 0
	99009 GASTROENTEROLOGY CLINIC	-9, 720			90.0
0. 11 0	99011 NEUROLOGY CLINIC	-565			90. 1
	99012 OPTHAMOLOGY CLINIC	0			90. 1
	99013 ALLERGY CLINIC	0			90.1
	99014 WOUND CARE 99100 EMERGENCY	136- 2, 123, 469-			90. 1 91. 0
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	-2, 123, 409	2,741,002		91.0
	THER REIMBURSABLE COST CENTERS				
	09500 AMBULANCE SERVICES PECIAL PURPOSE COST CENTERS	0	2, 359, 804		95. C
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	-11, 778, 103	81, 321, 433		118. C
	ONREIMBURSABLE COST CENTERS 9000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190. 0
	9200 PHYSI CI ANS' PRI VATE OFFI CES	0	29, 599, 796		190.0
	7950 THORNTOWN OFFICE BUILDING	0	0		194. C
94.010	07951 CAFE/BOUTI QUE	0	0		194. C
	07952 OTHER NONRELMB	0	142, 904		194.0
94.030 00.00	7953 RETAIL PHARMACY TOTAL (SUM OF LINES 118 through 199)	0 -11, 778, 103	1, 409, 689 112, 473, 822		194. 0 200. 0

	Financial Systems		WI THAM MEMORI			orm CMS-2552-10
RECLAS	SI FI CATI ONS			Provider CCN: 15-	From 01/01/2017	heet A-6
						Time Prepared: 2018 7:49 am
	Cost Center	Increases Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	•			1.00
	TOTALS B - INSURANCE		0	431, 775		
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	168, 145		1.00
	<u>FIX</u> T					
	TOTALS		0	168, 145		
1.00	C – CAFETERI A CAFETERI A	11.00	164, 573	233, 168		1.00
	TOTALS		164, 573	233, 168		
	D - DEPRECIATION					
1.00	NEW CAP REL COSTS-MVBLE	2.00	0	3, 865, 336		1.00
2.00	EQUI P	0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00 6.00		0.00 0.00	0	0		5. 00 6. 00
7.00		0.00	0	0		7.00
8.00		0.00	0	Ő		8.00
9.00		0.00	0	0		9.00
10. 00 11. 00		0.00	0	0		10.00
12.00		0.00 0.00	0	0		11.00 12.00
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 17. 00		0.00 0.00	0	0		16.00 17.00
18.00		0.00	0	0		18.00
19.00		0.00	О	0		19.00
20.00		0.00	0	0		20.00
21.00 22.00		0.00 0.00	0	0		21.00 22.00
22.00		0.00	0	0		22.00
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 28.00		0.00 0.00	0	0		27.00 28.00
29.00		0.00	0	Ö		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00 33.00		0.00 0.00	0	0		32.00 33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
36.00		0.00	0	0		36.00
37.00 38.00		0.00 0.00	0	0		37.00 38.00
36.00	TOTALS	0.00	— — — 0	3, 865, 336		38.00
	E - DRUGS	· · ·				
1.00	DRUGS_CHARGED_TO_PATIENTS		<u>0</u>	2, 168, 020		1.00
	TOTALS F - MED SUPPLY IMPLANTS		0	2, 168, 020		
1.00	I MPL. DEV. CHARGED TO	72.00	0	3, 118, 992		1.00
	PATI ENT					
2.00	-	0.00	0	0		2.00
3.00 4.00		0.00 0.00	0	0		3.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00				0		7.00
	TOTALS G - CHARGEABLE MED SUPPLIES	I I	0	3, 118, 992		
1.00	MEDICAL SUPPLIES CHARGED TO	71.00		2, 814, 490		1.00
	PATIENTS					
2.00		0.00	0	0		2.00
3.00 4.00		0.00 0.00	0	0		3.00
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

In Lieu of Form CMS-2552-10 Worksheet A-6

RECLAS	STFICATIONS			Provider C	CN: 15-0104	From 01/01/2017	worksneet A-0	5
							Date/Time Pro	
		Increases					5/22/2018 7:4	49 am
	Cost Center	Line #	Salary	Other				
	2. 00	3.00	4.00	5.00				
9.00		0.00	0	0				9.00
10. 00 11. 00		0. 00 0. 00	0	0 0				10.00 11.00
12.00		0.00	0	0				12.00
13.00		0.00	Ö	0				13.00
14.00		0.00	О	0				14.00
15.00		0.00	0	0				15.00
16.00		0.00	0	0				16.00
17.00 18.00		0. 00 0. 00	0	0 0				17.00 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 24.00		0.00	0	0 0				23.00
24.00 25.00		0. 00 0. 00	0	0				24.00 25.00
26.00		0.00	0	0				26.00
27.00		0.00	0	0				27.00
28.00		0.00	0	0				28.00
29.00			§	0				29.00
	TOTALS H - BONUS		Ō	2, 814, 490				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	18, 427	0				1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	342, 971	0				2.00
3.00	OPERATION OF PLANT	7.00	14, 909	0				3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	564	0				4.00
5.00 6.00	HOUSEKEEPI NG DI ETARY	9.00 10.00	8, 071 13, 650	0 0				5.00 6.00
7.00	NURSING ADMINISTRATION	13.00	15, 639	0				7.00
8.00	PHARMACY	15.00	10, 924	0				8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	30, 749	0				9.00
10.00	ADULTS & PEDIATRICS	30.00	67, 202	0				10.00
11.00	INTENSIVE CARE UNIT	31.00	26, 159	0 0				11.00
12. 00 13. 00	SUBPROVIDER - IPF SKILLED NURSING FACILITY	40. 00 44. 00	27, 357 17, 745	0				12.00 13.00
14.00	OPERATING ROOM	50.00	49, 592	0				14.00
15.00	RADI OLOGY-DI AGNOSTI C	54.00	36, 451	0				15.00
16.00	ULTRA SOUND	55.01	6, 558	0				16.00
17.00	CT SCAN	57.00	4, 255	0				17.00
18.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	9, 026	0				18.00
19.00	CARDIAC CATHETERIZATION	59.00	3, 322	0				19.00
20.00	LABORATORY	60.00	48, 490	0				20.00
21.00	PHYSI CAL THERAPY	66.00	39, 704	0				21.00
22.00	OCCUPATIONAL THERAPY	67.00	6, 869	0				22.00
23.00		67.01	4, 872	0				23.00
24.00 25.00	SPEECH PATHOLOGY CARDI OLOGY	68.00 69.01	2, 922 20, 092	0 0				24.00
26.00	OTHER OUTPATIENT SERVICE	90.01	4, 001	0				26.00
	COST CENTER		.,	Ũ				
27.00	GASTROENTEROLOGY CLINIC	90.09	1, 627	0				27.00
28.00	ALLERGY CLINIC	90.13	1, 797	0				28.00
29. 00 30. 00	WOUND CARE EMERGENCY	90. 14 91. 00	16, 385 54, 259	0				29.00 30.00
30.00 31.00	AMBULANCE SERVICES	91.00	54, 259 36, 531	0				30.00
200	TOTALS		941, 120	<u> </u>				
500.00	Grand Total: Increases		1, 105, 693	12, 799, 926				500.00

	inancial Systems FICATIONS		WI THAM MEMORI A			Peri od:	eu of Form CMS-2552 Worksheet A-6
						From 01/01/2017 To 12/31/2017	Date/Time Prepare
		Decreases					5/22/2018 7:49 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	_	
	6.00	7.00	8.00	9.00	10.00		
	ADMINISTRATIVE & GENERAL	5.00	0	431, 775	5 (1.
-	TOTALS		o	431, 775			
-	3 - INSURANCE				1		
	ADMI NI STRATI VE & GENERAL	5.00	0	<u>168, 1</u> 45		2	1.
-	TOTALS CAFETERIA		0	168, 145			
	DI ETARY	10.00	164, 573	233, 168	3 ()	1.
-	TOTALS		164, 573	233, 168			
-	D - DEPRECIATION				I.	1	
	NEW CAP REL COSTS-BLDG &	1.00	0	245, 450) 9	9	1.
	FIXT	4.00	о	4, 734	1 C		2.
	ADMINISTRATIVE & GENERAL	5.00	0	828, 536			3.
	OPERATION OF PLANT	7.00	0	119, 938			4.
	_AUNDRY & LINEN SERVICE	8.00	0	160			5.
	HOUSEKEEPING	9.00	0	2, 147			6.
	DI ETARY NURSI NG ADMI NI STRATI ON	10.00	0	25, 254		-	7.
	PHARMACY	13.00 15.00	0	44, 214 2, 026			8. 9.
	MEDICAL RECORDS & LIBRARY	16.00	0	5, 980		-	10.
	ADULTS & PEDIATRICS	30.00	0	126, 694			11.
	NTENSIVE CARE UNIT	31.00	0	35, 809			12.
	SUBPROVIDER - IPF	40.00	0	6, 236			13.
	SKILLED NURSING FACILITY OPERATING ROOM	44.00 50.00	0	68, 406 366, 672		-	14.
	RADI OLOGY-DI AGNOSTI C	54.00	0	321, 627			16.
	JLTRA SOUND	55.01	Ö	4, 805		-	17.
	CT SCAN	57.00	О	367, 875			18.
	MAGNETIC RESONANCE IMAGING	58.00	0	317, 889	9 (D	19.
		50.00		157 1/1			20
	CARDIAC CATHETERIZATION	59.00 60.00	0	157, 161 178, 234			20.
	BLOOD STORING, PROCESSING &	63.00	0	641			21.
	TRANS.		-				
	PHYSICAL THERAPY	66.00	0	18, 098			23.
	DCCUPATIONAL THERAPY	67.00	0	609			24.
	AUDI OLOGY SPEECH PATHOLOGY	67.01 68.00	0	15, 465 43			25. 26.
	CARDI OLOGY	69.01	0	85, 088	-	-	20.
	OTHER OUTPATIENT SERVICE	90.01	0	4, 592			28.
0	COST CENTER						
	SURGERY CLINIC	90.05	0	1, 332			29.
		90.07	0	535 37, 161		1	30.
	OPTHAMOLOGY CLINIC	90. 12 90. 13	0	1, 180			31.
	WOUND CARE	90.14	Ö	24, 330			33.
	EMERGENCY	91.00	О	86, 969			34
	AMBULANCE SERVICES	95.00	0	156, 564		-	35.
	PHYSICIANS' PRIVATE OFFICES	192.00	0	199, 133		-	36.
	OTHER NONREIMB RETAIL PHARMACY	194.02 194.03	0	1, 188 2, 561			37. 38.
-	TOTALS		of	3, 865, 336			50.
	E – DRUGS				-		
	PHARMACY	15.00	0	2, 168, 020)	1.
- F			0	2, 168, 020)		
	F - MED SUPPLY IMPLANTS	31.00	0	3/5			1.
	NTENSIVE CARE UNIT	31.00 50.00	0	363 2, 945, 211			2.
	RADI OLOGY-DI AGNOSTI C	54.00	ő	28, 276			3.
	CARDI AC CATHETERI ZATI ON	59.00	0	72, 581			4.
	MEDI CAL SUPPLI ES CHARGED TO	71.00	0	616	6 (5.
	PATIENTS	72 00		10 200			
	DRUGS CHARGED TO PATIENTS	73.00 90.14	0	48, 309 23, 636			6. 7.
	TOTALS		<u>0</u>	2 <u>3, 636</u> 3, 118, 992			/.
	G - CHARGEABLE MED SUPPLIES		0	5, 110, 772	-1	I	
	EMPLOYEE BENEFITS DEPARTMENT	4.00		1, 629			1.
	ADMINISTRATIVE & GENERAL	5.00		12, 240			2.
	OPERATION OF PLANT	7.00		123			3.
	_AUNDRY & LINEN SERVICE	8.00		81 222		-	4.
	HOUSEKEEPI NG DI ETARY	9.00 10.00		732 35			5.
- L	PHARMACY	15.00		17, 238			7.

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	S

WITHAM MEMORIAL HOSPITAL

	Financial Systems		WI THAM MEMOR		2011 45 0404		u of Form CMS	
RECLAS	SEFECATIONS			Provider (CCN: 15-0104	Period: From 01/01/2017	Worksheet A-	6
						To 12/31/2017	Date/Time Pr 5/22/2018 7:	
		Decreases					372272010 7.	
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref			
0.00	6.00	7.00	8.00	9.00	10.00			
8.00 9.00	MEDICAL RECORDS & LIBRARY ADULTS & PEDIATRICS	16.00 30.00		28 223, 274		0		8.00 9.00
9.00 10.00	INTENSIVE CARE UNIT	31.00		103, 056		0		10.00
11.00	SUBPROVIDER - IPF	40.00		24, 440		0		11.00
12.00	SKILLED NURSING FACILITY	40.00		43, 004		0		12.00
13.00	OPERATING ROOM	50.00		1, 847, 545		0		13.00
14.00	RADI OLOGY-DI AGNOSTI C	54.00		13, 610		o		14.00
15.00	ULTRA SOUND	55.01		6, 190		o		15.00
16.00	CT SCAN	57.00		13, 330		o		16.00
17.00	MAGNETIC RESONANCE IMAGING	58.00		4, 386		o		17.00
	(MRI)							
18.00	CARDI AC CATHETERI ZATI ON	59.00		6, 026		0		18.00
19.00	LABORATORY	60.00		14, 546		0		19.00
20.00	PHYSI CAL THERAPY	66.00		2, 589		0		20.00
21.00	OCCUPATIONAL THERAPY	67.00		34		0		21.00
22.00		67.01		7 151		0		22.00
23.00 24.00	CARDI OLOGY OTHER OUTPATI ENT SERVI CE	69. 01 90. 01		7, 151 5, 238		0		23.00 24.00
24.00	COST CENTER	90.01		5, 230		0		24.00
25.00	ALLERGY CLINIC	90. 13		250)	o		25.00
26.00	WOUND CARE	90.14		25, 189		o		26.00
27.00	EMERGENCY	91.00		348, 780		0		27.00
28.00	AMBULANCE SERVICES	95.00		16, 011		o		28.00
29.00	PHYSICIANS' PRIVATE OFFICES	192.00		77, 728		o		29.00
	TOTALS		0	2, 814, 490)			
1 00	H - BONUS	4.00		0.44, 400				1 00
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00 0.00	0	, . = =		0		1.00
2.00 3.00		0.00	0	0		0		2.00 3.00
4.00		0.00	0	0		0		4.00
5.00		0.00	0	0		0		5.00
6.00		0.00	0	0		o		6.00
7.00		0.00	0	0)	0		7.00
8.00		0.00	0	0		o		8.00
9.00		0.00	0	0		o		9.00
10.00		0.00	0	0		o		10.00
11.00		0.00	0	0		0		11.00
12.00		0.00	0	0		0		12.00
13.00		0.00	0	0		0		13.00
14.00 15.00		0.00 0.00	0	0		0		14.00 15.00
15.00 16.00		0.00	0			0		15.00
17.00		0.00	0	0		0		17.00
18.00		0.00	0	0		0		18.00
19.00		0.00	0	0		o		19.00
20.00		0.00	0	0		0		20.00
21.00		0.00	0	0		o		21.00
22.00		0.00	0	0		o		22.00
23.00		0.00	0	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				27.00
28.00		0.00 0.00	0			0		28.00
29. 00 30. 00		0.00	0					29.00 30.00
30.00 31.00		0.00	0			0		30.00
51.00	TOTALS		<u>0</u>	941, 120	<u> </u>	1		51.00
500.00	Grand Total: Decreases		164, 573			1		500.00
					•			•

Heal th	Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0104	Period: From 01/01/2017 To 12/31/2017		pared:
				Acqui si ti on	S		
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
	1	1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE				-	1	
1.00	Land	15, 269, 174	409, 651		0 409, 651	-64, 553	
2.00	Land Improvements	0	0		0 0	0	
3.00	Buildings and Fixtures	83, 856, 912	1, 137, 025		0 1, 137, 025	0	3.00
4.00	Building Improvements	0	0		0 0	0	4.00
5.00	Fixed Equipment	2, 240, 495	0		0 0	12, 340	5.00
6.00	Movable Equipment	52, 056, 134	5, 804, 713		0 5, 804, 713	1, 181, 091	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	153, 422, 715	7, 351, 389		0 7, 351, 389	1, 128, 878	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	153, 422, 715	7, 351, 389		0 7, 351, 389	1, 128, 878	10.00
		Endi ng Bal ance	Fully				
		-	Depreci ated				
			Assets				
		6.00	7.00			-	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	15, 743, 378	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	84, 993, 937	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	2, 228, 155	0				5.00
6.00	Movable Equipment	56, 679, 756	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	159, 645, 226	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	159, 645, 226	0				10.00

Heal th	Financial Systems	WI THAM MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0104	Period:	Worksheet A-7	
					From 01/01/2017 To 12/31/2017		narod
					10 12/31/2017	5/22/2018 7:49	9 am
			SL	JMMARY OF CAP	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	``	
		0.00	40.00	11.00		instructions)	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	9.00	10.00	11.00	12.00	13.00	
1.00	NEW CAP REL COSTS-BLDG & FIXT	5, 283, 956			0		1.00
2.00	NEW CAP REL COSTS-BEDG & FIXT	5, 265, 950	0		0 0	0	2.00
2.00	Total (sum of lines 1-2)	5, 283, 956	0		0 0	0	3.00
3.00		SUMMARY 0			0 0	0	3.00
		JOININART O	I CALLIAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	5, 283, 956				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	5, 283, 956				3.00

Health Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	1	Period: From 01/01/2017 To 12/31/2017	Worksheet A-7 Part III Date/Time Prep 5/22/2018 7:49	
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capitalized	Gross Assets		Insurance	
		Leases	for Ratio (col. 1 - col 2)	instructions)		
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00 NEW CAP REL COSTS-BLDG & FIXT	85, 058, 490				0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	2, 240, 495		_/ _ / _ /		0	2.00
3.00 Total (sum of lines 1-2)	87, 298, 985		0112,01,0			3.00
	ALLOCA	TION OF OTHER (CAPITAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		-				
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	, s		0 4, 987, 356		1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 3, 865, 336		2.00
3.00 Total (sum of lines 1-2)	0	0		0 8, 852, 692	-99, 093	3.00
		SL	JMMARY OF CAPI			
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
	11.00	10.00	10.00	instructions)	45.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	11.00	12.00	13.00	14.00	15.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT		168, 145		0 0	5, 056, 408	1.00
2.00 NEW CAP REL COSTS-BLDG & FIXT	0			0 0	5, 056, 408 3, 865, 336	2.00
3.00 Total (sum of lines 1-2)	0	-		0 0	3, 805, 330 8, 921, 744	2.00
3.00 10tal (Sull 01 111185 1-2)	1 0	100, 145	I		0, 721, 744	3.00

	Financial Systems MENTS TO EXPENSES		WI THAM MEMORI	Provider CCN: 15-0104 P	eriod: rom 01/01/2017	u of Form CMS-2 Worksheet A-8 Date/Time Pre	pared:
				Expense Classification on To/From Which the Amount is		5/22/2018 7:4	
					, ,		
	Cost Costos Decesistias	Dania (Cada (2)	Amount	Cost Contor	ling #	Wkat A 7 Daf	
	Cost Center Description	1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter		C	NEW CAP REL COSTS-BLDG & FLXT	1.00	0	1.00
2.00	2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		C	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Ínvestment income - other		C		0.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time		C		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of		C		0.00	0	5.00
6.00	expenses (chapter 8) Rental of provider space by		C		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter	В	-4, 673	ADMI NI STRATI VE & GENERAL	5.00	0	7.00
8.00	21) Tel evision and radio service		C		0.00	0	8.00
9. 00 10. 00	(chapter 21) Parking Lot (chapter 21) Provider-based physician	A-8-2	C -2, 555, 553		0.00	0	
11.00	adjustment Sale of scrap, waste, etc.	A 0 2	2, 000, 000		0.00	0	
12.00	(chapter 23) Related organization	A-8-1	(0100	0	
13.00	transactions (chapter 10) Laundry and linen service	A U I	(0.00	0	
	Cafeteria-employees and guests Rental of quarters to employee	В	C C	DI ETARY	0.00 10.00 0.00	0	14.00
16. 00	and others Sale of medical and surgical supplies to other than		C		0. 00	0	16.00
17.00	patients Sale of drugs to other than		C		0.00	0	17.00
18.00	patients Sale of medical records and		C		0.00	0	18.00
19.00	abstracts Nursing and allied health education (tuition, fees,		C		0. 00	0	19.00
20. 00 21. 00	books, etc.) Vending machines Income from imposition of interest, finance or penalty charges (chapter 21)	В	-2, 018 C	BDI ETARY	10. 00 0. 00	0 0	
22.00	Interest expense on Medicare overpayments and borrowings to		C		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	C	*** Cost Center Deleted ***	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66.00		24.00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		C	*** Cost Center Deleted ***	114.00		25.00
26.00	(chapter 21) Depreciation - NEW CAP REL		C	NEW CAP REL COSTS-BLDG &	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - NEW CAP REL		C	FIXT NEW CAP REL COSTS-MVBLE	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		C	EQUIP)*** Cost Center Deleted ***	19.00		28.00
29.00 30.00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	C	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29.00 30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		C	ADULTS & PEDIATRICS	30. 00		30. 99
31.00	instructions) Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	C	SPEECH PATHOLOGY	68.00		31.00

	MENTS TO EXPENSES				eriod: rom 01/01/2017 p 12/31/2017	Worksheet A-8 Date/Time Pre	pare
				Expense Classification on To/From Which the Amount is		5/22/2018 7:4	9 am
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
2.00	CAH HIT Adjustment for	1.00	2.00	3.00	4.00	5.00	32.
	Depreciation and Interest		0				
3. 00	HOSPI TAL ADMI NI STRAT SPONSORSHI PS/DO	A	-470, 231	ADMINISTRATIVE & GENERAL	5.00	0	33.
8. 01	LEASE INCOME	В	-63, 968	NEW CAP REL COSTS-BLDG &	1.00	10	33
8. 02	RENTAL REVENUE	В	-31, 725	FIXT NEW CAP REL COSTS-BLDG &	1.00	10	33
. 03	1208 N LEBANON RENTAL INCOME	В	-3.400	FIXT NEW CAP REL COSTS-BLDG &	1.00	10	33
				FLXT			
. 04 . 05	WELLNESS REVENUE EDUCATION REVENUE	B B		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4.00 5.00	0	
. 06	MEDI CAL STAFF FEES	B		ADMI NI STRATI VE & GENERAL	5.00	0	
. 07	VOLUNTEER MISC REVENUE	В		ADMI NI STRATI VE & GENERAL	5.00	0	33
. 08	VOLUNTEER MEMORIALS	В	-50	ADMI NI STRATI VE & GENERAL	5.00	0	33
. 09	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33
. 10	PATIENT ACCOUNTS	В		ADMI NI STRATI VE & GENERAL	5.00	0	
. 11 . 12	MISC INCOME RECEIVED MEALS ON WHEELS	B B		ADMI NI STRATI VE & GENERAL DI ETARY	5.00 10.00	0	
. 12	HEAD START & CASH(SHORT) OVER	B		DI ETARY	10.00	0	
. 14	CASH(SHORT) OVER	В		DIETARY	10.00	0	
. 15	CI COA MEAL VOUCHERS	В		DI ETARY	10.00	0	
. 16	MEDI CAL RECORDS	В		MEDICAL RECORDS & LIBRARY	16.00	0	
. 17	RADI OLOGY DI AGNOSTI C-PURCHASI NG DI SC	В	-96	RADI OLOGY-DI AGNOSTI C	54.00	0	33
. 18	CENTRAL SUPPLY PURCHASING DI SCOUNTS	В	-49, 814	MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	71.00	0	33
8. 19	AMBULANCE	В		AMBULANCE SERVICES	95.00	0	
3. 20	DERMATOLOGY CLINIC RENT	A		DERMATOLOGY CLINIC	90.03	0	
8. 21 8. 22	SURGERY CLINIC RENT UROLOGY CLINIC RENT	A A		SURGERY CLINIC UROLOGY CLINIC	90. 05 90. 07	0	
. 22	GASTROENTEROLOGY CLINIC RENT	A		GASTROENTEROLOGY CLINIC	90.07	0	
. 24	NEUROLOGY CLINIC RENT	A		NEUROLOGY CLINIC	90.11	0	
8. 25	EYE INSTITUTE RENT	A		OPTHAMOLOGY CLINIC	90. 12	0	
. 26	DI ALYSI S CENTER	A		WOUND CARE	90.14	0	
. 27	2010 PREMIUM AMORTIZATION	В	-24, 133	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	3:
8. 28	2010 BOND INTEREST ON INVEST	В	-7, 387	NEW CAP REL COSTS-BLDG & FLXT	1.00	9	33
3. 29	2015 BOND INTEREST ON INVEST	В	-19, 630	NEW CAP REL COSTS-BLDG &	1.00	9	33
3. 30		В	224, 424	ADMI NI STRATI VE & GENERAL	5.00	9	33
8. 31	BORROW GAIN ON INVESTMENT	В	-407 224	ADMI NI STRATI VE & GENERAL	5.00	9	33
. 32	VOLUNTEER REVENUE INTEREST	B		ADMI NI STRATI VE & GENERAL	5.00	0	3
8. 33	GAIN/(LOSS) CIHA	A	-854, 439	ADMI NI STRATI VE & GENERAL	5.00	0	33
3. 34	GAIN/(LOSS) SHO SPC	В		ADMI NI STRATI VE & GENERAL	5.00	0	
. 35 . 36	GAIN/(LOSS) SHO RRG OTHER ADJUSTMENTS (SPECIFY)	В	-1, 193	ADMI NI STRATI VE & GENERAL	5.00 0.00	0	
. 37	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	
	(3)		000.010				
3.38 3.39	HEARING AID COSTS OTHER ADJUSTMENTS (SPECIFY) (3)	A	-229, 212 0	AUDI OLOGY	67. 01 0. 00	0 0	33
. 40		A		ADMI NI STRATI VE & GENERAL	5.00	0	
8.41 8.42		A A		ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL	5.00 5.00	0	
. 42 . 43	NON-REIMBURSABLE ADVERTISING	A		ADMINISTRATIVE & GENERAL	5.00	0	
2 1 1	COSTS	В	_2 100 400	EMDLOVEE RENEELTS DEDADTMENT	4.00	0	
3.44 3.45	SELF INSURANCE CLAIMS PAID HAF FEE	A		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4.00 5.00		
8. 46	OTHER ADJUSTMENTS (SPECIFY)		2,004,100		0.00	0	
3. 47). 00	(3) EMPLOYEE HEALTH REV CLIENT TOTAL (sum of lines 1 thru 49)	В	-86, 817 -11, 778, 103	ADMI NI STRATI VE & GENERAL	5.00	0	33
. 00	(Transfer to Worksheet A, column 6, line 200.)		- 11, 770, 103				

Health Financial Systems	WI THAM MEMORI	AL HOSPITAL	In Lieu of Form CMS-2552-10			
ADJUSTMENTS TO EXPENSES			Period: From 01/01/2017	Worksheet A-8		
				To 12/31/2017		
			Expense Classification o			
			To/From Which the Amount is	s 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) 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.

Hool th	Financial Syste		WI THAM MEMOR			le li	ou of Form CMS	2552 10
	R BASED PHYSIC				CCN: 15-0104	In Lieu of Form CMS-2552-10 Period: Worksheet A-8-2		
FROVIDE	N DAGED FINGIC	TAN ADJUSTMENT				From 01/01/2017 To 12/31/2017	,	epared:
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		SUBPROVIDER - IPF	80, 000	0			584	1.00
2.00		SKILLED NURSING FACILITY	3, 800	3, 800		0	-	
3.00		RADI OLOGY-DI AGNOSTI C	148, 005			0	-	
4.00		LABORATORY	182	182		0 0	0	
5.00		LABORATORY	251, 000		(°	0	
6.00		EMERGENCY	1, 040, 880			0 0	0	
7.00		EMERGENCY	100, 000	100, 000		0 0	0	
8.00		EMERGENCY	982, 589	982, 589	(- -	0	
9.00	0.00		0	0	(- -	0	9.00
10.00	0.00		0	0	(0	
200.00			2, 606, 456				584	200.00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
	1.00	2.00	8,00	9,00	Education 12.00	12	14.00	
1.00		2.00 SUBPROVIDER - IPF	<u>8.00</u> 50.903	9.00		13.00 0 0		1.00
2.00		SUBPROVIDER - TPF	50, 903	2, 545			0	
2.00		RADI OLOGY-DI AGNOSTI C	0				0	
3.00 4.00		LABORATORY	0	0			0	
4.00 5.00		LABORATORY	0	0		°	0	
6.00		EMERGENCY	0	0			0	
7.00		EMERGENCY	0	0			0	
8.00		EMERGENCY	0	0			0	11.00
8.00 9.00	91.00 0.00		0	0		-	0	
10.00	0.00		0	0			0	
200.00	0.00		50, 903	2, 545			0	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	WRSt. A LINE π	I denti fi er	Component	Limit	Di sal I owance	Aujustilient		
		i denti i i ei	Share of col.		Disarrowance			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	40.00	SUBPROVIDER - IPF	0	50, 903	29,09	7 29,097		1.00
2.00	44.00	SKILLED NURSING FACILITY	0	0	. (3,800		2.00
3.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	(148,005		3.00
4.00		LABORATORY	0	0	(182		4.00
5.00		LABORATORY	0	0	(251,000		5.00
6.00		EMERGENCY	0	0	(1, 040, 880		6.00
7.00		EMERGENCY	0	0	(7.00
8.00		EMERGENCY	0	0	(8.00
9.00	0.00		0	0	(9.00
10.00	0.00		0	0	(0 0		10.00
200.00			0		29,09	2, 555, 553		200.00
					•			

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	WI THAM MEMORIA	AL HOSPITAL Provider CC		eriod:	u of Form CMS-: Worksheet B	2552-10
				Fi To	rom 01/01/2017 0 12/31/2017	Part I Date/Time Pre	
			CAPI TAL REL	CAPI TAL RELATED COSTS		5/22/2018 7:4	
Cost Center Description		Net Expenses for Cost Allocation (from Wkst A	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		<u>col.7)</u> 0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS						
1.00 2.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP	5, 056, 408 3, 865, 336	5, 056, 408	3, 865, 336			1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	8, 475, 987	11, 500	8, 791	8, 496, 278		4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	12, 304, 853	367, 513	280, 943	1,004,249	13, 957, 558	
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	3, 038, 918 300, 724	481, 482	368, 065 0	102, 038 4, 502	3, 990, 503 305, 226	
9.00	00900 HOUSEKEEPI NG	609, 970	55, 443	42, 383	61, 903	769, 699	
10.00	01000 DI ETARY	908, 313	124, 105	94, 871	95, 940	1, 223, 229	
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	397, 741 643, 224	0	0	26, 260 94, 287	424, 001 737, 511	
15.00	01500 PHARMACY	3, 134, 027	38, 312	29, 288	87, 330	3, 288, 957	
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 580, 512	60, 521	46, 265	194, 625	1, 881, 923	16.00
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	4, 285, 590	402, 545	307, 723	517, 472	5, 513, 330	30.00
30.00	03100 INTENSIVE CARE UNIT	4, 285, 590	402, 545 110, 550	307, 723 84, 509	177, 727	5, 513, 330 1, 882, 462	
40.00	04000 SUBPROVI DER – I PF	1, 346, 368	126, 575	96, 759	188, 111	1, 757, 813	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	24, 908	0	0	0	0 24, 908	
44.00	04400 SKILLED NURSING FACILITY	1, 513, 598	95, 850	73, 272	154, 618	1, 837, 338	1
50.00	ANCI LLARY SERVICE COST CENTERS	0 (70 (50)	004 070	0.45 500	000.0(7	0.570.004	1 50 00
50.00 54.00	05000 OPERATI NG ROOM 05400 RADI OLOGY-DI AGNOSTI C	2, 679, 458 3, 824, 426	321, 278 392, 923	245, 598 300, 367	323, 967 213, 131	3, 570, 301 4, 730, 847	50.00 54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	213, 131	4,730,047	55.00
55.01	05501 ULTRA SOUND	454, 185	0	0	54, 664	508, 849	
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	605, 507 815, 894	0	0	23, 124	628, 631 936, 481	57.00 58.00
58.00 59.00	05900 CARDI AC CATHETERI ZATI ON	373, 524	33, 708 28, 413	25, 768 21, 720	61, 111 22, 591	446, 248	
60.00	06000 LABORATORY	5, 698, 587	183, 243	140, 079	349, 402	6, 371, 311	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	168, 996	0	0	0	168, 996	
64.00 66.00	06400 I NTRAVENOUS THERAPY 06600 PHYSI CAL THERAPY	1, 956, 158	177, 355	135, 578	275, 210	0 2, 544, 301	64.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	313, 391	0	0	44, 716	358, 107	67.00
67.01	06701 AUDI OLOGY	136, 508	0	0	29, 485	165, 993	
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	151, 678	0	0	21, 999	173, 677 0	
69.01	06901 CARDI OLOGY	1, 148, 576	18, 277	13, 972	156, 798	1, 337, 623	1
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	2, 764, 424	0	0	0	2, 764, 424	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS	3, 118, 992 2, 119, 711	0	0	0	3, 118, 992 2, 119, 711	
70.00	OUTPATIENT SERVICE COST CENTERS	2,117,711	0		0	2, 117, 711	/ 0.00
90.00	09000 CLINIC	0	0	0	0	0	
90. 01 90. 02	09001 OTHER OUTPATIENT SERVICE COST CENTER 09002 CLINIC	299, 511	75, 518	57, 729	29, 132	461, 890 0	
90.03	09003 DERMATOLOGY CLINIC	0	0	0	0	0	1
90.04	09004 ENT CLINIC	0	0	0	0	0	
90. 05 90. 07	09005 SURGERY CLINIC 09007 UROLOGY CLINIC	0	0	0	0	0	90.05 90.07
90. 07 90. 09	09009 GASTROENTEROLOGY CLINIC	0	o	0	303	303	90.07
90. 11	09011 NEUROLOGY CLINIC	0	0	0	0	0	90.11
90. 12 90. 13	09012 OPTHAMOLOGY CLINIC 09013 ALLERGY CLINIC	5, 467	0	0	15 707	5, 467 148, 445	90.12
90. 13 90. 14	09013 ALLERGY CLINIC 09014 WOUND CARE	132, 648 456, 233	69, 235	0 52, 926	15, 797 36, 833	148, 445 615, 227	90.13
91.00	09100 EMERGENCY	2, 741, 602	485, 394	371, 056	359, 608	3, 957, 660	91.00
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)					0	92.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	2, 359, 804	94, 052	71, 897	320, 376	2, 846, 129	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00		81, 321, 433	3, 753, 792	2, 869, 559	5, 047, 309	75, 574, 071	118.00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	ol	12, 329	9, 425	0	21 754	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	29, 599, 796	848, 481	648, 616	3, 398, 754	34, 495, 647	
	07950 THORNTOWN OFFICE BUILDING	0	0	0	О		194.00
	07951 CAFE/BOUTI QUE 07952 OTHER NONREI MB	0 142, 904	27, 978 405, 924	21, 388 310, 306	0 10, 707	49, 366 869, 841	194.01
	07952 OTHER NORRETMB	1, 409, 689	405, 924 7, 904	6, 042	39, 508	1, 463, 143	
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers		0	0	0	0	201.00

Health Financial Systems	WI THAM MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO	F	Period: From 01/01/2017 Fo 12/31/2017		
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
202.00 TOTAL (sum lines 118 through 201)	112, 473, 822	5, 056, 408	3, 865, 336	8, 496, 278	112, 473, 822	202.00

	Financial Systems	WI THAM MEMORI A			In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 01/01/2017	Worksheet B Part I	
					0 12/31/2017	Date/Time Pre	pared:
	Cost Center Description	ADMI NI STRATI VE	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	5/22/2018 7:4 DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5.00	7.00	8.00	9.00	10.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	1					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	13, 957, 558					5.00
7.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	565, 366	4, 555, 869				7.00
8.00 9.00	00900 HOUSEKEEPING	43, 244 109, 049	C 69, 548				8.00 9.00
10.00	01000 DI ETARY	173, 305	155, 677		-		
11.00	01100 CAFETERI A	60, 072	C		,		
13.00	01300 NURSI NG ADMI NI STRATI ON	104, 489	0	-	-,		
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	465, 973 266, 627	48, 059 75, 918			0	
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	200, 027	75, 910		39,207	0	10.00
30.00	03000 ADULTS & PEDIATRICS	781, 118	504, 952	17, 934	297, 847	752, 506	30.00
31.00	03100 I NTENSI VE CARE UNI T	266, 703	138, 674	4, 491	79, 097	0	31.00
40.00	04000 SUBPROVIDER - IPF	249, 043	158, 775		-	303, 981	
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0	C		-	0	
42.00	04300 NURSERY	3, 529		1,871	0	0	42.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	260, 310	120, 234			554, 522	
	ANCI LLARY SERVI CE COST CENTERS	1 1		I			
50.00	05000 OPERATING ROOM	505,833	403, 010				
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	670, 257	492, 881 C				
55.00 55.01	05501 ULTRA SOUND	72, 093	C		-	0	
57.00	05700 CT SCAN	89, 063	C			0	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	132, 679	42, 284			0	
59.00	05900 CARDI AC CATHETERI ZATI ON	63, 224	35, 641			0	59.00
60.00 63.00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	902, 675 23, 943	229, 859 C			0	
64.00	06400 I NTRAVENOUS THERAPY	23, 943	C	3, 216		0	
66.00	06600 PHYSI CAL THERAPY	360, 471	222, 473				
67.00	06700 OCCUPATI ONAL THERAPY	50, 736	C	-,			
67.01	06701 AUDI OLOGY	23, 518	C				
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	24,606	C	.,		0	68.00 69.00
69.00	06901 CARDI OLOGY	189, 512	22, 926	-	-	0	69.01
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	391, 658	C			0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	441, 893	C			0	
73.00	07300 DRUGS CHARGED TO PATIENTS	300, 316	C	23, 899	18, 581	0	73.00
90.00	OUTPATIENT SERVICE COST CENTERS	0	C	0	0	0	90.00
	09001 OTHER OUTPATIENT SERVICE COST CENTER	65, 440	94, 730				90.01
90. 02	09002 CLI NI C	0	C				90.02
90.03	09003 DERMATOLOGY CLINIC	0	C	0	0	0	
90.04		0	C	0	-	0	
90. 05 90. 07	09005 SURGERY CLINIC 09007 UROLOGY CLINIC	0	C C	0 0		0	
90.09	09009 GASTROENTEROLOGY CLINIC	43	C	0		0	1
90. 11	09011 NEUROLOGY CLINIC	0	C	0	0	0	90.11
90.12	09012 OPTHAMOLOGY CLINIC	775	C	0	0	0	90.12
90.13	09013 ALLERGY CLINIC	21,031	04 046	624		0	90.13
90. 14 91. 00	09014 WOUND CARE 09100 EMERGENCY	87, 164 560, 713	86, 848 608, 877			0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	500,715	000, 077	32, 734	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	403, 234	43, 622	3, 833	0	0	95.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	0 700 705	2 554 000	010 170	948, 296	1 411 000	110 00
110.00	NONREIMBURSABLE COST CENTERS	8, 729, 705	3, 554, 988	348, 470	948, 290	1, 611, 009	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	3, 082	15, 466	0	0	0	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	4, 887, 245	940, 405			0	192.00
194.00	07950 THORNTOWN OFFICE BUILDING	0	C	0	0		194.00
		6, 994	35, 096	0	0		194.01
	07952 OTHER NONREIMB 07953 RETAIL PHARMACY	123, 237 207, 295	0 9, 914		0		194.02 194.03
200.00		207, 295	7, 714			0	200.00
200.00		0	C	0	0		201.00
202.00	5	13, 957, 558	4, 555, 869	348, 470	948, 296		

Health Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		eriod: rom 01/01/2017	Worksheet B Part I	
				o 12/31/2017	Date/Time Pre	
Cost Center Description	CAFETERI A	NURSI NG	PHARMACY	MEDI CAL	<u>5/22/2018</u> 7:4 Subtotal	
		ADMI NI STRATI ON		RECORDS &		
	11.00	13.00	15.00	LI BRARY 16.00	24.00	
GENERAL SERVICE COST CENTERS						1
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 ADMINI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	503, 677					10.00
13. 00 01300 NURSING ADMINISTRATION	9, 745	860, 609				13.00
15. 00 01500 PHARMACY	19, 491	0	3, 840, 379			15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	39, 494	0	0	2, 303, 169		16.00
30. 00 03000 ADULTS & PEDI ATRI CS	132, 845	190, 311	16, 547	565, 988	8, 773, 378	30.00
31. 00 03100 INTENSIVE CARE UNIT	10, 771	55, 539	321	117, 680	2, 555, 738	
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	16, 926 0	83, 082 0	80 0		2, 807, 471 0	40.00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42.00
43.00 04300 NURSERY 44.00 04400 SKILLED NURSING FACILITY	0	0 76, 000	0 14, 522	0	30, 308 2, 865, 935	43.00 44.00
ANCI LLARY SERVICE COST CENTERS	0	78,000	14, 522	0	2, 805, 935	44.00
50. 00 05000 OPERATI NG ROOM	11, 797	128, 063	27, 188		4, 914, 832	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	14, 361 0	0	2, 671 0	543, 570 0	6, 562, 809 0	54.00 55.00
55. 01 05501 ULTRA SOUND	1, 539	0	1, 219	-	656, 394	55.01
57.00 05700 CT SCAN	2,052	0	778		839, 401	57.00
58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 59.00 05900 CARDI AC CATHETERI ZATI ON	5, 129	0 6, 635	8, 792 0		1, 183, 369 554, 748	58.00 59.00
60. 00 06000 LABORATORY	42, 059	0	132	-	7, 660, 306	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		227, 348	
64. 00 06400 I NTRAVENOUS THERAPY 66. 00 06600 PHYSI CAL THERAPY	21, 029	63, 838	6, 049	-	3, 216 3, 348, 120	64.00 66.00
67.00 06700 OCCUPATI ONAL THERAPY	8, 719	27, 579	0	47, 632	501, 887	67.00
67. 01 06701 AUDI OLOGY 68. 00 06800 SPEECH PATHOLOGY	9, 232 9, 745	0 6, 992	0 836	-	204, 019 219, 428	67.01 68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0, 772	030		0	69.00
69. 01 06901 CARDI OLOGY	21,029	62, 263	24		1, 777, 457	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	10, 771 0	0	0 0	-	3, 173, 928 3, 569, 464	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0		2, 462, 507	73.00
OUTPATI ENT SERVI CE COST CENTERS 90. 00 O90000 CLI NI C	0	0	0	0	0	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	17, 439	10, 806	9	235, 360	931, 359	90.00
90. 02 09002 CLINIC	0	0	0	0	67, 164	90.02
90. 03 09003 DERMATOLOGY CLINIC 90. 04 09004 ENT CLINIC	0	0	0	0	0	90. 03 90. 04
90. 05 09005 SURGERY CLI NI C	0	0	0	0	0	90.05
90. 07 09007 UROLOGY CLINIC 90. 09 09009 GASTROENTEROLOGY CLINIC	0	0	1, 416	0	1, 583	
90. 09 09009 GASTROENTEROLOGY CLINIC 90. 11 09011 NEUROLOGY CLINIC	0	9, 472 0	4 839	0	9, 822 839	90. 09 90. 11
90. 12 09012 OPTHAMOLOGY CLINIC	0	0	0	0	6, 242	90.12
90. 13 09013 ALLERGY CLINIC 90. 14 09014 WOUND CARE	0	5, 623 17, 616	303 17, 188		176, 026 828, 671	90. 13 90. 14
91. 00 09100 EMERGENCY	32, 826	110, 926	108, 521		5, 412, 457	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			·			92.00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	66, 678	0	40, 211	0	3, 403, 707	95.00
SPECIAL PURPOSE COST CENTERS	00,070		40, 211	0	3, 403, 707	75.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	503, 677	854, 745	247, 650	2, 286, 358	65, 729, 933	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	o	40, 302	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	2, 452	2, 891, 588		43, 234, 148	192.00
194. 00 07950 THORNTOWN OFFICE BUILDING	0	0	0	0		194.00
194. 01 07951 CAFE/BOUTI QUE 194. 02 07952 OTHER NONREI MB	0	3, 412	0	0	91, 456 996, 490	194. 01 194. 02
194. 03 07953 RETAIL PHARMACY	0	0	701, 141	o	2, 381, 493	194.03
200.00Cross Foot Adjustments201.00Negative Cost Centers	0	0	0	_		200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	503, 677	860, 609	3, 840, 379	2, 303, 169	112, 473, 822	
	'					

	ncial Systems TION - GENERAL SERVICE COSTS	WITHAM MEMORIAL	HOSPITAL Provider CCN: 15-01		u of Form CMS-2552- Worksheet B
ST ALLUCA	HUN - GLINERAL SERVICE CUSIS			From 01/01/2017	Part I
				To 12/31/2017	Date/Time Prepared 5/22/2018 7:49 am
	Cost Center Description	Intern &	Total		
		Residents Cost & Post			
		Stepdown			
		Adjustments	26.00		
GENER	AL SERVICE COST CENTERS	25.00	26.00		
00 00100	NEW CAP REL COSTS-BLDG & FIXT				1. (
-	NEW CAP REL COSTS-MVBLE EQUIP				2. (
1	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL				4. (
1	OPERATION OF PLANT				7.0
1	LAUNDRY & LINEN SERVICE				8.0
1	HOUSEKEEPING				9. (
	DI ETARY CAFETERI A				10. (
	NURSI NG ADMI NI STRATI ON				13. (
. 00 01500	PHARMACY				15. (
	MEDICAL RECORDS & LIBRARY				16. (
	I ENT ROUTINE SERVICE COST CENTERS	0	8, 773, 378		30.0
	INTENSIVE CARE UNIT	0	2, 555, 738		31. (
. 00 04000	SUBPROVIDER - IPF	0	2, 807, 471		40. (
	SUBPROVIDER - IRF	0	0		41. (
	SUBPROVI DER NURSERY	0	0 30, 308		42. (
	SKILLED NURSING FACILITY	0	2, 865, 935		43. (
	LARY SERVICE COST CENTERS				
1	OPERATING ROOM	0	4, 914, 832		50.0
1	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	0	6, 562, 809 0		54. (
	ULTRA SOUND	0	656, 394		55.
1	CT SCAN	0	839, 401		57.
	MAGNETIC RESONANCE I MAGING (MRI)	0	1, 183, 369		58.0
	CARDI AC CATHETERI ZATI ON	0	554, 748 7, 660, 306		59. (60. (
	BLOOD STORING, PROCESSING & TRANS.	0	227, 348		63. (
	INTRAVENOUS THERAPY	0	3, 216		64.0
	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0	3, 348, 120		66.
	AUDI OLOGY	0	501, 887 204, 019		67.0
	SPEECH PATHOLOGY	0	219, 428		68.
	ELECTROCARDI OLOGY	0	0		69.
	CARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 777, 457 3, 173, 928		69. 71.
	IMPL. DEV. CHARGED TO PATIENT	0	3, 569, 464		72.
	DRUGS CHARGED TO PATIENTS	0	2, 462, 507		73.
	TIENT SERVICE COST CENTERS				
	CLINIC OTHER OUTPATIENT SERVICE COST CENTER	0	0 931, 359		90. 90.
02 09002		0	67, 164		90.
	DERMATOLOGY CLINIC	0	0		90.
		0	0		90.
	SURGERY CLINIC UROLOGY CLINIC	0	0 1, 583		90. 90.
	GASTROENTEROLOGY CLINIC	0	9, 822		90.
11 09011	NEUROLOGY CLINIC	0	839		90.
	OPTHAMOLOGY CLINIC	0	6, 242		90.
	ALLERGY CLINIC WOUND CARE	0	176, 026 828, 671		90. 90.
	EMERGENCY	0	5, 412, 457		90.
	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.
OTHER	REIMBURSABLE COST CENTERS		0.400.707		
	AMBULANCE SERVICES AL PURPOSE COST CENTERS	0	3, 403, 707		95.
3. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	65, 729, 933		118.
	IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	40, 302		190.
	PHYSICIANS' PRIVATE OFFICES	0	43, 234, 148		190.
1.0007950	THORNTOWN OFFICE BUILDING	0	0		194.
		0	91, 456		194.
	OTHER NONREIMB RETAIL PHARMACY	0	996, 490 2, 381, 493		194. 194.
4. 03 07953 D. 00	Cross Foot Adjustments	0	2, 381, 493		200.
1.00	Negative Cost Centers	0	ō		201. (
	TOTAL (sum lines 118 through 201)	0	112, 473, 822		202. (

	Financial Systems TION OF CAPITAL RELATED COSTS	WI THAM MEMORI .	Provider CC	Fr	eriod: com 01/01/2017	u of Form CMS-: Worksheet B Part II	
				To	12/31/2017	Date/Time Pre 5/22/2018 7:4	
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Di rectl y Assi gned New Capi tal	NEW BLDG & FIXT	NEW MVBLE EQUI P	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
1 00	GENERAL SERVICE COST CENTERS						1 1 00
1.00 2.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	11, 500	8, 791	20, 291	20, 291	
5.00	00500 ADMI NI STRATI VE & GENERAL	0	367, 513	280, 943	648, 456	2, 398	
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	481, 482	368, 065 0	849, 547	244 11	
9.00	00900 HOUSEKEEPI NG	0	55, 443	42, 383	97, 826	148	
10. 00	01000 DI ETARY	0	124, 105	94, 871	218, 976	229	10.00
11.00	01100 CAFETERIA	0	0	0	0	63	
13.00 15.00	01300 NURSI NG ADMI NI STRATI ON 01500 PHARMACY	0	0 38, 312	0 29, 288	0 67, 600	225 209	
	01600 MEDICAL RECORDS & LIBRARY	0	60, 521	46, 265	106, 786	465	
	INPATIENT ROUTINE SERVICE COST CENTERS	1			,		
	03000 ADULTS & PEDIATRICS	0	402, 545	307, 723	710, 268	1, 236	
31.00 40.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	0	110, 550 126, 575	84, 509 96, 759	195, 059 223, 334	424 449	
40.00	04100 SUBPROVIDER - IRF	0	120, 575	90, 739	223, 334	449	
42.00	04200 SUBPROVI DER	0	0	0	0	0	
43.00	04300 NURSERY	0	0	0	0	0	
44.00	04400 SKILLED NURSING FACILITY	0	95, 850	73, 272	169, 122	369	44.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	321, 278	245, 598	566, 876	774	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	392, 923	300, 367	693, 290	509	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	
55.01	05501 ULTRA SOUND	0	0	0	0	131	
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0 33, 708	0 25, 768	0 59, 476	55 146	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	28, 413	21, 720	50, 133	54	
60.00	06000 LABORATORY	0	183, 243	140, 079	323, 322	834	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	
64.00 66.00	06400 I NTRAVENOUS THERAPY 06600 PHYSI CAL THERAPY	0	0 177, 355	0 135, 578	0 312, 933	0 657	
67.00	06700 OCCUPATI ONAL THERAPY	0	0	133, 378	0	107	
67.01	06701 AUDI OLOGY	0	0	0	0	70	67.01
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	53	
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 CARDI OLOGY	0	0 18, 277	0 13, 972	0 32, 249	0 374	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10, 277	13, 772	52, 249	0	
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
90.00	OUTPATIENT SERVICE COST CENTERS		0	0	0	0	90.00
	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	75, 518	57, 729	133, 247	70	
	09002 CLI NI C	0	0	0	0	0	
90.03	09003 DERMATOLOGY CLINIC	0	0	0	0	0	
	09004 ENT CLINIC 09005 SURGERY CLINIC	0	0	0	0	0	90.04 90.05
	09007 UROLOGY CLINIC	0	0	0	0	0	90.00
	09009 GASTROENTEROLOGY CLINIC	0	0	0	0	1	
90. 11	09011 NEUROLOGY CLINIC	0	0	0	0	0	
	09012 OPTHAMOLOGY CLINIC	0	0	0	0	0	
90. 13 90. 14	09013 ALLERGY CLINIC 09014 WOUND CARE	0	0 69, 235	0 52, 926	0 122, 161	38 88	
91. 00	09100 EMERGENCY	0	485, 394	371, 056	856, 450	859	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	94, 052	71, 897	165, 949	765	95.00
95.00	SPECIAL PURPOSE COST CENTERS	0	94, 052	/1,89/	105, 949	705	95.00
118.00		0	3, 753, 792	2, 869, 559	6, 623, 351	12, 055	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	12, 329	9, 425	21, 754		190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 THORNTOWN OFFICE BUILDING	0	848, 481 0	648, 616 0	1, 497, 097 0		192.00 194.00
	07951 CAFE/BOUTIQUE	0	27, 978	21, 388	49, 366		194.00
194.02	07952 OTHER NONREIMB	0	405, 924	310, 306	716, 230	26	194. 02
	07953 RETAIL PHARMACY	0	7, 904	6, 042	13, 946	94	194.03
200.00				0	0	0	200.00
201.00	Negative Cost Centers						

ALL DCATTOR OF CAPITAL RELATED COSTS Providem Cost 15:0114 Part intl Trans 02072017 Part intl DCATTOR Part intl Trans 02072017 Part intl DCATTOR Part intl	Heal th	Financial Systems	WI THAM MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
To 12/21/2011 District Tume Program District Control Control of Control						eri od:	Worksheet B	
Cost Genter Description PAURE TUP OPERATION OF & CREWAL PLANT PLARENT SOURCE PLARENT						b 12/31/2017	Date/Time Pre	pared:
Bit PLANT LIPPL SERVICE 0 10.0 1.00 00000 1.00 0.000 1.00 0.000 1.00 00000 00000 1.00 0.000 1.00 0.0000 1.00 00000 00000 00000 00000 00000 00000 00000 1.00 1.00 1.00 000000		Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPING		9 am
OPERAL SERVICE COST CENTERS 1.00 0 00000 MR CORP RT CESTS MILE TOULD 1.00 0.0000 MR CORP RT CESTS MILE TOULD 2.00 0.0000 CORP CLARATER MILE TOULD 2.000 0.0000 CORP CLARATER MILE SERVICE 2.017 0.00000 CORP CLARATER MILE SERVICE COST CENTERS 3.04 0.00000 CORP CLARATER MILE MILE MILE SERVICE COST CENTERS 3.00 0.000000 CORP CLARATER MILE MILE MILE MILE MILE MILE MILE MILE		bost center bescription	& GENERAL	PLANT	LINEN SERVICE			
1.00 DOTOD INFO FOR FLAT SILLOS IS SILLOS A LINK 1.00 0.00 DOTOD INFO FOR FLAT SIST CLEMP FUELDIN 2.00 0.00 DOTOD INFO FOR FLAT SIST CLEMP FUELDIN 2.00 0.00 DOTOD INFO FOR FLAT SIST CLEMP FUELDIN 2.00 0.00 DOTOD INFO FOR FLAT SIST CLEMP FUELDIN 2.00 0.00 DOTOD INFO FOR FLAT SIST CLEMP FUELDIN 2.00 0.00 DOTOD INFO FOR FLAT SIST CLEMP FUELDIN 2.00 0.00 DOTOD INFO FOR FLAT SIST CLEMP FUELDIN 2.00 0.00 DOTOD INFO FOR FLAT SIST CLEMP FUELDIN 2.00 0.00 DOTOD INFO FOR FLAT SIST CLEMP FUELDIN 1.10 0.00 DOTOD INFO FOR FLAT SIST CLEMP FUELDIN 1.10 0.00 DOTOD INFO FOR FLAT SIST CLEMP FUELDIN 1.10 0.00 DOTOD INFO FOR FLAT SIST CLEMP FUELDIN 1.10 0.00 DOTOD INFO FOR FLAT SIST CLEMP FUELDIN 1.10 0.00 DOTOD INFO FOR FLAT SIST CLEMP FUELDIN 1.10 0.00 DOTOD FOR FLAT SIST CLEMP FUELDIN 1.10 0.00 DOTOD FOR FLAT SIST CLEMP FUELDIN 1.10 0.00<		CENEDAL SEDVICE COST CENTEDS	5.00	7.00	8.00	9.00	10.00	
4.00 BOUND ENFLOYCE EXCEPTS DEPARTMENT 4.00 0.000000 OPELATION STRATUS C. BEREAL 26.08 876, 166 7.00 0.000000 OPELATION STRATUS C. BEREAL 26.085 876, 166 7.00 0.000000 OPELATION STRATUS N. N.100 110, 444 9.00 0.000000 OPETERIA 2, 2001 0 0.2, 477 9.4, 445 0.0000000 OPETERIA 2, 2001 0 0.2, 477 9.4, 445 0.000000000000 OPETERIA 2, 2001 0 0.2, 470 0 1.0, 00 0.00000000000000 OPETERIA 4, 973 0 0 2, 198 0 15.00 0.00000000000000000000000000000000000	1.00							1.00
5.00 DORDOLARMIN ISTATIVE & EFMICE 2.017 0 2.028 5.00 <								
7.00 DOTOD (DEFERTION OF PLANT 26, 365 BF6, 156			450 954					
8.00 00000 LAMMERY A LINER SERVICE 2.017 0 2.028 4 8.00 9.00 0.00 00000 DEFEAR A.000 TAUDA B.000 Z 9.00 2.010 0 2.000 0000 DEFEAR 0 0.000 DEFEAR 0.000 DEFEAR 0 0.000 DEFEAR 0.0000 DEFEAR 0.000 D				876, 156				
10. 00 01000 DETARY 8, 662 29, 939 0 7, 19 2264, 45 10. 00 11.00 011000 CAPTERIA 2, 801 0 0 2, 477 64 11. 00 11.00 011000 CAPTERIA 2, 801 0 2, 477 0 11. 00 11.00 011000 CAPTERIA 2, 431 0 0 2, 79 0 2, 79 0 1, 60 11. 00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
11.00 01100 CAFTERIA 2.001 0 0 0.407 13.00 01500 PHABAKCY 21,730 0,242 0 1.008 0 15.00 01500 PHABAKCY 21,730 0,242 0 0.1000 0.00000 0.000000 0.000000 0.0								
11.000 01300 NRESING ADMINISTRATION 4, 873 0 0 1,048 0 15,00 15.00 01500 01500 02,1730 9,242 0 2,1730 9,242 0 2,1730 9,242 0 2,1730 9 15,00 14,00								
16:00 DISON DEDICAL RECORDS & LIBRARY 12,434 14,000 0 4,814 0 16.00 IMPATILER SURTE ASSURCE COST CENTES 36,427 97,109 99 36,500 123,523 30,00 40,00 <					-		-	
INPART ENT. REVIT RESERVICE COST CENTERS 36.427 0.0 03000 (INTERS PER ATRICS 36.427 31.00 03100 (INTERS VE CARE UNIT 12.437 0.0 03100 (INTERS VE CARE UNIT 12.437 0.0 03100 (INTERS VE CARE UNIT 12.437 0.0 0000 (000 SIGNER) 0 0.100 (SUBSERV) DER - LPF 1.1674 0.100 (SUBSERV) DER - LPF 0 0.100 (SUBSERV) DER - LPF 1.2173 0.100 (SUBSERV) DER - LRF 0 0.400 (SWI LLED NURSING FACILITY 12.139 1.00 (SODO OPERATING ROOM 23.522 0.00 (SODO OPERATING ROOM 2.1564 0.00 (SODO OPERATING ROOM 2.1579 0.00 (SODO OPERATING ROOM 2.322 0.00 (SODO OPERATING ROOM 2.362 0.00 (SODO OPERATING ROOM	15.00	01500 PHARMACY		9, 242	0		0	15.00
30. 00 03000 ADULTS & PEDLATRICS 36, 427 97, 109 90 66, 570 12.25, 523 30. 00 40. 00 04000 SUBREVID DER - IPF 11, 614 30. 535 20 11, 549 49, 898 40. 00 41. 00 04000 SUBREVID DER - IPF 11, 614 30. 535 20 11, 549 49, 898 40. 00 41. 00 40. 00 0 0 0 41. 00 40. 00 40. 00 40. 00 40. 00 40. 00 40. 00 40. 00 44. 00 40. 00 50. 00 <t< td=""><td>16.00</td><td></td><td>12, 434</td><td>14, 600</td><td>0</td><td>4, 814</td><td>0</td><td>16.00</td></t<>	16.00		12, 434	14, 600	0	4, 814	0	16.00
31.00 03100 INTERSIVE CARE. UNIT 12,437 20,669 25 9,712 0 31.00 41.00 04100 SUBPROVIDER - IPF 11,614 30.552 20 11,549 48.80 40.00 41.00 04100 SUBPROVIDER - IPF 16 0 0 0 42.00 42.00 04200 SUBPROVIDER - IPF 12,139 23.120 10 0 42.00 42.00 04200 SUBPROVIDER - IPF 12,139 23.120 10 0 42.00 44.00 SUBPROVIDER - IPF 12,139 23.120 10 0 42.00 42.00 44.00 50.00 50.00 50.00 50.00 50.00 50.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 57.00 22.78 68.00 55.00 50.00 50.00 55.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00	30.00		36 427	97 109	99	36 570	123 523	30.00
11 00 UDDPROVIDER IFF 0								
42.00 0200 SUBPROVIDER 0								
43.00 04300 NURSERY 165 0 10 0 43.00 44.00 044000 0511 12.39 23, 123 17 0 91.024 AND LLARY SERVICE COST CENTERS 37.757 54 265 2.155 50.0 54.00 05400 (RADI OLOV-TH RAPEUTIC 3.257 94,788 159 9,754 55.0 55.01 05500 (DEBCH IN REPARPEUTIC 3.262 0 48 628 55.0 55.0 55.01 05500 (CARDI AC CATHER PAPEUTIC 3.262 0 48 628 55.0 56.0 56.00 05500 (CARDI AC CATHERPAPEUTION 4.362 0 48 628 56.0 <td></td> <td></td> <td>-</td> <td>0</td> <td></td> <td>-</td> <td>-</td> <td></td>			-	0		-	-	
44.00 0 04400_SKILLED_NURSING_FACILITY 12,139 23,123 17 0 91,024 44.00 MOLLARY SERVICE COST CENTRES 30.00 50.00 05000 (JPEATING_ROM) 23,589 77,504 265 2,156 50.00 55.00 56.00			U U	0		-	-	
50.00 05000 OPEEATING ROOM 23,559 77,594 255.00 54.00 50.00 05500 RADIOLOCY-THERAPEUTIC 0 0 0 0 55.00 50.00 05500 RADIOLOCY-THERAPEUTIC 0 0 0 0 0 55.00 50.00 05500 (CT SCAN 4.153 0 242 963 57.00 55.01 05500 (ARADIOLOCY-THERAPEUTIC 0 48.62 0 58.00 58.00 58.00 58.00 58.00 58.00 55.00 58.00 58.00 59.00 05900 (ARADIAC CATHETERIZATION 2.948 6.854 17 0 59.00 00.300 BLOD STORING, PROCESSING & TRANS. 1.117 0 5 4.123 06.00 67.00 67.01 67.00 67.01 67.01 67.01 67.00		04400 SKILLED NURSING FACILITY		23, 123			-	
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57.00 05700 CT SCAN 4,153 0 242 963 0 57.00 59.00 05600 CARDIA C CATHETERI ZATI ON 2,948 6,854 17 0 6,800 60.00 06600 LARDRATORY 42,205 424 0 6,60 63.00 05000 ENDOR STORI NG, PROCESSI NG & TRANS. 1,117 40 5 4,123 0 64.00 64.00 06400 INTRAVENDIA THERAPY 16,810 42,785 47 1,486 0 64.00 67.00 0CT0 ADD INTRAVENDIAL THERAPY 2,366 18 712.0 67.00 67.00 67.00 67.00 67.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 69.00 71.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00							-	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 6. 187 8. 12 78 921 0 58. 00 00 0000 (ADDIAC CARDIA CCATHERE TER ZATION 2. 948 6. 854 17 0 65. 00 00 0000 (LADDATORY 42. 995 44. 20 54. 40 0 63. 00 04 00 06000 INTRAVENOUS THEERPY 16. 810 78. 79 64. 00 66. 00 66. 00 06000 OPHYSICAL THERAPY 2. 366 0 18 712 67. 01 06700 OCUPATIONAL THERAPY 2. 366 0 18 712 67. 01 06700 OCUPATIONAL THERAPY 1. 997 0 6 52.3 67. 01 06700 OCUPATIONAL THERAPY 1. 497 0 6 60. 00 60. 00 60. 00 60. 00 66. 00 66. 00 67. 00 60. 00 60. 00 60. 00 70. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 <td< td=""><td></td><td></td><td></td><td>0</td><td></td><td></td><td>-</td><td></td></td<>				0			-	
59.00 05900 CARDIN AC CATHETERIZATION 2,948 6,854 17 0 59.00 59.00 CARDINA CATHETERIZATION 2,948 6,854 177 0 59.00 59.00 59.00 59.10 59.10 59.12 59.10 59.12 50.00 60.00 71.00 72.00 72.00 72.00 72.00 72.00 <				0			-	
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17.100 VOID			9 838			-		
72.00 IMPL DEV. CHARGED TO PATIENT 20,607 0 47 0 0 73.00 0.73.00 D07300 DRUGS CHARGED TO PATIENTS 14,005 0 132 2,281 0 73.00 0.010 OPODO CLINIC 0<							-	
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90.00 00000 CLINIC 0 <	73.00		14,005	0	132	2, 281	0	73.00
90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER 3,052 18,218 0 5,609 90.01 90.02 09002 CLINIC 0 0 0 8,247 0 90.03 90.03 D9003 DERMATDLOGY CLINIC 0 <t< td=""><td>90 00</td><td></td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>90 00</td></t<>	90 00		0	0	0	0	0	90 00
90. 03 09003 DERMATOLOGY CLINIC 0<					-		_	
90.04 09004 ENT CLINIC 0			0	0	0			
90.05 09005 SURGERY CLINIC 0			0	0	0	-		
90.07 09007 UROLOGY CLINIC 0 1 0 0 90.07 90.07 09009 GASTROENTEROLOGY CLINIC 2 0 0 0 90.09 90.11 09011 NEUROLOGY CLINIC 2 0 0 0 90.07 90.12 09011 NEUROLOGY CLINIC 36 0 0 90.11 90.13 09013 ALLERGY CLINIC 36 0 0 90.12 90.14 09014 WOUND CARE 4,065 16,702 26 0 90.14 90.14 09010 EMERGENCY 26,148 117,095 182 0 0 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 26,148 117,095 182 0 0 91.00 950.0 MBURABLE COST CENTERS 18,804 8,389 21 0 92.00 700.0 190.00 IFT, FLOWER, COFFEE SHOP, & CANTEEN 144, 2,974 0 0 190.00 192.00			0	0	0	0	-	
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90.13 09013 ALLERGY CLINIC 981 0 3 0 0 90.13 90.14 09014 WOUND CARE 4,065 16,702 26 0 0 90.14 91.00 09100 EMERGENCY 26,148 117,095 182 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 26,148 117,095 182 0 0 91.00 95.00 09500 AMBULANCE SERVICES 18,804 8,389 21 0 0 95.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 407,100 683,673 2,028 116,434 264,445 118.00 NONRE I MBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFE SHOP, & CANTEEN 144 2,974 0 0 190.00 190.00 192.00 PHYSI CLANS' PRI VATE OFFICES 227,870 180,853 0 0 192.00 194.00 07950 THORNTOWN OFFICE BUI LDING 0 0 0 194.00 194			36	0	0	0	-	
91.00 09100 EMERGENCY 26, 148 117, 095 182 0 0 91.00 92.00 92.00 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 92.00 95.00				0	3	0	-	
92.00 0BSERVATI ON BEDS (NON-DI STINCT PART) 92.00 0THER REI MBURSABLE COST CENTERS 92.00 95.00 OPSCOLALS (SUM OF LINES 1 Through 117) 18,804 8,389 21 0 0 95.00 SUBTOTALS (SUM OF LINES 1 Through 117) 407,100 683,673 2,028 116,434 264,445 118.00 NONREL MBURSABLE COST CENTERS 190.00 IPODO GIFT, FLOWER, COFFEE SHOP, & CANTEEN 144 2,974 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 227,870 180,853 0 0 192.00 194.00 07950 THORNTOWN OFFI CE BUI LDI NG 0 0 0 0 194.00 194.02 07952 OTHER NONREI MB 5,747 0 0 0 194.01 194.02 07952 OTHER NONREI MB 5,747 0 0 0 194.02 194.03 07953 RETAIL PHARMACY 9,667 1,907 0 0 194.03 194.03 07953 RETAIL PHARMACY 9,667 1,907 0 <td>90.14</td> <td>09014 WOUND CARE</td> <td></td> <td></td> <td></td> <td>0</td> <td>-</td> <td>90.14</td>	90.14	09014 WOUND CARE				0	-	90.14
OTHER REI MBURSABLE COST CENTERS 95.00 OPSCO AMBULANCE SERVICES 18,804 8,389 21 0 0 95.00 SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS 118.00 NONREL MBURSABLE COST CENTERS 190.00 SPECIAL PURPOSE COST CENTERS 190.00 SUBTOTALS (SUM OF LINES 1 through 117) 407, 100 683, 673 2,028 116, 434 264, 445 190.00 SUBTOTALS (SUM OF LINES 1 through 117) 407, 100 683, 673 2,028 116, 434 264, 445 190.00 SUBTOTALS (SUM OF LINES 1 through 117) 407, 100 0 190.00 190.00 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 144 2,974 0 0 190.00 192.00 192.00 0 192.00								

Health Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CC		eri od:	Worksheet B	
			T	rom 01/01/2017 o 12/31/2017	Part II Date/Time Pre	
Cost Center Description	CAFETERI A	NURSI NG	PHARMACY	MEDI CAL	5/22/2018 7:4 Subtotal	
		ADMI NI STRATI ON		RECORDS & LI BRARY		
	11.00	13.00	15.00	16.00	24.00	
1.00 GENERAL SERVICE COST CENTERS						1.00
2. 00 00200 NEW CAP REL COSTS MUBLE EQUI P						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
7. 00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING						8.00
10. 00 01000 DI ETARY						9.00 10.00
11. 00 01100 CAFETERIA	5, 271					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 15. 00 01500 PHARMACY	102		101, 183			13.00 15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	413	0	0	139, 512		16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	1, 391	1, 391	436	34, 286	1, 042, 736	30.00
31. 00 03100 I NTENSI VE CARE UNI T	113	406	8	7, 128	251, 981	31.00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	177		2	8, 486 0	336, 671 0	40.00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42.00
43. 00 04300 NURSERY 44. 00 04400 SKI LLED NURSI NG FACI LI TY			0 383	0	175 296, 732	
ANCI LLARY SERVI CE COST CENTERS	1			-		
50. 00 05000 OPERATI NG ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	123		716 70	12, 305 32, 926	685, 244 862, 903	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
55. 01 05501 ULTRA SOUND 57. 00 05700 CT SCAN	16	1	32 20	3, 564 4, 073	7, 781 9, 527	55.01 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	54	. 0	232	2, 206	77, 432	
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0 440		0 3	0 3, 394	60, 054 414, 717	59.00 60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	440		0 0	3, 394 0	5, 245	
64. 00 06400 I NTRAVENOUS THERAPY	0	1	0	0	18	64.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	220		159 0	6, 619 2, 885	382, 182 6, 381	66.00 67.00
67. 01 06701 AUDI OLOGY	97		0	0	1, 793	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	102		22 0	0	1, 695 0	68.00 69.00
69. 01 06901 CARDI OLOGY	220	1	1	6, 365	56, 144	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	113	1	0	0	18, 417 20, 654	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	16, 418	
0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C	0	0	0	0	0	90.00
90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER	182		0	14, 257	174, 714	90. 01
90. 02 09002 CLI NI C 90. 03 09003 DERMATOLOGY CLI NI C			0	0	8, 247 0	90. 02 90. 03
90. 04 09004 ENT CLINIC	0	0	0	0	0	90.04
90. 05 09005 SURGERY CLINIC 90. 07 09007 UROLOGY CLINIC	0	0	0 37	0	0 38	90.05 90.07
90. 09 09009 GASTROENTEROLOGY CLINIC	0	69	0	0	72	90.09
90. 11 09011 NEUROLOGY CLINIC 90. 12 09012 0PTHAMOLOGY CLINIC	0	0	22 0	0	22	
90. 13 09013 ALLERGY CLINIC	0	41	8	0	1, 071	90.13
90. 14 09014 WOUND CARE 91. 00 09100 EMERGENCY	0 344		453 2, 859	0	143, 624 1, 004, 747	90. 14 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	544	810	2,039	0	1, 004, 747	92.00
0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	(00		1 050	0	105 (05	
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	698	0	1, 059	0	195, 685	95.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	5, 271	6, 245	6, 522	138, 494	6, 083, 156	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	24, 872	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	18	76, 188	1, 018	1, 991, 160	192.00
194. 00 07950 THORNTOWN_OFFICE_BUILDING 194. 01 07951 CAFE/BOUTIQUE	0	0	0	0	56, 441	194. 00 194. 01
194.0207952 OTHER NONREIMB	0	25	0	0	722, 028	194. 02
194.03 07953 RETAIL PHARMACY 200.00 Cross Foot Adjustments	C	0	18, 473	0	0	194. 03 200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	5, 271	6, 288	101, 183	139, 512	8, 921, 744	∠U2. UU

	Financial Systems FION OF CAPITAL RELATED COSTS	WI THAM MEMORI AL	Provider CCN: 15		eu of Form CMS-2552-1 Worksheet B
	TON OF CHITTLE RELATED COSTS			From 01/01/2017	
				10 12/31/2017	5/22/2018 7:49 am
	Cost Center Description	Intern & Residents Cost	Total		
		& Post			
		Stepdown			
		Adjustments 25.00	26.00		
(GENERAL SERVICE COST CENTERS	20.00	20.00		
	00100 NEW CAP REL COSTS-BLDG & FIXT				1.0
	00200 NEW CAP REL COSTS-MVBLE EQUIP				2.0
	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL				4. C 5. C
	00700 OPERATION OF PLANT				7.0
	00800 LAUNDRY & LINEN SERVICE				8. C
	00900 HOUSEKEEPING				9.0
	01000 DI ETARY 01100 CAFETERI A				10.0
	01300 NURSI NG ADMI NI STRATI ON				13.0
	01500 PHARMACY				15. C
	01600 MEDICAL RECORDS & LIBRARY				16.0
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	1,042,736		30.0
	03100 INTENSIVE CARE UNIT	0	251, 981		31.0
	04000 SUBPROVI DER – I PF	0	336, 671		40.0
	04100 SUBPROVI DER – I RF	0	0		41. C
	04200 SUBPROVI DER	0	0		42.0
	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	0	175 296, 732		43. C 44. C
	ANCI LLARY SERVICE COST CENTERS	<u> </u>	290, 732		44.0
	05000 OPERATI NG ROOM	0	685, 244		50. C
	05400 RADI OLOGY-DI AGNOSTI C	0	862, 903		54.0
	05500 RADI OLOGY-THERAPEUTI C	0	0		55.0
	05501 ULTRA SOUND 05700 CT SCAN	0	7, 781 9, 527		55. (
	05800 MAGNETIC RESONANCE I MAGI NG (MRI)	0	77, 432		58.0
	05900 CARDI AC CATHETERI ZATI ON	0	60, 054		59.0
	06000 LABORATORY	0	414, 717		60.0
	06300 BLOOD STORING, PROCESSING & TRANS. 06400 I NTRAVENOUS THERAPY	0	5, 245 18		63. 0 64. 0
	06600 PHYSI CAL THERAPY	0	382, 182		66.0
	06700 OCCUPATI ONAL THERAPY	0	6, 381		67.0
	06701 AUDI OLOGY	0	1, 793		67.0
		0	1, 695		68.0
	06900 ELECTROCARDI OLOGY 06901 CARDI OLOGY	0	0 56, 144		69. 0 69. 0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	18, 417		71.0
	07200 IMPL. DEV. CHARGED TO PATIENT	0	20, 654		72.0
	07300 DRUGS CHARGED TO PATIENTS	0	16, 418		73.0
	OUTPATIENT SERVICE COST CENTERS	0	0		90.0
	09000 OTHER OUTPATIENT SERVICE COST CENTER	0	174, 714		90.0
	09002 CLINIC	0	8, 247		90. 0
	09003 DERMATOLOGY CLINIC	0	0		90. 0
		0	0		90. (
	09005 SURGERY CLINIC 09007 UROLOGY CLINIC	0	38		90. (90. (
	09009 GASTROENTEROLOGY CLINIC	0	72		90.0
	09011 NEUROLOGY CLINIC	0	22		90. 1
	09012 OPTHAMOLOGY CLINIC	0	36		90. 1
	09013 ALLERGY CLINIC	0	1,071		90. 1
	09014 WOUND CARE 09100 EMERGENCY	0	143, 624 1, 004, 747		90.1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	.,		92. 0
¢	OTHER REIMBURSABLE COST CENTERS	· · · · · ·	1		
	09500 AMBULANCE SERVICES	0	195, 685		95. (
18. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	0	6, 083, 156		118. (
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	24, 872		190. (
	19200 PHYSICIANS' PRIVATE OFFICES	0	1, 991, 160		190.0
94.00	07950 THORNTOWN OFFICE BUILDING	0	0		194.
	07951 CAFE/BOUTI QUE	0	56, 441		194.
	07952 OTHER NONREI MB	0	722, 028		194.
94.03 00.00	07953 RETAIL PHARMACY Cross Foot Adjustments	0	44, 087		194. (200. (
00.00	Negative Cost Centers	0	0		200.0
	TOTAL (sum lines 118 through 201)	0	8, 921, 744		202.0

ALLUUA	ncial Systems ATION - STATISTICAL BASIS	WI THAM MEMORI A	Provider CC		eriod:	u of Form CMS-2 Worksheet B-1	-002
					rom 01/01/2017 o 12/31/2017	Date/Time Pre	pared
		CAPITAL REL	ATED COSTS			5/22/2018 7:4	
	Cost Center Description	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFITS	Reconciliation	ADMI NI STRATI VE & GENERAL	
		(SQUARE	(SQUARE	DEPARTMENT		(ACCUM.	
		FEET)	FEET)	(GROSS		COST)	
		1.00	0.00	SALARI ES)	F A	F 00	<u> </u>
GENE	RAL SERVICE COST CENTERS	1.00	2.00	4.00	5A	5.00	
	O NEW CAP REL COSTS-BLDG & FIXT	255, 907					1.0
	O NEW CAP REL COSTS-MVBLE EQUIP		255, 907				2.0
	O EMPLOYEE BENEFITS DEPARTMENT	582	582	53, 247, 055			4.0
	0 ADMINISTRATIVE & GENERAL 0 OPERATION OF PLANT	18, 600 24, 368	18, 600 24, 368	6, 293, 749 639, 482		98, 516, 264 3, 990, 503	5. (7. (
	0 LAUNDRY & LINEN SERVICE	24, 300	24, 500	28, 214	0	305, 226	
	O HOUSEKEEPI NG	2, 806	2, 806	387, 955	0	769, 699	
	0 DI ETARY	6, 281	6, 281	601, 269	0	1, 223, 229	
		0	0	164, 573	0	424,001	
	O NURSI NG ADMI NI STRATI ON O PHARMACY	1, 939	0 1, 939	590, 910 547, 310	0	737, 511 3, 288, 957	13. 15.
	O MEDICAL RECORDS & LIBRARY	3, 063	3, 063	1, 219, 737	0	1, 881, 923	
I NPA	TIENT ROUTINE SERVICE COST CENTERS		3, 000	., 2.,, , , , , , , , , , , , , , , , ,		.,	
	0 ADULTS & PEDIATRICS	20, 373	20, 373	3, 243, 060		5, 513, 330	
		5, 595	5, 595	1, 113, 836	0	1, 882, 462	
	0 SUBPROVI DER – I PF 0 SUBPROVI DER – I RF	6, 406	6, 406	1, 178, 914	0	1, 757, 813 0	40. 41.
	0 SUBPROVI DER	0	0	0	0	0	41.
	0 NURSERY	0	0	0	0	24, 908	
	O SKILLED NURSING FACILITY	4, 851	4, 851	969, 010	0	1, 837, 338	44.
	LLARY SERVICE COST CENTERS	1	1 (0 (0			0.570.001	
	O OPERATI NG ROOM O RADI OLOGY-DI AGNOSTI C	16, 260	16, 260	2,030,336		3, 570, 301	50.
	0 RADI OLOGY - DI AGNOSTI C 0 RADI OLOGY - THERAPEUTI C	19, 886	19, 886 0	1, 335, 716 0	0	4, 730, 847 0	54. 55.
	1 ULTRA SOUND	0	0	342, 585	0	508, 849	
	O CT SCAN	0	0	144, 923	0	628, 631	57.
	O MAGNETIC RESONANCE IMAGING (MRI)	1, 706	1, 706	382, 987	0	936, 481	
	O CARDI AC CATHETERI ZATI ON	1,438	1,438	141, 578		446, 248	
	0 LABORATORY 0 BLOOD STORING, PROCESSING & TRANS.	9, 274	9, 274 0	2, 189, 745	0	6, 371, 311 168, 996	
	O I NTRAVENOUS THERAPY	0	0	0	0	100, 770	64.
	0 PHYSI CAL THERAPY	8, 976	8, 976	1, 724, 775	0	2, 544, 301	66.
	0 OCCUPATIONAL THERAPY	0	0	280, 238		358, 107	67.
	1 AUDI OLOGY 0 SPEECH PATHOLOGY	0	0	184, 789	0	165, 993	
	0 ELECTROCARDI OLOGY	0	0	137, 873	0	173, 677 0	68. 69.
	1 CARDI OLOGY	925	925	982, 669	0	1, 337, 623	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		2, 764, 424	71.
	O I MPL. DEV. CHARGED TO PATIENT	0	0	0		3, 118, 992	
	O DRUGS CHARGED TO PATIENTS	0	0	0	0	2, 119, 711	73.
	ATIENT SERVICE COST CENTERS	0	0	0	0	0	90.
	1 OTHER OUTPATIENT SERVICE COST CENTER	3, 822	3, 822	182, 573	0	461, 890	
	2 CLINIC	0	0	0	0	0	90.
	3 DERMATOLOGY CLINIC	0	0	0	0	0	90.
		0	0	0	0	0	90.
	5 SURGERY CLINIC 7 UROLOGY CLINIC	0	0	0	0	0	90. 90.
	9 GASTROENTEROLOGY CLINIC	0	0	1, 899	0	303	90.
	1 NEUROLOGY CLINIC	0	0	0	0	0	90.
	2 OPTHAMOLOGY CLINIC	0	0	0	0	5, 467	90.
	3 ALLERGY CLINIC	0	0	99, 000		148, 445	90.
	4 WOUND CARE 0 EMERGENCY	3, 504 24, 566	3, 504 24, 566	230, 834 2, 253, 705		615, 227 3, 957, 660	90. 91.
	O OBSERVATION BEDS (NON-DISTINCT PART)	24, 500	24, 500	2,200,700		5, 757,000	91.
	R REIMBURSABLE COST CENTERS	Г I					
0 0950	O AMBULANCE SERVICES	4, 760	4, 760	2, 007, 835	0	2, 846, 129	95.
00	I AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) EI MBURSABLE COST CENTERS	189, 981	189, 981	31, 632, 079	-13, 957, 558	61, 616, 513	118.
	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	624	624	0	0	21, 754	190
	O PHYSI CI ANS' PRI VATE OFFI CES	42, 942	42, 942	21, 300, 272	0	34, 495, 647	
00 0795	O THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.
0410705	1 CAFE/BOUTI QUE	1, 416	1, 416	0	0	49, 366	
			20 544	67, 103	0	869, 841	1194
02 0795	2 OTHER NONREI MB	20, 544	20, 544		0		
02 0795	2 OTHER NONREIMB 3 RETAIL PHARMACY Cross Foot Adjustments	20, 544 400	20, 544 400	247, 601	0	1, 463, 143	

Health Financial Systems		WITHAM MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0104			Period: From 01/01/2017	Worksheet B-1		
					To 12/31/2017			
		CAPITAL REL	ATED COSTS					
Cost Center Description		NEW BLDG & FLXT (SQUARE FEET)	NEW MVBLE EQUI P (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconci I i ati on	ADMI NI STRATI VE & GENERAL (ACCUM. COST)		
		1.00	2.00	4.00	5A	5.00		
202.00 Cost to be allocated (per Wks Part I)	t. B,	5, 056, 408	3, 865, 336	8, 496, 278	3	13, 957, 558	202.00	
203.00 Unit cost multiplier (Wkst. B	, Part I)	19. 758772	15. 104456	0. 159563	3	0. 141678	203.00	
204.00 Cost to be allocated (per Wks Part II)	t. B,			20, 29	1	650, 854	204.00	
205.00 Unit cost multiplier (Wkst. B	, Part			0.00038	1	0. 006607	205.00	
206.00 NAHE adjustment amount to be (per Wkst. B-2)	allocated						206. 00	
207.00 NAHE unit cost multiplier (Wk Parts III and IV)	st. D,						207. 00	

COST ALLOCATION - STATISTICAL DALS Provider CM: 15:010 Period (minimized control bescription (statical) Period (statical) Period (stati	Health Financial Systems	WI THAM MEMORI	AL_HOSPITAL		In Lieu	u of Form CMS-2	2552-10
Learning	COST ALLOCATION - STATISTICAL BASIS		Provider CO			Worksheet B-1	
Cost Center Description OPECNION OF PLANT LANDER'S (DOUS) DIDEPLATING SUPPLICE DIDEPLATING SUPPLICE CONCELS SUPPLICE 100 CONSTRUCT 0.0000 0.00000 0.0000 0.0000<							
CSUDART CREADS SERVED SERVED SERVED 1.00 CREADS SERVED 1.00 10.00 11.00 11.00 1.00 CREADS SERVED 1.00 10.00 11.00 11.00 11.00 1.00 CREADS SERVED 1.00 10.00 11.00 10.00	Cost Center Description					CAFETERI A	
TEED OreAccess							
Delived.		FEET)		JERVICE)	SERVED	SERVED)	
1.00 DOTOD NEW CAP HEL COST-SHUE & FIXI 2.00 0 1.00 2.00 0 1.00 2.00 0 1.00 2.00 0 1.00 1.00 0 0 1.00 0 0 1.00		7.00	8.00	9.00	10.00	11.00	
4 00 00400 D04000 EPRLIVEE ENERTS DEPARTMENT 4.00 4.00 7 00 00700 D07700 0FFRATION OF PLANT 183, R13 3.20, SNP, 4V9 7.00 7 00 00700 D07700 1FFRATION OF PLANT 2.00 19, 00 31 4.7, 880 9.00 10 00 01000 DELENTER S.20, SNP, 4V9 0 2.26, 50 0 19, 00 31 4.7, 880 9.00 10 00 01000 DELENTER S.20, SNP, 4V9 0 2.26, 50 0 7.00 9.00 9.20, 50<							1.00
5.00 DOCKOM ANMIN STATUPE & GENERAL 1 5.00 DOCK AND OF PLANT 1 5.00 DOCK AND OF PLANT S.00 DOCK AND OF PLANT D							
7.00 00700 00700 00700 00700 00700 00 000000 000000 0							
9.00 DORDON DINSENTER IN INS 2.888 0 139.073 0 9.00 10.00 DORDON DETARY 6.281 0 8.252 47.860 10.00 11.00 DETARY 0.200 2.575 0 9.00 10.00 11.00 DETADOL CALETERA IN INSTRATION 0 0 5.750 0 7.71 10.00 10.00 DETADOL RECARCEORS & LIBRARY 3.003 0 5.750 0 7.71 10.00 10.00 DETADOL RECARCEORS & LIBRARY 3.003 0 5.750 0 7.71 10.00 10.00 DETADOL RECARCEORS & LIBRARY 4.861 3.227.477 13.774 8.97 23.00 0		183, 813					
10.00 01000 DETARY 6.281 0 8.232 77. 6.00 10.00 13.00 01300 MRSI K. ALMIN STRATION 1 00 01300 014300 01400 01400 01400 01400 01400 01400 01400 01400 01400 01400 01400 01400 014000 01400 01400 014000 01500 01000 01500		-					
11. 00 01100 CAFETERIA 0 0 2, 257 0 982 11. 00 15. 00 01500 PHARMACY 1, 959 0 2, 425 0 35 15. 00 16. 00							
15. DO DISOD PHARILARY 1, 339 0 2, 625 0 750 770			-			982	
16.00 DIADD MEDICAL DECORDS & LIBORY 3.0e3 0 5.750 7.750 7.750 30.00 03000 ADULTS & FUDIATRICS 20.372 16.498.900 45.681 22,178 229 30.00 10.00 0100 USERSON DEE - LEF 6.408 3.299.90 11.700 6.96 21.100 41.00 04100 USERSON DEE - LEF 6.408 3.299.90 12.778 6.96 0 41.00 41.00 04030 NURSERY 0 1.721.650 0 0 42.00 43.00 41.00 04030 NURSERY 0 1.723.650 0 0 43.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 40.25.75 0 16.3.43 94.40 44.00 40.25.91 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 <td< td=""><td></td><td></td><td>-</td><td></td><td></td><td></td><td></td></td<>			-				
INPART ENT. ROUT NE SERVICE COST CENTERS 1 1 0.0 000000 00000 0100 11.00 0.73 0.43.661 22.778 229 30.00 31.00 00000 00000 0.995 4.131.790 11.400 0 213.00 41.00 00000 00000 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
31.00 03100 INTERSIVE CARE. UNIT 5.995 4, 131, 790 11, 000 0 21 31.00 41.00 04100 SUBPROVIDER - IFF 0 0 0 0 0 41.00 42.00 04200 SUBPROVIDER - IFF 0 0 0 0 42.00 43.00 94300 KURSERY 0 1, 721, 665.0 0 0 43.00 44.00 MOTORINERS FACILITY 4, 651 2, 726.578 0 16, 343 04 50.00 05500 OFANILLED WELC MORENTIC 19, 886 24, 479.776 11, 660 0 28 50.00 55.00 05500 05500 0 0 0 0 0 0 0 0 55.00 55.00 05500 05700 0		0,000		0,700			10.00
40.00 04000 SUBPROVIDER IPF 6.406 3.329,497 13.794 8.959 33 40.00 41.00 0400 SUBPROVIDER 0 0 0 42.00 43.00 04300 URSERY 4.00 0 0 0 44.00 0400 USTAT EMPROVIDER 16.240 44.00 44.00 44.00 0400 USTAT EMPROVIDER 16.240 44.00 44.00 44.00 0400 USTAT EMPROVIDER 16.240 44.00 45.00 2.575 0 23 50.00 0500 0500 OPROVPATING ROWELING 19.866 26.479,776 11.650 0 55.01 0500 ULTRA SOUND 0 40.200,434 750 0 35.01 55.01 0500 ULTRA SOUND 0 2.981,582 1.100 0 18.80 26.00 0 45.00 04.00 04000 TOPK COPC 59.80,572 0							
11:00 01100 0							
13.00 01300 NURSERY 0 1.721,600 0 0 0 0 43.00 AKCILLARY SERVICE COST CENTERS		-					41.00
44.00 04400 SKULLED NURSI NG FACILITY 4,851 2,766,578 0 16,343 0 44.00 ANCLLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROW 16,260 44.106,603 2,575 0 23 50.00 55.00			0	, v	0		
MACILLARY SERVICE COST CENTRES 1 54.00 05000 (PERATIN & ROAM 16, 26.0 41, 106, 603 2, 575 0 23 50.0 55.01 05300 (RADICLGX-PIARMESTIC 19, 884 26, 479, 776 11, 650 0 25 65.00 0 <td></td> <td>-</td> <td></td> <td></td> <td>16, 343</td> <td></td> <td></td>		-			16, 343		
54. 00 654.00 654.00 654.00 656.00 660.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00	ANCILLARY SERVICE COST CENTERS				10,010	Ŭ	11100
55.00 05500 RAD LOLGY-THERAPEUT C 0 0 0 0 0 55.00 55.01 05501 01700 0 8.00,345 750 0 35.00 55.00 05500 CT SCAN 0 40,285,483 1,150 0 4 57.00 59.00 05500 CARDIA C CATHETER JATI ON 1,1438 2,760,332 0 0 26.00 0.00 06300 BLOOR STOR ING, PROCESSI ING & TRANS. 0 760,942 4,925 0 0 64.00 66.00 06400 DHTRAVENDIX THERAPY 0 3.05,817 850 0 76.0 67.01 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.01 67.01 66.00 67.01 67.01 67.01 67.01 67.01 67.01 67.01 67.01 67.01 67.01							
55. 01 05501 ULTRA SOUND 0 8. 040, 345 750 0 3 55. 01 57. 00 05700 05700 05700 05700 05700 0 0 0 58. 00 58. 00 05800 MAGNETIC RESONANCE I MAGI NG (NRI) 1, 438 2, 760, 532 0 0 0 59. 00 60. 00 06000 CARDI AC CATHEREN ZATION 1, 438 2, 760, 532 0 0 63. 00 63. 00 06300 BLOOD STORI NG, PROCESSING & TRANS. 0 760, 942 4, 925 0 63. 00 64. 00 06400 INTRAVENUS THERAPY 0 2, 958, 550 0 0 64. 00 66.00 06600 DEVISICAL THERAPY 0 76, 977 7, 894, 714 1, 775 0 41 66 76.00 0 0 0 0 0 0 0 0 0 69. 01 70.00 0.700 0.6200 SPE.CETROLARDIOLOCY 0 0 0 0 0 0 0 0 71.00 0.700 DEVINEL ES CHARCED TO PATI ENTS 0 2, 225. 00 0 0 0 0 0 72.00 DTADENEL							
58. 00 OSB00 MACRETIC RESONANCE I MAGING (MRI) 1,706 12,951,869 1,100 0 100 58. 00 60. 00 CARDIA CCATHETERIZATION 1,438 2,760,332 0 0 69. 00 59. 00 59. 00 59. 00 59. 00 59. 00 59. 00 66. 00 67. 01 68. 00 0 0 67. 01 68. 00 0 72. 00 71. 00 71. 00 71. 00 71. 00 71. 00 72. 00 72. 00 72. 00	55.01 05501 ULTRA SOUND	-	8, 040, 345		-		
59.00 05900 (ARDIA C CATHETERI ZATION 1,438 2,760,332 0 0 0 59.00 06.00 06000 (LABORATORY 9,274 53,528,765 0 0 63.00 66.00 0 66.00 0 66.00 0 64.00 66.00 0 64.00 66.00 0 64.00 66.00 0 64.00 66.00 0 64.00 66.00 0 67.01 67.01 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 68.00 68.00 68.00 68.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 72.00 <td></td> <td>-</td> <td></td> <td></td> <td>Ű</td> <td></td> <td></td>		-			Ű		
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64 00 0 6000 INTRAVENUES THERRAPY 0 2.958.550 0 0 0 64.00 66 00 6600 06700 0CUPATIONAL THERRAPY 8.976 7.894,714 1.775 0 117 67.00 67 00 06700 0CUPATIONAL THERRAPY 0 932,942 625 0 18 67.01 68 00 06800 SPECCH PATHOLOGY 0 933.658 375 0 41 69.00 69 00 06900 LECTEOCARDIOLOGY 0	60. 00 06000 LABORATORY				-		
66.00 06600 PHYSI CAL THERAPY 8,976 7,894,714 1,775 0 41 66.00 70 06700 0CUPTATIONAL THERAPY 0 3,052,817 850 0 18 67.01 66.00 06800 SPEECH PATHOLOCY 0 933,858 375 0 19 68.00 69.00 06900 ELECTROCARDI OLOGY 0 933,858 375 0 21 69.00 69.00 69.01 69.00 69.01 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 73.00 00.00 0 0 0 0 0 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00		-			0		
67:00 0c700 0CCUPATIONAL THERAPY 0 3, 05, 817 BS0 0 17 67:00 67:00 0c701 ADDI ADDI ADDI ADDI ADDI 68:00 0 0800 SPECCI PATHOLOGY 0 932, 942 625 0 18 67:00 69:00 0 0 0 0 0 0 0 0 68:00 69:00 0		-			0		
68:00 ORGON SPEECH PATHOLOGY 0 973 0 19 68:00 69:00 06900 ELECTCRACROIOLOGY 0	67.00 06700 OCCUPATI ONAL THERAPY		3, 052, 817	850	0	17	67.00
69:00 OG900 ELECTROCARDIOLOGY O <td></td> <td>-</td> <td></td> <td></td> <td>-</td> <td></td> <td></td>		-			-		
171.00 IDP ICAL SUPPLIES CHARGED TO PATIENTS 0 6, 508, 665 0 0 21 71.00 172.00 07300 DRUGS CHARGED TO PATIENTS 0 21, 986, 485 2, 725 0 0 73.00 0010 07300 DRUGS CHARGED TO PATIENTS 0 21, 986, 485 2, 725 0 0 73.00 0010 07000 CLINIC COST CENTERS 0 0 0 0 0 90.00 90.01 07000 CLINIC 0 0 0 0 0 90.00 90.02 07030 DEMATOLOGY CLINIC 0		-			Ű		
12:00 07200 IMPL DEV. CHARGED TO PATIENT 0 21:892,514 0 0 73:00 007300 DORUGS CHARGED TO PATIENTS 0 21:986,485 2:725 0 0 73:00 0017PATIENT SERVICE COST CENTERS 0					0		
73.0 D DATLENTS O 21,986,485 2,725 O O 73.0 90.00 09000 CLINIC 0<		-			0		
90.00 00 00 0 </td <td></td> <td>-</td> <td></td> <td>-</td> <td></td> <td></td> <td></td>		-		-			
90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER 3,822 0 6,700 0 34 90.01 90.02 02002 CLINIC 0 0 9,850 0 0 90.02 90.03 D69003 DERMATOLOGY CLINIC 0 0 0 0 0 90.03 90.04 90003 DERMATOLOGY CLINIC 0 0 0 0 90.04 90.05 09007 UROLOGY CLINIC 0 153,718 0 0 90.07 90.07 09007 UROLOGY CLINIC 0 0 0 0 90.07 90.11 POTI INELROGY CLINIC 0 0 0 0 90.07 90.12 OPTHAMOLOGY CLINIC 0 0 0 90.12 90.13 POTHAMOLOGY CLINIC 0 573,785 0 0 90.14 90.14 09014 WOUNC CARE 3,504 4,257,476 0 0 90.14 91.00 PS200 DESERVATION BEDS (NON-DISTINCT PART) 24,566 30,298,386 0 0 <t< td=""><td></td><td>-</td><td>-</td><td>-</td><td></td><td>-</td><td></td></t<>		-	-	-		-	
90.02 09002 CLINIC 0 9,850 0 0 90.02 90.03 09003 DERMATOLOGY CLINIC 0					-		
90. 04 09004 ENT CLINIC 0		0	-				
90.05 09005 SURGERY CLINIC 0		0	0				
90.07 09007 UROLOGY CLINIC 0 153,718 0		0	0	0	0		
90.11 O9011 NEUROLOGY CLINIC 0 <td></td> <td>0</td> <td>153, 718</td> <td>0</td> <td>0</td> <td></td> <td></td>		0	153, 718	0	0		
90.12 09012 0PTHAMOLOGY CLINIC 0 0 0 0 90.12 90.13 O9013 ALLERGY CLINIC 0 573,785 0 0 0 90.13 90.14 O9014 WOUND CARE 3,504 4,257,476 0 0 0 90.14 91.00 DMERGENCY 24,566 30,298,386 0 0 64 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 24,566 30,298,386 0 0 95.00 95.00 MSRABLE COST CENTERS 92.00 92.00 95.00 95.00 MSRABLE COST CENTERS 95.00 95.00 95.00 130 95.00 95.00 95.00 96.00 0 0 130 95.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 143,431 320,539,499 139,073 47,480 982 118.00 192.00 PHYSI CLANS' PRI VATE OFFICES 37,942 0 0 0 192.00 192.00 194.01 194.01 194.02		0	-				
90.13 09013 ALLERGY CLINIC 0 573,785 0 0 0 90.13 90.14 09014 WOUND CARE 3,504 4,257,476 0 0 0 90.14 91.00 09100 EMERGENCY 24,566 30,298,386 0 0 64 91.00 92.00 09200 DSERVATI ON BEDS (NON-DI STINCT PART) 92.00 <td></td> <td>0</td> <td></td> <td></td> <td>0</td> <td></td> <td></td>		0			0		
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92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 92.00 0THER REI MBURSABLE COST CENTERS 92.00 95.00 09500 AMBULANCE SERVI CES 1,760 3,526,208 0 0 130 95.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 143,431 320,539,499 139,073 47,480 982 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 624 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 37,942 0 0 0 192.00 194.00 07950 THORNTOWN OFFI CE BUI LDI NG 0 0 0 194.00 0 0 194.01 194.02 07952 OTHER NONREI MB 0 0 0 0 194.02 0 0 194.02 0 0 194.02 0 0 194.02 0 0 0 194.02 0 0 0 0 0 <td< td=""><td></td><td></td><td></td><td></td><td>0</td><td></td><td></td></td<>					0		
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SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 143,431 320,539,499 139,073 47,480 982 118.00 NONREI MBURSABLE COST CENTERS 0 0 0 0 190.00 19200 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 624 0 0 0 192.00 192.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 37,942 0 0 0 192.00 194.00 07950 THORNTOWN OFFICE BUILDING 0 0 0 194.00 194.01 07951 CAFE/BOUTIQUE 1,416 0 0 0 194.01 194.02 07952 OTHER NONREI MB 0 0 0 194.02 194.03 07953 RETAI L PHARMACY 400 0 0 194.02 200.00 Cross Foot Adj ustments 200.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00	OTHER REIMBURSABLE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 143,431 320,539,499 139,073 47,480 982 118.00 NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS 0 0 0 0 190.00 0 0 0 0 190.00 0 0 0 0 190.00 0 0 0 0 0 0 0 0 190.00 192.00 192.00 0 0 0 0 192.00 192.00 192.00 0 0 0 0 192.00 192.00 192.00 0 0 0 192.00 192.00 192.00 192.00 194.00 0 0 0 192.00 194.00 194.00 0 0 0 194.01 194.02 194.02 07952 0THER NONREI MB 0 0 0 0 0 194.02 194.02 194.03 07953 RETAI L PHARMACY 400 0 0 0 194.03 200.00 200.00 <		1, 760	3, 526, 208	0	0	130	95.00
190.00 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 624 0 0 0 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 37,942 0 0 0 192.00 194.00 07950 THORNTOWN OFFICE BUILDING 0 0 0 0 194.00 194.01 07951 CAFE/BOUTIQUE 1,416 0 0 0 194.01 194.02 07952 OTHER NONREI MB 0 0 0 0 194.02 194.03 07953 RETAIL PHARMACY 400 0 0 0 194.02 200.00 Cross Foot Adjustments 200.00 0 0 0 201.00 201.00 202.00 203.677 202.00 202.00 Cost to be allocated (per Wkst. B, 4,555,869 348,470 948,296 1,611,009 503,677 202.00		143, 431	320, 539, 499	139, 073	47, 480	982	118.00
192.00 PHYSICIANS' PRIVATE OFFICES 37,942 0 0 0 192.00 194.00 07950 THORNTOWN OFFICE BUILDING 0 0 0 0 194.00 194.01 07951 CAFE/BOUTIQUE 1,416 0 0 0 194.00 194.02 07952 OTHER NONREIMB 0 0 0 0 194.01 194.02 07952 OTHER NONREIMB 0 0 0 0 194.02 194.03 07953 RETAIL PHARMACY 400 0 0 0 194.03 200.00 Cross Foot Adjustments 200.00 200.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 202.00 202.00 203.677 202.00 202.00 2048,470 948,296 1,611,009 503,677 202.00		(04					100.00
194.00 07950 THORNTOWN OFFICE BUILDING 0 0 0 0 194.00 194.01 07951 CAFE/BOUTLQUE 1,416 0 0 0 194.01 194.02 07952 OTHER NONREIMB 0 0 0 0 194.02 194.03 07953 RETAIL PHARMACY 400 0 0 0 194.03 200.00 Cross Foot Adjustments 400 0 0 200.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 202.00 748,296 1,611,009 503,677 202.00							
194.02 07952 OTHER NONREIMB 0 0 0 0 194.02 194.03 07953 RETAL PHARMACY 400 0 0 0 194.03 200.00 Cross Foot Adjustments 400 0 0 200.00 200.00 201.00 Negative Cost Centers 201.00 201.00 201.00 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 4,555,869 348,470 948,296 1,611,009 503,677 202.00	194.0007950 THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.03 07953 RETAIL PHARMACY 400 0 0 0 194.03 200.00 Cross Foot Adjustments 400 0 0 200.00 200.00 201.00 Negative Cost Centers 201.00 201.00 201.00 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 4,555,869 348,470 948,296 1,611,009 503,677 202.00		1, 416	0	0	0		
200.00 Cross Foot Adjustments 200.00 200.00 200.00 200.00 200.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 202.00		400		0 0	0		
202.00 Cost to be allocated (per Wkst. B, Part I) 4,555,869 348,470 948,296 1,611,009 503,677 202.00	200.00 Cross Foot Adjustments					0	200. 00
Part I)		4 EEE 0/0	240 470	040-007	1 411 000	E00 / 77	
		4, 000, 869	348, 470	748, 296	1, 011, 009	503, 077	202.00
	203.00 Unit cost multiplier (Wkst. B, Part I)	24. 785347	0. 001087	6. 818692	33.930265	512.909369	203.00

Heal th	inancial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS			Provider CO	Provider CCN: 15-0104		Worksheet B-1	
					To 12/31/2017	Date/Time Pre 5/22/2018 7:4	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NO	G DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(HOURS OF	(MEALS	(MEALS	
		(SQUARE	(GROSS	SERVICE)	SERVED)	SERVED)	
		FEET)	CHARGES)				
		7.00	8.00	9.00	10.00	11.00	
204.00	Cost to be allocated (per Wkst. B,	876, 156	2, 028	116, 43	34 264, 445	5, 271	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	4. 766562	0. 000006	0. 8372	15 5. 569608	5. 367617	205.00
	11)						
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						

	Financial Systems _LOCATION - STATISTICAL BASIS	WITHAM MEMORIA	L HOSPITAL Provider CO	CN: 15-0104	In Lie Period:	u of Form CMS-2 Worksheet B-1	2552-10
					From 01/01/2017 To 12/31/2017	Date/Time Prep	oared:
	Cost Costas Description			MEDI CAL		5/22/2018 7:49	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	PHARMACY (COSTED	RECORDS &			
			REQUIS.)	LIBRARY			
		(DI RECT NRSI NG HRS)		(TIME SPENT)			
		13.00	15.00	16.00	-		
ł	GENERAL SERVICE COST CENTERS						
	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
	00800 LAUNDRY & LINEN SERVICE						8.00
	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00 10.00
	01100 CAFETERI A						11.00
	01300 NURSI NG ADMI NI STRATI ON	400, 512					13.00
		0	2, 586, 651	41 10	0		15.00
	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	0	0	41, 10	0		16.00
	03000 ADULTS & PEDI ATRI CS	88, 567	11, 145	10, 10	0		30.00
	03100 I NTENSI VE CARE UNI T	25, 847	216	2, 10			31.00
	04000 SUBPROVIDER - IPF	38, 665	54	2, 50			40.00
	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0	0		0		41.00 42.00
1	04300 NURSERY	0	0		0		43.00
	04400 SKILLED NURSING FACILITY	35, 369	9, 781		0		44.00
	ANCI LLARY SERVI CE COST CENTERS	F0 F00	10 212	2 (2	c		F0 00
	05400 RADI OLOGY-DI AGNOSTI C	59, 598 0	18, 312 1, 799	3, 62 9, 70			50.00 54.00
	05500 RADI OLOGY-THERAPEUTI C	0	0		0		55.00
	05501 ULTRA SOUND	0	821	1, 05			55.01
	05700 CT SCAN	0	524 5, 922	1, 20			57.00 58.00
	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	3, 088	5, 922	65	0		58.00
	06000 LABORATORY	0	89	1, 00	0		60.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0		63.00
	06400 I NTRAVENOUS THERAPY 06600 PHYSI CAL THERAPY	0 29, 709	0 4, 074	1, 95	0		64.00 66.00
	06700 OCCUPATI ONAL THERAPY	12, 835	4,074	85			67.00
	06701 AUDI OLOGY	0	0		0		67.01
	06800 SPEECH PATHOLOGY	3, 254	563		0		68.00
	06900 ELECTROCARDI OLOGY 06901 CARDI OLOGY	0 28, 976	0 16	1, 87	5		69.00 69.01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	20, 770	0		0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0		72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0		73.00
	OUTPATI ENT SERVICE COST CENTERS	0	0		0		90.00
	09001 OTHER OUTPATIENT SERVICE COST CENTER	5, 029	6	4, 20	-		90.01
	09002 CLI NI C	0	0		0		90. 02
	09003 DERMATOLOGY CLINIC	0	0		0		90.03
	09004 ENT CLINIC 09005 SURGERY CLINIC	0	0		0		90.04 90.05
	09007 UROLOGY CLINIC	0	954		0		90.07
	09009 GASTROENTEROLOGY CLINIC	4, 408	3		0		90.09
	09011 NEUROLOGY CLINIC	0	565		0		90.11
	09012 OPTHAMOLOGY CLINIC 09013 ALLERGY CLINIC	2, 617	0 204		0		90. 12 90. 13
	09014 WOUND CARE	8, 198	11, 577		0		90.14
	09100 EMERGENCY	51, 623	73, 093		0		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
	09500 AMBULANCE SERVICES	0	27, 084		0		95.00
	SPECIAL PURPOSE COST CENTERS				-		
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	397, 783	166, 802	40, 80	0		118.00
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN		0		0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	1, 141	0 1, 947, 602	30	-		190.00
194.00	07950 THORNTOWN OFFICE BUILDING	0	0		0		194.00
	07951 CAFE/BOUTI QUE	0	0		0		194.01
	07952 OTHER NONRELMB	1, 588	0		0		194.02
194.03 200.00	07953 RETAIL PHARMACY Cross Foot Adjustments	0	472, 247		U		194. 03 200. 00
200.00	Negative Cost Centers						200.00
202.00	Cost to be allocated (per Wkst. B,	860, 609	3, 840, 379	2, 303, 16	9		202.00
	Part I)						1

Heal th Fi	nancial Systems	WI THAM MEMORI A	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLO	OCATION - STATISTICAL BASIS		Provider CC		Period: From 01/01/2017	Worksheet B-1	
					To 12/31/2017	Date/Time Prep 5/22/2018 7:49	
	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			
203.00	Unit cost multiplier (Wkst. B, Part I)	2. 148772	1. 484692	56.03817	5		203.00
204.00	Cost to be allocated (per Wkst. B,	6, 288	101, 183	139, 51	2		204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 015700	0. 039117	3. 39445	3		205.00
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						

CDMPUTATION OF RATIO OF COSTS TO CHARGES Provider CDM: 15-0104 Prod: from C1/27/2020 Prost der CL From C1/27/2020 P	Health Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
Cost Center Description Total Cost f From Watt. B, Part 1, col. Therapy Limit Ad. Total Costs Ad. Total Costs Disal Learner Disal Disal Learner Disal Learner Disal Learner Disal Disal Dis	COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0104	From 01/01/2017	Part I Date/Time Pre	
Cost Center Description Total Cost (from Wkst, B) 260 Total Costs (b) 200 Total Costs (b) 200 <thtotal costs<="" td=""><td></td><td></td><td></td><td></td><td>Hocpi tal</td><td></td><td>9 am</td></thtotal>					Hocpi tal		9 am
Cost Center Description Total Cost Adj. Total Cost Adj. Total Costs Adj. RCE Disal owance Total Costs Impart LNF POUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 0.00 0.000000 0.0115 & PERATINE S 9.773.378 0 9.773.378 0 2.555.748 1.00 2.007.471 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>PP3</td> <td></td>						PP3	
IMPART LENT ROUTINE SERVICE COST CENTERS Impart Lent Routine SERVICE COST CENTERS 0.0 0000000 00000 00000 00000 00000 000000 00000 000000 000000 000000 0000000 00000000 0000000000 000000000000000000000000000000000000	Cost Center Description	(from Wkst. B, Part I, col.		Total Costs	RCE	Total Costs	
30:00 3000 ADULTS & PEDIATRICS 8, 773, 378 9, 773, 378 0, 8, 773, 378 0, 8, 773, 378 0, 0, 8, 773, 378 0, 0, 8, 773, 378 0, 0, 8, 773, 378 0, 0, 8, 773, 378 0, 0, 8, 773, 378 0, 0, 8, 773, 378 0, 0, 8, 773, 378 0, 0, 2, 55, 758 30.00 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0			2.00	3.00	4.00	5.00	
31:0.0 03100 INTENSI VE CARE UNIT 2,555,738 2,555,738 0 2,555,738 0 2,555,738 0 2,555,738 0 2,555,738 0		-			-		
40.00 40000 SUBPROVIDER - IPF 2,807,471 29,07,471 29,097 2,836,568 40.00 41.00 641000 0 0 0 0 41.00 43.00 043000 NURSEEY 30,308 0 30.00 43.00 044000 SKILED NURSING FACILITY 2,865,935 2.865,935 0 2,865,935 50.00 05000 (PEEATI NG ROOM 4,914,832 0 4,914,832 0 4,914,832 50.00 05500 (PEEATI NG ROOM 4,914,832 0 6,562,809 6,562,809 50.00 55.00 05500 (RADI OLCO-THERAPUTI C 6,562,809 6,563,94 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 50.00 50.00 5.00							•
41.00 04100 SUBPROVIDER 1 RF 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td>_,</td> <td>•</td>						_,	•
42:00 04200 SUBPROVIDER 0				2, 807, 47	-		
43. 00 04300 VIESERY 30, 308 30, 308 30, 308 43. 00 44. 00 04400 SKILLED NURSING FACILITY 2, 865, 935 2, 865, 935 0 2, 865, 935 0 2, 865, 935 0 2, 865, 935 0 0, 900 0, 652, 809 0 0, 900 6, 562, 809 0		-			-	-	•
44.00 0.04400 SKILLED NURSING FACLITY 2,865,935 2,865,935 0 2,865,935 44.00 00 05000 OPERATING ROOM 4,914,832 4,914,832 0 4,914,832 50.00 6,562,809 6,562,809 0 6,562,809 0 6,562,809 0 6,562,809 0 6,562,809 0 6,562,809 0 6,562,809 0 6,562,809 0 55.00 0 0 0 0 55.00 0 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 56.00 0 56.00 0 56.00 0 56.00 0 56.00 56.00 0 56.00 0 56.00 0 56.00 0 56.00 0 56.00 0 56.00 0 56.00 0 56.00 0 56.00 0 0 0 0 0 0 0 0		-			-	-	
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54. 00 054.00 RADIOLOGY-DI AGNOSTIC 6, 562, 809 6, 562, 809 6, 562, 809 54. 00 55. 00 05500 NEOD RADIOLOGY-DI REAPEUTIC 0 0 0 55. 01 70.00 05700 CTAC 839, 401 830, 401 839, 401 830, 401 839, 401 830, 401 839, 401 830, 401 <td></td> <td>4 014 922</td> <td></td> <td>4 014 97</td> <td>2</td> <td>4 014 022</td> <td></td>		4 014 922		4 014 97	2	4 014 022	
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58. 00 058.00 MAGNETI C RESONANCE I MAGI NG (MRI) 1, 183, 369 1, 183, 369 0, 1, 183, 369 564, 748 554, 748 554, 748 0, 554, 748 554, 748 0, 227, 348 0, 227, 348 0, 227, 348 0, 227, 348 0, 227, 348 0, 227, 348 0, 3, 216 0, 3, 216 0, 3, 216 0, 3, 216 0, 3, 216 0, 3, 216 0, 3, 216 0, 3, 216 0, 3, 216 0, 3, 248, 120 0, 3, 348, 120 0, 3, 348, 120 0, 3, 348, 120 0, 3, 348, 120 0, 3, 348, 120 64. 00 0.0 0.0000 OCUPATI IONAL THERAPY 3, 348, 120 0, 3, 348, 120 0, 3, 348, 120 0, 3, 348, 120 0, 3, 348, 120 0, 3, 348, 120 0, 3, 348, 120 0, 3, 348, 120 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0							
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90.12 09012 0PTHAMOLOGY CLINIC 6,242 6,242 0 6,242 90.12 90.13 09013 ALLERGY CLINIC 176,026 176,026 0 176,026 90.13 90.14 09014 WOUND CARE 828,671 828,671 0 828,671 90.14 91.00 09100 EMERGENCY 5,412,457 5,412,457 0 5,412,457 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 1,656,304 1,656,304 1,656,304 1,656,304 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 3,403,707 0 3,403,707 95.00 200.00 Subtotal (see instructions) 67,386,237 0 67,386,237 29,097 67,415,334 200.00 201.00 Less Observation Beds 1,656,304 1,656,304 1,656,304 1,656,304 201.00							•
90.13 09013 ALLERGY CLINIC 176,026 176,026 0 176,026 90.13 90.14 09014 WOUND CARE 828,671 828,671 0 828,671 90.14 91.00 09100 EMERGENCY 5,412,457 5,412,457 0 5,412,457 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1,656,304 1,656,304 1,656,304 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 3,403,707 0 3,403,707 95.00 200.00 Subtotal (see instructions) 67,386,237 0 67,386,237 29,097 67,415,334 200.00 201.00 Less Observation Beds 1,656,304 1,656,304 1,656,304 1,656,304 201.00							
90. 14 09014 WOUND CARE 828, 671 828, 671 0 828, 671 90. 14 91. 00 09100 EMERGENCY 5, 412, 457 5, 412, 457 0 5, 412, 457 91. 00 92. 00 09200 DBSERVATI ON BEDS (NON-DI STINCT PART) 1, 656, 304 1, 656, 304 1, 656, 304 92. 00 0THER REI MBURSABLE COST CENTERS 3, 403, 707 3, 403, 707 95. 00 3, 403, 707 95. 00 3, 403, 707 95. 00 3, 403, 707 95. 00 0 3, 403, 707 95. 00 0 7, 386, 237 29, 097 67, 415, 334 200. 00 201. 00 Less Observati on Beds 1, 656, 304 1, 656, 304 1, 656, 304 1, 656, 304 201. 00							
91.00 09100 EMERGENCY 5, 412, 457 5, 412, 457 0 5, 412, 457 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 1, 656, 304 1, 656, 304 1, 656, 304 92.00 0THER REIMBURSABLE COST CENTERS 3, 403, 707 3, 403, 707 95.00 3, 403, 707 95.00 3, 403, 707 95.00 95.00 400, 70500 400, 70500 400, 70500 400, 70500 96.00 96.00 96.00 96.00 96.00 96.00 96.00 96.00 97.00 96.00							
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1,656,304 1,656,304 1,656,304 92.00 0THER REIMBURSABLE COST CENTERS 3,403,707 0 3,403,707 95.00 3,403,707 95.00 3,403,707 0 3,403,707 95.00 200.00 Subtotal (see instructions) 67,386,237 0 67,386,237 29,097 67,415,334 200.00 201.00 Less Observation Beds 1,656,304 1,656,304 1,656,304 201.00							
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI CES 3, 403, 707 0 3, 403, 707 95.00 200.00 Subtotal (see instructions) 67, 386, 237 0 67, 415, 334 200.00 201.00 Less Observation Beds 1, 656, 304 1, 656, 304 1, 656, 304 201.00							
200.00 Subtotal (see instructions) 67, 386, 237 0 67, 386, 237 29, 097 67, 415, 334 200.00 201.00 Less Observation Beds 1, 656, 304 1, 656, 304 1, 656, 304 1, 656, 304 201.00							1
200. 00 Subtotal (see instructions) 67, 386, 237 0 67, 386, 237 29, 097 67, 415, 334 200. 00 201. 00 Less Observation Beds 1, 656, 304 1, 656, 304 1, 656, 304 1, 656, 304 201. 00	95. 00 09500 AMBULANCE SERVI CES	3, 403, 707		3, 403, 70	07 0	3, 403, 707	95.00
	200.00 Subtotal (see instructions)	67, 386, 237	0	67, 386, 23	29, 097	67, 415, 334	200. 00
202. 00 Total (see instructions) 65, 729, 933 0 65, 729, 933 29, 097 65, 759, 030 202. 00							
	202.00 Total (see instructions)	65, 729, 933	0	65, 729, 93	33 29, 097	65, 759, 030	202.00

COMPUTAT	ION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0104	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/22/2018 7:4	epared: 9 am
				XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	Charges Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS	13, 717, 847		13, 717, 84			30.00
	3100 I NTENSI VE CARE UNI T	4, 131, 790		4, 131, 79			31.0
	4000 SUBPROVI DER – I PF	3, 329, 497		3, 329, 49			40.0
	4100 SUBPROVI DER – I RF	0			0		41.0
	4200 SUBPROVI DER	0			0		42.0
	4300 NURSERY	1, 721, 650		1, 721, 6			43.0
	4400 SKI LLED NURSI NG FACI LI TY	2, 768, 578		2, 768, 5	78		44.0
	NCI LLARY SERVI CE COST CENTERS	7 (50.001	2/ 447 502	44 104 44	0 111 401	0,000000	
	5000 OPERATI NG ROOM 5400 RADI OLOGY-DI AGNOSTI C	7,659,021	36, 447, 582			0.00000	
	5500 RADI OLOGY - DI AGNOSTI C 5500 RADI OLOGY - THERAPEUTI C	1, 350, 976	25, 128, 800	26, 479, 7	76 0. 247842 0 0. 000000	0. 000000 0. 000000	
	5500 RADIOLOGY-THERAPEUTIC 5501 ULTRA SOUND	430, 752	7, 609, 593	8, 040, 34		0. 000000	
	5700 CT SCAN	4,233,274	36, 052, 209			0. 000000	
	5700 CT SCAN 5800 MAGNETIC RESONANCE IMAGING (MRI)	4, 233, 274 488, 791	12, 462, 798			0. 000000	
	5900 CARDIAC CATHETERIZATION	488, 791 926, 850	1, 833, 482			0. 000000	
	6000 LABORATORY	8, 857, 718	44, 671, 047			0. 000000	
	6300 BLOOD STORING, PROCESSING & TRANS.	370, 141	390, 801			0. 000000	
	6400 I NTRAVENOUS THERAPY	1, 326, 701	1, 631, 849			0.000000	
	6600 PHYSI CAL THERAPY	2, 469, 884	5, 424, 830			0. 000000	
	6700 OCCUPATI ONAL THERAPY	2, 336, 822	715, 995			0.000000	
	6701 AUDI OLOGY	928	932, 014			0. 000000	
	6800 SPEECH PATHOLOGY	221, 469	712, 389			0. 000000	
	6900 ELECTROCARDI OLOGY	0	0		0 0.000000	0.000000	
	6901 CARDI OLOGY	5, 127, 112	7,077,969	12, 205, 08		0.000000	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,000,165	3, 508, 500			0. 000000	
	7200 IMPL. DEV. CHARGED TO PATIENT	2, 615, 266	5, 277, 248			0. 000000	
3.00 07	7300 DRUGS CHARGED TO PATIENTS	8, 624, 677	13, 361, 808	21, 986, 48	0. 112001	0. 000000	73.0
οι	UTPATIENT SERVICE COST CENTERS						
0.00 09	9000 CLINIC	0	C)	0 0.000000	0. 000000	90.0
0.01 09	9001 OTHER OUTPATIENT SERVICE COST CENTER	0	C)	0 0.000000	0. 000000	90.0
	9002 CLI NI C	0	C		0 0.000000	0. 000000	
	9003 DERMATOLOGY CLINIC	0	0		0 0. 000000	0. 000000	
	9004 ENT CLINIC	0	0		0 0. 000000	0. 000000	
	9005 SURGERY CLINIC	0	0		0 0. 000000	0. 000000	
	9007 UROLOGY CLINIC	2, 360	151, 358	153, 7		0. 000000	
	9009 GASTROENTEROLOGY CLINIC	0	C		0 0.000000	0. 000000	
	9011 NEUROLOGY CLINIC	0	0		0 0. 000000	0.00000	
	9012 OPTHAMOLOGY CLINIC	0	0		0 0. 000000	0.00000	
	9013 ALLERGY CLINIC	0	573, 785			0.00000	
	9014 WOUND CARE	70, 870	4, 186, 606			0.00000	
	9100 EMERGENCY	3, 703, 493	26, 594, 893			0.00000	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 781, 103	2, 781, 10	0. 595557	0. 000000	92.0
	THER REIMBURSABLE COST CENTERS	20,000	2 404 204	2 524 24		0.000000	
	9500 AMBULANCE SERVICES	29,902	3, 496, 306			0. 000000	
200.00	Subtotal (see instructions)	79, 516, 534	241, 022, 965	320, 539, 49	77		200.0
201.00 202.00	Less Observation Beds	70 514 524		220 520 44	20		201.0
UZ UU	Total (see instructions)	79, 516, 534	241, 022, 965	320, 539, 49	77		1202.

	Financial Systems TION OF RATIO OF COSTS TO CHARGES	WI THAM MEMORIAL	Provi der CCN: 15-0104	Peri od:	u of Form CMS-2 Worksheet C	-552-
				From 01/01/2017 To 12/31/2017	Part I Date/Time Prep	pared
			Title XVIII	Hospi tal	5/22/2018 7:49 PPS	/ am
	Cost Center Description	PPS Inpatient Ratio		nospi tui	113	
		11.00				
	NPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS					30.0
	03100 I NTENSI VE CARE UNI T					31.0
	04000 SUBPROVIDER - IPF					40.0
	04100 SUBPROVIDER - IRF					41. (
	04200 SUBPROVI DER					42.0
	04300 NURSERY					43.0
	04400 SKILLED NURSING FACILITY					44. (
	ANCI LLARY SERVI CE COST CENTERS					
	D5000 OPERATING ROOM	0. 111431				50. (
	05400 RADI OLOGY-DI AGNOSTI C	0. 247842				54.(
	05500 RADI OLOGY-THERAPEUTI C	0. 000000				55.(
	05501 ULTRA SOUND	0. 081638				55.0
	D5700 CT SCAN	0. 020836				57.
	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 091369				58.
9.00 0	05900 CARDI AC CATHETERI ZATI ON	0. 200971				59.
0.00 C	06000 LABORATORY	0. 143106				60.
3.00 C	D6300 BLOOD STORING, PROCESSING & TRANS.	0. 298772				63.
4.00 C	06400 I NTRAVENOUS THERAPY	0. 001087				64.
6.00 C	06600 PHYSI CAL THERAPY	0. 424096				66.
7.00 0	06700 OCCUPATI ONAL THERAPY	0. 164401				67.
7.01 C	06701 AUDI OLOGY	0. 218683				67.
8.00 C	06800 SPEECH PATHOLOGY	0. 234969				68.
9.00 0	06900 ELECTROCARDI OLOGY	0.000000				69.
9.01 0	06901 CARDI OLOGY	0. 145633				69.
1.00 0	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 487647				71.
2.00 0	07200 IMPL. DEV. CHARGED TO PATIENT	0. 452259				72.
3. 00 C	07300 DRUGS CHARGED TO PATIENTS	0. 112001				73.
C	DUTPATIENT SERVICE COST CENTERS					
0.00 🖸	09000 CLI NI C	0.000000				90.
0. 01 0	09001 OTHER OUTPATIENT SERVICE COST CENTER	0.000000				90.
0. 02 0	09002 CLINIC	0.000000				90.
0. 03 0	D9003 DERMATOLOGY CLINIC	0.000000				90.
0. 04 C	D9004 ENT CLINIC	0.000000				90.
0. 05 C	09005 SURGERY CLINIC	0.000000				90.
	09007 UROLOGY CLINIC	0.010298				90.
	09009 GASTROENTEROLOGY CLINIC	0.000000				90.
	09011 NEUROLOGY CLINIC	0. 000000				90.
-	09012 OPTHAMOLOGY CLINIC	0.000000				90.
	09013 ALLERGY CLINIC	0. 306780				90.
	09014 WOUND CARE	0. 194639				90.
	D9100 EMERGENCY	0. 178638				91.
1	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 595557				92.
	THER REIMBURSABLE COST CENTERS	0.070007				12.
	09500 AMBULANCE SERVICES	0.965260				95.
00.00	Subtotal (see instructions)	0. 700200				200.
01.00	Less Observation Beds					200.
01.00	Total (see instructions)					201.

Health Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0104	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre	
			e XIX	Hospi tal	5/22/2018 7:4 Cost	9 am
		1111		Costs	COST	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs		Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS				-		
30. 00 03000 ADULTS & PEDI ATRI CS	8, 773, 378		8, 773, 37		8, 773, 378	
31.00 03100 I NTENSI VE CARE UNI T	2, 555, 738		2, 555, 73		2, 555, 738	
40.00 04000 SUBPROVIDER - IPF	2, 807, 471		2, 807, 47	-	2, 836, 568	
41.00 04100 SUBPROVIDER - IRF	0			0 0	0	
42. 00 04200 SUBPROVI DER	0			0 0	0	42.00
43.00 04300 NURSERY	30, 308		30, 30		30, 308	
44. 00 04400 SKI LLED NURSI NG FACI LI TY	2, 865, 935		2, 865, 93	35 0	2, 865, 935	44.00
	4 014 922		4 014 02	2	4 014 022	E0 00
50. 00 05000 OPERATI NG ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 914, 832		4, 914, 83		4, 914, 832	
55. 00 05500 RADI OLOGY - THERAPEUTI C	6, 562, 809 0		6, 562, 80	0 0	6, 562, 809 0	1
55. 01 05500 KADIOLOGI - THERAPEUTIC 55. 01 05501 ULTRA SOUND	656, 394		656, 39		656, 394	
57. 00 05700 CT SCAN	839, 401		839, 40		839, 401	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 183, 369		1, 183, 36		1, 183, 369	
59. 00 05900 CARDI AC CATHETERI ZATI ON	554, 748		554, 74		554, 748	
60. 00 06000 LABORATORY	7, 660, 306		7, 660, 30		7, 660, 306	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	227, 348		227, 34		227, 348	
64. 00 06400 I NTRAVENOUS THERAPY	3, 216		3, 21		3, 216	
66. 00 06600 PHYSI CAL THERAPY	3, 348, 120				3, 348, 120	
67. 00 06700 OCCUPATI ONAL THERAPY	501, 887	0			501, 887	67.00
67. 01 06701 AUDI OLOGY	204, 019				204, 019	
68.00 06800 SPEECH PATHOLOGY	219, 428		219, 42		219, 428	
69. 00 06900 ELECTROCARDI OLOGY	0	-	,	0 0	0	69.00
69. 01 06901 CARDI OLOGY	1, 777, 457		1, 777, 45	57 0	1, 777, 457	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 173, 928		3, 173, 92		3, 173, 928	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	3, 569, 464		3, 569, 46		3, 569, 464	
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 462, 507		2, 462, 50	07 0	2, 462, 507	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0			0 0	0	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	931, 359		931, 35	59 0	931, 359	90.01
90. 02 09002 CLI NI C	67, 164		67, 16	04 0	67, 164	90.02
90. 03 09003 DERMATOLOGY CLINIC	0			0 0	0	90.03
90. 04 09004 ENT CLINIC	0			0 0	0	90.04
90. 05 09005 SURGERY CLINIC	0			0 0	0	90.05
90. 07 09007 UROLOGY CLINIC	1, 583		1, 58		1, 583	
90. 09 09009 GASTROENTEROLOGY CLINIC	9, 822		9, 82		9, 822	1
90. 11 09011 NEUROLOGY CLINIC	839		83		839	
90. 12 09012 OPTHAMOLOGY CLINIC	6, 242		6, 24		6, 242	
90. 13 09013 ALLERGY CLINIC	176, 026		176, 02			
90. 14 09014 WOUND CARE	828, 671		828, 67			
91.00 09100 EMERGENCY	5, 412, 457		5, 412, 45		5, 412, 457	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REI MBURSABLE COST CENTERS	1, 656, 304		1, 656, 30	/4	1, 656, 304	92.00
95. 00 09500 AMBULANCE SERVICES	3, 403, 707		3, 403, 70	07 0	3, 403, 707	05 00
200.00 Subtotal (see instructions)	67, 386, 237					
201.00 Less Observation Beds	1, 656, 304		1, 656, 30		1, 656, 304	
202.00 Total (see instructions)	65, 729, 933					
	00,727,700	0	00,727,70	27,077	00,707,000	1202.00

OMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0104	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/22/2018 7:4	epared: 9 am
			Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description	I npati ent	Charges Outpatient	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	13, 717, 847		13, 717, 8	47		30.00
31.00	03100 I NTENSI VE CARE UNI T	4, 131, 790		4, 131, 7			31.00
0.00	04000 SUBPROVI DER – I PF	3, 329, 497		3, 329, 4	97		40.00
1.00	04100 SUBPROVI DER – I RF	0			0		41.00
2.00	04200 SUBPROVI DER	0			0		42.00
3. 00	04300 NURSERY	1, 721, 650		1, 721, 6			43.00
4.00	04400 SKILLED NURSING FACILITY	2, 768, 578		2, 768, 5	78		44.00
	ANCILLARY SERVICE COST CENTERS	1 1		1		1	
50.00	05000 OPERATING ROOM	7, 659, 021	36, 447, 582			0. 000000	
64.00	05400 RADI OLOGY-DI AGNOSTI C	1, 350, 976	25, 128, 800	26, 479, 7		0. 000000	
5. 00	05500 RADI OLOGY-THERAPEUTI C	0	C		0 0.00000		
5. 01	05501 ULTRA SOUND	430, 752	7, 609, 593				
57.00	05700 CT SCAN	4, 233, 274	36, 052, 209			0.000000	
8.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	488, 791	12, 462, 798				
9. 00	05900 CARDI AC CATHETERI ZATI ON	926, 850	1, 833, 482			0. 000000	
0.00	06000 LABORATORY	8, 857, 718	44, 671, 047			0. 000000	
3.00	06300 BLOOD STORING, PROCESSING & TRANS.	370, 141	390, 801			0.00000	
4.00	06400 I NTRAVENOUS THERAPY	1, 326, 701	1, 631, 849			0.00000	
6. 00	06600 PHYSI CAL THERAPY	2, 469, 884	5, 424, 830			0.00000	
7.00	06700 OCCUPATI ONAL THERAPY	2, 336, 822	715, 995			0.00000	
7.01	06701 AUDI OLOGY	928	932, 014			0.00000	
8.00	06800 SPEECH PATHOLOGY	221, 469	712, 389	933, 8			
9.00	06900 ELECTROCARDI OLOGY	0	0	10.005.0	0 0.00000	0.000000	
9.01	06901 CARDI OLOGY	5, 127, 112	7,077,969			0.00000	
1.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	3,000,165	3, 508, 500			0.00000	
2.00	07200 I MPL. DEV. CHARGED TO PATIENT	2, 615, 266	5, 277, 248				
3. 00	07300 DRUGS CHARGED TO PATIENTS	8, 624, 677	13, 361, 808	21, 986, 4	85 0. 112001	0. 000000	73.00
0 00	OUTPATIENT SERVICE COST CENTERS	0			0 000000	0,000000	
90.00 90.01		0	0		0 0.000000 0 0.000000	0.00000	
0.01	09001 OTHER OUTPATIENT SERVICE COST CENTER 09002 CLINIC	0	0		0 0.000000	0. 000000	
0.02	09003 DERMATOLOGY CLINIC	0	0	1	0 0.000000	0. 000000	
0.03 0.04	09004 ENT CLINIC	0	0		0 0.000000	0. 000000	
0.04	09005 SURGERY CLINIC	0	0		0 0.000000	0. 000000	
0.03	09007 UROLOGY CLINIC	2,360	151, 358				
0.07	09009 GASTROENTEROLOGY CLINIC	2, 300	151, 356	1	0 0.000000	0. 000000	
0.09	09011 NEUROLOGY CLINIC	0	0		0 0.000000	0. 000000	
0.11	09012 OPTHAMOLOGY CLINIC	0			0 0.000000	0. 000000	
0.12	09013 ALLERGY CLINIC	0	573, 785	573, 7		0. 000000	
0.13	09014 WOUND CARE	70, 870	4, 186, 606				
1. 00	09100 EMERGENCY	3, 703, 493	26, 594, 893				
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3,703,493	20, 394, 893			0. 000000	
2.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	2,701,103	2,701,1	0. 575557	0.00000	72.00
5 00	09500 AMBULANCE SERVICES	29,902	3, 496, 306	3, 526, 2	08 0. 965260	0. 000000	95.0
200. OC		79, 516, 534	241, 022, 965				200.00
201.00		, , , , , , , , , , , , , , , , , , , ,	211,022,700	020,007,4	· ·		201.00
	Total (see instructions)	79, 516, 534	241, 022, 965	320, 539, 4		1	201.00

Health Fir	nancial Systems	WI THAM MEMORIAL	- HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATI	ON OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0104	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre	nared
				10 12/31/2017	5/22/2018 7:4	
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
	PATIENT ROUTINE SERVICE COST CENTERS	11.00				
	DOO ADULTS & PEDIATRICS					30.00
	100 INTENSIVE CARE UNIT					31.00
	DOO SUBPROVIDER - IPF					40.00
	100 SUBPROVI DER – I RF					41.00
	200 SUBPROVI DER					42.00
	300 NURSERY					43.00
	400 SKILLED NURSING FACILITY					44.00
	CILLARY SERVICE COST CENTERS	1 1				
50.00 050	DOO OPERATING ROOM	0. 000000				50.00
54.00 054	400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
55.00 055	500 RADI OLOGY-THERAPEUTI C	0. 000000				55.00
55.01 055	501 ULTRA SOUND	0. 000000				55.01
57.00 057	700 CT SCAN	0. 000000				57.00
	BOO MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.00
	900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
	DOO LABORATORY	0. 000000				60.00
	300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
	400 I NTRAVENOUS THERAPY	0. 000000				64.00
	600 PHYSI CAL THERAPY	0. 000000				66.00
	700 OCCUPATIONAL THERAPY	0. 000000				67.00
		0. 000000				67.01
	BOO SPEECH PATHOLOGY 900 ELECTROCARDI OLOGY	0.000000				68.00 69.00
	900 ELECTROCARDI OLOGI 901 CARDI OLOGY	0. 000000				69.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
	200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
	300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
	IPATIENT SERVICE COST CENTERS	0.000000				/ 0. 00
		0.000000				90.00
90.01 090	DO1 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000				90.01
90. 02 090	DO2 CLINIC	0. 000000				90.02
90.03 090	DO3 DERMATOLOGY CLINIC	0. 000000				90.03
90.04 090	DO4 ENT CLINIC	0. 000000				90.04
	DO5 SURGERY CLINIC	0. 000000				90.05
	DO7 UROLOGY CLINIC	0. 000000				90.07
	DO9 GASTROENTEROLOGY CLINIC	0. 000000				90.09
	D11 NEUROLOGY CLINIC	0. 000000				90.11
	D12 OPTHAMOLOGY CLINIC	0. 000000				90.12
	D13 ALLERGY CLINIC	0. 000000				90.13
	D14 WOUND CARE	0.000000				90.14
	100 EMERGENCY	0.000000				91.00
	200 OBSERVATION_BEDS_(NON-DISTINCT_PART) HER_REIMBURSABLE_COST_CENTERS	0.000000				92.00
	500 AMBULANCE SERVICES	0. 000000				95.00
200.00	Subtotal (see instructions)	0.000000				200.00
200.00	Less Observation Beds					200.00
202.00	Total (see instructions)					202.00
		1 I				

Health Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 01/01/2017 To 12/31/2017		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1, 042, 736		1, 042, 73			
31.00 INTENSIVE CARE UNIT	251, 981		251, 98	31 1, 751	143.91	31.00
40. 00 SUBPROVIDER – IPF	336, 671	0	336, 67	2, 890	116. 50	40.00
41.00 SUBPROVIDER – IRF	0	0		0 0	0.00	41.00
42. 00 SUBPROVI DER	0	0		0 0	0.00	42.00
43.00 NURSERY	175		17	75 1, 083		
44.00 SKILLED NURSING FACILITY	296, 732		296, 73	32 5, 272	56.28	44.00
200.00 Total (lines 30 through 199)	1, 928, 295		1, 928, 29	95 17, 453		200.00
Cost Center Description	Inpati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)	-			
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 ADULTS & PEDIATRICS	2, 213					30.00
31.00 INTENSIVE CARE UNIT	802	115, 416				31.00
40. 00 SUBPROVIDER - IPF	2,444	284, 726				40.00
41.00 SUBPROVIDER - IRF	0	0				41.00
42.00 SUBPROVI DER	0	0				42.00
43.00 NURSERY	0	0				43.00
44.00 SKILLED NURSING FACILITY	3, 469					44.00
200.00 Total (lines 30 through 199)	8, 928	952, 754	1			200.00

	Financial Systems	WI THAM MEMORI		001 45 0404		u of Form CMS-2	2552-10
APPORI	IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der	CCN: 15-0104	Period: From 01/01/2017	Worksheet D Part II	
					To 12/31/2017	Date/Time Pre	pared:
						5/22/2018 7:4	
		_		le XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charge	s Ratio of Cos	st Inpatient	Capital Costs	
		Related Cost	(from Wkst.	C, to Charges	Program	(column 3 x	
		(from Wkst. B,			I. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
	1	1.00	2.00	3.00	4.00	5.00	
	ANCI LLARY SERVI CE COST CENTERS	1		- 1	- 1	r	
50.00	05000 OPERATING ROOM	685, 244				68, 242	
54.00	05400 RADI OLOGY-DI AGNOSTI C	862, 903				29, 845	
55.00	05500 RADI OLOGY-THERAPEUTI C	0		0 0.0000		0	
55.01	05501 ULTRA SOUND	7, 781				68	
57.00	05700 CT SCAN	9, 527					
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	77, 432					
59.00	05900 CARDI AC CATHETERI ZATI ON	60, 054					
60.00	06000 LABORATORY	414, 717	53, 528, 7	65 0.0077	48 4, 263, 596	33, 034	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	5, 245	760, 9	42 0.0068	93 125, 058	862	63.00
64.00	06400 I NTRAVENOUS THERAPY	18	2, 958, 5	50 0.0000	06 514, 482	3	64.00
66.00	06600 PHYSI CAL THERAPY	382, 182	7, 894, 7	0. 0484	10 354, 355	17, 154	66.00
67.00	06700 OCCUPATI ONAL THERAPY	6, 381	3, 052, 8	0. 0020	90 209, 679	438	67.00
67.01	06701 AUDI OLOGY	1, 793	932, 9	42 0.0019	22 466	1	67.01
68.00	06800 SPEECH PATHOLOGY	1, 695	933, 8	58 0. 0018	15 38, 994	71	68.00
69.00	06900 ELECTROCARDI OLOGY	0		0 0.0000	00 0	0	69.00
69. 01	06901 CARDI OLOGY	56, 144	12, 205, 0	0. 0046		12, 350	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	18, 417	6, 508, 6	65 0.0028	30 1, 154, 974	3, 269	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	20, 654	7, 892, 5	0. 0026	17 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	16, 418	21, 986, 4	0. 0007	47 3, 186, 452	2, 380	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0		0 0.0000		0	90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	174, 714		0 0.0000	00 0	0	90.01
90.02	09002 CLI NI C	8, 247		0 0.0000			90.02
90.03	09003 DERMATOLOGY CLINIC	0		0 0.0000			90.03
90.04	09004 ENT CLINIC	0		0 0.0000		-	90.04
90.05	09005 SURGERY CLINIC	0		0 0.0000			90.05
90.07	09007 UROLOGY CLINIC	38				0	90.07
90.09	09009 GASTROENTEROLOGY CLINIC	72		0 0.0000	00 0	0	90.09
90.11	09011 NEUROLOGY CLINIC	22		0 0.0000		0	90.11
90. 12	09012 OPTHAMOLOGY CLINIC	36		0 0.0000		0	
90.13	09013 ALLERGY CLINIC	1,071	573, 7	35 0. 0018	67 0	0	90.13
90.14	09014 WOUND CARE	143, 624	4, 257, 4	76 0. 0337	35 671	23	90.14
91.00	09100 EMERGENCY	1,004,747	30, 298, 3	0. 0331	62 1, 853, 510	61, 466	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	196, 855	2, 781, 1	0. 0707	83 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
							1 05 00
95.00 200.00	09500 AMBULANCE SERVICES Total (lines 50 through 199)	4, 156, 031	291, 343, 9		22, 072, 232	232, 948	95.00

Health Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	ER PASS THROUGH COST	S Provider C		Period: From 01/01/2017 To 12/31/2017		pared: 9 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Post-Stepdown	Nursing School	Post-Stepdowr	Allied Health Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	-	
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	
40. 00 04000 SUBPROVIDER - IPF	0	C		0 0	0	
41. 00 04100 SUBPROVIDER - IRF	0	C		0 0	0	
42. 00 04200 SUBPROVI DER	0	0		0 0	0	
43. 00 04300 NURSERY	0	C		0 0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	C		0 0		44.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	I npati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,	-			
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1	- F		
30. 00 03000 ADULTS & PEDI ATRI CS	0	C	6, 45			30.00
31.00 03100 INTENSIVE CARE UNIT		0	1, 75	1 0.00	802	31.00
40. 00 04000 SUBPROVIDER - IPF	0	0	2, 89	0.00	2, 444	40.00
41.00 04100 SUBPROVIDER - IRF	0	0		0.00	0	41.00
42. 00 04200 SUBPROVI DER	0	C		0.00	0	42.00
43. 00 04300 NURSERY		C	1, 08	3 0.00	0	43.00
44.00 04400 SKILLED NURSING FACILITY		C	5, 27	2 0.00	3, 469	44.00
200.00 Total (lines 30 through 199)		C				200.00
Cost Center Description	I npati ent			-		
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS			-		-	
30, 00 03000 ADULTS & PEDIATRICS	0					1 30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
40. 00 04000 SUBPROVIDER - IPF	0					40.00
41. 00 04100 SUBPROVIDER - IRF	0					41.00
42. 00 04200 SUBPROVI DER	0					42.00
43. 00 04300 NURSERY	0					42.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0					43.00
	0					200.00
200.00 Total (lines 30 through 199)	i U					∠UU. UU

Health Financial Systems	WI THAM MEMORI				In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider C	CN: 15-0104	Perio	d: 01/01/2017	Worksheet D Part IV	
THROUGH COSTS					12/31/2017		nared
				10	12/01/2017	5/22/2018 7:4	9 am
		Title	XVIII	Hc	ospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing Scho	ol Alli	ed Health	Allied Health	
	Anestheti st	Post-Stepdown	-	Post	t-Stepdown		
	Cost	Adjustments		Adj	ustments		
	1.00	2A	2.00		3A	3.00	
ANCILLARY SERVICE COST CENTERS			_	_			
50. 00 05000 OPERATI NG ROOM	0	0		0	0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
55. 01 05501 ULTRA SOUND	0	0		0	0	0	55.01
57.00 05700 CT SCAN	0	0		0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60. 00 06000 LABORATORY	0	0		0	0	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0	63.00
64.00 06400 INTRAVENOUS 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
67. 01 06701 AUDI OLOGY	0	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 0	69.00
69. 01 06901 CARDI OLOGY	0	0		0	0	0	69.01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0	0	-	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	-	73.00
OUTPATIENT SERVICE COST CENTERS	0	0	I	<u> </u>	0	0	/ 5. 00
90. 00 09000 CLINIC	0	0		0	0	0	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	0		90.01
90. 02 09002 CLINIC	0	0		0	0		90.01
90. 03 09003 DERMATOLOGY CLINIC	0	0		0	0	0	90.02
90. 04 09004 ENT CLINIC	0	0		0	0	0	90.03
90. 05 09005 SURGERY CLINIC	0	0		0	0	0	90.04
90. 03 09003 SURGERT CETNIC 90. 07 09007 UROLOGY CLINIC	0	0		0	0	0	90.03
	0	0		0	0	-	
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		U	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 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0		1	0		0	92.00
OTHER REIMBURSABLE COST CENTERS	1						05 05
95. 00 09500 AMBULANCE SERVICES		-		~	-		95.00
200.00 Total (lines 50 through 199)	0	0		0	0	0	200.00

Health Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS	RVICE OTHER PASS	S Provider C		Period: From 01/01/2017 To 12/31/2017	Date/Time Pre	
					5/22/2018 7:4	9 am
			XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of col 1	Outpatient	(from Wkst. C,	to Charges	
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col. 2, 3 and	1 8)	7)	
	4.00	5.00	4) 6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	4.00	0.00	0.00	7.00	0.00	
50. 00 05000 OPERATING ROOM	0	0		0 44, 106, 603	0.000000	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			0 26, 479, 776		1
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0.000000	1
55. 01 05501 ULTRA SOUND	0	0		8, 040, 345		1
57. 00 05700 CT SCAN	0	0		0 40, 285, 483		1
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 12, 951, 589		1
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 2, 760, 332		1
60. 00 06000 LABORATORY	0	0		0 53, 528, 765		1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 760, 942		1
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0 2, 958, 550		1
66. 00 06600 PHYSI CAL THERAPY	0	0		0 7, 894, 714		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 3, 052, 817		1
67. 01 06701 AUDI OLOGY	0	0		0 932, 942		1
68. 00 06800 SPEECH PATHOLOGY	0			0 933, 858		
69. 00 06900 ELECTROCARDI OLOGY	0			0 755, 050		1
69. 01 06901 CARDI OLOGY	0			0 12, 205, 081		1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 6, 508, 665		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 7, 892, 514		1
73.00 07300 DRUGS CHARGED TO PATIENTS	0	-		0 21, 986, 485		1
OUTPATIENT SERVICE COST CENTERS	0	0		0 21, 900, 403	0.00000	/ 3.00
90. 00 09000 CLINIC	0	0		0 0	0.00000	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	-		0 0		
90. 02 09002 CLINIC	0	0			0.000000	
90. 03 09003 DERMATOLOGY CLINIC	0	0		0 0		
90. 04 09004 ENT CLINIC	0	0		0 0		
90. 05 09005 SURGERY CLINIC	0	0		0 0		1
90. 07 09007 UROLOGY CLINIC	0	0		0 153, 718		
90. 09 09009 GASTROENTEROLOGY CLINIC	0	0		0 100,710		
90. 11 09011 NEUROLOGY CLINIC	0	0				1
90. 12 09012 OPTHAMOLOGY CLINIC	0	0			0.000000	
90. 13 09013 ALLERGY CLINIC	0	n		0 573, 785		
90. 14 09014 WOUND CARE	0			0 4, 257, 476		
91. 00 09100 EMERGENCY	0	0		0 30, 298, 386		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 2, 781, 103		
OTHER REIMBURSABLE COST CENTERS		0	1	2,701,100	0.00000	1 2.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 291, 343, 929		200.00
	-	-	•			

-	Financial Systems	WI THAM MEMORI A			In Lie	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provider C	CN: 15-0104	Peri od:	Worksheet D	
THROUG	H COSTS				From 01/01/2017 To 12/31/2017	Part IV Date/Time Pre	nared
					10 12/01/2017	5/22/2018 7:4	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)	10.00	x col. 10)	10.00	x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
	ANCI LLARY SERVICE COST CENTERS	0,000000	4 202 502		0 11 51(007	0	50.00
50.00	05000 OPERATI NG ROOM	0. 000000	4, 392, 502		0 11, 516, 007 0 9, 322, 856	0	
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0. 000000 0. 000000	915, 841 0		0 9, 322, 856 0 0	0	54.00 55.00
55.00 55.01	05501 ULTRA SOUND	0. 000000	0			0	55.00
55.01	05700 CT SCAN	0.000000	69, 967 1, 956, 184		0 876, 058 0 9, 719, 038	0	57.00
57.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	275, 836			0	57.00
58.00 59.00	05900 CARDI AC CATHETERI ZATI ON	0.000000	275, 830 74, 947		0 4, 363, 923 0 130, 426	0	59.00
60.00	06000 LABORATORY	0.000000	4, 263, 596		0 4, 804, 335	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	4, 203, 590		0 4, 804, 335	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	514, 482		0 357, 782	0	64.00
66.00	06600 PHYSI CAL THERAPY	0.000000	354, 355		0 18, 595	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	209, 679		0 4, 663	0	67.00
67.01	06701 AUDI OLOGY	0. 000000	466		0 4,003	0	67.01
68.00	06800 SPEECH PATHOLOGY	0. 000000	38, 994		0 134, 103	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	30, 774 0		0 0	0	69.00
69. 01	06901 CARDI OLOGY	0. 000000	2, 684, 718		0 3, 248, 236	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 154, 974		0 808, 671	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000	1, 101, 771		0 52, 780	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	3, 186, 452		0 4, 945, 939	0	•
70.00	OUTPATIENT SERVICE COST CENTERS	0.000000	0,100,102	<u> </u>	1, 710, 707	0	/0.00
90.00	09000 CLINIC	0. 000000	0		0 0	0	90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	0		0 0	0	
90.02	09002 CLINIC	0, 000000	0		0 0	0	90.02
90.03	09003 DERMATOLOGY CLINIC	0. 000000	0		0 0	0	90.03
90.04	09004 ENT CLINIC	0. 000000	0		0 0	0	90.04
90.05	09005 SURGERY CLINIC	0. 000000	0		0 0	0	90.05
90.07	09007 UROLOGY CLINIC	0. 000000	0		0 0	0	90.07
90.09	09009 GASTROENTEROLOGY CLINIC	0. 000000	0		0 0	0	90.09
90.11	09011 NEUROLOGY CLINIC	0. 000000	0		0 0	0	90.11
90.12	09012 OPTHAMOLOGY CLINIC	0. 000000	0		0 0	0	90.12
90.13	09013 ALLERGY CLINIC	0. 000000	0		0 0	0	90.13
90.14	09014 WOUND CARE	0. 000000	671		0 1, 156, 936	0	90.14
91.00	09100 EMERGENCY	0. 000000	1, 853, 510		0 4, 832, 648	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 1, 525, 142	0	92.00
	OTHER REIMBURSABLE COST CENTERS				_		
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		22, 072, 232		0 57, 981, 076	0	200.00

Health Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES	AND VACCINE COST	Provider C		Period: From 01/01/2017 To 12/31/2017		pared:
					5/22/2018 7:4	9 am
		litl€	e XVIII	Hospi tal	PPS	
Cost Conton Decerintian	Coot to Charge		Charges Cost	Cost	Costs PPS Services	
Cost Center Description	Ratio From	PPS Reimbursed Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Servi ces Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS					•	
50. 00 05000 OPERATI NG ROOM	0. 111431	11, 516, 007	1	0 0	1, 283, 240	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 247842	9, 322, 856		0 0	2, 310, 595	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
55.01 05501 ULTRA SOUND	0. 081638	8 876, 058	8	0 0	71, 520	55.01
57.00 05700 CT SCAN	0. 020836	9, 719, 038	8	0 8, 198	202, 506	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 091369	4, 363, 923		0 0	398, 727	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 200971	130, 426		0 0	26, 212	59.00
60. 00 06000 LABORATORY	0. 143106	4, 804, 335	j -	0 0	687, 529	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 298772	162, 938	8	0 0	48, 681	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 001087	357, 782		0 0	389	64.00
66. 00 06600 PHYSI CAL THERAPY	0. 424096	18, 595		0 0	7, 886	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 164401	4, 663		0 0	767	67.00
67. 01 06701 AUDI OLOGY	0. 218683	6 C		0 0	0	67.01
68.00 06800 SPEECH PATHOLOGY	0. 234969			0 0	31, 510	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			0 0	0	69.00
69. 01 06901 CARDI OLOGY	0. 145633			0 0	473, 050	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				0 0	394, 346	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 452259			0 0	23, 870	•
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 112001	4, 945, 939		0 24, 508	553, 950	73.00
OUTPATIENT SERVICE COST CENTERS		1	1			
90. 00 09000 CLINIC	0.000000			0 0		
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER				0 0	0	
90. 02 09002 CLINIC	0. 000000			0 0	0	
90. 03 09003 DERMATOLOGY CLINIC	0.00000			0 0	0	90.03
90. 04 09004 ENT CLINIC	0.00000			0 0	0	90.04
90. 05 09005 SURGERY CLINIC	0.00000			0 0	0	
90. 07 09007 UROLOGY CLINIC	0. 010298			0 0	0	
90. 09 09009 GASTROENTEROLOGY CLINIC	0.000000			0 0	0	90.09
90. 11 09011 NEUROLOGY CLINIC	0. 000000			0 0	0	
90. 12 09012 OPTHAMOLOGY CLINIC	0.00000			0 0	0	90.12
90. 13 09013 ALLERGY CLINIC	0. 306780			0 0	0	
90. 14 09014 WOUND CARE	0. 194639			0 1, 143	225, 185	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 178638			0 0	863, 295	
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS	0. 595557	1, 525, 142		0 0	908, 309	92.00
95.00 09500 AMBULANCE SERVICES	0. 965260		1	0	I	95.00
200.00 Subtotal (see instructions)	0. 905200	57, 981, 076		0 33, 849	8, 511, 567	
201.00 Less PBP Clinic Lab. Services-Progra	am	37, 901, 070		0 33,849	0, 011, 007	200.00
Only Charges	4111					201.00
202.00 Net Charges (line 200 - line 201)		57, 981, 076		0 33, 849	8, 511, 567	202.00
	I	1	I		,,,,	

	MENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		Provider CC	JN: 15-0104	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/22/2018 7:4	epared: 49 am
				Title	XVIII	Hospi tal	PPS	_
		Cos	sts					
	Cost Center Description	Cost		Cost				
		Reimbursed	Re	eimbursed				
		Servi ces	Ser	rvices Not				
		Subject To	Su	ıbject To				
		Ded. & Coins.	Ded	. & Coins.				
		(see inst.)	(s	ee inst.)				
		6.00		7.00				
ANC	CILLARY SERVICE COST CENTERS							
60. 00 050	DOO OPERATING ROOM	0		0				50.00
64.00 054	400 RADI OLOGY-DI AGNOSTI C	0		0				54.00
5.00 055	500 RADI OLOGY-THERAPEUTI C	0		0				55.00
	501 ULTRA SOUND	0		0				55.01
	700 CT SCAN	0		171				57.00
	BOO MAGNETIC RESONANCE IMAGING (MRI)	0		0				58.00
	200 CARDI AC CATHETERI ZATI ON	0		0				59.00
	DOO LABORATORY	0		0				60.00
	300 BLOOD STORING, PROCESSING & TRANS.	0		0				63.00
	400 INTRAVENOUS THERAPY	0		0				64.00
		0		-				
	600 PHYSI CAL THERAPY	0		0				66.00
	700 OCCUPATIONAL THERAPY	0		0				67.00
	701 AUDI OLOGY	0		0				67.01
	BOO SPEECH PATHOLOGY	0		0				68.00
	POO ELECTROCARDI OLOGY	0		0				69.00
	PO1 CARDI OLOGY	0		0				69.01
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0				71.00
	200 IMPL. DEV. CHARGED TO PATIENT	0		0				72.00
	300 DRUGS CHARGED TO PATIENTS	0		2, 745				73.00
	IPATIENT SERVICE COST CENTERS							
	DOO CLINIC	0		0				90.00
0.01 090	DO1 OTHER OUTPATIENT SERVICE COST CENTER	0		0				90.01
0. 02 090	DO2 CLINIC	0		0				90.02
0. 03 090	DO3 DERMATOLOGY CLINIC	0		0				90.03
0. 04 090	DO4 ENT CLINIC	0		0				90.04
0. 05 090	DO5 SURGERY CLINIC	0		0	1			90.05
0. 07 090	DO7 UROLOGY CLINIC	0		0				90.07
0. 09 090	DO9 GASTROENTEROLOGY CLINIC	0		0				90.09
	D11 NEUROLOGY CLINIC	0		0				90, 11
	012 OPTHAMOLOGY CLINIC	0		0				90.12
	D13 ALLERGY CLINIC	0		0				90.13
	D14 WOUND CARE	0		222				90.14
	100 EMERGENCY	0		0				91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0				92.00
	ER REIMBURSABLE COST CENTERS	U	1	0	I			- 72.00
	500 AMBULANCE SERVICES	0						95.00
		-		2 1 2 0				
200.00	Subtotal (see instructions) Less PBP Clinic Lab. Services-Program	0		3, 138				200.00
	TIESS PER LITER TAD SERVICES-PROGRAM	1 01	1					201.00
201.00	Only Charges							

APPORTI ONI	MENT OF INPATIENT ANCILLARY SERVICE CAPITA	U COSTS	Provider C	CN: 15-0104	Period:	Worksheet D	2552-10
ALLONTON	MENT OF THEATTENT ANOTELANT SERVICE CALLY	L 00313	i i ovider ci	GN. 13-0104	From 01/01/2017	Part II	
			Component	CCN: 15-S104	To 12/31/2017	Date/Time Pre 5/22/2018 7:4	
			Title	e XVIII	Subprovider - IPF	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	·	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col	L. Charges	column 4)	
		Part II, col.	8)	2)			
		26)	2.00	2.00	4.00	E 00	
ANC		1.00	2.00	3.00	4.00	5.00	
	I LLARY SERVICE COST CENTERS	(05.044	44 104 402	0.0155	0 1/1	140	50.00
	OO OPERATING ROOM	685, 244				142	
	00 RADI OLOGY-DI AGNOSTI C	862, 903				833	
	00 RADI OLOGY-THERAPEUTI C	0	-	0.0000		0	
	01 ULTRA SOUND	7, 781	8, 040, 345			7	55.01
	OO CT SCAN	9, 527				11	57.00
	BOO MAGNETIC RESONANCE IMAGING (MRI)	77, 432				22	58.00
	200 CARDI AC CATHETERI ZATI ON	60, 054				0	59.00
	DOO LABORATORY	414, 717				4, 158	
	OO BLOOD STORING, PROCESSING & TRANS.	5, 245				0	63.00
	00 INTRAVENOUS THERAPY	18				0	64.00
66.00 066	00 PHYSI CAL THERAPY	382, 182	7, 894, 714			615	66.00
67.00 067	OO OCCUPATIONAL THERAPY	6, 381	3, 052, 817	0.0020	90 1, 957	4	67.00
	O1 AUDI OLOGY	1, 793	932, 942	0.00192	22 0	0	67.01
	BOO SPEECH PATHOLOGY	1, 695	933, 858	0.0018	15 6, 592	12	68.00
69.00 069	200 ELECTROCARDI OLOGY	0	0	0.0000	0 00	0	69.00
	PO1 CARDI OLOGY	56, 144	12, 205, 081	0.00460	00 65, 228	300	69.01
71.00 071	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	18, 417	6, 508, 665	0.00283	30 84, 446	239	71.00
	OO IMPL. DEV. CHARGED TO PATIENT	20, 654	7, 892, 514	0.0026	17 0	0	72.00
73.00 073	OO DRUGS CHARGED TO PATIENTS	16, 418	21, 986, 485	0.00074	47 717, 619	536	73.00
OUT	PATIENT SERVICE COST CENTERS		_				
	DOO CLINIC	0	0	0.0000	0 00	0	90.00
90.01 090	01 OTHER OUTPATIENT SERVICE COST CENTER	174, 714	0	0.0000	0 00	0	90.01
	02 CLINIC	8, 247	0	0.0000	0 00	0	90.02
90.03 090	O3 DERMATOLOGY CLINIC	0	0	0.0000	0 00	0	90.03
	04 ENT CLINIC	0	0	0.0000	0 00	0	90.04
90.05 090	05 SURGERY CLINIC	0	0	0.0000	0 00	0	90.05
90. 07 090	07 UROLOGY CLINIC	38	153, 718	0.00024	47 0	0	90.07
90.09 090	09 GASTROENTEROLOGY CLINIC	72	0		0 00	0	90.09
90. 11 090	11 NEUROLOGY CLINIC	22	l o	0, 00000	0 00	0	90.11
90.12 090	012 OPTHAMOLOGY CLINIC	36	l o	0.0000	0 00	0	90.12
	13 ALLERGY CLINIC	1,071	573, 785			0	90.13
	14 WOUND CARE	143, 624				0	90.14
	OO EMERGENCY	1,004,747				354	91.00
	OO OBSERVATION BEDS (NON-DISTINCT PART)	0				0	
	ER REI MBURSABLE COST CENTERS						1
	OO AMBULANCE SERVICES						95.00

PPORTI ONMEN	T OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider C	CN: 15-0104	Period:	Worksheet D	
HROUGH COST	S		Component		From 01/01/2017 To 12/31/2017		noroc
			component	CCN: 15-S104	10 12/31/2017	5/22/2018 7:4	9 am
			Title	× XVIII	Subprovider -	PPS	
					I PF		
	Cost Center Description			Nursing Schoo	I Allied Health	Allied Health	
			Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
ANCLL	ARY SERVICE COST CENTERS	1.00	2A	2.00	3A	3.00	
	OPERATING ROOM	0	0		0 0	0	50.
	RADI OLOGY-DI AGNOSTI C	0	0		0 0	-	
	RADI OLOGY-THERAPEUTI C	0	0		0 0		
	ULTRA SOUND	0	0		0 0	0	
	CT SCAN	0	0		0 0		
	MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0		
	CARDIAC CATHETERIZATION	0	0		0 0		
	LABORATORY	0	0		0 0		
	BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	
	INTRAVENOUS THERAPY	0	0		0 0	0	
	PHYSICAL THERAPY	0	0		0 0		
	OCCUPATIONAL THERAPY	0	0		0 0	0	
	AUDI OLOGY	0	0		0 0		
	SPEECH PATHOLOGY	0	0		0 0		
		0	0		0 0	-	
	ELECTROCARDI OLOGY	0	0		0 0	0	
	CARDI OLOGY	0	0		0 0	0	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	-	1
	IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	1
	DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.
	CLINIC	0	0		0 0	0	90.
	OTHER OUTPATIENT SERVICE COST CENTER	0	0		0 0	-	
	CLINIC	0	0		0 0	0	
	DERMATOLOGY CLINIC	0	0		0 0	0	
	ENT CLINIC	0	0			0	
	SURGERY CLINIC	0	0			0	
	UROLOGY CLINIC	0	0			0	
	GASTROENTEROLOGY CLINIC	0	0			0	
	NEUROLOGY CLINIC	0	0			0	
	OPTHAMOLOGY CLINIC	0	0			0	
	ALLERGY CLINIC	0	0			0	
. 14 09014		0	0			0	
	EMERGENCY	0	0		0 0	0	
	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	0	
	REIMBURSABLE COST CENTERS	0		1	~		1 '2.
	AMBULANCE SERVICES					1	95.
	Total (lines 50 through 199)	0	C	1	0 0	1	200.

	Financial Systems	WI THAM MEMORI				u of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	S Provider C	CN: 15-0104	Peri od:	Worksheet D	
THROUG	GH COSTS		Component		From 01/01/2017 To 12/31/2017		nared
			component		10 12/01/2017	5/22/2018 7:4	9 am
			Title	e XVIII	Subprovider -	PPS	
					I PF		
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medical	(sum of col 1	Outpatient	(from Wkst. C,	to Charges	
		Education Cost	5	Cost (sum of		(col. 5 ÷ col.	
			4)	col. 2, 3 and 4)	(8 1	7)	
		4.00	5.00	6.00	7.00	8.00	
	ANCI LLARY SERVICE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
50.00	05000 OPERATI NG ROOM	0	0		0 44, 106, 603	0.00000	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	-		0 26, 479, 776		
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 20, 11, 1, 10	0.000000	
55.01	05501 ULTRA SOUND	0	0		8, 040, 345		
57.00	05700 CT SCAN	0	0		0 40, 285, 483		
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 12, 951, 589		
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 2, 760, 332		
60.00	06000 LABORATORY	0	0		0 53, 528, 765		
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 760, 942		
64.00	06400 INTRAVENOUS THERAPY	0	0		0 2, 958, 550		
66.00	06600 PHYSI CAL THERAPY	0	0		0 7, 894, 714		
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 3, 052, 817	0.000000	67.00
67.01	06701 AUDI OLOGY	0	0		0 932, 942	0.000000	67.01
68.00	06800 SPEECH PATHOLOGY	0	0)	0 933, 858	0. 000000	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0)	0 0	0. 000000	69.00
69.01	06901 CARDI OLOGY	0	0		0 12, 205, 081	0. 000000	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0)	0 6, 508, 665	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 7, 892, 514		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 21, 986, 485	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS		-				
90.00	09000 CLI NI C	0	-		0 0	0. 000000	
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	-		0 0		
90. 02	09002 CLI NI C	0	0		0 0	0.000000	
90. 03	09003 DERMATOLOGY CLINIC	0	0		0 0		
90.04	09004 ENT CLINIC	0	0		0 0	0.000000	
90.05	09005 SURGERY CLINIC	0	0		0 0		
90.07	09007 UROLOGY CLINIC	0	0		0 153, 718		
90.09	09009 GASTROENTEROLOGY CLINIC	0	0		0 0		
90.11	09011 NEUROLOGY CLINIC	0	0		0 0		
90.12	09012 OPTHAMOLOGY CLINIC	0	0		0 0	0.000000	
90.13	09013 ALLERGY CLINIC	0	0		0 573, 785		
90.14	09014 WOUND CARE	0	0		0 4, 257, 476		
91.00	09100 EMERGENCY	0	-		0 30, 298, 386		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	I	0 2, 781, 103	0. 000000	92.00
05 00	OTHER REIMBURSABLE COST CENTERS			1		1	
95.00 200.00	09500 AMBULANCE SERVICES Total (lines 50 through 199)	0	0		0 291, 343, 929		95.00 200.00
∠00. UU	I I I I I I I I I I I I I I I I I I I	0	0	1	0 291, 343, 929	I	I∠00. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT /	ANCILLARY SER	VICE OTHER PASS	Provider CO	CN: 15-0104	Peri od:	Worksheet D	
THROUGH COSTS					From 01/01/2017	Part IV	
			Component (CCN: 15-S104	To 12/31/2017	Date/Time Pre 5/22/2018 7:4	
			Title	XVIII	Subprovider - IPF	PPS	
Cost Center Description		Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Throug		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)	40.00	x col. 10)	10.00	x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVICE COST CENTERS		0.000000	0.4/4			0	1 50 0
50. 00 05000 OPERATI NG ROOM		0.000000	9, 161		0 0	0	
54.00 05400 RADI OLOGY-DI AGNOSTI C		0.000000	25, 570		0 0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.00000	0		0 0	0	
55. 01 05501 ULTRA SOUND		0.000000	6, 722		0 0	0	
57. 00 05700 CT SCAN	(1151.)	0.000000	48, 314		0 0	0	
58. 00 05800 MAGNETIC RESONANCE I MAGI NG	(MRI)	0.000000	3, 701		0 0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.000000	0		0 0	0	
50. 00 06000 LABORATORY		0.000000	536, 653		0 0	0	
53. 00 06300 BLOOD STORING, PROCESSING	& TRANS.	0.000000	0		0 0	0	63.0
54. 00 06400 I NTRAVENOUS THERAPY		0.00000	0		0 0	0	64.0
56. 00 06600 PHYSI CAL THERAPY		0.000000	12, 698		0 0	0	66.0
57.00 06700 OCCUPATIONAL THERAPY		0.000000	1, 957		0 0	0	
57. 01 06701 AUDI OLOGY		0.000000	0		0 0	0	
58.00 06800 SPEECH PATHOLOGY		0.000000	6, 592		0 0	0	
59. 00 06900 ELECTROCARDI OLOGY		0.00000	0		0 0	0	
59. 01 06901 CARDI OLOGY		0.00000	65, 228		0 0	0	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO		0.00000	84, 446		0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATI	LN I	0.00000	0		0 0	0	1
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 000000	717, 619		0 0	0	73.0
OUTPATIENT SERVICE COST CENTERS		0.000000			0	0	
0.00 09000 CLINIC	OCT CENTED	0.00000	0		0 0	0	
0. 01 09001 OTHER OUTPATIENT SERVICE C	JST CENTER	0.000000	0		0 0	0	
0. 02 09002 CLINIC 0. 03 09003 DERMATOLOGY CLINIC		0.000000	0		0 0	0	
0.03 09003 DERMATOLOGY CLINIC 0.04 09004 ENT CLINIC		0.000000	0		0 0	0	
0. 05 09005 SURGERY CLINIC		0.000000	0		0 0		
					-	0	
		0.000000	0			0	
0. 09 09009 GASTROENTEROLOGY CLINIC		0.000000	0			0	90.0
0. 11 09011 NEUROLOGY CLINIC 0. 12 09012 OPTHAMOLOGY CLINIC		0.000000	0		0 0	0	90.1
0. 12 09012 0PTHAMOLOGY CLINIC 0. 13 09013 ALLERGY CLINIC		0.000000	0		0 0	0	90.1
0. 13 09013 ALLERGY CLINIC 0. 14 09014 WOUND CARE		0.000000	0		0 0	0	
01. 00 09100 EMERGENCY		0.000000	10, 670		0 3, 150	0	
92.00 09200 OBSERVATION BEDS (NON-DIST	NCT DADT)	0.000000	10, 870		0 3, 150	0	
OTHER REIMBURSABLE COST CENTERS	NGT FART)	0.000000	0	L	0	0	72.0
25. 00 09500 AMBULANCE SERVICES		T					95.0

	Financial Systems	WI THAM MEMORI	AL_HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Peri od:	Worksheet D	
			Component		From 01/01/2017 To 12/31/2017		
			Title	e XVIII	Subprovider - IPF	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	ANCI LLARY SERVI CE COST CENTERS		-	1	-	-	
50.00	05000 OPERATING ROOM	0. 111431			0 0	-	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 247842			0 0		
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000			0 0	-	
55. 01	05501 ULTRA SOUND	0. 081638			0 0	0	
57.00	05700 CT SCAN	0. 020836			0 0	0	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 091369			0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 200971	C		0 0	0	59.00
60.00	06000 LABORATORY	0. 143106	C		0 0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 298772	C)	0 0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0. 001087	C		0 0	0	64.00
66.00	06600 PHYSI CAL THERAPY	0. 424096	C C		0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 164401	C)	0 0	0	67.00
67.01	06701 AUDI OLOGY	0. 218683	C)	0 0	0	67.01
68.00	06800 SPEECH PATHOLOGY	0. 234969	c c		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	c		0 0	l o	69.00
69. 01	06901 CARDI OLOGY	0. 145633	c		0 0	l o	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 487647			0 0	l o	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 452259			0 0	0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 112001			0 14, 823		
/0/00	OUTPATIENT SERVICE COST CENTERS	01112001					
90.00	09000 CLINIC	0. 000000	0		0 0	0	90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000			0 0		
90.02	09002 CLINIC	0. 000000			0 0	-	
90.03	09003 DERMATOLOGY CLINIC	0. 000000			0 0	o o	
90.04	09004 ENT CLINIC	0. 000000			0 0	o o	
90.05	09005 SURGERY CLINIC	0. 000000			0 0	0	
90.07	09007 UROLOGY CLINIC	0. 010298			0 0	0	
90.09	09009 GASTROENTEROLOGY CLINIC	0. 000000			0 0		
90.11	09011 NEUROLOGY CLINIC	0. 000000			0 0		
90.12	09012 OPTHAMOLOGY CLINIC	0. 000000			0 0	0	
90.12	09013 ALLERGY CLINIC	0. 306780			0 0	0	
90. 13 90. 14	09014 WOUND CARE	0. 194639			0 0	-	
90.14	09100 EMERGENCY	0. 178638			0 0	-	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 595557	3, 150 C		0 0		
7Z. UU	OTHER REIMBURSABLE COST CENTERS	0. 393357		1	0	0	72.00
95.00	09500 AMBULANCE SERVICES	0. 965260		1	0		95.00
200.00		0. 703200	3, 150		0 14, 823	542	200.00
200.00			3, 150		0 14, 823		200.00
201.00	5				0		201.00
202.00	Only Charges Net Charges (line 200 - line 201)		3, 150		0 14, 823	542	202.00
202.00	Inter charges (The 200 - The 201)	I	1 5, 150	1	0 14, 023	1 505	202.00

leal th Financia		WI THAM MEMORI				u of Form CMS-	2552-1
APPORTI ONMENT	OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0104	Period: From 01/01/2017	Worksheet D Part V	
			Component (CCN: 15-S104	To 12/31/2017	Date/Time Pre	pared:
						5/22/2018 7:4	9 am
			Title	XVIII	Subprovider - IPF	PPS	
		Cos			1	I	
Со	ost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To Ded. & Coins.	Subject To Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
ANCI LLAR	RY SERVICE COST CENTERS	0100					
0.00 05000 0P	PERATING ROOM	0	0				50. C
4.00 05400 RA	DI OLOGY-DI AGNOSTI C	0	0				54.0
	DI OLOGY-THERAPEUTI C	0	0				55.0
	TRA SOUND	0	0				55. C
7.00 05700 CT		0	0				57.0
	GNETIC RESONANCE IMAGING (MRI)	0	0				58.0
	ARDI AC CATHETERI ZATI ON	0	0				59.0
	BORATORY	0	0				60.0
	OOD STORING, PROCESSING & TRANS.	0	0				63.
	ITRAVENOUS THERAPY	0	0				64.
	IYSI CAL THERAPY	0	0				66. (
	CCUPATIONAL THERAPY	0	0				67.0
7.01 06701 AU		0	0				67.0
		0	0				68. 0 69. 0
	ECTROCARDI OLOGY RDI OLOGY	0	0				69.0
	EDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.0
	IPL. DEV. CHARGED TO PATIENTS	0	0				72.0
	RUGS CHARGED TO PATIENTS	0	1, 660				73.0
	ENT SERVICE COST CENTERS		1,000				1 / 0. (
0.00 09000 CL		0	0				90. 0
0. 01 09001 OT	HER OUTPATIENT SERVICE COST CENTER	0	0				90.0
0. 02 09002 CL	I NI C	0	0				90.0
0. 03 09003 DE	RMATOLOGY CLINIC	0	0				90. (
	IT CLINIC	0	0				90.0
	IRGERY CLI NI C	0	0				90. (
	ROLOGY CLINIC	0	0				90.0
	STROENTEROLOGY CLINIC	0	0				90. (
	UROLOGY CLINIC	0	0				90. ⁻
	PTHAMOLOGY CLINIC	0	0				90.
		0	0				90.
0.14 09014 WO		0	0				90.
1.00 09100 EM 2.00 09200 0B	BERGENCY SERVATION BEDS (NON-DISTINCT PART)	0	0				91.0
	EIMBURSABLE COST CENTERS	U	0	1			72.0
	IBULANCE SERVICES	0					95.0
	ibtotal (see instructions)	0	1, 660				200.0
	ess PBP Clinic Lab. Services-Program	0	,				201.0
	ly Charges						
202.00 Ne	et Charges (line 200 - line 201)	0	1, 660				202.0

PORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY	SERVICE OTHER PASS	S Provider C	CN: 15-0104	Peri od:	Worksheet D	
ROUGH COSTS				From 01/01/2017	Part IV	
		Component	CCN: 15-5832	To 12/31/2017	Date/Time Pre 5/22/2018 7:4	pare
		Title	XVIII	Skilled Nursing		7 aiii
				Facility	115	
Cost Center Description	Non Physician	Nursing School	Nursing Scho	ol Allied Health	Allied Health	
· · · · ·		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS	F		1			
. 00 05000 OPERATING ROOM	0	0		0 0	0	
. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	-	
. 00 05500 RADI OLOGY-THERAPEUTI C	0	C		0 0	0	1 00.
. 01 05501 ULTRA SOUND	0	C		0 0	0	
. 00 05700 CT SCAN	0	C		0 0	0	
. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	C		0 0	0	
. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0	
00 06000 LABORATORY	0	0		0 0	0	
. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	
. 00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0	
00 06600 PHYSI CAL THERAPY	0	0		0 0	0	
. 00 06700 OCCUPATIONAL THERAPY	0	0		0 0	0	
. 01 06701 AUDI OLOGY	0	0		0 0	0	
0 06800 SPEECH PATHOLOGY	0	0		0 0	0	
. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	
01 06901 CARDI OLOGY	0	0		0 0	0	
. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	5 0	0		0 0	0	1
. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	1
. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	73.
00 09000 CLINIC	0	0		0 0	0	90.
. 00 09000 CETNIC . 01 09001 OTHER OUTPATIENT SERVICE COST CENTE	P 0	0		0 0	-	
. 02 09002 CLINIC	к 0			0 0		
. 03 09003 DERMATOLOGY CLINIC	0	0		0 0		
. 04 09004 ENT CLINIC	0	0			0	
. 05 09005 SURGERY CLINIC	0	0			0	
07 09007 UROLOGY CLINIC	0	0			0	
. 09 09009 GASTROENTEROLOGY CLINIC	0	0		0 0	0	
. 11 09011 NEUROLOGY CLINIC	0	0		0 0	0	
. 12 09012 OPTHAMOLOGY CLINIC	0	0		0 0	0	
. 13 09013 ALLERGY CLINIC	0	0		0 0	l o	
. 14 09014 WOUND CARE	0	0		0 0	l o	
. 00 09100 EMERGENCY	0	C C		0 0	0	
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0	Ū		0	0	
OTHER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					1
. 00 09500 AMBULANCE SERVICES						95.
0.00 Total (lines 50 through 199)	0	C		0 0	0	200.

Health Financial Systems	WI THAM MEMORI				eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	S Provider C	CN: 15-0104	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-5832	From 01/01/201 To 12/31/201		epared: 19 am
		Title	e XVIII	Skilled Nursin		
				Facility		
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of col 1	Outpati ent	(from Wkst. C		
	Education Cost	through col.	Cost (sum of			
		4)	col. 2, 3 an	d 8)	7)	
			4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	-	-	1			1
50. 00 05000 OPERATI NG ROOM	0	-		0 44, 106, 60		1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	-		0 26, 479, 77		
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0.000000	
55. 01 05501 ULTRA SOUND	0	0		0 8, 040, 34		
57.00 05700 CT SCAN	0	0		0 40, 285, 48		1
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 12, 951, 58		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 2, 760, 33		
60. 00 06000 LABORATORY	0	-		0 53, 528, 76		
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 760, 94		
64.00 06400 I NTRAVENOUS THERAPY	0	0		0 2, 958, 55		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 7, 894, 71		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 3, 052, 81		
67. 01 06701 AUDI 0L0GY	0	0		0 932, 94		
68.00 06800 SPEECH PATHOLOGY	0	0		0 933, 85		1
69. 00 06900 ELECTROCARDI OLOGY	0	0		-	0.00000	
69. 01 06901 CARDI OLOGY	0	0		0 12, 205, 08		
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	-		0 6, 508, 66		
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	-		0 7, 892, 51		1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	1	0 21, 986, 48	5 0.00000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	-		0	0. 000000	
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	0.00000	
90. 02 09002 CLINIC	0			0	0.00000	
90. 03 09003 DERMATOLOGY CLINIC	0			-	0.00000	1
90. 04 09004 ENT CLINIC 90. 05 09005 SURGERY CLINIC	0			0	0.000000	
	0					
	0			0 153, 71		
90. 09 09009 GASTROENTEROLOGY CLINIC	0			-	0. 000000	
90. 11 09011 NEUROLOGY CLINIC	0			-		
90. 12 09012 OPTHAMOLOGY CLINIC 90. 13 09013 ALLERGY CLINIC	0			0	0.000000	
90. 13 09013 ALLERGY CLINIC 90. 14 09014 WOUND CARE	0			0,01,10		
90. 14 09014 WOUND CARE 91. 00 09100 EMERGENCY	0			0 4, 257, 47 0 30, 298, 38		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	-		0 30, 298, 38 0 2, 781, 10		
0THER REIMBURSABLE COST CENTERS	0	0	1	2,701,10	0.00000	92.00
95. 00 09500 AMBULANCE SERVICES			1		1	95.00
200.00 Total (lines 50 through 199)	0	0		0 291, 343, 92	0	200.00
	0	1 0	1	2/1, 343, 72	1	1200.00

APPORTIONMENT OF INP	tems ATIENT/OUTPATIENT ANCILLARY SE	WI THAM MEMORIA	Provider C	°N· 15_0104	Peri od:	u of Form CMS-2 Worksheet D	
THROUGH COSTS	ATTENT/ OUT ATTENT ANOTELANT SE	KVICE OTHER TASS		GN. 13-0104	From 01/01/2017	Part IV	
			Component (CCN: 15-5832	To 12/31/2017		pared: 9 am
			Ti tl e	e XVIII	Skilled Nursing Facility	PPS	
Cost Cer	iter Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Throug		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
	/I CE COST CENTERS						
50.00 05000 OPERATI N		0. 000000	9, 772		0 0		50.00
54.00 05400 RADI OLOG		0. 000000	25, 411		0 0		54.00
55. 00 05500 RADI OLOG		0. 000000	0		0 0		55.00
55.01 05501 ULTRA SC	DUND	0. 000000	12, 103		0 0	0	55.0
57.00 05700 CT SCAN		0. 000000	0		0 0	0	57.00
	RESONANCE IMAGING (MRI)	0. 000000	0		0 0	-	58.00
	CATHETERI ZATI ON	0. 000000	0		0 0	-	59.0
60. 00 06000 LABORATC		0. 000000	271, 573		0 0	0	60.0
	ORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.0
64.00 06400 INTRAVEN		0. 000000	0		0 0	0	64.0
66. 00 06600 PHYSI CAL		0. 000000	1, 215, 876		0 0	0	66.0
67.00 06700 0CCUPATI		0. 000000	1, 322, 573		0 0	0	67.00
67. 01 06701 AUDI 0L00		0. 000000	0		0 0	0	67.0
68.00 06800 SPEECH F		0. 000000	119, 930		0 0	0	68.0
69.00 06900 ELECTROC		0. 000000	0		0 0		69.0
69. 01 06901 CARDI OLC		0. 000000	413, 881		0 0	0	69.0
	SUPPLIES CHARGED TO PATIENTS	0. 000000	280, 048		0 0	0	71.0
	V. CHARGED TO PATIENT	0. 000000	0		0 0		72.0
	IARGED TO PATIENTS	0. 000000	1, 528, 392		0 0	0	73.0
	RVICE COST CENTERS						
90. 00 09000 CLI NI C		0. 000000	0		0 0		90.0
	ITPATIENT SERVICE COST CENTER	0. 000000	0		0 0		90.0
90. 02 09002 CLI NI C		0. 000000	0		0 0		90.0
0. 03 09003 DERMATOL		0. 000000	0		0 0		90.0
90.04 09004 ENT CLIN		0. 000000	0		0 0		90.0
09005 SURGERY		0. 000000	0		0 0		90.0
90. 07 09007 UROLOGY		0. 000000	0		0 0	0	90.0
	ITEROLOGY CLINIC	0. 000000	0		0 0		90.0
90. 11 09011 NEUROLOG		0. 000000	0		0 0	0	90.1
90.12 09012 OPTHAMOL		0. 000000	0		0 0	0	90.1
90. 13 09013 ALLERGY		0. 000000	0		0 0	0	90.1
90.14 09014 WOUND CA		0. 000000	0		0 0	0	90.1
91.00 09100 EMERGENC		0. 000000	3, 338		0 0		91.0
	I ON BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.0
	SABLE COST CENTERS						
95.00 09500 AMBULANC					-	_	95.00
200.00 Total (I	ines 50 through 199)	1	5, 202, 897	1	0 0	I 0	200. 0

	Financial Systems	WI THAM MEMORI	AL_HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-0104	Period: From 01/01/2017	Worksheet D Part V	
			Component	CCN: 15-5832	To 12/31/2017		
			Title	e XVIII	Skilled Nursing Facility		
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursec	<u>v</u>	Cost	PPS Services	
	•	Ratio From	Services (see	Rei mbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	ANCI LLARY SERVI CE COST CENTERS		-	1	-	-	
50.00	05000 OPERATI NG ROOM	0. 111431			0 0	-	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 247842			0 0		
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000			0 0	0	
55.01	05501 ULTRA SOUND	0. 081638			0 0	0	
57.00	05700 CT SCAN	0. 020836			0 0	0	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 091369			0 0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 200971			0 0	0	
60.00	06000 LABORATORY	0. 143106			0 0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 298772			0 0	0	
64.00	06400 I NTRAVENOUS THERAPY	0. 001087			0 0	0	
66.00	06600 PHYSI CAL THERAPY	0. 424096			0 0	0	
67.00	06700 OCCUPATIONAL THERAPY	0. 164401	0		0 0	0	
67.01	06701 AUDI OLOGY	0. 218683			0 0	0	
68.00	06800 SPEECH PATHOLOGY	0. 234969			0 0	0	
69.00	06900 ELECTROCARDI OLOGY	0. 000000			0 0	0	
69.01	06901 CARDI OLOGY	0. 145633			0 0	0	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0. 487647			0 0	-	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 452259			0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 112001	0)	0 2,631	0	73.00
~~ ~~	OUTPATIENT SERVICE COST CENTERS	0.000000					
90.00	09000 CLINIC	0.00000			0 0		
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0.00000			0 0	-	
90.02	09002 CLINIC	0.00000			0 0	-	
90.03	09003 DERMATOLOGY CLINIC	0. 000000			0 0	0	
90.04		0. 000000				0	
90.05	09005 SURGERY CLINIC	0.00000				0	
90.07	09007 UROLOGY CLINIC	0. 010298			0	0	
90.09	09009 GASTROENTEROLOGY CLINIC	0. 000000			0 0	0	
90.11	09011 NEUROLOGY CLINIC	0.00000				0	
90.12	09012 OPTHAMOLOGY CLINIC 09013 ALLERGY CLINIC	0.00000				0	
90.13		0. 306780				-	
90. 14 91. 00	09014 WOUND CARE 09100 EMERGENCY	0. 194639 0. 178638				0	
91.00		0. 178638				-	
72.00	09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REIMBURSABLE COST CENTERS	0. 393557	L (<u>'</u>		0	92.00
95.00	09500 AMBULANCE SERVICES	0. 965260		1	0		95.00
200.00		0. 703200	, 		0 2,631	_	200.00
200.00				<u></u>	0 2,031		200.00
201.00	Only Charges						201.00
202.00			0		0 2,631	n –	202.00
202.00		1		1	2,001		1-02.00

lealth Financial Systems	WI THAM MEMORI	AL_HOSPITAL		In Lie	u of Form CMS-	2552-1
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVIO	CES AND VACCINE COST	Provider C	CN: 15-0104	Peri od:	Worksheet D	
		Component	CCN: 15-5832	From 01/01/2017 To 12/31/2017	Part V Date/Time Pre	pared.
		•			5/22/2018 7:4	9 am
		Title	e XVIII	Skilled Nursing Facility	PPS	
	Cos	sts		Tacifity		
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins. (see inst.)	Ded. & Coins. (see inst.)				
	6.00	7.00	-			
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00		· · · · ·		
50. 00 05000 OPERATI NG ROOM	0	0				50.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.0
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.0
55. 01 05501 ULTRA SOUND	0	0				55.0
57.00 05700 CT SCAN	0	0				57.0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.0
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.0
0. 00 06000 LABORATORY	0	0				60.0
3.00 06300 BLOOD STORING, PROCESSING & TRAN	S. 0	0				63.0
4. 00 06400 I NTRAVENOUS THERAPY	0	0				64.0
6. 00 06600 PHYSI CAL THERAPY	0	0	1			66.0
57.00 06700 OCCUPATIONAL THERAPY	0	0				67.0
57. 01 06701 AUDI OLOGY	0	0				67.0
58.00 06800 SPEECH PATHOLOGY	0	0				68.0
59. 00 06900 ELECTROCARDI OLOGY	0	0				69.0
59. 01 06901 CARDI OLOGY	0	0				69.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATI	ENTS 0	0				71.0
72.00 07200 I MPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	295				72.0
OUTPATIENT SERVICE COST CENTERS	0	290				/3.0
0. 00 09000 CLINIC	0	0				90.0
0. 01 09001 OTHER OUTPATIENT SERVICE COST CE	-	0	•			90.0
0. 02 09002 CLINIC	0	0				90.0
0. 03 09003 DERMATOLOGY CLINIC	0	0				90.0
0. 04 09004 ENT CLINIC	0	0				90.0
0. 05 09005 SURGERY CLINIC	0	0				90.0
0.07 09007 UROLOGY CLINIC	0	0				90.0
0. 09 09009 GASTROENTEROLOGY CLINIC	0	0				90. C
0. 11 09011 NEUROLOGY CLINIC	0	0				90.1
0. 12 09012 OPTHAMOLOGY CLINIC	0	0				90.1
0. 13 09013 ALLERGY CLINIC	0	0	•			90.1
20.14 09014 WOUND CARE	0	0	•			90.1
91.00 09100 EMERGENCY	0	0				91.0
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT P	ART) 0	0				92.0
OTHER REI MBURSABLE COST CENTERS			1			05 0
25. 00 09500 AMBULANCE SERVICES	0	0.05				95.0
200.00 Subtotal (see instructions)	0	295				200.0
201.00 Less PBP Clinic Lab. Services-Pro	ogram O					201.0
0nly Charges 202.00 Net Charges (line 200 - line 201) 0	295				202.0
Loz. ool Inter charges (The 200 - The 201	, , , , , , , , , , , , , , , , , , , ,	290	I			1202. (

	Financial Systems WITHAM ME ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0104	Period: From 01/01/2017	Worksheet D-1	
			To 12/31/2017	Date/Time Pre 5/22/2018 7:49	
		Title XVIII	Hospi tal	PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	Inpatient days (including private room days and swing-b	bed days, excluding newborn)		6, 457	1
00	Inpatient days (including private room days, excluding			6, 457	2
00	Private room days (excluding swing-bed and observation do not complete this line.	bed days). If you have only pr	rivate room days,	0	3
00	Semi -private room days (excluding swing-bed and observa			5, 238	4
00	Total swing-bed SNF type inpatient days (including priv reporting period	vate room days) through Decembe	er 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including priv	vate room days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this lin		21 of the east	0	7
00	Total swing-bed NF type inpatient days (including priva reporting period	are room days) through becember	31 OF the COST	0	'
00	Total swing-bed NF type inpatient days (including priva	ate room days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this lin Total inpatient days including private room days applic		swing-bed and	2, 213	9
	newborn days)	5	5		
00	Swing-bed SNF type inpatient days applicable to title X through December 31 of the cost reporting period (see i		oom days)	0	10
00	Swing-bed SNF type inpatient days applicable to title X		oom days) after	0	11
00	December 31 of the cost reporting period (if calendar y Swing-bed NF type inpatient days applicable to titles V		a raam daya)	0	1.
. 00	through December 31 of the cost reporting period	of XIX only (Including privat	e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V			0	13
00	after December 31 of the cost reporting period (if cale Medically necessary private room days applicable to the			0	14
00	Total nursery days (title V or XIX only)	······································		0	15
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to	services through December 31 c	of the cost	0.00	17
~~	reporting period			0.00	
. 00	Medicare rate for swing-bed SNF services applicable to reporting period	services after becember 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to s reporting period	services through December 31 of	the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to s	services after December 31 of t	he cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instr	suctions)		8, 773, 378	21
. 00	Swing-bed cost applicable to SNF type services through		ing period (line	o, 773, 370 0	
~~	5 x line 17)				
. 00	Swing-bed cost applicable to SNF type services after De x line 18)	ecember 31 of the cost reportin	ig period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through D	December 31 of the cost reporti	ng period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after Dec	cember 31 of the cost reporting	period (line 8	0	25
00	x line 20) Tatal aving had agat (aga instructions)			0	26
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed	d cost (line 21 minus line 26)		8, 773, 378	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding sw Private room charges (excluding swing-bed charges)	Ving-bed and observation bed cr	arges)	0	28
	Semi -private room charges (excluding swing-bed charges)	•		0	30
	General inpatient routine service cost/charge ratio (li			0.000000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ li			0.00 0.00	
	Average per diem private room charge differential (line		tions)	0.00	
00	Average per diem private room cost differential (line 3	34 x line 31)		0.00	35
. 00 . 00	Private room cost differential adjustment (line 3 x lin General inpatient routine service cost net of swing-bed		fferential (line	0 8, 773, 378	36
. 00	27 minus line 36)			0, 113, 370	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH CO Adjusted general inpatient routine service cost per die			1, 358. 74	38
. 00	Program general inpatient routine service cost (line 9	x line 38)		3, 006, 892	39
	Medically necessary private room cost applicable to the	y		0	40
. 00	Total Program general inpatient routine service cost (I	ine 39 + line 40)		3, 006, 892	41

	Financial Systems ATION OF INPATIENT OPERATING COST	WITHAM MEMORIAL	HOSPITAL	N: 15-0104	In Lie Period:	u of Form CMS-: Worksheet D-1	
					From 01/01/2017 To 12/31/2017	Date/Time Pre 5/22/2018 7:4	
	Cost Center Description	Total Inpatient CostIr 1.00	Title Total npatient DaysD 2.00	Average Per		PPS Program Cost (col. 3 x col. 4) 5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.0			42.00
	Intensive Care Type Inpatient Hospital Units	0.555.300		1.150.5	<u>a</u>	4 470 504	
43.00 44.00 45.00 46.00 47.00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) Cost Center Description	2, 555, 738	1, 751	1, 459. 5	9 802	1, 170, 591	43.00 44.00 45.00 46.00 47.00
						1.00	
48.00	Program inpatient ancillary service cost (Wks					3, 287, 594	
49.00	Total Program inpatient costs (sum of lines 4	1 through 48)(se	ee instruction	is)		7, 465, 077	49.00
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	tiont routing co	prvi coc (from	Wkct D cum	of Dorte L and	472, 793	50.00
50.00	(111)		ervices (110m	WKSL. D, SUM	OF PAILS F ANU	472, 793	50.00
51.00	Pass through costs applicable to Program inpa and IV)	atient ancillary	services (fro	m Wkst. D, s	um of Parts II	232, 948	51.00
52.00	Total Program excludable cost (sum of lines !					705, 741	1
53.00	Total Program inpatient operating cost excluding medical education costs (line 49 minus line 5		ated, non-phys	ician anesth	etist, and	6, 759, 336	53.00
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55.00	Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)	0	1				
57.00	Difference between adjusted inpatient operati	0	57.00				
58.00	Bonus payment (see instructions)					0	
59.00	Lesser of lines 53/54 or 55 from the cost rep market basket	0 1	0		mpounded by the		
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of If line 53/54 is less than the lower of lines which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i	s 55, 59 or 60 er n expected costs	nter the lesse	er of 50% of		0. 00 0	
62. 00 63. 00	63.00 Allowable Inpatient cost plus incentive payment (see instructions)						
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	s through Decemb	per 31 of the	cost reporti	na period (See	0	64.00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost					0	
66.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	ne costs (line 64	4 plus line 65)(title XVII	I only). For	0	66.00
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	e costs through [December 31 of	the cost re	porting period	0	67.00
68.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine (line 12 x line 20)	e costs after Dec	cember 31 of t	he cost repo	rting period	0	68.00
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient n PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00
70.00	Skilled nursing facility/other nursing facili						70.00
71.00	Adjusted general inpatient routine service co	ost per diem (lir				l	71.00
72.00	Program routine service cost (line 9 x line 7	· ·		\			72.00
73.00 74.00	Medically necessary private room cost applica Total Program general inpatient routine servi	0	•	e 35)			73.00
75.00	Capital -related cost allocated to inpatient i 26, line 45)			rksheet B, P	art II, column		75.00
76.00	Per diem capital-related costs (line 75 ÷ lin	ne 2)				1	76.00
77.00	Program capital-related costs (line 9 x line						77.00
78.00	Inpatient routine service cost (line 74 minus	,		`			78.00
79.00	Aggregate charges to beneficiaries for excess				ue line 70)	ł	79.00
80.00 81.00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		scinitation	(IIIe /ơ min	us IIIe /4)	l .	80.00
82.00	Inpatient routine service cost per drem rim					1	82.00
83.00	Reasonable inpatient routine service costs (s)			l	83.00
84.00	Program inpatient ancillary services (see ins						84.00
85.00	Utilization review - physician compensation					l	85.00
86.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ougn 85)				86.00
	PART IV - CONTOTATION OF OBSERVATION BED PASS						
87.00	Total observation bed days (see instructions)	1				1, 219	87.00
87. 00 88. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per o		ine 2)			1, 219 1, 358. 74	

Health Financial Systems	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/22/2018 7:4	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1,042,736	8, 773, 378	0. 11885	2 1, 656, 304	196, 855	90.00
91.00 Nursing School cost	0	8, 773, 378	0.00000	0 1, 656, 304	0	91.00
92.00 Allied health cost	0	8, 773, 378	0.00000	0 1, 656, 304	0	92.00
93.00 All other Medical Education	0	8, 773, 378	0. 00000	0 1, 656, 304	0	93.00

OMPUT	Financial Systems WITHAM MEMORIAL ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0104	Peri od:	u of Form CMS-2 Worksheet D-1	
		Component CCN: 15-S104	From 01/01/2017 To 12/31/2017	Date/Time Pre 5/22/2018 7:4	
		Title XVIII	Subprovider -	PPS	/ am
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
~~	INPATIENT DAYS				
. 00 . 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			2, 890 2, 890	
. 00	Private room days (excluding private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		ivate room dave	2,890	
. 00	do not complete this line.	ays). It you have only pr	Tvate Toolii days,	0	J.
. 00	Semi-private room days (excluding swing-bed and observation b	ped days)		2, 890	4.
. 00	Total swing-bed SNF type inpatient days (including private ro	oom days) through Decembe	er 31 of the cost	0	5.
00	reporting period		04 6 11 1	0	
. 00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	om days) through December	31 of the cost	0	7.
. 00	reporting period	sin days) through becomen		0	, · ·
. 00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	8.
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable t	to the Program (excluding	swing-bed and	2, 444	9.
D. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including privato r	coom dave)	0	10.
0.00	through December 31 of the cost reporting period (see instruc		oom days)	0	10.
1.00	Swing-bed SNF type inpatient days applicable to title XVIII of	only (including private r	room days) after	0	11.
	December 31 of the cost reporting period (if calendar year, e				
2.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	12.
3. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	13.
5. 00	after December 31 of the cost reporting period (if calendar y			0	13.
1.00	Medically necessary private room days applicable to the Progr			0	14.
	Total nursery days (title V or XIX only)			0	
6.00	Nursery days (title V or XIX only)			0	16.
7.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	cos through December 21 c	of the cost	0.00	1 1 7
7.00	reporting period	ces thiodgh becember 51 c	in the cost	0.00	17.
3. 00	Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18.
	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	the cost	0.00	19.
D. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0.00	20.
0.00	reporting period			0.00	20.
1. 00	Total general inpatient routine service cost (see instruction			2, 836, 568	21.
2.00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost report	ing period (line	0	22.
3. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	a 21 of the cost reportin	a pariod (line 6	0	22
5.00	x line 18)	ST OF THE COST TEPOLIT	ig period (inne o	0	23.
4.00	Swing-bed cost applicable to NF type services through December	er 31 of the cost reporti	ng period (line	0	24.
	7 x line 19)				
5.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25.
6. 00	x line 20) Total swing-bed cost (see instructions)			0	26.
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 836, 568	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	
9.00	Private room charges (excluding swing-bed charges)			0	
D. 00	Semi-private room charges (excluding swing-bed charges)	· Lino 28)		0	
1.00 2.00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	- 1118 20)		0.000000	
3.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
1.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00	
5.00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
5.00	Private room cost differential adjustment (line 3 x line 35)	and makes the set	for an and the state	0	
7.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	TTERENTIAL (line	2, 836, 568	37.
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	JUSTMENTS			1
3. 00	Adjusted general inpatient routine service cost per diem (see			981.51	38.
. 00		- 38)		2, 398, 810	39.
9.00	Program general inpatient routine service cost (line 9 x line				
9.00 0.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39	ram (line 14 x line 35)		2, 398, 810 2, 398, 810	40.

Health Financial Systems COMPUTATION OF INPATIENT OPERATING COST	WI THAM MEMORIAL	HOSPI TAL Provi der C	CN: 15-0104	In Lie Period:	u of Form CMS- Worksheet D-1	
			CCN: 15-S104	From 01/01/2017 To 12/31/2017	Date/Time Pre	pared:
		Title	e XVIII	Subprovider -	5/22/2018 7:4 PPS	9 am
Cost Conton Description	Tatal		1	I PF		
Cost Center Description	Total Inpatient CostIn	Total patient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Uni	0	C	0.	00 0	0	42.00
43.00 INTENSIVE CARE UNIT	0	C	0.	00 0	0	
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT 46.00 SURGICAL INTENSIVE CARE UNIT						45.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3,	line 200)			226, 265	48.00
49.00 Total Program inpatient costs (sum of line	es 41 through 48)(se	e instructio	ins)		2, 625, 075	49.00
PASS THROUGH COST ADJUSTMENTS 50.00 Pass through costs applicable to Program i	npatient routine se	rvices (from	Wkst. D. su	m of Parts I and	284, 726	50.00
51.00 Pass through costs applicable to Program i and IV)	npatient ancillary	services (fr	om Wkst. D,	sum of Parts II	7, 233	51.00
52.00 Total Program excludable cost (sum of line					291, 959	52.00
53.00 Total Program inpatient operating cost exc medical education costs (line 49 minus lin		ted, non-phy	sician anest	hetist, and	2, 333, 116	53.00
TARGET AMOUNT AND LIMIT COMPUTATION	ie 52)					
54.00 Program di scharges					0	
55.00 Target amount per discharge 56.00 Target amount (line 54 x line 55)					0.00	
57.00 Difference between adjusted inpatient oper	ating cost and targ	et amount (I	ine 56 minus	line 53)	0	
58.00 Bonus payment (see instructions)					0	
59.00 Lesser of lines 53/54 or 55 from the cost market basket	reporting period en	ding 1996, t	pdated and c	ompounded by the	0.00	59.0
60.00 Lesser of lines 53/54 or 55 from prior yea					0.00	60.0
61.00 If line 53/54 is less than the lower of li which operating costs (line 53) are less t					0	61.0
amount (line 56), otherwise enter zero (se		(TTHES 54 X	00), 01 1% 0	i the target		
62.00 Relief payment (see instructions)					0	
63.00 Allowable Inpatient cost plus incentive pa PROGRAM INPATIENT ROUTINE SWING BED COST	iyment (see instruct	ions)			0	63.00
64.00 Medicare swing-bed SNF inpatient routine c	costs through Decemb	er 31 of the	cost report	ing period (See	0	64.00
instructions)(title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine c	osts after December	31 of the c	ost reportin	a period (See	0	65.00
instructions) (title XVIII only)		ST OF the t		g period (see		05.00
66.00 Total Medicare swing-bed SNF inpatient rou	itine costs (line 64	plus line 6	5)(title XVI	ll only). For	0	66.00
CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient rout	ine costs through D	ecember 31 c	of the cost r	eporting period	0	67.00
(line 12 x line 19)	0					
68.00 Title V or XIX swing-bed NF inpatient rout (line 13 x line 20)	ine costs after Dec	ember 31 of	the cost rep	orting period	0	68.00
69.00 Total title V or XIX swing-bed NF inpatien	nt routine costs (li	ne 67 + line	68)		0	69.00
PART III - SKILLED NURSING FACILITY, OTHER 70.00 Skilled nursing facility/other nursing fac)	1	70.00
70.00 Skilled nursing facility/other nursing fac 71.00 Adjusted general inpatient routine service)		70.00
72.00 Program routine service cost (line 9 x lin			>			72.00
73.00 Medically necessary private room cost appl 74.00 Total Program general inpatient routine se						73.0
75.00 Capital -related cost allocated to inpatien				Part II, column		75.00
26, line 45) 76.00 Per diem capital-related costs (line 75 ÷	lino 2)					76.00
77.00 Program capital-related costs (line 9 x li						77.00
78.00 Inpatient routine service cost (line 74 mi	-					78.00
79.00 Aggregate charges to beneficiaries for exc 30.00 Total Program routine service costs for co				nus line 70)		79.00
31.00 Inpatient routine service cost per diem li	•	t rimitati Ol				81.0
32.00 Inpatient routine service cost limitation						82.0
83.00 Reasonable inpatient routine service costs 84.00 Program inpatient ancillary services (see						83. 0 84. 0
85.00 Utilization review - physician compensation)				85.0
86.00 Total Program inpatient operating costs (s	sum of lines 83 thro					86. 00
PART IV - COMPUTATION OF OBSERVATION BED P 87.00 Total observation bed days (see instruction					0	87.00
88.00 Adjusted general inpatient routine cost pe	er diem (line 27 ÷ l	ine 2)			0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)				0	89.00

Health Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2017	Worksheet D-1	
		Component (To 12/31/2017	Date/Time Pre 5/22/2018 7:4	pared: 9 am
		Title	XVIII	Subprovider - IPF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	336, 671	2, 836, 568	0. 11869	0 0	0	90.00
91.00 Nursing School cost	0	2, 836, 568	0.00000	0 0	0	91.00
92.00 Allied health cost	0	2, 836, 568	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 836, 568	0.00000	0 0	0	93.00

INP 00 Inp 00 Inp 00 Pri 00 Sem 00 Tot 00 Swi 00 Swi 00 Swi 00 Med 00 Nur 00 SWI 00 Med	Cost Center Description RT I - ALL PROVIDER COMPONENTS PATIENT DAYS patient days (including private room days and swing-bed days patient days (including private room days, excluding swing-le ivate room days (excluding swing-bed and observation bed day not complete this line. mi-private room days (excluding swing-bed and observation bed tal swing-bed SNF type inpatient days (including private room porting period tal swing-bed SNF type inpatient days (including private room porting period tal swing-bed NF type inpatient days (including private room porting period tal swing-bed NF type inpatient days (including private room porting period tal swing-bed NF type inpatient days (including private room porting period tal swing-bed NF type inpatient days (including private room porting period tal inpatient days including private room days applicable to tal inpatient days applicable to title XVIII on comber 31 of the cost reporting period (if calendar year, end ing-bed NF type inpatient days applicable to title XVIII on comber 31 of the cost reporting period (if calendar year, end ing-bed NF type inpatient days applicable to title XVIII on comber 31 of the cost reporting period (if calendar year, end ing-bed NF type inpatient days applicable to title XVIII on tal inpatient days applicable to title XVIII on tal inpatient days applicable to title XVIII on tal inpatient days applicable	bed and newborn days) ys). If you have only pr ed days) om days) through Decembe om days) after December m days) after December 3 o the Program (excluding nly (including private re tions) nly (including private re	r 31 of the cost 31 of the cost 31 of the cost 1 of the cost swing-bed and	Date/Time Pret 5/22/2018 7:49 PPS 1.00 5,272 5,272 5,272 0 5,272 0 0 5,272 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	19 a
INP 00 Inp 00 Inp 00 Pri 00 Sem 00 Tot 00 Swi 00 Swi 00 Swi 00 Med 00 Nur 00 SWI 00 Med	AT I - ALL PROVIDER COMPONENTS ATIENT DAYS patient days (including private room days and swing-bed days patient days (including private room days, excluding swing- ivate room days (excluding swing-bed and observation bed day not complete this line. mi-private room days (excluding swing-bed and observation bed tal swing-bed SNF type inpatient days (including private roo porting period tal swing-bed SNF type inpatient days (including private roo porting period (if calendar year, enter 0 on this line) tal swing-bed NF type inpatient days (including private roo porting period (if calendar year, enter 0 on this line) tal swing-bed NF type inpatient days (including private roo porting period (if calendar year, enter 0 on this line) tal swing-bed NF type inpatient days (including private room porting period (if calendar year, enter 0 on this line) tal inpatient days including private room days applicable to title XVIII of rough December 31 of the cost reporting period (see instruct ing-bed SNF type inpatient days applicable to title XVIII of rough December 31 of the cost reporting period (see instruct ing-bed NF type inpatient days applicable to title XVIII of rough NF type inpatient days applicable to title XVIII of rough NF type inpatient days applicable to title XVIII of rough NF type inpatient days applicable to title XVIII of rough NF type inpatient days applicable to title XVIII of rough NF type inpatient days applicable to title XVIII of rough NF type inpatient days applicable to title XVIII of rough NF type inpatient days applicable to title XVIII of rough NF type inpatient days applicable to title XVIII of rough NF type inpatient days applicable to title XVIII of rough NF type inpatient days applicable to title XVIII of rough NF type inpatient days applicable to title XVIII of rough NF type inpatient days applicable to title XVIII of rough NF type inpatient days applicable to title XVIII of rough NF type inpatient days applicable to title XVIII of rough NF type inpatient d	s, excluding newborn) bed and newborn days) ys). If you have only pr ed days) om days) through December om days) after December m days) after December 3 o the Program (excluding nly (including private re tions) nly (including private re	Facility ivate room days, r 31 of the cost 31 of the cost 31 of the cost 1 of the cost swing-bed and	PPS 1.00 5,272 5,272 0 5,272 0 0 0 0 0 0 0 0 0 0	2 1 2 2 3 3 2 4 5
INP 00 Inp 00 Inp 00 Pri 00 Sem 00 Tot 00 Swi 00 Swi 00 Swi 00 Med 00 Nur 00 SWI 00 Med	AT I - ALL PROVIDER COMPONENTS ATIENT DAYS patient days (including private room days and swing-bed days patient days (including private room days, excluding swing- ivate room days (excluding swing-bed and observation bed day not complete this line. mi-private room days (excluding swing-bed and observation bed tal swing-bed SNF type inpatient days (including private roo porting period tal swing-bed SNF type inpatient days (including private roo porting period (if calendar year, enter 0 on this line) tal swing-bed NF type inpatient days (including private roo porting period (if calendar year, enter 0 on this line) tal swing-bed NF type inpatient days (including private roo porting period (if calendar year, enter 0 on this line) tal swing-bed NF type inpatient days (including private room porting period (if calendar year, enter 0 on this line) tal inpatient days including private room days applicable to title XVIII of rough December 31 of the cost reporting period (see instruct ing-bed SNF type inpatient days applicable to title XVIII of rough December 31 of the cost reporting period (see instruct ing-bed NF type inpatient days applicable to title XVIII of rough NF type inpatient days applicable to title XVIII of rough NF type inpatient days applicable to title XVIII of rough NF type inpatient days applicable to title XVIII of rough NF type inpatient days applicable to title XVIII of rough NF type inpatient days applicable to title XVIII of rough NF type inpatient days applicable to title XVIII of rough NF type inpatient days applicable to title XVIII of rough NF type inpatient days applicable to title XVIII of rough NF type inpatient days applicable to title XVIII of rough NF type inpatient days applicable to title XVIII of rough NF type inpatient days applicable to title XVIII of rough NF type inpatient days applicable to title XVIII of rough NF type inpatient days applicable to title XVIII of rough NF type inpatient days applicable to title XVIII of rough NF type inpatient d	bed and newborn days) ys). If you have only pr ed days) om days) through Decembe om days) after December m days) after December 3 o the Program (excluding nly (including private re tions) nly (including private re	ivate room days, r 31 of the cost 31 of the cost 31 of the cost 1 of the cost swing-bed and	5, 272 5, 272 0 5, 272 0 0 0 0 0 0	2 2) 3 2 4) 5
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thr 00 Swi aft 00 Med 00 Tot 00 Nur SWI 00 Med rep 00 Med			a room davc)	0	12
00 Swi aft 00 Med 00 Tot 00 Nur SWI 00 Med rep 00 Med	rough December 31 of the cost reporting period	v only (including privat	e room uays)	U	
00 Med 00 Tot 00 Nur SWI 00 Med rep 00 Med	ing-bed NF type inpatient days applicable to titles V or XIX	X only (including privat	e room days)	0	13
00 Tot 00 Nur SWI 00 Med rep 00 Med	ter December 31 of the cost reporting period (if calendar ye				
00 Nur SWI 00 Med rep 00 Med	dically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	
00 Med rep 00 Med	tal nursery days (title V or XIX only) rsery days (title V or XIX only)			0	
00 Med rep 00 Med	NG BED ADJUSTMENT			0	- ''
00 Med	dicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17
	porting period				
	dicare rate for swing-bed SNF services applicable to service porting period	es after December 31 of	the cost	0.00	18
	dicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19
	porting period				
	dicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20
	porting period tal general inpatient routine service cost (see instructions			2 945 925	1 21
	ing-bed cost applicable to SNF type services through Decembe		ing period (line	2, 865, 935	22
	x line 17)			0	
00 Swi	ing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23
	line 18)				
	ing-bed cost applicable to NF type services through December x line 19)	r 31 of the cost reporti	ng period (line	0	24
	ing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25
хI	line 20)			5	
	tal swing-bed cost (see instructions)	(1) 04 1		0	
	neral inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 865, 935	27
	VATE ROOM DIFFERENTIAL ADJUSTMENT neral inpatient routine service charges (excluding swing-bea	d and observation bed ch	arges)	0	28
	ivate room charges (excluding swing-bed charges)			0	
	mi-private room charges (excluding swing-bed charges)			0	
1	neral inpatient routine service cost/charge ratio (line 27 -	÷líne 28)		0.000000	
	erage private room per diem charge (line 29 ÷ line 3) erage semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
	erage per diem private room per diem charge (inne 30 ÷ inne 4) erage per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00	
	erage per diem private room cost differential (line 34 x lin			0.00	
00 Pri	ivate room cost differential adjustment (line 3 x line 35)			0	36
	neral inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	2, 865, 935	37
	minus line 36) RT II - HOSPITAL AND SUBPROVIDERS ONLY				-
	GTTT - HOSPITAL AND SUBPROVIDERS UNLY DGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			1
	justed general inpatient routine service cost per diem (see				38
00 Pro					
00 Med 00 Tot	ogram general inpatient routine service cost (line 9 x line				39

OMPUTATION OF INPATIENT OPERATING COST		AL HOSPITAL Provider CO	CN: 15-0104	Peri od:	eu of Form CMS- Worksheet D-1		
			CCN: 15-5832	From 01/01/2017 To 12/31/2017	Date/Time Pre	pared	
		Title	XVIII	Skilled Nursing	5/22/2018 7:4	9 am	
				Facility			
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00	40.0	
2.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Uni	ts					42.0	
3. 00 INTENSIVE CARE UNIT						43.0	
4. 00 CORONARY CARE UNIT 5. 00 BURN INTENSIVE CARE UNIT						44. C	
6.00 SURGICAL INTENSIVE CARE UNIT						46.0	
7. 00 OTHER SPECIAL CARE (SPECIFY)						47.0	
Cost Center Description					1.00		
8.00 Program inpatient ancillary service cost (48.0	
9.00 Total Program inpatient costs (sum of line PASS THROUGH COST ADJUSTMENTS	es 41 through 48)(see instructio	ns)			49.0	
0.00 Pass through costs applicable to Program i	npatient routine	services (from	Wkst. D, su	m of Parts I and		50.0	
)	nnationt andillar	v corvices (fr	om Wkot D	our of Dorto II		E1 (
1.00 Pass through costs applicable to Program i and IV)	npatrent andrian	y SELVICES (FF	UNI WNST. D,	Sum OF PALLS II		51.0	
2.00 Total Program excludable cost (sum of line						52. C	
3.00 Total Program inpatient operating cost exc medical education costs (line 49 minus lin		lated, non-phy	sıcıan anest	netist, and		53.0	
TARGET AMOUNT AND LIMIT COMPUTATION							
4.00 Program discharges 5.00 Target amount per discharge						54.0	
6.00 Target amount (line 54 x line 55)		56.					
Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							
Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the							
9.00 Lesser of lines 53/54 or 55 from the cost market basket	reporting period	churng 1770, u		shipourlaca by the		59.	
0.00 Lesser of lines 53/54 or 55 from prior yea						60.	
1.00 If line 53/54 is less than the lower of li which operating costs (line 53) are less t						61.	
amount (line 56), otherwise enter zero (se				5			
2.00 Relief payment (see instructions) 3.00 Allowable Inpatient cost plus incentive pa	uvment (see instru	ctions)				62.0	
PROGRAM INPATIENT ROUTINE SWING BED COST							
4.00 Medicare swing-bed SNF inpatient routine c instructions)(title XVIII only)	costs through Dece	mber 31 of the	cost report	ing period (See		64.0	
5.00 Medicare swing-bed SNF inpatient routine of	osts after Decemb	er 31 of the c	ost reportin	g period (See		65.0	
instructions)(title XVIII only) 6.00 Total Medicare swing-bed SNF inpatient rou	tina anata (lina	(1 plup line (E) (+; + ~ V)/I				
6.00 Total Medicare swing-bed SNF inpatient rou CAH (see instructions)	TITTHE COSTS (TTHE	o4 prus rine o	5)(LILIE XVI	FOI ONLY). FOI		66.0	
7.00 Title V or XIX swing-bed NF inpatient rout	ine costs through	December 31 o	f the cost r	eporting period		67.0	
(line 12 x line 19) 8.00 Title V or XIX swing-bed NF inpatient rout	ine costs after D	ecember 31 of	the cost rep	orting period		68. (
(line 13 x line 20)				or tring porrod			
9.00 Total title V or XIX swing-bed NF inpatier PART III - SKILLED NURSING FACILITY, OTHER						69.0	
0.00 Skilled nursing facility/other nursing fac	ility/ICF/IID rou	tine service c	ost (line 37)	2, 865, 935	70.	
1.00 Adjusted general inpatient routine service		ine 70 ÷ line	2)		543.61		
2.00 Program routine service cost (line 9 x lin3.00 Medically necessary private room cost appl		(line 14 x li	ne 35)		1, 885, 783		
4.00 Total Program general inpatient routine se	ervice costs (line	72 + line 73)	ŗ		1, 885, 783	74.	
5.00 Capital-related cost allocated to inpatier 26, line 45)	it routine service	costs (from W	orksheet B,	Part II, column	0	75.	
6.00 Per diem capital-related costs (line 75 ÷	line 2)				0.00	76.	
7.00 Program capital-related costs (line 9 x li	· ·				0		
8.00 Inpatient routine service cost (line 74 mi 9.00 Aggregate charges to beneficiaries for exc		rovi der record	s)		0		
0.00 Total Program routine service costs for co	mparison to the c			nus line 79)	0	80.	
1.00 Inpatient routine service cost per diem li 2.00 Inpatient routine service cost limitation)			0.00		
3.00 Reasonable inpatient routine service cost limitation	•	* .			1, 885, 783		
4.00 Program inpatient ancillary services (see	instructions)				1, 177, 116	84.	
5.00 Utilization review - physician compensation 6.00 Total Program inpatient operating costs (s					0 3, 062, 899		
PART IV - COMPUTATION OF OBSERVATION BED P					3,002,899	00.	
						1	
7.00 Total observation bed days (see instructions 8.00 Adjusted general inpatient routine cost pe					0	87.0 88.0	

Health Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2017	Worksheet D-1	
		Component (CCN: 15-5832	To 12/31/2017	Date/Time Pre 5/22/2018 7:4	pared: 9 am
		Ti tl e	XVIII	Skilled Nursing	PPS	
				Facility		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from		
				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	0	0	0.0000	0 0	0	90.00
91.00 Nursing School cost	0	0	0.0000	0 0	0	91.00
92.00 Allied health cost	0	0	0.0000	0 0	0	92.00
93.00 All other Medical Education	0	0	0.00000		0	93.00

MPUT.	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0104	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Pre	par	
		Title XIX	Hospi tal	5/22/2018 7:4 Cost	<u>9 a</u>	
	Cost Center Description		-	1.00	-	
	PART I - ALL PROVIDER COMPONENTS		· · · · · · · · · · · · · · · · · · ·			
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	s excluding newborn)	I	6, 457	.	
00	Inpatient days (including private room days, excluding swing-	bed and newborn days)		6, 457		
00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ys). If you have only pr	rivate room days,	0	3	
00	Semi-private room days (excluding swing-bed and observation b	ed days)		5, 238		
00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	er 31 of the cost	0	5	
00	reporting period Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6	
20	reporting period (if calendar year, enter 0 on this line)	m dava) through December	a 21 of the east	0		
00	Total swing-bed NF type inpatient days (including private roo reporting period	in days) through becember	31 OF the cost	0		
00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	0	8	
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	o the Program (excluding	a swing-bed and	189	4	
00	newborn days)	0				
00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc		room days)	0	10	
00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private i	room days) after	0	1	
. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		te room davs)	0	12	
	through December 31 of the cost reporting period		5 /			
00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13	
	Medically necessary private room days applicable to the Progr			-	14	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			1, 083	1!	
00	SWING BED ADJUSTMENT					
00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es through December 31 o	of the cost	0.00	1	
00						
00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	f the cost	0.00	10	
	reporting period	C				
00	Medicaid rate for swing-bed NF services applicable to service reporting period	s arter becember 31 or	the cost	0.00	20	
00	Total general inpatient routine service cost (see instruction	·		8, 773, 378		
00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	er 31 of the cost report	ting period (line	0	22	
00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23	
00	x line 18) Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	na period (line	0	24	
	7 x line 19)					
00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	g period (line 8	0	25	
	Total swing-bed cost (see instructions)			0		
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(iine zi minus line 26)		8, 773, 378	27	
	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0		
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0		
00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	3	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00		
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	ctions)	0.00		
	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 25)	ne 31)		0.00		
. 00 . 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	0 8, 773, 378		
	27 minus line 36)				1	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS				
	Adjusted general inpatient routine service cost per diem (see	instructions)		1, 358. 74		
00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	-		256, 802 0		
00	medicarry necessary private room cost appricable to the Progr	+ line 40)		0	1 40	

COMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	WITHAM MEMORIA	Provider CO	CN: 15-0104	Peri od:	eu of Form CMS- Worksheet D-1	
					From 01/01/2017 To 12/31/2017		epare
						5/22/2018 7:4	
	Cost Center Description	Total	Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
		Inpatient Costl		Diem (col. 1		(col. 3 x col.	
		1.00	2.00	col. 2)	4.00	4) 5.00	
2.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00) 42.
	Intensive Care Type Inpatient Hospital Units	00,000	.,				
8.00	INTENSIVE CARE UNIT	2, 555, 738	1, 751	1, 459. 5	59 0	C	
. 00	CORONARY CARE UNI T BURN INTENSIVE CARE UNI T						44.
5.00 5.00	SURGICAL INTENSIVE CARE UNIT						45.
	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description						
. 00	Program inpatient ancillary service cost (Wk	at D-3 col 3	Line 200)			1.00	3 48.
. 00	Total Program inpatient costs (sum of lines			ns)		364, 160	
	PASS THROUGH COST ADJUSTMENTS	··· ··· ··· ··· ··· ··· ··· ··· ··· ··					
0. 00	Pass through costs applicable to Program inpa	atient routine s	services (from	Wkst. D, sum	of Parts I and	C	50.
. 00	<pre>III) Pass through costs applicable to Program inpa</pre>	atient ancillary	, services (fr	om Wkst D s	um of Parts II	0	51.
. 00	and IV)		y services (II	UNI WKSt. D, S			
2.00	Total Program excludable cost (sum of lines !					c	
3.00	Total Program inpatient operating cost exclud		ated, non-phy	sician anesth	etist, and	C	53.
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	oZ)					
. 00	Program di scharges					0	54
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0	
2.00 3.00	Difference between adjusted inpatient operati Bonus payment (see instructions)	line 53)					
9.00	Lesser of lines 53/54 or 55 from the cost rep	mpounded by the					
	market basket	0.1	0				
). 00	Lesser of lines 53/54 or 55 from prior year of				4 h a	0.00	
. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					C) 61
	amount (line 56), otherwise enter zero (see i		5 (THES 54 X		the target		
2.00	Relief payment (see instructions)					C	
8. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	ctions)			<u> </u>) 63
. 00	Medicare swing-bed SNF inpatient routine cost	ts through Decem	mber 31 of the	cost reporti	na period (See	0	64
	instructions)(title XVIII only)	5			5 1 2 2		
6. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the c	ost reporting	period (See	C	65
5.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	ne costs (line A	54 nlus line 6	5)(title XVII	Lonly) For	0	66.
. 00	CAH (see instructions)			5)((11)(2,0))	r onry). ror		
7.00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 o	f the cost re	porting period	C	67.
3. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	a costs after De	combor 21 of	the cost room	rting poriod		68.
5. 00	(line 13 x line 20)		ecember 31 01	the cost repo	n tring period		00.
9.00	,	routine costs (I	ine 67 + line	68)		с с	69.
	PART III - SKILLED NURSING FACILITY, OTHER NU					1	1
). 00 . 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co	2		• • •			70
2.00	Program routine service cost (line 9 x line		ne 70 ÷ Trne	2)			72
8.00	Medically necessary private room cost applica		(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine servi						74
6. 00	Capital-related cost allocated to inpatient (26, line 45)	routine service	costs (from W	orksheet B, F	art II, column		75
. 00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
. 00	Program capital-related costs (line 9 x line	76)					77
. 00	Inpatient routine service cost (line 74 minus	,					78
. 00 . 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				us line 70)		80
. 00	Inpatient routine service costs for compa		ost i i mitati ON		103 IIIE /7)		80
. 00	Inpatient routine service cost limitation (li)				82
. 00	Reasonable inpatient routine service costs (see instructions					83
. 00	Program inpatient ancillary services (see ins		>				84
. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85
. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS		ough 00)			1	
7.00	Total observation bed days (see instructions))				1, 219	
8.00	Adjusted general inpatient routine cost per o		line 2)			1, 358. 74	
. 00	Observation bed cost (line 87 x line 88) (see					1, 656, 304	

Health Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/22/2018 7:4	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1,042,736	8, 773, 378	0. 11885	2 1, 656, 304	196, 855	90.00
91.00 Nursing School cost	0	8, 773, 378	0.00000	0 1, 656, 304	0	91.00
92.00 Allied health cost	0	8, 773, 378	0.00000	0 1, 656, 304	0	92.00
93.00 All other Medical Education	0	8, 773, 378	0.00000	1, 656, 304	0	93.00

Health Financial Systems WI THAM MEMORIAL				eu of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0104	Period: From 01/01/2017	Worksheet D-3	
			To 12/31/2017	Date/Time Pre	pared:
				5/22/2018 7:4	
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			2, 150, 205		30.00
31. 00 03100 I NTENSI VE CARE UNI T			1, 826, 227		31.00
40. 00 04000 SUBPROVI DER – I 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
ANCI LLARY SERVI CE COST CENTERS		1			
50. 00 05000 OPERATING ROOM		0. 1114		489, 461	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.2478		226, 984	1
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.0000		0	55.00
55. 01 05501 ULTRA SOUND		0.0816		5, 712	
57. 00 05700 CT SCAN		0.0208		40, 759	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.0913		25, 203	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 2009		15, 062	
60. 00 06000 LABORATORY		0. 1431		610, 146	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 2987			
64. 00 06400 I NTRAVENOUS THERAPY		0.0010		559	
66. 00 06600 PHYSI CAL THERAPY		0. 4240		150, 281	
67. 00 06700 0CCUPATI ONAL THERAPY 67. 01 06701 AUDI 0L0GY		0.1644		34, 471 102	
68. 00 06800 SPEECH PATHOLOGY		0. 2186 0. 2349		9, 162	1
69. 00 06900 ELECTROCARDI OLOGY		0. 2349		9, 102	
69. 01 06901 CARDI 0L0GY		0. 1456		390, 984	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 4876		563, 220	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 4522		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1120		356, 886	
OUTPATIENT SERVICE COST CENTERS		0.1120	5, 100, 452		/ 0.00
90. 00 09000 CLI NI C		0.0000	0 00	0	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER		0.0000	0 00	0	90.01
90. 02 09002 CLINIC		0.0000	0 00	0	90.02
90. 03 09003 DERMATOLOGY CLINIC		0.0000	0 00	0	90.03
90. 04 09004 ENT CLINIC		0.0000	0 00	0	90.04
90. 05 09005 SURGERY CLINIC		0.0000	0 00	0	90.05
90. 07 09007 UROLOGY CLINIC		0. 0102	98 0	0	
90. 09 09009 GASTROENTEROLOGY CLINIC		0.0000		0	
90. 11 09011 NEUROLOGY CLINIC		0.0000		0	
90. 12 09012 OPTHAMOLOGY CLINIC		0.0000		0	
90. 13 09013 ALLERGY CLINIC		0. 3067		0	
90. 14 09014 WOUND CARE		0. 1946		131	
91.00 09100 EMERGENCY		0. 1786		331, 107	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		0. 5955	57 0	0	92.00
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES					95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			22, 072, 232	3, 287, 594	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		22, 072, 232	3,207,394	200.00
202.00 Net charges (line 200 minus line 201)			22, 072, 232		201.00
		I	22,012,232	I	1202.00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider (CN: 15-0104	Peri od:	Worksheet D-3	2552-1
NPATIENT ANGILLART SERVICE COST APPORTIONMENT	Provider C	CN. 15-0104	From 01/01/2017	WOLKSHEEL D-3)
	Component	CCN: 15-S104	To 12/31/2017		
		e XVIII	Subprovider -	5/22/2018 7:4 PPS	9 am
	IIII		IPF	PP3	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1.00	2.00	0100	
0. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
1.00 03100 INTENSIVE CARE UNIT			0		31.00
0. 00 04000 SUBPROVIDER - IPF			2, 773, 259		40.00
1. 00 04100 SUBPROVIDER - IRF			0		41.00
2. 00 04200 SUBPROVI DER			0		42.00
3. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS		0 1114	0.1/1	1 001	
0. 00 05000 OPERATI NG ROOM 4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1114			
5. 00 05500 RADIOLOGY-DIAGNOSTIC		0. 2478			
5. 01 05501 ULTRA SOUND		0.0816		-	
7. 00 05700 CT SCAN		0.0208			
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0200		338	
9. 00 05900 CARDI AC CATHETERI ZATI ON		0.2009			
0. 00 06000 LABORATORY		0. 1431			
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 2987			
4. 00 06400 I NTRAVENOUS THERAPY		0.0010			
6. 00 06600 PHYSI CAL THERAPY		0. 4240			
7. 00 06700 OCCUPATI ONAL THERAPY		0. 1644		322	
7. 01 06701 AUDI OLOGY		0. 2186	83 0	0	67.0
8.00 06800 SPEECH PATHOLOGY		0. 2349	69 6, 592	1, 549	68.0
9. 00 06900 ELECTROCARDI OLOGY		0.0000	00 0	0	69.0
9. 01 06901 CARDI OLOGY		0. 1456		9, 499	69.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 4876		41, 180	
2.00 07200 I MPL. DEV. CHARGED TO PATIENT		0. 4522			
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1120	01 717, 619	80, 374	73.0
OUTPATI ENT SERVI CE COST CENTERS 0. 00 09000 CLI NI C		0.0000	00 0	0	90.0
0. 01 09001 OTHER OUTPATI ENT SERVICE COST CENTER		0.0000			
0. 02 09002 CLINIC		0.0000			
0. 03 09003 DERMATOLOGY CLINIC		0.0000			
0. 04 09004 ENT CLINIC		0.0000			
0. 05 09005 SURGERY CLI NI C		0.0000			
0. 07 09007 UROLOGY CLINIC		0. 0102		0	
0. 09 09009 GASTROENTEROLOGY CLINIC		0.0000		0	90.0
0. 11 09011 NEUROLOGY CLINIC		0.0000	00 0	0	90.1
0. 12 09012 OPTHAMOLOGY CLINIC		0.0000		0	
0. 13 09013 ALLERGY CLINIC		0. 3067			
0.14 09014 WOUND CARE		0. 1946			
1.00 09100 EMERGENCY		0. 1786			
2. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		0. 5955	57 0	0	92.0
OTHER REI MBURSABLE COST CENTERS 5.00 09500 AMBULANCE SERVI CES		1			95.0
00.00 Total (sum of lines 50 through 94 and 96 through 98)			1, 529, 331	226, 265	
01.00 Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		1, 529, 531		200.0
		1	0	1	1201.0

IPATIENT ANCILLARY SERVICE COST APPORTIONMENT	rovider C	CN: 15-0104	In Lie Period:	Worksheet D-3	
			From 01/01/2017		
C	omponent	CCN: 15-5832	To 12/31/2017	Date/Time Pre 5/22/2018 7:4	
	Ti tl e	e XVIII	Skilled Nursing Facility		<i>y</i> can
Cost Center Description		Ratio of Cos		I npati ent	
·		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
0. 00 03000 ADULTS & PEDI ATRI CS			0		30. 0
I. 00 03100 I NTENSI VE CARE UNI T			0		31.0
0. 00 04000 SUBPROVIDER - IPF			0		40.0
I. 00 04100 SUBPROVIDER - IRF			0		41.0
2. 00 04200 SUBPROVI DER			0		42.0
3. 00 04300 NURSERY					43.0
ANCI LLARY SERVI CE COST CENTERS		1			
D. 00 O5000 OPERATING ROOM		0. 1114			
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2478			
5. 00 05500 RADI OLOGY-THERAPEUTI C		0.0000		-	
5. 01 05501 ULTRA SOUND		0.0816			
7. 00 05700 CT SCAN		0.0208			
3. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.0913			
2. 00 05900 CARDI AC CATHETERI ZATI ON D. 00 06000 LABORATORY		0.2009		-	
		0. 1431 0. 2987			
3. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 1. 00 06400 I NTRAVENOUS THERAPY		0. 2987			
5. 00 06600 PHYSI CAL THERAPY		0. 4240		-	
7. 00 06700 OCCUPATI ONAL THERAPY		0. 1644			
7. 01 06701 AUDI OLOGY		0. 2186		0	
3. 00 06800 SPEECH PATHOLOGY		0. 2349			
P. 00 06900 ELECTROCARDI OLOGY		0.0000		0	
9. 01 06901 CARDI OLOGY		0. 1456		60, 275	
I. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 4876			
2.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 4522	59 0	0	72.0
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1120	01 1, 528, 392	171, 181	73. (
OUTPATIENT SERVICE COST CENTERS				-	
0. 00 09000 CLINIC		0.0000			
0. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER		0.0000			
0. 02 09002 CLINIC		0.0000			
0. 03 09003 DERMATOLOGY CLINIC		0.0000			
		0.0000		-	
0. 05 09005 SURGERY CLINIC		0.0000			
D. 07 09007 UROLOGY CLINIC D. 09 09009 GASTROENTEROLOGY CLINIC		0.0102		-	
D. 09 09009 GASTROENTEROLOGY CLINIC D. 11 09011 NEUROLOGY CLINIC		0.0000			
D. 12 09012 0PTHAMOLOGY CLINIC		0.0000		-	
0. 13 09013 ALLERGY CLINIC		0. 3067		-	
0. 14 09014 WOUND CARE		0. 1946		-	
I. 00 09100 EMERGENCY		0. 1786			
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5955			
OTHER REIMBURSABLE COST CENTERS		0.0700		. 0	1 2.0
5. 00 09500 AMBULANCE SERVICES					95.0
00.00 Total (sum of lines 50 through 94 and 96 through 98)			5, 202, 897	1, 177, 116	
01.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.0
02.00 Net charges (line 200 minus line 201)			5, 202, 897		202.0

INPATIENT AN	ICI al Systems WI THAM MER VCI LLARY SERVICE COST APPORTIONMENT	Provi der C	CN· 15-0104	Peri od:	Worksheet D-3	2552-10
				From 01/01/2017		
				To 12/31/2017	Date/Time Pre	
			e XIX	Hospi tal	5/22/2018 7:4 Cost	9 am
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
					2)	
LNDAT			1.00	2.00	3.00	
	I ENT ROUTI NE SERVI CE COST CENTERS ADULTS & PEDI ATRI CS			494, 812		30.00
	INTENSIVE CARE UNIT			62, 881		31.00
	SUBPROVIDER - IPF			02,001		40.00
	SUBPROVIDER - IRF			0		41.00
	SUBPROVI DER			0		42.00
	NURSERY			129, 651		43.00
	LARY SERVICE COST CENTERS		1			
	OPERATING ROOM		0. 1114	31 87, 032	9, 698	50.00
	RADI OLOGY-DI AGNOSTI C		0. 2478		3, 572	54.00
55.00 05500	RADI OLOGY-THERAPEUTI C		0.0000	00 00	0	55.00
55.01 05501	ULTRA SOUND		0. 0816	38 5, 008	409	55.01
57.00 05700	CT SCAN		0. 0208	36 46, 140	961	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)		0. 0913	69 1, 778	162	58.00
	CARDI AC CATHETERI ZATI ON		0. 2009		2, 081	
	LABORATORY		0. 1431		17, 482	
	BLOOD STORING, PROCESSING & TRANS.		0. 2987		2, 702	
	INTRAVENOUS THERAPY		0.0010		0	
	PHYSI CAL THERAPY		0. 4240		1, 322	
	OCCUPATIONAL THERAPY		0. 1644		274	
	AUDI OLOGY		0. 2186		0	
	SPEECH PATHOLOGY		0.2349		0	
	ELECTROCARDI OLOGY CARDI OLOGY		0.0000		0	
			0. 1456 0. 4876		7, 250 43, 926	
	MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENT		0. 4878		43, 920	
	DRUGS CHARGED TO PATIENTS		0. 4322		9, 748	
	TIENT SERVICE COST CENTERS		0.1120	01 07,033	7,740	/ 3.00
			0.0000	00 00	0	90.00
90.01 09001	OTHER OUTPATIENT SERVICE COST CENTER		0.0000		0	90.01
90.02 09002	CLINIC		0.0000	00 00	0	90.02
90.03 09003	DERMATOLOGY CLINIC		0.0000	00 0	0	90.03
	ENT CLINIC		0.0000	00 0	0	90.04
	SURGERY CLINIC		0.0000		0	
	UROLOGY CLINIC		0. 0102		0	
	GASTROENTEROLOGY CLINIC		0.0000		0	
	NEUROLOGY CLINIC		0.0000		0	
	OPTHAMOLOGY CLINIC		0.0000		0	
	ALLERGY CLINIC		0.3067		0	
	WOUND CARE		0. 1946		99 57 - 72	
	EMERGENCY		0. 1786		7,672	
	OBSERVATI ON BEDS (NON-DI STINCT PART) REIMBURSABLE COST CENTERS		0. 5955	57 0	0	92.00
	AMBULANCE SERVICES					95.00
200.00	Total (sum of lines 50 through 94 and 96 through 9	98)		571, 063	107, 358	
	Less PBP Clinic Laboratory Services-Program only of			0,1,000	107,000	201.00
201.00				11		1201.00

	Financial Systems WITHAM MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Period: From 01/01/2017 To 12/31/2017	u of Form CMS-2 Worksheet E Part A Date/Time Pre 5/22/2018 7:4	pared:
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
. 00 . 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr	ing prior to October 1	(see	0 0	1.00 1.01
. 02	instructions) DRG amounts other than outlier payments for discharges occurr	1 (see	6, 280, 766	1. 02	
. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI f	prior to October	0	1. 03	
. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI f	or discharges occurring	on or after	0	1.04
. 00	October 1 (see instructions) Outlier payments for discharges. (see instructions)			17, 258	2.00
. 01 . 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instruct	i ons)		0	2.0
. 00	Managed Care Simulated Payments			0	3.00
. 00	Bed days available divided by number of days in the cost repo Indirect Medical Education Adjustment	rting period (see instru	uctions)	64.66	4.00
. 00	FTE count for all opathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	t recent cost reporting	period ending on	0.00	5.00
. 00	FTE count for allopathic and osteopathic programs which meet for new programs in accordance with 42 CFR 413.79(e)	the criteria for an add	on to the cap	0.00	6.00
. 00	MMA Section 422 reduction amount to the IME cap as specified	under 42 CFR §412.105(f)	(1)(iv)(B)(1)	0.00	7.00
. 01	ACA § 5503 reduction amount to the IME cap as specified under cost report straddles July 1, 2011 then see instructions.	42 CFR §412.105(f)(1)(i	v)(B)(2) If the	0.00	7.0 [°]
. 00	Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.0		
. 01	The amount of increase if the hospital was awarded FTE cap sl	0.00	8. 0		
. 02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap sl under & 5506 and (cop instructions)	ng hospital	0.00	8. 0	
. 00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin instructions)	(see	0.00	9.00	
0. 00	FTE count for allopathic and osteopathic programs in the curr	ent year from your recom	-ds		10. 0
1.00	FTE count for residents in dental and podiatric programs.			0.00	
2.00 3.00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.				12.0 13.0
4.00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ar ended on or after Sep	otember 30, 1997,		14. C
5.00	Sum of Lines 12 through 14 divided by 3.			0.00	15.0
	Adjustment for residents in initial years of the program				16.0
	Adjustment for residents displaced by program or hospital clo Adjusted rolling average FTE count	sure			17.0 18.0
9.00	Current year resident to bed ratio (line 18 divided by line 4)		0.000000	
	Prior year resident to bed ratio (see instructions)	, ·		0.000000	
1.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21.0
2.00	IME payment adjustment (see instructions)			0	22.0
2. 01	IME payment adjustment - Managed Care (see instructions)			0	22.0
3. 00	Indirect Medical Education Adjustment for the Add-on for § 42. Number of additional allopathic and osteopathic IME FTE resid		CFR 412. 105	0.00	23.0
4.00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			0.00	24.0
4.00 5.00	If the amount on line 24 is greater than -0-, then enter the instructions)	lower of line 23 or line	e 24 (see		24. C
6. 00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26. C
7.00	IME payments adjustment factor. (see instructions)			0.000000	27.0
	IME add-on adjustment amount (see instructions)			0	28.0
8.01	IME add-on adjustment amount - Managed Care (see instructions			0	28.0
	Total IME payment (sum of lines 22 and 28)	1)		0	29.0
9. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0 Disproportionate Share Adjustment	····)		0	29.0
0. 00	Percentage of SSI recipient patient days to Medicare Part A p	atient days (see instru	ctions)	2 23	30.0
1.00	Percentage of Medicaid patient days (see instructions)			25.92	
	Sum of Lines 30 and 31			28.15	
3.00	Allowable disproportionate share percentage (see instructions)		12.00	
	Disproportionate share adjustment (see instructions)			188, 423	31

	Financial Systems WITHAM MEMORIAL H	OSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prep 5/22/2018 7:49	oared: 9 am
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
	Uncompensated Care Adjustment		-		
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35. 01 35. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, enter	zoro on this line) (cos	0. 00000000 338, 490	0. 00000000 639, 760	35. 01 35. 02
33. UZ	instructions)	zero on this rine) (see	330, 490	039, 700	30. UZ
35.03	Pro rata share of the hospital uncompensated care payment amoun	it (see instructions)	253, 172	161, 255	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		414, 427		36.00
	Additional payment for high percentage of ESRD beneficiary disc		h_46)		
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding di	scharges for MS-DRGs	0		40.00
	652, 682, 683, 684 and 685 (see instructions)	(a) (a5 (
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683	, 684 an 685. (see	0		41.00
41.01	instructions) Total ESRD Medicare covered and paid discharges excluding MS-DR	9Ge 652 682 683 684	0		41.01
41.01	an 685. (see instructions)	03 052, 002, 005, 004	0		41.01
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, 682,	683, 684 an 685. (see	0		43.00
	instructions)				
44.00	Ratio of average length of stay to one week (line 43 divided by	line 41 divided by 7	0.000000		44.00
45.00	days)		0.00		45 00
45.00 46.00	Average weekly cost for dialysis treatments (see instructions) Total additional payment (line 45 times line 44 times line 41.0	11)	0.00		45.00 46.00
40.00	Subtotal (see instructions)	(1)	6, 900, 874		40.00
48.00	Hospital specific payments (to be completed by SCH and MDH, sma	ll rural hospitals	0, 700, 071		48.00
	only. (see instructions)				
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)	5		6, 900, 874	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and			510, 548	
51.00 52.00	Exception payment for inpatient program capital (Wkst. L, Pt. I Direct graduate medical education payment (from Wkst. E-4, line			0	51.00 52.00
53.00	Nursing and Allied Health Managed Care payment	47 See That detrons).		0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intruc			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III		rough 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 11 line 200)		0	58.00
59.00 60.00	Total (sum of amounts on lines 49 through 58) Primary payer payments			7, 411, 422 0	59.00 60.00
61.00	Total amount payable for program beneficiaries (line 59 minus l	ine 60)		7, 411, 422	61.00
62.00	Deductibles billed to program beneficiaries			889, 364	
63.00	Coinsurance billed to program beneficiaries			10, 199	
64.00	Allowable bad debts (see instructions)			93, 812	64.00
	Adjusted reimbursable bad debts (see instructions)			60, 978	
66.00	Allowable bad debts for dual eligible beneficiaries (see instru	ictions)		74, 631	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			6, 572, 837	67.00
68.00 69.00	Credits received from manufacturers for replaced devices for ap Outlier payments reconciliation (sum of lines 93, 95 and 96). (F			0	68.00 69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	or som see mistructions	7	0	69.00 70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstra	ition) adjustment (see i	nstructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	,		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instru	ictions)			70. 89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70. 90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70. 93 70. 94	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			11, 230 -6, 003	70. 93 70. 94
	Recovery of accel erated depreciation				70.94 70.95
, 5. 75				0	, 0. , 0

CULATION OF REIMBURSEMENT SETTLEMENT	Provider CC	CN: 15-0104	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Pre 5/22/2018 7:4	
	Title	XVIII	Hospi tal	PPS	
		FF	((уууу)	Amount	
			0	1.00	
96 Low volume adjustment for federal fiscal year (yyyy) (Enter i	in column O		2017	20, 570	70.
 the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or at 			2018	651, 909	
 98 Low Volume Payment-3 99 HAC adjustment amount (see instructions) 00 Amount due provider (line 67 minus lines 68 plus/minus lines 01 Sequestration adjustment (see instructions) 02 Demonstration payment adjustment amount after sequestration 	69 & 70)			0 0 7, 250, 543 145, 011 0	70. 71. 71. 71. 71.
00 Interim payments				6, 843, 637	
 Tentative settlement (for contractor use only) Balance due provider/program (line 71 minus lines 71.01, 71.0 73) 	02, 72, and			0 261, 895	73. 74.
00 Protested amounts (nonallowable cost report items) in accorda CMS Pub. 15-2, chapter 1, §115.2	ance with			122, 802	75.
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see ins	structions)			0	
00 Capital outlier from Wkst. L, Pt. I, line 2				0	91.
00 Operating outlier reconciliation adjustment amount (see instr	ructions)			0	92
00 Capital outlier reconciliation adjustment amount (see instruc	ctions)			0	93
00 The rate used to calculate the time value of money (see instr	ructions)			0.00	94
00 Time value of money for operating expenses (see instructions))			0	95
00 Time value of money for capital related expenses (see instruct	ctions)			0	96
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
0.00 HSP bonus amount (see instructions)			0	0	100
HVBP Adjustment for HSP Bonus Payment					
1.00 HVBP adjustment factor (see instructions)			0. 000000000	0.000000000	
2.00 HVBP adjustment amount for HSP bonus payment (see instruction	ns)		0	0	102
HRR Adjustment for HSP Bonus Payment					
3.00 HRR adjustment factor (see instructions)			0.0000	0.0000	103
4.00 HRR adjustment amount for HSP bonus payment (see instructions	s)		0	0	104
Rural Community Hospital Demonstration Project (§410A Demonst	tration) Adju	stment			
0.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.	eriod under t	he 21st			200
Cost Reimbursement	no. 40)				201
I.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir	ne 49)				201 202
2.00 Medicare discharges (see instructions)					
3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period)	n first year	of the curre	nt 5-year demonst	ration	203
1.00 Medicare target amount					204
5.00 Case-mix adjusted target amount (line 203 times line 204)					205
5.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement)				206
7.00 Program reimbursement under the §410A Demonstration (see ins	tructions)				207
3.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	, line 59)				208
9.00 Adjustment to Medicare IPPS payments (see instructions)	-				209
					210
).00 Reserved for future use					211
).00 Reserved for future use 1.00 Total adjustment to Medicare IPPS payments (see instructions))				-
)				
1.00 Total adjustment to Medicare IPPS payments (see instructions)	•				212
1.00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	•				212 213

ow vo	LUME CALCULATION EXHIBIT 4			Provider CC	F	Period: From 01/01/2017	Worksheet E Part A Exhibit	
						o 12/31/2017	Date/Time Prep 5/22/2018 7:49	
					XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
00	DRG amounts other than outlier payments	1.00	0	0	C	0 0	0	1
01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 01	0	0	C		0	1
02	DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	6, 280, 766	0		6, 280, 766	6, 280, 766	1
03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	C		0	1
04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	
00	Outlier payments for discharges (see instructions)	2.00	17, 258	0	C) 17, 258	17, 258	2
01	Outlier payments for	2. 02	0	0	C	0 0	0	2
00	discharges for Model 4 BPCI Operating outlier reconciliation	2. 01	0	0	C	0	0	:
00	Managed care simulated payments	3.00	0	0	C	0 0	0	4
00	Indirect Medical Education Adju Amount from Worksheet E, Part	ustment 21.00	0. 000000	0. 000000	0.00000	0. 000000		
00	A, line 21 (see instructions) IME payment adjustment (see	21.00	0.000000	0.000000	0.00000	0.000000	0	
DU D1	instructions) IME payment adjustment for	22.00	0	0			0	
	managed care (see instructions)							
00	Indirect Medical Education Adju IME payment adjustment factor	ustment for the 27.00	e Add-on for Se 0.000000			0. 000000		-
00	(see instructions)	27.00	0.000000	0.000000	0.00000	0.000000	0	
	IME adjustment (see instructions)	28.00	0	0	(0	
)1	IME payment adjustment add on for managed care (see instructions)	28.01	0	0) 0	0	
00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	C	0 0	0	,
)1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	C	0 0	0	'
	Disproportionate Share Adjustme							
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 1200	0. 1200	0. 1200	0. 1200		1
00	Disproportionate share adjustment (see instructions)	34.00	188, 423	0	C	188, 423	188, 423	1
01	Uncompensated care payments	36.00	414, 427		253, 172	2 161, 255	414, 427	1
00	Additional payment for high per Total ESRD additional payment	46.00	0 October of a charge	di scharges 0	(0 0	0	1
00 00	(see instructions) Subtotal (see instructions) Hospital specific payments	47.00 48.00	6, 900, 874 0	0 0	253, 172 (2 6, 647, 702 0 0	6, 900, 874 0	1
	(completed by SCH and MDH, small rural hospitals only.) (see instructions)							
00	Total payment for inpatient operating costs (see instructions)	49.00	6, 900, 874	0				
00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	510, 548	0	C	510, 548	510, 548	10
00	Special add-on payments for new technologies	54.00	0	0	C	0 0	О	1
01 02	Net organ aquisition cost Credits received from manufacturers for replaced	68.00	0	0	c	0	0	1 [.] 1 [.]

Heal th	Financial Systems		WI THAM MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
LOW VO	LUME CALCULATION EXHIBIT 4			Provider C	F	Period: From 01/01/2017 Fo 12/31/2017	Worksheet E Part A Exhibi Date/Time Pre 5/22/2018 7:4	pared:
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01		
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	(0 0	0	18.00
10 00	SUBTOTAL			0	253, 172	7, 158, 250	7, 411, 422	10 00
19.00		W/S L, line	(Amounts from L)	0	233, 172	7, 130, 230	7,411,422	17.00
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier		509, 402	0			509, 402	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier		0	0	(0	0	
21.00	Capital DRG outlier payments	2.00	1, 146	0	(1, 146	1, 146	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		(0	0	
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	(0 0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	(0 0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	510, 548	0	(510, 548	510, 548	26.00
		W/S E, Part A						
		line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70. 96			0. 081250 20, 570		20, 570	27.00 28.00
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				651, 909	651, 909	29. 00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

	Financial Systems AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	WITHAM MEMORI TION EXHIBIT 5	Provider CC	CN: 15-0104	Peri od:	eu of Form CMS-2 Worksheet E	
					From 01/01/2017 To 12/31/2017	Part A Exhibi	pared:
				XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0		0	0	1. 01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6, 280, 766		6, 280, 766	6, 280, 766	1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0		0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	17, 258		0 17, 258	17, 258	2.00
2. 01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2. 01
3.00	Operating outlier reconciliation	2.01	0		0 0	0	3.00
4.00	Managed care simulated payments	3.00	0		0 0	0	4.00
5.00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21	21.00	0. 000000	0.0000	0. 000000		5.00
(00	(see instructions)	22.00			0		6.00
6. 00 6. 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see instructions)	22. 00 22. 01	0		0 0 0 0		6. 00 6. 01
	Indirect Medical Education Adjustment for the	Add-on for Se	ection 422 of t	he MMA			
7.00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.0000	0. 000000		7.00
8. 00 8. 01	<pre>IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)</pre>	28.00 28.01	0		0 0 0 0	0	8. 00 8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	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	0	9. 01
	Disproportionate Share Adjustment						
10. 00	Allowable disproportionate share percentage (see instructions)	33.00	0. 1200	0. 120	0. 1200		10.00
11.00	Di sproporti onate share adj ustment (see i nstructi ons)	34.00	188, 423		0 188, 423	188, 423	11.00
11.01	Uncompensated care payments	36.00	414, 427	253, 17	72 161, 255	414, 427	11.01
	Additional payment for high percentage of ESR					1	
12.00	Total ESRD additional payment (see instructions)	46.00	0		0 0		
13.00 14.00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	47.00 48.00	6, 900, 874 0	253, 17	72 6, 647, 702 0 0	6, 900, 874 0	13.00 14.00
15.00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	6, 900, 874	253, 17	6, 647, 702	6, 900, 874	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	510, 548		0 510, 548	510, 548	16.00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54.00	0		0 0	0	17. 00 17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	18.00
19.00	SUBTOTAL			253, 17	72 7, 158, 250	7, 411, 422	19.00

	Financial Systems	WI THAM MEMORI				eu of Form CMS-	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CO	CN: 15-0104	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Exhibi Date/Time Pre 5/22/2018 7:4	pared:
			Title	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	509, 402		0 509, 402	509, 402	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0 0	20.01
21.00	Capital DRG outlier payments	2.00	1, 146		0 1, 146	1, 146	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0 0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.000	0.000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.000	0.000)	24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0		0 0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	510, 548		0 510, 548	510, 548	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	20, 570	20, 5	70	20, 570	28.00
29.00	Low volume adjustment on or after October 1	70. 97	651, 909		651, 909	651, 909	29.00
30.00	HVBP payment adjustment (see instructions)	70. 93	11, 230		0 11, 230	11, 230	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 01
31. 00 31. 01	HRR adjustment (see instructions) HRR adjustment for HSP bonus payment (see instructions)	70. 94 70. 91	-6, 003 0		0 -6, 003 0 0	-6, 003 0 0	31.00 31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCUI	Financial Systems WITHAM MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT	HOSPITAL Provider CCN: 15-0104	Period:	u of Form CMS-2 Worksheet E	2552-10
UNE OUL			From 01/01/2017 To 12/31/2017	Part B Date/Time Pre 5/22/2018 7:4	
		Title XVIII	Hospi tal	PPS	9 80
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)	+:>		3, 138	
2.00 3.00	Medical and other services reimbursed under OPPS (see instruc OPPS payments	tions)		8, 511, 567 9, 248, 237	
4.00	Outlier payment (see instructions)			30, 777	
4.01	Outlier reconciliation amount (see instructions)			0	
5.00 6.00	Enter the hospital specific payment to cost ratio (see instru Line 2 times line 5	ctions)		0.000	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	
11.00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			-	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES			-1	
40.00	Reasonabl e charges			00.040	1 1 0 00
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		33, 849	
	Total reasonable charges (sum of lines 12 and 13)			-	14.00
	Customary charges				
15. 00 16. 00	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable fo			0	15.00 16.00
10.00	had such payment been made in accordance with 42 CFR §413.13(on a chargebasis	0	10.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
	Total customary charges (see instructions)	ly if line 10 evenede li	no. 11) (coo		18.00
19.00	Excess of customary charges over reasonable cost (complete on instructions)	i y i f i i ne 18 exceeds i i	ne II) (see	30, 711	19.00
20.00	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds li	ne 18) (see	0	20.00
01 00	instructions)			2 120	21 00
21.00 22.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			3, 138	21.00 22.00
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	1
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			9, 279, 014	24.00
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions)			0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (fo	r CAH, see instructions)	1, 812, 348	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			7, 469, 804	27.00
28.00	instructions) Direct graduate medical education payments (from Wkst. E-4, I	ino 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	The SO)		0	
	Subtotal (sum of lines 27 through 29)			7, 469, 804	
31.00	Primary payer payments			520	
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	(CES)		7, 469, 284	32.00
33.00	Composite rate ESRD (from Wkst. 1-5, line 11)			0	33.00
	Allowable bad debts (see instructions)			130, 556	
35.00 36.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		84, 861 122, 020	
37.00	Subtotal (see instructions)			7, 554, 145	
	MSP-LCC reconciliation amount from PS&R			-5	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instruction	s)			39.50
	Demonstration payment adjustment amount before sequestration			0	
39. 98 39. 99	Partial or full credits received from manufacturers for repla RECOVERY OF ACCELERATED DEPRECIATION	ceu devices (see instruc		0	
40.00	Subtotal (see instructions)			7, 554, 150	
40. 01	Sequestration adjustment (see instructions)			151, 083	
	Demonstration payment adjustment amount after sequestration			0	
41.00 42.00	Interim payments Tentative settlement (for contractors use only)			7, 322, 693	
42.00 43.00	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)			0 80, 374	
44.00	Protested amounts (nonallowable cost report items) in accorda	nce 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
	Outlier reconciliation adjustment amount (see instructions)			0	1
	The rate used to calculate the Time Value of Money			0.00	92.00
92.00 93.00	Time Value of Money (see instructions)			0	93.00

LCUL	Financial Systems ATION OF REIMBURSEMENT SETTLEMENT		HOSPITAL Provider CCN: 15-0104	Period: From 01/01/2017	u of Form CMS-2 Worksheet E Part B	
			Component CCN: 15-S104	To 12/31/2017	Date/Time Pre	
			Title XVIII	Subprovider -	5/22/2018 7:4 PPS	9 811
				I PF		
	PART B - MEDICAL AND OTHER HEALTH SERVICES				1.00	-
00	Medical and other services (see instructions)				1, 660	
00	Medical and other services reimbursed under 0	PPS (see instruc	ctions)		563	
00 00	OPPS payments Outlier payment (see instructions)				875 0	
01	Outlier reconciliation amount (see instructio	ns)			0	
00	Enter the hospital specific payment to cost r	atio (see instru	uctions)		0.000	
00	Line 2 times line 5	1			0	
00 00	Sum of lines 3, 4, and 4.01, divided by line Transitional corridor payment (see instructio				0.00	
00	Ancillary service other pass through costs fr		IV, col. 13, line 200		0	
. 00	Organ acqui si ti ons				0	10.0
. 00	Total cost (sum of lines 1 and 10) (see instr	uctions)			1, 660	11. C
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges					-
. 00	Ancillary service charges				14, 823	12. C
. 00	Organ acquisition charges (from Wkst. D-4, Pt		ine 69)		0	13.0
. 00	Total reasonable charges (sum of lines 12 and Customary charges	13)			14, 823	14. C
. 00	Aggregate amount actually collected from pati	ents liable for	payment for services on	a charge basis	0	1 15. C
. 00	Amounts that would have been realized from pa				0	16. C
~~	had such payment been made in accordance with		(e)		0,000000	47.0
. 00 . 00	Ratio of line 15 to line 16 (not to exceed 1. Total customary charges (see instructions)	000000)			0. 000000 14, 823	
. 00	Excess of customary charges over reasonable c	ost (complete or	nlyifline 18 exceeds li	ne 11) (see	13, 163	
	instructions)		5	, ,		
. 00	Excess of reasonable cost over customary char	ges (complete or	nly if line 11 exceeds li	ne 18) (see	0	20.0
. 00	instructions) Lesser of cost or charges (see instructions)				1, 660	21.0
. 00	Interns and residents (see instructions)				0	
. 00	Cost of physicians' services in a teaching ho		ructions)		0	
. 00	Total prospective payment (sum of lines 3, 4, COMPUTATION OF REIMBURSEMENT SETTLEMENT	4.01, 8 and 9)			875	24. C
. 00	Deductibles and coinsurance (for CAH, see ins	tructions)			0	25.0
. 00	Deductibles and Coinsurance relating to amoun	t on line 24 (fo			0	
. 00	Subtotal [(lines 21 and 24 minus the sum of l	ines 25 and 26)	plus the sum of lines 22	and 23] (see	2, 535	27.0
. 00	instructions) Direct graduate medical education payments (f	rom Wkst. E-4. I	ine 50)		0	28.0
. 00	ESRD direct medical education costs (from Wks				0	
. 00	Subtotal (sum of lines 27 through 29)				2, 535	
. 00 . 00	Primary payer payments				0	31.0
. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PR	OFESSI ONAL SERVI	CES)		2, 535	32.0
. 00	Composite rate ESRD (from Wkst. I-5, line 11)		/		0	33. 0
. 00	Allowable bad debts (see instructions)				0	
. 00 . 00	Adjusted reimbursable bad debts (see instruct Allowable bad debts for dual eligible benefic		ructions)		0	35. 0 36. 0
. 00	Subtotal (see instructions)				2, 535	
. 00	MSP-LCC reconciliation amount from PS&R				0	38. (
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY				0	
. 50 . 97	Pioneer ACO demonstration payment adjustment		is)		0	39.5
. 97 . 98	Demonstration payment adjustment amount befor Partial or full credits received from manufac	•	aced devices (see instruc	tions)	0	
. 99	RECOVERY OF ACCELERATED DEPRECIATION				0	39.9
. 00	Subtotal (see instructions)				2, 535	
. 01	Sequestration adjustment (see instructions)	ooguootroti on			51	40.0
. 02 . 00	Demonstration payment adjustment amount after Interim payments	sequestiation			0 3, 762	
. 00	Tentative settlement (for contractors use onl	y)			0	
. 00	Balance due provider/program (see instruction	s)			-1, 278	
. 00	Protested amounts (nonallowable cost report i	tems) in accorda	ance with CMS Pub. 15-2,	chapter 1,	0	44.0
	§115.2 TO BE COMPLETED BY CONTRACTOR					1
. 00	Original outlier amount (see instructions)				0	90.0
. 00	Outlier reconciliation adjustment amount (se				0	
. 00	The rate used to calculate the Time Value of Time Value of Money (see instructions)	Money				92.0
. 00	LINE VALUE OF MODEV (SEE INSTRUCTIONS)				0	93. C

lth Financi LCULATION O	REIMBURSEMENT SETTLEMENT	WI THAM MEMORI	Provi der CCN: 15-0104	Peri od:	u of Form CMS-2 Worksheet E	2002-1
			Component CCN: 15-5832	From 01/01/2017 To 12/31/2017	Part B Date/Time Pre	
			Title XVIII	Skilled Nursing	5/22/2018 7:4 PPS	9 am
				Facility		
DADT B	- MEDICAL AND OTHER HEALTH SERVIC	Ϋ́Fς			1.00	
	and other services (see instruct				295	1.0
	and other services reimbursed ur	nder OPPS (see instr	ructions)		0	2.0
	yments payment (see instructions)					3.0
	reconciliation amount (see instr	ructions)				4.0
	he hospital specific payment to o	cost ratio (see inst	ructions)			5. C
	times line 5 lines 3, 4, and 4.01, divided by	line 6			0 0.00	6. C
	ional corridor payment (see instr				0.00	
	ry service other pass through cos		. IV, col. 13, line 200		0	9.0
0	icqui si ti ons				0	10.0
	ost (sum of lines 1 and 10) (see TION OF LESSER OF COST OR CHARGES				295	11.0
	ble charges	<u>, </u>				1
	iry service charges				2, 631	1
	icquisition charges (from Wkst. D-		line 69)		0	13.0
	<u>easonable charges (sum of lines ´</u> ry charges	12 anu 13)			2, 631	14. C
	te amount actually collected from	n patients liable fo	or payment for services on	a charge basis	0	15.0
	that would have been realized fr		1 5	n a chargebasis	0	16.0
	h payment been made in accordance of line 15 to line 16 (not to exce		3(e)		0.000000	17.0
	sustomary charges (see instruction				2, 631	
00 Excess	of customary charges over reasona	· ·	only if line 18 exceeds li	ne 11) (see	2, 336	
i nstru	· ·		and with the second of the	10) (0	000
00 Excess instru	of reasonable cost over customary	/ cnarges (complete	only if line ii exceeds ii	ne 18) (see	0	20.0
	of cost or charges (see instructi	ons)			295	21.0
	and residents (see instructions)				0	
	physicians' services in a teachi				0	
	prospective payment (sum of lines TION OF REIMBURSEMENT SETTLEMENT	3, 4, 4.01, 8 200 9	,,		0	24.0
	bles and coinsurance (for CAH, se	ee instructions)			0	25.0
	bles and Coinsurance relating to				0.05	26.0
00 Subtota instru	II [(lines 21 and 24 minus the sum tions)	n of lines 25 and 26	b) plus the sum of lines 22	and 23] (see	295	27.0
	graduate medical education paymer	nts (from Wkst. E-4,	line 50)		0	28.0
	rect medical education costs (fro	om Wkst. E-4, line 3	36)		0	
	I (sum of lines 27 through 29)				295 0	
	v payer payments I (line 30 minus line 31)				295	
ALLOWAE	LE BAD DEBTS (EXCLUDE BAD DEBTS F		VI CES)			1
00 Compos	te rate ESRD (from Wkst. I-5, lir				0	
	le bad debts (see instructions) ed reimbursable bad debts (see ins	structions)			0	
	ble bad debts for dual eligible be		nstructions)		0	36.0
	I (see instructions)				295	37.0
	reconciliation amount from PS&R					38.0
	DJUSTMENTS (SEE INSTRUCTIONS) (SF · ACO demonstration payment adjust	· · · · · · · · · · · · · · · · · · ·	ons)		0	39. (39. 5
	ration payment adjustment amount				0	
1	or full credits received from ma			tions)	0	
	RY OF ACCELERATED DEPRECIATION				0	
	l (see instructions) ration adjustment (see instructio	nc)			295	40.0
	ration payment adjustment amount		1		0	
	payments				516	41.0
	ve settlement (for contractors us	J ,			0	
	e due provider/program (see instru red amounts (nonallowable cost rep		dance with CMS Dub 15 0	chanter 1	-227	
§115. 2		Join Thems, The accor	dance with two Pub. 13-2,	chapter I,	0	44.0
	OMPLETED BY CONTRACTOR					1
· · · ·	I outlier amount (see instruction	· ·	、			90.0
00 Outlie	reconciliation adjustment amount re used to calculate the Time Valu	•	5)			91. C
		Le UI WUHEY				
00 The ra	lue of Money (see instructions)	5				93.0

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO		Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part I Date/Time Prep 5/22/2018 7:49	
		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	tВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00 3.00	Total interim payments paid to provider 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, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		6, 843, 63	7 0	7, 322, 693 0	1.00 2.00 3.00
0.00	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					0.00
3.01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.02				0	0	3.02
3.03 3.04				0	0	3.03 3.04
3.05				0	0	3.05
	Provider to Program	1		1		
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51 3.52				0	0	3.5 ² 3.52
3.53				0	0	3. 53
3.54				0	0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		6, 843, 63	7	7, 322, 693	4.00
5.00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.00
5.00	desk review. Al so show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.00
5.01	TENTATI VE TO PROVIDER			0	0	5. 01
5.02				0	0	5. 02
5.03				0	0	5.03
E E0	Provider to Program TENTATIVE TO PROGRAM			0	0	E E 7
5.50 5.51	I ENTATIVE TU PRUGRAM			0	0	5.50 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 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		261, 89		80, 374 0	6.0
6.02 7.00	Total Medicare program liability (see instructions)		7, 105, 53	0	0 7, 403, 067	6.02 7.00
			,, 100, 00	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	

ALYS	IS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	CN: 15-0104 CCN: 15-S104	Period: From 01/01/2017 To 12/31/2017		
		Title	e XVIII	Subprovider -	PPS	<u>, an</u>
		I npati en	it Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider 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, write "NONE" or enter a zero		2, 172, 7	51 0	3, 762 0	1. (2. (
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			0	0	3.
02				0	0	3.
03				0	0	3.
04				0	0	3.
05				0	0	3.
50	Provider to Program ADJUSTMENTS TO PROGRAM		1	0	0	2
50 51	ADJUSTMENTS TU PRUGRAM			0	0	3
52				0	0	3
52 53				0	0	3
54 54				0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3
	3. 50-3. 98)			0	Ŭ	0
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)		2, 172, 7	51	3, 762	4
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider				1	
)1	TENTATI VE TO PROVI DER			0	0	5
)2				0	0	5
)3				0	0	5
	Provider to Program		1		-	-
0	TENTATIVE TO PROGRAM			0	0	5
51 52				0	0	5 5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
7	5. 50-5. 98)					5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER			8	0	6
)2	SETTLEMENT TO PROGRAM			0	1, 278	6
00	Total Medicare program liability (see instructions)		2, 172, 7		2, 484	7
				Contractor	NPR Date	
			-	Number	(Mo/Day/Yr)	
	Name of Contractor	(C	1.00	2.00	8

IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-0104 CCN: 15-5832	Period: From 01/01/201 To 12/31/201		
			× XVIII	Skilled Nursin	<u>5/22/2018 7:49</u> a PPS	9 am
				Facility	-	
		I npati en	it Part A	Pa	nrt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider 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, write "NONE" or enter a zero		1, 421, 9	40 0	516 0	1. 2.
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.
D1	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3.
)3				0	0	3
)4)5				0	0	3
5	Provider to Program			0	0	
0	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	3
52				0	0	
53				0	0	3
54 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3
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)		1, 421, 9	40	516	4
	TO BE COMPLETED BY CONTRACTOR			-		
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
)1	Program to Provider TENTATIVE TO PROVIDER		1	0	0	5
)2	TENTATIVE TO PROVIDER			0	0	
)3				0	0	
	Provider to Program					
0	TENTATI VE TO PROGRAM			0	0	
1				0	0	5
2	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
0	5. 50-5. 98) Determined net settlement amount (balance due) based on			0	0	6
)1	the cost report. (1) SETTLEMENT TO PROVIDER			0	0	6
)2	SETTLEMENT TO PROVIDER			0	227	6
00	Total Medicare program liability (see instructions)		1, 421, 9	-	289	
				Contractor	NPR Date	
				<u>Number</u> 1.00	(Mo/Day/Yr) 2.00	

Heal th	Financial Systems WITHAM MEMO	RIAL HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0104	Peri od: From 01/01/2017 To 12/31/2017	Date/Time Pre 5/22/2018 7:4	epared:
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORT	-			
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULA				
1.00					1.00
2.00	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2.00
3.00	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. Line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines	1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 20	0			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col.	3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase line 168	of certified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instruction	s)			8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestrat	ion (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 a	nd line 31) (see instruction	ns)		32.00

	Financial Systems WITHAM MEMORIAL TION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Peri od:	u of Form CMS-2 Worksheet E-3	
ALCULA	II UN UF REI WIDURSEWENT SETTLEWENT	Component CCN: 15-S104	From 01/01/2017 To 12/31/2017	Part II Date/Time Pre	
				5/22/2018 7:4	
		Title XVIII	Subprovider -	PPS	
			-	1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS				
	Net Federal IPF PPS Payments (excluding outlier, ECT, and med	lical education payments)		2, 386, 192	1.0
	Net LPE PPS Outlier Payments			19, 615 0	2. (3. (
	Net IPF PPS ECT Payments Jnweighted intern and resident FTE count in the most recent c	ost report filed on or b	efore November	0.00	4. (
	15, 2004. (see instructions)			0.00	
	Cap increases for the unweighted intern and resident FTE cour	t for residents that wer	e displaced by	0.00	4.0
F	program or hospital closure, that would not be counted withou	it a temporary cap adjust	ment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
	New Teaching program adjustment. (see instructions)			0.00	5.0
	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	eriod of a "new	0.00	6. (
	teaching program" (see instuctions) Current year's unweighted I&R FTE count for residents within	the new program growth p	oriod of a "now	0.00	7.(
	teaching program" (see instuctions)	the new program growth p		0.00	/.
	Intern and resident count for IPF PPS medical education adjust	tment (see instructions)		0.00	8.
	Average Daily Census (see instructions)			7.917808	
. 00 T	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to	the power of .5150 -1}.		0.00000	10.
. 00 T	Teaching Adjustment (line 1 multiplied by line 10).			0	11.0
	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			2, 405, 807	
1	Nursing and Allied Health Managed Care payment (see instructi	on)		0	
	Organ acquisition (DO NOT USE THIS LINE)				14.
	Cost of physicians' services in a teaching hospital (see inst Subtotal (see instructions)	ructions)		2 405 907	
	Subtotal (see instructions) Primary payer payments			2, 405, 807 0	16. 17.
	Subtotal (line 16 less line 17).			2, 405, 807	
	Deducti bl es			153, 832	
	Subtotal (line 18 minus line 19)			2, 251, 975	
. 00 0	Coinsurance			34, 874	21.0
. 00 5	Subtotal (line 20 minus line 21)			2, 217, 101	22.
. 00 A	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		0	23. (
	Adjusted reimbursable bad debts (see instructions)			0	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
	Subtotal (sum of lines 22 and 24)	i (0)		2, 217, 101	
	Direct graduate medical education payments (from Wkst. E-4, I	The 49)		0	
	Other pass through costs (see instructions) Dutlier payments reconciliation			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	
	Demonstration payment adjustment amount before sequestration			0	
. 00 T	Total amount payable to the provider (see instructions)			2, 217, 101	31.0
	Sequestration adjustment (see instructions)			44, 342	31.0
	Demonstration payment adjustment amount after sequestration			0	
	Interim payments			2, 172, 751	
	Tentative settlement (for contractor use only)	2 22 and 22)		0	
	Balance due provider/program (line 31 minus lines 31.01, 31.0 Protostod amounts (nonallowable cost report items) in accorda		chaptor 1	8 0	
	Protested amounts (nonallowable cost report items) in accorda §115.2	INCE WITH CMS PUD. 15-2,	chapter I,	0	35.1
	O BE COMPLETED BY CONTRACTOR				1
	Driginal outlier amount from Worksheet E-3, Part II, line 2			19, 615	50.0
	Dutlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	52. (
	Time Value of Money (see instructions)			0	53.0

	Financial Systems WITHAM MEMORIA			u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104 Component CCN: 15-5832	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VI Date/Time Pre 5/22/2018 7:4	pared:
		Title XVIII	Skilled Nursing Facility	PPS	<u>/ un</u>
			iddiffity		
				1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OT SERVICES	THER HEALTH SERVICES FOR T	ITLE XVIII PART A	PPS SNF	
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				1
1.00	Resource Utilization Group Payment (RUGS)			1, 625, 000	1.00
2.00	Routi ne service other pass through costs			1, 023, 000	2.00
3.00	Ancillary service other pass through costs			0	3.00
4.00	Subtotal (sum of lines 1 through 3)			1, 625, 000	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES			.,	
5.00	Medical and other services (Do not use this line as vaccine	costs are included in lin	e 1 of W/S E,		5.00
	Part B. This line is now shaded.)				
6.00	Deducti bl e			0	6.00
7.00	Coinsurance			174, 041	7.00
8.00	Allowable bad debts (see instructions)			0	
9.00	Reimbursable bad debts for dual eligible beneficiaries (see	instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)			0	10.00
11.00	Utilization review			0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines	10 and 11)(see instructio	ns)	1, 450, 959	
13.00	Inpatient primary payer payments			0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	>		0	14.00 14.50
14.50 14.99	Demonstration payment adjustment amount before sequestration			0	14.50
14.99	Subtotal (see instructions	I		1, 450, 959	
15.00	Sequestration adjustment (see instructions)			29,019	
15.02	Demonstration payment adjustment amount after sequestration			29,019	
16.00	Interim payments			1, 421, 940	
	Tentative settlement (for contractor use only)			1, 421, 740	
	Balance due provider/program (line 15 minus lines 15.01, 15.	02, 16, and 17)		0	
	Protested amounts (nonallowable cost report items) in accord §115.2		2, chapter 1,	0	

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Peri od:	Worksheet E-3	2552-10
			From 01/01/2017 To 12/31/2017	Part VII Date/Time Pre 5/22/2018 7:4	pared:
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR X	IX SERVICES		-
1 00	COMPUTATION OF NET COST OF COVERED SERVICES		2(4.1(0		1 1 00
1.00 2.00	Inpatient hospital/SNF/NF services Medical and other services		364, 160	0	1.00 2.00
2.00	Organ acquisition (certified transplant centers only)		0	0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		364, 160	0	•
5.00	Inpatient primary payer payments		0	Ũ	5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		364, 160	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routine service charges		557, 693		8.00
9.00	Ancillary service charges		571, 063	0	
10. 00 11. 00	Organ acquisition charges, net of revenue		0		10.00
12.00	Incentive from target amount computation Total reasonable charges (sum of lines 8 through 11)		1, 128, 756	0	12.00
12.00	CUSTOMARY CHARGES		1, 120, 730	0	12.00
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
14.00	basis Amounts that would have been realized from patients liable for	navment for services o	n O	0	14.00
14.00	a charge basis had such payment been made in accordance with 42		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15.00
16.00	Total customary charges (see instructions)		1, 128, 756	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only	ifline 16 exceeds	764, 596	0	17.00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds lin	e 0	0	18.00
19.00	16) (see instructions) Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instru	ctions)	0	0	
20.00	Cost of covered services (enter the lesser of line 4 or line 16		364, 160	0	
21100	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be c				200
22.00	Other than outlier payments	I I	0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		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	
27.00	Subtotal (sum of lines 22 through 26) 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)		364, 160	0	
29.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		304, 100	0	29.00
30.00	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)		364, 160	0	
32.00	Deductibles		0	0	32.00
33.00	Coinsurance		0	0	
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)	364, 160	0	
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	•
38.00	Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst. E-4)		364, 160	0	
39.00 40.00	Total amount payable to the provider (sum of lines 38 and 39)		364, 160	0	39.00 40.00
40.00	Interim payments		422, 742	0	
	Balance due provider/program (line 40 minus line 41)		-58, 582	0	1
42,00					
42.00 43.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	0	0	43.00

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet G Date/Time Pre 5/22/2018 7:4	pare 9 am
		General Fund	Specific Purpose Fund		Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	32, 894, 828		0 0	0	1.
00	Temporary investments	12, 850, 225		0 0	0	2.
00	Notes receivable	0		0 0	0	
00	Accounts receivable	18, 403, 667		0 0	0	
00	Other receivable	1, 596, 574		0 0	0	
00	Allowances for uncollectible notes and accounts receivable			0 0	0	6.
00 00	Inventory Prepaid expenses	2, 868, 389		0 0	0	7.
00	Other current assets	1, 506, 174		0 0	0	9
0.00	Due from other funds	1, 300, 174		0 0	0	10
. 00	Total current assets (sum of lines 1-10)	70, 119, 857		0 0	0	
	FI XED ASSETS	, 6, 11, , 66,				1
2. 00	Land	0		0 0	0	1 12
8. 00	Land improvements	15, 678, 825		0 0	0	13
. 00	Accumulated depreciation	0		0 0	0	14
5.00	Bui I di ngs	6, 268, 350		0 0	0	15
. 00	Accumulated depreciation	0		0 0	0	16
. 00	Leasehold improvements	0		0 0	0	17
3.00	Accumulated depreciation	0		0 0	0	18
	Fixed equipment	0		0 0	0	19
	Accumulated depreciation	0		0 0	0	20
	Automobiles and trucks			0 0 0 0	0	21
	Accumulated depreciation Major movable equipment	144, 692, 000		0 0	0	23
	Accumulated depreciation	-73, 152, 924		0 0	0	24
	Minor equipment depreciable	0, 102, 721		0 0	0	25
	Accumulated depreciation	0		0 0	0	26
	HIT designated Assets	0		0 0	0	27
	Accumulated depreciation	0		0 0	0	28
. 00	Mi nor equi pment-nondepreci abl e	0		0 0	0	29
0. 00	Total fixed assets (sum of lines 12-29)	93, 486, 251		0 0	0	30
	OTHER ASSETS					
	Investments	0		0 0	0	31
2.00	Deposits on Leases	0		0 0	0	32
8.00	Due from owners/officers	0		0 0	0	33
. 00	Other assets	20, 653, 218		0 0	0	34
	Total other assets (sum of lines 31-34)	20, 653, 218		0 0	0	35
o. 00	Total assets (sum of lines 11, 30, and 35)	184, 259, 326		0 0	0	36
00	CURRENT LI ABI LI TI ES Accounts payable	1, 936, 468		0 0	0	37
	Salaries, wages, and fees payable	8, 763, 128		0 0	0	38
9.00	Payroll taxes payable	0,703,120		0 0	0	
. 00	Notes and Loans payable (short term)	0		0 0	0	
	Deferred income	0		0 0	0	
	Accelerated payments	0				42
8. 00	Due to other funds	0		0 0	0	43
. 00	Other current liabilities	4, 224, 158		0 0	0	44
5.00	Total current liabilities (sum of lines 37 thru 44)	14, 923, 754		0 0	0	45
	LONG TERM LIABILITIES					
	Mortgage payable	0		0 0	0	
. 00	Notes payable	0		0 0	0	47
8.00	Unsecured Loans			0 0	0	
	Other long term liabilities	50, 060, 347		0 0 0 0	0	
	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	50, 060, 347 64, 984, 101		0 0 0 0	0	
. 00	CAPITAL ACCOUNTS	04, 964, 101		0 0	0	1 31
. 00	General fund balance	119, 275, 225				52
. 00	Specific purpose fund	117, 275, 225		0		53
. 00	Donor created - endowment fund balance - restricted			0		54
5.00	Donor created - endowment fund balance - unrestricted			0		55
. 00	Governing body created - endowment fund balance			0		56
. 00	Plant fund balance - invested in plant				0	
8.00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion					
). 00). 00	Total fund balances (sum of lines 52 thru 58)	119, 275, 225		0 0	0	
	Total liabilities and fund balances (sum of lines 51 and	184, 259, 326	1	0 0	0	60

Heal th	Financial Systems	WI THAM MEMORI A	L HOSPITAL			In Lie	eu of Form CMS	-25	52-10
STATEMENT OF CHANGES IN FUND BALANCES			Provider CC	CN: 15-0104		eriod: com 01/01/2017	Worksheet G-	1 epa	ared:
		General	Fund	Speci al	Pur	pose Fund	Endowment Fun	d	
								+	
1.00	Fund balances at beginning of period	1.00	2.00 108,873,993	3.00		4.00	5.00	_	1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)		10, 401, 232 119, 275, 225 0 119, 275, 225			0		0 · 0 · 0 ·	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 15. 00 16. 00
17.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	0 119, 275, 225		0	0 0		0	17.00 17.00 18.00 19.00
		Endowment Fund	PI ant	Fund			1		
		6.00	7.00	8.00					
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	000000000000000000000000000000000000000		0				1.00 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 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 0		0 0 0				10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

STATEN	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	N: 15-0104		iod: m 01/01/2017 12/31/2017	Worksheet G-2 Parts I & II Date/Time Pre 5/22/2018 7:4	pared:
	Cost Center Description		Inpati ent		Outpati ent	Total	
			1.00		2.00	3.00	
	PART I – PATIENT REVENUES						
	General Inpatient Routine Services						
1.00	Hospi tal		15, 439, 4	97		15, 439, 497	1.00
2.00	SUBPROVIDER - IPF		3, 329, 4	97		3, 329, 497	2.00
3.00	SUBPROVIDER - IRF			0		0	3.00
4.00	SUBPROVI DER			0		0	4.00
5.00	Swing bed - SNF			0		0	5.00
6.00	Swing bed - NF			0		0	6.00
7.00	SKILLED NURSING FACILITY		2, 768, 5	78		2, 768, 578	7.00
8.00	NURSING FACILITY						8.00
9.00	OTHER LONG TERM CARE						9.00
10.00	Total general inpatient care services (sum of lines 1-9)		21, 537, 5	72		21, 537, 572	10.00
	Intensive Care Type Inpatient Hospital Services						1
11.00	INTENSIVE CARE UNIT		4, 131, 7	90		4, 131, 790	11.00
12.00	CORONARY CARE UNI T						12.00
13.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGICAL INTENSIVE CARE UNIT						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (sum of	Lines	4, 131, 7	90		4, 131, 790	
	11-15)		.,			.,,	
17.00	Total inpatient routine care services (sum of lines 10 and 16)		25, 669, 3	62		25, 669, 362	17.00
18.00	Ancillary services		50, 040, 5		203, 238, 914	253, 279, 461	18.00
19.00	Outpatient services		3, 776, 7		34, 287, 745	38, 064, 468	
20.00	RURAL HEALTH CLINIC			0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	21.00
22.00	HOME HEALTH AGENCY			-	-	-	22.00
23.00	AMBULANCE SERVICES		29, 9	02	3, 496, 306	3, 526, 208	
24.00	CMHC		,.		-,,	-,,	24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.00
26.00	HOSPICE						26.00
27.00	EH&S, DIETARY, PHYSICIAN PRIVATE OFF		2,8	08	49, 563, 946	49, 566, 754	
27.01	PROFESSIONAL FEE		153, 8		2, 312, 767	2, 466, 653	
27.02	SELF-INSURED		739, 5		6, 207, 664	6, 947, 172	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	80, 412, 7		299, 107, 342	379, 520, 078	
	G-3, line 1)				,		
	PART II - OPERATING EXPENSES						1
29.00	Operating expenses (per Wkst. A, column 3, line 200)				124, 251, 925		29.00
30.00	ADD (SPECIFY)			0			30.00
31.00				0			31.00
32.00				0			32.00
33.00				0			33.00
34.00				0			34.00
35.00				0			35.00
36.00	Total additions (sum of lines 30-35)				0		36.00
37.00	DEDUCT (SPECI FY)			0	J. J		37.00
38.00				0			38.00
39.00				0			39.00
40.00				Ö			40.00
41.00				0			41.00
42.00	Total deductions (sum of lines 37-41)			Ĩ	0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer			124, 251, 925		43.00
	to Wkst. G-3, line 4)	.,			121,201,720		1 10.00

Heal th	Financial Systems	WITHAM MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATEM	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-0104		Worksheet G-3	
				From 01/01/2017 To 12/31/2017	Date/Time Pre	arod
				10 12/31/2017	5/22/2018 7:4	
					1.00	
1.00	Total patient revenues (from Wkst. G-2, Part				379, 520, 078	1.00
2.00	Less contractual allowances and discounts on	patients' account	ts		253, 240, 742	2.00
3.00	Net patient revenues (line 1 minus line 2)				126, 279, 336	3.00
4.00	Less total operating expenses (from Wkst. G-2		13)		124, 251, 925	4.00
5.00	Net income from service to patients (line 3 m	inus line 4)			2, 027, 411	5.00
	OTHER I NCOME					
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				0	7.00
8.00	Revenues from telephone and other miscellaneo	us communication	servi ces		0	8.00
9.00	Revenue from television and radio service				0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00 13.00	Parking lot receipts				0	12.00 13.00
13.00	Revenue from Laundry and Linen service	+			0	13.00
14.00	Revenue from meals sold to employees and gues Revenue from rental of living quarters	15			0	14.00 15.00
16.00	Revenue from sale of medical and surgical sup	plice to other th	an nationts		0	16.00
17.00	Revenue from sale of drugs to other than pati				0	17.00
18.00	Revenue from sale of medical records and abst				0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, e				0	19.00
20.00	Revenue from gifts, flowers, coffee shops, an				0	20.00
20.00	Rental of vending machines	u canteen			0	20.00
22.00	Rental of hospital space				0	22.00
23.00	Governmental appropriations				0	23.00
24.00	OTHER OPERATING INCOME				3, 201, 353	
24.01	NON-OPERATING INCOME				5, 172, 468	
25.00	Total other income (sum of lines 6-24)				8, 373, 821	25.00
26.00	Total (line 5 plus line 25)				10, 401, 232	26.00
27.00	OTHER EXPENSES (SPECIFY)				0	27.00
28.00	Total other expenses (sum of line 27 and subs	cripts)			0	28.00
	Net income (or loss) for the period (line 26				10, 401, 232	

ALCULATION OF CAPITAL PAYMENT	From 01/01/2017 Pa To 12/31/2017 Da	orksheet L arts I-III ate/Time Prep	
		22/2018 7:49/ PPS	9 am
	Title XVIII Hospital	PPS	
		1.00	
PART I - FULLY PROSPECTIVE METHOD			
CAPITAL FEDERAL AMOUNT			
00 Capital DRG other than outlier		509, 402	1.
01 Model 4 BPCI Capital DRG other than outlier		0	1.
00 Capital DRG outlier payments		1, 146	2.
01 Model 4 BPCI Capital DRG outlier payments		0	2.
00 Total inpatient days divided by number of days i	in the cost reporting period (see instructions)	19.64	3.
00 Number of interns & residents (see instructions))	0.00	4.
00 Indirect medical education percentage (see instr		0.00	5.
1.01) (see instructions)	line 5 by the sum of lines 1 and 1.01, columns 1 and	0	6.
30) (see instructions)	icare Part A patient days (Worksheet E, part A line	0.00	7
00 Percentage of Medicaid patient days to total day	ys (see instructions)	0.00	
00 Sum of lines 7 and 8		0.00	
.00 Allowable disproportionate share percentage (see		0.00	
.00 Disproportionate share adjustment (see instructi		0	
.00 Total prospective capital payments (see instruct	tions)	510, 548	12.
		1.00	
PART II – PAYMENT UNDER REASONABLE COST		1.00	
00 Program inpatient routine capital cost (see inst	tructions)	0	1
00 Program inpatient ancillary capital cost (see inst		0	2
00 Total inpatient program capital cost (line 1 plu		0	3
00 Capital cost payment factor (see instructions)	0	4	
00 Total inpatient program capital cost (line 3 x l	line 4)	0	5
			5
		1.00	
PART III - COMPUTATION OF EXCEPTION PAYMENTS	20)		-
00 Program inpatient capital costs (see instruction		0	1
00 Program inpatient capital costs for extraordinar 00 Net program inpatient capital costs (line 1 minu		0	2
00 Net program inpatient capital costs (line 1 minutes) 00 Applicable exception percentage (see instruction)		0.00	4
00 Capital cost for comparison to payments (line 3	,	0.00	4 5
00 Percentage adjustment for extraordinary circumst		0.00	56
00 Adjustment to capital minimum payment level for		0.00	7
00 Capital minimum payment level (line 5 plus line	3	0	8
00 Current year capital payments (from Part I, line		0	9
	ent level to capital payments (line 8 less line 9)	0	10.
.00 Carryover of accumulated capital minimum payment Worksheet L, Part III, line 14)		0	11.
.00 Net comparison of capital minimum payment level	to capital payments (line 10 plus line 11)	0	12.
.00 Current year exception payment (if line 12 is po		0	13.
	t level over capital payment for the following period	0	
(if line 12 is negative, enter the amount on thi		Ű	
i	,	0	15.
5.00 Current year allowable operating and capital pay			
.00 Current year allowable operating and capital pay .00 Current year operating and capital costs (see in		0	16