WITHAM MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 05-31-2019 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0104 Worksheet S Peri od. From 01/01/2018 Parts I-III AND SETTLEMENT SUMMARY 12/31/2018 Date/Time Prepared: То 5/24/2019 2:03 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically filed cost report Date: 5/24/2019 Time: 2:03 pm use only Manually submitted cost report 2 []If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. 3 Ο Ē 4

 [1] Cost Report Status
 6. Date Received:

 (1) As Submitted
 7. Contractor No.

 (2) Settled without Audit
 8. [N] Initial Report for this Provider CCN

 (3) Settled with Audit
 9. [N] Final Report for this Provider CCN

 Contractor 5. use only Δ (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OF FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL. CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WITHAM MEMORIAL HOSPITAL (15-0104) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature. (Si aned) Officer or Administrator of Provider(s) Title Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	49, 616	185, 560	0	-308, 229	1.00
2.00	Subprovider - IPF	0	2, 836	-629		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	5, 593	-573		0	7.00
200.00	Total	0	58, 045	184, 358	0	-308, 229	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 AL AND HOSPITAL HEALTH CARE COMPLEX		MEMORIAL H	Provi der		5-0104	Peri od:		u of For Workshe		
							From 01/01, To 12/31,				
	1.00	2	00	3	. 00			4.00	5/24/20	<u>)19 2:0</u>	03 pm
	Hospital and Hospital Health Care Co	mplex Address:									
0 0	Street: 2605 N. LEBANON STREET City: LEBANON	PO Box: State: I	N Zi	ip Code:	46052-	Coun	ty: BOONE				1
0		Component Na		CCN	CBSA	Provi der		Payme	ent Syst	em (P,	2
			Nu	umber	Number	Туре	Certified		, 0, or		4
		1.00		2.00	3.00	4.00	5.00	V 6.00	XVIII 7.00	XI X 8.00	-
	Hospital and Hospital-Based Componer	nt Identification:					1				
0	Hospi tal	WI THAM MEMORIAL HOSPI TAL	15	50104	26900	1	07/01/1966	N	P	0	3
0	Subprovider - IPF	WI THAM HOSPI TAL	15	5S104	26900	4	01/01/2000	N	Р	N	4
0	Subprovider - IRF										5
0 0	Subprovider – (Other) Swing Beds – SNF										6
0	Swing Beds - NF										8
0	Hospital-Based SNF	WITHAM HOSPITAL I	ECU 15	55832	26900		05/07/2015	N	Р	N	9
00 00	Hospi tal -Based NF Hospi tal -Based OLTC										10
00	Hospi tal -Based HHA										12
00	Separately Certified ASC										13
00 00	Hospital-Based Hospice Hospital-Based Health Clinic - RHC										14
00	Hospital-Based Health Clinic - FQHC										16
00	Hospital-Based (CMHC) I										17
00	Renal Dialysis Other										18
		1	I	I			From		То		
00	Cost Reporting Period (mm/dd/yyyy)						1.00		2. (12/31,		20
	Type of Control (see instructions)						9	0.0			21
						1.00	2.00		3. (00	
00	Inpatient PPS Information Does this facility qualify and is it	currently receiv	ing navmen	ts for		Y	N				22
00	disproportionate share hospital adju						14				22
	§412.106? In column 1, enter "Y" fo										
	facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo			ent							
01	Did this hospital receive interim un	compensated care	payments f			Y	Y				22
	cost reporting period? Enter in colu the portion of the cost reporting pe										
	Enter in column 2, "Y" for yes or "N				st						
	reporting period occurring on or aft	er October 1. (se	e instruct	i ons)							
02	Is this a newly merged hospital that payments to be determined at cost re					Ν	N				22
	Enter in column 1, "Y" for yes or "N	" for no, for the	portion o	of the							
	cost reporting period prior to Octob										
	or "N" for no, for the portion of th October 1.	e cost reporting	herroa ou	or arte							
03	Did this hospital receive a geograph					Ν	N		N	l	22
	rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c				as						
	for the portion of the cost reportin	ng period prior to	October 1	. Enter							
	in column 2, "Y" for yes or "N" for										
	reporting period occurring on or aft Does this hospital contain at least										
	counted in accordance with 42 CFR 41										
00	yes or "N" for no. Which method is used to determine Me	dicaid dave on Li	nes 24 and	1/or 25			3 N				23
	below? In column 1, enter 1 if date	of admission, 2 i	f census d	lays, or			- IN				20
	if date of discharge. Is the method reporting period different from the				st						
	reporting period different from the reporting period? In column 2, ente										
			In-State	In-Sta		ut-of		ledi ca		ther	
			Medicaid paid days	Medica eligib		State di cai d	State H Medicaid	IMO da		di cai d days	
				unpai	d pai		eligible			5	
			1.00	days 2.00		3.00	unpai d 4. 00	5.00		6. 00	-
				2.00							
00	If this provider is an IPPS hospital	, enter the	184	1,	221	0	0		602	C	24
00	in-state Medicaid paid days in colum	n 1, in-state		1,	221	0	0		602	C	24
00	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col	n 1, in-state umn 2,		1,	221	0	0		602	(24.
00	in-state Medicaid paid days in colum	n 1, in-state umn 2, column 3, d days in column		1,	221	0	0		602	(24.

JSPI	TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA I	Provider CC	N: 15-0104	Period: From 01/0		Part I		
				Out of		Madia a	5/24/2	ime Pre 2019 2:0	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medica HMO da	ys Me	Other edi cai d days	
5.00	If this provider is an IRF, enter the in-state	1.00	2.00	3.00	4.00	5.00	0	6.00	25.0
	Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.		0	0		Pural S		f Geogr	
					1.			00	1
5. 00 7. 00 5. 00	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	r rural. age) status r "2" for ru ication in d	at the end ural. If ap column 2.	l of the cos pplicable,	t	1 1 0			26. 27. 35.
					Begi n			i ng:	
. 00	Enter applicable beginning and ending dates of SCH st	tatus. Subs [,]	cript line	36 for numb	er	00	2.	00	36.
	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter	es.				0			37.
7.00	is in effect in the cost reporting period.	the number	or period	IS MDH Statu	5	0			37.
. 01	Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)								37.
. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38.
	ontor subsequent dates.				Y/			/N	
9.00	Does this facility qualify for the inpatient hospital	l navment a	liustmont f	for low volu	1. me			00 Y	39.
. 00	hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet f accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob), (ii), or the mileage ii)? Enter i n adjustmen ber 1. Enter	(iii)? Ent requiremen n column 2 t? Enter "Y "Y" for y	er in colum hts in ""Y" for ye " for yes o	n s r N			N	40.
	no in column 2, for discharges on or after October 1.	<u>(see inst</u>	ructions)			V	XVIII	XIX	
						1.00	_	_	
. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)	nt for disp	roporti onat	e share in	accordance	N	N	N	45.
. 00	Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					N	N	N	46.
. 00 . 00	Is this a new hospital under 42 CFR §412.300(b) PPS or Is the facility electing full federal capital payment Teaching Hospitals	•		2		N N	N N	N N	47. 48.
~~	Is this a hospital involved in training residents in or "N" for no.				5	N			56.
	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont	r yes or "N' th of this o Y", complete	' for no in cost report e Worksheet	i column 1. ing period?	If column Enter "Y				57.
	for yes or "N" for no in column 2. If column 2 is "\ "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	і, іт аррііч		ins' servi ce	s as				58.
. 00	for yes or "N" for no in column 2. If column 2 is "N	bursement fo							
. 00 . 00	for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb	bursement fo complete Wi	kst. D-5.	Pt. I.	_	N			59.
5. 00 7. 00 8. 00 9. 00	for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	bursement fo complete Wi	kst. D-5.		35 Worksh Lin	neet A e #	Qualif	Through ication on Code	
. 00	for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	bursement fo complete Wi	kst. D-5.	Pt. I. NAHE 413.8		e #	Qualif Criteri	ication	

U3PI	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC		eriod: rom 01/01/2018 p 12/31/2018	Date/Time Pre	pared:
		Y/N	IME	Direct GME	IME	5/24/2019 2:0 Direct GME	
		1.00	2.00	3.00	4.00	5.00	
1.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in				0.00	0.00	61.0
	column 1. (see instructions)						
1. 01	Enter the average number of unweighted primary care						61.0
	FTEs from the hospital's 3 most recent cost reports						
	ending and submitted before March 23, 2010. (see instructions)						
1. 02	Enter the current year total unweighted primary care						61.0
	FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of						
	ACA). (see instructions)						
1. 03	Enter the base line FTE count for primary care						61. C
	and/or general surgery residents, which is used for						
	determining compliance with the 75% test. (see instructions)						
1. 04	Enter the number of unweighted primary care/or						61.0
	surgery allopathic and/or osteopathic FTEs in the						
1 05	current cost reporting period.(see instructions). Enter the difference between the baseline primary						61.0
	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)						
1.06	Enter the amount of ACA §5503 award that is being						61.0
	used for cap relief and/or FTEs that are nonprimary						
	care or general surgery. (see instructions)	Pro	ogram Name	Program Code	Unweighted IME	Unweighted	
			byr ann Manie			Direct GME FTE	
						Count	-
1. 10	Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	61.1
1. 10	special ty, if any, and the number of FTE residents				0.00	0.00	
	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						
1 00	FTE unweighted count.				0.00	0.00	
1.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE				0.00	0.00	61.2
	residents for each expanded program. (see						
	instructions) Enter in column 1, the program name.						
	Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4,						
	the direct GME FTE unweighted count.						
						1.00	-
	ACA Provisions Affecting the Health Resources and Ser	rvi ces /	Administration	(HRSA)		1.00	
2. 00	Enter the number of FTE residents that your hospital		in this cost	reporting peri	od for which	0.00	62.0
2. 01	your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a		ng Health Cent	ter (THC) into	vour bosnital	0.00	62.0
2.01	during in this cost reporting period of HRSA THC proc				your nospi tui	0.00] 02.0
	Teaching Hospitals that Claim Residents in Nonprovide						
3.00	Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple					N	63.0
				Unweighted	Unweighted	Ratio (col. 1/	
				FTES		(col. 1 + col.	
				Nonprovider Site	Hospi tal	2))	
				1.00	2.00	3.00	1
			der Settings				
	Section 5504 of the ACA Base Year FTE Residents in No						
1 00	period that begins on or after July 1, 2009 and befor	re June	30, 2010.	0.00	0.00	0 00000	61 0
4. 00		<u>re June</u> ty trair	30, 2010. ned residents	0.00	0.00	0. 000000	64.0
4. 00	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in	<u>re June</u> y trair -primar all nor	30, 2010. ned residents ry care nprovider	0.00	0.00	0. 000000	64.0
4. 00	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor	re June ty trair a-primar all nor d non-pr	30, 2010. ned residents ry care nprovider rimary care	0. 00	0.00	0. 000000	64.

		ATA Provi der	Fr	eriod: com 01/01/2018		
			To	12/31/2018	Date/Time Pre 5/24/2019 2:0	epared 3 pm
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	1
			FTES	FTEs in	$(\operatorname{col} \cdot 3 + \operatorname{col} \cdot$	
			Nonprovider Site	Hospi tal	4))	
-	1.00	2.00	3.00	4.00	5.00	1
00 Enter in column 1, if line 63			0.00	0.00	0. 000000	65.
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3						
divided by (column 3 + column 4)). (see instructions)						
			Unwei ghted	Unwei ghted	Ratio (col. 1/	
			FTES	FTEs in	$(\operatorname{col} \cdot 1 + \operatorname{col} \cdot$	
			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				
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	unweighted non-prima al. Enter in column column 2)). (see in	ry care resident 3 the ratio of				
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	
		Program Code	FTĔs Nonprovider Site	FTES in Hospital	(col. 3 + col. 4))	
00 Enter in column 1, the program	Program Name		FTĔs Nonprovi der	FTEsin	(col. 3 + col. 4)) 5.00	_
OO 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)		Program Code	FTĔs Nonprovi der Si te 3.00	FTES in Hospital	(col. 3 + col. 4)) 5.00	_
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column	U U	Program Code	FTĔs Nonprovi der Si te 3.00	FTES in Hospital	(col. 3 + col. 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)	1.00 25	Program Code 2.00	FTĚs Nonprovi der Si te 3.00 0.00	FTES in Hospi tal 4.00 0.00 1.0	(col . 3 + col . 4)) 5.00 0.000000 0.0000000	0 67.
<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>	1.00 1.00 2S /chiatric Facility (the facility have a ≥fore November 15, 2 umn 2: Did this fac ≥ 112.424 (d)(1)(iii) ;ate which program y	Program Code 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for	FTĚs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for n s in a new teach yes or "N" for n	FTES in Hospital 4.00 0.00 1.0 rovider? Y he most o. (see ing o.	(col . 3 + col . 4)) 5.00 0.000000 0.0000000 0.0000000 0.000000	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>	1.00 1.00 2S ychiatric Facility (the facility have a effore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii ate which program y y PPS habilitation Facilit	Program Code 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for ear began during thi	FTËs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for n s in a new teach yes or "N" for n	FTES in Hospital 4.00 0.00 1.0 rovider? Y he most o. (see ing o.	(col . 3 + col . 4)) 5.00 0.000000 0 2.00 3.00 0 0 0 2.00 3.00	_

Heal th	Financial Systems WITHAM MEMORIA	L HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 15-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Pre 5/24/2019 2:0	epared:
					1.00	-
80. 00 81. 00	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes Is this a LTCH co-located within another hospital for part o "Y" for yes and "N" for no.	and "N" for r all of the	no. cost reportin	g period? Enter	N N	80. 00 81. 00
86.00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) Did this facility establish a new Other subprovider (exclude §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 00 86. 00
	Is this hospital an extended neoplastic disease care hospita 1886(d)(1)(B)(vi)? Enter "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 Services					
90.00	Does this facility have title V and/or XIX inpatient hospita yes or "N" for no in the applicable column.	I services? E	nter "Y" for	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through t full or in part? Enter "Y" for yes or "N" for no in the appl			N	Y	91.00
	Are title XIX NF patients occupying title XVIII SNF beds (du	al certificat			N	92.00
	instructions) Enter "Y" for yes or "N" for no in the applica Does this facility operate an ICF/IID facility for purposes		d XIX? Enter	Ν	N	93.00
94.00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for n	o in the	N	N	94.00
	applicable column. f line 94 is "Y", enter the reduction percentage in the app			0. 00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.	or "N" for n	o in the	N	N	96.00
98.00	.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 .00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in 0.00					
98. 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti title XIX.		Y	98. 01		
98. 02	Does title V or XIX follow Medicare (title XVIII) for the ca bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o for title V, and in column 2 for title XIX.			Y	Y	98. 02
98. 03	Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye for title V, and in column 2 for title XIX.				N	98. 03
98. 04	Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XIX.			N	N	98.04
	Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c column 2 for title XIX.				Y	98.05
	Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y	Y	98.06
105 00	Rural Providers Does this hospital qualify as a CAH?			N	[105.00
	If this facility qualifies as a CAH, has it elected the all-	inclusive met	hod of paymen			106.00
107.00	for outpatient services? (see instructions) If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col.	1. (see inst	ructions) If	N		107.00
	reimbursed. If yes complete Wkst. D-2, Pt. II. Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dul e? See 42	Ν		108. 00
		Physi cal 1.00	Occupationa 2.00	I Speech 3.00	Respi ratory 4.00	-
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
					1.00	
	Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	Y" for yes or	"N" for no.	lf yes,	N	110.00

leal th Financial Systems WITHAM MEMORIAL HOSPI HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Prov	vider CCN: 15-0104	Period: From 01/01/		u of For Workshe Part I		
		To 12/31/		Date/Ti 5/24/20	me Pre 019 2:0	epared:)3 pm
		1.00		2.0	20	-
111.00 If this facility qualifies as a CAH, did it participate in the From Health Integration Project (FCHIP) demonstration for this cost repor "Y" for yes or "N" for no in column 1. If the response to column 1 integration prong of the FCHIP demo in which this CAH is participat Enter all that apply: "A" for Ambulance services; "B" for additional for tele-health services.	orting period? Enter is Y, enter the ting in column 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" for is yes, enter the method used (A, B, or E only) in column 2. If col 3 either "93" percent for short term hospital or "98" percent for l psychiatric, rehabilitation and long term hospitals providers) base Pub.15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for yes	umn 2 is "E", enter ong term care (incl ed on the definition	in column udes	N		0	115.00
I17.00 Is this facility legally-required to carry malpractice insurance? E no.	Enter "Y" for yes or	"N" for	Y			117.00
I18.00 Is the malpractice insurance a claims-made or occurrence policy? Er claim-made. Enter 2 if the policy is occurrence.	nter 1 if the policy	/is	2			118.00
	Premi ums	Losse	5	Insur	ance	
	1.00	2.00		3. (-
118.01 List amounts of malpractice premiums and paid losses:	210, 9	978	0		(0 118. 0'
18.02 Are malpractice premiums and paid losses reported in a cost center		1.00 N		2. (00	118. 02
Administrative and General? If yes, submit supporting schedule lis and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmle §3121 and applicable amendments? (see instructions) Enter in column "N" for no. Is this a rural hospital with < 100 beds that qualifies Hold Harmless provision in ACA §3121 and applicable amendments? (see	sting cost centers ess provision in AC/ n 1, "Y" for yes or s for the Outpatient	A N		N		119. 00 120. 00
Enter in column 2, "V" for yes or "N" for no. [21.00]Did this facility incur and report costs for high cost implantable	,	Y				121.00
patients? Enter "Y" for yes or "N" for no. 22.00Does the cost report contain healthcare related taxes as defined in	\$1903(w)(3) of the	e N				122.00
Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" the Worksheet A line number where these taxes are included.						122.0
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes a	and "N" for no. If	N				125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the in column 1 and termination date, if applicable, in column 2.	e certification date	9				126. 00
127.00 If this is a Medicare certified heart transplant center, enter the in column 1 and termination date, if applicable, in column 2.	certification date					127. 0
28.00 If this is a Medicare certified liver transplant center, enter the in column 1 and termination date, if applicable, in column 2.	certification date					128. 0
29.00 If this is a Medicare certified lung transplant center, enter the c column 1 and termination date, if applicable, in column 2.		n				129. 0
30.00 If this is a Medicare certified pancreas transplant center, enter 1 date in column 1 and termination date, if applicable, in column 2.						130. 0
31.00 If this is a Medicare certified intestinal transplant center, enter date in column 1 and termination date, if applicable, in column 2.						131.0
32.00 If this is a Medicare certified islet transplant center, enter the in column 1 and termination date, if applicable, in column 2.						132.0
33.00 If this is a Medicare certified other transplant center, enter the in column 1 and termination date, if applicable, in column 2.						133.0
134.00 If this is an organ procurement organization (0P0), enter the 0P0 r and termination date, if applicable, in column 2.						134.00
All Providers						

OSPITAL AND HOSPITAL HEALTH CARE COMPLE		IAL HOSPITAL Provider CCM	N: 15-0104	Peri From To		u of Form CMS Worksheet S- Part I Date/Time Pr 5/24/2019 2:	2 epared:
1.00	2.				3.00		
If this facility is part of a cha				e name	and address	of the	
home office and enter the home of 41.00Name:	Contractor name and Contractor's Name:	contractor number		ctor's	Number:		
42.00 Street:	PO Box:		Contra	0101 3	Number .		142.0
43. 00 Ci ty:	State:		Zip Co	de:			143.0
						1.00	
44.00 Are provider based physicians' co	sts included in Worksheet	A?				Y	144. C
				_	1.00	2.00	-
45.00 f costs for renal services are c	aimed on Wkst. A, line 74	1, are the costs	for		1.00	2.00	145.0
inpatient services only? Enter "Y				;			
no, does the dialysis facility in	clude Medicare utilization	n for this cost m	reporting				
period? Enter "Y" for yes or "N"			10				
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no i				l f	Ν		146. (
yes, enter the approval date (mm/		15-2, chapter 40	J, 34020)	''			
						1.00	
17.00 Was there a change in the statist						N	147.
48.00 Was there a change in the order o						N	148.
49.00Was there a change to the simplif	ed cost finding method? I	Part A	<u>s or "N" f</u> Part B		Title V	N Title XIX	149.
		1,00	2.00		3.00	4,00	-
Does this facility contain a prov	der that qualifies for a			cation			
or charges? Enter "Y" for yes or							
55. 00 Hospi tal	•	N	Ν		Ν	N	155.
56.00 Subprovider - IPF		Ν	N		Ν	N	156.
57.00 Subprovider - IRF		N	N		N	N	157.0
58. 00 SUBPROVI DER 59. 00 SNF		N	N		N	N	158.0
60.00HOME HEALTH AGENCY		N N	N N		N N	N N	160. (
61. OO CMHC		IN IN	N		N	N	161. 0
						1.00	
Multicampus					0001.0	••	
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has or	ne or more campus	ses in dif	ferent	CBSAs?	N	165. (
Enter f for yes of N for no.	Name	County	State	Zip Coo	de CBSA	FTE/Campus	
	0	1.00	2.00	3.00		5.00	-
66.00 If line 165 is yes, for each						0.0	0 166. (
compute optor the name in column							
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,							
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)						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				nent Ac	t		
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful use	under §1886(n)? Enter '	Y" for yes or "N	N" 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 use 68.00 If this provider is a CAH (line 10	r under §1886(n)? Enter ' D5 is "Y") and is a meanim	'Y" for yes or "N ngful user (line	N" for no.				
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 use 58.00 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)	N" for no. 167 is "Y	"), en	ter 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) Health Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 10	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	V" for no. 167 is "Y qualify f	′″), en† °or a ha	ter 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) Health Information Technology (HI 57.001s this provider a meaningful use 58.001f this provider is a CAH (line 1 reasonable cost incurred for the 1 58.011f this provider is a CAH and is i 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 in	V" for no. 167 is "Y qualify f nstruction	("), ent for a ha	ter the ardship	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 use 58.001f this provider is a CAH (line 1 reasonable cost incurred for the 1 58.011f 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 in	V" for no. 167 is "Y qualify f nstruction	("), ent for a ha is) s "N"),	ter the ardship , enter the	Y 9. ç	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 use 58.00 If this provider is a CAH (line 1) reasonable cost incurred for the 1 68.01 If this provider is a CAH and is exception under \$413.70(a)(6)(i)) 59.00 If this provider is a meaningful	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 in	V" for no. 167 is "Y qualify f nstruction	("), ent for a ha is) s "N"),	ter the ardship , enter the Beginning	Y 9. 9 Endi ng	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 use 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the 1 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 "N ngful user (line ons) es this provider for no. (see in d is not a CAH (l	N" for no. 167 is "Y qualify f nstruction ine 105 i	("), ent for a ha is) s "N"),	ter the ardship , enter the Beginning 1.00	Y 9. 9 Endi ng 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) Health Information Technology (HI 57.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the 1 exception under §413.70(a) (6) (ii) 59.00 If this provider is a meaningful of transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR	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 "N ngful user (line ons) es this provider for no. (see in d is not a CAH (l	N" for no. 167 is "Y qualify f nstruction ine 105 i	("), ent for a ha is) s "N"),	ter the ardship , enter the Beginning	Y 9. 9 Endi ng	0168.0
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 use 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the 10 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 "N ngful user (line ons) es this provider for no. (see in d is not a CAH (l	N" for no. 167 is "Y qualify f nstruction ine 105 i	("), ent for a ha is) s "N"),	ter the ardship , enter the Beginning 1.00	Y 9. 9 Endi ng 2. 00	0168.0
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 57.001s this provider a meaningful use 68.001f this provider is a CAH (line 10 reasonable cost incurred for the 1 seception under §413.70(a) (6) (ii) 59.001f this provider is a meaningful of transition factor. (see instruction 70.00Enter in columns 1 and 2 the EHR	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 "N ngful user (line ons) es this provider for no. (see in d is not a CAH (l	N" for no. 167 is "Y qualify f nstruction ine 105 i	("), ent for a ha is) s "N"),	ter the ardship , enter the <u>Beginning</u> 1.00 07/01/2017	Y 9.9 Endi ng 2.00 09/30/2017	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 use 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 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 in d is not a CAH (l date for the rep	N" for no. 167 is "Y qualify f nstruction ine 105 i porting	("), ent for a ha is) s "N"),	ter the ardship , enter the Beginning 1.00	Y 9.9 Endi ng 2.00 09/30/2017 2.00	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 use 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the 1 68.01 If this provider is a CAH and is 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	r under §1886(n)? Enter ' 25 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 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 in d is not a CAH (l date for the rep ndividuals enroll	N" for no. 167 is "Y qualify f instruction ine 105 i porting ed in	/"), en for a ha is) s "N"),	ter the ardshi p , enter the Begi nni ng 1.00 07/01/2017 1.00	Y 9.9 Endi ng 2.00 09/30/2017 2.00	0168. (168. (99169. (

IOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider (CCN: 15-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet S- Part II Date/Time Pro 5/24/2019 2:	epared:
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	esnonses Entr	1.00	2.00	
	mm/dd/yyyy format.		caponaca. Ente		ine .	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c	beginning of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in c	orunn z. (see	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" fo or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled,	Y	A		4. C
. 00	Are the cost report total expenses and total revenues diffe		N			5.0
	those on the filed financial statements? If yes, submit rec	onciliation.		Y/N	Legal Oper.	-
				1.00	2.00	+
	Approved Educational Activities					
. 00	Column 1: Are costs claimed for nursing school? Column 2:	lfyes, is t	he provider is	s N		6.0
. 00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in:	structions		Ν		7.0
. 00	Were nursing school and/or allied health programs approved a cost reporting period? If yes, see instructions.		d during the	N		8.0
. 00	Are costs claimed for Interns and Residents in an approved	0	cal education	N		9.0
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.		the current	Ν		10. 0
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	proved	N		11. (
	Bad Debts				Y/N 1.00	
2.00	Is the provider seeking reimbursement for bad debts? If yes				Y	12.0
	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.				N	13.0
4.00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	nts waived? I	r yes, see in:	STFUCTIONS.	N	14.0
5.00	Did total beds available change from the prior cost reporti	<u>v</u> .			N + P	15. C
		Y/N	rt A Date	Par Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data		-			
6. 00	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 instructions)	Ν		N		16.0
7. 00	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	01/15/2019	Y	01/15/2019	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. (
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. (

Heal th	Fi nanci al	Systems	

In Lieu of Form CMS-2552-10

cui tri i munor ur	Systems WI THAM MEMOR			III LIE	<u>u of Form CM</u>	3-2002-1
OSPITAL AND HOS	PITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0104	Period: From 01/01/2018 To 12/31/2018		repared:
		Descri	iption	Y/N	Y/N	
			0	1.00	3.00	
	6 or 17 is yes, were adjustments made to PS&R ta for Other? Describe the other adjustments:			N	N	20. 0
· · ·		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	ost report prepared only using the provider's	N		N		21.0
		-			1.00	
COMPLETED	BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	IOSPI TALS)		1.00	
Capital Re	el ated Cost		,			
2.00 Have asse	ts been relifed for Medicare purposes? If yes, se	e instructions				22.0
3.00 Have chan	ges occurred in the Medicare depreciation expense	e due to apprais	als made dur	ing the cost		23.0
reporti ng	period? If yes, see instructions.			-		
.00 Were new	leases and/or amendments to existing leases enter	ed into during	this cost re	porting period?		24.0
lf yes, s	ee instructions					
5.00 Have ther instructi	e been new capitalized leases entered into during ons.	the cost repor	ting period?	lf yes, see		25.0
5.00 Were asse instructi	ts subject to Sec.2314 of DEFRA acquired during t	he cost reporti	ng period? I	f yes, see		26.0
	rovider's capitalization policy changed during th	e cost reportin	ng period? If	ves, submit		27.0
copy.		1	5 1	J		
Interest I	xpense					
.00 Were new	loans, mortgage agreements or letters of credit e	entered into dur	ing the cost	reporting		28. (
period? I	f yes, see instructions.					
	rovider have a funded depreciation account and/or		bt Service R	eserve Fund)		29. (
	s a funded depreciation account? If yes, see inst ing debt been replaced prior to its scheduled mat		debt? If yes	, see		30.
instructi		3	5			
	been recalled before scheduled maturity without i	ssuance of new	debt? If yes	, see		31. (
instructi						
Purchased					I	
	ges or new agreements occurred in patient care se		ed through co	ntractual		32.0
	nts with suppliers of services? If yes, see instr					22
	2 is yes, were the requirements of Sec. 2135.2 ap	pried pertainin	ig to competi	tive blading? IT		33. (
	nstructions.					
	Based Physicians ces furnished at the provider facility under an a	rrongomont with		and physical apo?		- 24 (
	ee instructions.	irrangement with	i provider-bas	sed physicians?		34.0
	4 is yes, were there new agreements or amended ex	visting agreemen	ts with the	nrovi der-based		35. 0
	s during the cost reporting period? If yes, see i			pi ovi dei -based		55.0
physician	s darrig the cost reporting period. In yes, see h			Y/N	Date	
				1.00	2.00	
Home Offic	e Costs					
.00 Were home	office costs claimed on the cost report?					36.0
7.00 If line 3	6 is yes, has a home office cost statement been p	repared by the	home office?			37.0
lf yes, s	ee instructions.					
	6 is yes , was the fiscal year end of the home of					38. (
	der? If yes, enter in column 2 the fiscal year en					
the provi						
the provi 0.00 If line 3		ier chai'n compon	see instructions.			
0.00 If line 3 see instr	uctions.		5	,		
0.00 If line 3 see instr	uctions. 6 is yes, did the provider render services to the		5	,		
0.00 If line 3 see instr 0.00 If line 3	uctions. 6 is yes, did the provider render services to the	home office?	5		00	
2.00 If line 3 see instr 0.00 If line 3 instructi	uctions. 6 is yes, did the provider render services to the	home office?	lf yes, see		00	
2.00 If line 3 see instr 0.00 If line 3 instructi	uctions. 6 is yes, did the provider render services to the ons.	home office?	lf yes, see		00	40.0
the provi 1 f line 3 see instr 0.00 If line 3 instructi Cost Repor .00 Enter the	uctions. 6 is yes, did the provider render services to the ons. The Preparer Contact Information	home office?	lf yes, see	2.	00	40. (
the provi .00 If line 3 see instr .00 If line 3 instructi	uctions. 6 is yes, did the provider render services to the ons. <u>T Preparer Contact Information</u> first name, last name and the title/position he cost report preparer in columns 1, 2, and 3,	e home office?	If yes, see	2.	00	40. (
the provi 1 f line 3 see instr 1 f line 3 instructi Cost Repor Enter the held by t respectiv	uctions. 6 is yes, did the provider render services to the ons. <u>T Preparer Contact Information</u> first name, last name and the title/position he cost report preparer in columns 1, 2, and 3,	home office?	If yes, see	2.	00	40. (
the provi 1.00 If line 3 see instr 1.00 If line 3 instructi Cost Report 1.00 Enter the held by t respectiv 2.00 Enter the preparer.	A contract of the provider render services to the prosent of the provider of the	e home office?	If yes, see	2.	00	39. 0 40. 0 41. 0 42. 0
2.00 the provi 9.00 If line 3 see instr see instr 1f line 3 instructi 0.00 If line 3 instructi instructi 1.00 Enter the held by t respectiv 2.00 Enter the preparer. 3.00 Enter the	uctions. 6 is yes, did the provider render services to the ons. The Preparer Contact Information first name, last name and the title/position he cost report preparer in columns 1, 2, and 3, ely.	e home office?	If yes, see	2.		40. (

Heal th	Financial Systems	WITHAM MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	TI ONNAI RE	Provi der	CCN: 15-0104	Period:	Worksheet S-2	
					From 01/01/2018 To 12/31/2018	Part II Date/Time Pre 5/24/2019 2:0	pared: <u>3 pm</u>
				3.00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title,	/position N	/ANAGER				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 re	eport					42.00
	preparer.						
43.00	Enter the telephone number and email address of	of the cost					43.00
	report preparer in columns 1 and 2, respective	el y.					

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	WITHAM MEMORIA	Provider C	CN· 15-0104	Peri od:	u of Form CMS-2 Worksheet S-3	
1105111	AL AND HOST THE HEALTH CARE COMPLEX STATISTIC			5N. 13-0104	From 01/01/2018	Part I	
					To 12/31/2018	Date/Time Pre 5/24/2019 2:0	
						I/P Days / 0/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	60	21, 9	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovi der						3.00
4.00	HMO I RF Subprovi der						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		60	21, 9	0.00	0	7.00
	beds) (see instructions)			,.		-	
8.00	INTENSIVE CARE UNIT	31.00	8	2, 9	20 0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		68	24, 8	20 0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	10	3, 6		0	16.00
17.00	SUBPROVIDER - IRF	41.00	0		0	0	17.00
18.00	SUBPROVI DER	42.00	0	, F	0	0	18.00
19.00	SKILLED NURSING FACILITY	44.00	18	6, 5	/0	0	19.00
20.00 21.00	NURSING FACILITY OTHER LONG TERM CARE						20.00
21.00	HOME HEALTH AGENCY						21.00
22.00	AMBULATORY SURGICAL CENTER (D. P.)						22.00
24.00	HOSPI CE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC	00.00					25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		96				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges				1		33.01

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0104	Period: From 01/ To 12/	01/2018 31/2018		pared:
		I/P Days	/ O/P Visits	/ Trips	Ful	I Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total I & Resi	nterns dents	Employees On Payroll	
		6.00	7.00	8.00	9.	00	10.00	
. 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, 263	105	5, 40	56			1.00
. 00	HMO and other (see instructions)	1, 109	1, 799					2.00
. 00	HMO IPF Subprovider	26	0					3.00
. 00	HMO IRF Subprovider	0	0					4.00
. 00	Hospital Adults & Peds. Swing Bed SNF	0	0		0			5.00
. 00	Hospital Adults & Peds. Swing Bed NF		0		0			6.00
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	2, 263	105	5, 40	56			7.00
8.00	INTENSIVE CARE UNIT	834	20	1, 7	76			8.0
. 00	CORONARY CARE UNI T							9.0
0.00	BURN INTENSIVE CARE UNIT							10.0
1.00	SURGICAL INTENSIVE CARE UNIT							11.0
2.00	OTHER SPECIAL CARE (SPECIFY)							12.0
3.00	NURSERY		58	1, 00	50			13.0
4.00	Total (see instructions)	3, 097	183	8, 30		0.00	899.63	
5.00	CAH visits	3, 0 / /	0	0, 50	0	0.00	077.03	15.0
6.00	SUBPROVIDER - IPF	2, 558	0	3, 13	-	0.00	30. 71	
7.00	SUBPROVIDER - IRF	2, 330	0	5, 1	0	0.00		
8.00	SUBPROVI DER	U	0		0	0.00		
9.00	SKILLED NURSING FACILITY	2, 994	0	5, 02	-	0.00	30.03	
0.00	NURSING FACILITY	2, 774	0	5,02	~ /	0.00	30.03	20.0
1.00	OTHER LONG TERM CARE							20.0
2.00	HOME HEALTH AGENCY							21.0
3.00								22.0
4.00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE							23.0
4.10					0			24.0
	HOSPICE (non-distinct part)				0			
5.00	CMHC - CMHC							25.0
6.00	RURAL HEALTH CLINIC		0		0	0.00	0.00	26.0
6.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.00		
7.00	Total (sum of lines 14-26)		0	4 5	. /	0.00	960.37	
8.00	Observation Bed Days		0	1, 54	16			28.0
9.00	Ambul ance Trips	1, 716			-			29.0
0.00	Employee discount days (see instruction)			10				30.0
1.00	Employee discount days - IRF				0			31.0
2.00	Labor & delivery days (see instructions)	0	25	4	12			32.0
2. 01	Total ancillary labor & delivery room				0			32.0
	outpatient days (see instructions)							
3.00	LTCH non-covered days	0						33.0
3 01	LTCH site neutral days and discharges	0						33.0

	CAL DATA	Provider (CCN: 15-0104	Period: From 01/01/2018 To 12/31/2018		
	Full Time Equivalents		Dis	scharges	072172017 2.0	5 pm
Component	Nonpai d	Title V	Title XVII	Title XIX	Total All	
	Workers		10.00		Patients	
00 Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00	13.00 0 8	14.00	15.00 2,316	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) HMO and other (see instructions) HMO IPF Subprovider HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT O GORONARY CARE UNIT SURGICAL INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT O Total (see instructions) NURSERY O Total (see instructions) SUBPROVIDER - IPF SUBPROVIDER - IRF O SUBPROVIDER - IRF O SUBPROVIDER - IRF O SUBPROVIDER - IRF O SUBPROVIDER INTENSING FACILITY O OTHER LONG TERM CARE O HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE H HOSPICE (non-distinct part) C CMHC - CMHC C RURAL HEALTH CLINIC S FEDERALLY QUALIFIED HEALTH CENTER O Total (sum of lines 14-26) O Observation Bed Days O Ambulance Trips 	0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00		ο ε	73 43 03 427 0 0 0 73 43 83 0 0 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 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 00 25. 00 26. 00 26. 00 27. 00 28. 00 29. 00 30. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 20. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 20. 00

SPI T	Financial Systems AL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2018 To 12/31/2018		pared
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adj usted Sal ari es (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	
	SALARI ES							
00	Total salaries (see instructions)	200.00	60, 233, 427	1, 087, 444	61, 320, 87	1 1, 633, 598. 00	37.54	1.0
00	Non-physician anesthetist Part		C	0 0	(0.00	0.00	2.0
00	A Non-physician anesthetist Part		C	0		0.00	0.00	3. (
00	В					0.00		
	Physician-Part A - Administrative		C					
D1 D0	Physicians - Part A - Teaching Physician and Non		C			0 0.00 0 0.00		
	Physician-Part B		· · · · ·					
00	Non-physician-Part B for hospital-based RHC and FQHC services		C	0		0 0.00	0.00	6.
00	Interns & residents (in an	21.00	C	0	(0 0.00	0.00	7.
01	approved program) Contracted interns and residents (in an approved		C	0 0	(0.00	0.00	7.
00	programs) Home office and/or related organization personnel		C	0 0		0 0.00		
00	SNF Excluded area salaries (see instructions)	44.00	975, 379 28, 808, 807					
00	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		1, 462, 596	5 0	1, 462, 59	6 20, 000. 00	73. 13	1 1 1
	Care							
00	Contract Labor: Top Level management and other management and administrative		C	0 0		0 0.00	0.00	12.
00	services Contract Labor: Physician-Part		(o o		0.00	0. 00	13.
00	A - Administrative Home office and/or related organization salaries and		C	0 0	(0 0.00	0.00	14.
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		C	0 0	(0 0.00	0.00	15
00	Home office and Contract Physicians Part A - Teaching WAGE-RELATED COSTS		(0 0		0 0.00	0.00	16
00	Wage-related costs (core) (see		9, 203, 898	3 0	9, 203, 89	8		17
00	instructions) Wage-related costs (other)		C	0		0		18
	(see instructions)							
00 00	Excluded areas Non-physician anesthetist Part		7, 044, 882 (2 0 0 0	7, 044, 88:	0		19 20
00	A Non-physician anesthetist Part		C	0	(0		21
00	B Physician Part A - Administrative		C	o	(ο		22
01	Physician Part A - Teaching		(0		22
00	Physician Part B Wage-related costs (RHC/FQHC)		(ס וכ ס וכ		0		23. 24.
00	Interns & residents (in an		C	0	(D		25.
50	approved program) Home office wage-related (core)		C	0 0	(O		25.
51	Related organization		C	o o	(0		25.
52	wage-related (core) Home office: Physician Part A - Administrative -		C	0 0		O		25.
53	wage-related (core) Home office & Contract Physicians Part A - Teaching - wage-related (core)		C	0	(o		25.
	OVERHEAD COSTS - DIRECT SALARIE				007 70	10,000,00		
00	Employee Benefits Department Administrative & General	4.00 5.00	871, 741 6, 248, 119					

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 CC		Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part II Date/Time Pre 5/24/2019 2:0	pared:
		Wkst. A Line		Recl assi 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, 518, 631	0	1, 518, 63	1 9, 226. 00	164.60	28.00
29.00	Maintenance & Repairs	6.00	0	0	(0.00	0.00	29.00
30.00	Operation of Plant	7.00	661, 018	21, 185	682, 20	3 23, 243. 00	29.35	30.00
31.00	Laundry & Linen Service	8.00	28, 044	671	28, 71	5 2, 144. 00	13.39	31.00
32.00	Housekeepi ng	9.00	452, 393	8, 041	460, 43	4 31, 234. 00	14. 74	32.00
33.00	Housekeeping under contract (see instructions)		0	0	(0.00	0.00	33.00
34.00	Dietary	10.00	875, 108	-180, 116	694, 993	2 35, 474. 00	19. 59	34.00
35.00	Dietary under contract (see instructions)		0	0	(0.00	0.00	35.00
36.00	Cafeteria	11.00	0	201, 548	201, 54	8 12, 621. 00	15.97	36.00
37.00	Maintenance of Personnel	12.00	0	0	(0.00	0.00	37.00
38.00	Nursing Administration	13.00	813, 103	17, 866	830, 96	9 19, 867. 00	41.83	38.00
39.00	Central Services and Supply	14.00	0	0	(0.00	0.00	39.00
40.00	Pharmacy	15.00	662, 895	12, 883	675, 77	B 19, 600. 00	34.48	40.00
41.00	Medi cal Records & Medi cal Records Library	16. 00	1, 309, 734			9 48, 743.00	27.54	41.00
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	TAL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2018	Worksheet S-3 Part III	
						To 12/31/2018		pared:
							5/24/2019 2:0	
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)		col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY		1			-	
1.00	Net salaries (see		61, 752, 058	1, 087, 444	62, 839, 50	2 1, 642, 824. 00	38. 25	1.00
	instructions)							
2.00	Excluded area salaries (see		29, 784, 186	109, 366	29, 893, 55	2 666, 669. 00	44.84	2.00
	instructions)							
3.00	Subtotal salaries (line 1		31, 967, 872	978, 078	32, 945, 95	0 976, 155. 00	33. 75	3.00
	minus line 2)							
4.00	Subtotal other wages & related		1, 462, 596	0	1, 462, 59	6 20, 000. 00	73. 13	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		9, 203, 898	0	9, 203, 89	8 0.00	27.94	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		42, 634, 366					
7.00	Total overhead cost (see		13, 440, 786	470, 311	13, 911, 09	7 413, 136. 00	33.67	7.00
	instructions)							

HOSPI TAL WAGE RELATED COSTS Provider CCN: 15-0104 Period: Prom 1/01/2018 To 12/31/2018 Worksheet 5-3 From 1/01/2018 Worksheet 5-3 From 1/01/2018 Worksheet 5-3 From 1/01/2018 PART IV - WAGE RELATED COSTS Reported 1.00 Amount Reported 1.00 Part A - Core List Reported 1.00 1.00 1.00 1.00 1.00 Tax Shel tered Amui by (TSA) Employer Contribution 2,630,710 1.00 2.00 2.00 Tax Shel tered Amui by (TSA) Employer Contribution 0.0 3.00 2.00 3.00 0.00 HOMMINISTRATIVE COSTS (and to External Organization) 0.0 6.00 6.00 6.00 5.00 4.00 0.01 Heal th Insurance (Purchased or Self Funded) 0.0 6.00 6.00 9.00 8.00 8.03	Heal th	Financial Systems WITHAM MEMORI	I AL HOSPI TAL	In Lie	u of Form CMS-2	2552-10
PART IV - WAGE RELATED COSTS Amount Reported Amount Reported Part A - Core List 1.00 RETI REVENT COST 1.00 1.00 401K Employer Contributions 2.630.710 2.00 Tax Sheltered Annulty (TSA) Employer Contribution 0.200 3.00 Nonqual If idd Defined Benefit Plan Cost (see instructions) 0 4.00 PLAN AMINISTRATIVE COSTS (Paid to External Organization) 0 5.00 Alok/TSA Plan Administration fees 0 6.00 Legal Accounting/Management Fees-Pension Plan 0 7.00 Employee Managed Care Program Administration Fees 0 8.00 Healt Insurance (Purchased or Self Funded) 7.00 8.01 Healt Insurance (Self Funded with that a Third Party Administrator) 7.612.902 8.00 Prescription Drug Plan 0 8.00 9.00 Prescription Drug Plan 2.208.315 9.00 10.00 Dental, Hearing and Vision Plan 481.250.00 0 12.00 10.00 Dental, Hearing and Vision Plan 484.231.10.00 0 12.00 10.00	HOSPI T	AL WAGE RELATED COSTS	Provider CCN: 15-0104	From 01/01/2018	Part IV Date/Time Pre	pared:
PART IV - WACE RELATED COSTS Part A - Core List RETIREMENT COST 1.00 401K Employer Contributions 2.00 100 401K Employer Contributions 2.01 100 401K Employer Contributions 2.03.00 Nonquali Fied Defined Benefit P Ian Cost (see instructions) 00 00 11 Fied Defined Benefit P Ian Cost (see instructions) 00 00 00 01 00 01 00 00 00 00 00 00 01 00 01 01 02 03 04 05 06 07 08 09 00 00 00 00 01 02			· · · ·			5 pili
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST 1.00 200 Tax Shel tered Annul by (TSA) Employer Contribution 2,630,710 2.00 Tax Shel tered Annul by (TSA) Employer Contribution 2,030,070 2.00 Tax Shel tered Annul by (TSA) Employer Contribution 0 3.00 Audin Signative Costs (See instructions) 0 4.00 Data I field Defined Benefit Plan Cost (See instructions) 0 5.00 Addit Kapin INE Costs (Paid to External Organization) 0 5.00 Employee Managed Care Program Administration Fees 0 7.00 Employee Managed Care Program Administration Fees 0 8.00 Heal th Insurance (Sel F Funded without a Third Party Administrator) 7, 612, 92 8.01 8.01 Heal th Insurance (Sel Funded without a Third Party Administrator) 0 8.02 8.02 Heal th Insurance (Purchased) 0 8.02 9.00 Prescription Drug Plan 2, 463, 151 9.00 10.00 Detai, Hearing and Vision Plan 481, 623 10.00 10.00 Disbility Insurance (If employee is owner or beneficlary) 0 12.0						
Part A - Core ListRETIREMENT COST1.00401K Employer Contributions2,630,7102.00Tax Sheltered Annuity (TSA) Employer Contribution2,030,7102.00Nonquil Field Defined Benefit Plan Cost (see instructions)00Quali Field Defined Benefit Plan Cost (see instructions)00AddMINISTRATIVE COST Cyclaid to External Organization)05.00401K/TSA Plan Administration fees06.00Legal /Accounting/Management Fees-Pension Plan00Employee Managed Care Program Admin istration Fees07.00Health Insurance (Purchased or Self Funded)08.00Health Insurance (Self Funded with a Third Party Administrator)7, 612, 9928.01Health Insurance (Self Funded with a Third Party Administrator)08.02Health Insurance (Self Funded with a Third Party Administrator)08.00Derscription Drug Plan00.01bescription Drug Plan2, 463, 1510.02escription Drug Plan2, 463, 1510.03Diability Insurance (If employee is owner or beneficiary)841, 2500.04cident Insurance (If employee is owner or beneficiary)220, 8730.05Wackers Compensation Insurance01.00Ling-Term Care Insurance (If employee is owner or beneficiary)22, 275, 4130.00Norckers* Compensation Insurance01.00If ensurance (Self Funded Verrent Verre						
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HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-		eri od:	Worksheet S-3	
					rom 01/01/2018		
					o 12/31/2018	Date/Time Pre 5/24/2019 2:03	
	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, 462, 596	16, 248, 780	1.00
2.00	Hospi tal				1, 462, 596	16, 248, 780	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	Hospi tal -Based Hospi ce						13.00
14.00	Hospital-Based Health Clinic RHC						14.00
15.00	Hospital-Based Health Clinic FQHC						15.00
16.00	Hospital-Based-CMHC						16.00
17.00	Renal Dialysis						17.00
18.00	Other				0	0	18.00

		ORIAL HOSPITAL			u of Form CMS-2	
PROSPE	CTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider C	F	eriod: rom 01/01/2018	Worksheet S-7	
				o 12/31/2018	Date/Time Pre 5/24/2019 2:03	
				1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all			N	2100	1.00
	or was there no Medicare utilization? Enter "Y" for yes complete the rest of this worksheet.	In column I and c	io 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	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
3.00	T	1.00 RUX	2.00	3.00	4.00	2.00
3.00 4.00		RUL	0		0	3.00 4.00
5.00 6.00		RVX RVL	47 0		47 0	5.00 6.00
7.00		RHX	0	0	0	7.00
8.00 9.00		RHL RMX	16		16 0	8.00 9.00
10.00		RML	0	0	0	10.00
11.00 12.00		RLX RUC	0 62		0 62	11.00 12.00
13.00		RUB	111	0	111	13.00
14.00 15.00		RUA RVC	68 503		68 503	
16.00		RVB	647		647	16.00
17.00 18.00		RVA RHC	492 345		492 345	17.00 18.00
19.00 20.00		RHB RHA	285 163		285 163	
20.00		RMC	41	-	41	20.00
22.00 23.00		RMB RMA	44		44 39	22.00 23.00
24.00		RLB	4	0	4	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 31. 00		HE1	0		0 14	30.00 31.00
32.00		HD2 HD1	0		0	32.00
33.00 34.00		HC2 HC1	14		14 0	33.00 34.00
35.00		HB2	0	0	0	35.00
36.00 37.00		HB1 LE2	6		6	36.00 37.00
38.00		LE1	0	0	0	38.00
39.00 40.00		LD2 LD1	3		3 14	39.00 40.00
41.00 42.00		LC2 LC1	0		0	41.00 42.00
43.00		LB2	0	0	0	43.00
44.00 45.00		LB1 CE2	3		3	44.00 45.00
46.00		CE1	0	0	0	46.00
47.00 48.00		CD2 CD1	9		9	47.00 48.00
49.00		CC2	0	0	0	49.00
50. 00 51. 00		CC1 CB2	21		21 0	50.00 51.00
52.00 53.00		CB1 CA2	6		6 0	52.00 53.00
54.00		CA1	24	0	24	54.00
55.00 56.00		SE3 SE2			0	55.00 56.00
57.00		SE1	0	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
63.00 64.00		I A2 I A1	0		0	63.00 64.00
65.00		BB2	0	0	0	65.00
66. 00 67. 00		BB1 BA2	0		0	66.00 67.00
68.00		BA1	0			

Health Financial Systems WI	THAM MEMORIAL HOS	PI TAL		1	n Lie	u of Form CMS-:	2552-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA			CN: 15-0104	Peri od:	-	Worksheet S-7	
				From 01/01/ To 12/31/		Date/Time Pre 5/24/2019 2:0	
	G	roup	SNF Days	Swing Bed	I SNF	Total (sum of	
				Days		col. 2 + 3)	
		. 00	2.00	3.00		4.00	
69.00		PE2		0	0	0	
70.00		PE1		0	0	0	
71.00		PD2		0	0	0	
72.00		PD1		4	0	4	
73.00		PC2		0	0	0	
74.00		PC1		0	0	0	
75.00		PB2		0	0	0	
76.00		PB1		0	0	0	
77.00		PA2		0	0	0	
78.00		PA1			0	1	78.00
199.00		AAA		0	0		199.00
200. 00 TOTAL			2, 9	CBSA a	+	CBSA on/after	200.00
				Beginning		October 1 of	
				Cost Repo			
				Peri o		Reporting	
				101100	u	Period (if	
						appl i cabl e)	
				1.00		2.00	
SNF SERVICES							
201.00 Enter in column 1 the SNF CBSA code or 5 charact	er non-CBSA code	if a rur	al facility,	26900		26900	201.00
in effect at the beginning of the cost reporting							
in effect on or after October 1 of the cost repo	orting period (if	appl i cab					
			Expenses	Percenta	age	Associ ated	
						with Direct	
						Patient Care	
						and Related	
			1.00	2.00		Expenses? 3.00	
A notice published in the Federal Register Volum	0 69 No 140 Aug	uet 1 - 2					
payments beginning 10/01/2003. Congress expected							
expenses. For lines 202 through 207: Enter in co							
column 2 the percentage of total expenses for ea							
line 7, column 3. In column 3, enter "Y" for yes							
with direct patient care and related expenses for			tructions)				
202.00 Staffing			975, 3	79 :	35.03	Y	202.00
203.00 Recruitment				0	0.00		203.00
204.00 Retention of employees				0	0.00		204.00
205. 00 Trai ni ng				0	0.00		205.00
206.00 SNF OTHER EXPENSE			771, 20		27. 70	Y	206.00
207.00 Total SNF revenue (Worksheet G-2, Part I, line 7	7, column 3)		2, 784, 78	32			207.00

Heal th	Financial Systems WI THAM MEMORIAL	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	CN: 15-0104	Period: From 01/01/2018	Worksheet S-1	
				To 12/31/2018	Date/Time Pre 5/24/2019 2:0	
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 d	ivided by li	ne 202 colum	ו 8)	0. 192275	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				8, 100, 304	
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or suppleme			ai d?	Y O	4.00 5.00
5.00 6.00	If line 4 is no, then enter DSH and/or supplemental payments Medicaid charges	from medical	a		44, 213, 921	6.00
7.00	Medicaid cost (line 1 times line 6)				8, 501, 232	
8.00	Difference between net revenue and costs for Medicaid program	(line 7 min	us sum of lin	nes 2 and 5: if	400, 928	
	< zero then enter zero)	-				
	Children's Health Insurance Program (CHIP) (see instructions	for each lin	e)		1	
9.00	Net revenue from stand-al one CHIP				0	
10. 00 11. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0	
	Difference between net revenue and costs for stand-alone CHIP	(line 11 mi	nus lino 0: i	f < zero then		
12.00	enter zero)					12.00
	Other state or local government indigent care program (see in				-	
	Net revenue from state or local indigent care program (Not in				0	
14.00	Charges for patients covered under state or local indigent ca	re program (Not included	in lines 6 or	0	14.00
15.00	10) State or local indigent care program cost (line 1 times line	14)			0	15.00
	Difference between net revenue and costs for state or local i		program (li	ne 15 minus line	0	
	13; if < zero then enter zero)	5			-	
	Grants, donations and total unreimbursed cost for Medicaid, C	HIP and state	e/local indig	gent care program	ns (see	
17.00	instructions for each line) Private grants, donations, or endowment income restricted to	fundi na char	ity caro		0	17.00
	Government grants, appropriations or transfers for support of				0	
	Total unreimbursed cost for Medicaid , CHIP and state and loc			s (sum of lines	400, 928	
	8, 12 and 16)			-		
			Uni nsured pati ents	Insured patients	Total (col. 1 + col. 2)	
			1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire f (see instructions)	acility	3, 972, 6	33 905, 401	4, 878, 034	20.00
21.00	Cost of patients approved for charity care and uninsured disc	ounts (see	763, 8	905, 401	1, 669, 239	21.00
22.00	instructions) Payments received from patients for amounts previously writte	n off as		0 0	0	22.00
22.00	charity care		7/2 0	005 401	1 ((0 000	23.00
23.00	Cost of charity care (line 21 minus line 22)		763, 8	38 905, 401	1, 669, 239	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for pati		ond a length	of stay limit	N	24.00
25.00	imposed on patients covered by Medicaid or other indigent car If line 24 is yes, enter the charges for patient days beyond		care progra	n's length of	0	25.00
	stay limit				0 007 040	
26.00	Total bad debt expense for the entire hospital complex (see i				8, 887, 349	
	Medicare reimbursable bad debts for the entire hospital compl Medicare allowable bad debts for the entire hospital complex	•	,		254, 445 391, 453	
	Non-Medicare bad debt expense (see instructions)	(See This thuc	(10115)		8, 495, 896	
	Cost of non-Medicare and non-reimbursable Medicare bad debt e	xpense (see	instructions`		1, 770, 556	
	Cost of uncompensated care (line 23 column 3 plus line 29)			,	3, 439, 795	
	Total unreimbursed and uncompensated care cost (line 19 plus	line 30)			3, 840, 723	

	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider CC		eriod: rom 01/01/2018	Worksheet A	2552-10
				T		Date/Time Pre 5/24/2019 2:0	
	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		3, 822, 999	3, 822, 999	-29, 515	3, 793, 484	1.00
2.00	00200 NEW CAP REL COSTS MVBLE EQUIP		0,022,777	0,022,777		4, 187, 247	2.00
3.00	00300 OTHER CAPITAL RELATED COSTS		0	0	-	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	871, 741	14, 138, 936	15, 010, 677		14, 332, 677	4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	6, 248, 119 661, 018	11, 838, 082 2, 593, 827	18, 086, 201 3, 254, 845		17, 077, 682 3, 155, 951	
8.00	00800 LAUNDRY & LINEN SERVICE	28,044	2, 373, 827	3, 234, 843		3, 155, 951	•
9.00	00900 HOUSEKEEPI NG	452, 393	333, 140	785, 533		789, 922	
10.00	01000 DI ETARY	875, 108	1, 022, 558	1, 897, 666		1, 410, 731	
11.00		0	0	0		480, 775	•
13.00 15.00	01300 NURSI NG ADMI NI STRATI ON 01500 PHARMACY	813, 103 662, 895	115, 149 9, 209, 754	928, 252 9, 872, 649		902, 159 7, 562, 144	
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 309, 734	399, 733	1, 709, 467		1, 734, 743	
	INPATIENT ROUTINE SERVICE COST CENTERS	.,		.,		.,	1
	03000 ADULTS & PEDIATRICS	3, 507, 808	1, 350, 029	4, 857, 837		4, 556, 802	
31.00	03100 I NTENSI VE CARE UNI T	1, 124, 754	552, 904	1, 677, 658		1, 574, 036	
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	1, 092, 438	170, 862 0	1, 263, 300	-3, 234 0	1, 260, 066 0	40.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43.00	04300 NURSERY	0	48, 430	48, 430	- 759	47, 671	•
44.00	04400 SKILLED NURSING FACILITY	975, 379	771, 268	1, 746, 647	-80, 257	1, 666, 390	44.00
50.00	ANCI LLARY SERVICE COST CENTERS	0.000.000	(044 555	0.010.500	(470 005	0.000.000	50.00
50.00 54.00	05000 OPERATI NG ROOM 05400 RADI OLOGY-DI AGNOSTI C	2, 200, 983 1, 478, 145	6, 811, 555 4, 214, 492	9, 012, 538 5, 692, 637		2, 839, 233 5, 354, 108	50.00 54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 478, 145	4, 214, 492	5, 092, 037		5, 354, 108	55.00
55.01	05501 ULTRA SOUND	310,000	329, 173	639, 173	-	565, 698	•
57.00	05700 CT SCAN	196, 755	1, 091, 149	1, 287, 904	-413, 463	874, 441	•
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	318, 296	763, 251	1, 081, 547		767, 205	•
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	286, 334	1, 806, 348 4, 492, 093	2,092,682		1, 256, 709 6, 953, 821	59.00 60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2, 649, 220 0	4, 492, 093 171, 112	7, 141, 313 171, 112		6, 953, 821 169, 575	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0		0	64.00
66.00	06600 PHYSI CAL THERAPY	1, 757, 498	278, 441	2, 035, 939		2, 065, 741	66.00
67.00	06700 OCCUPATI ONAL THERAPY	356, 844	34, 296	391, 140		399, 934	67.00
67.01 68.00	06701 AUDI OLOGY 06800 SPEECH PATHOLOGY	205, 031 172, 741	214, 979 23, 916	420, 010 196, 657		413, 662 200, 249	
69.00	06900 ELECTROCARDI OLOGY	0	23, 910	190,037		200, 249	1
69.01	06901 CARDI OLOGY	1,056,745	310, 878	1, 367, 623	-103, 893	1, 263, 730	•
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-4, 930	-4, 930		2, 916, 982	•
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0		4, 754, 083	
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	0	2, 236, 856	2, 236, 856	73.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	193, 305	85, 315	278, 620	-1, 149	277, 471	90.01
90.02	09002 CLINIC	0	0	0	0	0	
	09003 DERMATOLOGY CLINIC	0	1, 728	1, 728		1, 728	
90. 04 90. 05	09004 ENT CLINIC 09005 SURGERY CLINIC	0	0 1, 351	0 1, 351	-	0 277	90.04 90.05
90.03 90.07	09007 UROLOGY CLINIC	0	2, 082	2, 082		767	90.03
90.09	09009 GASTROENTEROLOGY CLINIC	3, 286	8, 543	11, 829	2, 829	14, 658	
90.11	09011 NEUROLOGY CLINIC	0	8, 480	8, 480	0	8, 480	90.11
	09012 OPTHAMOLOGY CLINIC	102 172	40, 436	40, 436		7,200	
90. 13 90. 14	09013 ALLERGY CLINIC 09014 WOUND CARE	103, 472 251, 339	41, 396 351, 990	144, 868 603, 329		145, 883 360, 809	
	09100 EMERGENCY	2, 354, 530	3, 448, 578	5, 803, 108		5, 411, 980	•
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS	I	1		1		
95.00	09500 AMBULANCE SERVICES	2, 262, 639	574, 956	2, 837, 595	-123, 501	2, 714, 094	95.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	34, 779, 697	71, 763, 445	106, 543, 142	287, 432	106, 830, 574	1118 00
110.00	NONREI MBURSABLE COST CENTERS	54,779,097	71,703,443	100, 343, 142	207, 432	100, 030, 374	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0			190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	25, 123, 550	9, 692, 164	34, 815, 714		34, 532, 590	
194.00	07950 THORNTOWN OFFICE BUILDING	0	0	0	0		194.00
	07951 CAFE/BOUTI QUE	0	0	0 175, 660	0 -1, 191	0 174, 469	194.01
194.02	07952 OTHER NONREIMB 07953 RETAIL PHARMACY	71, 491 258, 689	104, 169 1, 173, 747	1, 432, 436		1, 429, 319	

	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF		AL HOSPITAL Provider CCN: 15-01	04 Period: Workshee	<u>CMS-2552</u> et A
					ne Prepare 9 2:03 pm
	Cost Center Description		Net Expenses For Allocation		
1	GENERAL SERVICE COST CENTERS	6.00	7.00		
	00100 NEW CAP REL COSTS-BLDG & FIXT	-497, 315	3, 296, 169		1.
	00200 NEW CAP REL COSTS-MVBLE EQUIP	0	4, 187, 247		2.
	00300 OTHER CAPITAL RELATED COSTS	0	0		3.
00	00400 EMPLOYEE BENEFI TS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL	-4, 341, 347 -4, 308, 249	9, 991, 330 12, 769, 433		4.5.
	00700 OPERATION OF PLANT	-4, 300, 249	3, 155, 026		7.
	00800 LAUNDRY & LINEN SERVICE	0	322, 720		8.
	00900 HOUSEKEEPI NG	0	789, 922		9.
	01000 DI ETARY	-352, 955	1,057,776		10
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0	480, 775 902, 159		11
	01500 PHARMACY	-94	7, 562, 050		15
	01600 MEDICAL RECORDS & LIBRARY	-477	1, 734, 266		16
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
	03000 ADULTS & PEDIATRICS	0	4, 556, 802		30
	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	0	1, 574, 036		31
	04000 SUBPROVIDER - TPF 04100 SUBPROVIDER - TRF	0	1, 260, 066 0		40
	04200 SUBPROVI DER	0	0		42
00	04300 NURSERY	0	47, 671		43
	04400 SKI LLED NURSI NG FACI LI TY	-5, 800	1, 660, 590		44
		0	2 020 222		
	05000 OPERATI NG ROOM 05400 RADI OLOGY-DI AGNOSTI C	0 -380, 522	2, 839, 233 4, 973, 586		50
	05500 RADI OLOGY-THERAPEUTI C	0	4, 773, 566		55
	05501 ULTRA SOUND	0	565, 698		55
	05700 CT SCAN	0	874, 441		57
	05800 MAGNETIC RESONANCE I MAGI NG (MRI)	0	767, 205		58
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0 -251,000	1, 256, 709 6, 702, 821		59 60
	06300 BLOOD STORING, PROCESSING & TRANS.	-231,000	169, 575		63
	06400 I NTRAVENOUS THERAPY	0	0		64
	06600 PHYSI CAL THERAPY	0	2, 065, 741		66
	06700 OCCUPATI ONAL THERAPY	0	399, 934		67
	06701 AUDI OLOGY 06800 SPEECH PATHOLOGY	-253, 367 0	160, 295 200, 249		67
	06900 ELECTROCARDI OLOGY	0	200, 249		69
01	06901 CARDI OLOGY	0	1, 263, 730		69
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-51, 758	2, 865, 224		71
	07200 I MPL. DEV. CHARGED TO PATIENT	0	4, 754, 083		72
	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	2, 236, 856		73
	09000 CLINIC	0	0		90
	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	277, 471		90
	09002 CLINIC	0	0		90
	09003 DERMATOLOGY CLINIC 09004 ENT CLINIC	-1, 728	0		90 90
	09004 ENT CLINIC 09005 SURGERY CLINIC	0 -277	0		90
	09007 UROLOGY CLINIC	-767	0		90
09	09009 GASTROENTEROLOGY CLINIC	-14, 658	0		90
	09011 NEUROLOGY CLINIC	-8, 480	0		90
	09012 OPTHAMOLOGY CLINIC	-7, 200	145 992		90
-	09013 ALLERGY CLINIC 09014 WOUND CARE	0 - 40, 292	145, 883 320, 517		90 90
	09100 EMERGENCY	-2, 602, 200	2, 809, 780		91
00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92
	OTHER REIMBURSABLE COST CENTERS		0.740.040		
	09500 AMBULANCE SERVICES	-3, 852	2, 710, 242		95
. 00		-13, 123, 263	93, 707, 311		118
	NONREIMBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0 34, 532, 590		190 192
	07950 THORNTOWN OFFICE BUILDING	0	34, 332, 390		192
	07951 CAFE/BOUTI QUE	0	o		194
. 01			174, 469		194
. 02	07952 OTHER NONREIMB 07953 RETAIL PHARMACY	U	1, 429, 319		194

	Financial Systems SIFICATIONS		WI THAM MEMORI A	AL HOSPITAL Provider CCN:		Lieu of Form CMS-2552-10 Worksheet A-6
					To 12/31/2	018 Date/Time Prepared: 5/24/2019 2:03 pm
		Increases				072172017 2.00 pm
	Cost Center 2.00	Li ne # 3.00	Salary 4.00	0ther 5.00		
	A - EMPLOYEE BENEFITS	3.00	4.00	3.00		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	402, 439		1.00
	TOTALS B - INSURANCE RECLASS		0	402, 439		
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	156, 080		1.00
	FI XT		— — — ₀			
	C - CAFETERIA RECLASS		0	156, 080		
1.00	CAFETERI A		201, 548	279, 227		1.00
			201, 548	279, 227		
1.00	D - MME DEPRECIATION NEW CAP REL COSTS-MVBLE	2.00	0	4, 187, 247		1.00
	EQUI P					
2.00 3.00		0.00 0.00	0	0		2.00 3.00
3.00 4.00		0.00	0	0		4.00
5.00		0.00	о	0		5.00
6.00		0.00	0	0		6.00
7.00 8.00		0.00 0.00	0	0		7.00 8.00
9.00		0.00	О	0		9.00
10.00		0.00	0	0		10.00
11. 00 12. 00		0.00 0.00	0	0		11. 00 12. 00
13.00		0.00	О	0		13.00
14.00		0.00	0	0		14.00
15. 00 16. 00		0.00 0.00	0	0		15. 00 16. 00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00 20.00		0.00 0.00	0	0		19.00 20.00
20.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00 24.00		0.00 0.00	0	0		23.00 24.00
24.00		0.00	0	0		24.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28. 00 29. 00		0.00 0.00	0	0		28.00 29.00
30.00		0.00	o	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	Ő		34.00
35.00		0.00	0	0		35.00
36.00	TOTALS		0	<u> </u>		36.00
	E - DRUGS RECLASS		<u> </u>	1,107,217		
1.00	DRUGS_CHARGED_TO_PATIENTS		0	2, 298, 923		1.00
	TOTALS F - MED SUPPLY IMPLANTS		0	2, 298, 923		
1.00	IMPL. DEV. CHARGED TO	72.00	0	4, 754, 083		1.00
	PATI ENT					
2.00 3.00		0.00 0.00	0	0		2.00 3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00 7.00		0.00	0	0		6.00 7.00
7.00	TOTALS		<u>0</u>	4, 754, 083		7.00
4 0-	G - CHARGABLE MED SUPPLIES					
1.00	MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	71.00	0	2, 935, 015		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00 0.00	0	0		4.00
5.00 6.00		0.00	0	0		5.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9. 00 10. 00		0. 00 0. 00	0	0		9.00 10.00
	1		5	51		

	Financial Systems SIFICATIONS		WI THAM MEMORIA	L HOSPITAL Provider CCN: 15-0104	Period:	u of Form CMS-2552 Worksheet A-6
LULAS.	STITCATIONS				From 01/01/2018 To 12/31/2018	Date/Time Prepare
					10 12/31/2010	5/24/2019 2:03 pm
	Cost Center	Li ne #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00		0.00	0	0		11.
2.00		0.00	0	0		12.
3.00 4.00		0.00	0	0		13.
4.00 5.00		0.00 0.00	0	0		14.
6.00		0.00	o	Ö		16.
7.00		0.00	0	0		17.
8.00		0.00	0	0		18.
9.00		0.00	0	0		19.
0.00 1.00		0.00 0.00	0	0		20. 21.
2.00		0.00	0	0		21.
3.00		0.00	o	Ö		23.
4.00		0.00	0	0		24.
5.00		0.00	0	0		25.
6.00		0.00	0	0		26.
7.00		0.00	0	0		27.
8.00 9.00		0.00 0.00	0	0		28. 29.
0.00		0.00	0	0		30.
1.00		0.00	0	0		31.
2.00		0.00	0	0		32.
3. 00		0.00	0	0		33.
4.00		0.00	0	0		34.
35.00	TOTALS			00000000		35.
	H - BONUS RECLASS		U	2, 935, 015		
I. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	15, 979	0		1.
2.00	ADMINISTRATIVE & GENERAL	5.00	339, 679	0		2.
3.00	OPERATION OF PLANT	7.00	21, 185	0		3.
1.00	LAUNDRY & LINEN SERVICE	8.00	671	0		4.
5.00 5.00	HOUSEKEEPI NG DI ETARY	9. 00 10. 00	8, 041 21, 432	0		5.
7.00 .00	NURSING ADMINISTRATION	13.00	17, 866	0		7.
3.00	PHARMACY	15.00	12, 883	0		8.
9.00	MEDI CAL RECORDS & LI BRARY	16.00	32, 575	0		9.
0.00	ADULTS & PEDIATRICS	30.00	82, 305	0		10.
1.00		31.00	36, 306	0		11.
2.00 3.00	SUBPROVIDER - IPF SKILLED NURSING FACILITY	40.00 44.00	30, 896 23, 078	0		12.
4.00	OPERATING ROOM	50.00	56, 483	0		13.
5.00	RADI OLOGY-DI AGNOSTI C	54.00	53, 006	0		15.
6.00	ULTRA SOUND	55.01	7, 858	0		16.
7.00	CT SCAN	57.00	6, 818	0		17.
8.00	MAGNETIC RESONANCE I MAGI NG	58.00	10, 809	0		18.
9.00	(MRI) CARDIAC CATHETERIZATION	59.00	5, 970	0		19.
9.00	LABORATORY	60.00	66, 886	0		20.
1.00	PHYSI CAL THERAPY	66.00	49, 160	Ö		21.
2.00	OCCUPATI ONAL THERAPY	67.00	9, 343	0		22.
3.00	AUDI OLOGY	67.01	4, 466	0		23.
4.00	SPEECH PATHOLOGY	68.00	3, 593	0		24.
5.00	CARDI OLOGY	69.01 90.01	30, 968	0		25.
6. 00	OTHER OUTPATIENT SERVICE COST CENTER	90.01	6, 412	U		26.
27.00	GASTROENTEROLOGY CLINIC	90.09	2, 829	0		27.
8.00	ALLERGY CLINIC	90.13	1, 886	Ö		28.
9.00	WOUND CARE	90.14	9, 941	0		29.
0.00	EMERGENCY	91.00	62, 728	0		30.
1.00	AMBULANCE SERVICES	95.00	55, 392	0		31.
	TOTALS Grand Total: Increases		1, 087, 444 1, 288, 992	0 15, 013, 014		500.

	Financial Systems SIFICATIONS		WI THAM MEMORIA			Period: Wo	<u>f Form CMS-2552-1</u> orksheet A-6
					F	From 01/01/2018 To 12/31/2018 Da	te/Time Prepared:
		Decreases				57	24/2019 2:03 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00 A - EMPLOYEE BENEFITS	7.00	8.00	9.00	10.00		
00	ADMI NI STRATI VE & GENERAL	5.00	0	402, 439			1.0
	TOTALS		0	402, 439	9		
00	B - I NSURANCE RECLASS ADMI NI STRATI VE & GENERAL	5.00	0	156, 080) 12		1.0
00	TOTALS		<u>0</u>	156, 080			1.0
	C – CAFETERIA RECLASS			· · · · · · · · · · · · · · · · · · ·	1		
00		<u>10.00</u>	201, 548	27 <u>9, 2</u> 27			1.0
	TOTALS D - MME DEPRECIATION		201, 548	279, 227	/		
00	NEW CAP REL COSTS-BLDG &	1.00	0	185, 595	5 9		1.0
	FIXT						
00 00	EMPLOYEE BENEFITS DEPARTMENT	4.00 5.00	0	6, 912 777, 548			2.0
00	OPERATION OF PLANT	7.00	0	120, 043	-		4.0
00	LAUNDRY & LINEN SERVICE	8.00	0	160	0 0		5.0
00	HOUSEKEEPING	9.00	0	2, 410			6.0
00 00	DI ETARY NURSI NG ADMI NI STRATI ON	10. 00 13. 00	0	27, 123 43, 958			7.0
00	PHARMACY	15.00	0	2, 191	-		9.0
. 00	MEDICAL RECORDS & LIBRARY	16.00	0	7, 239			10.0
. 00	ADULTS & PEDIATRICS	30.00	0	156, 200			11.0
. 00 . 00	I NTENSI VE CARE UNI T SUBPROVI DER – I PF	31.00 40.00	0	37, 173 8, 525			12. 0 13. 0
. 00	SKILLED NURSING FACILITY	44.00	0	62, 555			14.0
. 00	OPERATING ROOM	50.00	0	532, 812			15.0
. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	330, 565			16.0
. 00 . 00	ULTRA SOUND CT SCAN	55. 01 57. 00	0	72, 184 405, 185			17.0 18.0
. 00 . 00	MAGNETIC RESONANCE I MAGI NG	58.00	0	320, 751	-		19.0
	(MRI)			, -			
0.00	CARDIAC CATHETERIZATION	59.00	0	171, 384			20.0
. 00	LABORATORY BLOOD STORING, PROCESSING &	60.00 63.00	0	235, 143 1, 537			21. 0 22. 0
. 00	TRANS.	03.00	0	1, 557			22.0
. 00	PHYSI CAL THERAPY	66.00	0	18, 207			23.0
. 00	OCCUPATIONAL THERAPY	67.00	0	406			24.0
. 00	AUDI OLOGY CARDI OLOGY	67.01 69.01	0	10, 803 121, 662			25. 0 26. 0
. 00	OTHER OUTPATIENT SERVICE	90.01	0	5, 025			27.0
	COST CENTER	00.05		4 07			
. 00 . 00	SURGERY CLINIC	90.05 90.12	0	1, 074 33, 236			28.0 29.0
. 00	ALLERGY CLINIC	90.12	0	701	-		30.0
. 00	WOUND CARE	90. 14	0	24, 996			31.0
. 00		91.00	0	95, 633			32.0
. 00	AMBULANCE SERVICES PHYSICIANS' PRIVATE OFFICES	95.00 192.00	0	160, 554 203, 544			33. 0 34. 0
. 00	OTHER NONREI MB	194.02	0	1, 188			35.0
. 00	RETAIL PHARMACY	194.03	0	3, 025			36.0
			0	4, 187, 247	7		
00	E - DRUGS RECLASS PHARMACY	15.00	0	2, 298, 923	3 0		1.0
00	TOTALS		<u>o</u>	2, 298, 923			1.0
	F - MED SUPPLY IMPLANTS						
00	INTENSIVE CARE UNIT	31.00	0	726			1.0
00 00	OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C	50.00 54.00	0	3, 789, 779 31, 788			2.0
00	CARDI AC CATHETERI ZATI ON	59.00	0	655, 092			4.0
00	MEDICAL SUPPLIES CHARGED TO	71.00	0	13, 103	3 0		5.0
00	PATIENTS DRUGS CHARGED TO PATIENTS	73.00	0	62, 067	7 0		6.0
00	WOUND CARE	90.14	0	201, 528			7.0
	TOTALS		<u>0</u>	4, 754, 083			
	G - CHARGABLE MED SUPPLIES						
00 00	EMPLOYEE BENEFITS DEPARTMENT	4.00 5.00	0	2,062			1.0
00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5.00	0	12, 131 36			2.0
00	LAUNDRY & LINEN SERVICE	8.00	o	1	-		4.0
00	HOUSEKEEPI NG	9.00	О	1, 242			5.0
00		10.00	0	469			6.0
00 00	NURSING ADMINISTRATION PHARMACY	13.00 15.00	0	1 22, 274			7.0
00	MEDICAL RECORDS & LIBRARY	16.00	0	22, 27-			9.0

Health Financial Systems RECLASSIFICATIONS

WITHAM MEMORIAL HOSPITAL

Health Financial Systems			WI THAM MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10		
RECLASS	SEFECATIONS			Provider (CCN: 15-0104	Peri od:	Worksheet A-	6
						From 01/01/2018 To 12/31/2018	Date/Time Pr	enared
							5/24/2019 2:	
		Decreases				. 1		
	Cost Center 6.00	Line # 7.00	Salary 8.00	0ther 9.00	Wkst. A-7 Ref 10.00	<u>.</u>		
10.00	ADULTS & PEDIATRICS	30.00	0	227, 140		0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	102, 029		0		11.00
12.00	SUBPROVI DER – I PF	40.00	0	25, 605		0		12.00
13.00	NURSERY	43.00	0	759		0		13.00
14.00	SKILLED NURSING FACILITY	44.00	0	40, 780		0		14.00
15.00	OPERATING ROOM	50.00	0	1, 907, 197		0		15.00
16.00 17.00	RADI OLOGY-DI AGNOSTI C ULTRA SOUND	54.00 55.01	0	29, 182 9, 149		0		16.00 17.00
17.00	CT SCAN	57.00	0	9, 149 15, 096		0		17.00
19.00	MAGNETIC RESONANCE I MAGI NG	58.00	o	4, 400		0		19.00
	(MRI)					-		
20.00	CARDI AC CATHETERI ZATI ON	59.00	0	15, 467		0		20.00
21.00	LABORATORY	60.00	0	19, 235		0		21.00
22.00	PHYSICAL THERAPY	66.00	0	1, 151		0		22.00
23.00 24.00	OCCUPATI ONAL THERAPY AUDI OLOGY	67.00 67.01	0	143 11		0		23.00 24.00
24.00	SPEECH PATHOLOGY	68.00	0	1		0		24.00
26.00	CARDI OLOGY	69.01	0	13, 199		0		26.00
27.00	OTHER OUTPATIENT SERVICE	90.01	0	2, 536		0		27.00
	COST CENTER							
28.00	UROLOGY CLINIC	90.07	0	1, 315		0		28.00
29.00 30.00	ALLERGY CLINIC WOUND CARE	90. 13 90. 14	0	170 25, 937		0		29.00 30.00
30.00	EMERGENCY	90.14	0	358, 223		0		30.00
32.00	AMBULANCE SERVICES	95.00	0	18, 339		0		32.00
33.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	79, 580		0		33.00
34.00	OTHER NONREI MB	194.02	0	3		0		34.00
35.00	RETAIL PHARMACY	<u> </u>	•	92		<u>o</u>		35.00
	TOTALS H - BONUS RECLASS		0	2, 935, 015				-
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 087, 444		0		1.00
2.00		0.00	0	0		0		2.00
3.00		0.00	0	0		0		3.00
4.00		0.00	0	0		0		4.00
5.00		0.00	0	0		0		5.00
6.00		0. 00 0. 00	0	0		0		6.00
7.00 8.00		0.00	0	0		0		7.00 8.00
9.00		0.00	0	0		0		9.00
10.00		0.00	0	0		0		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
16.00		0.00	0	0		0		16.00
17.00		0.00	Ő	0		0		17.00
18.00		0.00	0	0		0		18.00
19.00		0.00	0	0		0		19.00
20.00		0.00	0	0		0		20.00
21. 00 22. 00		0. 00 0. 00	0	0 0		0		21.00 22.00
22.00		0.00	0	0		0		22.00
24.00		0.00	0	0		0		24.00
25.00		0.00	0	0		0		25.00
26.00		0.00	О	0		0		26.00
27.00		0.00	0	0		0		27.00
28.00		0.00	0	0		0		28.00
29. 00 30. 00		0.00 0.00	0	0		0		29.00 30.00
30.00		0.00	0	0		0		30.00
	TOTALS		0	1, 087, 444		_		
500.00	Grand Total: Decreases		201, 548	16, 100, 458				500.00

Health Financial Systems	WITHAM MEMORIAL HOSPITAL			In Lieu of Form CMS-25		
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-0104	Period: From 01/01/2018 To 12/31/2018		
				10 12/31/2010	5/24/2019 2:0	areu. 3 pm
			Acqui si ti on	S		
	Begi nni ng	Purchases	Donati on	Total	Disposals and	
	Bal ances				Retirements	
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET					1	
1.00 Land	15, 743, 378	76, 582		0 76, 582		
2.00 Land Improvements	0	0		0 0		
3.00 Buildings and Fixtures	84, 993, 937	839, 521		0 839, 521		3.00
4.00 Building Improvements	0	0		0 0	-	4.00
5.00 Fixed Equipment	2, 228, 155	43, 486		0 43, 486		5.00
6.00 Movable Equipment	56, 679, 756	4, 046, 329		0 4, 046, 329		
7.00 HIT designated Assets	150 (45 00)			0 0 00	, U	
8.00 Subtotal (sum of lines 1-7)	159, 645, 226	5, 005, 918		0 5, 005, 918		
9.00 Reconciling Items	150 (15 00)	5 005 010			0	
10.00 Total (line 8 minus line 9)	159, 645, 226	5,005,918		0 5,005,918	12, 996	10.00
	Endi ng Bal ance	Fully Depreciated				
		Assets				
	6,00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		7.00				
1.00 Land	15, 819, 960	0				1.00
2.00 Land Improvements	0	0				2.00
3.00 Buildings and Fixtures	85, 833, 458	0				3.00
4.00 Building Improvements	0	0				4.00
5.00 Fixed Equipment	2, 271, 641	0				5.00
6.00 Movable Equipment	60, 713, 089	0				6.00
7.00 HIT designated Assets	0	0				7.00
8.00 Subtotal (sum of lines 1-7)	164, 638, 148	0				8.00
9.00 Reconciling Items	0	0				9.00
10.00 Total (line 8 minus line 9)	164, 638, 148	0				10.00

Heal th	Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lieu of Form CMS-2552-10		
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-0104	Period:	Worksheet A-7	
					From 01/01/2018 To 12/31/2018		narod
					10 12/31/2010	5/24/2019 2:03	
			SU	JMMARY OF CAP	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	``	
			10.00	11.00		instructions)	
	DADT LL DECONCLULATION OF ANOUNTS FROM WORL	9.00	10.00	11.00	12.00	13.00	
4 00	PART II - RECONCILIATION OF AMOUNTS FROM WORK			na 2			1 00
1.00	NEW CAP REL COSTS-BLDG & FIXT	3, 822, 999	0		0 0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	3, 822, 999			0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	3, 822, 999				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	3, 822, 999				3.00

Health Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2018 To 12/31/2018		pared: 3 pm
	COM	PUTATION OF RAT	-1 0S	ALLOCATION OF		
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
PART III - RECONCILIATION OF CAPITAL COSTS CE	1.00	2.00	3.00	4.00	5.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT 2.00 NEW CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	85, 833, 458 2, 271, 641 88, 105, 099	0	2, 271, 64 88, 105, 09	1 0. 025783	0 0 0 F. CAPI TAL	1.00 2.00 3.00
Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		r	Γ			
1.00 NEW CAP REL COSTS-BLDG & FIXT 2.00 NEW CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0	0		0 3, 637, 404 0 4, 187, 247 0 7, 824, 651		1.00 2.00 3.00
	0	Ŭ	IMMARY OF CAPI		-70,004	3.00
Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		I	[
1.00 NEW CAP REL COSTS-BLDG & FLXT 2.00 NEW CAP REL COSTS-MVBLE EQUIP	-420, 511 0			0 0 0 0	3, 296, 169 4, 187, 247	1.00 2.00
3.00 Total (sum of lines 1-2)	-420, 511	-		0 0 0 0	4, 187, 247 7, 483, 416	2.00 3.00

	Financial Systems MENTS TO EXPENSES		WI THAM MEMORI	Provider CCN: 15-0104 Pe	eriod: com 01/01/2018	u of Form CMS-2 Worksheet A-8	
				To		Date/Time Pre 5/24/2019 2:03	
				Expense Classification on To/From Which the Amount is			
	Cost Center Description	Basis/Code (2) 1.00	Amount	Cost Center 3.00		Wkst. A-7 Ref.	
. 00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter	1.00	-	3.00 NEW CAP REL COSTS-BLDG & FIXT	4.00 1.00	<u>5.00</u> 0	1.00
2.00	2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter			NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
. 00	2) Investment income - other		0		0.00	0	3.00
. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.00
. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.00
o. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter	В	-4, 066	ADMI NI STRATI VE & GENERAL	5.00	0	7.00
8. 00	21) Television and radio service (chapter 21)		0		0.00	0	8.00
7.00 10.00	Parking lot (chapter 21) Provider-based physician	A-8-2	0 -3, 240, 912		0.00	0 0	
11.00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11.00
2.00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	0			0	12.00
	Laundry and linen service	В	-284, 844	DI ETARY	10.00	0	
	Cafeteria-employees and guests Rental of quarters to employee and others		0		0.00 0.00	0 0	
6. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
7.00	patients Sale of drugs to other than patients		0		0.00	0	17.00
8.00	Sale of medical records and abstracts		0		0.00	0	18.00
9. 00	Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
	books, etc.) Vending machines Income from imposition of interest, finance or penalty	В	-1, 832 0	DI ETARY	10. 00 0. 00	0 0	
2. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
. 00	(chapter 21) Depreciation - NEW CAP REL			NEW CAP REL COSTS-BLDG &	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - NEW CAP REL		0	FLXT NEW CAP REL COSTS-MVBLE	2.00	0	27.00
	COSTS-MVBLE EQUIP Non-physician Anesthetist			EQUIP *** Cost Center Deleted ***	19.00		28.00
	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0 0	OCCUPATI ONAL THERAPY	0.00 67.00	0	29.00 30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

		WI THAM MEMORI			2552-10		
ADJUST	MENTS TO EXPENSES				Period:	Worksheet A-8	
					From 01/01/2018 To 12/31/2018	Date/Time Pre 5/24/2019 2:0	
				Expense Classification on	Worksheet A	572472017 2.0	
				To/From Which the Amount is	to be Adjusted		
			A .		1		
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
32.00	CAH HIT Adjustment for	1.00	0		0.00		32.00
	Depreciation and Interest						
33.00	HOSP ADMIN SPONSORSHIPS/DONATIONS	A	-11, 385	ADMI NI STRATI VE & GENERAL	5.00	0	33.00
33. 01	LEASE INCOME	В	-43,484	NEW CAP REL COSTS-BLDG &	1.00	10	33.01
		_		FIXT			
33. 02	RENTAL REVENUE	В	-33, 320	NEW CAP REL COSTS-BLDG &	1.00	10	33. 02
33. 03	WELLNESS REVENUE	В	-55 035	FIXT EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.03
	EDUCATION REVENUE	B		ADMI NI STRATI VE & GENERAL	5.00		33.04
	MEDICAL STAFF FEES	В		ADMI NI STRATI VE & GENERAL	5.00		
	VOLUNTEER MISC REVENUE	В		ADMI NI STRATI VE & GENERAL	5.00		
33.07	VOLUNTEER MEMORIALS	В		ADMI NI STRATI VE & GENERAL	5.00		33.07
	PATIENT ACCOUNTS	В	-518	ADMINISTRATIVE & GENERAL	5.00	0 0	33.08
	MISC INCOME RECEIVED	В		ADMINISTRATIVE & GENERAL	5.00	0 0	33.09
	PLANT OPERATI ONS	В		OPERATION OF PLANT	7.00		
	MEALS ON WHEELS	В		DI ETARY	10.00		
	HEAD START & CASH (SHORT)OVER	В		DIETARY	10.00		33.12
	CI COA MEAL VOUCHERS	В		DIETARY	10.00		33.13
	PHARMACY REVENUE	В		PHARMACY	15.00		
	MEDI CAL RECORDS	B		MEDICAL RECORDS & LIBRARY	16.00 54.00		
33.10	RADI OLOGY DI AGNOSTI C PURCHASI NG DI SC	D	-02	RADI OLOGY-DI AGNOSTI C	54.00	0	33.10
33. 17	CENTRAL SUPPLY PURCHASING DISC	В	-51, 758	MEDICAL SUPPLIES CHARGED TO	71.00	0	33. 17
33. 18	AMBULANCE	В	-2 400	PATIENTS AMBULANCE SERVICES	95.00	0	33. 18
	DERMATOLOGY CLINIC RENT	A		DERMATOLOGY CLINIC	90.03		
	SURGERY CLINIC RENT	A		SURGERY CLINIC	90.05		
	UROLOGY CLINIC RENT	А		UROLOGY CLINIC	90.07		
33. 22	GASTROENTEROLOGY CLINIC RENT	A	-14, 658	GASTROENTEROLOGY CLINIC	90.09	0	33. 22
33. 23	NEUROLOGY CLINIC RENT	A	-8, 480	NEUROLOGY CLINIC	90.11	0	33. 23
33.24	EYE INSTITUTE RENT	A		OPTHAMOLOGY CLINIC	90.12		
	DIALYSIS CENTER	A		WOUND CARE	90.14		
33. 26	2010 BOND INTEREST ON INVEST	В	-1, 335	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33. 26
33. 27	2015 BOND INTEREST ON INVEST	В	-45, 664	NEW CAP REL COSTS-BLDG & FLXT	1.00	11	33. 27
33. 28	INTEREST INCOME UNNECESSARY BORROW	В		NEW CAP REL COSTS-BLDG &	1.00	11	33. 28
33. 29	GAIN ON INVESTMENT	В	-468, 667	NEW CAP REL COSTS-BLDG &	1.00	11	33. 29
33. 30	VOLUNTEER REVENUE INTEREST	В		FIXT ADMINISTRATIVE & GENERAL	5.00	0	33.30
	GAIN/(LOSS) CIHA	A		ADMINISTRATIVE & GENERAL	5.00		
	GAIN/(LOSS) SHO SPC	В		ADMI NI STRATI VE & GENERAL	5.00		
	GAIN/(LOSS) SHO RRG	В		ADMI NI STRATI VE & GENERAL	5.00		
	HEARING AID COSTS	Ā		AUDI OLOGY	67.01		1
	BANK FEES	A		ADMI NI STRATI VE & GENERAL	5.00		
33.36	LOBBYING EXPENSE IHA DUES	A	-2,839	ADMI NI STRATI VE & GENERAL	5.00	0	33.36
	LOBBYING EXPENSE AHA DUES	A		ADMI NI STRATI VE & GENERAL	5.00		
33. 38	NONREI MBURSABLE ADVERTI SI NG COSTS	A	-191, 483	ADMI NI STRATI VE & GENERAL	5.00	0	33. 38
33. 39	SELF INSURANCE CLAIMS PAID	В	-4, 286, 312	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.39
	HAF FEE	Ā		ADMI NI STRATI VE & GENERAL	5.00		
	EMPLOYEE HEALTH REV CLIENT	В		ADMI NI STRATI VE & GENERAL	5.00		
	2017 BOND INTEREST ON	В		NEW CAP REL COSTS-BLDG &	1.00		
50.00	INVESTMENT TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,		-13, 123, 263	FI XT			50.00
	column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(2) Additional ediustrate results are the read on the and subparients thereaft

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
 Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Syste	ems	WI THAM MEMOR	IAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (CCN: 15-0104	Peri od:	Worksheet A-8	3-2
						From 01/01/2018		
						To 12/31/2018	Date/Time Pre 5/24/2019 2:0	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	44.00	SKILLED NURSING FACILITY	5, 800	5, 800	(0 0	0	1.00
2.00	54.00	RADI OLOGY-DI AGNOSTI C	380, 460	380, 460	(0 0	0	2.00
3.00	60.00	LABORATORY	251,000	251, 000	(0 0	0	3.00
4.00	91.00	EMERGENCY	2, 602, 200	2, 602, 200	(0 0	0	4.00
5.00	95.00	AMBULANCE SERVICES	1, 452	1, 452	(0 0	0	5.00
6.00	0.00		0	0	(0 0	0	6.00
7.00	0.00		0	0	(0 0	0	7.00
8.00	0.00		0	0	(0 0	0	8.00
9.00	0.00		0	0	(0 0	0	9.00
10.00	0.00		0	0	(0 0	0	10.00
200.00			3, 240, 912	3, 240, 912	(b	0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		Identifier	Limit	Unadjusted RCE	Memberships &	Component	of Mal practi ce	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		SKILLED NURSING FACILITY	0	-		0 0	-	
2.00		RADI OLOGY-DI AGNOSTI C	0	-		0 0	-	
3.00		LABORATORY	0	-		0 0	0	
4.00		EMERGENCY	0	0		0 0	0	
5.00		AMBULANCE SERVICES	0			0 0	0	
6.00	0.00		0	0	(0	0	0.00
7.00	0.00		0	0	(°	0	
8.00	0.00		0	0		0 0	0	
9.00	0.00		0	e e e e e e e e e e e e e e e e e e e		0 0	0	
10.00	0.00		0	-		0 0	-	
200.00			0	0		0 0	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adj ustment		
		Identifier	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14 15.00	16.00	17.00	18.00		
1.00		SKI LLED NURSI NG FACI LI TY	15.00		17.00			1.00
2.00		RADI OLOGY-DI AGNOSTI C	0	-		380, 460		2.00
3.00		LABORATORY	0			251,000		3.00
4.00		EMERGENCY	0	-		2, 602, 200		4.00
4.00 5.00		AMBULANCE SERVICES						4.00 5.00
6.00	0.00	4		-		0 1,432		6,00
7.00	0.00		0	e e e e e e e e e e e e e e e e e e e		-		7.00
8.00	0.00							8.00
9.00	0.00		0	-				9.00
7.00 10.00	0.00		0					10,00
200.00	0.00		0	-		3, 240, 912		200.00
200.00	I	1	. 0	. 0	I	-1 0,210,712	I	

	Financial Systems	WI THAM MEMORIA				u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	F	eriod: rom 01/01/2018	Worksheet B Part I	
					o 12/31/2018	Date/Time Pre 5/24/2019 2:0	pared: <u>3 pm</u>
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Net Expenses	NEW BLDG &	NEW MVBLE	EMPLOYEE	Subtotal	
		for Cost Allocation	FIXT	EQUI P	BENEFI TS DEPARTMENT		
		(from Wkst A			DEFFICIENCE		
		<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	3, 296, 169 4, 187, 247	3, 296, 169	4, 187, 247			1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	9, 991, 330	7, 496	9, 523	10, 008, 349		4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	12, 769, 433 3, 155, 026	239, 574 313, 868	304, 340 398, 718		14, 404, 352 3, 980, 592	5.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	322, 720	0	0	4, 755	3, 700, 372	8.00
9.00	00900 HOUSEKEEPI NG	789, 922	36, 142	45, 913		948, 229	
10.00 11.00	01000 DI ETARY 01100 CAFETERI A	1, 057, 776 480, 775	80, 901 0	102, 772 0		1, 356, 547 514, 153	10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	902, 159	Ö	0	137, 617	1, 039, 776	
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	7, 562, 050	24, 975 39, 452	31, 727 50, 118		7, 730, 668	
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1, 734, 266	39,432	50, 116		2, 046, 136	18.00
30.00	03000 ADULTS & PEDIATRICS	4, 556, 802	262, 411	333, 351	594, 559	5, 747, 123	
31.00 40.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	1, 574, 036 1, 260, 066	72, 065 82, 511	91, 548 104, 817	192, 283 186, 035	1, 929, 932 1, 633, 429	
41.00	04100 SUBPROVI DER – I RF	0	0	0	0	0	41.00
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	0	0	0	0	0	42.00 43.00
43.00	04400 SKI LLED NURSI NG FACI LI TY	47, 671 1, 660, 590	62, 483	79, 374	165, 354	47, 671 1, 967, 801	43.00
	ANCI LLARY SERVICE COST CENTERS						
50.00 54.00	05000 OPERATI NG ROOM 05400 RADI OLOGY-DI AGNOSTI C	2, 839, 233 4, 973, 586	209, 434 256, 138	266, 052 325, 382		3, 688, 578 5, 808, 680	
55.00	05500 RADI OLOGY-THERAPEUTI C	4, 773, 500	230, 130	0	200, 0/4	0	55.00
55.01	05501 ULTRA SOUND	565, 698	0	0	52, 640	618, 338	
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	874, 441 767, 205	0 21, 974	0 27, 914	33, 714 54, 503	908, 155 871, 596	
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 256, 709	18, 522	23, 529		1, 347, 168	
60.00	06000 LABORATORY	6, 702, 821	119, 452	151, 745 0	449, 814 0	7, 423, 832	60.00
63.00 64.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY	169, 575 0	0	0	0	169, 575 0	63.00 64.00
66.00	06600 PHYSI CAL THERAPY	2, 065, 741	115, 614	146, 869		2, 627, 425	
67.00 67.01	06700 OCCUPATI ONAL THERAPY 06701 AUDI OLOGY	399, 934 160, 295	0	0	60, 644 34, 695	460, 578 194, 990	67.00 67.01
68.00	06800 SPEECH PATHOLOGY	200, 249	0	0		229, 452	
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
69.01 71.00	06901 CARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	1, 263, 730 2, 865, 224	11, 914	15, 135 0	180, 136 0	1, 470, 915 2, 865, 224	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	4, 754, 083	0	0	Ŭ	4, 754, 083	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 236, 856	0	0	0	2, 236, 856	73.00
90.00	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	277, 471	49, 229	62, 537	33, 075	422, 312	90.01
90. 02 90. 03	09002 CLINIC 09003 DERMATOLOGY CLINIC	0	0	0	0	0	90.02 90.03
90. 03 90. 04	09004 ENT CLINIC	0	0	0	0	0	90.03
90.05	09005 SURGERY CLINIC	0	0	0	0	0	90.05
90. 07 90. 09	09007 UROLOGY CLI NI C 09009 GASTROENTEROLOGY CLI NI C	0	0	0	0 1, 013	0 1, 013	90.07 90.09
90.09 90.11	09011 NEUROLOGY CLINIC	0	0	0	1, 013	1, 013	90.09
90. 12	09012 OPTHAMOLOGY CLINIC	0	0	0	0	0	90. 12
90. 13 90. 14	09013 ALLERGY CLINIC 09014 WOUND CARE	145, 883 320, 517	0 45, 133	0 57, 334	17, 448 43, 271	163, 331 466, 255	90. 13 90. 14
90. 14 91. 00	09100 EMERGENCY	2, 809, 780	316, 418	401, 958		3, 928, 478	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	2, 710, 242	61, 310	77, 885	383, 889	3, 233, 326	95.00
701.00	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	93, 707, 311	2, 447, 016	3, 108, 541	5, 792, 941	87, 564, 044	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	8, 037	10, 210	ol	18, 247	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	34, 532, 590	553, 111	702, 633		39, 949, 061	192.00
	07950 THORNTOWN OFFICE BUILDING 07951 CAFE/BOUTIQUE	0	0 18, 239	0 23, 169	0	0 41, 408	194.00 194.01
	07951 CAFEZ BOUT QUE	174, 469	264, 614	336, 149		787, 072	194.02
	07953 RETAIL PHARMACY	1, 429, 319	5, 152	6, 545	42, 841	1, 483, 857	
200.00 201.00			0	0	0		200.00 201.00
	1 1 <u>9</u> 1901 00010	ı I	9	0	<u> </u>	0	

Health Financial Systems	WI THAM MEMORI	WITHAM MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS	ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0104		Period: Worksheet B From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared: 5/24/2019 2:03 pm	
		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)	129, 843, 689	3, 296, 169	4, 187, 247	10, 008, 349	129, 843, 689	202.00

Heal th	Financial Systems	WI THAM MEMORI A	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
	LLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 01/01/2018	Worksheet B Part I	
					0 12/31/2018	Date/Time Pre	pared:
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	5/24/2019 2:0 DI ETARY	3 pm
	cost center bescription	& GENERAL	PLANT	LINEN SERVICE	HOUSEKEEPING	DIETART	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	TT			1		
1.00 2.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	14, 404, 352					5.00
7.00	00700 OPERATION OF PLANT	496, 694	4, 477, 286				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	40, 862	0	368, 337			8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	118, 319 169, 269	68, 348 152, 992			1, 754, 539	9.00 10.00
11.00	01100 CAFETERI A	64, 155	132, 772			1, 734, 337	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	129, 742	C	0		0	13.00
15.00	01500 PHARMACY	964, 625	47, 230			0	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	255, 315	74, 608	0	50, 499	0	16.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	717, 120	496, 242	17, 688	383, 626	837, 539	30.00
31.00	03100 I NTENSI VE CARE UNI T	240, 815	136, 282			037, 339	31.00
40.00	04000 SUBPROVI DER - I PF	203, 818	156, 036			352, 074	40.00
41.00	04100 SUBPROVI DER – I RF	0	0	-		0	41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43.00 44.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	5, 948 245, 540	0 118, 160	1,720		0 564, 926	43.00 44.00
44.00	ANCI LLARY SERVICE COST CENTERS	243, 340	110, 100	2,704	<u> </u>	504, 720	44.00
50.00	05000 OPERATI NG ROOM	460, 257	396, 058	46, 927	22, 615	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	724, 801	484, 380			0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		-	0	55.00
55. 01 57. 00	05501 ULTRA SOUND 05700 CT SCAN	77, 156 113, 319	0			0	55.01 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	108, 757	41, 554			0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	168, 098	35, 027			0	59.00
60.00	06000 LABORATORY	926, 338	225, 895			0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	21, 159	0			0	63.00
64.00 66.00	06400 I NTRAVENOUS THERAPY 06600 PHYSI CAL THERAPY	0 327, 847	0 218, 636	-,		0	64.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	57, 470	210,000			0	67.00
67.01	06701 AUDI OLOGY	24, 331	C	950	5, 489	0	67.01
68.00	06800 SPEECH PATHOLOGY	28, 631	0	.,		0	68.00
69.00	06900 ELECTROCARDI OLOGY 06901 CARDI OLOGY	192 520	0 22, 531	12 107	-	0	69.00 69.01
69. 01 71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	183, 539 357, 520	22, 531			0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	593, 210	C			0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	279, 113	0	34, 927	23, 932	0	73.00
00.00	OUTPATIENT SERVICE COST CENTERS			J			
	09000 CLINIC 09001 OTHER OUTPATIENT SERVICE COST CENTER	0 52, 696	0 93, 096		0 58, 842	0	90. 00 90. 01
	09002 CLINIC	52,070	93, 070 C			0	90.01
90.03	09003 DERMATOLOGY CLINIC	0	C	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 90. 09	09007 UROLOGY CLINIC 09009 GASTROENTEROLOGY CLINIC	126	U	142 0		0	90. 07 90. 09
90.11	09011 NEUROLOGY CLINIC	0	C	0	0	0	90.11
90.12	09012 OPTHAMOLOGY CLINIC	0	C	0	0	0	90.12
90.13	09013 ALLERGY CLINIC	20, 380	C	671		0	90.13
90.14	09014 WOUND CARE	58, 179	85, 350			0	90.14
	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	490, 192	598, 374	30, 056	0	0	91.00 92.00
72.00	OTHER REIMBURSABLE COST CENTERS	11		1	<u> </u>		/2.00
95.00	09500 AMBULANCE SERVI CES	403, 451	42, 870	3, 849	0	0	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00		9, 128, 792	3, 493, 669	368, 337	1, 134, 896	1, 754, 539	118.00
190 00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2, 277	15, 199	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	4, 984, 752	924, 184				192.00
	07950 THORNTOWN OFFICE BUILDING	0	0		0		194.00
	07951 CAFE/BOUTI QUE	5, 167	34, 491	0	0		194.01
	07952 OTHER NONREI MB	98, 210	0	0	0		194.02
194.03 200.00	O7953 RETALL PHARMACY Cross Foot Adjustments	185, 154	9, 743		0	0	194. 03 200. 00
200.00		0	C	0	0	0	200.00
202.00	5	14, 404, 352	4, 477, 286	368, 337	1, 134, 896		
	-						

Health Financial Systems	WI THAM MEMORI A	AL HOSPITAL		In Lieu	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		eriod: rom 01/01/2018	Worksheet B Part I	
				0 12/31/2018	Date/Time Pre 5/24/2019 2:0	pared:
Cost Center Description	CAFETERI A	NURSI NG	PHARMACY	MEDI CAL	Subtotal	
	4	ADMI NI STRATI ON		RECORDS & LI BRARY		
	11.00	13.00	15.00	16.00	24.00	
1.00 OO100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY						9.00 10.00
	603, 558					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 15. 00 01500 PHARMACY	11, 678 23, 356	1, 192, 613 0	8, 788, 933			13.00 15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY	47, 326	0	0			16.00
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS	159, 188	270, 074	12, 839	607, 936	9, 249, 375	30.00
31. 00 03100 I NTENSI VE CARE UNI T	12, 907	80, 005	578		2, 633, 255	
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	20, 282	100, 468 0	269 0		2, 741, 672	40.00 41.00
41.00 04100 SUBPROVIDER - TRP 42.00 04200 SUBPROVIDER	0	0	0	0 0	0	41.00
43. 00 04300 NURSERY	0	0	0	0	55, 344	43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	0	98, 089	7, 307	0	3, 004, 527	44.00
50.00 OPERATING ROOM	14, 136	180, 410	41, 765		5, 068, 941	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	17, 209 0	0	3, 006 0		7, 755, 938 0	54.00 55.00
55. 01 05501 ULTRA SOUND	1, 844	0	3, 604	-	778, 927	55.01
57.00 05700 CT SCAN	2,458	0	1, 130		1, 149, 131	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION	6, 146 0	0 19, 159	11, 537 0		1, 102, 752 1, 584, 893	58.00 59.00
60. 00 06000 LABORATORY	50, 399	0	347		8, 784, 935	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 64.00 06400 I NTRAVENOUS THERAPY	0	0	0		191, 596 3, 171	63.00 64.00
66. 00 06600 PHYSI CAL THERAPY	25, 199	85, 492	7, 482	-	3, 432, 971	
67. 00 06700 OCCUPATI ONAL THERAPY 67. 01 06701 AUDI OLOGY	10, 449 11, 063	26, 157 18, 574	0		616, 478 255, 397	67.00 67.01
68. 00 06800 SPEECH PATHOLOGY	11, 678	12, 431	0		286, 501	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	-	0	69.00
69.01 06901 CARDIOLOGY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	25, 199 12, 907	83, 924 0	56 0		1, 945, 365 3, 243, 919	69.01 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		5, 360, 400	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	0	0	2, 574, 828	73.00
90. 00 09000 CLINIC	0	0	0	0	0	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER 90. 02 09002 CLINIC	20, 897	16, 863	8 0		917, 520	90. 01 90. 02
90. 02 09002 CETNIC 90. 03 09003 DERMATOLOGY CLINIC	0	0	0	0	0 0	90.02
90. 04 09004 ENT CLINIC	0	0	0		0	90.04
90. 05 09005 SURGERY CLINIC 90. 07 09007 UROLOGY CLINIC	0	0	702 841		702 983	90. 05 90. 07
90. 09 09009 GASTROENTEROLOGY CLINIC	0	12, 680	0		13, 819	90.09
90. 11 09011 NEUROLOGY CLINIC 90. 12 09012 0PTHAMOLOGY CLINIC	0	0	0	0	0	90. 11 90. 12
90. 13 09013 ALLERGY CLINIC	0	7, 878	5, 170		197, 430	90.12
90. 14 09014 WOUND CARE	0	21, 845	23, 902		659, 252	90.14
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	39, 336	149, 482	210, 268	0	5, 446, 186	91.00 92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	79, 901	0	89, 865	0	3, 853, 262	95.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	603, 558	1, 183, 531	420, 676	2, 455, 826	72, 909, 470	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0		0		35, 723	190 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	3, 102	5, 861, 495	18, 058	51, 740, 652	
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	0 5, 980	0	0	81, 066 891, 262	
194. 03 07953 RETAIL PHARMACY	0	0	2, 506, 762	0	4, 185, 516	194.03
200.00Cross Foot Adjustments201.00Negative Cost Centers	0	0	0	0		200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	603, 558	1, 192, 613	8, 788, 933	2, 473, 884	129, 843, 689	

	al Systems DN - GENERAL SERVICE COSTS	WI THAM MEMORIAL	HOSPITAL Provider CCN: 15-C		u of Form CMS-2552- Worksheet B
JI ALLUCAIIU	UN - GLIVERAL SERVICE CUSIS			From 01/01/2018	Part I
				To 12/31/2018	Date/Time Prepared 5/24/2019 2:03 pm
Co	ost Center Description	Intern &	Total		
		Residents Cost & Post			
		Stepdown			
		Adjustments			
GENERAL	SERVICE COST CENTERS	25.00	26.00		
	EW CAP REL COSTS-BLDG & FIXT				1.0
	EW CAP REL COSTS-MVBLE EQUIP				2.0
	MPLOYEE BENEFITS DEPARTMENT DMINISTRATIVE & GENERAL				4.0
	PERATION OF PLANT				5.0
	AUNDRY & LINEN SERVICE				8.0
1 1	OUSEKEEPING				9.0
. 00 01000 D . 00 01100 C					10.0
	AFETERIA URSING ADMINISTRATION				13. 0
00 01500 PI					15.0
	EDICAL RECORDS & LIBRARY				16. 0
	NT ROUTINE SERVICE COST CENTERS		0.040.075		
	DULTS & PEDIATRICS NTENSIVE CARE UNIT	0	9, 249, 375 2, 633, 255		30. 0 31. 0
	UBPROVIDER - IPF	0	2, 741, 672		40.0
. 00 04100 SI	UBPROVIDER – IRF	0	0		41.0
1 1	UBPROVI DER	0	0		42.0
. 00 04300 NI . 00 04400 SI	URSERY KILLED NURSING FACILITY	0	55, 344 3, 004, 527		43.0
	RY SERVICE COST CENTERS	<u> </u>	3,004,327		
	PERATING ROOM	0	5, 068, 941		50.0
1 1	ADI OLOGY-DI AGNOSTI C	0	7, 755, 938		54.0
	ADI OLOGY-THERAPEUTI C LTRA SOUND	0	0		55.0
00 05700 C		0	778, 927 1, 149, 131		57.0
	AGNETIC RESONANCE IMAGING (MRI)	0	1, 102, 752		58.0
	ARDI AC CATHETERI ZATI ON	0	1, 584, 893		59. (
	ABORATORY	0	8, 784, 935		60.0
	LOOD STORING, PROCESSING & TRANS. NTRAVENOUS THERAPY	0	191, 596 3, 171		63. 0 64. 0
	HYSI CAL THERAPY	0	3, 432, 971		66.0
	CCUPATIONAL THERAPY	0	616, 478		67.0
		0	255, 397		67.
	PEECH PATHOLOGY LECTROCARDI OLOGY	0	286, 501		68. 69.
	ARDI OLOGY	0	1, 945, 365		69.
	EDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 243, 919		71.
	MPL. DEV. CHARGED TO PATIENT	0	5, 360, 400		72. (
	RUGS CHARGED TO PATIENTS ENT SERVICE COST CENTERS	0	2, 574, 828		73. (
00 09000 CI		0	0		90. (
. 01 09001 0	THER OUTPATIENT SERVICE COST CENTER	0	917, 520		90.
02 09002 CI		0	0		90.
	ERMATOLOGY CLINIC NT CLINIC	0	0		90. 90.
	URGERY CLINIC	0	702		90. 90.
07 09007 UI	ROLOGY CLINIC	0	983		90.
09 09009 G	ASTROENTEROLOGY CLINIC	0	13, 819		90.
		0	0		90.
	PTHAMOLOGY CLINIC LLERGY CLINIC	0	0 197, 430		90. 90.
	OUND CARE	0	659, 252		90.
00 09100 EI	MERGENCY	0	5, 446, 186		91. (
	BSERVATION BEDS (NON-DISTINCT PART)	0			92. (
	EI MBURSABLE COST CENTERS MBULANCE SERVI CES	0	3, 853, 262		95.0
	PURPOSE COST CENTERS		3, 033, 202		45.0
3. 00 SI	UBTOTALS (SUM OF LINES 1 through 117) BURSABLE COST CENTERS	0	72, 909, 470		118. 0
	BURSABLE COST CENTERS	0	35, 723		190. 0
	HYSICIANS' PRIVATE OFFICES	0	51, 740, 652		190.0
4. 00 07950 TI	HORNTOWN OFFICE BUILDING	0	0		194. (
		0	81,066		194. (
	THER NONREIMB ETAIL PHARMACY	0	891, 262 4, 185, 516		194. (194. (
	ross Foot Adjustments	0	4, 185, 516		200. 0
1 1	egative Cost Centers	0	ő		200.0
	OTAL (sum lines 118 through 201)	0	129, 843, 689		202.0

	Financial	Systems APITAL RELATED COSTS	WI THAM MEMORI A	AL HOSPITAL Provider CC	CN: 15-0104 Pe	In Lieu eriod:	u of Form CMS-: Worksheet B	2552-10
					Fr To	om 01/01/2018	Part II Date/Time Pre 5/24/2019 2:0	pared:
				CAPI TAL REL	ATED COSTS		572472019 2:0	
	Cos	t Center Description	Directly Assigned New Capital	NEW BLDG & FIXT	NEW MVBLE EQUI P	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
			Related Costs 0	1.00	2.00	2A	4.00	
		SERVICE COST CENTERS						
1.00 2.00		CAP REL COSTS-BLDG & FIXT						1.00 2.00
4.00		LOYEE BENEFITS DEPARTMENT	0	7, 496	9, 523	17, 019	17, 019	4.00
5.00		IINISTRATIVE & GENERAL	0	239, 574	304, 340	543, 914	1, 858	1
7.00		RATION OF PLANT	0	313, 868	398, 718	712, 586	192	7.00
8.00 9.00		NDRY & LINEN SERVICE SEKEEPING	0	36, 142	45, 913	82, 055	8 130	8.00 9.00
10.00	01000 DI E		0	80, 901	102, 772	183, 673	196	
11.00	01100 CAF		0	0	0	0	57	11.00
13.00 15.00	01300 NUR 01500 PHA	SENG ADMENTSTRATION	0	0 24, 975	0 31, 727	0 56, 702	234 191	13.00 15.00
16.00		I CAL RECORDS & LI BRARY	0	39, 452	50, 118	89, 570	379	16.00
	I NPATI ENT	ROUTINE SERVICE COST CENTERS	· · · ·					
30.00		LTS & PEDIATRICS	0	262, 411	333, 351	595, 762	1, 012	
31.00 40.00		ENSIVE CARE UNIT PROVIDER – IPF	0	72, 065 82, 511	91, 548 104, 817	163, 613 187, 328	327 317	31.00 40.00
41.00		PROVIDER - IRF	0	02,011	0	0	0	41.00
42.00	04200 SUB		0	0	0	0	0	42.00
43.00 44.00	04300 NUR	SERY LLED NURSING FACILITY	0	0 62, 483	0 79, 374	0 141, 857	0 282	43.00 44.00
44.00	-	SERVICE COST CENTERS	0	02,403	77, 374	141,007	202	44.00
50.00	05000 OPE	RATING ROOM	0	209, 434	266, 052	475, 486	637	50.00
54.00		I OLOGY-DI AGNOSTI C	0	256, 138	325, 382	581, 520	432	1
55. 00 55. 01	05500 RAD	I OLOGY-THERAPEUTI C	0	0	0	0	0 90	
57.00	05700 CT		0	0	0	0	57	57.00
58.00		NETIC RESONANCE IMAGING (MRI)	0	21, 974	27, 914	49, 888	93	1
59.00 60.00	05900 CAR 06000 LAB	DIAC CATHETERIZATION	0	18, 522	23, 529	42, 051	82	1
63.00		OD STORING, PROCESSING & TRANS.	0	119, 452 0	151, 745 0	271, 197 0	766 0	63.00
64.00	06400 I NT	RAVENOUS THERAPY	0	0	0	0	0	64.00
66.00		SI CAL THERAPY	0	115, 614	146, 869	262, 483	509	66.00
67.00 67.01	06700 0CC	UPATIONAL THERAPY	0	0	0	0	103 59	67.00 67.01
68.00		ECH PATHOLOGY	0	0	0	0	50	68.00
69.00	1 1	CTROCARDI OLOGY	0	0	0	0	0	69.00
69.01 71.00	06901 CAR		0	11, 914	15, 135	27, 049	307	69.01
		I CAL SUPPLIES CHARGED TO PATIENTS L. DEV. CHARGED TO PATIENT	0	0	0	0	0	
		GS CHARGED TO PATIENTS	0	0	0	0	0	73.00
00.00		IT SERVICE COST CENTERS		ol	0	ol		
90. 00 90. 01	09000 CLI	IER OUTPATIENT SERVICE COST CENTER	0	49, 229	62, 537	0 111, 766	0 56	90.00 90.01
90.02	09002 CLI		0	0	02,007	0	0	90.02
90.03		MATOLOGY CLINIC	0	0	0	0	0	90.03
90. 04 90. 05	09004 ENT	CLINIC GERY CLINIC	0	0	0	0	0	90.04 90.05
		LOGY CLINIC	0	0	0	0	0	90.03
90.09		TROENTEROLOGY CLINIC	0	0	0	0	2	90.09
90. 11 90. 12		ROLOGY CLINIC HAMOLOGY CLINIC	0	0	0	0	0	90. 11 90. 12
90. 12 90. 13		ERGY CLINIC	0	0	0	0	30	90.12
90.14	09014 WOU		0	45, 133	57, 334	102, 467	74	90.14
91.00	09100 EME		0	316, 418	401, 958	718, 376	682	91.00
92.00		ERVATION BEDS (NON-DISTINCT PART) MBURSABLE COST CENTERS				0		92.00
95.00		ULANCE SERVICES	0	61, 310	77, 885	139, 195	654	95.00
110 00		PURPOSE COST CENTERS		2 447 014	2 100 541		0.0(/	110 00
118.00		TOTALS (SUM OF LINES 1 through 117) IRSABLE COST CENTERS	0	2, 447, 016	3, 108, 541	5, 555, 557	9, 800	118.00
	19000 GI F	T, FLOWER, COFFEE SHOP, & CANTEEN	0	8, 037	10, 210	18, 247		190. 00
		SICIANS' PRIVATE OFFICES	0	553, 111	702, 633	1, 255, 744		192.00
		RNTOWN OFFICE BUILDING E/BOUTIQUE	0	0 18, 239	0 23, 169	0 41, 408		194.00 194.01
194.02	07952 OTH	ER NONREIMB	0	264, 614	336, 149	600, 763	20	194. 02
		ALL PHARMACY	0	5, 152	6, 545	11, 697	73	194.03
200.00 201.00	1 1	ss Foot Adjustments ative Cost Centers		0	Ω	0	Ω	200.00
202.00		AL (sum lines 118 through 201)	0	3, 296, 169	4, 187, 247	7, 483, 416		202.00
		• ·	•	•		•		

	inancial Systems ON OF CAPITAL RELATED COSTS	WI THAM MEMORI /	AL HOSPITAL Provider C	Fi	eriod: ^om 01/01/2018	u of Form CMS-: Worksheet B Part II	
				Т	0 12/31/2018	Date/Time Pre 5/24/2019 2:0	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
	ENERAL SERVICE COST CENTERS 0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	0200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT	F 45 770					4.00
	0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT	545, 772 18, 820	731, 598				5.00 7.00
	0800 LAUNDRY & LINEN SERVICE	1, 548	0				8.00
	0900 HOUSEKEEPI NG	4, 483	11, 168		97, 836	001 011	9.00
	1000 DI ETARY 1100 CAFETERI A	6, 414 2, 431	24, 999 0		6, 529 2, 177	221, 811 0	10.00
	1300 NURSI NG ADMI NI STRATI ON	4, 916	0		984	0	13.00
		36, 551	7, 717		1, 987	0	15.00
	1600 MEDICAL RECORDS & LIBRARY NPATIENT ROUTINE SERVICE COST CENTERS	9,674	12, 191	0	4, 353	0	16.00
	3000 ADULTS & PEDI ATRI CS	27, 172	81, 087	73	33, 070	105, 882	30.00
	3100 I NTENSI VE CARE UNI T	9, 125	22, 269		8, 782	0	31.00
	4000 SUBPROVIDER - IPF 4100 SUBPROVIDER - IRF	7, 723	25, 497 0		10, 444 0	44, 510 0	40.00
	4200 SUBPROVI DER	0	0	0	0	0	42.00
	4300 NURSERY	225	0	7	0	0	43.00
	4400 SKILLED NURSING FACILITY NCILLARY SERVICE COST CENTERS	9, 304	19, 308	11	0	71, 419	44.00
	5000 OPERATING ROOM	17, 440	64, 717	193	1, 950	0	50.00
	5400 RADI OLOGY-DI AGNOSTI C	27, 463	79, 149		8, 820	0	54.00
	5500 RADI OLOGY-THERAPEUTI C 5501 ULTRA SOUND	0 2, 924	0	-	0 568	0	55.00 55.01
	5700 CT SCAN	4, 294	0		871	0	57.00
	5800 MAGNETIC RESONANCE IMAGING (MRI)	4, 121	6, 790		833	0	58.00
	5900 CARDI AC CATHETERI ZATI ON 6000 LABORATORY	6, 369 35, 100	5, 723 36, 912		0 3, 729	0	59.00 60.00
	6300 BLOOD STORING, PROCESSING & TRANS.	802	30, 712		3, 724	0	63.00
	6400 INTRAVENOUS THERAPY	0	0		0	0	64.00
	6600 PHYSI CAL THERAPY	12, 422 2, 178	35, 726 0		1, 344 644	0	66.00 67.00
	6700 OCCUPATI ONAL THERAPY 6701 AUDI OLOGY	2, 178	0		473	0	67.00
68.00 00	6800 SPEECH PATHOLOGY	1, 085	0	4	284	0	68.00
	6900 ELECTROCARDI OLOGY 6901 CARDI OLOGY	0	0 3. 682	Ŭ	0	0	69.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 954 13, 547	3, 082		2, 858 0	0	69.01 71.00
72.00 0	7200 IMPL. DEV. CHARGED TO PATIENT	22, 477	0		0	0	72.00
	7300 DRUGS CHARGED TO PATIENTS	10, 576	0	144	2, 063	0	73.00
	UTPATI ENT SERVICE COST CENTERS 9000 CLINIC	0	0	0	0	0	90.00
	9001 OTHER OUTPATIENT SERVICE COST CENTER	1, 997	15, 212		5, 073	0	
	9002 CLINIC 9003 DERMATOLOGY CLINIC	0	0	0	0	0 0	90. 02 90. 03
	9004 ENT CLINIC	0	0	0	0	0	90.03
	9005 SURGERY CLINIC	0	0	0	0	0	90. 05
	9007 UROLOGY CLINIC 9009 GASTROENTEROLOGY CLINIC	0	0	1	0	0	90. 07 90. 09
	9011 NEUROLOGY CLINIC	0	0	0	0	0	90.09
90.12 0	9012 OPTHAMOLOGY CLINIC	0	0	0	0	0	90. 12
	9013 ALLERGY CLINIC	772	0	3	0	0	90. 13 90. 14
	9014 WOUND CARE 9100 EMERGENCY	2, 204 18, 574	13, 946 97, 776		0	0	90. 14 91. 00
92.00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART)				-		92.00
	THER REIMBURSABLE COST CENTERS 9500 AMBULANCE SERVICES	15, 287	7,005	16	0	0	95.00
	PECIAL PURPOSE COST CENTERS	15,207	7,005	10	0	0	95.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) DNREIMBURSABLE COST CENTERS	345, 899	570, 874	1, 556	97, 836	221, 811	118.00
	9000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	86	2, 484	0	0	0	190.00
192.0019	9200 PHYSI CLANS' PRI VATE OFFI CES	188, 854	151, 012		0	0	192.00
	7950 THORNTOWN OFFICE BUILDING 7951 CAFE/BOUTIQUE	0	0	0	0		194. 00 194. 01
	7951 CAFE/BOUTIQUE 7952 OTHER NONREIMB	196 3, 721	5, 636 0	0	0		194.01 194.02
194.030	7953 RETAIL PHARMACY	7, 016	1, 592	0	Ö		194.03
200.00	Cross Foot Adjustments		~			0	200.00
201.00 202.00	Negative Cost Centers TOTAL (sum lines 118 through 201)	0 545, 772	0 731, 598	1, 556	0 97, 836		201.00 202.00
1			,		·		•

Health Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0104	Period: From 01/01/2018	Worksheet B Part II	
				To 12/31/2018		pared:
Cost Center Description	CAFETERI A	NURSI NG	PHARMACY	MEDI CAL	Subtotal	
		ADMI NI STRATI ON		RECORDS & LI BRARY		
	11.00	13.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
7. 00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG						8.00
10. 00 01000 DI ETARY						9.00 10.00
11.00 01100 CAFETERIA	4,665					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 15. 00 01500 PHARMACY	90		103, 32	29		13.00 15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	366			0 116, 533		16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 O30000 ADULTS & PEDI ATRI CS	1, 227	1, 410	11	51 28, 639	875, 485	30.00
31.00 03100 INTENSIVE CARE UNIT	100	418		7 5, 954	210, 613	
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	157 C			3 7,088 0 0	283, 606 0	40.00
41. 00 04100 SUBPROVIDER - TRI 42. 00 04200 SUBPROVIDER				0 0	0	41.00
43. 00 04300 NURSERY	C	-		0 0	232	43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	L	512		36 0	242, 779	44.00
50. 00 05000 OPERATI NG ROOM	109		49		572, 242	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	133		:	35 27, 503 0 0	725, 186 0	54.00 55.00
55. 01 05501 ULTRA SOUND	14	0		42 2, 977	6, 649	55.01
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	19			13 3, 402 36 1, 843	8, 828 63, 811	57.00 58.00
59. 00 05900 CARDIAC CATHETERIZATION			1.	0 0	54, 389	
60.00 06000 LABORATORY	390			4 2, 835	351, 196	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 64.00 06400 I NTRAVENOUS THERAPY				0 0 0 0	806 13	63.00 64.00
66. 00 06600 PHYSI CAL THERAPY	195		ł	38 5, 529	318, 775	1
67. 00 06700 OCCUPATI ONAL THERAPY 67. 01 06701 AUDI OLOGY	81			0 2, 410 0 0	5, 566 1, 641	67.00 67.01
68.00 06800 SPEECH PATHOLOGY	90	65		0 0	1, 578	68.00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI OLOGY	195	-		0 0 1 5, 316	0 46, 854	69.00 69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	100	0		0 0	13, 681	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT 73. 00 07300 DRUGS CHARGED TO PATIENTS				0 0	22, 531 12, 783	
OUTPATIENT SERVICE COST CENTERS					12,703	/3.00
90.00 09000 CLINIC 90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER	162	0 88		0 0 0 11, 908	0 146, 262	
90. 02 09002 CLINIC	C			0 0	140, 202	90.01
90. 03 09003 DERMATOLOGY CLINIC 90. 04 09004 ENT CLINIC	C	0		0 0	0	90.03
90. 04 09004 ENT CLINIC 90. 05 09005 SURGERY CLINIC		0		0 0 8 0	0 8	90. 04 90. 05
90. 07 09007 UROLOGY CLINIC	C	0		10 0	11	
90. 09 09009 GASTROENTEROLOGY CLINIC 90. 11 09011 NEUROLOGY CLINIC		66 0		0 0	73 0	90. 09 90. 11
90. 12 09012 OPTHAMOLOGY CLINIC	C	0		0 0	0	90. 12
90. 13 09013 ALLERGY CLINIC 90. 14 09014 WOUND CARE		41 114		61 0 31 0	907 119, 101	90. 13 90. 14
91.00 09100 EMERGENCY	304		2, 4		839, 088	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REI MBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVI CES	618	0	1, 0	57 0	163, 832	95.00
SPECIAL PURPOSE COST CENTERS	4.445	4 177	4.0	115 (0)	E 000 E24	110.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	4,665	6, 177	4, 9	46 115, 682	5, 088, 526	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	C		(0.0)	0 0		190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 194.00 07950 THORNTOWN OFFICE BUILDING		16 0	68, 9	12 851 0 0	1, 672, 449 0	192.00 194.00
194. 01 07951 CAFE/BOUTI QUE	C	Ő		0 0	47, 240	194.01
194. 02 07952 OTHER NONREIMB 194. 03 07953 RETAIL PHARMACY		31 0	29, 4	0 0 71 0	604, 535 49, 849	194. 02 194. 03
200.00 Cross Foot Adjustments			27, 7		0	200. 00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	4,665	0 6, 224	103, 3	0 0 29 116, 533		201.00
	-, 003	0,224	100, 0.		7, 100, 110	

	Financial Systems TION OF CAPITAL RELATED COSTS	WI THAM MEMORIAL	HOSPITAL Provider CCN: 15-0104	In Lieu of Form CMS Period: Worksheet B	8-2552-10
ALLUCA	TION OF CAPITAL RELATED COSTS		Provider CCN. 15-0104	From 01/01/2018 Part II To 12/31/2018 Date/Time Pr	renared
				5/24/2019 2:	
	Cost Center Description	Intern & Residents Cost	Total		
		& Post			
		Stepdown			
		Adjustments			
		25.00	26.00		_
1.00	GENERAL SERVICE COST CENTERS				1.00
2.00	00200 NEW CAP REL COSTS-BEDG & TTAT				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500 ADMI NI STRATI VE & GENERAL				5.00
7.00	00700 OPERATION OF PLANT				7.00
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00	00900 HOUSEKEEPI NG				9.00
10.00	01000 DI ETARY				10.00
					11.00
	01300 NURSI NG ADMI NI STRATI ON				13.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY				15.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS				10.00
30.00	03000 ADULTS & PEDIATRICS	0	875, 485		30.00
31.00	03100 I NTENSI VE CARE UNI T	0	210, 613		31.00
40.00	04000 SUBPROVI DER – I PF	0	283, 606		40.00
	04100 SUBPROVI DER – I RF	0	0		41.00
	04200 SUBPROVI DER	0	0		42.00
	04300 NURSERY	0	232		43.00
44.00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	242, 779		44.00
50.00	05000 OPERATING ROOM	0	572, 242		50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	725, 186		54.00
	05500 RADI OLOGY-THERAPEUTI C	0	0		55.00
55.01	05501 ULTRA SOUND	0	6, 649		55.01
	05700 CT SCAN	0	8, 828		57.00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	63, 811		58.00
	05900 CARDI AC CATHETERI ZATI ON	0	54, 389		59.00
60.00 63.00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	0	351, 196 806		60.00 63.00
	06400 I NTRAVENOUS THERAPY	0	13		64.00
66.00	06600 PHYSI CAL THERAPY	0	318, 775		66.00
	06700 OCCUPATI ONAL THERAPY	0	5, 566		67.00
67.01	06701 AUDI OLOGY	0	1, 641		67.01
	06800 SPEECH PATHOLOGY	0	1, 578		68.00
	06900 ELECTROCARDI OLOGY	0	0		69.00
	06901 CARDI OLOGY	0	46, 854		69.01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	13, 681 22, 531		71.00
	07300 DRUGS CHARGED TO PATIENTS	0	12, 783		73.00
/0/00	OUTPATIENT SERVICE COST CENTERS		12,700		
90.00	09000 CLI NI C	0	0		90.00
	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	146, 262		90.01
	09002 CLI NI C	0	0		90.02
	09003 DERMATOLOGY CLINIC	0	0		90.03
	09004 ENT CLINIC 09005 SURGERY CLINIC		U ol		90.04
	09007 UROLOGY CLINIC		11		90.05
	09009 GASTROENTEROLOGY CLINIC	0	73		90.07
	09011 NEUROLOGY CLINIC	0	0		90.11
90.12	09012 OPTHAMOLOGY CLINIC	0	0		90. 12
	09013 ALLERGY CLINIC	0	907		90.13
	09014 WOUND CARE	0	119, 101		90.14
	09100 EMERGENCY	0	839, 088		91.00
72. UU	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0			92.00
95.00	09500 AMBULANCE SERVICES	0	163, 832		95.00
	SPECIAL PURPOSE COST CENTERS				
118.00		0	5, 088, 526		118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	20, 817		190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	1, 672, 449		192.00
	07950 THORNTOWN OFFICE BUILDING	0	0		194.00
	07951 CAFE/BOUTI QUE	0	47, 240		194.01
	07952 OTHER NONREI MB	0	604, 535		194.02
	07953 RETAIL PHARMACY Cross Foot Adjustments	0	49, 849		194.03 200.00
200 00		1 ()	0		1200 00
200.00 201.00		0	õ		201.00

	Financial Systems LLOCATION - STATISTICAL BASIS	WITHAM MEMORIA	AL HOSPITAL Provider CC	NN 15 0104 D	In Lie eriod:	u of Form CMS-2	2552-10
CUST A	LLUCATION - STATISTICAL DASIS		Provider CC	F	rom 01/01/2018 o 12/31/2018	Worksheet B-1 Date/Time Pre	
		CAPI TAL REL	ATED COSTS			5/24/2019 2:0	
	Cost Center Description	NEW BLDG & FI XT (SQUARE FEET)	NEW MVBLE EQUI P (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00 4.00 5.00 7.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	255, 907 582 18, 600 24, 368	255, 907 582 18, 600 24, 368	60, 433, 151 6, 587, 798 682, 203	0	115, 439, 337 3, 980, 592	1.00 2.00 4.00 5.00 7.00
13.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01500 PHARMACY	0 2, 806 6, 281 0 0 1, 939	0 2, 806 6, 281 0 0 1, 939	28, 715 460, 434 694, 992 201, 548 830, 969 675, 778	0 0 0	327, 475 948, 229 1, 356, 547 514, 153 1, 039, 776 7, 730, 668	8.00 9.00 10.00 11.00 13.00 15.00
	01500 PHARMACT 01600 MEDICAL RECORDS & LIBRARY	3,063	3, 063	1, 342, 309	0	2, 046, 136	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY	20, 373 5, 595 6, 406 0 0 0	20, 373 5, 595 6, 406 0 0 0	3, 590, 113 1, 161, 060 1, 123, 334 0 0 0 0	0 0 0 0 0 0	5, 747, 123 1, 929, 932 1, 633, 429 0 0 47, 671	30. 00 31. 00 40. 00 41. 00 42. 00 43. 00
44.00	04400 SKILLED NURSING FACILITY	4, 851	4, 851	998, 457	0	1, 967, 801	44.00
	ANCI LLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 05400 RADI OLOGY-DI AGNOSTI C	16, 260 19, 886	16, 260 19, 886	2, 257, 466 1, 531, 151	0	3, 688, 578 5, 808, 680	50.00 54.00
	05500 RADI OLOGY-THERAPEUTI C 05501 ULTRA SOUND	0 0	0 0	0 317, 858	0	0 618, 338	55. 00 55. 01
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0 1, 706	0 1, 706	203, 573 329, 105	0	908, 155 871, 596	58.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	1, 438 9, 274	1, 438 9, 274	292, 304 2, 716, 106	0	1, 347, 168 7, 423, 832	59.00 60.00
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0	2, 710, 100	0	169, 575	63.00 64.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	8, 976 0	8, 976 0	1, 806, 658 366, 187		2, 627, 425 460, 578	66.00
67. 01 68. 00	06701 AUDI OLOGY 06800 SPEECH PATHOLOGY	0	0	209, 497 176, 334	0	194, 990 229, 452	67.01 68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
	06901 CARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	925	925	1, 087, 713	0	1, 470, 915 2, 865, 224	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	4, 754, 083	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	<u> </u>	U	0	0	2, 236, 856	73.00
90. 01	09000 CLINIC 09001 OTHER OUTPATIENT SERVICE COST CENTER	0 3, 822	0 3, 822	0 199, 717	0	0 422, 312	90.00 90.01
	09002 CLINIC 09003 DERMATOLOGY CLINIC 09004 ENT CLINIC	0	0	0	0	0 0 0	90. 02 90. 03 90. 04
	09005 SURGERY CLINIC	0	0	0	0	0	90.04 90.05
	09007 UROLOGY CLINIC 09009 GASTROENTEROLOGY CLINIC	0	0	0	0	0	90. 07 90. 09
	09009 GASTROENTEROLOGY CLINIC	0	0	6, 115 0	0	1, 013 0	90.09
90. 12	09012 OPTHAMOLOGY CLINIC	0	0	0	0	0	90. 12
90. 13 90. 14	09013 ALLERGY CLINIC 09014 WOUND CARE	0 3, 504	0 3, 504	105, 358 261, 280	0	163, 331 466, 255	90. 13 90. 14
	09100 EMERGENCY	24, 566	24, 566	2, 417, 258	0	3, 928, 478	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	4, 760	4, 760	2, 318, 031	0	3, 233, 326	95.00
118.00		189, 981	189, 981	34, 979, 421	-14, 404, 352	73, 159, 692	118.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	624	624		0	18, 247	
	19200 PHYSICIANS' PRIVATE OFFICES 07950 THORNTOWN OFFICE BUILDING	42, 942 0	42, 942 0	25, 123, 550 0	0	39, 949, 061 0	192.00 194.00
194.01	07951 CAFE/BOUTI QUE	1, 416	1, 416	0	0	41, 408	194. 01
194.03	07952 OTHER NONREIMB 07953 RETAIL PHARMACY	20, 544 400	20, 544 400	71, 491 258, 689	0	787, 072 1, 483, 857	194. 03
200. 00 201. 00							200. 00 201. 00
0	ingen it toot contor c	I			1	1	

Health Fina	ancial Systems	WI THAM MEMORI A	AL_HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOC	ATION - STATISTICAL BASIS				Period: From 01/01/2018	Worksheet B-1	
					Fo 12/31/2018		
		CAPI TAL REL	ATED COSTS				
	Cost Center Description	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFITS	Reconci l i ati on	& GENERAL	
		(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT (GROSS SALARI ES)		(ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	3, 296, 169	4, 187, 247	10, 008, 34	9	14, 404, 352	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	12.880339	16. 362378	0. 16561	D	0. 124779	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			17, 01	9	545, 772	204. 00
205.00	Unit cost multiplier (Wkst. B, Part			0. 00028	2	0. 004728	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Health Financial Systems	WI THAM MEMORI	AL_HOSPITAL		In Lieu	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO		eriod: rom 01/01/2018	Worksheet B-1	
			T	0 12/31/2018	Date/Time Pre 5/24/2019 2:0	
Cost Center Description	OPERATION OF	LAUNDRY & LINEN SERVICE	HOUSEKEEPING (HOURS OF	DI ETARY	CAFETERI A	
	PLANT (SQUARE	(GROSS	SERVICE)	(MEALS SERVED)	(MEALS SERVED)	
	FEET) 7.00	CHARGES) 8.00	9.00	10.00	11 00	
GENERAL SERVICE COST CENTERS	7.00	0.00	9.00	10.00	11.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	100.010					5.00
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE	183, 813	379, 193, 901				7.00 8.00
9. 00 00900 HOUSEKEEPI NG	2, 806	0				9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	6, 281	0	8, 623 2, 875		982	10.00 11.00
13. 00 01300 NURSING ADMINISTRATION	0	0	1, 300		19	13.00
15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY	1, 939 3, 063				38 77	15.00 16.00
INPATIENT ROUTINE SERVICE COST CENTERS	3,003	0	5,750	0		18.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	20, 373			23, 125	259	30.00
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER – I PF	5, 595 6, 406			0 9, 721	21 33	31.00 40.00
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY	0	0 1, 776, 485	0	0	0	42.00 43.00
44.00 04400 SKILLED NURSING FACILITY	4, 851	2, 784, 782		15, 598	0	44.00
ANCI LLARY SERVI CE COST CENTERS	16, 260	48, 328, 351	2, 575	0	23	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	19, 886				28	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
55. 01 05501 ULTRA SOUND 57. 00 05700 CT SCAN	0	8, 442, 283 42, 985, 910		-	3	55.01 57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 706	14, 805, 232	1, 100	0	10	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	1, 438 9, 274		0 4, 925	0	0 82	59.00 60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	888, 126	0	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY 66. 00 06600 PHYSI CAL THERAPY	0 8, 976	3, 265, 907 8, 164, 154		0	0 41	64.00 66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0, 770	3, 291, 358		0	17	67.00
67. 01 06701 AUDI 0L0GY	0	978, 602		0	18	67.01
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	1, 046, 819 0	375 0	0	19 0	68.00 69.00
69. 01 06901 CARDI OLOGY	925	13, 580, 789		0	41	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	8, 515, 031 13, 498, 637		0	21 0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	35, 970, 008			0	73.00
OUTPATI 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	3, 822	0	6, 700	-	34	90. 01
90. 02 09002 CLINIC 90. 03 09003 DERMATOLOGY CLINIC	0	0	0	0	0	90. 02 90. 03
90. 04 09004 ENT CLINIC	0	0	0	0	0	90.03
90. 05 09005 SURGERY CLINIC	0	0	0	0	0	90.05
90. 07 09007 UROLOGY CLINIC 90. 09 09009 GASTROENTEROLOGY CLINIC	0	146, 056 0	0		0	90. 07 90. 09
90. 11 09011 NEUROLOGY CLINIC	0	0	0	0	0	90. 11
90. 12 09012 0PTHAMOLOGY CLINIC 90. 13 09013 ALLERGY CLINIC	0	0 691, 366	0	0	0	90. 12 90. 13
90. 14 09014 WOUND CARE	3, 504	3, 832, 589	0	0	0	90. 14
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	24, 566	30, 953, 463	0	0	64	91.00 92.00
OTHER REIMBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVI CES SPECI AL PURPOSE COST CENTERS	1, 760	3, 963, 666	0	0	130	95.00
SPECIAL PORPOSE COST CENTERS118.00SUBTOTALS (SUM OF LINES 1 through 117)	143, 431	379, 193, 901	129, 223	48, 444	982	118.00
NONREI MBURSABLE COST CENTERS	624	0	0	ol	0	100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES	624 37, 942	0	0			190. 00 192. 00
194.0007950 THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194. 01 07951 CAFE/BOUTI QUE 194. 02 07952 OTHER NONREI MB	1, 416 0	0	0	0		194. 01 194. 02
194. 03 07953 RETAIL PHARMACY	400	0	0	o		194. 03
200.00Cross Foot Adjustments201.00Negative Cost Centers						200. 00 201. 00
202.00 Cost to be allocated (per Wkst. B,	4, 477, 286	368, 337	1, 134, 896	1, 754, 539	603, 558	
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I)	24. 357831	0. 000971	8. 782461	36. 217880	614. 621181	203 00
	27.007001	0.0007/1	1 02.701		5	

Heal th	Health Financial Systems WITHAM MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10						
COST AL	COST ALLOCATION - STATISTICAL BASIS		Provider CO	Provider CCN: 15-0104			
					To 12/31/2018	Date/Time Pre 5/24/2019 2:0	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NO	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(HOURS OF	(MEALS	(MEALS	
		(SQUARE	(GROSS	SERVI CE)	SERVED)	SERVED)	
		FEET)	CHARGES)				
		7.00	8.00	9.00	10.00	11.00	
204.00	Cost to be allocated (per Wkst. B,	731, 598	1, 556	97, 83	6 221, 811	4, 665	204.00
	Part II)			0 7574			
205.00	Unit cost multiplier (Wkst. B, Part	3. 980121	0. 000004	0. 75711	0 4.578709	4. 750509	205.00
206.00	NAHE adjustment amount to be allocated						206. 00
207.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207.00
207.00	Parts III and IV)						207.00

	Financial Systems LOCATION - STATISTICAL BASIS	WI THAM MEMORIA	L HOSPITAL Provider CC	`N: 15_0104	Period:	u of Form CMS-2552- Worksheet B-1
CUST AL	LUCATION - STATISTICAL DASIS		FIOVIDEI CC	N. 15-0104	From 01/01/2018	
					To 12/31/2018	Date/Time Prepared 5/24/2019 2:03 pm
	Cost Center Description	NURSI NG ADMI NI STRATI ON	PHARMACY	MEDI CAL RECORDS &		
		ADMINI STRATI UN	(COSTED REQUI S.)	LIBRARY		
		(DI RECT		(TIME		
		NRSING HRS)		SPENT)	_	
	GENERAL SERVICE COST CENTERS	13.00	15.00	16.00		
-	00100 NEW CAP REL COSTS-BLDG & FIXT					1.0
	00200 NEW CAP REL COSTS-MVBLE EQUIP					2.0
	00400 EMPLOYEE BENEFITS DEPARTMENT					4.0
1	00500 ADMINISTRATIVE & GENERAL					5. C
1	00700 OPERATION OF PLANT					7.0
1	00800 LAUNDRY & LINEN SERVICE					8.0
	00900 HOUSEKEEPI NG 01000 DI ETARY					9. 0 10. 0
1	01100 CAFETERIA					11.0
	01300 NURSI NG ADMI NI STRATI ON	416, 004				13.0
15.00	01500 PHARMACY	0	3, 467, 831			15. C
	01600 MEDI CAL RECORDS & LI BRARY	0	0	41, 10	00	16.0
	INPATIENT ROUTINE SERVICE COST CENTERS	04.007	F 0//	10.10		
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	94, 207 27, 907	5, 066 228	10, 10 2, 10		30. 0 31. 0
1	04000 SUBPROVIDER - IPF	35, 045	106	2, 10		40.0
	04100 SUBPROVI DER – I RF	0	0	2,00	0	41.0
42.00	04200 SUBPROVI DER	0	0		0	42.0
43.00	04300 NURSERY	0	0		0	43.0
	04400 SKILLED NURSING FACILITY	34, 215	2, 883		0	44.0
	ANCI LLARY SERVICE COST CENTERS	(2.020	14 470	2.45		FO (
	05000 OPERATI NG ROOM 05400 RADI OLOGY-DI AGNOSTI C	62, 930	16, 479 1, 186	3, 62 9, 70		50. C 54. C
	05500 RADI OLOGY-THERAPEUTI C	0	0	7,70	0	55.0
	05501 ULTRA SOUND	0	1, 422	1, 05	0	55. C
57.00	05700 CT SCAN	0	446	1, 20	00	57. C
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	4, 552	65		58. C
	05900 CARDI AC CATHETERI ZATI ON	6, 683	0	1 00	0	59.0
	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	0	137 0	1,00	0	60. 0 63. 0
	06400 INTRAVENOUS THERAPY	0	0		0	64.0
	06600 PHYSI CAL THERAPY	29, 821	2, 952	1, 95	i0	66.0
67.00	06700 OCCUPATI ONAL THERAPY	9, 124	0	85	i0	67.0
	06701 AUDI OLOGY	6, 479	0		0	67.0
		4, 336	0		0	68.0
	06900 ELECTROCARDI OLOGY 06901 CARDI OLOGY	29, 274	0 22	1, 87	0	69. 0 69. 0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	29,274	22	1,07	0	71.0
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0	72.0
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	73.0
	DUTPATIENT SERVICE COST CENTERS	II				
		0	0	4.00	0	90.0
	09001 OTHER OUTPATIENT SERVICE COST CENTER 09002 CLINIC	5, 882	3	4, 20	0	90. 0 90. 0
	09002 CETNIC 09003 DERMATOLOGY CLINIC	0	0		0	90.0
	09004 ENT CLINIC	0	0		0	90.0
	09005 SURGERY CLINIC	0	277		0	90. C
	09007 UROLOGY CLINIC	0	332		0	90. C
	09009 GASTROENTEROLOGY CLINIC	4, 423	0		0	90.0
1	09011 NEUROLOGY CLINIC	0	0		0	90.1
	09012 OPTHAMOLOGY CLINIC 09013 ALLERGY CLINIC	2, 748	2,040		0	90. 1 90. 1
	09014 WOUND CARE	7,620	9, 431		0	90. 1
-	09100 EMERGENCY	52, 142	82, 965		0	91.0
1	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.0
	OTHER REIMBURSABLE COST CENTERS	r r				
	09500 AMBULANCE SERVICES	0	35, 458		0	95.0
-	SPECIAL PURPOSE COST CENTERS	412.02/	1/5 005	40.00		110 (
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	412, 836	165, 985	40, 80		118. 0
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0	190. 0
	19200 PHYSI CI ANS' PRI VATE OFFI CES	1, 082	2, 312, 758	30	00	192. 0
194.00	07950 THORNTOWN OFFICE BUILDING	0	О		0	194. C
	07951 CAFE/BOUTI QUE	0	0		0	194. C
	07952 OTHER NONREI MB	2,086	0		0	194.0
	07953 RETAIL PHARMACY	0	989, 088		U	194.0
200.00 201.00	Cross Foot Adjustments Negative Cost Centers					200. 0 201. 0
201.00	Cost to be allocated (per Wkst. B,	1, 192, 613	8, 788, 933	2, 473, 88	34	201.0
	Part I)	,	,,	, ,		

Health Financial Systems	WI THAM MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2018	Worksheet B-1
				To 12/31/2018	Date/Time Prepared: 5/24/2019 2:03 pm
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, P	art I) 2.866831	2. 534418	60. 191825	5	203.00
204.00 Cost to be allocated (per Wkst.	B, 6, 224	103, 329	116, 533	3	204.00
Part II)					
205.00 Unit cost multiplier (Wkst. B, P	art 0.014961	0. 029796	2.835353	3	205.00
206.00 NAHE adjustment amount to be all	ocated				206.00
(per Wkst. B-2)					200.00
207.00 NAHE unit cost multiplier (Wkst.	D,				207.00
Parts III and IV)					

	nancial Systems	WITHAM MEMORI.				u of Form CMS-2	2552-10
COMPUTATI	ON OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre	
				XV/LLL	llooni tol	5/24/2019 2:0	3 pm
			Intre	XVIII	<u>Hospi tal</u> Costs	PPS	
	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	
IN	PATIENT ROUTINE SERVICE COST CENTERS						
30.00 03	000 ADULTS & PEDIATRICS	9, 249, 375		9, 249, 37	75 0	9, 249, 375	30.00
31.00 03	100 INTENSIVE CARE UNIT	2, 633, 255		2, 633, 25	55 0	2, 633, 255	31.00
40.00 04	000 SUBPROVIDER - IPF	2, 741, 672		2, 741, 67	0 0	2, 741, 672	40.00
	100 SUBPROVIDER – IRF	0			0 0	0	41.00
42.00 04	200 SUBPROVI DER	0			0 0	0	42.00
43.00 04	300 NURSERY	55, 344		55, 34	14 0	55, 344	43.00
	400 SKILLED NURSING FACILITY	3, 004, 527		3, 004, 52	27 0	3, 004, 527	44.00
	CILLARY SERVICE COST CENTERS						
	000 OPERATING ROOM	5, 068, 941		5, 068, 94		5, 068, 941	
	400 RADI OLOGY-DI AGNOSTI C	7, 755, 938		7, 755, 93		7, 755, 938	•
	500 RADI OLOGY-THERAPEUTI C	0			0 0	0	
	501 ULTRA SOUND	778, 927		778, 92		778, 927	
	700 CT SCAN	1, 149, 131		1, 149, 13		1, 149, 131	57.00
	800 MAGNETIC RESONANCE IMAGING (MRI)	1, 102, 752		1, 102, 75		1, 102, 752	•
	900 CARDI AC CATHETERI ZATI ON	1, 584, 893		1, 584, 89		1, 584, 893	
	000 LABORATORY	8, 784, 935		8, 784, 93		8, 784, 935	
	300 BLOOD STORING, PROCESSING & TRANS.	191, 596		191, 59		191, 596	•
	400 I NTRAVENOUS THERAPY	3, 171		3, 17		3, 171	
	600 PHYSI CAL THERAPY	3, 432, 971	0	3, 432, 97		3, 432, 971	1
	700 OCCUPATI ONAL THERAPY	616, 478	0	616, 47		616, 478	1
	701 AUDI OLOGY	255, 397	0	255, 39		255, 397	67.01
	800 SPEECH PATHOLOGY	286, 501	0	286, 50		286, 501	68.00
	900 ELECTROCARDI OLOGY	0			0 0	0	69.00
	901 CARDI OLOGY	1, 945, 365		1, 945, 36		1, 945, 365	•
	100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	3, 243, 919		3, 243, 91		3, 243, 919	•
	200 I MPL. DEV. CHARGED TO PATIENT	5, 360, 400		5, 360, 40		5, 360, 400	•
	300 DRUGS CHARGED TO PATIENTS	2, 574, 828		2, 574, 82	28 0	2, 574, 828	73.00
	TPATIENT SERVICE COST CENTERS	0			0 0	0	90.00
	000 OTHER OUTPATIENT SERVICE COST CENTER	917, 520		917, 52		917, 520	•
	002 CLINIC	917, 520		717, 52	0 0	0	90.01
	003 DERMATOLOGY CLINIC	0			0 0	0	90.02
	004 ENT CLINIC	0			0 0	0	•
	005 SURGERY CLINIC	702		70		702	•
	007 UROLOGY CLINIC	983		98		983	•
	009 GASTROENTEROLOGY CLINIC	13, 819		13, 8		13, 819	•
	011 NEUROLOGY CLINIC	0		. 57 6	0 0	0	90.11
	012 OPTHAMOLOGY CLINIC	0			0 0	0	
	013 ALLERGY CLINIC	197, 430		197, 43			
	014 WOUND CARE	659, 252		659, 25		659, 252	
	100 EMERGENCY	5, 446, 186		5, 446, 18		5, 446, 186	
	200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 039, 298		2, 039, 29		2, 039, 298	
	HER REIMBURSABLE COST CENTERS]
95.00 09	500 AMBULANCE SERVI CES	3, 853, 262		3, 853, 26	62 0	3, 853, 262	95.00
1	Subtotal (see instructions)	74, 948, 768	0	74, 948, 76	68 0	74, 948, 768	200 00
200.00							
200.00 201.00 202.00	Less Observation Beds Total (see instructions)	2, 039, 298		2, 039, 29 72, 909, 47	98	2, 039, 298 72, 909, 470	201.00

OMPUT	TATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0104	Peri od:	Worksheet C	
					From 01/01/2018 To 12/31/2018	Part I Date/Time Pre 5/24/2019 2:0	pared
			Titl€	e XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
		6.00	7.00	8.00	9.00	<u>Ratio</u> 10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	9.00	10.00	
0. 00	03000 ADULTS & PEDIATRICS	14, 261, 173		14, 261, 17	73		30.0
1.00	03100 I NTENSI VE CARE UNI T	4, 588, 887		4, 588, 88			31.0
0.00	04000 SUBPROVIDER - IPF	3, 780, 153		3, 780, 15	53		40.0
1.00	04100 SUBPROVI DER – I RF	0			0		41.0
2.00	04200 SUBPROVI DER	0			0		42.0
3.00	04300 NURSERY	1, 776, 485		1, 776, 48			43.0
4.00	04400 SKILLED NURSING FACILITY	2, 784, 782		2, 784, 78	32		44.0
	ANCI LLARY SERVI CE COST CENTERS	1 1		1			-
0.00	05000 OPERATING ROOM	8, 493, 324	39, 835, 027			0.000000	
4.00	05400 RADI OLOGY-DI AGNOSTI C	1, 521, 417	31, 110, 247	32, 631, 66		0.000000	
5.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0.000000	0.000000	
5.01	05501 ULTRA SOUND	464, 785	7, 977, 498			0.000000	
7.00	05700 CT SCAN	4, 731, 190	38, 254, 720			0.000000	
8.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	698, 553	14, 106, 679			0.000000	
9.00	05900 CARDI AC CATHETERI ZATI ON	4, 591, 946	11, 310, 635			0.000000	
0.00		9, 279, 040	46, 886, 141			0. 000000 0. 000000	
3.00 4.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	509, 804 1, 456, 622	378, 322 1, 809, 285			0.000000	
4.00 6.00	06600 PHYSI CAL THERAPY	2, 622, 018	5, 542, 136			0.000000	
7.00	06700 OCCUPATIONAL THERAPY	2, 505, 651	785, 707			0.000000	
7.00	06701 AUDI OLOGY	2, 303, 031	978, 602			0. 000000	
8.00	06800 SPEECH PATHOLOGY	253, 569	793, 250			0. 000000	
9.00	06900 ELECTROCARDI OLOGY	200,007	, , 0, 200	1,010,0	0 0.000000	0. 000000	
9.01	06901 CARDI OLOGY	5, 330, 292	8, 250, 497	13, 580, 78		0. 000000	
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 669, 181	4, 845, 850			0. 000000	
2.00	07200 IMPL. DEV. CHARGED TO PATIENT	3, 378, 133	10, 120, 504			0. 000000	
3.00	07300 DRUGS CHARGED TO PATIENTS	8, 942, 305	27, 027, 703			0.000000	73.
	OUTPATIENT SERVICE COST CENTERS						
0. 00	09000 CLI NI C	0	C)	0 0.000000	0.000000	90.
0. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	C		0 0.000000	0.00000	90.
0. 02	09002 CLI NI C	0	0		0 0.000000	0.000000	
0. 03	09003 DERMATOLOGY CLINIC	0	0		0 0.000000	0.000000	
0. 04	09004 ENT CLINIC	0	C		0 0.000000	0.00000	
0. 05	09005 SURGERY CLINIC	0	C		0 0.000000	0.000000	
0. 07	09007 UROLOGY CLINIC	1, 240	144, 816			0.000000	
0.09	09009 GASTROENTEROLOGY CLINIC	0	0		0 0.000000	0.000000	
0.11	09011 NEUROLOGY CLINIC	0	0	1	0 0.00000	0.000000	
0.12	09012 OPTHAMOLOGY CLINIC	0	01 01	(01.0)	0 0.00000	0.000000	
0.13	09013 ALLERGY CLINIC	14 000	691, 366			0.000000	
0.14	09014 WOUND CARE 09100 EMERGENCY	14, 983 4, 070, 948	3,817,606			0. 000000 0. 000000	
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 070, 948	26, 882, 515 3, 954, 648			0.000000	
∠.00	OTHER REIMBURSABLE COST CENTERS	0	3, 904, 048	3, 734, 04	0.010071	0.00000	72.
5.00	09500 AMBULANCE SERVICES	4, 515	3, 959, 151	3, 963, 66	0. 972146	0. 000000	95.
00. 00		89, 730, 996	289, 462, 905			0.000000	200.
00.00		07,700,770	207, 402, 703	0, , , , , 0, , 0			200.
		1		1	1		

Health Financial Systems	WI THAM MEMORIAL			u of Form CMS-2552
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepare 5/24/2019 2:03 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient Ratio 11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30
31. 00 03100 INTENSIVE CARE UNIT				31
40. 00 04000 SUBPROVIDER - IPF				40
41.00 04100 SUBPROVIDER - IRF				41
42. 00 04200 SUBPROVI DER				42
43.00 04300 NURSERY				43
44.00 04400 SKILLED NURSING FACILITY				44
ANCI LLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 104885			50
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 237681			54
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55
55. 01 05501 ULTRA SOUND	0. 092265			55
57. 00 05700 CT SCAN	0. 026733			57
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 074484			58
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 099663			59
60. 00 06000 LABORATORY	0. 156412			60
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 215731			63
64. 00 06400 I NTRAVENOUS THERAPY	0. 000971			64
66. 00 06600 PHYSI CAL THERAPY	0. 420493			66
67. 00 06700 OCCUPATI ONAL THERAPY	0. 187302			67
67. 01 06701 AUDI OLOGY	0. 260981			67
68. 00 06800 SPEECH PATHOLOGY	0. 273687			68
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69
69. 01 06901 CARDI OLOGY	0. 143244			69
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 380964			71
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 397107			72
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 071583			73
OUTPATIENT SERVICE COST CENTERS	0.071303			/3
90. 00 09000 CLINIC	0. 000000			90
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000			90
90. 02 09002 CLINIC	0. 000000			90
90. 03 09003 DERMATOLOGY CLINIC	0. 000000			90
90. 04 09004 ENT CLINIC	0. 000000			90
90. 05 09005 SURGERY CLINIC	0. 000000			90
90. 07 09007 UROLOGY CLINIC	0.006730			90
90. 09 09009 GASTROENTEROLOGY CLINIC	0. 000730			90
90. 09 09009 GASTROENTEROLOGT CLINIC	0.000000			90
90. 12 09012 OPTHAMOLOGY CLINIC	0.000000			90
90. 13 09013 ALLERGY CLINIC	0. 285565			90
90. 13 09013 ALLERGT CLINIC 90. 14 09014 WOUND CARE	0. 285505			90
91. 00 09100 EMERGENCY	0. 172012			90
	0. 515671			91
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0.010071			92
95. 00 09500 AMBULANCE SERVICES	0. 972146			95
200.00 Subtotal (see instructions)	0. 772140			200
201.00 Less Observation Beds				200
202.00 Total (see instructions)				201
				1202

	inancial Systems	WI THAM MEMORI	AL_HOSPITAL			u of Form CMS-2	2552-10
COMPUTAT	TION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2018 To 12/31/2018	Date/Time Pre	
			Ti †I	e XIX	Hospi tal	5/24/2019 2:0 Cost	3 pm
					Costs	0031	
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS	9, 249, 375		9, 249, 37		9, 249, 375	
	3100 I NTENSI VE CARE UNI T	2, 633, 255		2, 633, 25		2, 633, 255	
	4000 SUBPROVI DER – I PF	2, 741, 672		2, 741, 67		2, 741, 672	
	4100 SUBPROVI DER – I RF	0			0 0	0	
	4200 SUBPROVI DER	0			0 0	0	42.00
	4300 NURSERY	55, 344		55, 34		55, 344	
	4400 SKI LLED NURSI NG FACI LI TY	3, 004, 527		3, 004, 52	.7 0	3, 004, 527	44.00
	NCI LLARY SERVICE COST CENTERS	F 0(0 041		F 0(0.0)	1 0	F 0(0 041	
	5000 OPERATI NG ROOM 5400 RADI OLOGY-DI AGNOSTI C	5,068,941		5, 068, 94		5, 068, 941	
	5500 RADI OLOGY - DI AGNOSTI C 5500 RADI OLOGY - THERAPEUTI C	7, 755, 938 0		7, 755, 93	8 0 0 0	7, 755, 938 0	
	5501 ULTRA SOUND	778, 927		778, 92	-	778, 927	
	5700 CT SCAN	1, 149, 131		1, 149, 13		1, 149, 131	57.00
	5700 MAGNETIC RESONANCE IMAGING (MRI)	1, 149, 131		1, 102, 75		1, 149, 131	1
	5900 CARDI AC CATHETERI ZATI ON	1, 584, 893		1, 584, 89		1, 584, 893	
	6000 LABORATORY	8, 784, 935		8, 784, 93		8, 784, 935	
	6300 BLOOD STORING, PROCESSING & TRANS.	191, 596		191, 59		191, 596	
	6400 I NTRAVENOUS THERAPY	3, 171		3, 17		3, 171	
	6600 PHYSI CAL THERAPY	3, 432, 971	0			3, 432, 971	
	6700 OCCUPATI ONAL THERAPY	616, 478	0			616, 478	1
	6701 AUDI OLOGY	255, 397	0			255, 397	67.01
	6800 SPEECH PATHOLOGY	286, 501	0			286, 501	68.00
	6900 ELECTROCARDI OLOGY	0	0	200,00	0 0	0	69.00
	6901 CARDI OLOGY	1, 945, 365		1, 945, 36	-	1, 945, 365	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 243, 919		3, 243, 91		3, 243, 919	
	7200 IMPL. DEV. CHARGED TO PATIENT	5, 360, 400		5, 360, 40		5, 360, 400	
	7300 DRUGS CHARGED TO PATIENTS	2, 574, 828		2, 574, 82		2, 574, 828	
	UTPATIENT SERVICE COST CENTERS			•			
	9000 CLI NI C	0			0 0	0	90.00
90.01 0	9001 OTHER OUTPATIENT SERVICE COST CENTER	917, 520		917, 52	0 0	917, 520	90.01
	9002 CLI NI C	0			0 0	0	90.02
	9003 DERMATOLOGY CLINIC	0			0 0	0	90.03
	9004 ENT CLINIC	0			0 0	0	
	9005 SURGERY CLINIC	702		70		702	
	9007 UROLOGY CLINIC	983		98		983	
	9009 GASTROENTEROLOGY CLINIC	13, 819		13, 81		13, 819	
	9011 NEUROLOGY CLINIC	0			0 0	0	90.11
	9012 OPTHAMOLOGY CLINIC	0		407	0 0	0	
	9013 ALLERGY CLINIC	197, 430		197, 43			
	9014 WOUND CARE	659, 252		659, 25			
	9100 EMERGENCY	5, 446, 186		5, 446, 18		5, 446, 186	
	9200 OBSERVATION BEDS (NON-DISTINCT PART) THER REIMBURSABLE COST CENTERS	2, 039, 298		2, 039, 29	0	2, 039, 298	92.00
	9500 AMBULANCE SERVICES	3 052 242		3 052 74	2 0	3, 853, 262	05 00
95.00 0 200.00	Subtotal (see instructions)	3, 853, 262		3, 853, 26			
200.00	Less Observation Beds	74, 948, 768 2, 039, 298		74, 948, 76 2, 039, 29		2, 039, 298	
201.00	Total (see instructions)	72, 909, 470					
202.00		12, 707, 470	0	1 12,707,41	U U	1 12, 707, 470	1202. UU

COMPUT	TATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0104	Peri od: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/24/2019 2:0	epared:)3 pm
				e XIX	Hospi tal	Cost	
	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	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	14, 261, 173		14, 261, 17			30.0
31.00	03100 I NTENSI VE CARE UNI T	4, 588, 887		4, 588, 88			31.0
0.00	04000 SUBPROVIDER - IPF	3, 780, 153		3, 780, 15			40.0
1.00	04100 SUBPROVIDER - IRF	0			0		41.0
2.00	04200 SUBPROVI DER	0		4 77 4	0		42.0
3.00	04300 NURSERY	1,776,485		1, 776, 48			43.0
4.00	04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	2, 784, 782		2, 784, 78	32		44.0
50.00	05000 OPERATING ROOM	8, 493, 324	39, 835, 027	48, 328, 35	0. 104885	0. 000000	50.0
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 521, 417	31, 110, 247			0.000000	
54.00	05500 RADI OLOGY-THERAPEUTI C	1, 521, 417	31, 110, 247	32,031,00	0 0.000000	0.000000	
5.00	05501 ULTRA SOUND	464, 785	7, 977, 498	8, 442, 28		0. 000000	
57.00	05700 CT SCAN	4, 731, 190	38, 254, 720			0. 000000	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	698, 553	14, 106, 679			0. 000000	
9.00	05900 CARDI AC CATHETERI ZATI ON	4, 591, 946	11, 310, 635			0. 000000	
0.00	06000 LABORATORY	9, 279, 040	46, 886, 141			0. 000000	
3.00	06300 BLOOD STORING, PROCESSING & TRANS.	509, 804	378, 322			0. 000000	
4.00	06400 I NTRAVENOUS THERAPY	1, 456, 622	1, 809, 285			0. 000000	
6.00	06600 PHYSI CAL THERAPY	2, 622, 018	5, 542, 136			0.000000	
7.00	06700 OCCUPATI ONAL THERAPY	2, 505, 651	785, 707			0.000000	
7.01	06701 AUDI OLOGY	0	978, 602			0.000000	67.0
8.00	06800 SPEECH PATHOLOGY	253, 569	793, 250	1, 046, 81	0. 273687	0.000000	68.0
9.00	06900 ELECTROCARDI OLOGY	0	0		0 0.000000	0.000000	69.0
9. 01	06901 CARDI OLOGY	5, 330, 292	8, 250, 497	13, 580, 78	0. 143244	0.000000	69.0
1.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	3, 669, 181	4, 845, 850	8, 515, 03	0. 380964	0.000000	71.0
2.00	07200 IMPL. DEV. CHARGED TO PATIENT	3, 378, 133	10, 120, 504	13, 498, 63	0. 397107	0.000000	
3.00	07300 DRUGS CHARGED TO PATIENTS	8, 942, 305	27,027,703	35, 970, 00	0. 071583	0.00000	73.0
	OUTPATIENT SERVICE COST CENTERS						
0.00	09000 CLINIC	0	C		0 0.000000	0.000000	
0. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	C		0 0.000000	0.000000	
0. 02	09002 CLINIC	0	0	1	0 0.000000	0.000000	
0.03	09003 DERMATOLOGY CLINIC	0	0		0 0.000000	0.000000	
0.04		0	0		0 0.000000	0.000000	
0.05	09005 SURGERY CLINIC	0	0 144_014		0 0.00000	0.000000	
0.07	09007 UROLOGY CLINIC	1, 240	144, 816			0.000000	
0.09	09009 GASTROENTEROLOGY CLINIC 09011 NEUROLOGY CLINIC	0	0		0 0.000000 0 0.000000	0.000000	
0.11	09012 OPTHAMOLOGY CLINIC	0	0			0.000000	
0.12	09012 OPTHAMOLOGY CLINIC	0	691, 366	691, 36		0.000000	
0. 13	09014 WOUND CARE	14, 983	3, 817, 606			0.000000	
1.00	09100 EMERGENCY	4, 070, 948	26, 882, 515			0.000000	
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4,070,948	3, 954, 648			0.000000	
2.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	5, 754, 040	1 5, 754, 04	0.010071	0.000000	1 /2.0
5.00	09500 AMBULANCE SERVICES	4, 515	3, 959, 151	3, 963, 66	0. 972146	0. 000000	95.0
200.00		89, 730, 996	289, 462, 905			0.00000	200.0
201.00			, .52, 700				201.0
202.00		89, 730, 996	289, 462, 905	379, 193, 90			202.0

Health Financial Systems	WI THAM MEMORIA			u of Form CMS-255	52-
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0104	Period: From 01/01/2018	Worksheet C Part I	
			To 12/31/2018	Date/Time Prepar 5/24/2019 2:03	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
INDATIENT DOUTINE SEDVICE COST CENTERS	11.00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 O3000 ADULTS & PEDI ATRI CS				2	30.0
31. 00 03100 NTENSI VE CARE UNI T				-	30. C
40. 00 04000 SUBPROVIDER - IPF					40. C
41. 00 04100 SUBPROVI DER – I RF					41. C
42. 00 04200 SUBPROVI DER					42.0
43.00 04300 NURSERY					43. C
44.00 04400 SKILLED NURSING FACILITY				4	44. C
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATI NG ROOM	0. 000000				50. C
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54. C
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000				55. C
55.01 05501 ULTRA SOUND	0. 000000				55. C
57.00 05700 CT SCAN	0. 000000				57. C
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58. C
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.0
	0. 000000				60. (
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.0
64. 00 06400 I NTRAVENOUS THERAPY 66. 00 06600 PHYSI CAL THERAPY	0. 000000 0. 000000				64. (66. (
67. 00 06700 OCCUPATIONAL THERAPY	0. 000000				67. C
67. 01 06701 AUDI OLOGY	0. 000000				67. C
68. 00 06800 SPEECH PATHOLOGY	0. 000000				68. C
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69. C
69. 01 06901 CARDI OLOGY	0. 000000				69.0
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0.000000				71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			7	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			7	73.0
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 000000				90. (
PO. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000				90. (
90. 02 09002 CLINIC	0. 000000				90. (
90. 03 09003 DERMATOLOGY CLINIC	0. 000000				90.0
20. 04 09004 ENT CLINIC	0. 000000				90. (
20. 05 09005 SURGERY CLINIC	0. 000000				90. (
20. 07 09007 UROLOGY CLINIC 20. 09 09009 GASTROENTEROLOGY CLINIC	0. 000000				90.0
20. 09 09009 GASTROENTEROLOGY CLINIC 20. 11 09011 NEUROLOGY CLINIC	0. 000000 0. 000000				90. (90. ⁻
20. 11 09011 NEUROLOGY CLINIC 20. 12 09012 OPTHAMOLOGY CLINIC	0. 000000				90. 90. ⁻
20. 13 09013 ALLERGY CLINIC	0. 000000				90. 90. ⁻
90. 14 09014 WOUND CARE	0. 000000				90.1
91. 00 09100 EMERGENCY	0. 000000				91. C
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.0
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0. 000000			9	95. C
200.00 Subtotal (see instructions)				20	00. C
201.00 Less Observation Beds					01. C
202.00 Total (see instructions)				20	02. C

Health Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 01/01/2018 To 12/31/2018	Date/Time Pre 5/24/2019 2:0	
		Title	e 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	875, 485	0	875, 48			
31.00 INTENSIVE CARE UNIT	210, 613		210, 61	3 1, 776	118. 59	31.00
40. 00 SUBPROVIDER – IPF	283, 606	0	283, 60	6 3, 133	90.52	40.00
41.00 SUBPROVIDER – IRF	0	0		0 0	0.00	41.00
42. 00 SUBPROVI DER	0	0		0 0	0.00	
43.00 NURSERY	232		23			
44.00 SKILLED NURSING FACILITY	242, 779		242, 77	9 5, 027	48.30	44.00
200.00 Total (lines 30 through 199)	1, 612, 715		1, 612, 71	5 18, 008		200.00
Cost Center Description	Inpati ent	Inpatient				
	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, 263					30.00
31. 00 INTENSIVE CARE UNIT	834					31.00
40. 00 SUBPROVIDER - IPF	2, 558	231, 550				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	2, 994					44.00
200.00 Total (lines 30 through 199)	8, 649	757, 622				200.00

From 01/10/2018 Date/Time Propared 5/20/2019 Part I I Date/Time Propared 5/20/2019 Part I I Date/Time Propared 5/20/2019 Part I I Date/Time Propared 5/20/2019 Part I Date/Time Propared 5/20/2019 0.000000 0.000000 0.000000 0.00100/01/10/2016 0.00100/01/10/2016 0.00100/01/10/2016 0.00100/01/10/2016 0.00100/01/10/2016 0.00100/01/2016 0.00100/01/2016 0.00100/01/2016 0.00100/01/2016 0.00100/01/2016 0.00100/01/2016 0.00100/01/2016 0.00100/01/2016 0.00100/01/2016 0.00100/01/2016 0.00100/01/2016 0.00100/01/2016 0.00100/01/2016 0.00100/01/2016 0.00100/01/2016 0.00100/01/2016 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0010/01/2016 0.00100/01/2016 0.000000 <th>Health Financial Systems</th> <th>WI THAM MEMORI</th> <th></th> <th></th> <th></th> <th>eu of Form CMS-2</th> <th>2552-10</th>	Health Financial Systems	WI THAM MEMORI				eu of Form CMS-2	2552-10
Cost Center Description Capital Related Cost (from WKst. C) (from Kst. C) (from WKst.	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-0104	Peri od:	Worksheet D	
Cost Center Description Capital Related Cost (from Wkst. B, pert I, col. 26) Title XVIII Hospital of Cost (from Wkst. B, pert I, col. 26) Inpatient (col. 1 + col. 20) Scalation 3 x col. ma 4							nared
Cost Center Description Capital Related Cost (from Wkst. c, 20) Ratio of Cost (from Wkst. c, 20) Ratio of Cost (from Wkst. c, 20) Inpatital (column 3, column 4) Capital (column 3, column 4) AMCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 (PERATING ROOM 572,242 48,328,351 0.011841 5.047,393 59,766 50.00 51.00 05500 (Abit Older' - HitRAPEUTI C 725,186 32,631,664 0.022223 1.01,40,30 22,535 55.00 55.00 05500 (RADI Cloce' - HitRAPEUTI C 725,186 32,61,664 0.0202078 61,493 48 55.00 50.00 05000 (ARADI Cloce' - HitRAPEUTI C 0.0002005 2,179,917 447 57.0 50.00 05000 (ARADI CLOSE') NOR 6,649 8,422,955,907 0.000205 2,179,917 447 57.0 50.00 05000 (ARADI AC CATHETER ZATION 54,389 15,902,581 0.000420 4.63,537 2,646. 60.00 06000 (DITRAVENOUS THERAPY 13,255,907 0.000000 611,160 146 63.0<					10 12/01/2010		
Related Cost (from Wist, C, b) (from Wist, C, b) Part II, col. 2) Col Umn 3 x (col Um 4) (col Umn 3 x) (col Um 4) ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 ANCI LLARY SERVICE COST CENTERS 5.01 5.02 1.00 2.00 3.00 4.00 5.047, 393 59, 766 50.0 05000 [OPERATI NG ROM 572, 242 48, 328, 351 0.011841 5.047, 393 59, 766 50.0 05500 [RADI LLOCY-THERAPEUTI C 0 0.0000788 0.0007088 6.49 8, 442, 985, 910 0.0002782 2, 179, 917 447 57.00 0 05000 [CARDI AC CATHETERI ZATI ON 54, 389 11, 44, 805, 232 0.004310 360, 920 2, 158 59.00 0 05000 [LABGMATORY 33, 196 56, 165, 181 0.00223 4, 371, 941 27, 38 60.00 0 05400 [NTRAKENDIS THERAPY 313 3, 265, 907 0.0000046 618, 537 2 64.0 0 05400 [NTRAKENDIS THERAPY 318, 1756 8, 164, 154 0.001677 78, 073 118 66.0 0 06000 [LA			Title	e XVIII	Hospi tal		
Related Cost (from Wist, C, b) (from Wist, C, b) Part II, col. 2) Col Umn 3 x (col Um 4) (col Umn 3 x) (col Um 4) ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 ANCI LLARY SERVICE COST CENTERS 5.01 5.02 1.00 2.00 3.00 4.00 5.047, 393 59, 766 50.0 05000 [OPERATI NG ROM 572, 242 48, 328, 351 0.011841 5.047, 393 59, 766 50.0 05500 [RADI LLOCY-THERAPEUTI C 0 0.0000788 0.0007088 6.49 8, 442, 985, 910 0.0002782 2, 179, 917 447 57.00 0 05000 [CARDI AC CATHETERI ZATI ON 54, 389 11, 44, 805, 232 0.004310 360, 920 2, 158 59.00 0 05000 [LABGMATORY 33, 196 56, 165, 181 0.00223 4, 371, 941 27, 38 60.00 0 05400 [NTRAKENDIS THERAPY 313 3, 265, 907 0.0000046 618, 537 2 64.0 0 05400 [NTRAKENDIS THERAPY 318, 1756 8, 164, 154 0.001677 78, 073 118 66.0 0 06000 [LA	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
Part II. col. 8) 2) 0 50 ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 OPERATING ROOM 572,242 48.328.51 0.011841 5.047,393 257,766 50.00 55.00 05500 RADIOLOGV-THERAPEUTIC 725,186 0.022223 1.014.030 22,535 54.0 55.00 05500 RADIOLOGV-THERAPEUTIC 6.649 8.42,283 0.000205 2.179,917 4447 55.00 56.00 05600 CARIAC CATHETERIZATION 54.42,283 0.00320 2.155 55.00 05500 CARIAL CATHETERIZATION 54.43.89 15.902.581 0.00320 2.155 55.00 05600 LABORATORY 3351.196 56.165.181 0.006203 4.371.941 27.38 60.0 06.00 06400 INTRAVENUS THERAPY 318.775 8.164.154 0.03700 61.16.36 6.0 61.0 06400 INTRIAVENUS THERAPY 318.775 8.164.154 0.03700 67.0 67.0 67.00 60.00 66.00		Related Cost				(column 3 x	
26) 200 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 5.00 5.00 5.00 5.00 5.00 5.01 5.01 5.01 5.01 5.01 5.01 5.01 0.00 0.00000 0 0 5.00 0.00000 0 5.00 0.00000 0 5.00 0.00000 0 5.00 0.00000 0 0 5.00 0.00000 0 5.00 0.00000 0 5.00 0.00000 0 0.00000 0 0.00000 0 5.00 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0.000000 0.000000 0 0.000000 0.000000 0.000000 0 0.000000 0.000000 0 0.000000 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.0000000 0.000000 0 <td></td> <td>(from Wkst. B,</td> <td>Part I, col.</td> <td>(col. 1 ÷ col</td> <td>. Charges</td> <td>column 4)</td> <td></td>		(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
I.OO 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 50.00 5000 OPERATING ROOM 572,242 48,328,351 0.011841 5.047,393 59,766 50.0 54.00 05400 RADIOLOGY-DI AGNOSTI C 725,186 32,631,664 0.02223 1,014,030 22,535 54.0 55.01 05500 (TASION FINERAPEUTI C 0 0 0.000000 0 0 55.01 05500 (TSCAN 8,828 42,985,910 0.000208 61,493 48 55.0 50.00 05600 (ARGINETI C RESONANCE I MAGI NG (MRI) 63,811 14,805,232 0.004310 369,800 1.594 58.0 00.6000 CARDI AC CATHETERI ZATION 54,4389 15,902,581 0.00320 63.0,920 2.158 59.0 60.00 06000 PHYSICAL THERERAPY 351,196 56,165,181 0.00320 61.16.0 146 63.0 61.00 05000 DEVENTINGL THERAPY 13,3265,077 0.000000 61.16.0 146.63 60.0 60.00 060000 DEVENCH ATHOLOGY <		Part II, col.	8)	2)			
ANCILLARY SERVICE COST CENTERS 572, 242 48, 328, 351 0.01181 5, 047, 393 59, 766 50.0 54, 00 05000 OPERATING ROM 572, 242 48, 328, 351 0.011811 5, 047, 393 59, 766 55.0 55, 00 05500 RADI OLGOY-THEAPEUTIC 0 0 0.000000 0 55.0 55, 00 05500 RADI OLGOY-THEAPEUTIC 0 0 0.0000205 2, 179, 917 447 57.0 55, 00 05500 CARDI AC CATHETERI ZATION 6, 649 8, 422, 985, 910 0.003420 630, 920 2, 186 59.00 50, 00 05000 CARDI AC CATHETERI ZATION 54, 389 15, 902, 581 0.003420 630, 920 2, 186 59.00 0.6000 PHYSICAL THERAPY 131 3, 265, 907 0.0000400 618, 137 2 64.0 64.00 64.00 64.010 161, 160 164 63.0 64.00 66.00 60000 OCCUPATIONAL THERAPY 131 3, 265, 907 0.000077 78, 073 186.60 6.0 66.00 66.00 66.00 66.00 66.00 66.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
50.00 05000 0FERATING ROM 572,242 48,328,351 0.011841 5,047,393 59,766 50.0 54.00 05400 RADIDLOCY-THERAPEUTIC 725,186 32,631,664 0.02222,51 51.0 0 55.00 0 0.000000 0 0 0.000000 65.0 55.0 0 55.00 0.5000 CMO 0.00025 2,179,917 447 57.0 55.00 0.5000 CAUC CAUPAC 68.92 2,186,910 0.004310 369,800 1.594 58.00 0.00020 CAUPAC 58.00 0.00020 CAUPAC 58.00 0.00020 CAUPAC 58.00 0.004310 369,800 1.594 58.00 0.00020 CAUPAC 58.00 0.00020 CAUPAC 58.00 0.00020 60.00 66.00 66.00 CAUPAC 73.186 60.00 66.00 1.594 58.00 1.594 58.00 1.594 58.00 60.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 1.5		1.00	2.00	3.00	4.00	5.00	
54.00 054.00 RADI LOLOY - DI AGNOSTI C 725, 186 32, 631, 664 0.022223 1, 014, 030 22, 535 54.0 55.00 05500 RADI LOLOY - THERAPEUTI C 0 0.000000 0 0550 55.01 05501 ULTRA SOUND 6, 649 8, 442, 283 0.000788 61, 493 48 55.0 57.00 0500 CASDI AC CATHETERIZATI ON 63, 811 14, 805, 232 0.004310 369, 800 1, 594 58.0 0.00300 463, 092 2, 158 59.00 05900 CARDI AC CATHETERIZATI ON 54, 389 15, 096 56, 165, 181 0.003420 6330, 920 2, 158 59.00 06300 HLOOD LABORATORY 313, 3, 265, 907 0.000006 618, 537 2, 54.0 64.0 64.00 64.00 64.00 64.00 66.00 INTRAVENDUS THERAPY 318, 775 8, 164, 154 0.039046 413, 946 16, 163 66.00 67.0 67.0 67.0 67.0 67.0 67.0 67.0 67.0 67.0 67.0 67.0 67.0 67.0 67.0 67.0 67.0 67.0 67.0 67.0							
55. 00 OSS00 RADI OLGGY-THERAPEUTI C O O O O O S5. 00 55. 01 05501 ULTRA SOUND 6, 649 8, 442, 283 0.000788 61, 493 48 55. 00 56. 01 05501 ULTRA SOUND 6, 649 8, 442, 283 0.000205 2, 179, 917 447 57. 00 58. 00 05800 CARDI AC CATHETERI ZATI NO 54, 389 15, 902, 581 0.003205 2, 179, 917 447 57. 05 60. 00 OGOO CARDI AC CATHETERI ZATI NO 54, 389 15, 902, 581 0.006200 LABORATORY 31 3, 265, 907 0.000008 161, 160 146 63. 0 64. 00 06400 INTRAVENOUS THERAPY 318, 775 8, 164, 154 0.039046 413, 946 16, 163 66. 0 60. 00 OCUPATI NAL THERAPY 5.566 3, 291, 358 0.001677 78, 073 118 68. 0 61. 00 OFTI AUDI OLGGY 1, 578 1, 046, 819 0.001607 78, 073 118 69. 00 <t< td=""><td></td><td>572, 242</td><td>48, 328, 351</td><td>0. 01184</td><td>5, 047, 393</td><td>59, 766</td><td>50.00</td></t<>		572, 242	48, 328, 351	0. 01184	5, 047, 393	59, 766	50.00
55.01 ULTRA SOUND 6,649 8,42,283 0.000788 61,493 48 57.0 57.00 05700 CT SCAN 8,828 42,985,910 0.000205 2,179,917 447 57.0 50.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 63,811 14,805,232 0.004310 369,800 1,554 58.0 60.00 06000 LABORATORY 351,196 55,65,155,181 0.003420 630,920 2,158 59.00 64.00 06400 ITRAYENDUS THERAPY 13 3,265,907 0.000004 618,537 2 64.0 64.00 06400 INTRAVENDUS THERAPY 318,775 8,164,154 0.039046 413,946 16,163 66.0 67.00 06700 0CCUPATIONAL THERAPY 5,566 3,291,358 0.001691 289,225 489 67.0 61.01 06400 PHSTI CAL THERAPY 1,578 1,046,819 0.001507 78.073 118 68.0 63.00 06400 SPECH PATHOLOGY 1,578 1,046,819 0.0003450 3,910,273 13,490 67.0 77.	54.00 05400 RADI OLOGY-DI AGNOSTI C	725, 186	32, 631, 664	0. 02222	1, 014, 030	22, 535	54.00
57.00 057.00 CT SCAN 8, 828 42, 965, 910 0.000205 2, 179, 917 447 57.00 58.00 05800 MAGNETIC RESONANCE IMGLING (MRI) 63, 811 14, 805, 232 0.004310 369, 800 1, 594 58.00 60.00 06000 LABORATORY PORCESSING & TRANS. 806 888, 15, 902, 581 0.004320 630, 920 2, 1188 59.00 60.00 06000 BLODD STORI NG, PROCESSING & TRANS. 806 888, 126 0.000908 161, 160 146 63.0 64.00 OFCOD OPHYSI CAL THERAPY 13 3, 265, 907 0.0000904 618, 1537 2 64.0 67.00 06700 OCCUPATI ONAL THERAPY 318, 775 8, 164, 154 0.039046 413, 946 16, 163 66.0 68.00 06800 SPECE H PATHOLOGY 1, 578 1, 046, 819 0.001507 78, 073 118 68.0 69.00 06900 LCARD IOLOGY 0 0 0.000000 0 0 0.000000 0 0 71.0 0 67.0 71.0 0 67.0 71.0 0		0	C	0.0000	0 0	0	55.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 63.811 14.805,232 0.004310 369,800 1,594 88.0 59.00 05900 CARDIA C CATHETERIZATION 54,389 15,902,581 0.003420 630,920 2,158 59.00 60.00 LABORATORY 351,196 56,165,181 0.004253 4,371,941 27,388 60.00 64.00 D4600 INTRAVENDUS THERAPY 13 3,265,907 0.00004 618,537 2 64.0 66.00 D6600 INTRAVENDUS THERAPY 318,775 8,164,154 0.039046 413,946 16,163 66.0 70.00 OG700 OCUPATI DNAL THERAPY 5,566 3,291,358 0.001691 289,225 489 67.0 67.00 O6700 OLOPATI DNAL THERAPY 5,566 3,291,358 0.001677 78,073 118 68.0 68.00 D4801 LARIDOGY 0 0.00000 0 69.0 0 0.001677 78,073 13.490 69.0 71.00	55. 01 05501 ULTRA SOUND	6, 649	8, 442, 283	0. 00078	38 61, 493	48	55.01
59.00 OS900 CARDI AC CATHETERI ZATI ON 54.389 15.902.581 0.003420 630.920 2.158 59.00 60.00 06000 LABORATORY 351.196 56.165.181 0.00253 4.371.941 27.338 60.00 60.00 06400 INTRAVENOUS THERAPY 13 3.255.907 0.000004 618.537 2 64.00 60.00 06400 INTRAVENOUS THERAPY 318.775 8.164.154 0.030464 413.946 16.163 66.00 60.00 06600 PHYSI CAL THERAPY 318.755 8.164.154 0.001607 78.073 118 68.0 67.01 06700 OCUPATI ONAL THERAPY 1,541 978.602 0.01607 78.073 118 68.0 69.00 06900 ELECTROCARDI OLOGY 0 0 0.000000 0 69.0 69.0 69.0 69.0 69.0 69.0 69.0 71.00 78.073 11.84 68.1 8.515.031 0.001607 1.410.565 2.267 71.00 72.0 72.00 70.00 69.0 0 0.000200 0 0.000000 <t< td=""><td>57.00 05700 CT SCAN</td><td>8, 828</td><td>42, 985, 910</td><td>0. 00020</td><td>2, 179, 917</td><td>447</td><td>57.00</td></t<>	57.00 05700 CT SCAN	8, 828	42, 985, 910	0. 00020	2, 179, 917	447	57.00
60.00 06000 LABDRATORY 351, 196 56, 165, 181 0.006253 4, 371, 941 27, 338 60.0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 806 888, 126 0.000004 618, 537 2 64.0 64.00 06400 INTRAVENOUS THERAPY 13 3, 265, 907 0.000004 618, 537 2 64.0 66.00 0000 OCUPATI UNAL THERAPY 5, 566 3, 291, 358 0.001671 0 67.0 67.00 67.01 06701 AUDI OLOGY 1, 641 978, 602 0.001677 0 67.0 68.00 06800 SEECH PATHOLOGY 1, 578 1, 046, 819 0.01607 1, 410, 565 2, 267 71.0 0.01000 ELECTROCARDI OLOGY 0 0 0.0003450 3, 910, 273 13.490 69.0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 12, 783 35, 970, 008 0.001607 1, 410, 565 2, 67 71.0 72.00 07200 IMELA DPATI ENT SERVICE COST CENTERS 12, 783	58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	63, 811	14, 805, 232	0. 00431	10 369, 800	1, 594	58.00
63.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 806 888, 126 0.000908 161, 160 146 63.0 64.00 06400 INTRAVENOUS THERAPY 13 3, 265, 907 0.00004 618, 537 2 64.0 60.00 06600 PHYSI CAL THERAPY 318, 775 8, 164, 154 0.039046 413, 946 16, 16, 16 66.6 67.01 06700 OCUPATI ONAL THERAPY 1, 641 978, 602 0.001697 289, 225 489 67.0 68.00 06800 SPEECH PATHOLOGY 1, 641 978, 602 0.001507 78, 073 118 68.0 69.00 06900 ELECTROCARDI OLOGY 0 0.003450 3, 910, 273 13, 490 69.0 69.0 69.0 69.0 69.0 69.0 69.0 69.0 69.0 69.0 69.0 69.0 72.0 71.00 07100 MEL DEV. CHARGED TO PATI ENTS 13, 580, 789 0.001607 1, 410, 565 2, 267 71.0 72.00 072001 IMPL DEV. CHARGED TO PATI ENTS 12, 783 35, 970, 080 0.0000355 3, 4	59. 00 05900 CARDI AC CATHETERI ZATI ON	54, 389	15, 902, 581	0.00342	630, 920	2, 158	59.00
64.00 06400 INTRAVENOUS THERAPY 13 3, 265, 907 0.000004 618, 537 2 64.00 66.00 06600 PHYSI CAL THERAPY 318, 775 8, 164, 154 0.039046 413, 946 16, 163 66.00 67.01 06701 AUDI OLOGY 1, 641 978, 602 0.001697 0 67.00 67.01 06400 ELECTROCARDI OLOGY 1, 641 978, 602 0.001697 78, 073 118 68.00 06900 ELECTROCARDI OLOGY 0 0 0.000000 0 69.00 72.00 72.00 73.00 71.00 71.00 71.00 71.00 71.01 74.11 74.0 71.00 71.00 71.01 71.01 71.01 71.01 71.01 71.01 71.01 71.01 71.01 71.01 71.01 71.01 71.01 71.01 71.01	60. 00 06000 LABORATORY	351, 196	56, 165, 181	0.00625	53 4, 371, 941	27, 338	60.00
66.00 06600 PHYSI CAL THERAPY 318,775 8,164,154 0.039046 413,946 16,163 66.07 67.00 06700 OCCUPATI ONAL THERAPY 5,566 3,291,358 0.001691 289,225 489 67.0 67.01 06701 AUDI LOGY 1,641 978,602 0.001507 78,073 118 68.00 69.00 06900 ELECTROCARDI OLOGY 1,578 1,046,819 0.003450 3,910,273 13,490 69.0 69.01 06901 CARDI OLOGY 46,854 13,580,789 0.003450 3,910,273 13,490 69.0 0 07200 IMPL. DEV. CHARGED TO PATI ENTS 12,783 13,498,637 0.001669 0 0 72.0 07300 DUTPATI ENT SERVI CE COST CENTERS 12,783 35,970,008 0.000355 3,412,199 1,211 73.0 00.03 OG030 DERMATOLOGY CLINIC 0 0 0.000000 0 90.0 90.00 90.00 90.00 90.00 90.00 90.00 <	63.00 06300 BLOOD STORING, PROCESSING & TRANS.	806	888, 126	0.00090	08 161, 160	146	63.00
67.00 06700 0CCUPATIONAL THERAPY 5,566 3,291,358 0.001691 289,225 489 67.0 067.01 06701 AUDIOLOGY 1,641 978,602 0.001677 0 0 67.0 67.01 67.01 0 67.01 0 67.01 67.01 0 67.01 0 67.01 0 67.01 0 0 67.01 0 67.01 0 0 0.001507 0 0 67.01 67.01 67.01 0 0.000000 0 0 67.00 67.01 0.01507 78.073 118.68 68.0 68.00 68.00 68.00 13.580,789 0.003450 3.910,273 13.490 69.0 72.00 72.00 17.00 07100 MPL DEV CHARGED TO PATIENTS 12.783 35.970,008 0.001669 0 0 72.00 73.00 0.000000 0 0 0.000000 0 90.00 90.00 90.00 90.00 90.00 90.00 90.00	64.00 06400 INTRAVENOUS THERAPY	13	3, 265, 907	0.0000	618, 537	2	64.00
67.01 06701 AUDI OLOGY 1, 641 978, 602 0.001677 0 67.0 68.00 06800 SPEECH PATHOLOGY 1, 578 1, 046, 819 0.001507 78, 073 118 68.0 69.00 06901 CARDI OLOGY 0 0.000000 0 0690 69.01 06901 CARDI OLOGY 46, 854 13, 580, 789 0.003450 3, 910, 273 13, 490 69.0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 13, 498, 637 0.001667 1, 410, 565 2, 267 71.0 0.07300 DRUSC CHARGED TO PATI ENTS 12, 733 13, 498, 637 0.001669 0 0 72.0 0.010001 OPTOD IMPL. DEV. CHARGED TO PATI ENTS 12, 733 13, 498, 637 0.000000 0 0 0.000355 3, 412, 199 1, 173.0 0.0100001 OPTOT IENT SERVICE COST CENTER 146, 262 0 0.0000000 0 0 0.000000 0 0 0.000000 0 0 0.000000 0 0 0.000000 0 0 0.0000000 0 0 <td>66. 00 06600 PHYSI CAL THERAPY</td> <td>318, 775</td> <td>8, 164, 154</td> <td>0. 03904</td> <td>413, 946</td> <td>16, 163</td> <td>66.00</td>	66. 00 06600 PHYSI CAL THERAPY	318, 775	8, 164, 154	0. 03904	413, 946	16, 163	66.00
68.00 06800 SPEECH PATHOLOGY 1,578 1,046,819 0.001507 78,073 118 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0.000000 0 69.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 13,681 8,515,031 0.001607 1,410,565 2,267 71.00 07300 IMPL. DEV. CHARGED TO PATIENT 12,783 35,970,008 0.00355 3,412,199 1,211 73.00 07300 DRUGS CHARGED TO PATIENT 12,783 35,970,008 0.000355 3,412,199 1,211 73.00 09000 CLINIC 0 0 0.000000 0 90.00	67.00 06700 OCCUPATIONAL THERAPY	5, 566	3, 291, 358	0. 00169	289, 225	489	67.00
69:00 06900 ELECTROCARDIOLOGY 0 0 0.00000 0 0 69.0 69:01 CARDIOLOGY 46,854 13,580,789 0.003450 3,910,273 13,490 69.0 71:00 O7200 IMPLICAL SUPPLIES CHARGED TO PATIENTS 13,681 8,515,031 0.001607 1,410,565 2,267 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 22,531 13,498,637 0.000355 3,412,199 1,211 73.00 07300 DRUGS CHARGED TO PATIENTS 12,783 35,970,008 0.000355 3,412,199 1,211 73.00 0000 G0000 CLINIC 0 0 0.000000 0	67. 01 06701 AUDI OLOGY	1, 641	978, 602	0. 00167	0 0	0	67.01
69.01 06901 CARDIOLOGY 46,854 13,580,789 0.003450 3,910,273 13,490 69.0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 13,681 8,515,031 0.001607 1,410,565 2,267 71.0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 22,531 13,498,637 0.001669 0 0 72.00 001700 CHARGED TO PATIENTS 12,783 35,970,008 0.000055 3,412,199 1,211 73.0 001700 DUTPATIENT SERVICE COST CENTERS 0 0 0.000000 0 90.0 90.01 09000 CLINIC 0 0 0.000000 0 90.0 90.02 09002 CLINIC 0 0 0.000000 0 90.0 90.03 09003 DERMATOLOGY CLINIC 0 0 0.000000 0 90.0 90.04 09004 ENT CLINIC 0 0 0.000000 0 90.0 90.05 09005 SURGERY CLINIC 73 0 0.000000 0 90.0	68.00 06800 SPEECH PATHOLOGY	1, 578	1, 046, 819	0.00150	78, 073	118	68.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 13, 681 8, 515, 031 0.001607 1, 410, 565 2, 267 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 22, 531 13, 498, 637 0.001669 0 0 72.00 001000 DRUGS CHARGED TO PATIENTS 12, 783 35, 970, 008 0.000355 3, 412, 199 1, 217 73.00 001001 OPO00 CLINIC 0 0 0.000000 0 90.00 90.00 09000 CLINIC 0 0 0.000000 0 90.00 90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER 146, 262 0 0.000000 0 90.00 90.02 09002 CLINIC 0 0 0.000000 0 90.00 90.03 09030 DERMATOLOGY CLINIC 0 0 0.000000 0 90.00 90.04 09004 ENT CLINIC 11 146, 056 0.000000 0 90.00 90.07 09007 URCLOGY CLINIC 11 146, 056 0.000000 0 90.	69.00 06900 ELECTROCARDI OLOGY	0	C	0. 00000	0 0	0	69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 13, 681 8, 515, 031 0.001607 1, 410, 565 2, 267 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 22, 531 13, 498, 637 0.001669 0 0 72.00 00100 DRUGS CHARGED TO PATIENTS 12, 783 35, 970, 008 0.00355 3, 412, 199 1, 21 73.00 00100 DUTPATIENT SERVICE COST CENTERS 0 0 0.000000 0 90.00 90.01 09001 CLINIC 0 0 0.000000 0 90.00 90.02 09002 CLINIC 0 0 0.000000 0 90.00 90.03 09030 DERMATOLOGY CLINIC 0 0 0.000000 0 90.00 90.04 09004 ENT CLINIC 0 0 0.000000 0 90.00 90.00 90.05 SURGERY CLINIC 11 146, 056 0.000000 0 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00	69. 01 06901 CARDI OLOGY	46, 854	13, 580, 789	0.00345	3, 910, 273	13, 490	69.01
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 22, 531 13, 498, 637 0.001669 0 72.00 73.00 DUTGS CHARGED TO PATIENTS 12, 783 35, 970, 008 0.000355 3, 412, 199 1, 211 73.00 0010 OUTPATIENT SERVICE COST CENTERS 0 0 0.000000 0 0 90.00 90.01 09000 CLINIC 0 0.000000 0 90.00 90.00 90.00 0.000000 0 90.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13, 681			1, 410, 565	2, 267	71.00
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0.0000 0.00000 0 00.00 90.00 90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER 146,262 0 0.000000 0 90.00 90.02 CLINIC 0 0 0.000000 0 90.00 90.03 DERMATOLOGY CLINIC 0 0 0.000000 0 90.00 90.04 09004 ENT CLINIC 0 0 0.000000 0 90.00 90.05 09005 SURGERY CLINIC 11 146,056 0.000000 0 90.00 90.07 09007 UROLOGY CLINIC 11 146,056 0.000000 0 90.00 90.10 09009 GASTROENTEROLOGY CLINIC 73 0 0.000000 0 90.00 90.11 09011 NEUROLOGY CLINIC 0 0 0.000000 0 90.00 90.12 09114 WUND CARE 119,101 3.832,589<	72.00 07200 IMPL. DEV. CHARGED TO PATIENT			0.00166	59 0	0	72.00
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0.0000 0.00000 0 00.00 90.00 90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER 146,262 0 0.000000 0 90.00 90.02 CLINIC 0 0 0.000000 0 90.00 90.03 DERMATOLOGY CLINIC 0 0 0.000000 0 90.00 90.04 09004 ENT CLINIC 0 0 0.000000 0 90.00 90.05 09005 SURGERY CLINIC 11 146,056 0.000000 0 90.00 90.07 09007 UROLOGY CLINIC 11 146,056 0.000000 0 90.00 90.10 09009 GASTROENTEROLOGY CLINIC 73 0 0.000000 0 90.00 90.11 09011 NEUROLOGY CLINIC 0 0 0.000000 0 90.00 90.12 09114 WUND CARE 119,101 3.832,589<	73.00 07300 DRUGS CHARGED TO PATIENTS	12, 783	35, 970, 008	0. 00035	3, 412, 199	1, 211	73.00
90.01 09001 OTHER OUTPATI ENT SERVICE COST CENTER 146,262 0 0.000000 0 90.02 90.02 09002 CLINIC 0 0 0.000000 0 90.02 90.03 09003 DERMATOLOGY CLINIC 0 0 0.000000 0 90.02 90.04 09004 ENT CLINIC 0 0 0.000000 0 90.02 90.05 SURGERY CLINIC 0 0 0.000000 0 90.02 90.05 SURGERY CLINIC 8 0.000000 0 90.02 90.07 UROLOGY CLINIC 11 146,056 0.000000 0 90.02 90.07 UROLOGY CLINIC 11 146,056 0.000000 0 90.02 90.09 GASTROENTEROLOGY CLINIC 73 0 0.000000 0 90.02 90.11 09011 NEUROLOGY CLINIC 0 0 0.000000 0 90.1 90.12 0914 WUND CARE 119,101 3,832,589 0.031076 582 18 90.1 91.00 </td <td></td> <td>· · · · · · · · · · · · · · · · · · ·</td> <td></td> <td>•</td> <td></td> <td></td> <td>1</td>		· · · · · · · · · · · · · · · · · · ·		•			1
90.02 CLINIC 0 0 0.00000 0 90.0 90.0 90.03 09003 DERMATOLOGY CLINIC 0 0 0.000000 0 90.0 90.04 09004 ENT CLINIC 0 0 0.000000 0 90.0 90.05 SURGERY CLINIC 0 0 0.000000 0 90.0 90.05 SURGERY CLINIC 8 0 0.00000 0 90.0 90.07 UROLOGY CLINIC 11 146,056 0.000000 0 90.0 90.09 GASTROENTEROLOGY CLINIC 73 0 0.000000 0 90.0 90.11 09011 NEUROLOGY CLINIC 0 0 0.000000 0 90.1 90.12 09114 NEUROLOGY CLINIC 0 0 0.000000 0 90.1 90.13 09013 ALLERGY CLINIC 907 691,366 0.01312 0 90.1 90.14 09014 WOUND CARE 119,101 3,832,589 0.031076 582 18 90.1 91.00<	90. 00 09000 CLINIC	0	C	0.0000	0 00	0	90.00
90.02 CLINIC 0 0 0.00000 0 90.0 90.0 90.03 09003 DERMATOLOGY CLINIC 0 0 0.000000 0 90.0 90.04 09004 ENT CLINIC 0 0 0.000000 0 90.0 90.05 SURGERY CLINIC 0 0 0.000000 0 90.0 90.05 SURGERY CLINIC 8 0 0.00000 0 90.0 90.07 UROLOGY CLINIC 11 146,056 0.000000 0 90.0 90.09 GASTROENTEROLOGY CLINIC 73 0 0.000000 0 90.0 90.11 09011 NEUROLOGY CLINIC 0 0 0.000000 0 90.1 90.12 09114 NEUROLOGY CLINIC 0 0 0.000000 0 90.1 90.13 09013 ALLERGY CLINIC 907 691,366 0.01312 0 90.1 90.14 09014 WOUND CARE 119,101 3,832,589 0.031076 582 18 90.1 91.00<	90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	146, 262	C	0. 00000	0 0	0	90.01
90.04 09004 ENT CLINIC 0 0 0.00000 0 90.05 90.00 90.05 SURGERY CLINIC 8 0 0.000000 0 90.00 90.00 90.07 09007 UROLOGY CLINIC 11 146,056 0.000000 0 90.00 90.00 90.09 GASTROENTEROLOGY CLINIC 11 146,056 0.000000 0 90.00 90.00 90.11 09011 NEUROLOGY CLINIC 0 0 0.000000 0 90.00 90.00 90.12 0912 OPTHAMOLOGY CLINIC 0 0 0.000000 0 90.10 90.11 90.13 09013 ALLERGY CLINIC 0 0 0.000000 0 90.1 90.14 09014 WUND CARE 119,101 3,832,589 0.031076 582 18 90.1 91.00 09100 EMERGENCY 839,088 30,953,463 0.027108 1,838,782 49,846 91.0 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 193,026 3,954,648 0.048810 0 <		0	c			0	90.02
90.05 O9005 SURGERY CLINIC 8 0 0.000000 0 90.05 90.07 09007 UROLOGY CLINIC 11 146,056 0.000005 0 90.05 90.09 09009 GASTROENTEROLOGY CLINIC 11 146,056 0.000000 0 90.05 90.11 09011 NEUROLOGY CLINIC 73 0 0.000000 0 90.07 90.12 09012 OPTHAMOLOGY CLINIC 0 0 0.000000 0 90.1 90.12 09012 OPTHAMOLOGY CLINIC 0 0 0.000000 0 90.1 90.13 09013 ALLERGY CLINIC 907 691,366 0.001312 0 0 90.1 90.14 09014 WOUND CARE 119,101 3,832,589 0.031076 582 18 90.1 91.00 OPLOE MEGENCY 839,088 30,953,463 0.027108 1,838,782 49,846 91.0 92.00 OBSERVATION BEDS (NON-DI STINCT PART) 193,026 3,954,648 0.048810 0 92.0 92.0 <tr< td=""><td>90. 03 09003 DERMATOLOGY CLINIC</td><td>0</td><td>c</td><td>0. 00000</td><td>0 0</td><td>0</td><td>90.03</td></tr<>	90. 03 09003 DERMATOLOGY CLINIC	0	c	0. 00000	0 0	0	90.03
90.07 09007 UROLOGY CLINIC 11 146,056 0.000075 0 0 90.07 90.09 GASTROENTEROLOGY CLINIC 73 0 0.000000 0 90.07 90.11 09011 NEUROLOGY CLINIC 73 0 0.000000 0 90.07 90.12 09112 OPTHAMOLOGY CLINIC 0 0 0.000000 0 90.1 90.12 09012 OPTHAMOLOGY CLINIC 0 0 0.000000 0 90.1 90.13 09013 ALLERGY CLINIC 907 691,366 0.001312 0 90.1 90.14 09014 WOUND CARE 119,101 3,832,589 0.031076 582 18 90.1 91.00 09100 EMERGENCY 839,088 30,953,463 0.027108 1,838,782 49,846 91.0 92.00 09SERVATI ON BEDS (NON-DI STINCT PART) 193,026 3,954,648 0.048810 0 92.0 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00	90. 04 09004 ENT CLINIC	0	c	0. 00000	0 0	0	90.04
90.09 GASTROENTEROLOGY CLINIC 73 0 0.00000 0 90.0 90.11 09011 NEUROLOGY CLINIC 0 0 0.000000 0 90.1 90.12 09012 OPTHAMOLOGY CLINIC 0 0 0.000000 0 90.1 90.13 09013 ALLERGY CLINIC 90 0 0.000000 0 90.1 90.14 09014 WOUND CARE 907 691,366 0.001312 0 0 90.1 90.14 09014 WOUND CARE 119,101 3,832,589 0.031076 582 18 90.1 91.00 OP100 EMERGENCY 839,088 30,953,463 0.027108 1,838,782 49,846 91.0 92.00 09SERVATION BEDS (NON-DI STINCT PART) 193,026 3,954,648 0.048810 0 0 92.0 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00	90. 05 09005 SURGERY CLINIC	8	c	0. 00000	0 0	0	90.05
90.09 GASTROENTEROLOGY CLINIC 73 0 0.00000 0 90.0 90.11 09011 NEUROLOGY CLINIC 0 0 0.000000 0 90.1 90.12 09012 OPTHAMOLOGY CLINIC 0 0 0.000000 0 90.1 90.13 09013 ALLERGY CLINIC 90 0 0.000000 0 90.1 90.14 09014 WOUND CARE 907 691,366 0.001312 0 0 90.1 90.14 09014 WOUND CARE 119,101 3,832,589 0.031076 582 18 90.1 91.00 OP100 EMERGENCY 839,088 30,953,463 0.027108 1,838,782 49,846 91.0 92.00 09SERVATION BEDS (NON-DI STINCT PART) 193,026 3,954,648 0.048810 0 0 92.0 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00		11	146, 056				90.07
90.11 09011 NEUROLOGY CLINIC 0 0 0.000000 0 90.1 90.12 09012 OPTHAMOLOGY CLINIC 0 0 0.000000 0 90.1 90.13 09013 ALLERGY CLINIC 0 0 0.001312 0 0 90.1 90.14 09014 WOUND CARE 119,101 3,832,589 0.031076 582 18 90.1 91.00 OP100 EMERGENCY 839,088 30,953,463 0.027108 1,838,782 49,846 91.0 92.00 0BSERVATI ON BEDS (NON-DI STINCT PART) 193,026 3,954,648 0.048810 <							90.09
90.12 09012 0PTHAMOLOGY CLINIC 0 0 0.000000 0 90.1 90.13 09013 ALLERGY CLINIC 907 691,366 0.001312 0 0 90.1 90.14 09014 WOUND CARE 119,101 3,832,589 0.031076 582 18 90.1 91.00 09100 EMERGENCY 839,088 30,953,463 0.027108 1,838,782 49,846 91.0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 193,026 3,954,648 0.048810 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>90.11</td>							90.11
90.13 09013 ALLERGY CLINIC 907 691, 366 0.001312 0 0 90.1 90.14 09014 WOUND CARE 119, 101 3, 832, 589 0.031076 582 18 90.1 91.00 09100 EMERGENCY 839, 088 30, 953, 463 0.027108 1, 838, 782 49, 846 91.0 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 193, 026 3, 954, 648 0.048810 0 0 0 20.0 95.00 09500 AMBULANCE SERVICES 95.00 95.00 95.00 95.00 95.00		0	0			0	90.12
90.14 09014 WOUND CARE 119,101 3,832,589 0.031076 582 18 90.1 91.00 09100 EMERGENCY 839,088 30,953,463 0.027108 1,838,782 49,846 91.0 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 193,026 3,954,648 0.048810 0 0 92.0 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00		907	691, 366				90.13
91.00 09100 EMERGENCY 839,088 30,953,463 0.027108 1,838,782 49,846 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 193,026 3,954,648 0.048810 0 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00		119, 101				18	90.14
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 193, 026 3, 954, 648 0. 048810 0 0 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00 95. 00							91.00
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00							92.00
95. 00 09500 AMBULANCE SERVICES 95. 0			, ., .,		,		1
							95.00
	200.00 Total (lines 50 through 199)	3, 505, 005	348, 038, 755		25, 808, 836	197, 636	

Health Financial Systems	WI THAM MEMORI.				eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	R PASS THROUGH COST	S Provider C		Period: From 01/01/2018 To 12/31/2018		pared: 3 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Healt	Allied Health	All Other	
	Post-Stepdown		Post-Stepdow	n Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	-	
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
40. 00 04000 SUBPROVIDER - IPF	0	0		0 0	0	40.00
41. 00 04100 SUBPROVI DER – I RF	0	0		0 0	0	41.00
42. 00 04200 SUBPROVI DER	0	0		0 0	0	42.00
43. 00 04300 NURSERY	0	0		0 0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		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 Patien ⁻	t Per Diem (col.	I npati ent	
	Adj ustment	(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	
30. 00 03000 ADULTS & PEDIATRICS	0	0	7, 01			30.00
31.00 03100 INTENSIVE CARE UNIT		0	1, 77			
40. 00 04000 SUBPROVI DER – I PF	0	0	3, 13	3 0.00	2, 558	40.00
41. 00 04100 SUBPROVI DER – I RF	0	0		0 0.00	0	41.00
42. 00 04200 SUBPROVI DER	0	0		0 0.00	0	42.00
43. 00 04300 NURSERY		0	1, 06	0 0.00	0	43.00
44.00 04400 SKILLED NURSING FACILITY		0	5, 02	7 0.00	2, 994	44.00
200.00 Total (lines 30 through 199)		0	18, 00	8	8, 649	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
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
	0					42.00
42. 00 04200 SUBPROVI DER						
42.00 04200 SUBPROVIDER 43.00 04300 NURSERY	0					43.00
	0					43.00 44.00

	Financial Systems	WITHAM MEMORIA			In	Lieu of Form	CMS-2	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	5 Provider C	CN: 15-0104	Peri od:	Workshee	t D	
THROUG	COSTS				From 01/01/2			
					To 12/31/20	018 Date/Tim	e Prep	pared:
			Titlo	XVIII	Hospi tal		5/24/2019 2:03 p PPS	
	Cost Center Description	Non Physician						
	Cost center bescription		Post-Stepdown	NUISING SCHO	Post-Stepdo			
		Cost	Adjustments		Adj ustment			
		1.00	2A	2.00	3A	3.00		
	ANCI LLARY SERVICE COST CENTERS	1.00	28	2.00	JA			
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
		-	0		0	0	-	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
55.01	05501 ULTRA SOUND	0	0		0	0	0	55.01
57.00	05700 CT SCAN	0	0		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60.00	06000 LABORATORY	0	0		0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	0	0	64.00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	0	66. OC
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.OC
67.01	06701 AUDI OLOGY	0	0		0	0	0	67.01
68.00	06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	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	o	o	71. OC
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	o	0	73. OC
, 0, 00	OUTPATIENT SERVICE COST CENTERS			<u> </u>				/0.00
90.00	09000 CLINIC	0	0		0	0	0	90. OC
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	0	0	90.01
90.02	09002 CLINIC	0	0		0	0	0	90.02
90.02 90.03	09003 DERMATOLOGY CLINIC	0	0		0	0	0	90.02
90.03	09004 ENT CLINIC	0	0		0	0	0	90.02
90.04	09005 SURGERY CLINIC	0	0		0	0	0	
		0	0		0	0		90.05
90.07	09007 UROLOGY CLINIC	0	0		0	0	0	90.07
90.09	09009 GASTROENTEROLOGY CLINIC	0	0		0	0	0	90.09
90.11	09011 NEUROLOGY CLINIC	0	0		0	0	0	90. 11
90. 12	09012 OPTHAMOLOGY CLINIC	0	0		0	0	0	90. 12
90.13	09013 ALLERGY CLINIC	0	0		0	0	0	90.13
90.14	09014 WOUND CARE	0	0		0	0	0	90.14
	09100 EMERGENCY	0	0		0	0	0	91. OC
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0		0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVI CES							95.00
95.00								

Health Financial Systems	WI THAM MEMORI			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	S Provider C		Period: From 01/01/2018	Worksheet D Part IV	
				To 12/31/2018		
		Title	2 XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	•	Cost (sum of	•	$(col. 5 \div col.$	
		4)	col s. 2, 3,	8)	7)	
			and 4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	1	1	1	_		
50.00 05000 OPERATI NG ROOM	0	-		0 48, 328, 351		1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	-		0 32, 631, 664		
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0.00000	1
55.01 05501 ULTRA SOUND	0	0		0 8, 442, 283		1
57.00 05700 CT SCAN	0	0		0 42, 985, 910		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 14, 805, 232		1
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 15, 902, 581		1
60. 00 06000 LABORATORY	0	0		0 56, 165, 181		
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 888, 126	0.00000	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 3, 265, 907	0.00000	64.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 8, 164, 154	0.00000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 3, 291, 358	0.00000	67.00
67. 01 06701 AUDI OLOGY	0	0		0 978, 602	0.00000	67.01
68.00 06800 SPEECH PATHOLOGY	0	0		0 1, 046, 819	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 13, 580, 789	0.000000	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 8, 515, 031	0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 13, 498, 637	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 35, 970, 008	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS	1	1		-		
90. 00 09000 CLINIC	0	-		0 0		
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	-		0 0		
90. 02 09002 CLINIC	0	0		0 0	0.00000	
90. 03 09003 DERMATOLOGY CLINIC	0	0		0 0	0.00000	1
90. 04 09004 ENT CLINIC	0	0		0 0	0.00000	1
90. 05 09005 SURGERY CLINIC	0	0		0 0	0.000000	1
90. 07 09007 UROLOGY CLINIC	0	0		0 146, 056		
90. 09 09009 GASTROENTEROLOGY CLINIC	0	0		0 0	0.000000	
90. 11 09011 NEUROLOGY CLINIC	0	0		0 0	0.000000	
90. 12 09012 OPTHAMOLOGY CLINIC	0	0		0 0	0.000000	
90. 13 09013 ALLERGY CLINIC	0	0		0 691, 366		
90. 14 09014 WOUND CARE	0	0		0 3, 832, 589		
91.00 09100 EMERGENCY	0			0 30, 953, 463		
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	0	0		0 3, 954, 648	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS			1			0.5.05
95. 00 09500 AMBULANCE SERVICES		_		240 000 755		95.00
200.00 Total (lines 50 through 199)	0	0	1	0 348, 038, 755	I	200. 00

Health Financial Systems	WI THAM MEMORI A	L HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLAF THROUGH COSTS	RY SERVICE OTHER PASS	Provider CO	CN: 15-0104	Period: From 01/01/2018 To 12/31/2018		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpatient Ratio of Cost	Inpatient Program	Inpatient Program	Outpatient Program	Outpatient Program	
	to Charges (col. 6 ÷ col.	Charges	Pass-Throug Costs (col.		Pass-Through Costs (col. 9	
	7) 9.00	10.00	x col. 10) 11.00	12.00	x col. 12) 13.00	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	0.000000	F 047 202	1	0 12 500 124		50.00
50. 00 05000 OPERATING ROOM	0. 000000	5,047,393		0 13, 509, 124	0	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 000000	1, 014, 030		0 8, 504, 410	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	
55. 01 05501 ULTRA SOUND	0. 000000	61, 493		0 892, 550	0	
57. 00 05700 CT SCAN	0. 000000	2, 179, 917		0 9, 739, 025	0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	369, 800		0 4, 719, 246	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	630, 920		0 1, 378, 672	0	
60. 00 06000 LABORATORY	0. 000000	4, 371, 941		0 5, 200, 929	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS		161, 160		0 104, 819	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	618, 537		0 438, 898	0	64.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	413, 946		0 15, 494	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	289, 225		0 9, 357	0	67.00
67. 01 06701 AUDI OLOGY	0. 000000	0		0 128, 533	0	67.01
68.00 06800 SPEECH PATHOLOGY	0. 000000	78, 073		0 806	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
69. 01 06901 CARDI OLOGY	0. 000000	3, 910, 273		0 5, 866, 087	0	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI EI		1, 410, 565		0 1, 255, 833	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0		0 24,969	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	3, 412, 199		0 8, 444, 476	0	73.00
	0,000000			0		00.00
90. 00 09000 CLINIC	0. 000000	0			0	
90. 01 09001 OTHER OUTPATIENT SERVICE COST CEN 90. 02 09002 CLINIC	TER 0. 000000 0. 000000	0			0	
	0.000000	0			0	
90. 03 09003 DERMATOLOGY CLINIC 90. 04 09004 ENT CLINIC	0.000000	0			0	
		-			-	
90. 05 09005 SURGERY CLINIC 90. 07 09007 UROLOGY CLINIC	0. 000000	0			0	
		0			0	
90. 09 09009 GASTROENTEROLOGY CLINIC	0. 000000	0		0 0	0	
90. 11 09011 NEUROLOGY CLINIC	0. 000000	0		0	0	90.11
90. 12 09012 OPTHAMOLOGY CLINIC	0. 000000	•			0	
90. 13 09013 ALLERGY CLINIC	0. 000000	0		0	0	90.13
90. 14 09014 WOUND CARE 91. 00 09100 EMERGENCY	0. 000000	1 929 792		001/202	0	90.14
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAI	0. 000000 RT) 0. 000000	1, 838, 782 0		0 4, 890, 665 0 2, 056, 475		
072.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR OTHER REIMBURSABLE COST CENTERS		0	I	2,056,475	0	92.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		25, 808, 836		0 67, 864, 620	0	200.00

	ancial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0104	Period: From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
						5/24/2019 2:0	3 pm
			l litle	XVIII	Hospi tal	PPS	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Charges Cost	Cost	Costs PPS Services	
	cost center bescription	Ratio From	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 SERVICE COST CENTERS					•	
50.00 0500	O OPERATING ROOM	0. 104885	13, 509, 124		0 0	1, 416, 904	50.00
54.00 0540	0 RADI OLOGY-DI AGNOSTI C	0. 237681	8, 504, 410		0 1	2, 021, 337	54.00
55.00 0550	0 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
55.01 0550	1 ULTRA SOUND	0. 092265	892, 550		0 0	82, 351	55.01
	O CT SCAN	0. 026733	9, 739, 025		0 7,058	260, 353	57.00
58.00 0580	O MAGNETIC RESONANCE IMAGING (MRI)	0. 074484	4, 719, 246	,	0 0	351, 508	58.00
	O CARDI AC CATHETERI ZATI ON	0. 099663	1, 378, 672		0 0	137, 403	59.00
60.00 0600	O LABORATORY	0. 156412	5, 200, 929		0 0	813, 488	60.00
63.00 0630	0 BLOOD STORING, PROCESSING & TRANS.	0. 215731	104, 819		0 0	22, 613	63.00
64.00 0640	O INTRAVENOUS THERAPY	0. 000971	438, 898		0 0	426	64.00
66.00 0660	0 PHYSI CAL THERAPY	0. 420493	15, 494		0 0	6, 515	66.00
67.00 0670	O OCCUPATIONAL THERAPY	0. 187302	9, 357		0 0	1, 753	67.00
67.01 0670	1 AUDI OLOGY	0. 260981	128, 533		0 0	33, 545	67.01
	O SPEECH PATHOLOGY	0. 273687	806	,	0 0	221	68.00
	0 ELECTROCARDI OLOGY	0. 000000			0 0	0	69.00
	1 CARDI OLOGY	0. 143244	5, 866, 087		0 0	840, 282	69.01
	O MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 380964	1, 255, 833		0 0	478, 427	71.00
	O IMPL. DEV. CHARGED TO PATIENT	0. 397107	24, 969		0 0	9, 915	72.00
	O DRUGS CHARGED TO PATIENTS	0. 071583	8, 444, 476		0 33, 174	604, 481	73.00
	ATIENT SERVICE COST CENTERS	-	1	1	- 1		
	DO CLINIC	0. 000000			0 0		
	1 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000		1	0 0	0	
	2 CLINIC	0. 000000			0 0	0	
	3 DERMATOLOGY CLINIC	0. 000000			0 0	0	90.03
	04 ENT CLINIC	0. 000000			0 0	0	90.04
	5 SURGERY CLINIC	0. 000000			0 0	0	
	07 UROLOGY CLINIC	0.006730			0 0	0	
	9 GASTROENTEROLOGY CLINIC	0. 000000			0 0	0	
	1 NEUROLOGY CLINIC	0. 000000			0 0	0	
	2 OPTHAMOLOGY CLINIC	0. 000000			0 0	0	90.12
	3 ALLERGY CLINIC	0. 285565			0 0	0	
	4 WOUND CARE	0. 172012			0 1, 287	117, 700	1
	O EMERGENCY	0. 175948			0 110	860, 503	
	0 OBSERVATION BEDS (NON-DISTINCT PART)	0. 515671	2,056,475		0 22	1, 060, 465	92.00
	R REIMBURSABLE COST CENTERS	0.07014/	1	1		1	1 05 00
	0 AMBULANCE SERVICES	0. 972146			0 41 452	0 100 100	95.00
200.00	Subtotal (see instructions)		67, 864, 620	1	0 41,652	9, 120, 190	
201.00	Less PBP Clinic Lab. Services-Program Only Charges				0		201.00
202.00	Net Charges (line 200 - line 201)		67, 864, 620		0 41,652	9, 120, 190	202 00
202.00		I	1 07,004,020	1		1 7, 120, 170	1-02.00

APPORTI ONN	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Pr	ovider CC	CN: 15-0104	Period: From 01/01/2 To 12/31/2	Worksheet D Part V Date/Time Pr 5/24/2019 2:	epared: 03 pm
				Title	XVIII	Hospi tal	PPS	
		Cos	sts					
	Cost Center Description	Cost	(Cost				
		Reimbursed	Rei	nbursed				
		Servi ces	Serv	ces Not				
		Subject To	Subj	ect To				
		Ded. & Coins.	Ded.	& Coins.				
		(see inst.)	(see	inst.)				
		6.00		7.00				
ANCI	LLARY SERVICE COST CENTERS							
50.00 050	DO OPERATING ROOM	0		0				50.00
54.00 0540	DO RADI OLOGY-DI AGNOSTI C	0		0				54.00
55.00 0550	DO RADI OLOGY-THERAPEUTI C	0		o				55.00
55.01 0550	D1 ULTRA SOUND	0		o				55.01
57.00 0570	DO CT SCAN	0		189				57.00
	DO MAGNETIC RESONANCE IMAGING (MRI)	0		0				58.00
	DO CARDI AC CATHETERI ZATI ON	0		0				59.00
	DO LABORATORY	0		0				60.00
	DO BLOOD STORI NG, PROCESSI NG & TRANS.	0		0				63.00
1	DO I NTRAVENOUS THERAPY	0		0				64.00
	DO PHYSI CAL THERAPY	0		0				66.00
	DO OCCUPATIONAL THERAPY	0		0				67.00
	DI AUDI OLOGY	0		0				67.00
		0		0				
		0		0				68.00
		0		-				69.00
		0		0				69.01
	DO MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0				71.00
	DO I MPL. DEV. CHARGED TO PATIENT	0		0				72.00
	DO DRUGS CHARGED TO PATIENTS	0		2, 375				73.00
	PATIENT SERVICE COST CENTERS		-					
		0		0				90.00
	01 OTHER OUTPATIENT SERVICE COST CENTER	0		0				90.01
	D2 CLINIC	0		0				90.02
	D3 DERMATOLOGY CLINIC	0		0				90.03
	D4 ENT CLINIC	0		0				90.04
	D5 SURGERY CLINIC	0		0				90.05
	D7 UROLOGY CLINIC	0		0				90.07
	D9 GASTROENTEROLOGY CLINIC	0		0				90.09
90. 11 090 ⁻	11 NEUROLOGY CLINIC	0		0				90.11
90. 12 090 [.]	12 OPTHAMOLOGY CLINIC	0		0				90.12
90. 13 090 [.]	13 ALLERGY CLINIC	0		0				90.13
90. 14 090 ⁻	14 WOUND CARE	0		221				90.14
91.00 0910	DO EMERGENCY	0		19				91.00
	OO OBSERVATION BEDS (NON-DISTINCT PART)	0		11				92.00
OTH	REIMBURSABLE COST CENTERS							
	DO AMBULANCE SERVICES	0						95.00
200.00	Subtotal (see instructions)	0		2, 815				200.00
201.00	Less PBP Clinic Lab. Services-Program	0						201.00
	Only Charges							
	Net Charges (line 200 - line 201)	0						202.00

PORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C	CN: 15-0104	Peri od:	Worksheet D	
				From 01/01/2018	Part II	
		Component	CCN: 15-S104	To 12/31/2018	Date/Time Pre 5/24/2019 2:0	pare 3 pm
		Title	e XVIII	Subprovider -	PPS	-
	_			I PF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	<u>26)</u> 1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	-
00 05000 OPERATING ROOM	572, 242	48, 328, 351	0.01184	12,019	142	50.
. 00 05400 RADI OLOGY-DI AGNOSTI C	725, 186				1, 077	
. 00 05500 RADI OLOGY-THERAPEUTI C	125, 180		0.02222		0	
. 01 05501 ULTRA SOUND	6, 649	-			0	
. 00 05700 CT SCAN	8, 828				10	
. 00 05500 MAGNETIC RESONANCE IMAGING (MRI)	63, 811				26	
. 00 05900 CARDI AC CATHETERI ZATI ON	54, 389				28	
00 06000 LABORATORY	351, 196				3, 529	
. 00 06300 BLOOD STORING, PROCESSING & TRANS.	806				3, 529	63
. 00 06400 INTRAVENOUS THERAPY	13				0	
. 00 06600 PHYSI CAL THERAPY	318, 775				1, 324	
. 00 06700 OCCUPATIONAL THERAPY	5, 566				34	
. 01 06701 AUDI OLOGY	1, 641				0	
. 00 06800 SPEECH PATHOLOGY	1, 578				13	
00 06900 ELECTROCARDI OLOGY	1, 370		1		0	
. 01 06901 CARDI 0LOGY	46, 854	-			263	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13, 681				90	
. 00 07200 IMPL. DEV. CHARGED TO PATIENT	22, 531				,0 0	
. 00 07300 DRUGS CHARGED TO PATIENTS	12, 783				260	
OUTPATIENT SERVICE COST CENTERS	12,703	33, 770, 000	0.0003	733, 073	200	1 ' '
00 09000 CLINIC	0	0	0.0000	0 00	0	1 90
01 09001 OTHER OUTPATIENT SERVICE COST CENTER	146, 262	-			0	
02 09002 CLINIC	0		0.00000		0	
03 09003 DERMATOLOGY CLINIC	0	0			0	
. 04 09004 ENT CLINIC	0				0	
05 09005 SURGERY CLINIC	8	c c			0	90
07 09007 UROLOGY CLINIC	11				0	90
09 09009 GASTROENTEROLOGY CLINIC	73				0	
. 11 09011 NEUROLOGY CLINIC	0				0	90
. 12 09012 OPTHAMOLOGY CLINIC	0	c c	0.0000		0	90
13 09013 ALLERGY CLINIC	907	-			0	
. 14 09014 WOUND CARE	119, 101				1	90
. 00 09100 EMERGENCY	839, 088				667	
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	
OTHER REIMBURSABLE COST CENTERS						1 `
. 00 09500 AMBULANCE SERVICES						95
0.00 Total (lines 50 through 199)	3, 311, 979	348, 038, 755		1, 645, 884	7, 466	

leal th Financial Systems	WI THAM MEMORI				u of Form CMS-	2552-1
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	6 Provider C	CN: 15-0104	Period: From 01/01/2018	Worksheet D Part IV	
THROUGH COSTS		Component	CCN: 15-S104	To 12/31/2018	Date/Time Pre	
		T: +1 -		Culture and states	5/24/2019 2:0	3 pm
		IITIE	XVIII	Subprovider - IPF	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing Schoo	ol Allied Health	Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	<u> </u>		0 0	0	
50. 00 05000 OPERATI NG ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0					
	0			0 0	0	1
55. 00 05500 RADI OLOGY-THERAPEUTI C 55. 01 05501 ULTRA SOUND	0			0 0	-	
	0			0 0	0	
57.00 05700 CT SCAN	0			0 0	0	1 01.0
8.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	-	
9.00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	
0.00 06000 LABORATORY	0	0		0 0	0	
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	U		0 0	0	
4.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0	
6.00 06600 PHYSI CAL THERAPY	0	0		0 0	0	00.0
7.00 06700 OCCUPATIONAL THERAPY	0	0		0 0	0	
07. 01 06701 AUDI 0LOGY	0	0		0 0	0	
8.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	
99. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	
69. 01 06901 CARDI OLOGY	0	0		0 0	0	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	73.0
00 00 0000 CLINIC	0	0		0 0	0	90.0
20. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0			0 0	0	
0. 02 09002 CLINIC	0			0 0	0	
0. 03 09003 DERMATOLOGY CLINIC	0			0 0	0	
0. 04 09004 ENT CLINIC	0			0 0	0	
0. 05 09005 SURGERY CLINIC	0			0 0	0	
0. 07 09007 UROLOGY CLINIC	0			0 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. 13 09013 ALLERGY CLINIC	0				0	
0. 14 09014 WOUND CARE	0				0	
1. 00 09100 EMERGENCY	0				0	
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	
OTHER REIMBURSABLE COST CENTERS	0		I		0	72.0
5. 00 09500 AMBULANCE SERVICES						95. C
200.00 Total (lines 50 through 199)	0	C		0 0	0	200.0
	0		I	U U	0	1200. U

THROUGH COSTS Component CCN: 15-S104 From 01/01/2018 To 12/31/2019 Part I W Date Time Prepared (S2/2019-2:03 part 1/V Date Time Prepared (S2/2019-2:03 part 1/V S1/2019-2:03 part 1/V S1/2019-2:04 part 1/V S1/2019-	Health Financial Systems	WI THAM MEMORI				eu of Form CMS-	2552-10
Instrumentation Component CCN: 15-S104 To 12/31/2018 Date Critic Prepared Display Cost Center Description All Other Medical Education Cost Total Cost Sum of Coils (2, 2, 3, and 4) Total Cost Cost Sum of Cost Sum of Sum of Cost Sum of Cost Sum of Cost Sum of Cost Sum of Sum of Cost Sum of Cost Sum of Sum of Cost Sum of Sum of Cost Sum of Sum of Cost Sum of Sum of Sum of Sum of Cost Sum of Sum of Cost Sum of Sum of Sum of Sum of Sum of Sum of Sum of Cost Sum of Sum of		RVICE OTHER PASS	S Provider C	CN: 15-0104	Peri od:	Worksheet D	
Title X/III Subprovider - IPF PPS Cost Center Description AII Other Medical Education Cost Total Cost (sum of Cost 4.00 Total Charges Subprovider - (sum of Cost 4.00 Total Charges Cost Subprovider - Subprovider - Subprovider - Cost Subprovider - Subprovider - S	THROUGH COSTS		Component	CCN: 15-S104		3 Date/Time Pre	epared:
Cost Center Description All Other Medical Education Cost (sum of cols. 1, 2, 3, and 4) Total Cost (sum of cols. 4, 3) Total Cost (sum of cols. 3, and 4) Total Cost (col. s. 2, 3, and 4) Total Cost (sot, 3, 44, 2, 88, 20, 0000005 Sot (sot, 3, 20, 00000005 Sot (sot (sot, 3, 20, 00000005 Sot (sot (sot, 3, 20, 000000006 Sot (sot, 3, 20, 00000006 <t< td=""><td></td><td></td><td>Ti tl c</td><td>XVIII</td><td>Subprovidor</td><td></td><td>03 pm</td></t<>			Ti tl c	XVIII	Subprovidor		03 pm
Medi cal Education Cost (sum of cols. 2, 3, and 0 Outpatient Cost (sum of cals. 2, 3, and 0 (from West. C. cols. 2, 3, and 0 (from West. 2, 3, and 0 (from West. 2, 3, 3, 3, 3, 3, 3, 3, 3, 0, 0000000 (from West. 2, 3, 3, 3, 3, 3, 3, 0, 0000000 (from West. 2, 3, 3, 3, 3, 3, 3, 3, 3, 3, 0, 0000000 (from West. 2, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 0, 0000000 (from West. 2, 3, 3, 3, 3, 3, 3, 3, 3, 3, 0, 000000 (from West. 2, 3, 3, 3, 3, 3, 3, 0, 0000000 (from West. 2, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3,				2 AVIII		FF3	
Education Cost 1, 2, 3, and (4) Cost Fart 1, col. (col. 5, 2, 01. 7) ANCILLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 ANCILLARY SERVICE COST CENTERS 0 0 0 44.02 6.00 7.00 8.00 50.00 05000 (PERATI NG ROM 0 0 0 44.328,351 0.000000 55.01 50.00 05001 (PERATI NG ROM 0 0 32,631,664 0.000000 55.01 50.00 055001 (CT SCAN 0 0 44.92,285,910 0.0000000 55.01 50.00 05600 (ARDI ACC) THERAPEUTI C 0 0 14.805,222 0.0000000 55.00 50.00 05600 (ARDI ACC) THERAPEUTERI ATI ON 0 0 15.900 0.000000 55.00 0.000000 55.00 0.0000000 55.00 0.0000000 55.00 0.0000000 55.00 0.0000000 55.00 0.0000000 55.00 0.0000000 55.00 0.0000000 55.00 0.0000000 55.00 0.0000000	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
4) cols. 2, 3, 8) 7) A.00 5.00 6.00 7.00 8.00 50.00 05000 (PERATING ROOM 0 0 48, 328, 351 0.000000 50.00 51.00 05500 (PERATING ROOM 0 0 48, 328, 351 0.000000 50.00 55.00 05500 (RADI OLGY-THERAPEUTI C 0 0 0 842, 233 0.000000 55.00 55.00 05500 (ARADEL C RESONANCE I MAGING (MRI) 0 0 0 42, 985, 910 0.000000 55.00 56.00 05600 (ARADEL C RESONANCE I MAGING (MRI) 0 0 0 14, 805, 232 0.000000 55.00 50.00 05600 (ARADEL C RESONANCE I TRAINS. 0 0 0 56, 161 0.000000 63.00 51.00 05000 DEVENT NOL, PROCESSING & TRAINS. 0 0 0 3, 265, 907 0.000000 64.00 66000 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00		Medi cal	(sum of cols.				
ANCI LLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 54.00 0 0.000000 55.00 54.00 05400 RADI OLGY-THERAPEUTI C 0 0 0 0.000000 55.00 55.01 05501 ULTRA SOUND 0 0 0 0.000000 55.01 55.00 05500 ULTRA SOUND 0 0 0 0.000000 55.01 55.01 05501 ULTRA SOUND 0 0 0 44.285,910 0.000000 55.01 56.00 05600 CARDIAC CATHETERI ZATI ON 0 0 0 15,902,581 0.000000 64.00 66.00 06600 INTRAVENDIS THERAPY 0 0 0 8.81,26 0.000000 64.00 66.00 06500 CCUPATI ONAL THERAPY 0 0 0 8.164, 154 0.000000 64.00 66.00 06600 PHYSI CAL THERAPY 0 0 8.164, 154 0.000000 67.00		Education Cost					
ANOLLARY SERVICE COST CENTERS 50.00 6000 0 6.00 7.00 8.00 50.00 05000 0PERATING ROM 0 0 0 8.00 54.00 05400 RADIOLOCY-DLAGNOSTIC 0 0 0 32,631,664 0.000000 55.00 55.01 05500 RADIOLOCY-THERAPEUTIC 0 0 0 4.42,283 0.000000 55.01 50.00 05500 MADIOLOCY-THERAPEUTIC 0 0 0 4.42,283 0.000000 55.01 50.00 05900 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 14,805,232 0.000000 55.01 50.00 05900 CARDIA CCATHETERIZATION 0 0 0 8.842 0.000000 56.00 60.00 06000 LABORATORY 0 0 0 8.864,1854 0.000000 67.00 61.00 06000 OPHYSICAL THERAPY 0 0 0 3.265,907 0.000000 67.00 67.01 0.6700 0.0			4)		8)	7)	
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92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 3, 954, 648 0. 000000 92. 00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00							
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00		-	-				
95.00 09500 AMBULANCE SERVICES 95.00		0		1	5, 754, 040	0.00000	72.00
				1			95 00
	200.00 Total (lines 50 through 199)	0	0		0 348, 038, 755	5	200.00

APPORTI	ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	Provider C	CN: 15-0104	Peri od:	Worksheet D	
THROUGH					From 01/01/2018	Part IV	
			Component (CCN: 15-S104	To 12/31/2018	Date/Time Pre 5/24/2019 2:0	pared: 3 pm
			Title	XVIII	Subprovider - IPF	PPS	
	Cost Center Description	Outpatient	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	
	ANCI LLARY SERVI CE COST CENTERS	1					
	05000 OPERATI NG ROOM	0. 000000	12, 019		0 0		50.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	48, 473		0 12	0	54.00
	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0		55.00
	05501 ULTRA SOUND	0. 000000	0		0 0		55.01
	05700 CT SCAN	0. 000000	47, 651		0 0	0	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	6, 110		0 0		58.00
	05900 CARDI AC CATHETERI ZATI ON	0. 000000	8, 065		0 0		59.00
	06000 LABORATORY	0. 000000	564, 324		0 0	0	60.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	1, 736		0 0	0	63.00
	06400 INTRAVENOUS THERAPY	0.000000	5, 300		0 0	-	64.00
66.00	06600 PHYSI CAL THERAPY	0.000000	33, 913		0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	19, 941		0 0	0	67.00
67.01	06701 AUDI OLOGY	0. 000000	0		0 0	0	67.01
68.00	06800 SPEECH PATHOLOGY	0. 000000	8, 366		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
69. 01	06901 CARDI OLOGY	0. 000000	76, 253		0 0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	56, 030		0 0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0		0 0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0.000000	733, 073		0 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS			_			
90.00	09000 CLI NI C	0. 000000	0		0 0	0	90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	0		0 0	0	90.0
	09002 CLI NI C	0. 000000	0		0 0	0	90.02
	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	19		0 0	0	90.14
	09100 EMERGENCY	0. 000000	24, 611		0 1, 213	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0		0 238	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95.00
					0 1,463		200.00

54 00 05400 RADI 0LOGY-DI AGNOSTI C 0.237681 12 0 0 3 55 00 05500 RADI 0LOGY-DI REAPEUTI C 0.000000 0		Financial Systems	WI THAM MEMORI				u of Form CMS-	2552-10
Component COX: 15-S104 To 12/31/2018 Date/Time Program V Title XVIII Subprovider - IPF PPS Cost Center Description Cost Conrage Cost Reinbursed Barlo From Worksheet C, Part I, col. 9 Cost Cost Reinbursed Subject To Ded. & Conrage Cost Reinbursed Subject To Ded. & Conrage Cost Subject To Ded. & Conrage PPS Services Subject To Ded. & Conrage Cost Subject To Ded. & Conrage PS Services Subject To Ded. & Conrage Cost Subject To Ded. & Conrage PS Services Subject To Ded. & Conrage Cost Subject To Ded. & Conrage PS Services Subject To Ded. & Conrage PS Services Subject To Ded. & Conrage PS Services Subject To Ded. & Conrage Cost Subject To Ded. & Conrage PS Services Subject To Ded. & Conrage Services Subject To Services Services Services Services Services </td <td>APPORT</td> <td>IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND</td> <td>O VACCINE COST</td> <td>Provider C</td> <td>CN: 15-0104</td> <td></td> <td></td> <td></td>	APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-0104			
Title XVIII Subprovider - 1PF PPS Cost Center Description Cost to Charges Ratio From Worksheet C. Cost to Charges Ratio From Vorksheet C. Cost Cost Services (see Inst.) Cost Services (see Inst.) Cost Services Services (see Inst.) PPS Services (see Inst.) MCILLARY SERVICE COST CENTES 1.00 2.00 3.00 4.00 5.00 50.00 05000 0FEATING ROM 05000 0FEATING ROM 0.104885 0.000 0 0 0 3.00 4.00 50.00 05000 0FEATING ROM 05000 0FEATING ROM 0.026733 0.000 0 0 0 0 3.00 4.00 0				Component	CCN: 15-S104		Date/Time Pre	epared:)3 pm
Cost Center Description Cost to Charges/PS Reinbursed Ratio From Worksheet (See inst.) Cost to Charges/PS Reinbursed Services (See inst.) Cost to Charges/PS Reinbursed Services (See inst.) Cost to Charges/PS Reinbursed Services (See inst.) Cost to Charges/PS Reinbursed Services (See inst.) Cost to PS Services (See inst.) Cost Services (See inst.) 50.00 05000 (PFRATING ROM 05000 (PFRATING ROM RADIOSO (PFRATING RADIOSO ROM RADIOSO (PFRATING ROM RADIOSO (PFRATING				Title	e XVIII			
Ratio From Services (see part I, col. 9 Retio From Services (see inst.) Retinbursed Services (see inst.) Retinbursed Services (see bel, & coln s Services (see inst.) Retinbursed Services (see inst.) MOLLLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 0.00 05000 (PERATI NG ROM 0.104885 0 0 0 0 0 51.00 05000 (RADI LOCY-THEAPFEUTIC 0.0237681 12 0				I	Charges		Costs	
Worksheet C, Part I, col. 9 inst.) Subject To Subject To Col. 4 Coins. (see inst.) Sources Subject To Col. 4 Coins. (see inst.) ANCILLARY SERVICE COST CENTERS 0 0.004 & Coins. (see inst.) 0 0 50.00 05000 0FEARI NG ROM 0.104865 0 0 0 0 51.00 05500 RADI LORY-THEAREUTIC 0.23761 12 0 0 0 55.00 05500 RADI LORY-THEAREUTIC 0.23761 12 0 0 0 55.00 05500 RADI LORY-THEAREUTIC 0.024733 0 0 0 0 59.00 05900 CARDI AC CATHETERIZATION 0.024733 0		Cost Center Description	Cost to Charge	PPS Reimbursec	Cost	Cost	PPS Services	
Part I, col. 9 Subject To Ded. & Colins. Ded. & Colins. (see Inst.) Subject To Ded. & Colins. (see Inst.) ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 Sociol OPERATING ROOM 0.104885 0 0 0 0 3.00 4.00 5.00 Sociol OPERATING ROOM 0.104885 0 0 0 3.00 4.00 5.00 Sociol OPERATING ROOM 0.237681 12 0 0 0 0 Sociol CT SCAN 0.000267 0.00000 0 <td></td> <td></td> <td>Ratio From</td> <td>Services (see</td> <td>Rei mbursed</td> <td>Reimbursed</td> <td>(see inst.)</td> <td></td>			Ratio From	Services (see	Rei mbursed	Reimbursed	(see inst.)	
Image: Control of the contro			Worksheet C,	inst.)	Servi ces	Services Not		
Image: construct of the services of the service of the services of the service of the service of the services of the service of the services of the service of the services of the service of the services o			Part I, col. 9					
Image: 100 2.00 3.00 4.00 5.00 ANOLLLARY SERVICE COST CENTERS 0.10485 0								
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50. 00 050.00 0F2000 0F2000 0			1.00	2.00	3.00	4.00	5.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC 0.237631 12 0 0 3 55.00 05500 RADIOLOGY-THERAPEUTIC 0.000000 0 0 0 0 55.01 05501 ILTRA SOUND 0.02265 0	50.00		0.404005			0		50.00
55:00 05500 NADIOLOGY-THERAPEUTIC 0.000000 0 0 0 55:01 05501 ULTRA SOUND 0.092265 0 0 0 0 58:00 05500 CT SCAN 0.022733 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
55.01 ULTRA SOUND 0.092265 0 0 0 57.00 05700 CTSON 0.26733 0 0 0 0 58.00 05800 MAGNETI C RESONANCE IMAGING (MRI) 0.074484 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>1</td></td<>								1
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58.00 OSBOO MAGNETIC RESONANCE I MAGE (MRI) 0.074484 0 0 0 0 59.00 05900 CARDIA C CATHETERIZATION 0.099663 0<				-		-		
59:00 OS900 CARDIA C CATHETREI ZATION 0.099663 0 0 0 0 60:00 06000 LABORATORY 0.156412 0 0 0 0 63:00 06300 BLODD STORING, PROCESSING & TRANS. 0.215731 0								
60.00 06000 LABDRATORY 0.156412 0 0 0 61.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.215731 0 0 0 64.00 06400 INTRAVENOUS THERAPY 0.420493 0 0 0 0 66.00 06000 CCUPATI INAL THERAPY 0.420493 0 0 0 0 0 67.01 6000 CCUPATI INAL THERAPY 0.187302 0								
63.00 0x300 BLOOD STORING, PROCESSING & TRANS. 0.215731 0 0 0 0 64.00 06400 INTRAVENOUS THERAPY 0.000971 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td>-</td> <td></td>						-	-	
64.00 06400 INTRAVENOUS THERAPY 0.000971 0 0 0 0 66.00 06600 PHYSI CAL THERAPY 0.420493 0<								
66.00 06600 PHYSI CAL THERAPY 0.420493 0 0 0 0 67.00 06700 CCUPATI ONLA THERAPY 0.187302 0								
67:00 06700 0CCUPATI ONAL THERAPY 0.187302 0 0 0 67:01 AUDI OLOGY 0.260981 0 0 0 0 68:00 06800 SPEECH PATHOLOGY 0.273687 0 0 0 0 0 69:00 IELECTROCARDI OLOGY 0.000000 0 0 0 0 0 0 69:01 OG901 CARDI OLOGY 0.143244 0 </td <td></td> <td></td> <td></td> <td>-</td> <td></td> <td>-</td> <td></td> <td></td>				-		-		
67.01 06701 AUDIOLOGY 0.260981 0 0 0 0 68.00 06800 SPECH PATHOLOGY 0.273687 0 0 0 0 0 69.00 6900 ELECTROCARDIOLOGY 0.00000 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
68.00 06800 SPEECH PATHOLOGY 0.273687 0 0 0 0 69.00 06900 ELECTROCARDIOLOGY 0.143244 0								
69.00 06900 ELECTROCARDIOLOGY 0.000000 0 0 0 0 69.01 CARDIOLOGY 0.143244 0								
69.01 06901 CARDI OLOGY 0.143244 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.38964 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.397107 0 0 0 0 0 0 00 07300 DRUGS CHARGED TO PATIENTS 0.071583 0 0 3,856 0 0 001 09001 CILINIC 0.00000 0								
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.380964 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.37107 0								
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.397107 0 0 0 3.856 0 007300 DRUGS CHARGED TO PATIENTS 0.071583 0 0 3.856 0 0010 09000 CLINIC 0.000000 0<						-		
73.00 DRUGS CHARGED TO PATIENTS 0.071583 0 3.856 0 0UTPATIENT SERVICE COST CENTERS 0 <						-		
OUTPATI ENT SERVICE COST CENTERS 0 <								
90.00 O9000 CLINIC 0.000000 0 0 0 0 90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER 0.000000 0 <td>73.00</td> <td></td> <td>0. 071583</td> <td>ij (</td> <td>)</td> <td>0 3,856</td> <td>0</td> <td>73.00</td>	73.00		0. 071583	ij ()	0 3,856	0	73.00
90.01 09001 0THER OUTPATIENT SERVICE COST CENTER 0.000000 0	00 00		0,00000		1	0	0	00 00
90.02 09002 CLINIC 0.000000 0 0 0 0 90.03 09003 DERMATOLOGY CLINIC 0.000000 0 0 0 0 0 90.04 09004 ENT CLINIC 0.000000 0 0 0 0 0 0 90.05 09005 SURGERY CLINIC 0.000000 0								
90.03 09003 DERMATOLOGY CLINIC 0.000000 0 0 0 0 90.04 09004 ENT CLINIC 0.000000 0 0 0 0 0 90.05 SURGERY CLINIC 0.000000 0								
90.04 09004 ENT CLINIC 0.000000 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
90.05 09005 SURGERY CLINIC 0.000000 0 <th0< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></th0<>								
90.07 09007 UROLOGY CLINIC 0.006730 0 0 0 0 90.09 GASTROENTEROLOGY CLINIC 0.000000 <						-	-	
90.09 09009 GASTROENTEROLOGY CLINIC 0.00000 0								
90.11 09011 NEUROLOGY CLINIC 0.000000 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
90.12 09712 0PTHAMOLOGY CLINIC 0.000000 0 0 0 0 90.13 09013 ALLERGY CLINIC 0.285565 0 0 0 0 0 90.14 09014 WOUND CARE 0.172012 0 0 150 0 91.00 09100 EMERGENCY 0.175948 1,213 0 0 213 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.515671 238 0 0 123 95.00 09500 AMBULANCE SERVICES 0.972146 0 4,826 339 2 200.00 Less PBP Clinic Lab. Services-Program Only Charges 0 4,826 339 2						-		
90.13 09013 ALLERGY CLINIC 0.285565 0 0 0 0 90.14 09014 WOUND CARE 0.172012 0 0 150 0 91.00 09100 EMERGENCY 0.175948 1,213 0 0 213 0 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.515671 238 0 0 123 0 0THER REI MBURSABLE COST CENTERS 0 0 123 133 133 143 143 0 1443 1443 1443 1443							-	
90.14 09014 WOUND_CARE 0.172012 0 0 150 0 91.00 09100 EMERGENCY 0.175948 1,213 0 0 213 9 92.00 09500 0BSERVATI ON_BEDS (NON-DI STINCT_PART) 0.515671 238 0 0 123 9 0THER_RELIMBUSABLE_COST_CENTERS 0 0 123 9 95.00 09500 AMBULANCE_SERVICES 0 123 9 9 9 1,463 0 4,826 339 2 2 9 0 1,463 0 4,826 339 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 3 3 2 2 3 3 2 2 3 3 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3							-	
91.00 09100 EMERGENCY 0.175948 1,213 0 0 213 0 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 0.515671 238 0 0 123 0 0THER REI MBURSABLE COST CENTERS 0 0.972146 0 123 123 0 123 123 123 123 123 123 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
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OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.972146 0 200.00 Subtotal (see instructions) 1,463 0 4,826 339 20 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 20 0 20								
95.00 09500 AMBULANCE SERVICES 0.972146 0 200.00 Subtotal (see instructions) 1,463 0 4,826 3392 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 0 20	12.00		0.010071	230	'I	<u> </u>	123	12.00
200.00 201.00Subtotal (see instructions) Less PBP Clinic Lab. Services-Program Only Charges1,46304,82633920201.00Less PBP Clinic Lab. Services-Program Only Charges0020	95 00		0 972146			0		95.00
201.00 Less PBP Clinic Lab. Services-Program 0 0 20 0nl y Charges 0 0 20			5. 772140			-	339	200.00
Only Charges				1, 100			337	200.00
		5						
202.00 Net Charges (line 200 - line 201) 1,463 0 4,826 339/20	202.00			1, 463		0 4, 826	339	202.00

	ncial Systems	WI THAM MEMORI		CN: 15 0104	Period:	u of Form CMS	-2552-
APPORTT UNME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0104	From 01/01/2018	Worksheet D Part V	
			Component	CCN: 15-S104	To 12/31/2018	Date/Time Pr 5/24/2019 2:	epared
			Title	e XVIII	Subprovider -	PPS	us pili
		Cos	sts		I PF		
	Cost Center Description	Cost	Cost				
	·	Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.) 6.00	(see inst.) 7.00	-			
ANCL	LLARY SERVICE COST CENTERS	0.00	7.00				
	O OPERATING ROOM	0	C)			50.0
4.00 0540	0 RADI OLOGY-DI AGNOSTI C	0	C				54.0
5.00 0550	0 RADI OLOGY-THERAPEUTI C	0	C				55.0
5. 01 0550 ⁻	1 ULTRA SOUND	0	C				55.0
	O CT SCAN	0	22	•			57.0
	O MAGNETIC RESONANCE I MAGING (MRI)	0	C	•			58.
	O CARDI AC CATHETERI ZATI ON	0	C	•			59.
	O LABORATORY	0	C	•			60.
	O BLOOD STORING, PROCESSING & TRANS.	0	C				63.
	0 I NTRAVENOUS THERAPY 0 PHYSI CAL THERAPY	0		•			64. 66.
	0 OCCUPATIONAL THERAPY	0	C				67.
	1 AUDI OLOGY	0	0				67.
	O SPEECH PATHOLOGY	0	C				68.
	0 ELECTROCARDI OLOGY	0	C	•			69.
9.01 0690	1 CARDI OLOGY	0	C				69.
1.00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C				71.
	OIMPL. DEV. CHARGED TO PATIENT	0	C				72.
	O DRUGS CHARGED TO PATIENTS	0	276				73.
	ATLENT SERVICE COST CENTERS			1			
	O CLINIC	0	C	•			90.
	1 OTHER OUTPATIENT SERVICE COST CENTER 2 CLINIC	0	C	•			90.
	3 DERMATOLOGY CLINIC	0	C	1			90.
	4 ENT CLINIC	0	C	1			90.
	5 SURGERY CLINIC	0	C	•			90.
	7 UROLOGY CLINIC	0	C				90.
0900	9 GASTROENTEROLOGY CLINIC	0	C				90.
0. 11 0901	1 NEUROLOGY CLINIC	0	C				90.
	2 OPTHAMOLOGY CLINIC	0	C				90.
	3 ALLERGY CLINIC	0	C	1			90.
	4 WOUND CARE	0	26				90.
	O EMERGENCY	0	C				91.
	O OBSERVATION BEDS (NON-DISTINCT PART)	0	C	1			92.
	R REIMBURSABLE COST CENTERS	0		1			95.
00.00	Subtotal (see instructions)	0	324				200.
01.00	Less PBP Clinic Lab. Services-Program	0	524				200.
	Only Charges						1.0.0
02.00	Net Charges (line 200 - line 201)	0	324				202.0

ealth Financial Systems PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	WI THAM MEMORI		CN: 15 0104	Peri od:	eu of Form CMS Worksheet D	2332-1
HROUGH COSTS	RVICE UINER PAS		CN. 13-0104	From 01/01/2018		
		Component	CCN: 15-5832	To 12/31/2018	Date/Time Pre	
			e XVIII	Skilled Nursing	5/24/2019 2:0 PPS	03 pm
		intre	: AVIII	Facility	PP3	
Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
	Anestheti st	Post-Stepdown	J J J J J J J J J J J J J J J J J J J	Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	-	-	1		-	
0.00 05000 OPERATING ROOM	0	0		0 0	0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	-	
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	
5. 01 05501 ULTRA SOUND	0	0		0 0	0	
7.00 05700 CT SCAN	0	0		0 0	0	
8. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)	0	0		0 0	0	
9. 00 05900 CARDI AC CATHETERI ZATI ON 0. 00 06000 LABORATORY	0	0		0 0	0	
	0	0		0 0	0	
3. 00 06300 BLOOD STORING, PROCESSING & TRANS. 4. 00 06400 INTRAVENOUS THERAPY	0	0		0 0	0	
5. 00 06600 PHYSI CAL THERAPY	0	0		0 0		
7. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	
7. 01 06700 OCCOPATIONAL THERAPY	0	0		0 0		
8. 00 06800 SPEECH PATHOLOGY	0	0		0 0		
9. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	
9. 01 06901 CARDI OLOGY	0	0		0 0	0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0				0	1
3. 00 07300 DRUGS CHARGED TO PATIENTS	0			0 0	-	
OUTPATIENT SERVICE COST CENTERS		0		0 0		1 / 0. 0
0. 00 09000 CLINIC	0	0		0 0	0	90.0
D. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0 0	0	90. (
D. 02 09002 CLINIC	0	0		0 0	0	90. (
D. 03 09003 DERMATOLOGY CLINIC	0	0		0 0	0	90. (
D. 04 09004 ENT CLINIC	0	0		0 0	0	90.
D. 05 09005 SURGERY CLINIC	0	0		0 0	0	90.
D. 07 09007 UROLOGY CLINIC	0	0		0 0	0	90.
0. 09 09009 GASTROENTEROLOGY CLINIC	0	0		0 0	0	90. (
D. 11 09011 NEUROLOGY CLINIC	0	0		0 0	0	90.
0. 12 09012 OPTHAMOLOGY CLINIC	0	0		0 0	0	
0. 13 09013 ALLERGY CLINIC	0	0		0 0	0	
D. 14 09014 WOUND CARE	0	0		0 0	0	
1.00 09100 EMERGENCY	0	0		0 0	0	1
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92. (
OTHER REI MBURSABLE COST CENTERS			1			
5. 00 09500 AMBULANCE SERVICES	_	_		-	_	95.0
00.00 Total (lines 50 through 199)	0	0		0 0	0	200. 0

	Financial Systems	WI THAM MEMORI					u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C	CN: 15-0104	Pe	ri od:	Worksheet D	
THROUG	H COSTS		Component	CCN: 15-5832	То	om 01/01/2018 12/31/2018		pared: 3 pm
			Title	× XVIII	Sk	illed Nursing Facility	PPS	
-	Cost Center Description	All Other	Total Cost	Total			Ratio of Cost	
	bost benter beschiption	Medi cal	(sum of cols.	Outpatient		from Wkst. C,	to Charges	
		Education Cost	•	Cost (sum o		•	(col. 5 ÷ col.	
			4)	col s. 2, 3,		8)	7)	
				and 4)			, í	
		4.00	5.00	6.00		7.00	8.00	
	ANCI LLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0		0	48, 328, 351	0. 000000	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	32, 631, 664	0.00000	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0.00000	55.00
55.01	05501 ULTRA SOUND	0	0		0	8, 442, 283	0.000000	55.01
57.00	05700 CT SCAN	0	0		0	42, 985, 910	0.00000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	14, 805, 232	0.00000	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	15, 902, 581	0.00000	59.00
60.00	06000 LABORATORY	0	0		0	56, 165, 181	0. 000000	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	888, 126	0. 000000	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0		0	3, 265, 907	0. 000000	64.00
66.00	06600 PHYSI CAL THERAPY	0	0		0	8, 164, 154	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	3, 291, 358	0.000000	67.00
67.01	06701 AUDI OLOGY	0	0		0	978, 602	0.000000	67.01
68.00	06800 SPEECH PATHOLOGY	0	0		0	1, 046, 819	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	13, 580, 789	0. 000000	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	8, 515, 031	0. 000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	13, 498, 637	0. 000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	35, 970, 008	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS							1
90.00	09000 CLI NI C	0	0		0	0	0. 000000	90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	0	0.00000	90.01
90. 02	09002 CLI NI C	0	0		0	0	0.00000	90.02
90.03	09003 DERMATOLOGY CLINIC	0	0		0	0	0.00000	90.03
90.04	09004 ENT CLINIC	0	0		0	0	0.00000	90.04
90.05	09005 SURGERY CLINIC	0	0		0	0	0.00000	90.05
90.07	09007 UROLOGY CLINIC	0	0		0	146, 056	0.00000	90.07
90.09	09009 GASTROENTEROLOGY CLINIC	0	0		0	0	0.00000	90.09
90.11	09011 NEUROLOGY CLINIC	0	0		0	0	0.00000	90.11
90. 12	09012 OPTHAMOLOGY CLINIC	0	0		0	0	0.00000	•
90.13	09013 ALLERGY CLINIC	0	0		0	691, 366	0.00000	
90.14	09014 WOUND CARE	0	0		0	3, 832, 589	0.00000	
91.00	09100 EMERGENCY	0	0		0	30, 953, 463	0. 000000	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	3, 954, 648	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS	1		1				
95.00 200.00	09500 AMBULANCE SERVICES Total (lines 50 through 199)	0	0		0	348, 038, 755		95.00 200.00

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0104	Peri od:	Worksheet D	
HROUGH COSTS				From 01/01/2018	Part IV	
		Component (CCN: 15-5832	To 12/31/2018	Date/Time Pre 5/24/2019 2:0	pared: 3 pm
		Title	e XVIII	Skilled Nursing	PPS	
				Facility		
Cost Center Description	Outpati ent	Inpati ent	Inpatient	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) 9.00	10.00	x col. 10)	12.00	x col. 12)	
ANCI LLARY SERVI CE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
0. 00 05000 OPERATING ROOM	0. 000000	41, 382		0 0	0	50.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0.000000	35, 943		0 0	0	54.0
5. 00 05500 RADI OLOGY - THERAPEUTI C	0.000000	35, 943		0 0	0	54.0
5. 01 05500 RADIOLOGI - THERAPEUTIC 5. 01 05501 ULTRA SOUND	0.000000	2, 524		0 0	0	55.0
7. 00 05700 CT SCAN	0.000000	2, 524		0 0	0	57.0
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0		0 0	0	57.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000	29, 217		0 0	0	59.0
						60.0
	0. 000000 0. 000000	211, 684 0		0 0	0	63.0
3. 00 06300 BLOOD STORING, PROCESSING & TRANS. 4. 00 06400 INTRAVENOUS THERAPY	0.000000	32, 941		0 0	0	64.0
6. 00 06600 PHYSI CAL THERAPY	0.000000	32, 941 1, 149, 993		0 0	0	66.0
7. 00 06700 OCCUPATIONAL THERAPY	0.000000	1, 149, 993		0 0	0	67.0
7. 01 06700 OCCOPATIONAL THERAPT 7. 01 06701 AUDI OLOGY	0.000000	1, 242, 200		0 0	0	67.0
8. 00 06800 SPEECH PATHOLOGY	0.000000	96, 754		0 0	0	68.0
9. 00 06900 ELECTROCARDI OLOGY	0.000000	90, 754		0 0	0	69.0
9. 01 06901 CARDI OLOGY	0.000000	324, 938		0 0	0	69.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	114,070		0 0	0	71.0
2. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	114,070		0 0	0	72.0
3. 00 07300 DRUGS CHARGED TO PATIENTS	0.000000	912, 638		0 0	0	73.0
OUTPATIENT SERVICE COST CENTERS	0.000000	712,030		0 0	0	/ 3. (
0. 00 09000 CLINIC	0. 000000	0		0 0	0	90.0
0. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	0		0 0	0	90.0
0. 02 09002 CLINIC	0. 000000	0		0 0	0	90.0
0. 03 09003 DERMATOLOGY CLINIC	0. 000000	0		0 0	0	90.0
0. 04 09004 ENT CLINIC	0. 000000	0		0 0	0	90.0
0. 05 09005 SURGERY CLINIC	0. 000000	0		0 0	0	90.0
0. 07 09007 UROLOGY CLINIC	0. 000000	0		0 0	0	90.0
0. 09 09009 GASTROENTEROLOGY CLINIC	0. 000000	0		0 0	0	90.0
0. 11 09011 NEUROLOGY CLINIC	0. 000000	0		0 0	0	90.
0. 12 09012 OPTHAMOLOGY CLINIC	0. 000000	0		0 0	0	90.
0. 13 09013 ALLERGY CLINIC	0. 000000	0		0 0	0	90.
0. 14 09014 WOUND CARE	0. 000000	69		0 0	0	90.
1. 00 09100 EMERGENCY	0. 000000	1, 265		0 0	0	91.0
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.
OTHER REIMBURSABLE COST CENTERS			1		0	1
5. 00 09500 AMBULANCE SERVICES						95.0
00.00 Total (lines 50 through 199)	1	4, 195, 624	1	0 0	0	200. (

	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		Period: From 01/01/2018	Worksheet D Part V	
			Component	CCN: 15-5832	To 12/31/2018	Date/Time Pre 5/24/2019 2:0	pared: 3 pm
			Title	e XVIII	Skilled Nursing Facility	PPS	<u>o piii</u>
				Charges	ruorrity	Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins (see inst.)	. Ded. & Coins. (see inst.)		
		1.00	2.00	3.00	4. 00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0. 104885	0)	0 0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 237681	C		0 0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	C		0 0	0	55.00
55.01	05501 ULTRA SOUND	0. 092265	0		0 0	0	
57.00	05700 CT SCAN	0. 026733	C		0 1, 385	0	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 074484	C		0 0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 099663	0		0 0	0	
60.00	06000 LABORATORY	0. 156412	0		0 0	0	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 215731	0		0 0	0	
64.00 66.00	06400 I NTRAVENOUS THERAPY 06600 PHYSI CAL THERAPY	0. 000971 0. 420493			0 0	0	
67.00	06700 OCCUPATI ONAL THERAPY	0. 420493			0 0	0	
67.01	06701 AUDI OLOGY	0. 260981	0		0 0	0	
68.00	06800 SPEECH PATHOLOGY	0. 273687	0		0 0	0	
69.00	06900 ELECTROCARDI OLOGY	0. 000000	Ő		0 0	0	
69.01	06901 CARDI OLOGY	0. 143244	C)	0 4	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 380964	C)	0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 397107	C		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 071583	C		0 2, 681	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000	C		0 0	0	
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	0		0 0	0	
90.02		0.000000	0		0 0	0	
90. 03 90. 04	09003 DERMATOLOGY CLINIC 09004 ENT CLINIC	0.000000	0		0 0	0	
90.04 90.05	09005 SURGERY CLINIC	0.000000			0 0	0	
90.03 90.07	09007 UROLOGY CLINIC	0.006730	0		0 0	0	
90.09	09009 GASTROENTEROLOGY CLINIC	0.000000	C		0 0	0	1
90.11	09011 NEUROLOGY CLINIC	0. 000000	Ő		0 0	0	
90.12	09012 OPTHAMOLOGY CLINIC	0. 000000	0		0 0	0	
90.13	09013 ALLERGY CLINIC	0. 285565	C)	0 0	0	
90.14	09014 WOUND CARE	0. 172012	C		0 0	0	90.14
91.00	09100 EMERGENCY	0. 175948	C		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 515671	C		0 0	0	92.00
05 05	OTHER REIMBURSABLE COST CENTERS	0.076111					0.5.05
95.00	09500 AMBULANCE SERVICES	0. 972146			0	_	95.00
200.00			C		0 4,070	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges				0 0		201.00
202.00			C		0 4,070	о	202.00
			-	1		-	

iear în Frina	ncial Systems	WI THAM MEMORI	AL_HOSPITAL		In Lie	u of Form CMS-	2552-1
APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0104	Peri od:	Worksheet D	
			Component	CCN: 15-5832	From 01/01/2018 To 12/31/2018	Part V Date/Time Pre	-nared
			component	56N. 15 5052	10 12/31/2010	5/24/2019 2:0	D3 pm
			Title	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.) 6.00	(see inst.) 7.00				
ANCL	LLARY SERVICE COST CENTERS	0.00	7.00				
	O OPERATING ROOM	0	0				50.0
54.00 05400	0 RADI OLOGY-DI AGNOSTI C	0	0				54.0
5.00 05500	0 RADI OLOGY-THERAPEUTI C	0	0				55.0
55. 01 0550 ⁻	1 ULTRA SOUND	0	0				55.0
57.00 05700	O CT SCAN	0	37				57.0
	O MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.0
	O CARDI AC CATHETERI ZATI ON	0	0				59.0
	0 LABORATORY	0					60.0
	0 BLOOD STORING, PROCESSING & TRANS.	0	0				63.0
	0 INTRAVENOUS THERAPY	0	0				64.0
	0 PHYSI CAL THERAPY	0					66.0
	0 OCCUPATI ONAL THERAPY	0	0				67.0
	1 AUDI OLOGY	0	0				67.0
	O SPEECH PATHOLOGY	0	0				68.0
	0 ELECTROCARDI OLOGY	0	0				69.0
	1 CARDI OLOGY	0					69.0
	0 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 IMPL. DEV. CHARGED TO PATIENT	0					71.0
	0 DRUGS CHARGED TO PATIENTS	0					73.0
	ATIENT SERVICE COST CENTERS	0	172				- /3.0
		0	0				90.0
	1 OTHER OUTPATIENT SERVICE COST CENTER	0					90.0
	2 CLINIC	0					90.0
	3 DERMATOLOGY CLINIC	0	0				90.0
0.04 09004	4 ENT CLINIC	0	0				90.0
0. 05 09005	5 SURGERY CLINIC	0	0				90.0
0. 07 0900	7 UROLOGY CLINIC	0	0				90.0
0.09 09009	9 GASTROENTEROLOGY CLI NI C	0	0				90.0
0. 11 0901	1 NEUROLOGY CLINIC	0	0				90.1
	2 OPTHAMOLOGY CLINIC	0					90.1
	3 ALLERGY CLINIC	0	0				90.1
	4 WOUND CARE	0	0				90.1
	O EMERGENCY	0					91.0
	O OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	0				92.0
	R REIMBURSABLE COST CENTERS	0					05 0
25.00 09500 200.00	O AMBULANCE SERVICES Subtotal (see instructions)	0					95. 0 200. 0
200.00	Less PBP Clinic Lab. Services-Program	0					200.0
201.00		0					201.0
	Only Charges						

MPUTA	TION OF INPATIENT OPERATING COST	Provider CCN: 15-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Pre	pare
		Title XVIII	Hospi tal	5/24/2019 2:03 PPS	3 pr
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1.00	
[INPATI ENT DAYS				
	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			7, 012 7, 012	1
	Private room days (excluding private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		rivate room davs.	7,012	
	do not complete this line.	5, 5, 5, 5,			
	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 21 of the cost	5, 466 0	4
	reporting period	Join days) thi ough becenibe	er st of the cost	0	
	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roc	am days) through Docombo	c 21 of the cost	0	7
50	reporting period	Jiii days) tili odgi becember	ST OF THE COST	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) Total inpatient days including private room days applicable t	to the Drogram (aveluding	a cwing bod and	2, 263	9
	newborn days)		y swing-bed and	2, 203	7
	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10
	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11
00	December 31 of the cost reporting period (if calendar year, e		com days) arter	0	
. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	te room days)	0	12
. 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	te room days)	0	13
	after December 31 of the cost reporting period (if calendar y			0	
	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT			0	
. 00 [Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 o	of the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	cas after December 31 of	the cost	0.00	19
. 00	reporting period	Les arter becember 51 01	the cost	0.00	
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of i	the cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instruction		ting popied (line	9, 249, 375	
. 00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	ber 31 of the cost report	ting period (inne	0	22
	Swing-bed cost applicable to SNF type services after December	- 31 of the cost reportin	ng period (line 6	0	23
	x line 18) Swing-bed cost applicable to NF type services through Decembe	ar 31 of the cost reporti	na period (line	0	24
	7 x line 19)		51 .	0	24
	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25
	x line 20) Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		9, 249, 375	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ad and abcompation in the			
	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	ed and observation bed ch	narges)	0	28
	Semi -private room charges (excluding swing-bed charges)			0	30
00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
	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	
00	Average per diem private room cost differential (line 34 x li	, ,		0.00	35
	Private room cost differential adjustment (line 3 x line 35)	and private noom east di	fforontial (line	0 9, 249, 375	36
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	inerentiar (IINe	7, 247, 3/5	3/
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			1 210 00	1 20
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	•		1, 319. 08 2, 985, 078	
	Medically necessary private room cost applicable to the Progr			0	40
. 00	Total Program general inpatient routine service cost (line 39	9 + line 40)		2, 985, 078	41

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	WI THAM MEMORI A	Provi der C		Period: From 01/01/2018	u of Form CMS- Worksheet D-1	
					To 12/31/2018	Date/Time Pre 5/24/2019 2:0	
				XVIII	Hospi tal	PPS	, o p
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only)	0	0	0. C	0 0	0) 42.
. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	2, 633, 255	1, 776	1, 482. 6	9 834	1, 236, 563	3 43.
. 00	CORONARY CARE UNIT	2,033,233	1,770	1,402.0	7 034	1, 230, 303	44.
. 00	BURN INTENSIVE CARE UNIT						45.
	SURGICAL INTENSIVE CARE UNIT						46
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
	cost center bescription					1.00	+
. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3,	line 200)			3, 558, 960) 48
. 00	Total Program inpatient costs (sum of lines 4	41 through 48)(s	see instructio	ns)		7, 780, 601	49
. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine s	ervices (from	Wkst D sum	of Parts L and	381, 462	2 50
. 00				WKST. D, Sui		301, 402	
. 00	Pass through costs applicable to Program inpa	atient ancillary	/ services (fr	om Wkst. D, s	um of Parts II	197, 636	51.
. 00	and IV)	50 and 51				579, 098	3 52.
. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclud		ated, non-phy	sician anesth	etist, and	579,098 7,201,503	
	medical education costs (line 49 minus line 5					,, 201, 303	
	TARGET AMOUNT AND LIMIT COMPUTATION						
. 00 . 00	Program discharges Target amount per discharge					0. 00	
. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
00	Difference between adjusted inpatient operati	ng cost and tar	get amount (I	ine 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)	0	0			C	
00	Lesser of lines 53/54 or 55 from the cost rep	porting period e	ending 1996, u	pdated and co	mpounded by the	0.00	59
. 00	market basket Lesser of lines 53/54 or 55 from prior year of	cost report upo	lated by the m	arket basket		0.00	60
. 00	If line 53/54 is less than the lower of lines				the amount by	0.00	
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	the target		
	amount (line 56), otherwise enter zero (see i	nstructions)					
. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)				
	PROGRAM INPATIENT ROUTINE SWING BED COST						
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	nber 31 of the	cost reporti	ng period (See	C	64
. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	ts after Decembe	or 21 of the c	ost roporting	poriod (Soo	C	65
. 00	instructions) (title XVIII only)			UST TEPOTITING	period (See		
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 6	64 plus line 6	5)(title XVII	l only). For	C	66
00	CAH (see instructions)		December 21	£ +			
. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 0	r the cost re	porting period	C	67
8. 00	Title V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost repo	rting period	C	68
	(line 13 x line 20)			()			
. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU			,		0) 69
. 00	Skilled nursing facility/other nursing facili						70
. 00	Adjusted general inpatient routine service co	ost per diem (li					71
. 00	Program routine service cost (line 9 x line 7			25)			72
. 00 . 00	Medically necessary private room cost applica Total Program general inpatient routine servi			ne 35)			73
. 00	Capital -related cost allocated to inpatient i	•	,	orksheet B. P	art II, column		75
	26, line 45)		、 · ·				
. 00	Per diem capital-related costs (line 75 ÷ lin	,					76
. 00 . 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77
00	Aggregate charges to beneficiaries for excess	,	ovider record	s)			79
00	Total Program routine service costs for compa	• •		· · · · · · · · · · · · · · · · · · ·	us line 79)		80
00	Inpatient routine service cost per diem limit						81
00	Inpatient routine service cost limitation (li	,					82
. 00 . 00	Reasonable inpatient routine service costs (s Program inpatient ancillary services (see ins		>)				83
. 00	Utilization review - physician compensation		ıs)				85
. 00	Total Program inpatient operating costs (sum	of lines 83 thr					86
00	PART IV - COMPUTATION OF OBSERVATION BED PASS					4 54	1
7.00	Total observation bed days (see instructions)					1, 546	
3. 00	Adjusted general inpatient routine cost per o	lem (line 27 ÷	line 21			1, 319. 08	

Health Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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	875, 485	9, 249, 375	0. 09465	3 2, 039, 298	193, 026	90.00
91.00 Nursing School cost	0	9, 249, 375	0.00000	2, 039, 298	0	91.00
92.00 Allied health cost	0	9, 249, 375	0.00000	2, 039, 298	0	92.00
93.00 All other Medical Education	0	9, 249, 375	0.00000	2, 039, 298	0	93.00

Component COX: 15-S104 From 01/07/12/31/208 bits/Time Presume TILLD XVIII Subprovider - IP 2/31/201	Component CON: 15-510 From 01/01/2018 To 12/31/2018 Date S/24 Title XVIII Subprovider - IPF Cost Center Description PART 1 - ALL PROVIDER COMPONENTS INPATIENT DAYS Inpatient days (including private room days, excluding sming-bed and newborn days) 100 Inpatient days (including private room days, excluding sming-bed and newborn days) 200 Inpatient days (including private room days, excluding sming-bed and observation bed days). 100 Total sming-bed XF type inpatient days (including private room days) through December 31 of the cost reporting period 101 Total sming-bed XF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 102 Total sming-bed XF type inpatient days (including private room days) after December 31 of the cost reporting period if the coal reporting period (if calendar year, enter 0 on this line) 100 Total sming-bed XF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 100 Total sming-bed XF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 100 Total sming-bed XF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting pe	/Ti me Pree /2019 2: 0. PPS 1. 00 3, 133 3, 133 0 3, 133 0 3, 133 0 0 0	pare 3 pm
Title XVIII Subgroup der lessoription PPF MAT 1 - ALL PROVIDER CONDUCTION 1.00 MAT 1 - ALL PROVIDER CONDUCTION 1.00 MAT 1 - ALL PROVIDER CONDUCTION 3.133 Martinitian AVXS 3.133 Mart 1 - ALL PROVIDER CONDUCTION 3.133	Title XVIII Subprovider - IPF Cost Center Description IPF PART I - ALL PROVIDER COMPONENTS InPatient days (including private room days and swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days) OF Inpatient days (including private room days, excluding swing-bed and newborn days) More than the days (including private room days, excluding swing-bed and observation bed days). Itel swing-bed SMF type inpatient days (including private room days) through December 31 of the cost reporting period (ir calendar year, enter 0 on this line) OTal swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (ir calendar year, enter 0 on this line) OTal inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) after December 31 of the cost reporting period (ir calendar year, enter 0 on this line) OTAL inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) OTAL inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (ir calendar year, enter 0 on this line) OTAL inpatient days applicable to title XVII only (including private room days) through December 31 of the cost reporting period (ir calendar year, enter 0 on this line) OTAL inpatient days applicable to title XVII only (including private room days) through December 31 of the cost reporting period (i	PPS 1. 00 3, 133 3, 133 0 3, 133 0 0 0	1. 2. 3. 4.
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3.00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.9.00Private room charges (excluding swing-bed charges)029.0.00Semi-private room charges (excluding swing-bed charges)030.1.00General inpatient routine service cost/charge ratio (line 27 ÷ line 28)0.00000031.2.00Average private room per diem charge (line 29 ÷ line 3)0.0032.3.00Average semi-private room charge differential (line 30 ÷ line 4)0.0033.4.00Average per diem private room charge differential (line 34 x line 31)0.0034.5.00Average per diem private room cost differential (line 3 x line 35)036.7.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27, 741, 67237.7.00General inpatient routine service cost per diem (see instructions)036.7.00General inpatient routine service cost per diem (see instructions)036.8.00Adj usted general inpatient routine service cost per diem (see instructions)875.0938.8.00Adj usted general inpatient routine service cost (line 9 x line 38)2, 238, 48039.9.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.	8.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 9.00 Private room charges (excluding swing-bed charges)	2, 741, 672	27.
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0.00 Semi-private room charges (excluding swing-bed charges) 0 30. 1.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.000000 31. 2.00 Average private room per diem charge (line 29 ÷ line 3) 0.00 32. 3.00 Average semi-private room per diem charge (line 30 ÷ line 4) 0.00 33. 4.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 34. 5.00 Average per diem private room cost differential (line 3 x line 31) 0.00 35. 5.00 Private room cost differential adjustment (line 3 x line 35) 0.30. 7.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 741, 672 37. 27 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDERS ONLY 27. PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 875.09 38. 3.00 Adjusted general inpatient routine service cost (line 9 x line 38) 2, 238, 480 39. 0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.			
1.00General inpatient routine service cost/charge ratio (line 27 ÷ line 28)0.00000031.2.00Average private room per diem charge (line 29 ÷ line 3)0.0000032.3.00Average semi-private room per diem charge (line 30 ÷ line 4)0.0033.4.00Average per diem private room charge differential (line 32 minus line 33) (see instructions)0.0034.5.00Average per diem private room cost differential (line 3 x line 31)0.0035.5.00Average per diem private room cost differential adjustment (line 3 x line 35)0.0035.7.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 741, 67237.27 minus line 36)PART 11 - HOSPITAL AND SUBPROVIDERS ONLY0.05PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS875.098.00Adjusted general inpatient routine service cost per diem (see instructions)875.098.00Medically necessary private room cost applicable to the Program (line 14 x line 35)00.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0	0.00 Semi-private room charges (excluding swing-bed charges)		
3. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 0.00 33. 4. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 34. 5. 00 Average per diem private room cost differential (line 34 x line 31) 0.00 34. 5. 00 Average per diem private room cost differential adjustment (line 3 x line 35) 0 36. 6. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 741, 672) 37. 7. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 741, 672) 37. PART 11 - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 875. 09 8. 00 Adjusted general inpatient routine service cost per diem (see instructions) 875. 09 38. 9. 00 Program general inpatient routine service cost (line 9 x line 38) 2, 238, 480 39. 0. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.			31.
Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 34. Average per diem private room cost differential (line 34 x line 31) 0.00 35. 00 Private room cost differential adjustment (line 3 x line 35) 0.00 36. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 741, 672 37. 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY 27. PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 875.09 8.00 Adjusted general inpatient routine service cost per diem (see instructions) 875.09 9.00 Program general inpatient routine service cost (line 9 x line 38) 2, 238, 480 9.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0	51 1 5 (
6.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35. 6.00 Private room cost differential adjustment (line 3 x line 35) 0 36. 7.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 741, 672) 37. 27 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDERS ONLY 27. PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 40 37. 8.00 Adjusted general inpatient routine service cost per diem (see instructions) 875.09 38. 9.00 Program general inpatient routine service cost (line 9 x line 38) 2, 238, 480 39. 0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.	5 1 5 1 5 1		
5.00 Private room cost differential adjustment (line 3 x line 35) 0 36. 7.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 741, 672) 0 36. 7.00 PART 11 - HOSPITAL AND SUBPROVIDERS ONLY 27. 0 27. 27. 27. 27.		0.00	
7.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2,741,672 37. 27 minus line 36) 37. 27 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 875. 09 38. 2,238,480 20.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 3. 00 Adjusted general inpatient routine service cost per diem (see instructions) 875.09 38. 9. 00 Program general inpatient routine service cost (line 9 x line 38) 2, 238, 480 39. 0. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.	, , , , , , , , , , , , , , , , , , ,	0.00	
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 3.00 Adjusted general inpatient routine service cost per diem (see instructions) 875.09 9.00 Program general inpatient routine service cost (line 9 x line 38) 2, 238, 480 0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0	5 1 .	0. 00 0]
3.00Adjusted general inpatient routine service cost per diem (see instructions)875.0938.30.00Program general inpatient routine service cost (line 9 x line 38)2,238,48039.30.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.	PART II - HOSPITAL AND SUBPROVIDERS ONLY	0. 00 0]
P. 00Program general inpatient routine service cost (line 9 x line 38)2, 238, 48039.D. 00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.		0. 00 0	
0 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		0. 00 0 2, 741, 672	1
		0.00 0 2,741,672 875.09	
		0.00 0 2,741,672 875.09 2,238,480	39.

alth Financial Systems MPUTATION OF INPATIENT OPERATING COST	WI THAM MEMORIAL		CN: 15-0104	In Lie Period:	eu of Form CMS- Worksheet D-	
			CCN: 15-S104	From 01/01/2018 To 12/31/2018	Date/Time Pre	epare
		Title	e XVIII	Subprovider -	5/24/2019 2:0 PPS	03 pm
Cost Center Description	Total	Total	Average Per	5	Program Cost	
	Inpatient CostIn		col. 2)		(col. 3 x col. 4)	
2.00 NURSERY (title V & XIX only)	1.00	2.00 C	3.00	4.00 00 C	5.00) 42.
Intensive Care Type Inpatient Hospital Uni			-			
B. OO INTENSIVE CARE UNIT I. OO CORONARY CARE UNIT	0	C	0.	00 C) 43. 44.
5. 00 BURN INTENSIVE CARE UNIT						44.
5. 00 SURGI CAL I NTENSI VE CARE UNI T						46.
7.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
8.00 Program inpatient ancillary service cost	(Wkst D-3 col 3	line 200)	-		1.00 213,324	4 48.
0.00 Total Program inpatient costs (sum of line			ons)		2, 451, 804	
PASS THROUGH COST ADJUSTMENTS 0.00 Pass through costs applicable to Program i	npatient routine se	rvices (from	n Wkst. D, su	m of Parts I and	231, 550	50.
.00 Pass through costs applicable to Program i	nnatient ancillary	services (fr	om Wkst D	sum of Parts II	7,466	5 51.
and IV)	1 5		Sar mot. Di			
2.00 Total Program excludable cost (sum of line 3.00 Total Program inpatient operating cost exe		ted. non-phy	sician anest	hetist, and	239, 016 2, 212, 788	
medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION					2,212,700	
1. 00 Program di scharges						54.
. 00 Target amount per discharge					0.00	
.00 Target amount (line 54 x line 55) .00 Difference between adjusted inpatient open	cating cost and targ	et amount (l	ine 56 minus	line 53)		
. 00 Bonus payment (see instructions)	atting boot and targ			11110 00)	0	
.00 Lesser of lines 53/54 or 55 from the cost	reporting period en	ding 1996, ι	updated and c	ompounded by the	0.00	59
market basket 0.00 Lesser of lines 53/54 or 55 from prior yea	ar cost report, upda	ted by the m	narket basket		0.00	0 60
.00 If line 53/54 is less than the lower of li	nes 55, 59 or 60 en	ter the less	er of 50% of	the amount by	(
which operating costs (line 53) are less amount (line 56), otherwise enter zero (se		(lines 54 x	60), or 1% o	f the target		
2.00 Relief payment (see instructions)					0	62
8.00 Allowable Inpatient cost plus incentive pa	ayment (see instruct	i ons)				63
. 00 PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine of	costs through Decemb	er 31 of the	e cost report	ing period (See		64
instructions)(title XVIII only) 0.00 Medicare swing-bed SNF inpatient routine of						0 65
instructions) (title XVIII only)		ST OF LIFE C	Jost reportin	g period (see		00.
 D. 00 Total Medicare swing-bed SNF inpatient rou CAH (see instructions) 	utine costs (line 64	plus line 6	o5)(title XVI	II only). For	0	66
2.00 Title V or XIX swing-bed NF inpatient rou	tine costs through D	ecember 31 c	of the cost r	eporting period	0	67.
(line 12 x line 19) 3.00 Title V or XIX swing-bed NF inpatient rou	tine costs after Dec	ember 31 of	the cost rep	orting period	0	68.
(line 13 x line 20) 2.00 Total title V or XIX swing-bed NF inpatien	nt routine costs (li	ne 67 + line	e 68)		0	0 69.
PART III - SKILLED NURSING FACILITY, OTHER	· · ·				1	
 0.00 Skilled nursing facility/other nursing fac .00 Adjusted general inpatient routine service 	5		•)		70
2.00 Program routine service cost (line 9 x lin		0 /0 / 1110				72
8.00 Medically necessary private room cost appl	÷.					73
.00 Total Program general inpatient routine so .00 Capital-related cost allocated to inpatien	•			Part II, column		74
26, line 45) 0.00 Per diem capital-related costs (line 75 ÷						76.
.00 Program capital-related costs (line 9 x li .00 Inpatient routine service cost (line 74 mi						77
0.00 Aggregate charges to beneficiaries for exc		vider record	ls)			79
0.00 Total Program routine service costs for co	•	t limitatior	n (line 78 mi	nus line 79)		80
.00 Inpatient routine service cost per diem li 2.00 Inpatient routine service cost limitation						81
8.00 Reasonable inpatient routine service cost	. ,					83
I. 00 Program inpatient ancillary services (see		`				84
5.00 Utilization review - physician compensation 5.00 Total Program inpatient operating costs (s						85
PART IV - COMPUTATION OF OBSERVATION BED F		agii 00)			I	
7.00 Total observation bed days (see instruction 3.00 Adjusted general inpatient routine cost pe		(ma 2)			0.00	

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 01/01/2018	Worksheet D-1	
		Component (CCN: 15-S104	To 12/31/2018	Date/Time Prep 5/24/2019 2:03	pared: 3 pm
		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	283, 606	2, 741, 672	0. 10344	3 0	0	90.00
91.00 Nursing School cost	0	2, 741, 672	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	2, 741, 672	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 741, 672	0.00000	0 0	0	93.00

OMPUT	ATION OF INPATIENT OPERATING COST	AL HOSPITAL Provider CCN: 15-0104	Peri od:	u of Form CMS-2 Worksheet D-1	
		Component CCN: 15-5832	From 01/01/2018 To 12/31/2018	Date/Time Pre 5/24/2019 2:0	
		Title XVIII	Skilled Nursing Facility	PPS	<u>o pi</u>
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS		l		
	INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed da Inpatient days (including private room days, excluding swing	ays, excluding newborn)		5,027	1
00 00	Private room days (excluding swing-bed and observation bed of		ivate room davs	5, 027 0	2
00	do not complete this line.	days). It you have only pr	I vate i ooni uays,	0	
00	Semi-private room days (excluding swing-bed and observation	bed days)		5, 027	4
00	Total swing-bed SNF type inpatient days (including private r	room days) through Decembe	r 31 of the cost	0	5
00	reporting period	com dava) after December	21 of the east	0	
00	Total swing-bed SNF type inpatient days (including private r reporting period (if calendar year, enter 0 on this line)	dom days) after becember	31 OF the cost	0	6
00	Total swing-bed NF type inpatient days (including private ro	oom davs) through December	31 of the cost	0	7
	reporting period				
00	Total swing-bed NF type inpatient days (including private ro	oom days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	to the Drogram (aveluding	swing had and	2, 994	9
00	newborn days)	to the Program (excruding	swing-bed and	2, 994	
). 00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private r	oom days)	0	10
	through December 31 of the cost reporting period (see instru		5 /		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII		oom days) after	0	11
2. 00	December 31 of the cost reporting period (if calendar year, Swing-bed NF type inpatient days applicable to titles V or >		a room dave)	0	12
. 00	through December 31 of the cost reporting period	ATA ONLY (THEFULING PERVAL	e room uays)	0	I∠
. 00	Swing-bed NF type inpatient days applicable to titles V or >	XIX only (including privat	e room days)	0	13
	after December 31 of the cost reporting period (if calendar				
	Medically necessary private room days applicable to the Prog	gram (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
5. 00	SWING BED ADJUSTMENT			0	
. 00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31 c	f the cost	0.00	17
	reporting period				
8. 00	Medicare rate for swing-bed SNF services applicable to servi reporting period	ces after December 31 of	the cost	0.00	118
9.00	Medicaid rate for swing-bed NF services applicable to servic	ces through December 31 of	the cost	0.00	19
	reporting period			0100	
0. 00	Medicaid rate for swing-bed NF services applicable to service	ces after December 31 of t	he cost	0.00	20
	reporting period	、 、		0 004 507	
	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decem		ing period (line)	3, 004, 527 0	21
2.00	5 x line 17)	ibel 31 01 the cost report	ring period (rine	0	
3.00	Swing-bed cost applicable to SNF type services after December	er 31 of the cost reportin	g period (line 6	0	23
	x line 18)				
1.00	Swing-bed cost applicable to NF type services through Decemb	per 31 of the cost reporti	ng period (line	0	24
5.00	7 x line 19) Swing-bed cost applicable to NF type services after December	c 31 of the cost reporting	period (line 8	0	25
	x line 20)		porrou (rrno o	Ũ	
5.00	Total swing-bed cost (see instructions)			0	26
7.00	General inpatient routine service cost net of swing-bed cost	t (line 21 minus line 26)		3, 004, 527	27
3. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b	and and observation had a	argoc)	0	28
	Private room charges (excluding swing-bed charges)	bed and observation bed ch	ai yes)	0	29
	Semi -private room charges (excluding swing-bed charges)			0	30
. 00	General inpatient routine service cost/charge ratio (line 27	7 ÷ line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 m		tions)	0.00	
	Average per diem private room cost differential (line 32 m	, ,	(10115)	0.00 0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0.00	36
	General inpatient routine service cost net of swing-bed cost		fferential (line	3,004,527	37
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD				-
8. 00	Adjusted general inpatient routine service cost per diem (se				38
	Program general inpatient routine service cost (line 9 x lin				39
	Medically necessary private room cost applicable to the Prog				40
	Total Program general inpatient routine service cost (line 3	20 . Line 40			4

Health Financial Systems	WI THAM MEMORI A	AL HOSPITAL Provider CO	CN: 15-0104	In Lie Period:	eu of Form CMS-: Worksheet D-1	
			CCN: 15-5832	From 01/01/2018 To 12/31/2018		pared:
		Title	XVIII	Skilled Nursing	972472019 2.0 PPS	s pili
Cost Center Description	Total Inpatient Costl	Total npatient Days			Program Cost (col. 3 x col.	
	1.00	2.00	<u>col.2)</u> 3.00	4.00	4) 5.00	
42.00 NURSERY (title V & XIX only)						42.0
43.00 INTENSIVE CARE UNIT	ni ts				1	43.0
44. 00 CORONARY CARE UNI T						44.0
45.00 BURN INTENSIVE CARE UNIT 46.00 SURGICAL INTENSIVE CARE UNIT						45.0 46.0
47.00 OTHER SPECIAL CARE (SPECIFY)						40.0
Cost Center Description			•		1.00	
48.00 Program inpatient ancillary service cost	(Wkst. D-3, col. 3,	line 200)			1.00	48.0
49.00 Total Program inpatient costs (sum of li	•		ns)			49.0
PASS THROUGH COST ADJUSTMENTS 50.00 Pass through costs applicable to Program	inpatient routine s	services (from	Wkst. D, su	m of Parts I and		50.0
	· · · · · · · · · · ·					
51.00 Pass through costs applicable to Program and IV)	inpatient ancillary	y services (fr	om wkst. D,	sum or Parts II		51.0
52.00 Total Program excludable cost (sum of li						52.0
53.00 Total Program inpatient operating cost ex medical education costs (line 49 minus li		lated, non-phy	sician anest	hetist, and		53.0
TARGET AMOUNT AND LIMIT COMPUTATION	1110 02)				1	
54.00 Program discharges 55.00 Target amount per discharge						54.0 55.0
56.00 Target amount (line 54 x line 55)						56. C
7.00 Difference between adjusted inpatient op	erating cost and tai	rget amount (I	ine 56 minus	line 53)		57.0
8.00 Bonus payment (see instructions)	t concerting ported	anding 100/	ndated and a	ampounded by the		58.0
59.00 Lesser of lines 53/54 or 55 from the cos market basket	t reporting period (enai ng 1996, lu	puated and c	ompounded by the		59.0
50.00 Lesser of lines 53/54 or 55 from prior ye						60.0
51.00 If line 53/54 is less than the lower of which operating costs (line 53) are less						61.0
amount (line 56), otherwise enter zero (s		S (THES ST X	00), 01 1% 0	i the target		
62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive p	anument (een instru					62. C
63.00 Allowable Inpatient cost plus incentive PROGRAM INPATIENT ROUTINE SWING BED COST	bayment (see finsting				1] 03.0
64.00 Medicare swing-bed SNF inpatient routine	costs through Decer	mber 31 of the	cost report	ing period (See		64.0
instructions)(title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine	costs after Decembe	er 31 of the c	ost reportin	g period (See		65.0
instructions) (title XVIII only)		(4	F) (+: + -)()/			
56.00 Total Medicare swing-bed SNF inpatient ro CAH (see instructions)	outine costs (line (64 plus line 6	5)(title XVI	II ONLY). FOr		66. C
67.00 Title V or XIX swing-bed NF inpatient ro	utine costs through	December 31 o	f the cost r	eporting period		67. C
(line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient rou	itine costs after De	ecember 31 of	the cost ren	orting period		68.0
(line 13 x line 20)				or tring porrou		
59.00 Total title V or XIX swing-bed NF inpation PART III - SKILLED NURSING FACILITY, OTHE						69.0
70.00 Skilled nursing facility/other nursing)	3, 004, 527	70.0
71.00 Adjusted general inpatient routine servi	ce cost per diem (li				597.68	
72.00 Program routine service cost (line 9 x li 73.00 Medically necessary private room cost ap	,	(line 14 x li	ne 35)		1, 789, 454 0	
74.00 Total Program general inpatient routine s					1, 789, 454	
75.00 Capital-related cost allocated to inpatio	ent routine service	costs (from W	orksheet B,	Part II, column	0	75. C
26, line 45) 76.00 Per diem capital-related costs (line 75 ·	÷line 2)				0.00	76.0
77.00 Program capital -related costs (line 9 x					0	
78.00 Inpatient routine service cost (line 74 m 79.00 Aggregate charges to beneficiaries for each		rovider record	s)		0	
80.00 Total Program routine service costs for e				nus line 79)	0	
81.00 Inpatient routine service cost per diem		`			0.00	
32.00 Inpatient routine service cost limitation 33.00 Reasonable inpatient routine service cos	•				0 1, 789, 454	
84.00 Program inpatient ancillary services (see	•	-,			947, 448	
35.00 Utilization review - physician compensation	ion (see instruction				0	
B6.00 Total Program inpatient operating costs PART IV - COMPUTATION OF OBSERVATION BED		rough 85)			2, 736, 902	86. 0
87.00 Total observation bed days (see instruct					0	87.0
88.00 Adjusted general inpatient routine cost	•	line 2)				88.0
39.00 Observation bed cost (line 87 x line 88)	(see instructions)				0	89.0

Health Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0104	Peri od:	Worksheet D-1	
		Component (CCN: 15-5832	From 01/01/2018 To 12/31/2018		
		Title	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	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	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 00	0	93.00

	Financial Systems WITHAM MEMORIAL HOSPI ATION OF INPATIENT OPERATING COST Prov	ider CCN: 15-0104	Period: From 01/01/2018 To 12/31/2018	u of Form CMS-2 Worksheet D-1 Date/Time Prep	
		Title XIX	Hospi tal	5/24/2019 2:03 Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days, exe	cluding newborn)		7, 012	1 1
00	Inpatient days (including private room days, excluding swing-bed and		····	7, 012	
00	Private room days (excluding swing-bed and observation bed days). do not complete this line.	ir you nave only pr	rivate room days,	0	3
00 00	Semi-private room days (excluding swing-bed and observation bed day Total swing-bed SNF type inpatient days (including private room day reporting period	, ,	er 31 of the cost	5, 466 0	
00	Total swing-bed SNF type inpatient days (including private room day	ys) 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 room days reporting period	s) through December	31 of the cost	0	1
00	Total swing-bed NF type inpatient days (including private room days reporting period (if calendar year, enter 0 on this line)	s) after December 3	31 of the cost	0	8
00	Total inpatient days including private room days applicable to the newborn days)	Program (excludino	g swing-bed and	105	Ģ
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (through December 31 of the cost reporting period (see instructions)		room days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private r	room days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, enter of Swing-bed NF type inpatient days applicable to titles V or XIX only through December 31 of the cost reporting period		e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only after December 31 of the cost reporting period (if calendar year,			0	13
00	Medically necessary private room days applicable to the Program (e: Total nursery days (title V or XIX only)	xcluding swing-bed	days)	0 1, 060	
. 00	Nursery days (title V or XIX only)				16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services th	rough December 31 (of the cost	0.00	1 17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to services af	0		0.00	
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services three	ough December 31 of	f the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after reporting period	er December 31 of 1	the cost	0.00	20
. 00 . 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31	of the cost report	ing period (line	9, 249, 375 0	
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 31 or	f the cost reportin	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through December 31 (7 x line 19)	of the cost reporti	ng period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December 31 of x line 20)	the cost reporting	g period (line 8	0	25
. 00 . 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line	21 minus line 26)		0 9, 249, 375	
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and	observation bed ch	narges)	0	28
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29
	General inpatient routine service cost/charge ratio (line 27 ÷ line	e 28)		0 0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus li	ine 33)(see instruc	ctions)	0. 00 0. 00	
. 00	Average per diem private room cost differential (line 34 x line 31)			0.00	35
. 00 . 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and p	rivate room cost di	fferential (line	0 9, 249, 375	36
. 00	27 minus line 36)			7, 247, 373	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTME	NTS			-
. 00	Adjusted general inpatient routine service cost per diem (see inst			1, 319. 08	38
. 00	Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (l	·		138, 503	
. 00				0	

OMPUT	Financial Systems TATION OF INPATIENT OPERATING COST	WITHAM MEMORIA	Provider CO	CN: 15-0104	Peri od:	u of Form CMS- Worksheet D-1	
					From 01/01/2018 To 12/31/2018		
			Ti †I	e XIX	Hospi tal	5/24/2019 2:0 Cost	03 pm
	Cost Center Description	Total Inpatient Costl	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
2 00	NUDSEDV (+i+lo)/ & VLV oply)	1.00	2.00	3.00	4.00	5.00	12
2.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	55, 344	1, 060	52.2	21 58	3, 028	42.
8. 00	INTENSIVE CARE UNIT	2, 633, 255	1, 776	1, 482. 6	9 20	29, 654	43.
1.00	CORONARY CARE UNI T						44.
5.00	BURN INTENSIVE CARE UNIT						45.
. 00							46.
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
						1.00	
8.00	Program inpatient ancillary service cost (Wks			201		107, 071	
0. 00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	FI through 48)(S	see instructio	115)		278, 256	49.
. 00	Pass through costs applicable to Program inpa	atient routine s	services (from	Wkst. D, sum	of Parts I and	C	50.
			•				
I. 00	Pass through costs applicable to Program inpa	atient ancillary	/ services (fr	om Wkst. D, s	sum of Parts II	C) 51.
2. 00	and IV) Total Program excludable cost (sum of lines {	50 and 51				C	52.
3.00	Total Program inpatient operating cost exclude		ated, non-phy	sician anesth	etist, and	0	
	medical education costs (line 49 minus line 5				·		
00	TARGET AMOUNT AND LIMIT COMPUTATION					C	
. 00						0.00	
. 00	0					0.00	
. 00	Difference between adjusted inpatient operati	ng cost and tar	get amount (I	ine 56 minus	line 53)	C	
. 00	Bonus payment (see instructions)					C	
. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period e	ending 1996, u	pdated and co	mpounded by the	0.00	59
. 00	market basket Lesser of lines 53/54 or 55 from prior year of	cost report. upo	lated by the m	arket basket		0.00	60
. 00	If line 53/54 is less than the lower of lines				the amount by	0	
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	the target		
0 00	amount (line 56), otherwise enter zero (see i	nstructions)				C	62.
2.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)				
	PROGRAM INPATIENT ROUTINE SWING BED COST						
. 00	5 1	ts through Decem	nber 31 of the	cost reporti	ng period (See	C	64.
5.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	ts after Decembe	or 31 of the c	ost reporting	period (See	C	65.
5.00	instructions) (title XVIII only)			UST TEPOTITING	period (see		05.
5.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 6	64 plus line 6	5)(title XVII	l only). For	C	66.
	CAH (see instructions)			с. н			
7.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 o	r the cost re	eporting period	C	67.
3. 00	Title V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost repo	orting period	C	68.
	(line 13 x line 20)					_	
9.00	Total title V or XIX swing-bed NF inpatient i PART III - SKILLED NURSING FACILITY, OTHER NU					0) 69.
. 00	Skilled nursing facility/other nursing facili						70
. 00	Adjusted general inpatient routine service co	3					71
. 00	Program routine service cost (line 9 x line 7	· ·		>			72
. 00	Medically necessary private room cost applica Total Program general inpatient routine servi	0	•	ne 35)			73
. 00	Capital -related cost allocated to inpatient	•		orksheet B. P	Part II. column		75
	26, line 45)						
. 00	Per diem capital-related costs (line 75 ÷ lir						76
. 00	Program capital -related costs (line 9 x line						77
. 00 . 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		ovider record	s)			78
00	Total Program routine service costs for compa	· · ·		·	us line 79)		80
. 00	Inpatient routine service cost per diem limit				,		81
. 00	Inpatient routine service cost limitation (li						82
. 00	Reasonable inpatient routine service costs (s		5)				83
. 00	Program inpatient ancillary services (see ins Utilization review - physician compensation		ls)				84
. 00							86
	PART IV - COMPUTATION OF OBSERVATION BED PASS	5 THROUGH COST	. ·/				
7.00	Total observation bed days (see instructions)					1, 546	
3.00	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see		rine 2)			1, 319. 08 2, 039, 298	
	TONSELVATION DEA COST (TIME OF & TIME OD) (See	= i listi ucti UliS)				I ∠, U37, Z98	1 0

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 01/01/2018 To 12/31/2018		
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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	875, 485	9, 249, 375	0. 09465	3 2, 039, 298	193, 026	90.00
91.00 Nursing School cost	0	9, 249, 375	0.00000	2, 039, 298	0	91.00
92.00 Allied health cost	0	9, 249, 375	0.00000	2, 039, 298	0	92.00
93.00 All other Medical Education	0	9, 249, 375	0.00000	2, 039, 298	0	93.00

	ystems WITHAM MEMORIAL Y SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0104	Peri od:	u of Form CMS- Worksheet D-3	
		li otraor o		From 01/01/2018		
				To 12/31/2018		
		Title	e XVIII	Hospi tal	5/24/2019 2:0 PPS	<u>3 pm</u>
Cost (enter Description		Ratio of Cos		Inpati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
					2)	L
			1.00	2.00	3.00	
	DUTI NE SERVI CE COST CENTERS & PEDI ATRI CS			2, 311, 850		30.00
	I VE CARE UNI T			1, 973, 650		31.00
40.00 04000 SUBPRO				0		40.00
41.00 04100 SUBPRC				0		41.00
42.00 04200 SUBPRO				0		42.00
43.00 04300 NURSER	Y					43.00
	RVICE COST CENTERS					
50.00 05000 OPERAT			0. 1048			
	OGY-DI AGNOSTI C		0. 2376			
	OGY-THERAPEUTI C		0.0000		0	
55.01 05501 ULTRA			0.0922			
57.00 05700 CT SCA			0.0267		58, 276	
	IC RESONANCE IMAGING (MRI)		0.0744			
	C CATHETERI ZATI ON		0.0996			
60. 00 06000 LABORA 63. 00 06300 BLOOD			0. 1564		683, 824	
	STORING, PROCESSING & TRANS. ENOUS THERAPY		0. 2157 0. 0009		34, 767 601	
66. 00 06600 PHYSIC			0. 4204			
	TIONAL THERAPY		0. 1873			
67.01 06701 AUDI OL			0. 2609		0	
68.00 06800 SPEECH			0. 2736			
69.00 06900 ELECTR			0.0000		0	1
69.01 06901 CARDI C			0. 1432		560, 123	69.01
71.00 07100 MEDI CA	L SUPPLIES CHARGED TO PATIENTS		0. 3809	64 1, 410, 565	537, 374	71.00
72.00 07200 I MPL.	DEV. CHARGED TO PATIENT		0. 3971	07 0	0	72.00
	CHARGED TO PATIENTS		0. 0715	83 3, 412, 199	244, 255	73.00
	ERVICE COST CENTERS		1		r	4
90.00 09000 CLINIC			0.0000			
	OUTPATIENT SERVICE COST CENTER		0.0000			
90. 02 09002 CLINIC			0.0000			
			0.0000			
90. 04 09004 ENT CL 90. 05 09005 SURGER			0.0000			
90. 05 09003 SURGER			0.0000			
	ENTEROLOGY CLINIC		0.0000			
90. 11 09011 NEUROL			0.0000			
	OLOGY CLINIC		0.0000			
90. 13 09013 ALLERG			0. 2855		-	
90.14 09014 WOUND			0. 1720			
91.00 09100 EMERGE			0. 1759			
92.00 09200 OBSERV	ATION BEDS (NON-DISTINCT PART)		0. 5156	71 0		
	IRSABLE COST CENTERS					
	NCE SERVICES					95.00
	(sum of lines 50 through 94 and 96 through 98)			25, 808, 836	3, 558, 960	
	BP Clinic Laboratory Services-Program only charge	s (line 61)		0		201.00
202.00 Net ch	arges (line 200 minus line 201)			25, 808, 836		202.00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0104	Peri od:	Worksheet D-3	2552-1
ATENT ANGLEART SERVICE COST AT ORTONWENT	in ovider c	CN. 13-0104	From 01/01/2018)
	Component	CCN: 15-S104	To 12/31/2018	Date/Time Pre	epared:
				5/24/2019 2:0)3 pm
	litle	e XVIII	Subprovider - IPF	PPS	
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	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	5.00	
D. 00 03000 ADULTS & PEDIATRICS			0		30. 0
1.00 03100 INTENSIVE CARE UNIT			0		31.0
D. 00 04000 SUBPROVI DER – I PF			3, 049, 439		40.0
1. 00 04100 SUBPROVI DER – I RF			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 05000 OPERATI NG ROOM		0. 1048			
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2376			
5. 00 05500 RADI OLOGY-THERAPEUTI C		0.0000			
5. 01 05501 ULTRA SOUND		0.0922			
7.00 05700 CT SCAN		0. 0267		1, 274	
B. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0744			
9. 00 05900 CARDI AC CATHETERI ZATI ON		0.0996			
D. 00 06000 LABORATORY		0. 1564			
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 2157			
4. 00 06400 INTRAVENOUS THERAPY		0.0009			
6. 00 06600 PHYSI CAL_THERAPY 7. 00 06700 OCCUPATI ONAL_THERAPY		0. 4204			
		0. 1873		3, 735	
7. 01 06701 AUDI OLOGY 8. 00 06800 SPEECH PATHOLOGY		0. 2609 0. 2736		-	
9. 00 06900 ELECTROCARDI OLOGY		0.2736		2, 290	
9. 01 06900 CARDI OLOGY		0. 1432			
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3809			
2. 00 07200 I MPL. DEV. CHARGED TO PATI ENT		0. 3971			
3. 00 07300 DRUGS CHARGED TO PATIENTS		0.0715		-	
OUTPATIENT SERVICE COST CENTERS		010710		02,170	
D. 00 09000 CLI NI C		0.0000	00 0	0	90.0
D. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER		0.0000	00 0	0	90.0
D. 02 09002 CLINIC		0.0000	00 0	0	90.0
D. 03 09003 DERMATOLOGY CLINIC		0.0000			
D. 04 09004 ENT CLINIC		0.0000	00 0	0	90.0
D. 05 09005 SURGERY CLINIC		0.0000	00 0	0	90.0
D. 07 09007 UROLOGY CLINIC		0.0067	30 0	0	90.0
D. 09 09009 GASTROENTEROLOGY CLINIC		0.0000		0	
D. 11 09011 NEUROLOGY CLINIC		0.0000		0	
D. 12 09012 OPTHAMOLOGY CLINIC		0.0000			
D. 13 09013 ALLERGY CLINIC		0. 2855			
D. 14 09014 WOUND CARE		0. 1720			
1.00 09100 EMERGENCY		0. 1759		4, 330	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5156	71 0	0	92.0
OTHER REI MBURSABLE COST CENTERS 5. 00 09500 AMBULANCE SERVICES		1			95. (
00 09500 AMBULANCE SERVICES 00.00 Total (sum of lines 50 through 94 and 96 through 98)			1 645 004	212 224	
		1	1, 645, 884	213, 324	1200. (
01.00 Less PBP Clinic Laboratory Services-Program only charge	c (lipo 61)		0		201.0

IPATI ENT ANCI LLARY SERVI CE COST APPORTI ONMENT	SPITAL	CN: 15-0104	Peri od:	eu of Form CMS- Worksheet D-3	
	ovraci o		From 01/01/2018		,
Co	mponent	CCN: 15-5832	To 12/31/2018	Date/Time Pre	pared
	Title	e XVIII	Skilled Nursing	5/24/2019 2:0 PPS	13 pm
			Facility		
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1			
0. 00 03000 ADULTS & PEDIATRICS			0		30.
. 00 03100 I NTENSI VE CARE UNI T			0		31.
0. 00 04000 SUBPROVIDER - IPF			0		40.
. 00 04100 SUBPROVIDER - IRF			0		41.
2. 00 04200 SUBPROVI DER			0		42.
3. 00 04300 NURSERY					43.
ANCI LLARY SERVI CE COST CENTERS		0. 1048	35 41, 382	4, 340	50.
1. OO 05400 OPERATING ROOM 1. OO 05400 RADI OLOGY-DI AGNOSTI C		0. 2376			
5. 00 05500 RADI OLOGY - THERAPEUTI C		0. 2376			
5. 01 05501 ULTRA SOUND		0.0922			
7. 00 05700 CT SCAN		0. 02673			
B. OO 05700 01 SEAN B. OO 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0744			
0. 00 05900 CARDI AC CATHETERI ZATI ON		0.0996			
0. 00 06000 LABORATORY		0. 1564			
8. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 2157			
00 06400 I NTRAVENOUS THERAPY		0.0009			
0. 00 06600 PHYSI CAL THERAPY		0. 4204			
2.00 06700 OCCUPATI ONAL THERAPY		0. 1873			
7. 01 06701 AUDI OLOGY		0. 2609	31 0	0	67.
B. 00 06800 SPEECH PATHOLOGY		0. 2736	96, 754	26, 480	68.
2. 00 06900 ELECTROCARDI OLOGY		0.0000	0 00	0	
2. 01 06901 CARDI OLOGY		0. 1432	44 324, 938	46, 545	69.
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3809	54 114, 070	43, 457	71.
2. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 3971	07 0	0	72.
8. 00 07300 DRUGS CHARGED TO PATIENTS		0. 0715	33 912, 638	65, 329	73.
OUTPATI ENT SERVI CE COST CENTERS		0.0000			1 00
		0.0000			
0. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER 0. 02 09002 CLINIC		0.0000			
0. 03 09003 DERMATOLOGY CLINIC		0.0000			
0. 04 09003 DERMATOLOGT CETNIC		0.0000			
05 09005 SURGERY CLINIC		0.0000			
0. 07 09007 UROLOGY CLINIC		0.00673			
0. 09 09009 GASTROENTEROLOGY CLINIC		0.0000			
. 11 09011 NEUROLOGY CLINIC		0.0000			
0. 12 09012 OPTHAMOLOGY CLINIC		0.0000			
0. 13 09013 ALLERGY CLINIC		0. 2855			
. 14 09014 WOUND CARE		0. 1720			
. 00 09100 EMERGENCY		0. 1759			
. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		0. 5156			
OTHER REI MBURSABLE COST CENTERS					
5. 00 09500 AMBULANCE SERVICES					95.
00.00 Total (sum of lines 50 through 94 and 96 through 98)			4, 195, 624		
11.00 Less PBP Clinic Laboratory Services-Program only charges (I	ıne 61)		0		201.
2.00 Net charges (line 200 minus line 201)		1	4, 195, 624		202.

Health Financial Systems WITHAM MEMORI INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	°N· 15_0104	Peri od:	u of Form CMS-: Worksheet D-3	
INFAITENT ANGIELART SERVICE COST AFFORTIONMENT	FIOVICEI C	GN. 15-0104	From 01/01/2018	WOLKSHEEL D-3	
			To 12/31/2018		
				5/24/2019 2:0	13 pm
Cost Center Description		e XIX Ratio of Cos	Hospital t Inpatient	Cost Inpatient	
cost center bescription		To Charges		Program Costs	
		10 ondriges	Charges	$(col \cdot 1 \times col \cdot$	
			g	2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			490, 268		30.00
31. 00 03100 I NTENSI VE CARE UNI T			67, 643		31.00
40. 00 04000 SUBPROVI DER - I PF			0		40.00
41.00 04100 SUBPROVIDER - IRF			0		41.00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY			Ű		42.00
ANCI LLARY SERVI CE COST CENTERS			174, 750		43.00
50. 00 05000 OPERATING ROOM		0. 1048	85 113, 047	11, 857	50.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 2376		4, 169	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.0000		4, 107 0	1
55. 01 05501 ULTRA SOUND		0.0922		611	
57. 00 05700 CT SCAN		0. 0267		1, 433	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.0744		393	
59. 00 05900 CARDIAC CATHETERIZATION		0.0996		2, 911	
60. 00 06000 LABORATORY		0. 1564		22, 264	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 2157		2, 770	
64.00 06400 I NTRAVENOUS THERAPY		0.0009	71 27, 752	27	64.00
66. 00 06600 PHYSI CAL THERAPY		0. 4204	93 5, 112	2, 150	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 1873	02 3, 733	699	67.00
67. 01 06701 AUDI OLOGY		0. 2609	81 0	0	67.01
68.00 06800 SPEECH PATHOLOGY		0. 2736	87 113	31	68.00
69. 00 06900 ELECTROCARDI OLOGY		0.0000	00 0	0	69.00
69. 01 06901 CARDI OLOGY		0. 1432		8, 256	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3809		31, 711	
72.00 07200 I MPL. DEV. CHARGED TO PATI ENT		0. 3971		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0.0715	83 125, 953	9, 016	73.00
		0.0000	00	0	00.00
90. 00 09000 CLINIC 90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER		0.0000		0	
90. 02 09002 CLINIC		0.0000		0	
90. 03 09003 DERMATOLOGY CLINIC		0.0000		0	
90. 04 09004 ENT CLINIC		0.0000		0	
90. 05 09005 SURGERY CLINIC		0.0000		0	
90. 07 09007 UROLOGY CLINIC		0.0067		0	1
90. 09 09009 GASTROENTEROLOGY CLINIC		0.0000		0	1
90. 11 09011 NEUROLOGY CLINIC		0.0000		0	
90. 12 09012 OPTHAMOLOGY CLINIC		0.0000		0	
90. 13 09013 ALLERGY CLINIC		0. 2855		0	1
90. 14 09014 WOUND CARE		0. 1720		0	90.14
91. 00 09100 EMERGENCY		0. 1759		8, 773	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5156	71 0	0	92.00
OTHER REIMBURSABLE COST CENTERS		1			
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)	<i>.</i>		733, 880	107, 071	
201.00 Less PBP Clinic Laboratory Services-Program only char	rges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		1	733, 880		202.00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT P	Provider CCN: 15-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Pre 5/24/2019 2:03	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
I.00 I.01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring instructions)	g prior to October 1 (see	0 5, 146, 293	1.00 1.01
. 02	DRG amounts other than outlier payments for discharges occurring instructions)	g on or after October	1 (see	1, 353, 827	1. 02
. 03	DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	di scharges occurri ng	prior to October	0	1. 03
. 04	DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions)	discharges occurring	on or after	0	1.04
2.00	Outlier payments for discharges. (see instructions)			81, 440	2.00
2.01 2.02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instruction	nc)		0	2.01 2.02
3.02	Managed Care Simulated Payments	113)		0	3.00
1.00	Bed days available divided by number of days in the cost reporti Indirect Medical Education Adjustment	uctions)	63.76	4.00	
5.00	FTE count for allopathic and osteopathic programs for the most i or before 12/31/1996. (see instructions)	period ending on	0.00	5.00	
5.00	FTE count for allopathic and osteopathic programs that meet the new programs in accordance with 42 CFR 413.79(e) $$		0.00	6.00	
7.00 7.01	MMA Section 422 reduction amount to the IME cap as specified und ACA § 5503 reduction amount to the IME cap as specified under 42 cost report straddles July 1, 2011 then see instructions.		0.00 0.00	7. 00 7. 01	
3. 00	Adjustment (increase or decrease) to the FTE count for allopathi affiliated programs in accordance with 42 CFR 413.75(b), 413.79			0.00	8. 00
3. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots report straddles July 1, 2011, see instructions.	ACA. If the cost	0.00	8. 01	
3. 02	The amount of increase if the hospital was awarded FTE cap slots under § 5506 of ACA. (see instructions)	ng hospi tal	0.00	8. 02	
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines instructions)	(8, 8,01 and 8,02) (see	0.00	9.00
0.00	FTE count for allopathic and osteopathic programs in the curren	t year from your recor	ds		10.00
1.00	FTE count for residents in dental and podiatric programs.				11.00
2.00 3.00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.				12.00 13.00
4.00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	ended on or after Sep	otember 30, 1997,		14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.0
6.00	Adjustment for residents in initial years of the program			0.00	16.00
7.00	Adjustment for residents displaced by program or hospital closu	re			17.00
	Adjusted rolling average FTE count				18.0
9.00	Current year resident to bed ratio (line 18 divided by line 4).			0.00000	
20.00 21.00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0.000000 0.000000	
22.00	IME payment adjustment (see instructions)			0.000000	1
22.01	IME payment adjustment - Managed Care (see instructions)			0	
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of Number of additional allopathic and osteopathic IME FTE residen		CFR 412.105	0.00	23.00
1 00	(f)(1)(iv)(C).				0.0
24.00 25.00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -O-, then enter the low instructions)	wer of line 23 or line	e 24 (see	0.00 0.00	24.00 25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	
28.00	IME add-on adjustment amount (see instructions)			0	
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	
29.00	Total IME payment (sum of lines 22 and 28)			0	
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			0	29.0 [°]
30.00	Percentage of SSI recipient patient days to Medicare Part A pati	ient days (see instruc	tions)	2. 11	30.00
31.00	Percentage of Medicaid patient days (see instructions)			23. 58	
32.00	Sum of lines 30 and 31				32.00
33.00	Allowable disproportionate share percentage (see instructions)			40.44	33.0

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Period: From 01/01/2018	Worksheet E Part A	
				Date/Time Prep 5/24/2019 2:03	
		Title XVIII	Hospi tal	PPS	s pili
		· ·	Prior to 10/1		
	Uncompanyated Caro Adjustment		1.00	2.00	
35.00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		0	0	35.00
35.00	Factor 3 (see instructions)		0. 00000000	0. 000000000	
35.02	Hospital uncompensated care payment (If line 34 is zero, ente	er zero on this line) (se		834, 440	
	instructions)				
35.03	Pro rata share of the hospital uncompensated care payment and		478, 505	210, 325	
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.0 Additional payment for high percentage of ESRD beneficiary di		688, 830 ab 46)		36.00
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding		0		40.00
	652, 682, 683, 684 and 685 (see instructions)	C			
41.00	5 5				41.00
41.01	instructions)		0		41.01
41.01	Total ESRD Medicare covered and paid discharges excluding MS- an 685. (see instructions)	-DRGS 052, 062, 063, 064	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not quali	ify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68	82, 683, 684 an 685. (see	0		43.00
	instructions)		0,000000		
44.00	Ratio of average length of stay to one week (line 43 divided days)	by line 41 divided by 7	0. 000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions	s)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41		0		46.00
47.00	Subtotal (see instructions)		7, 439, 555		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	0		48.00
	only. (see instructions)			Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions			7, 439, 555	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I ar			541, 302	
51.00 52.00	Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Li			0	51.00 52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.0
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6			0	55.00
56.00 57.00	Cost of physicians' services in a teaching hospital (see intr	-	anough 25)	0	56.00 57.00
58.00	Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt.		ni ougiri 55).	0	58.0
59.00	Total (sum of amounts on lines 49 through 58)			7, 980, 857	
60.00	Primary payer payments			5, 831	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		7, 975, 026	
62.00	Deductibles billed to program beneficiaries			873, 440	
63.00 64.00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			4, 020 77, 359	
65.00	Adjusted reimbursable bad debts (see instructions)			50, 283	
66.00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		18, 128	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	-		7, 147, 849	
68.00	Credits received from manufacturers for replaced devices for			0	68.0
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	.(For SCH see instruction	s)	0	69.0
70.00 70.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst	tration) adjustment (see	instructions)	0	70.0 70.5
70. 30	Demonstration payment adjustment amount before sequestration			0	70.3
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.8
	Pioneer ACO demonstration payment adjustment amount (see inst	tructions)			70.8
70.89	HSP bonus payment HVBP adjustment amount (see instructions)			0	
70. 90				0	70.9
70. 90 70. 91	HSP bonus payment HRR adjustment amount (see instructions)				
70. 90 70. 91 70. 92	Bundled Model 1 discount amount (see instructions)			0	70. 9
70. 90 70. 91					70. 9

alth Financial Systems WITHAM MEMORIAL ALCULATION OF REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0104	Peri od:	u of Form CMS-2 Worksheet E	
			From 01/01/2018 To 12/31/2018	Part A Date/Time Prepa	
				5/24/2019 2:0	3 pm
	litle	XVIII	Hospi tal	PPS	
		FFY	(уууу) 0	Amount 1.00	
0.96 Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		2018	569, 467	70.
the corresponding federal year for the period prior to 10/1)			2010	307, 407	/0.
D.97 Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period ending on or af			2019	195, 300	70.
). 98 Low Volume Payment-3				0	70.
0.99 HAC adjustment amount (see instructions)				0	
1.00 Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			7, 938, 200	
 1.01 Sequestration adjustment (see instructions) 1.02 Demonstration payment adjustment amount after sequestration 				158, 764 0	71. 71.
2. 00 Interim payments				7, 729, 820	
3.00 Tentative settlement (for contractor use only)	1 5				73.
4.00 Balance due provider/program (line 71 minus lines 71.01, 71.0 73)			49, 616	74.	
5.00 Protested amounts (nonallowable cost report items) in accorda CMS Pub. 15-2, chapter 1, §115.2	ance with			282, 029	75.
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)	6.0.02				
0.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum plus 2.04 (see instructions)	of 2.03			0	
.00 Capital outlier from Wkst. L, Pt. I, line 2 .00 Operating outlier reconciliation adjustment amount (see instr	suctions)			0	91 92
.00 Capital outlier reconciliation adjustment amount (see instruc	,			0	92
.00 The rate used to calculate the time value of money (see instruction and the time value of money (see instruction)				0.00	
.00 Time value of money for operating expenses (see instructions)	,			0.00	95
0.00 Time value of money for capital related expenses (see instruct				0	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount			1.00	2.00	100
0.00 HSP bonus amount (see instructions)				2.00	100
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			1.00	2.00	
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions)	 ns)		1.00	2.00 0 0.000000000	101
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions)	15)		0. 0000000000	2.00 0 0.000000000	101
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 	ns)		0. 0000000000	2.00 0 0.000000000	101 102
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions) 	5)		1.00 0 0.0000000000 0	2.00 0 0.000000000 0 0.0000	101 102 103
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst 	s) rration) Adju		1.00 0 0.000000000 0 0.0000	2.00 0 0.000000000 0 0.0000	101 102 103 104
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst 0.00 Is this the first year of the current 5-year demonstration period 	s) rration) Adju		1.00 0 0.000000000 0 0.0000	2.00 0 0.000000000 0 0.0000	101 102
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst 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. 	s) rration) Adju		1.00 0 0.000000000 0 0.0000	2.00 0 0.000000000 0 0.0000	101 102 103 104
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions) 6.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 	š) rration) Adju eriod under t		1.00 0 0.000000000 0 0.0000	2.00 0 0.000000000 0 0.0000	101 102 103 104 200
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment factor (see instructions) 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 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. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. 11, Iir 	š) rration) Adju eriod under t		1.00 0 0.000000000 0 0.0000	2.00 0.000000000 0 0.0000 0	101 102 103 104 200 201
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 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. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir 2.00 Medicare discharges (see instructions) 	š) rration) Adju eriod under t		1.00 0 0.000000000 0 0.0000	2.00 0.000000000 0 0.0000 0	101 102 103 104 200 201 202
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus Payment 3.00 HRR adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions) 6.00 HRR adjustment amount for HSP bonus payment (see instructions) 6.00 HRR adjustment amount for HSP bonus payment (see instructions) 7.00 HRR adjustment amount for HSP bonus payment (see instructions) 7.00 HSP adjustment factor (see instructions) 7.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir 2.00 Medicare discharges (see instructions) 8.00 Case-mix adjustment factor (see instructions) 7.00 Medicare of pemonstration Target Amount Limitation (N/A in period) 	s) rration) Adju eriod under t ne 49)	he 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0.0000 0 rati on	101 102 103 104 200 201 202 203
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions) 8.00 HRR adjustment amount for HSP bonus payment (see instructions) 8.00 HRR adjustment amount for HSP bonus payment (see instructions) 8.00 HRR adjustment amount for HSP bonus payment (see instructions) 8.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) 4.00 Medicare target amount 	s) rration) Adju eriod under t ne 49)	he 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0.0000 0 rati on	101 102 103 104 200 201 202 203
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 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. Cost Reimbursement 1.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 4.00 Medicare target amount 4.00 Medicare target amount 	s) cration) Adju eriod under t ne 49) n first year	he 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0.0000 0 rati on	101 102 103 104 200 201 202 203 203 204 204
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 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment factor (see instructions) 2.00 HRR adjustment for HSP Bonus Payment (see instruction HRR Adjustment factor (see instructions) 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 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. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjustment factor (see instructions) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare to Medicare Part A Inpatient Reimbursement 	s) rration) Adju eriod under t ne 49) n first year	he 21st	1.00 0.000000000 0 0.0000 0	2.00 0.0000000000 0 0.0000 0	101 102 103 104 200 201 202 203 204 205 206
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment (see instruction HRR adjustment factor (see instructions) 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 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. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instruction 	s) rration) Adju eriod under t ne 49) n first year	he 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0 0.0000 0	101 102 103 104 200 201 202 203 204 205 206 207
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment (see instructions) 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 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. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare negatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see inst 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 	s) rration) Adju eriod under t ne 49) n first year	he 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0.0000 0	101 102 103 104 200 201 202 203 204 205 206 207 208
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment (see instruction HRR adjustment for HSP Bonus Payment (see instructions) 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment for HSP bonus payment (see instructions) 4.00 HRR adjustment for HSP bonus payment (see instructions) 6.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see inst 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 9.00 Adjustment to Medicare IPPS payments (see instructions) 	s) rration) Adju eriod under t ne 49) n first year	he 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0.0000 0	101 102 103 104 200 201 202 203 204 205 206 207 208 207 208 209
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment factor (see instructions) 2.00 HRR adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions) 6.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instructions) 8.00 Medicare Part A inpatient Service costs (from Wkst. E, Pt. A, 9.00 Adjustment to Medicare IPPS payments (see instructions) 	s) rration) Adju eriod under t ne 49) n first year) tructions) line 59)	he 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0.0000 0	101 102 103 104 200 201 202 203 204 205 206 207 208 209 210
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment (see instruction HRR adjustment for HSP Bonus payment (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 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. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjustment factor (see instructions) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see inst 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 9.00 Adjustment to Medicare IPPS payments (see instructions) 0.00 Reserved for future use 1.00 Total adjustment to Medicare IPPS payments (see instructions) 	s) rration) Adju eriod under t ne 49) n first year h tructions) line 59)	he 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0.0000 0	101 102 103 104 200 201 202 203 204 205 206 207 208 209 210
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment (see instruction HRR adjustment amount for HSP bonus payment (see instructions) 3.00 HRR adjustment for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Rural community Hospital Demonstration Project (§410A Demonstration Project Reimbursement Contury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 100 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Demonstration of Demonstration Target Amount Limitation (N/A in period) 400 Medicare target amount 41.00 Medicare inpatient routine cost cap (line 202 times line 204) 42.00 Medicare Part A Inpatient Reimbursement 43.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Demonstration (see instructions) 43.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Demonstration of PPS versus Cost Reimbursement 43.00 Total adjustment to Medicare Part A IPPS payments (see instructions) 44.00 Comparision of PPS versus Cost Reimbursement 45.00 Total adjustment to Medicare Part A IPPS payments (from line 	s) rration) Adju eriod under t ne 49) n first year h tructions) line 59)	he 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0 0.0000 0	101 102 103 104 200 201 202 203 204 205 206 207 208 209 210 211 212
 00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment (see instruction HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Rural community Hospital Demonstration Project (§410A Demonstration period) 00 Is this the first year of the current 5-year demonstration period) 01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir period) 03.00 Case-mix adjustment factor (see instructions) 04.00 Medicare target amount 05.00 Case-mix adjusted target amount (line 203 times line 204) 06.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 07.00 Program reimbursement under the §410A Demonstration (see inst 88.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 99.00 Adjustment to Medicare IPPS payments (see instructions) 00 Reserved for future use 1.00 Total adjustment to Medicare IPPS payments (see instructions) 	s) rration) Adju eriod under t ne 49) n first year tructions) line 59) 211)	he 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0 0.0000 0	101 102 103 104 200 201 202 203 204 205 206

W VO	LUME CALCULATION EXHIBIT 4			Provider CO	F	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Exhibi Date/Time Pre 5/24/2019 2:0	pare
		W/S E, Part A line O	Amounts (from E, Part A) 1.00	Title Pre/Post Entitlement 2.00	XVIII Period Prior to 10/01 3.00	Hospital Period On/After 10/01 4.00	PPS Total (Col 2 through 4) 5.00	
00	DRG amounts other than outlier	1.00	0	0			0	1.
01	payments DRG amounts other than outlier payments for discharges	1. 01	5, 146, 293	0	5, 146, 293	3	5, 146, 293	1.
02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	1, 353, 827	0		1, 353, 827	1, 353, 827	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	1
00	Outlier payments for	2.00	81, 440	0	65, 345	5 16, 095	81, 440	2
D1	discharges (see instructions) Outlier payments for	2.02	0	0	C	0	0	2
00	discharges for Model 4 BPCI Operating outlier	2, 01	0	0	C C) 0	0	
00	reconciliation Managed care simulated payments	3. 00	0	0	C	0 0	0	
00	Indirect Medical Education Adju	ustment 21.00	0,000000	0,00000	0.00000			
	Amount from Worksheet E, Part A, line 21 (see instructions)		0. 000000	0. 000000				5
)0)1	IME payment adjustment (see instructions) IME payment adjustment for	22. 00 22. 01	0	0			0	
	managed care (see instructions)					-	-	
	Indirect Medical Education Adju					0.000000		1_
00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.00000				7
00	IME adjustment (see instructions)	28.00	0	0	C	0 0	0	
)1	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	C	0 0	0	8
00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	C	0 0	0	Ģ
)1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	C	O O	0	ç
00	Disproportionate Share Adjustme Allowable disproportionate	ent 33.00	0. 1041	0. 1041	0. 1041	0. 1041		10
00	share percentage (see instructions)	33.00	0. 1041	0.1041	0. 1041	0.1041		
00	Disproportionate share adjustment (see instructions)	34.00	169, 165	0	133, 932	2 35, 233	169, 165	11
01	Uncompensated care payments	36.00	688, 830	0	478, 505	210, 325	688, 830	11
00	Additional payment for high per Total ESRD additional payment	centage of ESF 46.00	RD beneficiary 0	di scharges 0	(0	0	12
00	(see instructions) Subtotal (see instructions)	47.00	7, 439, 555	0	5, 824, 075	5 1, 615, 480		
00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	48.00	0	0		0		14
00	(see instructions) Total payment for inpatient operating costs (see instructions)	49.00	7, 439, 555	0	5, 824, 075	5 1, 615, 480	7, 439, 555	15
00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	541, 302	0	428, 926	5 112, 376	541, 302	16
00	Special add-on payments for new technologies	54.00	0	0	C	0	0	17
01 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	C	0	0	17 17

Heal th	Financial Systems		WI THAM MEMORI	AL_HOSPITAL		In Lie	u of Form CMS-2	2552-10
LOW VO	LUME CALCULATION EXHIBIT 4			Provider C		Period: From 01/01/2018 To 12/31/2018		pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A	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
19 00	SUBTOTAL			0	6, 253, 00	1 1, 727, 856	7, 980, 857	19 00
		W/S L, line	(Amounts from L)	-				
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	529, 368	0	419, 21	6 110, 152	529, 368	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	11, 934	0	9, 71	0 2, 224	11, 934	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	0.0000	0.000	0 0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.0000	0.000	0 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	541, 302	0	428, 92	6 112, 376	541, 302	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. 09107 569, 46		569, 467	27.00 28.00
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70. 97				195, 300	195, 300	29.00
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Υ					100. 00

HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CC		Period: From 01/01/2018 To 12/31/2018	Date/Time Prep 5/24/2019 2:03	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	5, 146, 293		0	0	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1, 353, 827		6, 500, 120	6, 500, 120	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	81, 440		0 81, 440	81, 440	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. 00000	0 0. 000000		5.00
(00	(see instructions)	22.00				0	(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	0 0	6. 00 6. 01
	Indirect Medical Education Adjustment for the	Add-on for Se	ction 422 of t	he MMA	-1		
7.00	IME payment adjustment factor (see instructions)	27.00	0. 000000		0 0. 000000		7.00
8. 00 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed	28.00 28.01	0		0 0 0 0	0 0	8. 00 8. 01
9.00	care (see instructions) 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	33.00	0. 1041	0. 104	1 0. 1041		10.00
11.00	(see instructions) Disproportionate share adjustment (see	34.00	169, 165		0 169, 165	169, 165	11.00
11 01	instructions) Uncompensated care payments	36.00	688, 830	478, 50	5 210, 325	688, 830	11.01
11.01	Additional payment for high percentage of ESR			476, 30	210, 325	000, 030	11.01
12.00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12.00
13.00	Subtotal (see instructions)	47.00	7, 439, 555	478, 50	5 6, 961, 050	7, 439, 555	13.00
	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48.00	0		0 0		
15.00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	7, 439, 555	478, 50	5 6, 961, 050	7, 439, 555	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	541, 302		0 541, 302	541, 302	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

Health Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CC		Period: From 01/01/2018 To 12/31/2018		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	529, 368		0 529, 368		20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	1
21.00 Capital DRG outlier payments	2.00	11, 934		0 11, 934	11, 934	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	
22.00 Indirect medical education percentage (see	5.00	0.0000	0.00	0.000		22.00
23.00 Indirect medical education adjustment (see instructions)	6.00	0		0 C	0	23.00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.00	0. 0000		24.00
25.00 Disproportionate share adjustment (see instructions)	11.00	0		0 C	0	25.00
26.00 Total prospective capital payments (see instructions)	12.00	541, 302		0 541, 302	541, 302	26.00
	Wkst. E, Pt.	(Amt. from				
	A, line	Wkst. E, Pt. A)				
	0	1.00	2.00	3.00	4.00	
27.00			2.00	0.00	11 00	27.00
28.00 Low volume adjustment prior to October 1	70, 96	569, 467	569, 4	67	569, 467	28.00
29.00 Low volume adjustment on or after October 1	70, 97	195, 300		195, 300		
30.00 HVBP payment adjustment (see instructions)	70, 93	55, 265		0 55, 265		
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0		0 0	0	1
31.00 HRR adjustment (see instructions)	70, 94	-29, 681		0 -29, 681	-29, 681	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	-27,081		0 0	-29,001	
					(Amt. to Wkst.	
					E, Pt. A)	
	0	1.00	2.00	3.00	4.00	0.0.07
32.00 HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	02.00
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

	Financial Systems WI THAM MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT	HOSPITAL Provider CCN: 15-0104	Period:	u of Form CMS-2 Worksheet E	2552-10
5. 1200L			From 01/01/2018 To 12/31/2018	Part B Date/Time Pre	
		Title XVIII	Hospi tal	5/24/2019 2:03 PPS	3 pm
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			2, 815	1.00
2.00 3.00	Medical and other services reimbursed under OPPS (see instruc OPPS payments	ti ons)		9, 120, 190 11, 424, 579	
4.00	Outlier payment (see instructions)			7, 782	4.00
4.01	Outlier reconciliation amount (see instructions)			0	4.01
5.00 6.00	Enter the hospital specific payment to cost ratio (see instru Line 2 times line 5	ictions)		0. 000 0	5.00 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt.	IV col 13 line 200		0	8.00 9.00
9.00 10.00	Organ acquisitions	TV, COL. 13, TTHE 200		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			2, 815	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12.00	Ancillary service charges			41, 652	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			41, 652	14.00
15.00	Aggregate amount actually collected from patients liable for			0	15.00
16.00	Amounts that would have been realized from patients liable for	1 3	on a chargebasis	0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13(Ratio of line 15 to line 16 (not to exceed 1.000000)	()		0. 000000	17.00
	Total customary charges (see instructions)			41, 652	
19.00	Excess of customary charges over reasonable cost (complete on instructions)	ly if line 18 exceeds li	ne 11) (see	38, 837	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
21 00	instructions)			2 015	21 00
21.00 22.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			2,815	21.00 22.00
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			11, 432, 361	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instruction	is)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on lin	-	,	2, 102, 336	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	plus the sum of lines 2.	2 and 23] (see	9, 332, 840	27.00
	Direct graduate medical education payments (from Wkst. E-4, I			0	
	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 9, 332, 840	
	Primary payer payments				31.00
32.00	Subtotal (line 30 minus line 31)	252)		9, 331, 872	32.00
33 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI Composite rate ESRD (from Wkst. 1-5, line 11)	CES)		0	33.00
	Allowable bad debts (see instructions)			296, 410	
35.00	Adjusted reimbursable bad debts (see instructions)	ruoti ana)		192, 667	
36.00 37.00	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (see instructions)	ructions)		210, 658 9, 524, 539	
38.00	MSP-LCC reconciliation amount from PS&R			19	38.00
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	e)		0	39.00 39.50
	Demonstration payment adjustment amount before sequestration	15)		0	
39. 98	Partial or full credits received from manufacturers for repla	ced devices (see instru	ctions)	0	39. 98
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 9, 524, 520	
40.00 40.01	Sequestration adjustment (see instructions)			9, 324, 320 190, 490	
	Demonstration payment adjustment amount after sequestration			0	40. 02
41.00 42.00	Interim payments Tentative settlement (for contractors use only)			9, 148, 470 0	
43.00	Balance due provider/program (see instructions)			185, 560	43.00
44.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	44.00
	§115.2 TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)				90.00
91.00 92.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0	91.00 92.00
92.00 93.00	Time Value of Money (see instructions)			0	93.00
94.00	Total (sum of lines 91 and 93)			0	94.00

	Financial Systems WITHAM MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0104	Peri od:	u of Form CMS-2 Worksheet E	<u>-</u> JJZ-I
		Component CCN: 15-S104	From 01/01/2018 To 12/31/2018		
		Title XVIII	Subprovider -	PPS	<u>3 pili</u>
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			324	1. 00
. 00 . 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruc	ctions)		324 339	2.00
. 00	OPPS payments			409	3.00
. 00 . 01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			0	4.00 4.01
. 00	Enter the hospital specific payment to cost ratio (see instru	uctions)		0. 000	5.00
. 00 . 00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0 0. 00	6.00 7.00
. 00	Transitional corridor payment (see instructions)			0.00	8.00
. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	9.00
0.00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 324	10.00 11.00
	COMPUTATION OF LESSER OF COST OR CHARGES			021	
2 00	Reasonable charges Ancillary service charges			4 924	12.00
2.00 3.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	line 69)		4, 020	13.00
4.00	Total reasonable charges (sum of lines 12 and 13)			4, 826	
5.00	Customary charges Aggregate amount actually collected from patients liable for	navment for services on	a charge basis	0	15. OC
6.00	Amounts that would have been realized from patients liable for			0	16.00
7 00	had such payment been made in accordance with 42 CFR §413.13	(e)		0. 000000	17 00
7.00 8.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			4, 826	17.00
9.00	Excess of customary charges over reasonable cost (complete or	nlyifline 18 exceeds li	ne 11) (see	4, 502	19.00
0. 00	instructions) Excess of reasonable cost over customary charges (complete or	nlvifline 11 exceeds li	ne 18) (see	0	20.00
0.00	instructions)			0	20.00
1.00	Lesser of cost or charges (see instructions)			324	21.00
2.00 3.00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see ins	tructions)		0	22.00 23.00
4.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	•		409	24.00
5.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instruction	ns)		0	25.00
6.00	Deductibles and Coinsurance amounts relating to amount on lin	ne 24 (for CAH, see instr		0	26.00
7.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	plus the sum of lines 22	and 23] (see	733	27.00
8.00	Direct graduate medical education payments (from Wkst. E-4, I	line 50)		0	28.00
9.00	ESRD direct medical education costs (from Wkst. E-4, line 36))		0	29.00
0.00	Subtotal (sum of lines 27 through 29) Primary payer payments			733 0	30.00 31.00
2.00	Subtotal (line 30 minus line 31)			733	
3. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI Composite rate ESRD (from Wkst. I-5, line 11)	I CES)		0	33.00
4.00	Allowable bad debts (see instructions)			0	34.00
5.00	Adjusted reimbursable bad debts (see instructions)			0	35.00
6.00 7.00	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (see instructions)	tructions)		0 733	36.00 37.00
8.00	MSP-LCC reconciliation amount from PS&R			0	38.00
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
9.50 9.97	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration			0	39.50
9.97	Partial or full credits received from manufacturers for repla		tions)	0	39.97 39.98
9. 99	RECOVERY OF ACCELERATED DEPRECIATION	· ·	,	0	39.99
0. 00 0. 01	Subtotal (see instructions)			733	40.00
0.01	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			15 0	40. 01 40. 02
1.00	Interim payments			1, 347	41.00
2.00 3.00	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)			0 -629	42.00 43.00
4.00	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-2,	chapter 1,	-029	43.00
	§115. 2		• ·		
0 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
1.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
2.00	The rate used to calculate the Time Value of Money			0. 00 0	
3.00	Time Value of Money (see instructions)				

	Financial Systems ATION OF REIMBURSEMENT SETTLEMENT	WI THAM MEMORI A	Provider CCN: 15-0104	Peri od:	u of Form CMS-2 Worksheet E	∠00Z-1
			Component CCN: 15-5832	From 01/01/2018 To 12/31/2018	Date/Time Pre	
			Title XVIII	Skilled Nursing Facility	5/24/2019 2:0 PPS	s pili
				- Huerrity	1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES					
. 00 . 00	Medical and other services (see instructio Medical and other services reimbursed unde		uctions)		230	1.00
. 00	OPPS payments				0	3.00
. 00	Outlier payment (see instructions)					4.00
. 01 . 00	Outlier reconciliation amount (see instruc Enter the hospital specific payment to cos	,	ructions)			4.0 ⁻ 5.00
. 00	Line 2 times line 5				0	•
. 00	Sum of lines 3, 4, and 4.01, divided by li				0.00	•
. 00 . 00	Transitional corridor payment (see instruc Ancillary service other pass through costs		IV col 13 line 200		0	
0.00	Organ acqui si ti ons	TTOM WKSL. D, FL	. IV, COL. 13, THE 200		0	10.0
1.00	Total cost (sum of lines 1 and 10) (see in	structions)			230	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges					-
2.00	Ancillary service charges				4, 070	12.00
3. 00	Organ acquisition charges (from Wkst. D-4,		line 69)		0	13.0
4.00	Total reasonable charges (sum of lines 12	and 13)			4, 070	14.0
5.00	Customary charges Aggregate amount actually collected from p	atients liable fo	r payment for services on	a charge basis	0	15.0
6. 00	Amounts that would have been realized from	patients liable [·]	for payment for services o		0	16. 0
7.00	had such payment been made in accordance w Ratio of line 15 to line 16 (not to exceed		3(e)		0.000000	17.0
B. 00	Total customary charges (see instructions)	1.00000)			4, 070	
9.00	Excess of customary charges over reasonabl	e cost (complete (only if line 18 exceeds li	ne 11) (see	3, 840	
0 00	instructions)	harges (complete)	only if line 11 exceeds li	n_{0} (coo	0	20.0
0. 00	Excess of reasonable cost over customary c instructions)	narges (compreter)	only if the if exceeds if	ne to) (see	0	20.0
1. 00	Lesser of cost or charges (see instruction	s)			230	
2.00 3.00	Interns and residents (see instructions)	bosnital (soo in	structions)		0	
3.00 4.00	Cost of physicians' services in a teaching Total prospective payment (sum of lines 3,				0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT					
5.00 6.00	Deductibles and coinsurance amounts (for C Deductibles and Coinsurance amounts relati		-	uctions)	0	25.0
7.00	Subtotal [(lines 21 and 24 minus the sum o				230	
	instructions)					
8.00 9.00	Direct graduate medical education payments ESRD direct medical education costs (from				0	28.0
0.00	Subtotal (sum of lines 27 through 29)		5)		230	
1.00	Primary payer payments				0	
2.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR		VI CES)		230	32.0
3. 00	Composite rate ESRD (from Wkst. I-5, line		VICE3)		0	33.0
4.00	Allowable bad debts (see instructions)				0	34.0
5.00	Adjusted reimbursable bad debts (see instr	,	atruati ana)		0	35.0 36.0
6.00 7.00	Allowable bad debts for dual eligible bene Subtotal (see instructions)	ficiaries (see in:	structions)		0 230	
8.00	MSP-LCC reconciliation amount from PS&R					38.0
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPEC				0	
9.50 9.97	Pioneer ACO demonstration payment adjustme Demonstration payment adjustment amount be				0	39.5 39.9
9.98	Partial or full credits received from manu	•		tions)	0	1
9. 99	RECOVERY OF ACCELERATED DEPRECIATION		· ·	,	0	39.9
0.00	Subtotal (see instructions)	、 、			230	
0. 01 0. 02	Sequestration adjustment (see instructions Demonstration payment adjustment amount af				5	40.0
1.00	Interim payments				798	
2.00	Tentative settlement (for contractors use	5.			0	
3.00 4.00	Balance due provider/program (see instruct Protested amounts (nonallowable cost repor		dance with CMS Dub 15 0	chanter 1	-573 0	
т. UU	§115.2		aanoe wrth GWB FUD. 19-2,	chapter I,	0	44.0
	TO BE COMPLETED BY CONTRACTOR					1
	Original outlier amount (see instructions)	(coo i potruati a)			90.00
1.00 2.00	Outlier reconciliation adjustment amount The rate used to calculate the Time Value		J			91.0 92.0
	Time Value of Money (see instructions)					93.0
3.00						

VALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-0104	Period: From 01/01/2018 To 12/31/2018		
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	t 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		7, 729, 82	20	9, 148, 470 0	1. (2. (
00	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,				Ŭ	2. (
00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					3. (
	payment. If none, write "NONE" or enter a zero. (1)					
01	Program to Provider ADJUSTMENTS TO PROVIDER			0	0	3. (
02	ADJUSTWENTS TO FROVIDER			0	0	3.
03				0	0	3.
04				0	0	3.
05				0	0	3.
50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3
50 51	ADJUSTINIENTS TO PROGRAM			0	0	3
52				0	0	3
53				0	0	3
54				0	0	3.
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		7, 729, 82	20	9, 148, 470	4.
	appropriate) TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
01	Program to Provider TENTATIVE TO PROVIDER			0	0	5.
)2				0	0	5
)3				0	0	5
	Provider to Program			-		
50	TENTATI VE TO PROGRAM			0	0	5
51 52				0	0	5 5
99 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
D1	SETTLEMENT TO PROVIDER		49, 61	16	185, 560	6
02	SETTLEMENT TO PROGRAM			0	0	6
00	Total Medicare program liability (see instructions)		7, 779, 43		9, 334, 030	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
	Name of Contractor	C)	1.00	2.00	8.

IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	CN: 15-0104 CCN: 15-S104	Period: From 01/01/2018 To 12/31/2018		pared 3 pm
		Title	XVIII	Subprovider -	PPS	<u>o piii</u>
		Inpatien	t Part A		T B	
	-	mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
0.0		1.00	2.00	3.00	4.00	1.0
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, 342, 6	0	1, 347 0	1. C 2. C
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. C
01	ADJUSTMENTS TO PROVIDER			0	0	3. C
02				0	0	3. C
03				0	0	3. (
04				0	0	3. (
05			1	0	0	3. (
	Provider to Program		_			
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3.
52				0	0	3.
53				0	0	3.
54				0	0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3.
	3. 50-3. 98)					
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, 342, 6	81	1, 347	4.
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5.
	write "NONE" or enter a zero. (1)					
	Program to Provider			-	-	_
01	TENTATI VE TO PROVIDER			0	0	5.
)2				0	0	5.
03	Description to Description			0	0	5.
- 0	Provider to Program		1	0		-
50	TENTATI VE TO PROGRAM			0	0	5.
51 52				0	0	5. 5.
	Subtotal (sum of lines 5 01 5 40 minus sum of lines			0	0	
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			U	0	5.
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
01	SETTLEMENT TO PROVIDER		2,8	36	0	6.
02	SETTLEMENT TO PROGRAM		2,0	0	629	6.
00	Total Medicare program liability (see instructions)		2, 345, 5	17	718	7.
			2, 0, 0, 0	Contractor	NPR Date	7.
				Number	(Mo/Day/Yr)	
)	1.00	2.00	

VALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	CN: 15-0104 CCN: 15-5832	Period: From 01/01/201 To 12/31/201		nareo
					5/24/2019 2:03	3 pm
		IITIE	e XVIII	Skilled Nursin Facility	g PPS	
		I npati er	t Part A		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, 212, 5	62 0	798 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	Describer to Description			0	0	3.
50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3.
50 51	ADJUSTWIENTS TO FRUGRAW			0	0	3
52				0	0	3
53				0	0	3
54				0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3
	3. 50-3. 98)					
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, 212, 5	62	798	4
	TO BE COMPLETED BY CONTRACTOR			1	1	
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			
01	TENTATI VE TO PROVI DER			0	0	5
02				0	0	5
03				0	0	5
50	Provider to Program TENTATIVE TO PROGRAM		1	0	0	5
50 51	TENTATI VE TO PROGRAM			0	0	5
52				0	0	5
7 9	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		5, 5	93	0	6
02	SETTLEMENT TO PROGRAM			0	573	6
00	Total Medicare program liability (see instructions)		1, 218, 1		225	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
			C	1.00	2.00	

Heal th	Financial Systems WITHAM MEMORIAL	- HOSPI TAL	In Lie	u of Form CMS-	-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0104	Period: From 01/01/2018	Worksheet E-	1
			To 12/31/2018		
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				_
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	3-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	ine 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
	Balance due provider (line 8 (or line 10) minus line 30 and	ine 31) (see instruction	is)		32.00
					•

CALCULA	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part III Date/Time Pre 5/24/2019 2:03	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
	Net Federal PPS Payment (see instructions)			0	1.
1	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0000	2.
	Inpatient Rehabilitation LIP Payments (see instructions)			0	3.
	Outlier Payments			0	4.
. 00	Unweighted intern and resident FTE count in the most recent to November 15, 2004 (see instructions)	cost reporting period e	nding on or prior	0.00	5.
	Cap increases for the unweighted intern and resident FTE couprogram or hospital closure, that would not be counted with CFR $412.424(d)(1)(iii)(F)(1)$ or (2) (see instructions)			0.00	5.
	New Teaching program adjustment. (see instructions)			0.00	6.
	Current year's unweighted FTE count of I&R excluding FTEs in	n the new program growth	period of a "new	0.00	7.
	teaching program" (see instructions) Current year's unweighted I&R FTE count for residents within	n the new program growth	period of a "new	0.00	8.
	teaching program" (see instructions)				
. 00	Intern and resident count for IRF PPS medical education adju	ustment (see instructions))	0.00	9.
	Average Daily Census (see instructions)			14.975342	10
	Teaching Adjustment Factor (see instructions)			0.00000	11
	Teaching Adjustment (see instructions)			0	12
	Total PPS Payment (see instructions)			0	13
1	Nursing and Allied Health Managed Care payments (see instruc	ction)		0	14
	Organ acquisition (DO NOT USE THIS LINE)				15
1	Cost of physicians' services in a teaching hospital (see ins	structions)		0	16
1	Subtotal (see instructions)			0	17
	Primary payer payments			0	18
1	Subtotal (line 17 less line 18).			0	19
	Deductibles			0	20
	Subtotal (line 19 minus line 20)			0	21
	Coinsurance			0	22
	Subtotal (line 21 minus line 22)			0	23
	Allowable bad debts (exclude bad debts for professional serv	vices) (see instructions)		4, 452	
1	Adjusted reimbursable bad debts (see instructions)			2, 894	
1	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		0	26
1	Subtotal (sum of lines 23 and 25)	11 (0)		2, 894	
	Direct graduate medical education payments (from Wkst. E-4,	Tine 49)		0	28
1	Other pass through costs (see instructions)			0	29 30
	Outlier payments reconciliation OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	30
	Pioneer ACO demonstration payment adjustment (see instruction	one)		0	31
	Demonstration payment adjustment amount before sequestration			0	31
	Total amount payable to the provider (see instructions)	11		2, 894	
	Sequestration adjustment (see instructions)			58	
	Demonstration payment adjustment amount after sequestration			0	
	Interim payments			7, 729, 820	
	Tentative settlement (for contractor use only)			0	34
1	Balance due provider/program (line 32 minus lines 32.01, 32.	02 33 and 34)		-7, 726, 984	35
6. 00	Protested amounts (nonallowable cost report items) in accord §115.2		chapter 1,	0	36
	TO BE COMPLETED BY CONTRACTOR				
D. 00 🛛	Original outlier amount from Wkst. E-3, Pt. III, line 4			0	50
1.00	Outlier reconciliation adjustment amount (see instructions)			0	51
	The rate used to calculate the Time Value of Money			0.00	52
52.00					

	Financial Systems WITHAM MEMORIAL ATION OF RELIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0104	Peri od:	u of Form CMS-2 Worksheet E-3	
		Component CCN: 15-S104	From 01/01/2018 To 12/31/2018	Part II	pared
		Title XVIII	Subprovider -	PPS	s piii
				1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS				
00	Net Federal IPF PPS Payments (excluding outlier, ECT, and me	dical education payments)		2, 555, 467	1. (
00	Net IPF PPS Outlier Payments			13, 459	2.0
00	Net IPF PPS ECT Payments		- Course Noviemberg	0	3.0
00	Unweighted intern and resident FTE count in the most recent	cost report filed on or b	erore November	0.00	4.0
01	15, 2004. (see instructions) Cap increases for the unweighted intern and resident FTE cou	nt for residents that wer	e displaced by	0.00	4. (
01	program or hospital closure, that would not be counted witho			0.00	4.
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)				
00	New Teaching program adjustment. (see instructions)			0.00	5.0
00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	eriod of a "new	0.00	6.1
	teaching program" (see instuctions)				
00	Current year's unweighted I&R FTE count for residents within	the new program growth p	eriod of a "new	0.00	7.0
~~	teaching program" (see instuctions)			0.00	
00 00	Intern and resident count for IPF PPS medical education adju Average Daily Census (see instructions)	stment (see instructions)		0. 00 8. 583562	8. 9.
. 00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to	the nower of 5150 -1}		0.000000	
. 00	Teaching Adjustment (line 1 multiplied by line 10).	the power of . 5150 -1}.		0.000000	
00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			2, 568, 926	
00	Nursing and Allied Health Managed Care payment (see instruct			0	
. 00	Organ acquisition (DO NOT USE THIS LINE)			-	14.
. 00	Cost of physicians' services in a teaching hospital (see ins	tructions)		0	15.
. 00	Subtotal (see instructions)			2, 568, 926	16.
. 00	Primary payer payments			0	
. 00	Subtotal (line 16 less line 17).			2, 568, 926	
. 00	Deducti bl es			155, 344	
. 00	Subtotal (line 18 minus line 19)			2, 413, 582	
. 00 . 00	Coinsurance Subtotal (line 20 minus line 21)			23, 091 2, 390, 491	
. 00	Allowable bad debts (exclude bad debts for professional serv	ices) (see instructions)		4, 452	
. 00	Adjusted reimbursable bad debts (see instructions)			2, 894	
00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		2,0,1	
00	Subtotal (sum of lines 22 and 24)	,		2, 393, 385	
00	Direct graduate medical education payments (from Wkst. E-4,	line 49)		0	27.
00	Other pass through costs (see instructions)			0	-
. 00	Outlier payments reconciliation			0	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	、 、		0	
50	Pioneer ACO demonstration payment adjustment (see instruction			0	
99 00	Demonstration payment adjustment amount before sequestration Total amount payable to the provider (see instructions)			0 2, 393, 385	
01	Sequestration adjustment (see instructions)			2, 393, 383	
02	Demonstration payment adjustment amount after sequestration			47,000 0	
	Interim payments			2, 342, 681	
00	Tentative settlement (for contractor use only)			0	
00	Balance due provider/program (line 31 minus lines 31.01, 31.	02, 32 and 33)		2, 836	
. 00	Protested amounts (nonallowable cost report items) in accord	ance with CMS Pub. 15-2,	chapter 1,	0	35.0
	§115. 2				1
0.0	TO BE COMPLETED BY CONTRACTOR			10 1	50
	Original outlier amount from Worksheet E-3, Part II, line 2			13, 459	
	Outlier reconciliation adjustment amount (see instructions)			0 0. 00	
. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)				52. (53. (

	Financial Systems WI THAM MEMORIAL			u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104 Component CCN: 15-5832	Period: From 01/01/2018 To 12/31/2018		pared:
		Title XVIII	Skilled Nursing	5/24/2019 2:0 PPS	3 pm
		II tre xviii	Facility	PPS	
				1	
				1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTI	HER HEALTH SERVICES FOR T	ITLE XVIII PART A	PPS SNF	
	SERVICES				
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)			1, 419, 716	1.00
2.00	Routine service other pass through costs			0	2.00
3.00	Ancillary service other pass through costs			0	3.00
4.00	Subtotal (sum of lines 1 through 3) COMPUTATION OF NET COST OF COVERED SERVICES			1, 419, 716	4.00
5.00	Medical and other services (Do not use this line as vaccine	costs are included in lin	o 1 of W/S E		5.00
5.00	Part B. This line is now shaded.)		e i ui w/s e,		5.00
6.00	Deducti bl e			0	6.00
7.00	Coinsurance			182, 408	7.00
8.00	Allowable bad debts (see instructions)			8, 780	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see	instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	,		5, 707	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, 243, 015	12.00
13.00	Inpatient primary payer payments			0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instruction			0	14.50
14.99	Demonstration payment adjustment amount before sequestration			0	14.99
15.00	Subtotal (see instructions			1, 243, 015	
15.01	Sequestration adjustment (see instructions)			24, 860	
15.02	Demonstration payment adjustment amount after sequestration			0 1. 212. 562	15.0
16.00	Interim payments			1, 212, 562	16.00
	Tentative settlement (for contractor use only) Balance due provider/program (line 15 minus lines 15.01, 15.0	02 16 and 17		5, 593	
	Protested amounts (nonallowable cost report items) in accord.		2 chanter 1	5, 593	18.00
17.00	§115. 2	ance with GWS 17 FUD. 13-		0	17.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	OSPITAL Provider CCN: 15-0104	Peri od:	Worksheet E-3	2552-10
			From 01/01/2018 To 12/31/2018	Part VII Date/Time Pre	pared:
		Title XIX	Hospi tal	5/24/2019 2:0 Cost	3 pm
			Inpatient	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR X	I X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		278, 256		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		278, 256	0	
5.00	Inpatient primary payer payments		0	0	5.00
5.00	Outpatient primary payer payments		270 254	0	
7.00	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		278, 256	0	7.00
	Reasonable Charges				+
3. 00	Routi ne servi ce charges		732, 660		8.00
9.00	Ancillary service charges		733, 880	0	
10.00	Organ acquisition charges, net of revenue		0	-	10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		1, 466, 540	0	12.00
	CUSTOMARY CHARGES]
13.00	Amount actually collected from patients liable for payment for basis	services on a charge	0	0	13.00
14.00	Amounts that would have been realized from patients liable for		n 0	0	14.00
	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)	0,000000	0 00000	45 00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.00000	0.000000	
16.00 17.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	1, 466, 540 1, 188, 284	0	
17.00	line 4) (see instructions)	IT THE TO EXceeds	1, 100, 204	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds lin	e 0	0	18.00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	
20.00	Cost of physicians' services in a teaching hospital (see instru		0	0	
21.00	Cost of covered services (enter the lesser of line 4 or line 16		278, 256	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be c	ompleted for PPS provi		0	1 22 00
22.00 23.00	Other than outlier payments Outlier payments		0	0	
24.00	Program capital payments		0	0	23.00
25.00	Capital exception payments (see instructions)		0		24.00
26.00	Routine and Ancillary service other pass through costs		0	0	
27.00	Subtotal (sum of lines 22 through 26)		0	0	
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	
29.00	Titles V or XIX (sum of lines 21 and 27)		278, 256	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
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)		278, 256	0	
32.00	Deductibles		0	0	
33.00	Coinsurance		0	0	
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review	22)	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	278, 256	0	
37.00 38.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 36 ± line 37)		0 278, 256	0	
38.00 39.00	Direct graduate medical education payments (from Wkst. E-4)		270, 250	0	38.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		278, 256	0	
41.00	Interim payments		586, 485	0	
12.00	Balance due provider/program (line 40 minus line 41)		-308, 229	0	
13.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2.	000,227	0	
		· · · · -/	-	-	

ALANCE	inancial Systems WITHAM MEMORI SHEET (If you are nonproprietary and do not maintain be accounting records, complete the General Fund column	Provider C		Period: From 01/01/2018 To 12/31/2018	Worksheet G Date/Time Pre	pare
11 y)		General Fund	Specific Purpose Fund			3 pm
CI	URRENT ASSETS	1.00	2.00	3.00	4.00	
	Cash on hand in banks	30, 315, 517		0 0	0	1 1.
	emporary investments	11, 162, 657		0 0	0	2.
00 N	lotes recei vabl e	0		0 0	0	3.
00 A	accounts receivable	18, 140, 015		0 0	0	4.
)ther receivable	2, 093, 813		0 0	0	
	Allowances for uncollectible notes and accounts receivable	0		0 0	0	6
	nventory	3, 383, 251		0 0	0	
	Prepaid expenses Other current assets			0 0	0	8
	Due from other funds	1, 590, 837		0 0	0	10
	otal current assets (sum of lines 1-10)	66, 686, 090		0 0	0	
	I XED ASSETS	00,000,090		0 0	0	1 ' '
	and	0		0 0	0	12
	and improvements	15, 755, 407		0 0	0	13
	Accumulated depreciation	0		0 0	0	14
00 B	Buildings	29, 163, 673		0 0	0	15
00 A	Accumulated depreciation	0		0 0	0	16
	easehold improvements	0		0 0	0	17
	Accumulated depreciation	0		0 0	0	18
	ixed equipment	0		0 0	0	19
	Accumulated depreciation	0		0 0	0	20
	Automobiles and trucks	0		0 0	0	21
	Accumulated depreciation Najor movable equipment	149, 608, 340		0 0 0 0	0	22
	Accumulated depreciation	-80, 097, 717		0 0	0	23
	li nor equipment depreciable	-00,097,717		0 0	0	25
	Accumulated depreciation	0		0 0	0	26
	IIT designated Assets	o o		0 0	0	27
	Accumulated depreciation	0		0 0	0	
	li nor equi pment-nondepreci abl e	0		0 0	0	29
. 00 T	otal fixed assets (sum of lines 12-29)	114, 429, 703		0 0	0	30
	THER ASSETS					
	nvestments	0		0 0	0	31
	Deposits on Leases	0		0 0	0	32
	Due from owners/officers	21, 277, 961		0 0	0	33
	other assets (cum of lines 21,24)			0 0	0	34
	otal other assets (sum of lines 31-34)	21, 277, 961 202, 393, 754		0 0 0 0	0	35
	otal assets (sum of lines 11, 30, and 35) URRENT LIABILITIES	202, 393, 734			0	30
	Accounts payable	6, 408, 193		0 0	0	37
	Salaries, wages, and fees payable	9, 888, 404		0 0	0	38
	Payroll taxes payable	0		0 0	0	
	lotes and Loans payable (short term)	0		0 0	0	
	Deferred income	0		0 0	0	
. 00 A	accelerated payments	0				42
	Due to other funds	0		0 0	0	43
	Other current liabilities	5, 428, 880		0 0	0	
	otal current liabilities (sum of lines 37 thru 44)	21, 725, 477		0 0	0	45
	ONG TERM LIABILITIES				0	
	lortgage payable lotes payable	0			0	
	Insecured Loans				0	47
	Other long term liabilities	46, 381, 044		0 0	0	
	otal long term liabilities (sum of lines 46 thru 49)	46, 381, 044		0 0	0	
	otal liabilities (sum of lines 45 and 50)	68, 106, 521		0 0	0	
	APITAL ACCOUNTS			-, -,		
	General fund balance	134, 287, 233				52
	Specific purpose fund			0		53
	onor created - endowment fund balance - restricted			0		54
	Oonor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	121 207 222		0 0	0	59
	otal fund balances (sum of lines 52 thru 58) otal liabilities and fund balances (sum of lines 51 and	134, 287, 233 202, 393, 754		0 0	0	
		1 202,373,734	1	U U	0	1 00

Health Financial Systems	WI THAM MEMORI A	AL HOSPITAL		In Li	eu of Form CMS-2	2552-10
STATEMENT OF CHANGES IN FUND BALANCES		Provider CC		Period: From 01/01/2018 To 12/31/2018	B Date/Time Pre 5/24/2019 2:0	
	General	Fund	Speci al	Purpose Fund	Endowment Fund	
	1.00	0.00	0.00	1.00	5.00	
1.00 Fund balances at beginning of period	1.00	2.00 129,060,668	3.00	4.00	5.00	1.00
2.00 Net income (loss) (from Wkst. G-3, line 29)		5, 226, 565				2.00
3.00 Total (sum of line 1 and line 2) 4.00 Additions (credit adjustments) (specify)	0	134, 287, 233		0	0	3.00 4.00
5.00	0			0	0	5.00
6. 00 7. 00	0			0	0	6.00 7.00
8.00	0			0	0	8.00
9.00	0			0	0	9.00
10.00 Total additions (sum of line 4–9) 11.00 Subtotal (line 3 plus line 10)		0 134, 287, 233				10. 00 11. 00
12.00 Deductions (debit adjustments) (specify)	0	101,207,200		0	0	12.00
13.00 14.00	0			0	0	13.00 14.00
15. 00	0			0	0	14.00
16.00	0			0	0	16.00
17.00 18.00 Total deductions (sum of lines 12-17)	0	0		0	0	17.00 18.00
19.00 Fund balance at end of period per balance		134, 287, 233		(19.00
sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
1.00 Fund balances at beginning of period	6.00	7.00	8.00	0		1.00
2.00 Net income (loss) (from Wkst. G-3, line 29)				0		2.00
3.00 Total (sum of line 1 and line 2) 4.00 Additions (credit adjustments) (specify)	0	0		0		3.00 4.00
5.00		0				5.00
6.00		0				6.00
7.00 8.00		0				7.00 8.00
9.00		0				9.00
10.00 Total additions (sum of line 4–9) 11.00 Subtotal (line 3 plus line 10)	0			0		10. 00 11. 00
12.00 Deductions (debit adjustments) (specify)	0	0		0		12.00
13.00 14.00		0				13.00 14.00
15. 00		0				14.00 15.00
16.00		0				16.00
17.00 18.00 Total deductions (sum of lines 12-17)	o	0		0		17. 00 18. 00
19.00 Fund balance at end of period per balance	Ö			0		19.00
sheet (line 11 minus line 18)		I				

STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	N: 15-0104		iod: m 01/01/2018 12/31/2018	Worksheet G-2 Parts I & II Date/Time Pre 5/24/2019 2:0	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		16, 037, 6	58		16, 037, 658	1.00
2.00	SUBPROVIDER - IPF		3, 780, 1	53		3, 780, 153	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, 784, 7	82		2, 784, 782	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)		22, 602, 5	93		22, 602, 593	10.00
	Intensive Care Type Inpatient Hospital Services				· · · ·		1
11.00	INTENSIVE CARE UNIT		4, 588, 8	87		4, 588, 887	11.00
12.00	CORONARY CARE UNIT						12.00
13.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGICAL INTENSIVE CARE UNIT						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16. 00	Total intensive care type inpatient hospital services (sum of 11-15)	lines	4, 588, 8	87		4, 588, 887	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)		27, 191, 4	80		27, 191, 480	17.00
18.00	Ancillary services		58, 447, 8		250, 012, 803	308, 460, 633	
19.00	Outpatient services		8,041,8		31, 536, 303	39, 578, 122	
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		4, 5	15	3, 959, 151	3, 963, 666	23.00
24.00	СМНС						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, 3	37	55, 551, 757	55, 554, 094	27.00
27.01	PROFESSIONAL FEE		103, 1	73	2, 221, 869	2, 325, 042	
27.02	SELF INSURED		1, 237, 1	24	8, 229, 879	9, 467, 003	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	95, 028, 2	78	351, 511, 762	446, 540, 040	28.00
	G-3, line 1) PART II - OPERATING EXPENSES						
29.00	Operating expenses (per Wkst. A, column 3, line 200)				142, 966, 952		29.00
30.00	ADD (SPECIFY)			0	. 12, 700, 702		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)			Ŭ	0		36.00
37.00	DEDUCT (SPECIFY)			0	0		37.00
38.00				0			38.00
39.00				0			39.00
40.00				0			40.00
41.00				0			41.00
42.00	Total deductions (sum of lines 37-41)			Ŭ	0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer			142, 966, 952		43.00
.5.00	to Wkst. G-3, line 4)				172, 700, 732		-J. 00

Heal th	Financial Systems	WITHAM MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-0104	Peri od:	Worksheet G-3	
				From 01/01/2018 To 12/31/2018	Date/Time Pre	hared
				10 12/31/2010	5/24/2019 2:03	
	1				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part				446, 540, 040	1.00
2.00	Less contractual allowances and discounts on	patients' accoun	ts		301, 249, 006	2.00
3.00	Net patient revenues (line 1 minus line 2)				145, 291, 034	3.00
4.00	Less total operating expenses (from Wkst. G-		43)		142, 966, 952	4.00
5.00	Net income from service to patients (line 3	minus line 4)			2, 324, 082	5.00
(00	OTHER INCOME					(00
6.00	Contributions, donations, bequests, etc				0	6.00
7.00 8.00	Income from investments Revenues from telephone and other miscellane	ous communication	convi coc		0	7.00 8.00
8.00 9.00	Revenue from tel evision and radio service		Services		0	8.00 9.00
9.00 10.00	Purchase di scounts				0	9.00 10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13.00
14.00	Revenue from meals sold to employees and gue	sts			0	14.00
15.00	Revenue from rental of living guarters				0	15.00
16.00	Revenue from sale of medical and surgical su	pplies to other t	nan patients		o	16.00
17.00	Revenue from sale of drugs to other than pat				o	17.00
18.00	Revenue from sale of medical records and abs				0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms,	etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, a	nd canteen			0	20.00
21.00	Rental of vending machines				0	21.00
22.00	Rental of hospital space				0	22.00
23.00	Governmental appropriations				0	23.00
24.00	OTHER OPERATING INCOME				3, 126, 907	24.00
24.01	NONOPERATING INCOME				-224, 424	
25.00	Total other income (sum of lines 6-24)				2, 902, 483	
26.00	Total (line 5 plus line 25)				5, 226, 565	
27.00	OTHER EXPENSES (SPECIFY)				0	27.00
	Total other expenses (sum of line 27 and sub				0	28.00
29.00	Net income (or loss) for the period (line 26	minus line 28)			5, 226, 565	29.00

ealth Financial Systems ALCULATION OF CAPITAL PAYMENT	WITHAM MEMORIAL HOSPITAL In Lieu of Form CMS- Provider CCN: 15-0104 Period: Worksheet L	
	From 01/01/2018 Parts I-III To 12/31/2018 Date/Time Pre 5/24/2019 2:0	
	Title XVIII Hospital PPS	us piii
	1.00	
PART I - FULLY PROSPECTIVE METHOD		_
CAPITAL FEDERAL AMOUNT		
00 Capital DRG other than outlier	529, 368	
01 Model 4 BPCI Capital DRG other than outlier		
00 Capital DRG outlier payments	11, 934	
01 Model 4 BPCI Capital DRG outlier payments		
	rs in the cost reporting period (see instructions) 20.41	
00 Number of interns & residents (see instruction		
00 Indirect medical education percentage (see ins		
1.01) (see instructions)	Iy line 5 by the sum of lines 1 and 1.01, columns 1 and C	
30) (see instructions)	ledicare Part A patient days (Worksheet E, part A line 0.00	
00 Percentage of Medicaid patient days to total o		
00 Sum of lines 7 and 8	0.00	
.00 Allowable disproportionate share percentage (s	-	
. 00 Disproportionate share adjustment (see instruc		0 11.
.00 Total prospective capital payments (see instru	ructions) 541, 302	2 12.
	1.00	
PART II - PAYMENT UNDER REASONABLE COST	1.00	-
00 Program inpatient routine capital cost (see in	nstructions) C	J 1.
00 Program inpatient ancillary capital cost (see		
00 Total inpatient program capital cost (line 1)		
00 Capital cost payment factor (see instructions)	,	
00 Total inpatient program capital cost (line 3 x		5 4. 5 5.
		5 5.
	1.00	
PART III - COMPUTATION OF EXCEPTION PAYMENTS	·	
00 Program inpatient capital costs (see instructi 00 Program inpatient capital costs for extraordin		
00 Applicable exception percentage (see instructi 00 Capital cost for comparison to payments (line		
00 Percentage adjustment for extraordinary circur		
	for extraordinary circumstances (line 2 x line 6)	
00 Capital minimum payment level (line 5 plus lir		
00 Current year capital payments (from Part I, li		
		0 10. 0 11.
.00 Current year comparison of capital minimum pay .00 Carryover of accumulated capital minimum payme		
 00 Current year comparison of capital minimum payme 00 Carryover of accumulated capital minimum payme Worksheet L, Part III, line 14) 		1 12
 0.00 Current year comparison of capital minimum pays .00 Carryover of accumulated capital minimum payme Worksheet L, Part III, line 14) .00 Net comparison of capital minimum payment level 	rel to capital payments (line 10 plus line 11)	-
 0.00 Current year comparison of capital minimum payme Carryover of accumulated capital minimum payme Worksheet L, Part III, line 14) 0.00 Net comparison of capital minimum payment level 0.00 Current year exception payment (if line 12 is 	rel to capital payments (line 10 plus line 11) C s positive, enter the amount on this line) C	0 13.
 0.00 Current year comparison of capital minimum paymed Carryover of accumulated capital minimum paymed Worksheet L, Part III, line 14) 0.00 Net comparison of capital minimum payment level 0.00 Current year exception payment (if line 12 is concerned) 00 Carryover of accumulated capital minimum paymed 	rel to capital payments (line 10 plus line 11) C s positive, enter the amount on this line) C nent level over capital payment for the following period C	0 13.
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